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Seeking Insurance Parity During the Opioid Crisis

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INTRODUCTION

Kathryn Sexton was twenty-three years old, a lover of cats and the cello, with aspirations of becoming a nurse so she could care for her brother who has severe autism.[1] She lived in her family home in Muncie, Indiana until the day her mother found her unresponsive in bed. Katie had died of an overdose on Halloween, her favorite holiday.[2] Katie's cravings had been back, and she had called the pharmacy to get a prescription for buprenorphine.[3] It should have been easy—but her insurance had a waiting period, and she didn't get the medicine in time.[4]

Katie's tragic death was unnecessary, and reveals an unfortunate truth about private health insurance in the opioid epidemic. Too many privately insured face substantial barriers and delays to getting timely and affordable substance use disorder (SUD) care when they need it, sometimes with terrible and irreversible consequences.[5] Historically, private insurers have been reluctant to cover such services and have been glad to leave this responsibility to public systems like Medicaid.[6] Laws like the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act (ACA) were meant to make private insurance more generous, but these laws are underenforced and too weak to fully address the challenges of the opioid epidemic.[7] When patients and the country need

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[1] Yuki Noguchi, *Parents Lose Their Daughter and Their Life Savings to Opioids*, NPR (Apr. 19, 2018), https://www.npr.org/2018/04/19/603844597/parents-lose-their-daughter-and-their-life-savings-to-opioids [https://perma.cc/Q6LW-4BJT].

[2] *Id.*

[3] *Id*.

[4] *Id.*

[5] *See infra* Section II.B.

[6] *See* Sonja B. Starr, *Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment*, 111 YALE L.J. 2321, 2325 (2002).

[7] *See infra* Sections III.B and III.C.

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it most, private insurers are failing us is in both preventing and treating opioid addiction.

This Article considers why private insurers are contributing negatively to the opioid crisis and what we can do to hold them accountable in the future. Part I summarizes key provisions of the MHPAEA and the ACA, the two current laws that govern private insurers' coverage of SUD services. Part II examines the current state of private insurance in the midst of the opioid epidemic. It finds that insurers are underperforming. One, private insurers are not equaling Medicaid and other government programs in tackling the opioid epidemic. Two, private insurers continue to place harmful impediments and restrictions on SUD services compared with other medical care. Lastly, Part III considers ways to make private insurers carry their weight in the future including recognizing private insurance's role and responsibility in the opioid crisis, as well as state and federal legal reforms.

I. LAWS GOVERNING SUBSTANCE USE DISORDER COVERAGE BY PRIVATE INSURERS

Historically, health insurance coverage for SUD has been substandard relative to other medical benefits.[8] Some studies estimate that as few as 2 percent of people with addiction had insurance that adequately covered SUD before the implementation of the MHPAEA and the ACA.[9] Only 10 percent of health plans offered SUD benefits in parity with other types of services.[10] Between 1988 and 1998, employers decreased spending on SUD by approximately 60 percent and many plans over that time dramatically reduced the number of covered days of services.[11] In the individual market, insurance discrimination was rampant. In one study, 10 percent of insurance plans offered no coverage for SUD or mental health benefits; almost half the plans polled offered benefits for mental health but not for SUD.[12] If

[8] Emma Peterson & Susan Busch, *Achieving Mental Health and Substance Use Disorder Treatment Parity: A Quarter Century of Policy Making and Research*, 39 ANN. REV. PUB. HEALTH 421, 422 (2018).

[9] Starr, *supra* note 6, at 2323 (citing a statement by Representative Jim Ramstad in *Substance Abuse Treatment Parity: A Viable Solution to the Nation's Epidemic of Addiction?: Hearing Before the Subcomm. on Criminal Justice, Drug Policy, and Human Resources of the House Comm. on Government Reform*, 106th Cong. 27 (1999)).

[10] *Id.* (citation omitted).

[11] *Id.* at 2324. In employer sponsored insurance, as many 7% of people faced complete coverage bans. Richard G. Frank, et al., *Behavioral Health Parity and the Affordable Care Act,* 13 J. SOC. WORK DISABILITY REHAB. 31, 32 (2014).

[12] THE HENRY J. KAISER FAMILY FOUNDATION, HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH? 24 (2001), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-

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SUD services were covered, they were frequently subjected to prohibitively high cost-sharing, caps on coverage, or increased premiums.[13] Similar challenges existed with respect to mental health services.[14]

This inequality in the health care system increasingly came under scrutiny as public opinions about SUD evolved.[15] Medical studies consistently showed that mental health and substance use disorder were treatable with modern medical interventions.[16] While stigma against these conditions continues to this day, the public increasingly viewed SUD as deserving of and responsive to treatment.[17] Insurers contended that parity of SUD and mental health benefits would be prohibitively costly and would increase premiums for others, but studies showed minimal or no significant effect and, moreover, that greater parity would significantly help ease the financial burden for families with SUD.[18] These changes set the stage for the passage of the MHPAEA and for certain aspects of the ACA.

A. Mental Health Parity and Addiction Equity Act of 2008

The MHPAEA Act was passed in 2008 to alleviate inadequacies in the private health insurance market for SUD and mental health services.[19] Rather than mandate that certain SUD and mental health services be covered, the law instead sought to establish parity between these services and other medical and surgical benefits.[20]

Under the MHPAEA, group health insurers must not impose treatment or financial limits on SUD and mental health services unless these are in parity with surgical and medical benefits.[21] For treatment, there must be

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health-insurance-for-consumer-in-less-than-perfect-health-report.pdf. [https://perma.cc/57F8-34WX].

[13] For instance, copayments of 50% of the cost of services were common. Starr, *supra* note 6, at 2323 n.7; *see also* Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 566–74 (2014).

[14] The Mental Health Parity Act was passed in 1996 to address the parity issues for mental health services. A similar law to address the challenges of parity in SUD would not follow for twelve years. Peterson & Busch, *supra* note 8, at 422–23.

[15] *Id.* at 425.

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 (2008).

[20] *Id.*

[21] *Id.*

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parity with respect to the number of visits to an office or number of inpatient days covered.[22] For financial restrictions, SUD and mental health benefits cannot be subject to greater financial hurdles—like copays, deductibles, or other out-of-pocket expenses—than other benefits.[23] Implementing regulations also require parity in nonquantitative limits—for instance, whether there are prior authorizations that can delay access—and in care settings (if a medical service is available in an inpatient, outpatient, or home setting then similar services in similar settings must be made available for mental health and SUD).[24] The law allows for audits and financial penalties when noncompliance is discovered.[25]

One shortcoming of the MHPAEA was that it did not establish a mandate for insurers to cover SUD services.[26] Absent other laws, group plans were still free to exclude SUD and mental health services altogether.[27] Insurers sometimes responded to the MHPAEA by pushing SUD benefits out of network, which only increased the cost for consumers.[28] Another weakness was that the MHPAEA reached only group health insurers, so the individual insurance market—where discrimination was often most rampant—was left out.[29] The MHPAEA also exempted ERISA self-funded insurers, so if they chose to cover benefits, it did not need to be in parity with other types of benefits.[30] The ACA, passed two years later, substantially remedied some of these weaknesses.

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[22] For instance, inpatient hospitalization for SUD treatment could not have an annual limit of covered days without similar limits for other types of hospitalization. *Id.*

[23] For this reason, copays attached only to outpatient rehabilitation services for SUD are impermissible, though they are commonly seen. *Id.*

[24] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 26 C.F.R. § 54.9812 (2016); 29 C.F.R. § 2590.712 (2016); 45 C.F.R. §§ 146.136, 147.136, 147.160 (2016).

[25] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 (2008).

[26] Barnes & Worthy, *supra* note 13, at 567; Peterson & Busch, *supra* note 8, at 422.

[27] Indeed, greater regulatory restrictions, absent a mandate, might logically discourage some insurers from covering SUD at all. However, at least one study suggests that insurers generally did not drop coverage of SUD and mental health in response to the passage of the MHPAEA. Constance M. Horgan et al., *Health Plans' Early Response to Federal Parity Legislation for Mental Health and Addiction Services*, 67 PSYCHIATRY SERV. 162, 164 (2016).

[28] Emma E. McGinty et al., *Federal Parity Law Associated with Increased Probability of Using Out-Of-Network Substance Use Disorder Treatment Services*, 34 HEALTH AFF. 1331, 1331–32 (2015).

[29] Peterson & Busch, *supra* note 8, at 422–23.

[30] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 (2008).

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B. The Affordable Care Act of 2010

Although the ACA sought broader reforms to the health care system and insurance, it also made some important headway with respect to SUD and mental health services specifically. Expanding on the MHPAEA, the ACA requires that individual insurers also follow the parity law,[31] a provision that affects about eleven million people who purchase plans on the ACA exchanges.[32] The ACA forbids health-status-based discrimination in enrollment and renewal of plans, so insurers cannot avoid those individuals who may have SUD or mental health needs.[33] Community rating is imposed, meaning people with SUD or mental health disorders do not pay more for health care premiums than others do.[34]

Perhaps most importantly, the ACA mandates the coverage of "mental health and substance use disorder services including behavioral health treatment" as part of its essential health benefits requirement.[35] However, it does not go into specific detail on what those services include, so the matter is left to the states to choose their model state plans. Whatever model state plan is chosen, this becomes the minimum level of coverage for all plans being offered in that state on the exchange for that plan year. Coverage of preventive service is also mandated, including depression and alcohol abuse screening for adults[36] and alcohol, tobacco, and drug use screening for adolescents.[37] The ACA also expanded access to Medicaid, reducing rates of uninsurance amongst those with SUD.[38]

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[31] 42 U.S.C. § 18031(j) (2018) ("[The Parity Act] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.").

[32] Peterson & Busch, *supra* note 8, at 424.

[33] 42 U.S.C. §§ 300gg-1, -2 (2018).

[34] 42 U.S.C. § 300gg (2018).

[35] 42 U.S.C. § 18022(b)(1)(E) (2018). The EHB requirement also requires coverage of services in nine other areas: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric oral and vision care. *Id.* § 18022(b)(1).

[36] *Preventive Care Benefits for Adults*, HEALTHCARE.GOV, https://www.healthcare.gov/preventive-care-adults/ [https://perma.cc/8CBL-EGWQ].

[37] *Preventive Care Benefits for Children*, HEALTHCARE.GOV, https://www.healthcare.gov/preventive-care-children/ [https://perma.cc/CF3L-K6NH].

[38] Julia Zur & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, HENRY J. KAISER FAMILY FOUND. (Apr. 11, 2018), https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/ [https://perma.cc/3PRD-4JPA] (estimating that 17% of people with opioid addiction are uninsured).

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Overall, these two laws combine to greatly minimize discrimination in health insurance markets, including that which was based on substance use. Undeniably, the two laws have made improvements in the lives of people with SUD. However, as the next Part discusses, private insurance continues to lag behind Medicaid and fails to provide the level of SUD benefits needed to fully address the opioid epidemic.

II. PARITY PROBLEMS IN PRIVATE INSURANCE

The opioid epidemic is an important time to revisit the parity goals of the MHPAEA and the ACA. Health insurance holds an important role in tackling the opioid crisis, both in terms of preventing new cases of addiction and treating existing ones.[39] Private insurers are falling short in this crisis, underperforming compared to Medicaid, and failing the significant portion of people with SUD who rely on private insurance for their health needs.

A. Parity Between Private and Public Insurers

At the federal level, reforms to address the opioid crisis rarely consider health care financing at all and, when they do, they focus mainly on Medicaid with little or no attention paid to private insurers. Take the last two major federal laws passed to combat the opioid epidemic. The 2016 Comprehensive Addiction and Recovery Act completely ignored insurance altogether with one minor exception for some tweaks in the access to overdose therapies in the Veterans Health Administration system.[40] The 2018 Support for Patients and Communities Act offered no mention of private insurance but some reforms to Medicaid.[41] The law improves or guarantees Medicaid access for certain populations.[42] Medicaid must now cover medication-assisted treatment—including all FDA-approved drugs, counseling, and behavioral therapy—from October 2020 through September

[39] Valarie K. Blake, *Engaging Health Insurers in the War on Prescription Painkillers,* 11 HARV. L. & POL'Y REV. 485, 496–505 (2017).

[40] Comprehensive Addiction and Recovery Act, Pub. L. No. 114-198, 130 Stat. 695 (2016).

[41] Support for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

[42] For instance, the new law prohibits the terminating of Medicaid benefits for individuals younger than 21 or former foster care youth up to age 26 if incarcerated. The law also lifts a prior ban on Medicaid funds for SUD services for individuals living in "institutions for mental disease." *Id.* § 5012.

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2025, unless the state faces a provider shortage.[43] The law also dedicates funds to Medicaid treatments for SUD, offers a few broader efforts at reducing opioid prescribing, and allows for state experimentation of different programs to address opioid abuse.[44] The federal government also will now pay 90 percent of state costs for Medicaid home health services to coordinate care for people with SUD.[45]

Medicaid has other initiatives beyond these reforms as well. States are already required to cover some behavioral health as a condition of participation in Medicaid,[46] and many states, with federal financial support, optionally cover a host of other treatments including detoxification, inpatient and intensive outpatient treatment, psychotherapy, and peer support.[47] Recently, states have used 1,115 behavioral health waivers to be allowed to receive federal matching funds to provide special services like supportive housing and employment for those with SUD.[48]

Part of the focus on Medicaid may be because the government has an interest in reducing SUD. The cost savings for early treatment-and-prevention programs for addiction and mental illness are substantial.[49] A one-dollar investment in SUD prevention and early treatment leads to about seven dollars in other social benefits.[50] Private health insurers are not responsible for paying for these broader social costs and so they do not share these same incentives. Private insurers do, however, face some financial turmoil in this epidemic. Public and private insurers alike increasingly pick up the tab for the cost of the painkillers themselves.[51]

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[43] *Id*. § 1007. Prior to this law, most states covered at least one MAT medication but now states must cover all FDA approved ones. *See also* Zur & Tolbert, *supra* note 38.

[44] Title I sets forth new standards for Medicaid. *See* Support for Patients and Communities Act §§ 1001-1018.

[45] *Id.* at §1007.

[46] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, STATE POLICIES FOR BEHAVIORAL HEALTH SERVICES COVERED UNDER THE STATE PLAN (2016), https://www.macpac.gov/publication/behavioral-health-state-plan-services/. [https://perma.cc/NQM7-KVXD].

[47] *Id.*

[48] Zur & Tolbert, *supra* note 38.

[49] *See* S.L. Ettner et al., *Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"?*, 4 HEALTH SERV. RES. 192, 206 (2006).

[50] *Id.* at 192, 201, 206. In this study, $1,583 spent on SUD amounted to a societal benefit of $11,487 (or 7:1). "Sixty-five percent of the total benefit was attributable to reductions in crime costs, including incarceration. Twenty-nine percent was because of increased employment earnings, with the remaining 6 percent because of reduced medical and behavioral health care costs." *Id*. at 206.

[51] Spending on opioid medications has increased from $2.3 billion in 1999 to $7.4 billion in 2012 and insurers went from paying 42% of opioids in 1999 to 82% in 2012. At least some of this falls on private insurers. Chao Zhou et al., *Payments For Opioids Shifted*

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Moreover, opioid addiction is costly to treat and is certainly more expensive than preventing it.[52] Without regulation, however, insurers may be inclined to find cheap fixes that help their bottom line, rather than address broader public health goals.[53] For instance, insurers might seek to reduce new cases of addiction but may do little to help treat those who are already addicted.[54]

Although private insurance has received less attention than Medicaid in this epidemic, private insurance is equally important to the population with opioid addiction. Private insurance covers virtually the same amount of non-elderly adults with opioid addiction as Medicaid (37 percent vs. 38 percent),[55] yet Medicaid is clearly outperforming private insurance.[56] In a study of 2016 insurance plans by Kaiser Family Foundation, Medicaid participants were found to be almost twice as likely to receive inpatient treatment for SUD than those on private insurance[57] and three times as likely to receive outpatient care.[58] Shockingly, uninsured people were about as equally likely as those with private insurance to receive access to outpatient and inpatient SUD services.[59] Medicaid also shoulders the larger financial burden.[60] In 2014, government spending including Medicare, Medicaid block grants, and state and local funds accounted for 72 percent of the money spent on addiction treatment, while private insurance only paid 18 percent—and 9 percent of that came from out-of-pocket spending.[61]

Substantially to Public and Private Insurers While Consumer Spending Declined, 1999-2012, 35 HEALTH AFF. 824, 826–27 (2016).

[52] For instance, insurers may foot the bill for costly inpatient hospital stays associated with drug overdose. A Medicaid managed care insurer in Massachusetts estimates that a quarter of the inpatient hospital stays it reimburses each year are a result of substance abuse. *See* Deborah Becker, *Insurers Hire Social Workers to Tackle the Opioid Epidemic*, NPR (Jan. 25, 2016, 2:02 PM), http://www.npr.org/sections/health-shots/2016/01/25/463870922/insurers-hire-social-workers-to-tackle-the-opioid-epidemic [https://perma.cc/32UD-3TP9].

[53] *See* Blake, *supra* note 39, at 487.

[54] *Id.*

[55] The remaining 17% are uninsured and 8% are "other." Zur & Tolbert, *supra* note 38, at fig. 3.

[56] *Id.*

[57] Medicaid recipients received care 24% of the time compared to 13% for privately insured. *Id.* at fig. 4.

[58] 39% of Medicaid recipients received outpatient care compared to 17% of privately insured. *Id.*

[59] *Id.* Of course all of this data could suggest that the privately insured and uninsured simply seek services less than those with Medicaid—but this raises significant questions of why—whether it is because they have less need (which seems unlikely) or because of those other reason (limits on coverage, perceptions of inability to access care etc.).

[60] Zur & Tolbert, *supra* note 38.

[61] *Id.* at fig. 6.

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Medicaid spent 3 percent—roughly one billion dollars—more than private insurers even though private insurance and Medicaid cover a similar percentage of the population with SUD.[62]

Some may argue that Medicaid is more critical to addressing opioid addiction because, while private insurers and Medicaid cover equal portions of the community with SUD, Medicaid covers more low-income people.[63] Specifically, they cover 55 percent of those with SUD who live 200 percent or more below the federal poverty line.[64] However, Medicaid's importance does not suggest that private insurance is unimportant. The cost of the opioid crisis for those who are underinsured by private insurance is too great for the average American household. Recovery is expensive, even with insurance. Methadone treatment costs around $6,552 per year, including visits and appropriate psychosocial and medical support.[65] Buprenorphine in a certified outpatient therapy program costs about $5,980 per year.[66] Given these prices, many privately insured may find themselves reaching their deductible or even out-of-pocket limits each year or avoiding services if they cannot afford cost-sharing.

Katie Sexton's family is a testimony of the financial toll that falls on the privately insured. Katie's family has lost a daughter—an unfathomable tragedy for any family—but they have also lost their life savings.[67] Her parents had cashed out their pension to pay for rehabilitation services and, after Katie's death, there were funeral expenses, debt collectors calling about Katie's student loans and cellular phone bills, and more bills from the rehab center.[68] This is not to mention the health care premiums, copays, and deductibles which they paid[69] and which, across America, have consistently risen above the wage inflation index consuming the middle class's financial gains.[70]

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[62] *Id.* at figs. 2–5.

[63] *Id.*

[64] *Id.* at fig. 3.

[65] *How Much Does Opioid Treatment Cost?*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost [https://perma.cc/Y747-KQHU] (last updated June 2018).

[66] *Id.*

[67] Noguchi, *supra* note 1.

[68] *Id.*

[69] *Id.*

[70] *Premiums for Employer-Sponsored Family Health Coverage Rise 5% to Average $19,616; Single Premiums Rise 3% to $6,896*, HENRY J. KAISER FAMILY FOUND. (Oct. 3, 2018), https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/ [https://perma.cc/D34X-YT53]. Since 2008, annual deductibles for health plans have increased eight times as much as wages. *Id.*

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Insurers might argue that comprehensive SUD coverage in the midst of the opioid epidemic will only mean higher costs for consumers through higher premiums and higher taxes (that go towards subsidies).[71] But studies continue to demonstrate that coverage for SUD is not prohibitively expensive when spread across the insurance pool. One estimate is that inpatient and outpatient treatment for SUD raised premiums only $26 per year per person in 2016, up from $3 per person in 2004.[72] Opioid treatment is also no costlier relative to other conditions that insurers frequently cover without limitation. For instance, while MAT may cost around $6,000 per year, hospitalization for pneumonia clocks in at $9,793, congestive heart failure hospitalization costs $11,500 per stay, and an abdominal hernia hospitalization is $14,447.[73] And, of course, it is important to ask whether any premium hikes are necessary, or whether and by how much they are preserving the profits of the insurer.

B. Parity Between SUD and Other Health Care Services

A second parity issue persists post-ACA and -MHPAEA. Private insurers continue to seek carve-outs and exceptions to reduce or avoid covering SUD services despite the regulatory aims of making SUD and mental health be in parity with other benefits.

Several studies suggest that, despite the opioid crisis, insurers spend more on opioids than they do on other nonaddictive pain therapies, likely because opioids are comparatively cheaper.[74] One studied revealed that insurers are failing to cover or are placing hurdles in the way of nonaddictive treatments, for instance, by putting such treatments on higher cost-sharing tiers or requiring prior authorizations that complicate and delay

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[71] Barnes & Worthy, *supra* note 13, at 571.

[72] *A Look At How the Opioid Crisis Has Affected People With Employer Coverage*, PETERSON-KAISER HEALTH SYS. TRACKER, (Apr. 5, 2018), https://www.healthsystemtracker.org/brief/a-look-at-how-the-opioid-crisis-has-affected-people-with-employer-coverage/#item-start [https://perma.cc/94A9-VQUW].

[73] Mathew Michaels, *The 35 Most Expensive Reasons You Might Have to Visit a Hospital in the US—and How Much it Costs if You Do*, BUS. INSIDER (Mar. 1, 2018), https://www.businessinsider.com/most-expensive-health-conditions-hospital-costs-2018-2#2-heart-valve-disorders-34 [https://perma.cc/3J84-SJKL]. If you are curious, the costliest condition for hospitalization was congenital heart disease at $63,460 per stay. *Id.*

[74] *See, e.g.*, Dora H. Lin, et al., *Prescription Drug Coverage for Treatment of Low Back Pain Among US Medicaid, Medicare Advantage, and Commercial Insurers*, JAMA NETW. OPEN, June 2018, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2685625 [https://perma.cc/4EE3-4H6E].

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access to care.[75] In a study by Pro Publica and the New York Times, reporters found similar limitations on nonaddictive treatment in the private insurance-run Medicare Part D prescription drug plans.[76] The push to cover addictive over nonaddictive treatments can have significant impact on patients. For instance, one patient managed her two-year-long stabbing stomach pain well with a prescription for Butrans ($342 per month).[77] When her insurer, UnitedHealthcare, stopped covering the drug, the patient was left to take the long-acting morphine, which is much cheaper ($29 per month) but is also in a higher category of risk of abuse and dependence.[78] A young woman with a chronic pain problem that will continue long-term, she fears that she will inevitably grow addicted to the morphine and would much prefer a nonaddictive treatment.[79]

Insurers also continue to make access to rehabilitative and treatment services challenging. The Center on Addiction conducted a survey of 2017 insurance plans being offered on the ACA exchanges.[80] Thirty-three states had model insurance plans—the plans that states select to become the baseline for other plans' benefits—that required prior authorization for addiction treatment, despite the fact that the MHPAEA and ACA both sought to eliminate such SUD-only restrictions.[81] In particular, private insurers placed substantial hurdles in the way of buprenorphine.[82] Prior authorizations—as Katie Sexton's tragic death demonstrates—are harmful to patients because they delay access to care when the patient is ready and wanting to seek treatment. Another common tactic is fail-first policies where a patient has to "fail" non-evidence-based care before being able to access buprenorphine.[83] Some insurers cover buprenorphine but with such high costs that it is prohibitive for many patients[84] like Mandy, a twenty-

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[75] *Id.*

[76] Katie Thomas & Charles Ornstein, *Amid Opioid Crisis, Insurers Restrict Pricey, Less Addictive Painkillers*, N.Y. TIMES (Sept. 17, 2017), https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html [https://perma.cc/EKD9-3DSU].

[77] *Id.*

[78] *Id.*

[79] *Id*.

[80] NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, UNCOVERING COVERAGE GAPS: A REVIEW OF ADDICTION BENEFITS IN ACA PLANS (2016), http://www.centeronaddiction.org/download/file/fid/1678 [https://perma.cc/PK73-SLCM] [hereinafter UNCOVERING COVERAGE GAPS].

[81] *Id.* at 11.

[82] *See* Lin, *supra* note 74.

[83] *Id.*

[84] German Lopez, *There's a Highly Successful Treatment for Opioid Addiction. But Stigma is Holding it Back*, VOX (Nov. 15, 2017, 2:25 PM), https://www.vox.com/science-

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nine-year-old from Chicago who started using Vicodin in high school but is now in recovery.[85] Eight weeks out of an outpatient program, buprenorphine has done wonders for her cravings but costs her $300 a month.[86] She's constantly worried that she'll reach a point where she can no longer afford it.[87] Many states also have high daily cost-sharing for rehabilitation services, often as steep as $500–2,500.[88] This almost guarantees that a patient with SUD will either reach out-of-pocket maximums each year they seek treatment or will avoid seeking services.[89]

Another common strategy to limit SUD services is to restrict access to the providers who serve these populations. SUD providers continue to be paid substantially less than other types of medical and surgical providers.[90] And individuals with SUD often struggle with network adequacy problems.[91] Insurers push SUD services out of network, failing to cover enough providers, thus making it harder to access care and saving themselves money in the long run.[92]

As one researcher said of the model state plans,

> Predictably and regrettably, decisions on what coverage to offer are not informed by what research shows to be the amount and duration of treatment needed to help addicted people get on a path of recovery. A "minimum level of coverage" almost never translates into an effective level of service for what are often very complex and chronic disorders.[93]

III. ACHIEVING GREATER PARITY NOW

Private insurance is a critical component of tackling the opioid crisis. Progress will inevitably be slow and stunted if nearly 40 percent of the

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and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone [https://perma.cc/KS42-L7PS].

[85] *Id.*

[86] *Id.*

[87] *Id.*

[88] UNCOVERING COVERAGE GAPS, *supra* note 80, at 21.

[89] *Id.*

[90] *See* STEPHEN P. MALEK ET AL., ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: ANALYZING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT RATES, 2–5 (2017), http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf [https://perma.cc/A9BN-KN7D].

[91] *Id.*

[92] *Id.*

[93] UNCOVERING COVERAGE GAPS, *supra* note 80, at i.

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people struggling with SUD have inadequate access to appropriate treatment.[94] But the opioid epidemic is here and now. The public cannot afford to wait for health reform in 2020 and beyond or slow, incremental changes. Lives will be lost or radically harmed if we do not get private insurance to carry their fair share now. The next Section explores how to better hold private insurers accountable, including recognizing the importance of private insurance in this epidemic and addressing gaps in and underenforcement of the law.

A. Remembering the Goals of Parity

Critically, we need to first recognize that private insurance is at least as important as Medicaid in addressing the opioid crisis. It deserves greater regulatory scrutiny. Private insurers are finding ways to address the opioid crisis—but their aims may not accord with larger goals of public health.[95] For instance, instead of paying for more costly services that yield less likelihood of addiction, insurers continue to push cheaper and more addictive forms of pain treatment.[96] Insurers are closely monitoring their insureds for signs of opioid addiction so they can then limit access to opioids, but it is unclear if they are equally focused on channeling these people into treatment. Indeed, private insurers continue to place obstructions in the path of patients who need SUD treatment, sometimes with fatal consequences.[97]

It is noteworthy that the only two federal laws to address the opioid crisis were broad and sweeping but made no mention of private insurance. Even more so, when one notes that they made reforms to Medicaid, and still did not consider private insurance.[98] Regulators need to begin monitoring *how* private insurers are responding to this epidemic and to correct course as needed. While private insurance would require different fixes to its system than Medicaid, it could also benefit from the programs that the government is developing for Medicaid. For instance, it might be good to

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[94] *See supra* notes 55–59 and accompanying text.

[95] *See* Blake, *supra* note 39, at 487.

[96] James Heyward et al., *Coverage of Nonpharmacologic Treatments for Low Back Pain Among US Public and Private Insurers*, JAMA NETW. OPEN, Oct. 2018, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2705853 [https://perma.cc/6PQV-98CH].

[97] See Lin, *supra* note 74 (observing that insurers are placing hurdles in the path of non-addictive pain treatment, as frequently as they place hurdles in the path of addictive treatment); *see also* Blake, *supra* note 39, at 492–505 (showcasing a survey of ways that insurers limit access to both pain treatment and addiction treatment generally).

[98] *See supra* notes 37–41.

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find ways to incetivize private insurers to study how to achieve increased access to SUD and SUD providers. With private insurance covering almost 40 percent of the people who currently have an opioid addiction, we cannot afford to ignore that industry any longer.[99]

B. Addressing Underenforcement of the MHPAEA and ACA

When private insurance is scrutinized in the context of the opioid crisis, it is found to be underperforming. One significant reason is that private insurers are not living up to the standards of both the MHPAEA and the ACA.

In a study of insurance plans the year after the MHPAEA was passed, 90 percent of the plans complied with financial parity requirements.[100] However, 20–40 percent of the plans did not meet parity requirements for outpatient cost-sharing.[101] Twenty-eight percent of plans had prior authorization requirements inconsistent with the law.[102] A 2016 audit by the Mental Health and Substance Use Disorder Parity Task Force under President Obama found significant underenforcement of the MHPAEA.[103] The Task Force concluded that plans need much more guidance on disclosure requirements and other compliance issues with respect to the parity law.[104] Additionally, consumers were found to have a very low understanding of their rights under the law and to need greater outreach and education.[105] As evidence of this, while significant parity violations exist, government agencies have seen relatively few patient complaints.[106] The

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[99] *See* Zur & Tolbert, *supra* note 38.

[100] ERIC GOPLERUD, U.S. DEP'T OF HEALTH AND HUMAN SERVS., CONSISTENCY OF LARGE EMPLOYER AND GROUP HEALTH PLAN BENEFITS WITH REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 A-3 (2013), https://aspe.hhs.gov/system/files/pdf/117351/mhpaeAct_0.pdf [https://perma.cc/5C8A-5W5M].

[101] *Id.* at 23, tbl. 7.

[102] *Id.* at x.

[103] Cecilia Munoz & Thomas E. Perez, *Mental Health and Substance Use Disorder Parity Task Force, Our Report to the President on Mental Health and Substance Use Disorder Parity*, THE WHITE HOUSE: PRESIDENT BARACK OBAMA (Oct. 27, 2016, 12:21 PM), https://obamawhitehouse.archives.gov/blog/2016/10/27/our-report-president-mental-health-and-substance-use-disorder-parity [https://perma.cc/U55W-YYPZ].

[104] *Id.*

[105] *Id.*

[106] SARAH GOODELL, ROBERT WOOD JOHNSON FOUND., HEALTH POLICY BRIEF: ENFORCING MENTAL HEALTH PARITY 4 (2015), https://www.healthaffairs.org/do/10.1377/hpb20151109.624272/full/ [https://perma.cc/2RD5-9PVG].

Electronic copy available at: https://ssrn.com/abstract=3396117

Task Force responded by allocating nine million dollars to the states for enforcement efforts and websites dedicated to helping consumers identify and file complaints about parity.[107] Even after this, a more recent task force addressing the opioid crisis under the Trump Administration also found that the MHPAEA is insufficiently enforced.[108] Former New Jersey governor Chris Christie headed the task force and called for greater enforcement of the parity act again and observed that insurers are a necessary component of addressing the larger opioid crisis.[109]

There is also evidence of noncompliance by insurers regarding ACA requirements. In a 2017 review of ACA state model plans, two-thirds did not comply with ACA standards surrounding coverage for SUD benefits.[110] Eighteen percent contained clear violations of the parity law—as extended by the ACA—and another 31 percent contained possible violations.[111] Almost all the plans—88 percent—lacked sufficient plan documentation to demonstrate compliance with the ACA.[112]

While the ACA encounters a somewhat divided political climate, there is strong bipartisan support for remedying the opioid crisis.[113] The federal government, and the states where applicable need to undertake greater scrutiny of insurers to force compliance and to penalize and make examples of insurers falling short. Model state plans, in particular, should be scrutinized. Financial penalties are possible and regulators can also remove noncompliant plans from the exchange. This latter approach comes with substantial tradeoffs in states where there are too few insurers[114] but is certainly an important option in other locations.

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[107] Munoz & Perez*, supra* note 103.

[108] THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS 71 (2017) https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf [https://perma.cc/9685-28BU].

[109] *Id.*

[110] UNCOVERING COVERAGE GAPS, *supra* note 80, at 11.

[111] *Id.* at 14.

[112] *Id.* at 21.

[113] For instance, the 2016 Comprehensive Addiction and Recovery Act passed with a vote of 440-5 in the House and 94-1 in the Senate. 162 CONG. REC. S1404–S1416 (2016); 162 CONG. REC. H2355–H2374 (2016). In 2018, the Support for Patients and Communities Act passed in the House with a vote of 393-8 and in the Senate with a vote of 98-1. *See* Abby Vesoulis, *Opioid Bill Shows Congress Can Still Work Together*, TIME (Oct. 6, 2018), http://time.com/5416380/opioid-bill-congress/ [https://perma.cc/V5AA-PKVM].

[114] THE HENRY J. KAISER FAMILY FOUND., NUMBER OF ISSUERS PARTICIPATING IN THE INDIVIDUAL HEALTH INSURANCE MARKETPLACES: 2014–2019 (2019), https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-

Electronic copy available at: https://ssrn.com/abstract=3396117

C. *Opportunities to Improve Federal Law*

In addition to enforcement issues, there are significant gaps in existing law. Small group and individual insurers are subject to the Essential Health Benefit (EHB) requirement and so must cover SUD benefits.[115] But adequacy of those benefits greatly depends on the robustness of the model state plan.[116]

Perhaps the most worrisome gap is in the employer health plan market. About half of the population receives health insurance in this manner.[117] Employer plans—including self-funded ERISA plans—need not comply with the EHB mandate and thus are not required to cover SUD benefits.[118] Self-funded ERISA plans are also exempt from the MHPAEA and so, if they choose to cover benefits, the coverage need not be in parity with other types of benefits.[119] About 60 percent of employees have a self-funded plan.[120] Other employer plans must comply with the MHPAEA but are given a pass if the cost of compliance is greater than 1 percent.[121] Grandfathered plans, those that existed prior to the ACA and agreed not to

marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/9346-AAWL].

[115] KIRSTEN BERONIO ET AL., DEP'T OF HEALTH & HUMAN SERVS., AFFORDABLE CARE ACT EXPANDS MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND FEDERAL PARITY PROTECTIONS FOR 62 MILLION AMERICANS 2 (2013), https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans [https://perma.cc/NB87-LYMT].

[116] UNCOVERING COVERAGE GAPS, *supra* note 80, at 1.

[117] THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedDistributions=employer&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/7AJS-GQ7G].

[118] The EHB provision only applies to individual and small ground plans. 42 U.S.C. § 18022(b)(1) (2018).

[119] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 (2008).

[120] THE HENRY J. KAISER FAMILY FOUND., 2017 EMPLOYER HEALTH BENEFITS SURVEY, (Sept. 19, 2017), https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/ [https://perma.cc/2Z4Z-YGYT].

[121] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110–343, § 512, 122 Stat. 3765, 3881 (2008).

Electronic copy available at: https://ssrn.com/abstract=3396117

make certain changes, are also exempt from the EHB mandate.[122] About 17 percent of workers have a grandfathered plan.[123]

These gaps in the law expose people to underperforming insurance when they most need health care; take the health plan that covers states employees of West Virginia.[124] The state is known nationwide for startlingly high rates of opioid abuse and overdose,[125] which is also spilling over into increased rates of Hepatitis C and HIV.[126] All of this occurs in a state that already struggles economically.[127] The state health plan covers as many as hundreds of thousands of West Virginia state employees and their families.[128] Yet, its coverage for SUD is likely insufficient for many people. Inpatient treatment is limited to a maximum of thirty days per patient per plan year.[129] Precertification is required for inpatient treatment, and there is a one-hundred-dollar copay.[130] Outpatient treat is similarly limited, at a maximum of twenty visits per patient per year.[131] The plan states it is exempt from some benefit requirements because it is a self-funded ERISA plan.[132]

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[122] *FAQs About Grandfathered Health Plans*, SOC'Y FOR HUM. RESOURCE MGMT. (Aug. 26, 2013), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/faqs-grandfathered-plans.aspx [https://perma.cc/E3F2-VHH8].

[123] 2017 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 120.

[124] WEST VIRGINIA PUB. EMP. INS. AGENCY, SUMMARY PLAN DESCRIPTION PPB PLAN A, B, D, PLAN YEAR 2019, https://peia.wv.gov/Forms-Downloads/Documents/summary_plan_descriptions/Summary_Plan_DescriptionABD.pdf [https://perma.cc/C6V6-GDDH].

[125] NAT'L INST. ON DRUG ABUSE, WEST VIRGINIA OPIOID SUMMARY (2019), https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/west-virginia-opioid-summary [https://perma.cc/56KB-BK7A].

[126] WEST VIRGINIA HIV/AIDS SURVEILLANCE PROGRAM, WEST VIRGINIA HIV EPIDEMIOLOGIC PROFILE 51 (2017), https://dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/Documents/WV_HIV_Epi_Profile.pdf [https://perma.cc/D87S-35A2].

[127] West Virginia ranks 49th in the United States for per capita income. BUREAU OF ECONOMIC ANALYSIS, PER CAPITA PERSONAL INCOME 1 (Sept. 25, 2018), https://apps.bea.gov/regional/bearfacts/pdf.cfm?fips=54000&areatype=STATE&geotype=3 [https://perma.cc/PMJ3-QMA6].

[128] Sarah Liei, *A Look Inside What Happened with PEIA in West Virginia*, WCHS, (Feb. 21, 2018), https://wchstv.com/features/eyewitness-news-i-team-investigations/a-look-inside-what-happened-with-peia-in-west-virginia [https://perma.cc/UEW3-7W9E].

[129] WEST VIRGINIA PUB. EMP. INS. AGENCY, *supra* note 124, at 60.

[130] *Id.*

[131] *Id.*

[132] "Protections against having benefits for mental health and substance-use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan." *Id.* at ii. The plan also limits benefits on breast reconsutruction and hospital stays connected with labor and delivery. *Id.* at ii, 59–60, 65.

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These laws, particularly the ACA, are also being weakened dramatically by the Trump Administration.[133] Consumers may face modestly higher premiums after the Tax Cuts and Jobs Act eliminated the penalty associated with the individual mandate to purchase insurance.[134] Some subsidies to defray the expenses of insurance are also at stake.[135]

"Skimpy" plans are also being heavily pushed under the new administration. The Centers for Medicare and Medicaid Services (CMS) have allowed people to be covered by short-term, limited duration insurance plans for a year, even though the ACA allowed that coverage for only three months.[137] These plans are meant to be stopgaps for emergencies, such as job loss.[138] As such, they do not protect consumers to the same degree as other ACA plans: they need not offer essential health benefits, can impose annual and lifetime limits on coverage, and are free to discriminate based on health status and preexisting conditions.[139] The government is also making

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[133] Timothy S. Jost, *The Affordable Care Act Under the Trump Administration*, COMMONWEALTH FUND (Aug. 30, 2018), https://www.commonwealthfund.org/blog/2018/affordable-care-act-under-trump-administration [https://perma.cc/J8MT-GYMX] ("Some Trump administration actions have clearly undermined ACA initiatives.").

[134] The Commonwealth Fund estimates modest decreases in enrollment and increases in premiums associated with the loss of the penalty. The study estimates that enrollment could fall between 2.8 to 13 million people, with premiums in the bronze plans rising by about 13%. Prices and enrollment are somewhat contained by the fact that many individuals will still stay on the insurance exchanges because they are still eligible to receive subsidies that offset the price of purchasing insurance. Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, COMMONWEALTH FUND (July 11, 2018), https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors [https://perma.cc/5XKB-WE27]. However, many individuals may still stay on the insurance exchanges because they are still eligible to receive subsidies that offset the price of purchasing insurance. *Id.*

[135] The administration has refused to compensate insurers for cost-sharing subsidies, that ease financial strain for low-income consumers. While insurers have found a work around for now that pushes these cost back onto the federal government, ultimately this could mean higher premiums for consumers in the future if more long terms fixes are not had. Rabah Kamal et al., *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums*, HENRY J. KAISER FAMILY FOUND. (Oct. 27, 2017), https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/ [https://perma.cc/NNZ7-SGB6].

[137] 45 C.F.R. §144.103.

[138] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, HENRY J. KAISER FAMILY FOUND. (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/ [https://perma.cc/3BDR-H7PA].

[139] *Id.*

Electronic copy available at: https://ssrn.com/abstract=3396117

more people eligible for association health plans—plans that forbid health status discrimination but are not required to cover EHBs and can discriminate in premiums based on age and gender.[140]

Additionally, state model plans form the lowest common denominator for how thorough a plan's SUD coverage must be. The Trump Administration now permits states to choose model plans from across the fifty states (States previously used to have to pick from a plan in their own state).[141] This could allow for a race to the bottom with states picking the skimpiest and least protective model plans to be their baseline for benefits in their state. Lastly, current litigation by conservative states seeks to declare the entire ACA, or at least many of its core protections, unconstitutional.[142] Erosion of the ACA in this climate will only prove harmful for those individuals who need treatment for opioid addiction.[143] Lawmakers should better highlight the importance of the ACA for the opioid crisis and how ACA erosion will only amplify the current challenges.[144]

Federal legislation would be necessary to improve many of the gaps in these laws, especially to hold grandfathered plans and ERISA self-funded plans accountable for better benefits. Ideally, legislation would seek parity across all forms of insurance. That is, all insurance—large group, small group, and individual—would fall under the requirements of the ACA and the MHPAEA equally, regardless of grandfather and ERISA status. A simpler and clearer standard, it would likely improve public awareness and make compliance by regulators and insurers much easier.
Another possible federal reform is to require private insurers to have explicit parity with Medicaid. This is complicated by the fact that state Medicaid plans do vary, but all states have minimum standards and so private insurers could at least be expected to mirror those.[145]

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[140] *About Association Health Plans*, U.S. DEP'T OF LABOR, https://www.dol.gov/general/topic/association-health-plans [https://perma.cc/38GS-KFVV].

[141] Centers for Medicare & Medicaid Services Final Rule, 45 C.F.R. §§ 156.111 (2018).

[142] Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. Dec. 14, 2018), *appeal filed*, No. 19-10011, 2019 WL 1559340 (5th Cir. 2019) (holding that the individual mandate under 26 U.S.C. § 5000A(a) is unconstitutional and cannot be severed from remaining provisions of the ACA). The case is currently under appeal.

[143] Victoria Stanhope, *Scaling Back Obamacare Will Make the Opioid Crisis Worse*, CONVERSATION (Feb. 15, 2018, 6:36 AM), http://theconversation.com/scaling-back-obamacare-will-make-the-opioid-crisis-worse-89843 [https://perma.cc/L6SR-G5LB].

[144] At the most extreme, see the effect of a repeal and replace of the ACA on the opioid epidemic. Wishner, *supra* note 136.

[145] Julia Zur & Jennifer Tolbert, *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals*, HENRY J. KAISER FAMILY FOUND. (June 29, 2017),

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The federal government should also consider how to reward positive innovation in the private markets including increased access to nonaddictive pain therapies and addiction treatment. The 2018 Support for Patients and Communities Act allocates grants to ten states to plan SUD improvements for Medicaid and increases federal Medicaid matching funds to five states for dedicated SUD services.[146] Something similar could be done in the private insurance industry. Or private insurers that perform well on certain quality measures and outcomes could be rewarded, for instance, by receiving a portion of profits from insurers that are performing badly.[147] Lastly, politicians campaigning for 2020 might think hard about their healthcare platforms with respect to this dire issue. For instance, a Medicare-for-all or other 2020 health care proposal could be promoted for its ability to address the challenges raised in this Article, especially given the bipartisan support in remedying opioid addiction.[148]

D. A Role for States

In this political climate, some federal initiatives, particularly those related to the ACA, may be impossible to pass, as evidenced by Congress's inability to make either a sweeping repeal or a comprehensive reform to the law since its passage nearly a decade ago. Yet, while we await another election and, perhaps, more federal health reform, too many lives may be

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https://www.kff.org/report-section/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals-issue-brief/ [https://perma.cc/5HVV-AHYY] (discussing the mandatory benefits for SUD under Medicaid as well as state variations). For more on state-by-state innovation in SUD, see *1115 Substance Use Disorder Demonstrations*, MEDICAID.GOV, https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/1115-sud-demonstrations/index.html [https://perma.cc/F4UZ-LP6Q].

[146] Support for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

[147] This is similar to how the ACA attempts reinsurance across plans to disincentivize health status discrimination. For a general overview of these concepts, see Cynthia Cox et al., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridor*, HENRY J. KAISER FAMILY FOUND. (Aug. 17, 2016), https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/ [https://perma.cc/FR7F-ZKCH]. It also echoes movements, broadly, in Medicare to move away from volume and towards value. *See What are the value-based programs?*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html [https://perma.cc/AG88-J48W].

[148] Rex Santus, *Where the 2020 Democratic Hopefuls Stand on 2020 Medicare For All*, VICE NEWS (Feb. 14, 2019), https://news.vice.com/en_us/article/evepjm/where-the-2020-democratic-hopefuls-stand-on-medicare-for-all [https://perma.cc/KNU3-DPWG].

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lost or harmed by the failures of the private insurance industry to rise to the needs of the opioid epidemic.

State legislatures and leaders may be a more likely option in the immediate future to advance change. Notably, states have historically been the regulators of health care and other forms of insurance.[149] State law would have its limits; for instance, it may be unable to regulate the issues surrounding self-funded ERISA plans.[150] Barring these and some other constraints, states are free to regulate above and beyond the ACA and the MHPAEA or to solidify these protections at the state level to the extent they are under threat federally.

As one example, state legislatures are making efforts to adequately cover nonaddictive pain remedies. In 2018, Delaware passed a law requiring that there be no lifetime or annuals limits on nonaddictive treatments for back pain, like physical therapy.[151] An Illinois law passed in 2018 is the most comprehensive parity law at the state level; it forbids step therapy that delays access to nonaddictive treatments, among other things.[152]

State governments are also targeting limits on access to buprenorphine. In Pennsylvania, Governor Tom Wolf struck a deal with seven of the largest state private insurers to cease prior authorizations of medication-assisted therapy (MAT) for addiction.[153] The deal also requires insurers to make MAT medicines available at the lowest tier of cost-sharing.[154] This will get life-saving medicine into the hands of patients faster, when they need it. Such a fix could have possibly saved the life of Katie Sexton, and others

[149] A 1868 Supreme Court decision held that insurance was not governed by the Commerce clause. Paul v. Virginia, 75 U.S. 168 (1868). In 1945, the McCarran Ferguson Act was signed into law, clearly deferring insurance regulation to the states. 15 U.S.C. §§ 1011–1015.

[150] ERISA governs employer benefits and thus employee-sponsored health plans. State law in essence is free to regulate such plans if it deals with the regulation of insurance unless it creates new remedies, or in the case of self-funded plans. Ronald G. Dean & Lissa J. Paris, *ERISA Basics: Preemption*, AM. BAR ASS'N, https://apps.americanbar.org/labor/lel-aba-annual/papers/2000/paris.pdf [https://perma.cc/GD9Q-LZ4H].

[151] S.B. 225, 2017–2018 Leg., 149th Gen. Assembl. (Del. 2018).

[152] Kristen Thometz, *New Laws Boost Treatment of Opioid Abuse, Mental Health Access*, WTTW CHICAGO (Aug. 23, 2018, 3:20 PM), https://news.wttw.com/2018/08/23/new-laws-boost-treatment-opioid-abuse-mental-health-access [https://perma.cc/F5TC-RMGJ].

[153] Steven Ross Johnson, *Pennsylvania Health Insurers to End MAT Prior Authorizations*, MODERN HEALTHCARE (Oct. 12, 2018, 1:00 AM), https://www.modernhealthcare.com/article/20181012/NEWS/181019942 [https://perma.cc/B9D9-BAQW].

[154] *Id.*

Electronic copy available at: https://ssrn.com/abstract=3396117

like her, and could certainly help those who are struggling to pay the expenses of MAT therapy.

Lastly, there is a role for state attorneys general. States have gone after the makers of opioids for their contribution to the opioid crisis, with mixed results.[155] State attorneys general have also suggested a role in regulating insurers. In September 2017, thirty-seven state attorneys general wrote to America's Health Insurance Plans (AHIP)—a chief national lobbying group for insurance:

> As the chief legal officers of our States, we are charged with protecting consumers, including patients suffering from chronic pain and opioid addiction. Among other things, we are committed to protecting patients from unfair or deceptive business practices and ensuring that insurers provide consumers with transparent information about their products and services.[156]

They critiqued insurers for promoting cheap but addictive pain therapies over nonaddictive but costlier ones and observed that

> [a]ll else being equal, providers will often favor those treatment options that are most likely to be compensated, either by the government, an insurance provider, or a patient paying out-of-pocket. Insurance companies thus are in a position to make a very positive impact in the way that providers treat patients with chronic pain.[157]

This could signal greater regulation, monitoring and compliance, or even possible litigation in the future.

CONCLUSION

Private insurance covers almost 40 percent of people with opioid addiction. Yet, amid an epidemic with profound consequences for individual and public health, private insurers continue to fuel addiction by

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[155] Nicolas P. Terry, *The Opioid Litigation Unicorn*, 70 S.C. L. REV. 637, 639–44 (2019).

[156] Letter from National Assoc. of Attorneys General to Marilyn Tavenner, President and CEO, America's Health Insurance Plans, (Sept. 18, 2017), https://www.in.gov/bitterpill/files/Final%20NAAG%20Opioid%20Letter%20to%20AHIP%20(002).pdf [https://perma.cc/BAC3-DT53].

[157] *Id.*

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favoring addictive but affordable pain therapies over nonaddictive ones and by placing unreasonable, sometimes unlawful, hurdles and delays in the ways of addiction treatment. Action must be taken now to address these harms. Laws like the ACA and the MHPAEA need greater enforcement, while gaps in these laws can and should be addressed through broader federal and state initiatives. Private insurers must be regulated, and swiftly, to ensure that people with SUD and our nation stand a chance of recovering from this epidemic.

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