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THE OPIOID CRISIS: LESSONS FOR HEALTH REFORM

VALARIE K. BLAKE

INTRODUCTION

The opioid crisis has claimed the lives of over 450,000 Americans since it first took hold in the 1990s, with deaths increasing exponentially as the epidemic morphed from abuse of prescription drugs, to heroin, and finally to synthetic opioids like fentanyl.[1] The early days of the opioid crisis overlapped with a different health care crisis, one of health care access, which saw up to 18 percent of nonelderly Americans uninsured.[2] Those who had health insurance often found it to be of little help when confronting a substance use disorder (SUD), especially the many individuals who had private insurance, whether through an employer or some other means. Congressional testimony during the late 1990s described as few as 2 percent of people as having adequate coverage for their substance use disorder through their insurance.[3] Private insurance simply did not cover SUD treatments, denied access to those with SUD, or subjected SUD treatments to insurmountably high copays, deductibles, and strict limits on the number of covered days.[4] Several "parity" laws passed, aiming to make coverage equal between mental health and SUD services and other clinical ones, but none of these laws mandated that such care be covered and each had critical gaps regarding how insurers were governed.[5]

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1. *Understanding the Epidemic*, CDC, https://www.cdc.gov/drugoverdose/epidemic/index.html (last visited Mar. 27, 2021).

2. *Uninsured Rate Among the Nonelderly Population, 1972-2018*, KAISER FAM. FOUND. (Aug. 28, 2018), https://www.kff.org/uninsured/slide/uninsured-rate-among-the-nonelderly-population-1972-2018/.

3. Sonja B. Starr, *Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment*, 111 YALE L.J. 2321, 2323 (2002) (citing *Substance Abuse Treatment Parity: A Viable Solution to the Nation's Epidemic of Addiction?: Hearing Before the Subcomm. on Crim. Just., Drug Pol'y, and Hum. Res. of the H. Comm. on Gov't Reform*, 106th Cong. 27 (1999) (statement of Rep. Mica)).

4. Starr, *supra* note 3 at 2322-23.

5. President signed into law the 1996 Mental Health Parity Act which prohibited annual or lifetime caps on benefits beyond a specified threshold by group health plans of employers larger than 50 employees. The law expressly did not cover individuals with SUD, however. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944-46 (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)). The Paul Wellstone and Pete Domenici Mental Health Party and Addiction Equity Act (MHPAEA) of 2008 followed, requiring "parity" between clinical benefits and mental health and SUD benefits for group plans. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, in Emergency Economic Stabilization Act of

In 2010, the Patient Protection Affordable Care Act (ACA) was passed, the most significant national health reform since the passage of Medicare and Medicaid in 1965.[6] Uninsured rates rapidly shrunk,[7] owing to a combination of Medicaid expansion and consumer protections aimed at making private insurance more affordable and accessible, especially for those with preexisting conditions.[8] Though SUD access was not the particular focus of the ACA, the consumer protections put in place to help those with preexisting conditions would necessarily benefit those with opioid use disorder (OUD). Here, finally, was some cause for hope for the many who suffered from OUD that they may access treatments before it was too late.

Ten years post-ACA, while the opioid crisis continues to fester, the ACA has saved lives mainly through expanded access to Medicaid and the creative lengths Medicaid officials have undertaken to use Medicaid initiatives to meet the needs of the opioid crisis. The promises of the ACA to overhaul the private insurance market have born less fruit, with those with private insurance still facing significant cost and access barriers to SUD treatments, sometimes with fatal consequences.

This article explores the opioid crisis as an example of where the ACA has excelled and fallen short and what must be done in future efforts at health reform to ensure adequate access to care for people with OUD, as well as for all Americans. Part I explains the importance of the Medicaid expansion to the opioid epidemic. In the second half of Part I, the weak response of private insurance to the opioid epidemic is discussed, along with examples of where and why the ACA falls short in governing private insurance's discriminatory conduct. In Part II, the article proposes short-term and long-term health reforms that can address some of the ongoing challenges related to health care financing in the opioid crisis. It also suggests broader lessons we may learn from the story of the ACA and the opioid crisis to inform health reform in the future.

2008, Pub. L. No. 110-343, 122 Stat. 3765, 3881 (codified as amended at 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)) [hereinafter MHPAEA]. However, this law excluded self-funded employer plans and individual plans from its scope.

6. Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

7. Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND., (Nov. 6, 2020), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

8. For a useful summary of the ACA's various reforms, see THE IMPACTS OF THE AFFORDABLE CARE ACT ON PREPAREDNESS RESOURCES AND PROGRAMS: WORKSHOP SUMMARY, KEY FEATURES OF THE AFFORDABLE CARE ACT BY YEAR, https://www.ncbi.nlm.nih.gov/books/NBK241401/.

I. MEDICAID SHINES, PRIVATE INSURANCE LAGS IN ADDRESSING THE OPIOID CRISIS

The ACA was designed to improve access to health insurance, while also addressing affordability and adequacy of those benefits. It achieved this through expanding Medicaid and placing market reforms on private insurance. These reforms focused especially on small group and individual insurers which were historically the most discriminatory.

While no insurer has been perfect, Medicaid has far outpaced commercial insurers in addressing the needs of people with OUD and SUD. In 2017, the percentage of nonelderly adults with OUD who received their benefits from Medicaid (38%) was roughly equal to those with OUD who relied on private insurance (34%),[9] but Medicaid has taken the brunt of the responsibility in tackling the opioid crisis. This begs the question of why the ACA's consumer protections have not led to greater "parity" between Medicaid and private insurance and what can be done differently in the future to ensure adequate health care for people regardless of form of health insurance?

A. Medicaid Expansion and its Primary Role as Funder of OUD

Medicaid has carried a disproportionate burden in addressing the opioid crisis, even after the host of ACA reforms designed to make private insurance more consumer protective. Medicaid covers a large portion of people with OUD who are below the age of 65 (38%).[10] As the primary source of health care for low-income people, people with disabilities, and some elderly, Medicaid is a critical program for our most vulnerable populations who may be experiencing OUD.[11] The Medicaid expansion also played an important role in lowering uninsured rates for those with an income of 138% of the Federal Poverty Level (FPL) or lower.[12] A recent

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9. Kandal Orgera & Jennifer Tolbert, , *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, KAISER FAM. FOUND., at 3 (May 24, 2019), https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/ [hereinafter, KFF Medicaid's Role].

10. *Id.* A remaining 34% of nonelderly adults are on private insurance, 9% of them have another form of insurance, and 20% are uninsured.

11. Among nonelderly adults with OUD who are low-income, over half (55%) are covered by Medicaid. *Id.*

12. For a summary of the ways the ACA reduced uninsured rates, see Laura Skopec, John Holahan, & Caroline Elmendorf, *Changes in Health Insurance Coverage 2013–2016: Medicaid Expansion States Lead the Way*, ROBERT WOOD JOHNSON FOUND. & URB. INST.3, 10 (2018), https://www.urban.org/sites/default/files/publication/98989/changes_in_health_insurance_coverage_2013-2016_medicaid_expansion_states_lead_the_way_1.pdf. Particularly, the researchers note at page nineteen that uninsured rates from 2013-2016

study projects the Medicaid expansion may have saved 8,132 people from a fatal opioid overdose.[13]

Medicaid outpaces other forms of insurance in providing access to treatment for people with OUD. Those with Medicaid are over twice as likely to receive drug or alcohol treatment than those with private insurance.[14] One reason for this better performance is that Medicaid more expansively covers treatments for addiction. All Medicaid programs in every state now cover multiple drugs used in medication-assisted-treatment -- a gold standard for opioid care that combines medications with counseling and behavioral therapies; most states cover all three types of treatment.[15] Medicaid also tends to cover more forms of addiction treatment than other insurers, among them, inpatient vs. outpatient detoxification or rehabilitations, though the specifics of coverage vary by state.[16] The variety of benefits means there is no need for a one-size-fits-all approach to addiction recovery. Medicaid services also are available

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dropped lower overall in expansion states vs states that did not expand Medicaid. *Id.* at 3, 19 (15.3% to 7.6% in expansion states vs. 19.8% to 13.7% in non-expansion states). The Supreme Court was later to rule that an individual mandate of the Affordable Care Act imposing minimum essential coverage on states was unconstitutional, rendering the expansion of Medicaid optional for states. *See* NFIB v. Sebelius, 567 U.S. 519 (2012). Currently, 39 states including the District of Columbia have chosen to expand Medicaid. *See Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 22, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. There remains some important holdouts in large-population states like Florida, Georgia, and Texas. *Id.* at 7.

13. Nicole Kravitz-Wirtz et al., *Association of Medicaid Expansion with Opioid Overdose Mortality in the United States*, JAMA Network Open, at 7 (Jan. 10, 2020).

14. KFF's Medicaid Role, *supra* note 9, at 4.

15. *Id.* at 5 (most states cover buprenorphine, naltrexone, and methadone). *See also*, *Medicaid's Role in Addressing the Opioid Epidemic Infographic,* KAISER FAM. FOUND. (June 3, 2019), https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/ [hereinafter Medicaid and the Opioid Epidemic].

16. *See also* Medicaid and the Opioid Epidemic, *supra* note 15; *Medicaid Behavioral Health Services: Inpatient Detoxification*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-inpatient-detoxification/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 11, 2021) (43 states cover inpatient detoxification); *Medicaid Behavioral Health Services: Intensive Outpatient Treatment for Substance Use Disorder*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-intensive-outpatient-treatment-for-substance-use-disorder/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 11, 2021) (38 states cover intensive outpatient); *Medicaid Behavioral Health Services: Residential Rehabilitation*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-residential-rehabilitation/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22, %22sort%22:%22asc%22%7D (last visited Apr. 11, 2021) (33 states cover residential rehabilitation, and 31 states cover outpatient detoxication).

with little or no out of pocket cost to the patient, meaning there is no financial hurdles to access.

One of the more innovative ways that state Medicaid programs have tackled the opioid crisis is through 1115 waivers, which allow states to tailor their Medicaid benefits to address the unique needs of people with OUD in the state. Massachusetts used a 1115 waiver to more broadly cover outpatient, residential inpatient, and community services for SUD, with a combination of federal and state funds.[17] Virginia relied on a 1115 waiver to increase access to care and ensure that treatments paid for by Medicaid followed quality standards of the American Society of Addiction Medicine.[18] West Virginia relied on a waiver to increase access to methadone, to enhance access to peer recovery, withdrawal management, and residential treatments and to enforce quality standards in its addiction services.[19]

A drawback of Medicaid, however, is that the level of generosity of benefits has varied by the state. [20] Federal law establishes the baseline of benefits for Medicaid recipients and states may elect to go above those benefits, with matching federal financial support, in some cases, where a waiver is used or where a law permits. States may vary in their willingness to tackle the opioid crisis based on the severity of need in the state, the state budget, and the other factors involved.[21] In many states, the opioid crisis has taxed other state programs like unemployment, child welfare, and policing, providing states with extra incentive to keep the crisis under control in their borders.[22]

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17. *MassHealth Medicaid Section 1115 Demonstrations*, DEP'T HEALTH AND HUM. SERVS. CTR. MEDICARE AND MEDICAID SERVS., https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82006 (last visited, Apr. 12, 2021).

18. *Innovative Practices from Section 1115 Demonstrations Substance Use Disorder States: Virginia,* MEDICAID INNOVATION ACCELERATOR PROGRAM, https://www.medicaid.gov/sites/default/files/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/1115-sud-brief-va.pdf (last visited Feb. 28, 2021).

19. Letter from Calder Lynch, Acting Deputy Adm'r & Dir., Dep't of Health & Hum. Servs. Ctr. Medicare & Medicaid Servs., to Cynthia Beane, Comm'r, W. Va. Dep't Health & Hum. Servs. (Sep. 30, 2019), available at https://www.medicaid.gov/sites/default/files/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-enrollees-substance-ca.pdf (last visited Feb. 28, 2021).

20. For examples of variation in state approaches, *see* Julie Donohue et al., *Opioid Use Disorder Among Medicaid Enrollees: Snapshot of the Epidemic and State Responses,* KAISER FAM. FOUND. (Nov. 15, 2019), https://www.kff.org/report-section/opioid-use-disorder-among-medicaid-enrollees-snapshot-of-the-epidemic-and-state-responses-issue-brief/.

21. For a summary of six states overall Medicaid response to the opioid crisis, *see id.*

22. For a study of costs related to the opioid crisis, *see generally* Curtis Florence et al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the*

B. ACA Private Insurance Reforms Fall Short

Private insurance plays an equally important role in financing SUD care; it covers 34 percent of non-elderly adults with OUD, which is nearly the same percentage of non-elderly adults covered by Medicaid.[23] Yet, only half as many privately insured individuals received treatment for OUD as Medicaid participants in 2017.[24] In fact, people without insurance received care at almost the same rates as the privately insured.[25] While Medicaid spent relatively close to the vicinity of private insurance in 2016, studies project that Medicaid will pick up a larger tab by 2020 and private insurance spending will remain constant.[26]

Given the historic nature of discrimination by private insurers against people with SUD, it is unsurprising that private insurers have been slower and more reluctant than Medicaid to fully address the costs of the opioid crisis. Still, the parity laws and ACA's consumer protections were designed to limit discriminatory insurance practices, and yet, people with OUD on private insurance continue to suffer from poorer access to treatment for their addictions than those on Medicaid.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 required group insurers to cover SUD and mentalhealth services in parity with other clinical services.[27] The Affordable Care Act extended the MHPAEA to the individual insurance market.

The ACA also made the small group and individual markets more affordable and accessible by creating a marketplace for consumers to compare benefits,[28] by mandating that individuals purchase insurance or pay a penalty,[29] by requiring insurers not to discriminate on the basis of

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United States, 2013, 54 MED. CARE 901 (2016). For general state costs of SUD, *see* U.S. DEP'T HEALTH & HUM. SERVS. SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, SUBSTANCE ABUSE PREVENTION DOLLARS AND CENTS: A COST-BENEFIT ANALYSIS 6-9 (2008), https://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf.

23. KFF Medicaid's Role, *supra* note 9 at 3.

24. In the total of people to receive treatment for OUD in 2017, 54% were Medicaid participants while only 26% were privately insured. *Id.* at 4.

25. Of people receiving care for OUD, 26% were privately insured, while 20% were uninsured. *Id.*

26. Id. at 6. Studies project Medicaid will pay 28% of the costs for OUD treatment compared to private insurance's 22% beginning in 2020. *Id.*

27. MHPAEA, Pub. L. No. 110-343, 122 Stat. 3765, 3881.

28. For the primary marketplace, *see generally* DEP'T OF HEALTH & HUM. SERVS., https://www.healthcare.gov (last visited Mar. 5, 2021).

29. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat 119 (2010).

pre-existing conditions,[30] and by offering subsidies for copays and premiums to lower-income individuals.[31]

The ACA attempted to eliminate benefit discrimination on the private insurance side by requiring small group and individual insurers to offer "essential health benefits," a package of ten different categories of health services, including mental health and SUD services.[32] Department of Health and Human Services (HHS) provides some guidance through rule-making on what specific benefits must be covered; however, the matter is generally left to the states. States select a "benchmark" plan, typically a private plan from a large employer in the state, and all other insurance plans must be at or above the same level of coverage.[33]

Nevertheless, these laws have failed to achieve parity between Medicaid and private insurance due to a number of weaknesses in the black letter law.[34] One significant weakness being that the MPHAE exempts from its requirements ERISA self-funded employer plans, which about 60 percent of employees have.[35] The ACA's EHB requirements also don't help this group, as the provision only applies to small group and individual insurance. The ACA also exempts from many of its requirements grandfathered-in plans, which amount to 17 percent of plans.[36] For those insurers that must follow the EHB requirements, the state benchmark model means that plans vary greatly in how adequate coverage is.

Private insurers frequently fail to cover medication-assisted OUD treatment or impose prior authorizations, which may slow or stop patient

30. Insurers are not permitted to deny coverage based on health status, medical condition (both physical and mental), claims experience (the number of claims per patient), receipt of health care, medical history, genetic information, evidence of insurability (including domestic abuse), disability, and other health related factors as defined by the Secretary of Health and Human Services. 42 U.S.C. § 300gg-4 (2020). Insurance must be guarantee issue and guarantee renewable. 42 U.S.C. § 300gg-1 (2020); 42 U.S.C. § 300gg-2 (2020).

31. 26 U.S.C. § 36B (2020). For a summary of the overall impact of the ACA on insurance rates post-ACA and through the Trump era, *see* Sara R. Collins et al., *Health Insurance Coverage Eight Years After the ACA*, COMMONWEALTH FUND (Feb. 7, 2019), https://doi.org/10.26099/penv-q932.

32. 42 U.S.C. § 18022(b) (2020).

33. For the basics on state benchmark plans, *see Information on Essential Health Benefits Benchmark Plans*, U.S. CTR. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb (last visited Sept. 14, 2021).

34. For a summary of the weaknesses of the MHPAEA and the ACA with respect to the opioid crisis, *see* Valarie K. Blake, *Seeking Insurance Parity During the Opioid Epidemic*, 2019 UTAH L. REV. 811 (2019).

35. *2017 Employer Health Benefits Survey*, KAISER FAM. FOUND. (Sept. 19, 2017), https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/.

36. *Id.*

access.[37] Private insurers have also been reluctant to pay for opioid-alternatives, like physical therapy, because those treatments are often more costly in the short-term than opioids.[38] In the era of high-deductible plans, consumers frequently find that they pay large amounts out of pocket before their insurance kicks in, *if* it kicks in.[39] This has served to increase medical expenses for people and sometimes acted as a barrier to them accessing needed care altogether, with potentially deadly consequences.[40]

Even where the black letters laws may be adequate, compliance with those laws and enforcement has been lacking. President Obama and President Trump both formed task forces to examine compliance by insurers with parity laws and both task forces agreed that the parity laws have been under-enforced and under-complied with.[41] A 2017 study on benchmark state insurance plans post-ACA found that two-thirds of

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37. AMA & MANATT HEALTH, NATIONAL ROADMAP ON STATE LEVEL EFFORTS TO END THE NATION'S DRUG OVERDOSE EPIDEMIC 34 (Dec. 2020), https://www.ama-assn.org/system/files/2020-12/ama-manatt-health-2020-national-roadmap.pdf. For example, the California Health Care Foundation reports that "The California Society of Addiction Medicine (CSAM) recommends removing authorization requirements for buprenorphine, for initial treatment and for ongoing therapy, since insurance paperwork is cited as a major cause of treatment delay for patients, and a barrier for physicians thinking about integrating addiction treatment into their practice." CAL. HEALTH CARE FOUND., CHANGING COURSE: THE ROLE OF HEALTH PLANS IN CURBING THE OPIOID EPIDEMIC 18 (June 2016), https://www.chcf.org/wp-content/uploads/2017/12/PDF-ChangingHealthPlansOpioid.pdf. The Foundation also interviewed April Rovero, founder and executive director of the National Coalition Against Prescription Drug Abuse on the topic of preauthorization and she stated, "I've spoken with hundreds of parents across the US who have lost children to the epidemic... and too many tell a version of the same story: long, frustrating hours fighting with an insurance company to get treatment." *Id.* at 17.

38. Dora H. Lin et al., *Prescription Drug Coverage for Treatment of Low Back Pain Among US Medicaid, Medicare Advantage, and Commercial Insurers*, JAMA NETWORK OPEN (June 22, 2018), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2685625.

39. U.S. DEP'T OF HEALTH AND HUM. SERVS. ASSISTANT SEC'Y FOR PLAN. AND EVALUATION OFF. OF DISABILITY, AGING AND LONG-TERM CARE POL'Y, USE OF MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDERS IN EMPLOYER-SPONSORED HEALTH INSURANCE: OUT-OF-POCKET COSTS, at xi (Feb. 2019), https://aspe.hhs.gov/system/files/pdf/260631/MATOOP.pdf (exploring increasing high deductibles, copay, and out of pocket costs for SUD treatment).

40. For one example, see a story of a young woman who died of an overdose while waiting for a preapproval on a medication. Yuki Noguchi, *Parents Lose Their Daughter and Their Life Savings to Opioids*, NPR (Apr. 19, 2018 5:00AM), https://www.npr.org/2018/04/19/603844597/parents-lose-their-daughterand-their-life-savings-to-opioids.

41. Cecilia Muñoz & Thomas E. Perez, *Our Report to the President on Mental Health and Substance Use Disorder Parity*, THE WHITE HOUSE (Oct. 27, 2016 12:21PM), https://obamawhitehouse.archives.gov/blog/2016/10/27/our-report-president-mental-health-and-substance-use-disorder-parity; CHRIS CHRISTIE ET AL., THE PRESIDENT'S COMM'N ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS 71 (Nov. 1, 2017), https://atforum.com/wp-content/uploads/Download-PDF-1.pdf.

benchmark state plans did not comply with ACA requirements regarding SUD coverage, 18 percent held clear violations of parity laws, and another 31 percent had possible violations.[42] Another, more recent study of state benchmark plans, conducted by Professor Stacey Tovino, also found shortcomings in coverage for OUD services in state benchmark plans, with "prior authorization and prior certification [being] the most common substance use disorder coverage limitations or hurdles that an individual with substance use disorder must clear."[43] Worrisomely, although ACA regulations require states to cover an opioid reversal agent, 20 out of 51 state benchmark plans did not require one.[44]

Ultimately, even with expansive laws in place, private insurers lack the same incentive structure as Medicaid to address the wider effects of the opioid crisis. State officials determining Medicaid budgets view the expenses in light of offsets to other costs to their state driven by the epidemic. Private insurers have no such similar incentive and can avoid these costs largely by pushing them onto consumers through hiked premiums or high cost-sharing.[45] Additionally, private insurers rarely consider the long-term health impact on their enrollees, as people switch private insurance frequently or may become eligible for a government program.

State legislatures have had to step in and fill in federal regulatory gaps through a variety of state legislation but the effect has been patchwork. Some states have enacted their own versions of parity laws to capture insurers that are not covered under federal laws.[46] Additionally, these laws frequently call for greater enforcement by state regulators of both federal and state parity laws.[47] State legislatures have also attempted to improve access to treatments through various legislation that targets prior authorizations, but there is no similar federal mandate for insurers to do

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42. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, UNCOVERING COVERAGE GAPS: A REVIEW OF ADDICTION BENEFITS IN ACA PLANS 11-14 (2016), https://drugfree.org/reports/uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans/.

43. Stacey A. Tovino, *Substance Use Disorder Insurance Benefits: A Survey of State Benchmark Plans*, 52 CREIGHTON L. REV. 401, 408 (2019).

44. *Id.* at 409. Still another example, Texas imposed low lifetime and annual caps on benefits ($10,000 and $5,000) for Substance Use Disorder services that were not present on other clinical services. *Id.* at 410.

45. *See* U.S. DEP'T OF HEALTH AND HUM. SERVS. ASSISTANT SEC'Y FOR PLAN. & EVALUATION OFF. OF DISABILITY, AGING AND LONG-TERM CARE POL'Y, *supra* note 39, at xi.

46. AMA & MANATT HEALTH, *supra* note 37, at 25.

47. For example, both Indiana and Oklahoma have recently passed laws requiring greater reporting of benefits coverage by insurers to state officials so state officials can better account for whether insurers are complying with parity requirements. *Id.* at 26.

so.[48] Some state laws particularly have been designed to address the problems with access to SUD care that have worsened in light of the COVID-19 pandemic.[49]

II. LESSONS OF THE OPIOID CRISIS FOR HEALTH REFORM

The lack of parity between Medicaid and private insurers in response to the opioid crisis reveals a gap in access to healthcare for some that needs to be addressed in the short term. But it also suggests valuable insights into how private and public insurance health reform should be accomplished in the longer term.

A. Short Term: Addressing Unequal Access to Treatment for People with OUD

The challenges of access and coverage for people with OUD who are covered by private insurance are many. Two modest federal efforts could be immediately impactful to improve access and are likely achievable under the current makeup of Congress where Democrats lack a veto-proof majority in the Senate.

1. Medicaid Expansion in Holdout States

Medicaid has proven more effective and willing in addressing the needs of people with OUD. One clear pathway to progress would be to expand Medicaid in the twelve states that have currently elected not to.[50] Though this would do little to help those who have insufficient private insurance, it would cover a portion of the 20 percent of people with OUD who currently lack access to insurance.[51]

Lawmakers have passed legislation in the American Rescue Plan Act (ARPA) of 2021 to entice holdout states to expand Medicaid through extra monetary incentives, beyond those present in the ACA.[52]

When the Medicaid expansion first became law, the federal government agreed to pay 100% of all expansion population medical costs

48. *Id.* at 13.
49. *Id.* at 46.
50. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 22, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
51. KFF Medicaid's Role, *supra* note 9, at 3.
52. American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. (2021).

for three years.[53] Afterward, the federal medical assistance percentage (FMAP – the portion the federal government pays) decreased gradually, bottoming out at the federal government paying 90% of the tab and states paying the remaining 10%.[54] The Medicaid expansion was attractive for most states, which otherwise pay anywhere from 17% to 50% of the costs of their regular Medicaid recipients.

The ARPA provides several incentives to holdout states if they choose to expand Medicaid now. First, new expansion states would receive the 90% FMAP rate for expansion populations, that other previously expanded states already enjoy.[55] Second, and more importantly, new expansion states would be eligible for an additional 5% increase in FMAP for two years for their traditional Medicaid populations.[56] Estimates are that the increased FMAP for traditional Medicaid populations would more than fully offset any cost to states of expanding.[57] The ARPA incentives for Medicaid are eligible to twelve states that had not expanded Medicaid at the time of the passage of the ARPA, as well as two states (Missouri and Oklahoma) that had adopted the expansion but not yet implemented it at the time of passage of the ARPA.[58]

2. Greater Federal Standards and Enforcement of the ACA and Parity Laws

The federal government can also be more dedicated to enforcing the MHPAEA and the ACA.

To provide one example of the importance of compliance, one of the reasons why private insurance's coverage of OUD benefits is poor is because state benchmark plans for EHBs have been insufficient. These form the baseline for benefits for other private plans offered in the state and, given private insurance's historic failures to adequately comply with the MHPAEA and ACA, monitoring them for compliance is important. However, as aforementioned studies suggest,[59] these benchmark state

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53. *Questions and Answers: Medicaid and the Affordable Care Act*, MEDICAID.GOV (Feb. 2013), https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf.

54. *Id.*

55. H.R. 1319 § 9814.

56. H.R. 1319 § 9814.

57. Robin Rudowitz et al., *New Incentive for States to Adopt the ACA Medicaid Expansion: Implications for State Spending*, KAISER FAM. FOUND. (Mar. 17, 2021) https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/.

58. Id.

59. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 42, at 11-17; Tovino, *supra* note 43, at 408.

plans are often not in compliance with the minimum requirements of the ACA or parity laws. So, what can be done about this issue to ensure that people who pay into private plans get the benefits they deserve and that the law requires?

For one, the Secretary of HHS can be more proscriptive in regulations as to what benefits must be covered by state benchmark plans. For example, a regulation from HHS already mandates that state benchmark plans cover one drug in every United States Pharmacopeia category and class and this means that each state plan must cover at least one reversal agent.[60] However, as nearly half of state benchmark plans do not cover opioid reversal agents,[61] this shows a lack of compliance by the state benchmark plans and, concurrently, a lack of enforcement of regulations by HHS. Greater enforcement of the parity laws, the ACA, and regulations by HHS will be necessary to see improvement. Focusing on compliance in state benchmark plans is a great starting point as the strengths or weaknesses of these plans trickle down to the other private insurance plans in the state.

President Biden's choice for HHS Secretary, California Attorney General Xavier Becerra, is no stranger to the opioid crisis, having led litigation against opioid manufacturers.[62] Given his familiarity with the crisis, he may have an appetite to enforce more of the laws on the books requiring greater parity for SUD services by private insurers.

Admittedly, these efforts will not fully resolve the insurance crisis facing many people with OUD and other SUD disorders. Despite federal and state efforts at enforcement, problematic state benchmark plans and insurance plans may sometimes squeak through. There also remain too many gaps in the law that permit low quality insurance benefits. To address these gaps and the overarching problems this article raises requires broadscale reforms of our health care financing system.

B. Long Term: Lessons for Broadscale Health Reform

It is important first to acknowledge that legislation aimed expressly at addressing private insurance insufficiency in the opioid crisis is highly unlikely and even undesirable. Congress has passed two bipartisan pieces of legislation in recent years to address the opioid crisis and neither has

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60. Tovino, *supra* note 43, at 409.

61. *Id.* at 409.

62. Complaint at 1, California v. McKinsey & Company, Inc. (Cal. Super. Ct. Feb. 4, 2021) (No. RG21087649).

touched the private insurance industry.[63] Even government health insurance programs have largely been untouched in this legislation, except that the second law allowed Medicaid state agencies more flexibility in how they cover SUD benefits.[64] Nor is such a specific law necessarily desirable. Our health care system is profoundly cumbersome, fragmented into dozens of different health care financing systems, with even more fragmented laws and regulations to address them. People with OUD may have unique health care needs but they are certainly not alone in continuing to face challenges in access to health benefits. Ideally, broadscale reforms to the health care system will be undertaken with the interests of people with OUD in mind, as well as many other interest groups who may benefit from expanded health care access.

The likeliest option moving forward in the near future is a public option, a health reform proposal that President Biden advanced during his candidacy.[65] A public option creates a government health plan that people can opt to buy into or be automatically enrolled in if they meet certain qualifying criteria.[66] Who would qualify to be automatically enrolled or to purchase into the plan would be a major factor in how competitive the public option would be and how widely accessible it would be.[67]

A more generous public option would permit employees to choose the public option over their employer's plan, if it were better suited to them, and ideally use their employer's contribution to offset some of the premiums.[68] This would go a long way towards curing many of the crises of financing in the opioid epidemic. As noted previously, many of the gaps in consumer protections in current law fall on people with employer plans.[69] Additionally, a robust public option would permit people who are purchasing individual insurance on the exchange to opt for a government plan over a commercial one and to use eligible subsidies to purchase

63. Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 695; SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

64. SUPPORT for Patients and Communities Act § 1006, 132 Stat. at 3913 (increased matching funds for some states to cover SUD services and allocated grants to states to explore how to improve access to SUD services).

65. *Healthcare*, BIDEN-HARRIS, https://joebiden.com/healthcare/ (last visited Mar. 13, 2021) (focusing on the public option as this was President Biden's preferred model and the model most likely to advance in the nearer future.)

66. Tricia Neuman et al., *10 Key Questions on Public Option Proposals*, KAISER FAM. FOUND., at 4 (Dec. 18, 2019), https://files.kff.org/attachment/Issue-Brief-10-Key-Questions-on-Public-Option-Proposals.

67. *Id.* at 2-3.

68. *Id.* at 11.

69. *See supra* note 35 and accompanying text.

whichever plan they choose.[70] Again, this would offer a meaningful choice for people who require SUD services, as government plans have proven far superior to those plans offered in private markets, despite various federal reforms.

It is not clear, however, that a public option is a health reform that can be passed under the current political system. A public option is not suitable for passage under budget reconciliation and, lacking filibuster reform, it is unlikely to garner 60 votes in the current Senate.[71]

Interestingly, if a public option were to pass, it is not clear that consumers would have the knowledge or ability to recognize its value, in a SUD context or otherwise. Professor Allison Hoffman has suggested that weaknesses in consumer's ability to understand health insurance, or to predict future medical needs, often means consumers make irrational choices in purchasing decisions—and consumer choice in the public option may be no different.[72]

> This quick and only partial yet representative review of research on health plan selection is simply meant to illustrate that if the public option were not an obvious best alternative—and probably even if it were—people would not necessarily select it.[73]

While commercial insurers have been lagging in their coverage of SUD services, it is not clear that the average consumer knows that government plans have proven superior. Public debates and polling surrounding Medicare for All and the public option during the Democratic primaries suggests that the public still sees some value in private insurance, real or imaginary. [74] Of course, if not enough people elect the public options, then the public option does not achieve its purpose.

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70. Neuman et al., *supra* note 66, at 10.

71. For more on the politics of the public option, see *Patricia Boozang & Kyla Ellis,* The State of Play: Public Option at the Federal and State Level and What to Expect in 2021, STATE HEALTH & VALUE STRATEGIES (Jan. 7, 2021), https://www.shvs.org/the-state-of-play-public-option-at-the-federal-and-state-level-and-what-to-expect-in-2021/.

72. Allison K. Hoffman, *The Irony of Health Care's Public Option*, PA. L.: LEGAL SCHOLARSHIP REPOSITORY, Sept. 2020, at 10-11, https://scholarship.law.upenn.edu/faculty_scholarship/2214.

73. *Id.* at 12.

74. For example, in one poll, a Medicare for all style was more popular when private insurance remained as a choice. Nate Silver, *Medicare for All Isn't That Popular—Even Among Democrats,* FIVETHIRTYEIGHT (July 25, 2019, 1:29 PM), https://fivethirty eight.com/features/medicare-for-all-isnt-that-popular-even-among-democrats/.

> If, in turn, the public option failed to gain significant market share, it would not exert pressure on the private insurers to offer better quality or lower-priced plans. Thus, in the end of the day, the public option would co-exist with private plans. Yet, it would not serve the other promise … that of ensuring guaranteed universal access at controlled prices.[75]

A public option, then, must be carefully crafted to select the best possible government plan and then be thoroughly explained to consumers to help them to understand the gains for people struggling with a variety of different preexisting conditions where commercials markets continue to fail, SUD included.

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As we continue into a decades-long battle with opioid addiction, we must continue to assess the performance of our health care insurance industry, on both public and private sides. Access to SUD services means life or death for some. Our failures and strengths in this field are a mirror of the larger challenges and opportunities of health care system and health reform in the future.

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75. Hoffman, *supra* note 72, at 12.