



Journal of Law in Society & Levin Center at Wayne Law  
2021 Symposium

**Opioid Paradigms: How Crisis Can Inform Change**

Panel 1 - Access to Addiction Medical Care

Panelists: Professor Taleed El-Sabawi, Professor Katherine Vukadin, Professor Valarie Blake,  
Professor Matthew Lawrence

Moderator: Professor Lance Gable

Opening Remarks: Dean Richard Bierschbach



# SUD Treatment Financing

Taleed El-Sabawi

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# Payors

- Public
  - Health insurance (Medicaid (& CHIP), Medicare, etc.)
  - Funds (Federal grants, State/local government allocations)
- Private
  - Health insurance
  - Individual

**EXHIBIT 2****Spending on mental health, substance use disorders, and all health and distribution by payer, selected calendar years 1986–2014**

	1986	1992	1998	2004	2007	2009	2014
Mental health (millions)	\$32,444	\$51,936	\$68,956	\$111,412	\$134,071	\$145,126	\$186,089
Distribution by payer							
Out of pocket	18%	13%	13%	12%	12%	11%	10%
Private health insurance	20	20	23	27	28	28	28
Other private	5	6	3	3	3	3	3
Medicare	6	8	9	7	11	12	15
Medicaid <sup>a</sup>	17	21	24	29	25	26	25
Other federal <sup>a,b</sup>	6	5	5	5	5	5	6
Other state and local <sup>a</sup>	27	27	23	18	17	15	14
Substance use disorders (millions)	\$9,082	\$13,392	\$14,713	\$18,764	\$22,550	\$25,132	\$33,891
Distribution by payer							
Out of pocket	13%	12%	8%	7%	9%	10%	9%
Private health insurance	32	15	14	13	13	16	18
Other private	3	5	4	4	4	5	4
Medicare	4	4	5	5	4	5	6
Medicaid <sup>a</sup>	9	15	19	21	22	20	21
Other federal <sup>a,b</sup>	11	21	15	16	12	12	12
Other state and local <sup>a</sup>	27	27	34	35	35	32	29

Source: Tami L. Mark, et al. *Insurance Financing Increased for Mental Health Conditions But Not for Substance Use Disorders, 1986-2014*, 6 HEALTH AFFAIRS 35, 961 (2018).

# Cost-sharing



Premium



Deductible



Co-pay



Co-insurance



Limited by out-of-pocket maximum



Parity

# Coverage Restrictions



In-network  
providers



Out-of-network  
providers



Problem = network  
adequacy



Pre-authorization  
requirements



Fail-first protocols



Treatment limits

## Medicaid Outpacing Private Insurance

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- Medicaid & Private Insurance cover ~same portion of people with Opioid Use Disorder
- Medicaid outperforms in access to treatment, cost efficiency



## Why is Medicaid Performing Better?

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- No cost barriers
- Greater public accountability
- Less discrimination
- State “skin in the game”



## Solutions? More Medicaid Expansion!

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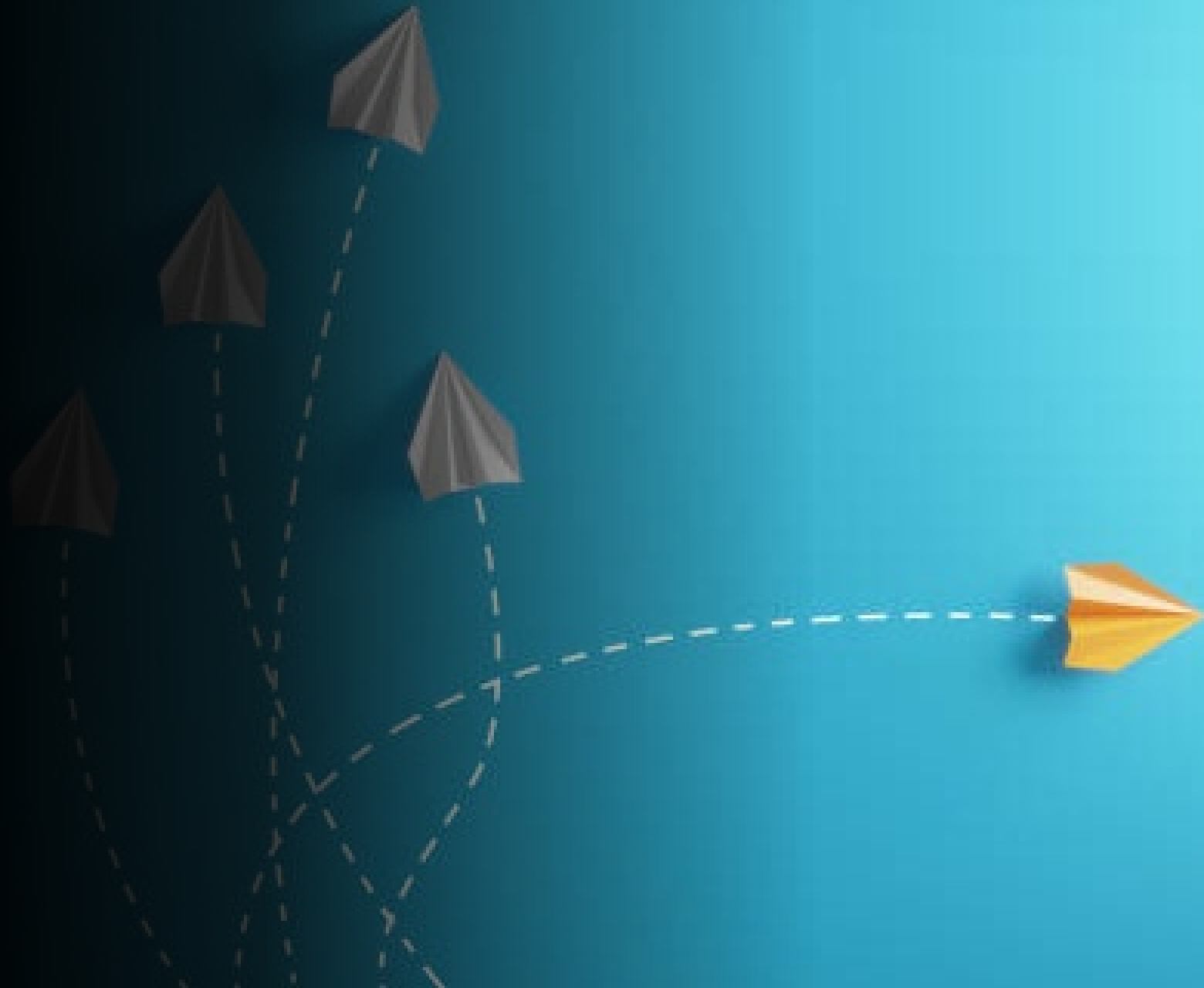
- Entice the 12 Holdout states
- Address uninsured, private underinsurance
- COVID law allows FMAP increase



## Solutions? BIG Health Reform

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- Learn from the OUD crisis in health reform
- Consider OUD in Public Option
- Inform Public of Private Insurance Failings





# **On Opioids and ERISA:** The Struggle for Contracted Care

**Katherine T. Vukadin**

**Professor of Law at South Texas College of Law Houston**



“Why won’t my health insurance cover my child’s treatment?”

“Who can help me?”

# Confusion and dismay

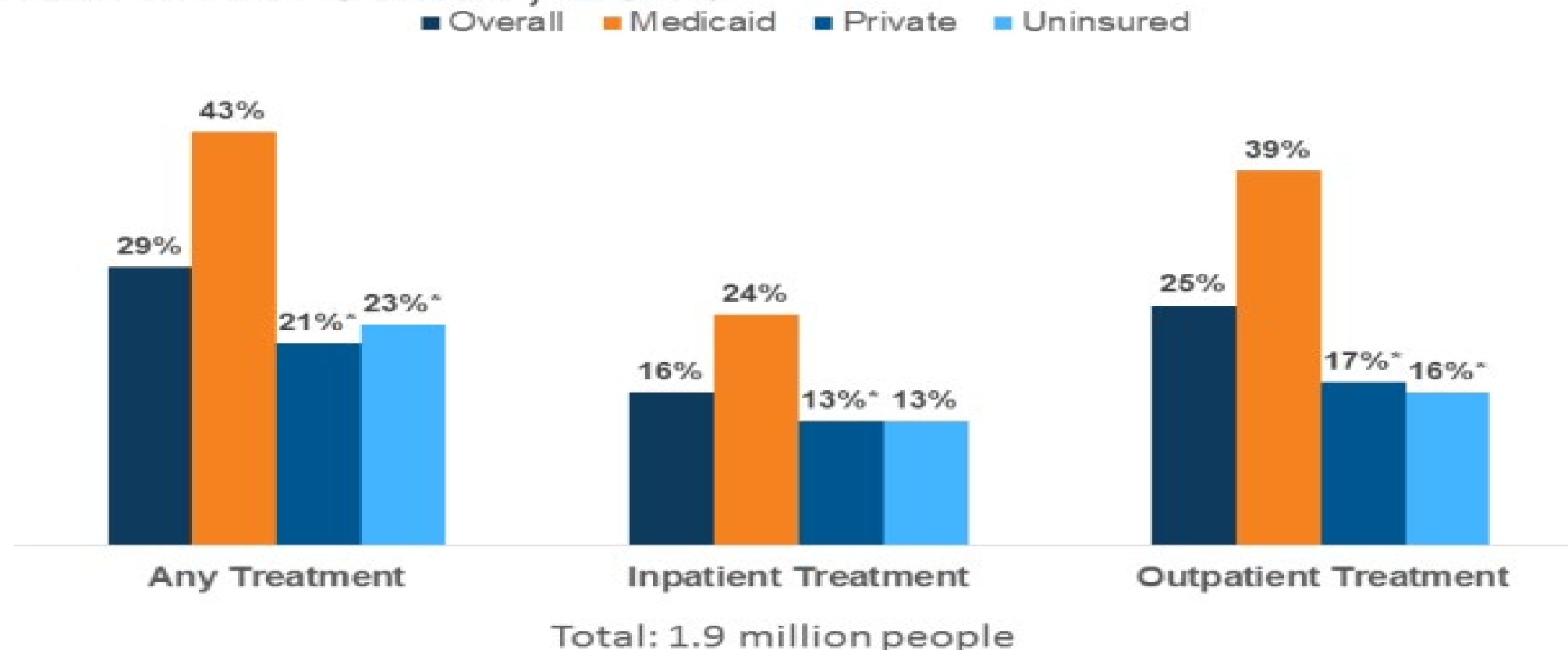


“Despite assurances from my employer’s insurance broker that [our plan] covers mental health issues, we have met with **flat denials.**”

“The conclusion [denial] is contrary to what we’ve observed and is **contrary to the opinions of [our daughter’s] treating providers.**”

Figure 4

## Past-Year Opioid Addiction Treatment Among Nonelderly Adults with Opioid Addiction by Insurance Status, 2016



NOTE: Differences between Medicaid and private insurance are statistically significant for all three measures. Differences between Medicaid and uninsured are statistically significant for any treatment and outpatient treatment only.

SOURCE: Kaiser Family Foundation Analysis of the 2016 National Survey on Drug Use and Health

# Mental health & substance abuse claims are hit hard



- Mental health and substance abuse claims denied much more often—up to **seven times** as often for **substance use disorder**

# ERISA

The Employee Retirement Income  
Security Act





Care Must Be **Medically Necessary**



# Care Must Be **Medically Necessary**

- **“Medically Necessary or Medical Necessity** means those services or supplies covered under the Plan which are: 1. Essential to, consistent with, and provided for the diagnosis or the direct care **and** treatment of the condition, sickness, disease, injury, or bodily malfunction; **and** 2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; **and** 3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; **and** 4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient. **The medical staff of [the Claim Administrator] shall determine whether a service or supply is Medically Necessary under the Plan** and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. **Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.”**



**DENIED**

Claim for opioid use disorder treatment

- “Not medically necessary. You could have been treated at a lower level of care.”

You send . . .

Letters from  
treating  
physicians

Therapy  
notes

Medical  
records

**Appeals:**

First level

Second level

External review

➡ Denied

➡ Denied

➡ Denied



# Discretionary Clause

- “The administrator has **sole discretion** and authority to determine **eligibility for benefits** or to **interpret the terms** or provisions of the policy or contract.”



# The Rising Tide Against Discretionary Clauses




Discretionary clauses are:

**Inequitable**

**Deceptive**

**Misleading**

--Nat'l Assoc. of Insurance  
Commissioners



# Banning discretionary clauses (at least, some of them)



Bans in 25 states (including Texas)

Bans apply to insured ERISA plans

Self-funded ERISA plans left vulnerable

# HOW WRONG MUST A DENIAL BE TO BE OVERTURNED?

“random”



“loud gaffaw”





## **Remedies are limited to ERISA remedy— claim for the benefit only**

- ➡ “Some remedy! You can be crippled for life because your health plan refused to authorize a test costing a few hundred dollars—and all you can recover is the cost of the test.” –Sen. Edward Kennedy



# Wit v. United Behavioral Health

No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205, at \*14 (N.D. Cal. Feb. 28, 2019).

- “United Behavioral Health denied mental health claims . . . using internal guidelines that were inconsistent with the terms of the class members’ health insurance plans . . . **To conceal its misconduct, UBH lied to state regulators . . . and deliberately attempted to mislead the Court at trial in this matter.**”



# Solutions?

- (1) Federal ban on discretionary clauses
- (2) Re-imagine attorney's fees provision



## In the meantime?

- Appeal through all the levels
- Appeal through external review
- Do not give up
- Be loud—complain to company executives, legislative representatives, employer, etc.



# Thank You

**Regulatory Pathways to Promote Treatment for Substance Use  
Disorder Using Risk Adjustment**

Matthew B. Lawrence  
Associate Professor  
Emory University School of Law

### Insurance **Problems:**

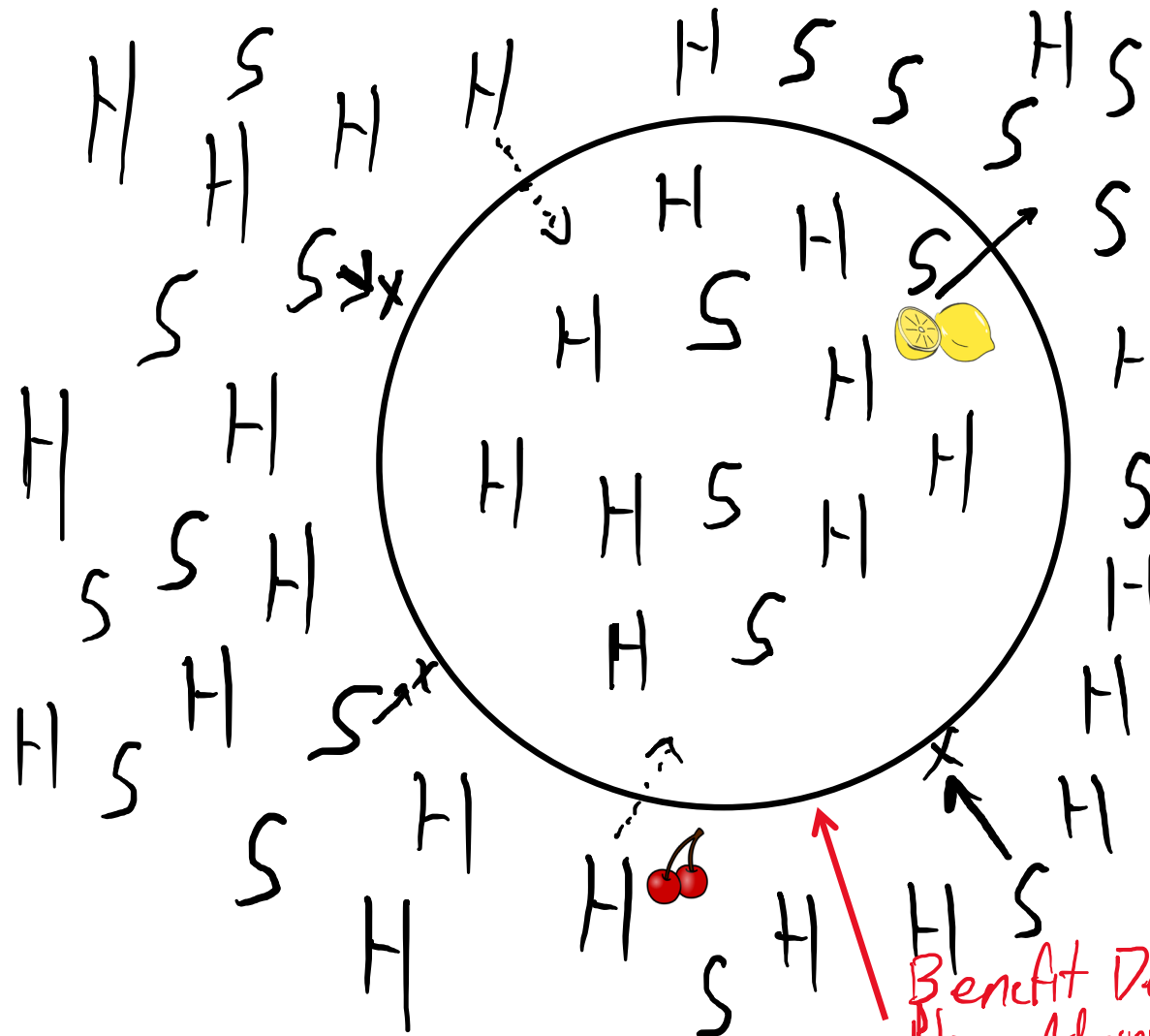
- Health insurance plans “have strong incentives to discriminate against services used by the high-cost patients on which they lose money.” T.G. McGuire, “Achieving Mental Health Care Parity Might Require Changes in Payments and Competition,” *Health Affairs*, 35, no. 6 (2016): 1029-1035.
- Stigma contributes to disparate treatment of mental illness in health insurance plan design and implementation. J.R. Cummings *et al.*, *Addressing Public Stigma and Disparities Among Persons With Mental Illness: The Role of Federal Policy*, 103 Am. J. Pub. Health 781 (2013).

## RISK ADJUSTMENT AND SUBSTANCE USE DISORDER

Matthew B. Lawrence

### Adverse Selection

- Insurers need balanced risk pool to stay solvent
- “Adverse selection” gives insurers economic incentive/compulsion to “cherry pick” and lemon drop”
- Insurers have several tools to do this
  - Benefit design
  - Plan administration
  - (sometimes) Exclusions and premium underwriting



Benefit Design  
Plan Administration  
Exclusions + Premium Underwriting

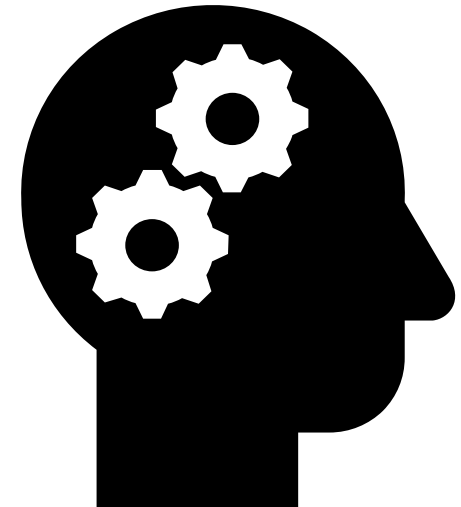
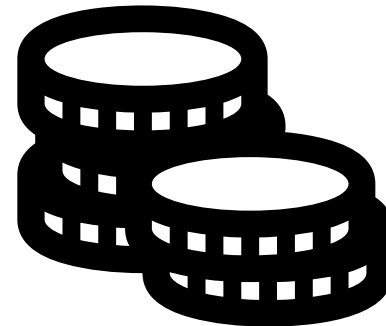
## Risk Adjustment and Substance Use Disorder

Matthew B. Lawrence

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### Solutions?

1. Parity Law
2. Benefit Mandates
3. Appeals
4. **Risk Adjustment**

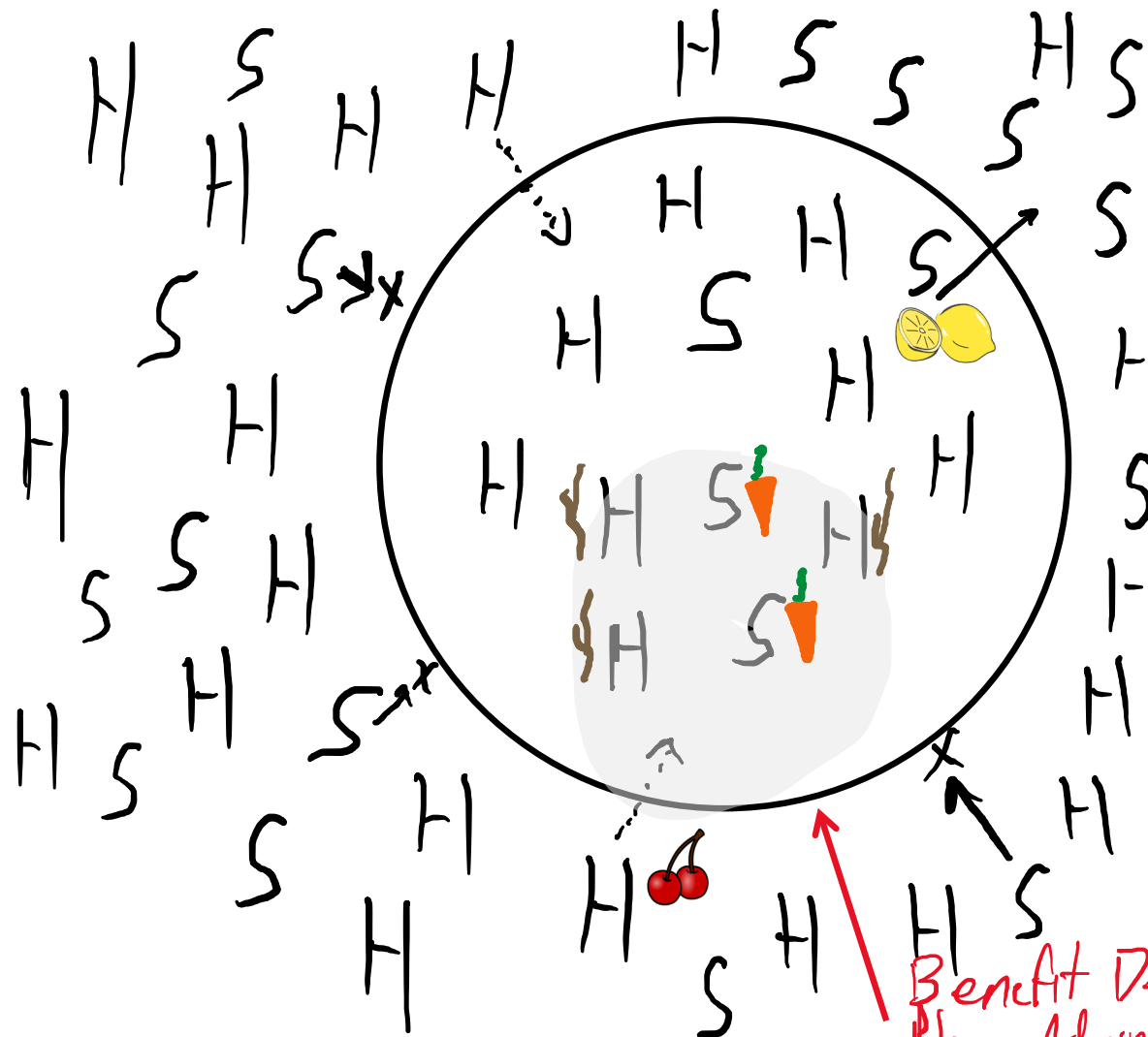


# RISK ADJUSTMENT AND SUBSTANCE USE DISORDER

Matthew B. Lawrence

## Risk Adjustment

- Insurer reimbursement based on health status of enrollees (“adjusted” for “risk”)
- Insurer makes more \$ on predictably costlier patients, mitigating incentive to discriminate
- In perfect world, carrots would cancel out lemons and sticks would cancel out cherries
- Difficult to do well, necessarily incomplete, encourages fraud
- A common feature in public insurance
  - Medicare Part C and D
  - ACA
  - Most Medicaid managed care plans



Benefit Design  
Plan Administration  
Exclusions + Premium Underwriting

## **POLICY POINT: RISK ADJUSTMENT ECONOMISTS SUGGEST CHANGES TO MORE EFFECTIVELY PROMOTE TREATMENT FOR ADDICTION**

### *SEE:*

- S.L. Bergquist, “Intervening on the Data to Improve the Performance of Health Plan Payment Methods,” NBER Working Paper No. 24491 (April 2018);
- A. Shrestha et al., “Mental Health Risk Adjustment with Clinical Categories and Machine Learning,” Health Services Research 15 (2017);
- E. Montz et al., “Risk-Adjustment Simulation: Plans May Have Incentives To Distort Mental Health and Substance Use Coverage,” Health Affairs 35, No. 6 (2016): 1022-1028;
- T.J. Layton, T.G. McGuire, and R.C. van Kleeef, “Deriving Risk Adjustment Payment Weights to Maximize Efficiency of Health Insurance Markets,” at 4 (NBER 2016);
- R.C. van Kleeef et al., “Improving Risk Equalization with Constrained Regression,” NBER Working Paper No. 21570 (Sept. 2015): 1-18.

## LEGAL POINT 1: STATE AND FEDERAL REGULATORS HAVE DISCRETION UNDER CURRENT LAW TO CONSIDER/MAKE CHANGES ECONOMISTS SUGGEST

## LEGAL POINT 2: ACA REQUIRES FEDERAL REGULATORS TO CONSIDER/MAKE CHANGES FOR MEDICARE PART C. 42 U.S.C. 1395w-23(a)(1)(c). HHS IS CURRENTLY IN VIOLATION OF THIS LAW.

(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

See Matthew B. Lawrence, *Parity Is Not Enough! Mental Health, Managed Care, and Medicaid*, 48 J. L. Med. & Ethics (2020); Matthew B. Lawrence, *Regulatory Pathways to Promote Treatment for Substance Use Disorder or Other Under-Treated Conditions Using Risk Adjustment*, 46 J. L. Med. & Ethics 935 (2018).



**Risk Adjustment and Substance Use Disorder**  
**Matthew B. Lawrence**

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Questions?

**Comments?**

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