Engaging Health Insurers in the War on Prescription Painkillers

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INTRODUCTION

While our nation was wholly occupied with the war on illicit drugs, a different deadly addiction has been creeping into doctors' offices to lawfully occupy us. Prescription painkiller abuse, or abuse of mainly opioid-based medicines like OxyContin, is now the leading contributor to drug overdoses and overdose deaths in the United States.[1] A war to successfully defeat painkiller addiction must be different in scope and nature than the other war on illicit street drugs in a number of meaningful ways. For one, the public appears to view prescription drug abuse as less dangerous than illicit drug use, perhaps because these drugs are available lawfully through the medical system and are seen as curative.[2] Likewise, abusers of opioids have been portrayed more sympathetically than other illicit drug users, again perhaps because many users initially came by the drugs lawfully.[3] And while the war on drugs takes place in illegal markets with underground actors, prescription painkillers are often lawfully prescribed by physicians and paid for by health insurers.

Some lessons from the war on drugs can be meaningfully extrapolated to the present painkiller epidemic. For example, we can learn from the long history of the war on drugs that drug enforcement, particularly criminalization, is costly and can target vulnerable groups.[4] But the prescription pain-

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[1] Deaths from opioids account for over six out of every ten overdose deaths. *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/epidemic/ [https://perma.cc/XS86-TXVJ]. Because of this dangerous trend in opioids, the article focuses on prescription painkiller abuse, but other prescription drugs like Adderall or Xanax can also be abused.

[2] *See* Deborah Ahrens, *Drug Panics in the Twenty-First Century: Ecstasy, Prescription Drugs, and the Reframing of the War on Drugs*, 6 ALB. GOV'T L. REV. 397, 418 (2013) ("[P]ortrayal of persons using the drug seems to have shifted from 'dangerous' to 'relatable' . . . . Addictions often start innocently and unintentionally, and the persons who intentionally use prescription drugs often are described as having done so under the erroneous impression that doing so is safe because the drugs can lawfully be prescribed.").

[3] *See id.* This difference, coupled with lessons learned from the broader war on drugs, may explain in part why criminalization of opioid abusers has been discouraged as a major policy initiative. This contrasts sharply with government policy with respect to illegal drug users.

[4] For essential reading on the "erosion of civil liberties" posed by the war on drugs, see Paul Finkelman, *The Second Casualty of War: Civil Liberties and the War on Drugs*, 66 S. CAL. L. REV. 1389 (1993). For a modern synopsis of the harms of the war on drugs and its broader application to criminal law reform, see Benjamin Levin, *Guns and Drugs*, 84 FORDHAM L. REV. 2173 (2016). For racial implications of the drug war, see Frank Rudy Cooper, *The*

killer epidemeic is a different enemy than illicit drugs, requiring different tactical approaches to fight it. An iatrogenic drug epidemic requires an iatrogenic cure. Thus, while criminal law certainly has its place in this epidemic, for example by targeting physicians who unlawfully abuse their prescriptions pads, prescription painkiller abuse is better handled by changes to how we regulate our healthcare system, in terms of both delivery and payment.

There is significant bipartisan support for making policy to address this epidemic. In 2016, Congress overwhelmingly passed the Comprehensive Addiction and Recovery Act, the first major legislation in forty years intended to tackle the opioid crisis.[5] The law is far-reaching, authorizing $181 million annually to tackle opioid abuse through prevention and educational programming, drug disposal programs, and other measures. While the Act tackles almost every dimension of opioid prescribing and abuse, it missed an opportunity by failing to consider health insurers and the role they can and must play in tackling this epidemic.[6]

Indeed, regulators have widely ignored insurers in prescription painkiller abuse reforms, instead focusing mainly on prescribers and patients. This is unfortunate because insurers hold significant power to mitigate or exacerbate this epidemic.[7] They pay for most of the opioids being prescribed and thus have significant leverage over prescriber patterns and how many drugs end up in the hands of patients. Moreover, insurers are typically the gateway to addiction treatment, which may be prohibitively expensive otherwise. Thus, they play a powerful role in controlling who gets these drugs and who gets treatment for addiction.

Insurers also have an incentive to defeat this epidemic because it is expensive. A recent study found that the average cost of covering an insured was $3,453 per year, but this rose to $19,333 when the insured had opioid

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Un-Balanced Fourth Amendment: A Cultural Study of the Drug War, Racial Profiling and Arvizu, 47 VILL. L. REV. 851 (2002). For gender implications, see Marne L. Lenox, *Neutralizing the Gendered Collateral Consequences of the War on Drugs*, 86 N.Y.U. L. REV. 280 (2011).

[5] Comprehensive Addiction and Recovery Act, Pub. L. No. 114-198, 130 Stat. 695 (2016), passed with a shocking 94-1 votes in the Senate and 400-5 votes in the House. *S.524–Comprehensive Addiction and Recovery Act of 2016*, https://www.congress.gov/bill/114th-congress/senate-bill/524/actions [https://perma.cc/8GTD-DTRW].

[6] The Act addressed payers in very limited ways and only with respect to easing access to overdose prevention drugs. It provides funds for Veterans Hospitals to increase access to naloxone (a fast-acting opioid overdose drug) by eliminating or reducing copays to purchase the drug and to attend educational sessions on how to use these drugs. It also creates grants to waive copays for these drugs in other insurance programs. Pub. L. No. 114-198, https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf [https://perma.cc/P8WZ-Z3FJ].

[7] "[The] problem of prescription drug abuse and overdose is complex and multi-faceted. There are multiple drivers of the problem, such as provider clinical practices; insufficient oversight to curb inappropriate prescribing; insurance and pharmacy benefit policies; and a belief by many people that prescription drugs are not dangerous, which is associated with increased use." PRESCRIPTION DRUG ABUSE SUBCOMM., U.S. DEP'T OF HEALTH & HUMAN SERVS., ADDRESSING PRESCRIPTION DRUG ABUSE IN THE UNITED STATES: CURRENT ACTIVITIES AND FUTURE OPPORTUNITIES (2013).

addiction.[8] Insurers must also worry about the attendant costs of communicable diseases that we will see as prescription painkiller abusers increasingly turn to intravenous drugs like heroin.[9]

While insurers have both the power and the motivation to curb the practice of harmful opioid prescribing, they may go about it in ways that could be counter-productive to larger public health goals. After all, insurers have historically discriminated against addiction like any other condition that leads to costly healthcare consumption. In the past, insurers have avoided enrolling addicted insureds and have limited rehabilitation services. To address this epidemic, insurers might engage in ways that could harm third parties. For example, to the extent they are permitted, insurers might avoid addicted enrollees altogether, or might limit coverage of addiction treatments in order to save money. They may overcorrect, sharply curbing most opioid prescriptions and relishing the money saved, while ignoring the harms to patients who depend on this form of pain management. Or they might focus too much on curbing prescriptions because it is cost-saving, while focusing less attention on adequate addiction treatment, which costs money. After all, their broader goal is typically not to improve the public's health, but to predict and avoid risk.

Insurers are already beginning to act on their own, for example by monitoring their insureds for opioid abuse and limiting opioids for some patients. Regulators need to be aware of insurer conduct and should monitor it for which practices are or are not likely to achieve positive outcomes in this public health crisis.[10] While insurers must be engaged in this epidemic, they must also be regulated to ensure that their efforts help and do not harm the broader goals of preventing and treating addiction. The Affordable Care Act (ACA) can play an important role in requiring insurers to cover necessary addiction rehabilitation and to act in ways that do not discriminate against addicted insureds. However, the various consumer protections in the ACA and its implementing rules are at risk under the new administration. Insurance regulation is necessary if insurers are to be meaningfully engaged in the battle over opioids—we cannot assume that insurers' interests will always align with broader public health goals. Discrimination will be a serious risk

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[8] Julie Appleby, *Insurance Data Show a Surge in Spending on Opioid Treatment and Testing*, NPR (Sept. 12, 2016), http://www.npr.org/sections/health-shots/2016/09/12/493618415/insurance-data-show-a-surge-in-spending-on-opioid-treatment-and-testing [https://perma.cc/EW3G-QXZ3].

[9] For example, increased IV drug use could increase the spread of HIV and Hepatitis C. The latter issue has become a source of increased strife among health policymakers and insurers over whether to cover Sovaldi, an $84,000 treatment that can cure Hepatitis C. For more on the debate over Sovaldi and possible policy responses, see Soumitri Barua et al., *Restrictions for Medicaid Reimbursement of Sofosbuvir for the Treatment of Hepatitis C Virus Infection in the United States*, 163 ANNALS OF INTERNAL MED. 215, 215–16, 220 (2015).

[10] It is impossible to predict the future of health reform in the near or distant future. For a fairly recent discussion of possible reforms that we might see when conservatives are in power, see Timothy Jost, *Taking Stock of Health Reform: Where We've Been, Where We're Going*, HEALTH AFFAIRS BLOG (Dec. 6, 2016), http://healthaffairs.org/blog/2016/12/06/taking-stock-of-health-reform-where-weve-been-where-were-going/ [https://perma.cc/9YYP-SCS5].

if the ACA and its protections are repealed and regulators must be prepared to identify and address this risk.

This article explores the promises and perils of engaging health insurers in tackling this epidemic. Of course, insurers are only one actor in the cycle of prescription pill prescribing and dispensing. Doctors, pharmacies, drug makers, patients, and others are all stakeholders who must be considered and engaged to truly address this crisis. However, insurers play a central role in the dispensing of prescriptions and have received inadequate attention from both academics and regulators. In focusing on insurers, I focus mainly on healthcare reforms practices but other areas of law also play a role in ending the opioid crisis, for example, criminal law, tort law,[11] labor and employment law,[12] and disability law.[13] Lastly, the prescription painkiller epidemic is fueling an illegal heroin market for those who cannot access opioid prescription painkillers for cost or other reasons.[14] This article focuses only on lawful channels of painkillers, recognizing that further discussion is needed to address the equally important topic of abuse of illicit substances. Improvements in the dispensing of opioid painkillers may, in the long term, help to reduce heroin abuse by reducing the overall percentage of the population who become addicted to opioids.[15] In the short term, however, any efforts to decrease the availability of opioids through lawful channels could lead those currently addicted to turn to heroin as opioids become costlier and harder to obtain.

This paper begins in Part I by describing the origins and the harms of prescription painkiller abuse. Part II turns to regulatory efforts to combat this epidemic. It briefly provides context for the reader about wider efforts to address prescription painkiller abuse including pharmacy and prescriber reforms, before turning to the role that insurers can play in changing these practices. Part II also describes practices that insurers are already engaging in to alter the course of the epidemic including (1) ways that insurers are

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[11] For a discussion of the role of criminal and civil litigation against drug makers who may have contributed to the prescription drug epidemic, see Richard C. Ausness, *The Role of Litigation in the Fight Against Prescription Drug Abuse*, 116 W. VA. L. REV. 1117 (2014).

[12] Labor and employment law can play an important role in combating opioid abuse, partly because workplace injuries and workplace compensation are a frequent area where opioids are initially prescribed and sometimes later abused. For details on this issue, see *The Role of Insurers in Preventing Misuse and Abuse of Controlled Substances*, PREVENTING PRESCRIPTION ABUSE IN THE WORKPLACE TECHNICAL ASSISTANCE CENTER, PUB. HEALTH, http://publichealth.hsc.wvu.edu/media/4023/insurers_pire_4_web508.pdf [https://perma.cc/LQN3-PFC5]. For a discussion of workers' rights and interests with respect to addiction in the workplace, see Elisa Y. Lee, *An American Way of Life: Prescription Drug Use in the Modern ADA Workplace*, 45 COLUM. J.L. & SOC. PROBS. 303 (2011).

[13] For a wider discussion of disability protections as applied to alcohol and drug abusers, see Ellen M. Weber, *Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities*, 57 RUTGERS L. REV. 631 (2005).

[14] Steve Almasy, *Opioid Epidemic is Getting Worse, Says CDC*, CNN (Dec. 9, 2016, 2:35 PM), http://www.cnn.com/2016/12/08/health/opioid-deaths-2015/ [https://perma.cc/8K2Y-NNHC].

[15] Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANN. REV. PUB. HEALTH 559, 560 (2015).

preventing future abuse of prescription painkillers and (2) ways that insurers can and are improving services for those who already suffer from addiction. In Part III, the article argues that regulators must regulate insurance practices to ensure that they achieve the broader goals of preventing and treating addiction. New regulations will be particularly critical if the ACA is repealed.

I. Prescription Painkiller Abuse as an Epidemic

The Centers for Disease Control and Prevention recognizes prescription painkiller abuse as an epidemic requiring widespread public health intervention.[16] Over twenty thousand people died of an overdose from prescription opioids in 2015, and an additional nearly thirteen thousand people died from heroin overdose.[17] Drug overdoses, as a general matter, have more than doubled in the last fourteen years, and prescription drug overdoses now account for half.[18] Deaths from opioid overdoses specifically have quadrupled since 1999.[19]

The epidemic creates a significant strain on the healthcare resources of the country. Enough prescriptions for opioids were written in 2012 to give every American his or her own bottle.[20] Americans, making up 4.4% of the world's population, consume 80% of its opioids.[21] This translates into increased need for addiction treatment. U.S. emergency rooms see one thousand patients per day for treatment related to opioid addiction,[22] with addiction treatment-seeking increasing 900% between 1997 and 2011.[23]

The roots of this epidemic are complex. Early American medicine relied heavily on opioids, particularly before its addictive properties were well understood.[24] For example, morphine was once regularly spooned out in the

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[16] Leonard Paulozzi et al., *CDC Grand Rounds: Prescription Drug Overdoses—A U.S. Epidemic*, 61 Morbidity & Mortality Wkly. Rep. (Jan. 13, 2012).

[17] *Underlying Cause of Death 1999–2015*, Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Statistics. Heroin deaths increased by twenty percent between 2014 and 2015. *Heroin Overdose Data*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/drugoverdose/data/heroin.html [https://perma.cc/H3A4-SGCH].

[18] *Deaths from Injuries Up Significantly Over Past Four Years in 17 State*s, Robert Wood Johnson Found. (June 17, 2015), http://www.rwjf.org/en/library/articles-and-news/2015/06/deaths-from-injuries-up-significantly-over-past-four-years-in-17.html [https://perma.cc/83WX-YY9J].

[19] Ctrs. for Disease Control & Prevention, *supra* note 1.

[20] The total amount then was 259 million prescriptions. *Opioid Painkiller Prescribing*, CDC Vital Signs (July 2014), https://www.cdc.gov/vitalsigns/opioid-prescribing [https://perma.cc/DWK7-NS83].

[21] *Id.*

[22] *Prescription Opioid Overdose Data*, CDC (last updated Dec. 16, 2016), http://www.cdc.gov/drugoverdose/data/overdose.html [https://perma.cc/RGE5-UP6H].

[23] Kolodny et al., *supra* note 15, at 560 (discussing Substance Abuse Mental Health Services data sets on treatment episodes and discharge from treatment).

[24] *See* Deborah Ahrens, *Methademic: Drug Policy in an Age of Ambivalence*, 37 Fla. St. U. L. Rev. 841, 849 (2010).

form of Mrs. Winslow's Soothing Syrup to silence fussy children.[25] Recreational use, meanwhile, waxed and waned based on the availability of the drugs, as well as the popularity of other substances like alcohol and cocaine.[26] The stage for the modern epidemic was set in the early 1990s with the growing recognition, predominantly driven by organized medical societies, that chronic pain was underdiagnosed and undertreated in patients.[27] The Federation of State Medical Boards encouraged state boards to punish physicians who undertreated pain.[28] The American Pain Society advocated for pain as a "fifth vital sign," to be assessed each time a patient had contact with a doctor as a measurement of their well being, just like body temperature, pulse, or blood pressure.[29] Responding to this progressive pain movement, pharmaceutical companies began reshaping their marketing approaches to create a bigger audience for opioid painkillers.[30] Painkillers were originally reserved for acute and limited episodes of pain, like during cancer treatment or immediately following a surgery.[31] However, pharmaceutical companies distributed information to clinicians suggesting that opioid painkillers could be prescribed safely for long-term use without risk of addiction in most patients.[32] They recommended use of these drugs not only for patients suffering from acute and temporary pain but also for chronic pain patients.[33] Thus, the market for prescription painkillers expanded, with greater populations of patients using increasing amounts of opioids as their tolerance grew over time.[34] This marketing has been frequently challenged in the courts as unlawful on a number of legal bases

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[25] James Nevius, *The Strange History of Opiates in America: From Morphine for Kids to Heroin for Soldiers*, GUARDIAN (Mar. 15, 2016, 6:30 AM), https://www.theguardian.com/commentisfree/2016/mar/15/long-opiate-use-history-america-latest-epidemic [https://perma.cc/4N6J-4LD8].

[26] *Id.*

[27] Kelly K. Dineen & James M. DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 AM. J.L. MED. 7 (2016); *see also* Andrea M. Garcia, *State Laws Regulating Prescribing of Controlled Substances: Balancing the Public Health Problems of Chronic Pain and Prescription Painkiller Abuse and Overdose*, 41 J. L. MED. & ETHICS 42 (2013).

[28] Celine Gounder, *Who Is Responsible for the Pain-Pill Epidemic?* NEW YORKER (Nov. 8, 2013), http://www.newyorker.com/business/currency/who-is-responsible-for-the-pain-pill-epidemic [https://perma.cc/J6CQ-XLLE].

[29] Dineen & Dubois, *supra* note 27; Garcia, *supra* note 27.

[30] *See* Kelly K. Dineen, *Addressing Prescription Opioid Abuse Concerns in Context: Synchronizing Policy Solutions to Multiple Complex Public Health Problems*, 40 L. & PSYCHOL. REV. 1, 3 (2016) [hereinafter Dineen, PSYCHOL. REV] ("The aggressive and illegal marketing by some pharmaceutical companies undoubtedly influenced prescribing of opioids and may have led some physicians to believe, albeit unreasonably, that some of the newer drugs, such as Oxycontin, were safer than in reality. In turn, some doctors may have been less careful than warranted in instructing patients.").

[31] *Id.*

[32] "Purdue trained its sales representatives to carry the message that the risk of addiction was 'less than one percent.'" Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221 (2009).

[33] *Id.*

[34] *Id.*

including: criminal complaints, negligence, products liability, fraudulent misrepresentation, negligent marketing, and violation of state consumer protections.[35]

Because this epidemic stemmed from inappropriate prescription of painkillers in a medical context, many of the population currently addicted to prescription painkillers began as chronic pain patients. Approximately one hundred million Americans suffer from chronic pain.[36] These patients obtain the drug lawfully from physicians who diagnose them with chronic conditions, like back pain or arthritis. Some of these patients become addicted to the medicine over time, turning to illegitimate abuse of the drug.[37] Many people, alternatively, began taking prescription painkillers without ever having a legitimate prescription or medical need (sometimes called nonmedical users).[38] These individuals might divert painkillers from family or friends or purchase them off the street.[39] Both medical and non-medical users may engage in "compulsive drug-seeking" in which they misrepresent medical needs in order to obtain or increase amounts of prescriptions for illegitimate uses.[40] Opioid abusers may engage in doctor shopping (seeing multiple physicians for multiple prescriptions) and may fill prescriptions across different states and in different pharmacies or by paying cash—all methods to avoid detection as frequent users.[41]

The prescription painkiller epidemic has created a third population, those who began abusing prescription painkillers but have turned to illicit opioids like heroin and illegal fentanyl because they are cheaper and easier to obtain than prescription painkillers.[42] Heroin and fentanyl interact with the brain in the same way as prescription painkillers because all are opioid drugs that interact with opioid brain receptors. To a person addicted to opioids, either painkillers or street drugs will have the same effect.[43] While heroin is

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[35] Ausness, *supra* note 11.

[36] *AAPM Facts and Figures on Pain*, Am. Acad. Pain Med., http://www.painmed.org/patientcenter/facts_on_pain.aspx#incidence [https://perma.cc/2R4S-LM28].

[37] About nine million opioid abusers can be classified in this category. Paulozzi et al., *supra* note 16; *see also* Kolodny et al., *supra* note 15. Medical users are frequently adults, while teenage populations more frequently use the drug recreationally. Opioid overdoses occur more in medical users than in non-medical users. For example, in a Utah study of 254 opioid overdose deaths, ninety-two percent of all deaths involved a legitimate medical prescription. Erin M. Johnson et al., *Unintentional Prescription Opioid-Related Overdose Deaths: Description of Decedents by Next of Kin or Best Contact, Utah, 2008–2009*, 28 J. Gen. Internal Med. 522 (2013).

[38] About five million people fit into this category. Kolodny et al., *supra* note 15.

[39] *Id.*

[40] *See* Joanna Shepherd, *Combating the Prescription Painkiller Epidemic: A National Prescription Drug Reporting Program*, 40 Am. J.L. & Med. 85, 86 (2014).

[41] *Id.*

[42] Kolodny et al., *supra* note 15. Dependence and overdose from illicit forms of opioids are growing problems. The CDC recently reported that deaths from illegally-made fentanyl and heroin rose seventy-three percent in 2015, as compared to an increase in prescription opioid deaths in that year of only four percent. Almasy, *supra* note 14.

[43] *What is Heroin?*, Nat'l Inst. on Drug Abuse, DrugFacts (Jan. 2017), https://www.drugabuse.gov/publications/drugfacts/heroin [https://perma.cc/MJ4K-WP25].

a problem in its own right, it is closely linked to the prescription painkiller crisis, with four out of every five new heroin users stating that his or her addiction began through abuse of painkillers.[44]

Today, in the face of an epidemic, several goals are in tension. Policymakers must prevent new cases of addiction, while also identifying and treating those who already are suffering from addiction.[45] They must balance efforts to limit painkillers with ensuring that patients who need painkillers appropriately and safely receive them.[46] And they must recognize the dual dimensions of a lawful market and an illicit market both feeding this epidemic.[47]

II. Regulatory Approaches to Addressing Prescription Painkiller Abuse

Many intersecting efforts by the federal government, various agencies, and the states across various types of law (employment, healthcare, and others) will be necessary to effectively grapple with the prescription painkiller epidemic crisis.[48] No single legal approach will suffice to fully address the problems of the prescription painkiller epidemic. Medical and non-medical users who abuse painkillers may be affected by strategies to reduce harmful prescribing of those substances. But many efforts aimed at the financing and delivery of healthcare will not properly reach those using illicit substances. This part briefly describes wider efforts in the healthcare field to prevent opioid abuse, before turning to the role for insurers in this regard.

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[44] C.M. Jones, *Heroin Use and Heroin Use Risk Behaviors Among Nonmedical Users of Prescription Opioid Pain Relievers—United States, 2002–2004 and 2008–2010*, 132 Drug & Alcohol Dependence 95, 96 (2013). The shift from legal prescriptions to illegal heroin is in part being driven by reduced availability of pills and, relatedly, the rising price of these pills when compared with heroin. *Opioid Addiction 2016 Facts & Figures*, Am. Soc'y Addiction Med., http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf [https://perma.cc/NHJ3-ZW83].

[45] Johns Hopkins Bloomberg Sch. of Pub. Health et al., The Prescription Opioid Epidemic: An Evidence-Based Approach (G.C. Alexander et al. eds., 2015) [hereinafter Johns Hopkins].

[46] For a discussion of relevant policy considerations in striking a balance between addiction and appropriate pain management, see Kelly K. Dineen, *Moral Disengagement of Medical Providers: Another Clue to the Continued Neglect of Treatable Pain?*, 13 Hous. J. Health L. & Pol'y 163, 188 (2013). *See also* Sigrid Frey-Revere & Elizabeth K. Do, *A Chronic Problem: Pain Management of Non-Cancer Pain in America*, 16 J. Health Care L. & Pol'y 193, 205 (2013).

[47] Johns Hopkins, *supra* note 45.

[48] *See* Kent Durning, *No Pain No Gain?! Who Will Make the Greatest Sacrifices in Curbing Opioid Analgesic Diversion and Abuse?* 93 Ky. L.J. 199, 241 (2004) (highlighting the comprehensive approaches to addressing opioid abuse in Kentucky by state and federal agencies and the need for coordination therein).

A. Healthcare System Reforms

Reforms are occurring at every level of the supply chain between pill and patient. The makers of prescription painkillers are being incentivized to produce less addictive painkillers and are monitored for how they market addictive substances.[49] Patients are receiving more education on the risks of addiction, along with greater access to resources to seek help for drug abuse problems and to safely handle and dispose of unused prescriptions so as to avoid diversion.[50]

Perhaps the most significant reforms have targeted the writing and filling of prescriptions. At the prescriber level, there have been increasing efforts to prosecute physicians who purposefully prescribe harmful substances with criminal intent.[51] Likewise, significant reforms of pain clinics are underway.[52] For the majority of prescribers who mean well but may simply be insufficiently informed about pain management, educational initiatives are stressing proper prescribing practices.[53] Most prominently, in 2016 the CDC released clinical guidelines on safe opioid prescribing practices.[54] Pharma-

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[49] For example, the FDA is increasingly approving painkillers that are more difficult to abuse. *See FDA Approves New Pain Pill Designed to Be Hard to Abuse*, TIME (July 24, 2014), http://time.com/3031100/fda-pain-bill-targiniq-er/ [https://perma.cc/JN4L-QA9K].

[50] JOHNS HOPKINS, *supra* note 45.

[51] Shepherd, *supra* note 40. For more on why and when physicians wrongfully prescribe, see Dineen & Dubois, *supra* note 27. *See also* Dineen, PSYCHOL. REV., *supra* note 30. For a critique of criminal enforcements as a strategy to combat opioid abuse, see Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 231, 235 (2008) ("Because many physicians fear criminal sanctions for prescribing opioids, pain sufferers may not be able to receive adequate pain care. The law enforcement climate surrounding prescribing opioid analgesics appears to be causing some physicians to stop prescribing opioids or stop treating chronic pain patients, reducing an already very small number of physicians willing to treat these needy patients. As a result, the physicians who continue to see patients with chronic pain also make themselves an easy target for law enforcement officials.").

[52] Garcia, *supra* note 27.

[53] For an argument on the federal government's right to mandate prescriber education on opioids and the role this policy effort can play in reducing the prescription pill epidemic, see Michael C. Barnes & Gretchen Arndt, *The Best of Both Worlds: Applying Federal Commerce and State Police Powers to Reduce Prescription Drug Abuse*, 16 J. HEALTH CARE L. & POL'Y 271, 274 (2013). Interestingly, providers end up in a split role, fearing prosecution themselves, but also in the power to monitor and report patients for criminal conduct. For a discussion of the strain on doctors of placing criminalization into the patient-physician relationship, see Elizabeth Chiarello, *The War on Drugs Comes to the Pharmacy Counter: Frontline Work in the Shadow of Discrepant Institutional Logics*, 40 L. & SOC. INQUIRY 86, 87 (2015).

[54] For more on physician prescribing issues with respect to the opioid epidemic, see Barnes & Arndt, *supra* note 53 (advocating for the Controlled Substances Act to require education on safe prescription pill prescribing as a condition of obtaining permission to prescribe). *See also* Comprehensive Addiction and Recovery Act, Public L. No. 114-198, 130 Stat. 695 (2016) (promoting continuing education requirements for prescription pill prescribers). Regulating providers' prescribing practices is not free of controversy and can be perceived as interfering with physicians' medical judgment. For a thorough discussion of the benefits and challenges of regulating providers prescribing practices, see Macon Jones, *Protecting Dr. Smith While Treating the Chronic Pain of Mrs. Jones: Why the Indiana Medical Licensing Board Should Pass Guidelines for Using Controlled Substances for Pain Treatment*, 9 IND. HEALTH L. REV. 695, 704–05, 717–18 (2012). Examples of responsible opioid prescribing

cies that fill painkiller prescriptions are also being regulated to ensure that they only fill appropriate prescriptions and that they monitor patients for doctor-shopping.[55] Prescription drug monitoring programs (PDMPs) aid both providers and pharmacies.[56] These programs require prescribers to input certain data every time they prescribe an addictive painkiller to a patient, including the name of the patient, the name of the prescriber, and the dose and type of medicine. Pharmacies can check that information before filling an opioid prescription.[57] In this way, pharmacies and doctors can be aware of patients who are doctor-shopping and have multiple prescriptions from multiple doctors.[58] Prescription drug monitoring programs have also been shown to help identify and discourage over-prescribers.[59]

B. Insurance Reforms

While all of these efforts are critical to fighting the prescription painkiller epidemic and have demonstrated at least some success in curbing abuse, insurers must play an equally critical role. Insurers are truly at the heart of prescribed opioids. They pay for the office visits in which the drugs are prescribed, the drugs themselves, the treatments when individuals overdose or suffer other medical consequences of addiction, and the treatments

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practices include requiring urine screens to catch drug diversion and implementing pain contracts with patients to outline the expectations and the limits of the therapeutic relationship if diversion or abuse is suspected. For a critique of opioid pain contracts, see Daniel S. Goldberg & Ben Rich, *Pharmacovigilance and the Plight of Chronic Pain Patients: In Pursuit of a Realistic and Responsible Ethic of Care*, 11 IND. HEALTH L. REV. 83, 118–20 (2014). For support of pain contracts as a standard of care in opioid therapy, see Scott M. Fishman et al., *The Opioid Treatment Agreement: A Real-World Perspective*, 10 AM J. BIOETHICS 14, 14–15 (2010).

[55] E-pharmacies, or pharmacies conducted predominantly online, can pose their own unique risks when it comes to improper filling of opioid prescriptions. For a discussion on how e-pharmacy abuse can be prevented and regulated, see Amy L. Cadwell, *In the War on Prescription Drug Abuse, E-Pharmacies Are Making Doctor Shopping Irrelevant*, 7 HOUS. J. HEALTH L. & POL'Y 85 (2006).

[56] For a good summary of how a state PDMP might regulate prescribers and prescribing practices, see Nathan Trexler, *Developments in Delaware Health Law: Addressing Prescription Drug Abuse*, 14 DEL. L. REV. 29, 30–32 (2013). *See also* Parker Tricarico, *A Nation in the Throes of Addiction: Why a National Prescription Drug Monitoring Program is Needed Before It Is Too Late*, 37 WHITTIER L. REV. 117, 119 (2015) (arguing that PDMPs are underfunded and underutilized, and advocating for a single federal system to track prescription drug use and prescribing as opposed to state-by-state programs).

[57] Currently, thirty-five states have functional PDMPs and another eleven have authorized but not fully implemented them. *Prescription Drug Monitoring Programs*, OFFICE OF NAT'L DRUG CONTROL POL'Y https://obamawhitehouse.archives.gov/ondcp/ondcp-fact-sheets/prescription-drug-monitoring-programs [https://perma.cc/MA93-MKUA].

[58] *Id.*

[59] *See, e.g.*, Hsien-Yen Chang et al., *Impact of Prescription Drug Monitoring Programs and Pill Mill Laws On High-Risk Opioid Prescribers: A Comparative Interrupted Time Series Analysis*, 165 DRUG & ALCOHOL DEPENDENCE 1, 3–7 (2016) (exploring through time series analysis the impact of a variety of Florida-based pill mill laws and the establishment of a state PDMP on the state's highest opioid prescribers).

for patients abusing these drugs.[60] Indeed, the increased coverage of opioid medicines by insurers appears to drive, in some instances, the increased prescription and consumption of these medicines.[61]

Insurers have a vested interest in reducing harmful abuse of opioids and clear leverage to play as the gatekeeper to access for these pharmaceuticals. Given this interest, it is unsurprising that insurers, both public and private, have already begun to make changes to adjust to this painkiller crisis including monitoring prescribing patterns and controlling access to opioids by some patients. However, regulators have paid little attention to the promise and perils of insurers in this regard. The next section describes current efforts by insurers to stem the tide of prescription painkiller abuse, before turning to some of the pitfalls of these efforts to which regulators must be alert.

1. Health Insurers' Interest in Curbing Prescription Painkiller Abuse

Insurers pay a heavy cost in the over-prescribing crisis.[62] Given the rise in painkiller consumption, spending on opioid painkillers has likewise significantly increased, rising from $2.3 billion in 1999 to $7.4 billion in 2012.[63] Insurers, both public and private, increasingly shoulder this burden. While insurers only paid for forty-two percent of all opioid spending in 1999, this rose to eighty-two percent in 2012.[64] The effect is particularly straining on public insurance programs. Medicare and Medicaid paid for about nine percent of all opioid drug spending in 1999, but since the adoption of Medicare Part D (the prescription drug plan aimed at lowering out-of-pocket drugs costs for the elderly) in 1996, Medicare alone has covered almost twenty to thirty percent of the overall pool of spending for opioids in the country.[65]

One reason for the increased expenditures by insurers may harken back to the pain-as-fifth-vital-sign movement, which resulted in increased pressure on insurers to cover painkillers.[66] Moreover, insurers, both public and private, were generally increasing coverage for drug plans around that same

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[60] *See* Sonia Moghe, *Health Insurance Companies Step Up to Fight the Opioid Epidemic*, CNN (May 19, 2016, 1:39 PM), http://www.cnn.com/2016/05/19/health/health-insurance-companies-opioid-epidemic/ [https://perma.cc/8DH6-KRGA].

[61] David Powell et al., *How Increasing Medical Access to Opioids Contributes to the Opioid Epidemic: Evidence from Medicare Part D* (NBER, Working Paper No. 21072, 2016).

[62] Chao Zhou et al., *Payments For Opioids Shifted Substantially to Public and Private Insurers While Consumer Spending Declined, 1999-2012*, 35 HEALTH AFF. 824, 826–27 (2016).

[63] *Id.*

[64] *Id.* at 828. Consumer spending dropped off during the same time from fifty-three percent to eighteen percent. *Id.*

[65] The majority of Medicare's spending on opioids is for persons under the age of sixty-five with a long-term disability or end-stage renal disease. *Id.* at 827.

[66] *Id.* at 824.

time.[67] Perversely, the increased spending by insurers on painkillers may have contributed to some abuse, as it removed the financial burden for patients to acquire these medications.[68] Insurance coverage appears to correlate with increased uptake of opioid prescriptions, in that providers may be more likely to recommend these drugs and patients more able to fill the prescriptions.[69] For example, when Medicare Part D expanded to cover opioid prescriptions, a significant uptick of prescriptions of these drugs followed.[70] Interestingly, abuse patterns tended to be greater in the nonmedical population than the medical population, suggesting some significant amount of diversion by Medicare patients, whether intentional or unintentional.[71]

Beyond the actual cost of prescriptions, insurers also foot the bill for some medical care related to addiction. CeltiCare, a Massachusetts-based managed care insurer that covers Medicaid patients, estimates that a quarter of the inpatient hospital stays it reimburses each year are a result of substance abuse, while ten percent of its annual spending went toward suboxone, a drug used to treat addiction.[72]

2. Health Insurers' Potential to Curb Prescription Painkiller Abuse

The expenses of this epidemic, shouldered by insurers, create an incentive on their part to heal this broken system. Moreover, the central role they play in purchasing these medications means they must necessarily be engaged in any regulatory effort.[73] This section describes key roles that insurers can play (and already are playing) on two battlefronts: (a) the prevention of new cases of prescription painkiller addiction and (b) the treatment and cure of existing cases of addiction. Many of the actions insurers can take are already being taken by public insurers and by some private insurers. To the extent that they prove successful, we can anticipate widespread adoption of some efforts by most private insurers. Regulators should be aware of these trends and assess whether they are helpful or harmful to the goals of remedying this crisis.

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[67] *Id.*

[68] Powell et al., *supra* note 61.

[69] *Id.*

[70] *Id.* at 15–16.

[71] *Id.*

[72] 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/Z7N5-6J7U].

[73] Insurers are increasingly being asked to take part in the advisory processes to come up with statewide and national plans to tackle this problem. For example, the New England Comparative Effectiveness Public Advisory Council engaged insurance stakeholders and provided specific guidance for insurance reform with respect to opioid dependence. *See New England Comparative Effectiveness Public Advisory Council Public Meeting—June 20, 2014, Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options Final Report—July 2014*, Inst. Clinical & Econ. Rev. (July 2014), http://icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf [https://perma.cc/X59A-PJP9].

a. Preventing New Cases of Prescription Painkiller Addiction

Insurers pay for the majority of opioids that are prescribed in this country.[74] Insurance claims data can be used—and already is being used—to monitor who fills prescriptions, how often, and where, to intervene in harmful prescribing relationships and to change the level of availability of prescription drugs overall as described below.

While coverage varies by insurer, one effort insurers can make is to cover more proven alternatives to addictive painkillers. Insurers at large typically do not cover certain services that can improve pain but are non-addictive, like physical therapy, psychological therapy, or aerobic and aquatic training.[75] Insurers can also promote pain treatments that are less readily abused. Certain formulations of opioids are harder to abuse; for example, some pills activate anti-opioid receptors if the pill is crushed or snorted, rather than swallowed.[76] States are encouraging insurers to cover these drugs, and insurers can make the drugs easier for physicians to prescribe by eliminating preapproval requirements for these drugs while still requiring it of other opioids.[77]

Insurers, as the payers of these medications, also have great sway in changing prescribing patterns. Insurers can collaborate with hospitals, providers, public health agencies, and others to enhance provider education through continuing education events and through collaborative guidelines.[78] They can also alter their covered medicine policies (or formularies) to make it more difficult for prescribers to act inappropriately. Insurers can review drug coverage policies for whether their coverage reflects the most recent state of evidence regarding safe and effective pain management.[79] And they can make it a practice to cover affordable strategies to quickly identify

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[74] *See* Zhou et al., *supra* note 62, at 828.

[75] Deborah Dowell et al., *CDC Guidelines for Prescribing Opioids for Chronic Pain—United States, 2016*, Ctrs. for Disease Control & Prevention (Mar. 18, 2016), https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm [https://perma.cc/E3UF-568U].

[76] For examples of these types of medications, see *FDA Approves New Pain Pill Designed to Be Hard to Abuse*, *supra* note 49.

[77] Nathaniel P. Katz et al., *Prescription Opioid Abuse: Challenges and Opportunities for Payers*, 19 Am. J. Managed Care 295 (2013). For more on "abuse-deterrent formulations" and how greater access to them can help to fight opioid addiction, see Kyle Simon et al., *Abuse-Deterrent Formulations: Transitioning the Pharmaceutical Market to Improve Public Health and Safety*, 6 Therapeutic Advances Drug Safety 67, 74–75 (2015).

[78] *Ensuring Safe and Appropriate Prescription Painkiller Use: The Important Role of Community Health Plans*, Alliance of Cmty. Health Plans (Nov. 2012), http://www.achp.org/wp-content/uploads/ACHP-Brief-Ensuring-Safe-and-Appropriate-Prescription-Painkiller-Use1.pdf [https://perma.cc/BVP2-X42U].

[79] For example, Medicaid has recommended removing methadone from its list of preferred drugs for pain management because it has been shown to be disproportionately linked to opioid overdose death. Ctrs. for Medicare & Medicaid Servs. Informational Bulletin, Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction (Jan. 28, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf [https://perma.cc/8K9N-ET3C].

opioid abuse. For example, many insurers do not currently cover urine-screening tests, which may disincentivize doctors from requiring them.[80]

Insurers can also reduce the chance of abuse by limiting the number of pills covered in a single prescription for painkillers. For example, if an individual is having a single surgery, the opioid prescription can be limited to a small amount, to lessen the chance that the individual extends use and risks addiction.[81] Insurers can also require step therapy, mandating that patients try other non-addictive pain therapies first and limiting opioid "use to only those patients for whom treatment with other pain medications is ineffective."[82] Forty state Medicaid agencies engage in some form of quantity limit or prior authorization in prescription painkillers.[83] These activities are likely enough to improve prescribing patterns by most well-intentioned prescribers. Of course, many of these efforts also sharply limit availability of opioids, so a balance must be struck between reducing the risk of addiction for patients while also ensuring that those patients who need opioids get them.

Healthcare fraud and abuse laws are another mechanism to address some problematic prescribing if it rises to the designated level of intent and/or criminality.[84] A 2012 study found that five state Medicaid agencies alone paid sixty-three million dollars in fraudulent controlled substance prescriptions and that efforts to find and enforce fraud were inadequate.[85] With a growing focus on healthcare fraud and growing funding being dedicated to these efforts, private and public insurers can monitor their claims data to identify providers who are outliers in their prescribing patterns.[86] They can also potentially use prescription drug monitoring programs to monitor prescriptions that are not in their claims data, if, for example, a patient is claiming coverage but also buying other prescriptions out-of-pocket.[87] However,

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[80] Dowell et al., *supra* note 75.

[81] Becker, *supra* note 72.

[82] CMS Bulletin, *supra* note 79, at 3.

[83] Pew Charitable Trusts, Curbing Prescription Drug Abuse With Patient Review and Restriction Programs: Learning from Medicaid Agencies (Mar. 28, 2016), http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/03/curbing-prescription-drug-abuse-with-patient-review-and-restriction-programs [https://perma.cc/RT2X-9B9X]. By limiting the quantity that can be prescribed in a single prescription, insurers have a better capacity to review the frequency and duration of the use of the drug for any given patient. CMS Bulletin, *supra* note 79.

[84] For an extensive discussion of the intersections between opioid addiction and fraud and abuse prosecutions, see *Prescription for Peril: How Insurance Fraud Finances Theft and Abuse of Addictive Prescription Drugs*, Coalition Against Ins. Fraud (Dec. 2007), http://www.insurancefraud.org/downloads/drugDiversion.pdf [https://perma.cc/SMU2-CP2K].

[85] Preventing Prescription Abuse in the Workplace Technical Assistance Center, *supra* note 12, at 1.

[86] While fraud and abuse laws are typically targeted at reclaiming stolen federal healthcare funds (for example, wrongful prescribing in Medicare and Medicaid), private insurers can monitor and try to recoup lost funds, too. For example, see the Public Private Partnership to Prevent Healthcare Fraud where public and private insurers share strategies for tackling healthcare fraud and abuse. *See, e.g.*, *Public-Private Partnership to Prevent Health Care Fraud*, STOP Medicaid Fraud, http://www.stopmedicare/fraud.gov [https://perma.cc/WRG5-3B8Y].

[87] Many states do not have access through their Medicaid systems to the PDMP either because the state does not permit insurers access, or because that access has not been imple-

fraud laws alone are not enough to tackle this epidemic. One reason is that they require broad and constant enforcement, which can be costly. Also, they are designed to target intentional and wrongful conduct—for example, where a doctor bills for services he did not provide. Many doctors who over-prescribe pain pills do not do so with criminal intent but out of a lack of understanding of good medical practice surrounding pain management.[88]

Insurers can use their claim data to monitor patients for signs of potential prescription painkiller abuse and intervene as needed.[89] Drug utilization review uses data to monitor groups of patients and individual patients at risk of addiction or overdose. Insurers can monitor their insureds for instances where patients are receiving high doses of opioids, high frequencies of prescriptions, or are receiving opioids from multiple prescribers and pharmacies.[90]

A related concept is the increasing use of patient review and restriction programs (PRRs). Like drug utilization review, PRRs identify potential abusers of opioids. However, instead of recommending treatment, PRRs respond to risk by controlling the patient's access to further opioids. Opioid access is limited to a single provider or single pharmacy, so as to better

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mented. The same is true for private insurers. *See* PEW CHARITABLE TRUSTS, *supra* note 83, at 17. Davis argues that insurers should have broader access to PDMPs because this type of population-level data is necessary to better understand trends occurring in the epidemic, just as population-level data is needed to understand movements in any epidemic. *See* Corey Davis et al., *Addressing the Overdose Epidemic Requires Timely Access to Data to Guide Interventions*, 35 DRUG & ALCOHOL REV. 383, 384 (2016).

By being able to monitor where more patient abusers are located and where more prescribers or high-filling pharmacies are located, insurers may be able to target efforts at communities and states where there is currently a more significant and immediate struggle. Insurers and state agencies view this failure of access to PDMPs as a major barrier to recognizing problematic prescribing in physicians and abuse in patients. *See* PEW CHARITABLE TRUSTS, *supra* note 83, at 23. Such monitoring may also enable insurers and the government to use fraud laws to go after patients who abuse opioids. This may be a positive act if insurers target patients who are diverting and selling drugs, though it may be problematic if they are seeking to fine and penalize significantly individuals who are addicted to and are abusing these drugs themselves. An extreme example of such a scenario involves a woman who allegedly visited area hospitals over 300 times with self-inflicted shoulder dislocations in order to obtain opioid prescriptions. The defendant was accused of visiting 100 different hospitals across 11 states to obtain over 190 prescriptions pills at the cost of over $600,000 to her insurance, Highmark. Amy Wadas, *Feds: Woman Repeatedly Dislocated Shoulder to Get Pain Pills*, CBS PITTSBURGH (May 31, 2016, 10:26 AM), http://pittsburgh.cbslocal.com/2016/05/31/feds-woman-repeatedly-dislocated-shoulder-to-get-pain-pills/ [https://perma.cc/Q72P-RWFD].

[88] Fraud and abuse laws typically require some sort of intentional misconduct on the part of the healthcare provider, or at least something above mere negligence. In some fraud cases, this can be easy to prove if, for example, a provider is billing for services they never provided. Cases of wrongful prescribing, though, often go to the heart of provider discretion with respect to what is appropriate medical care for their patients. As one example, did a physician prescribe an overly large quantity of opioids for a patient because he engaged in reckless medicine and did not appropriately monitor his patients, or did he take on patients who had high tolerances for opioids and needed large doses for pain management? For more on the tensions between fraud prosecutions and medical judgment, see generally Isaac D. Buck, *Caring Too Much: Misapplying the False Claims Act to Target Overtreatment*, 74 OHIO ST. L.J. 463 (2013).

[89] *See* Becker, *supra* note 72.

[90] *See* CMS BULLETIN, *supra* note 79, at 7.

control the patient's use of drugs. PRRs frequently use a pharmacist, a clinician, or a combination of healthcare workers to evaluate which patients may be candidates for the PRR; they exclude patients who are more likely to require extensive pain therapy (like cancer and sickle cell patients, patients in long-term care, and patients in hospice), and they use multiple measurements to determine who qualifies for PRR.[91] Once a patient has been designated for PRR, there can be an opportunity for appeal, and patients may be permitted to provide input on which provider or pharmacy they want to retain.[92] Medicare and Medicaid have implemented such efforts.[93] Private insurers have also begun to follow suit, including major national insurers like Cigna,[94] Aetna,[95] and Blue Cross.[96] Private insurers are seeing significant cost-savings through these efforts. For example, Aetna claims a fifteen percent decline in opioid abuse across its four million members over a two-year period after implementing such a program.[97] Blue Cross claims a reduction of six million pills across its Massachusetts insurance pool over an eighteen-month period.[98]

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[91] Common criteria include visiting a designated number of unique pharmacies or unique doctors over a given period of time, obtaining or filling a designated number of prescriptions, or visiting an emergency room a designated number of times. Referrals are also possible by providers who suspect a patient is abusing prescription drugs. *See* PEW CHARITABLE TRUSTS, *supra* note 83, at 8.

[92] *Id.* at 12.

[93] Medicare monitors prescription drug utilization by its beneficiaries through the Medicare Overutilization Monitoring System in Medicare Part D. High-risk beneficiaries are identified and reported to Part D sponsors who must follow up and report their efforts back to CMS. Medicare defines high-risk users as any beneficiary who has a morphine equivalent dose of 120 milligrams for at least 90 consecutive days, and receives their prescriptions from more than three pharmacies or prescribers. *Medicare Part D Overutilization Monitoring System (OMS) Summary*, DEP'T OF HEALTH & HUMAN SERVS. (Nov. 3, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-11-03.html [https://perma.cc/E86B-CAEC]. Medicaid, as of December 2015, newly measures which patients have multiple prescriptions of high levels of opioids from more than one provider, as one example. *See* CMS BULLETIN, *supra* note 79, at 7. PRR is very popular among Medicaid agencies. Of fifty-two state Medicaid programs, forty-nine have some form of PRR with the exceptions of California, South Dakota, and Puerto Rico. PEW CHARITABLE TRUSTS, *supra* note 83, at 3.

[94] Moghe, *supra* note 60. Cigna is monitoring patient use and provider prescribing practices for signs of inappropriate activity. Cigna also provides hotlines to funnel patients into available treatment centers. *See One Insurer's Efforts to Assist in Massachusetts' Opioid Overdose Crisis*, AM. SOC'Y ADDICTION MED. (Mar. 11, 2016), http://www.asam.org/magazine/read/article/2016/03/11/one-insurer-s-efforts-to-assist-in-massachusetts-opioid-overdose-crisis [https://perma.cc/PAF6-YGDE]; Katz, *supra* note 77 (discussing patient screening generally).

[95] Aetna's program limits the number of available pills for at-risk patients, notifies pharmacies if they are filling scripts at outlier rates, refers high-using patients to behavioral health, and, where patients decline offers of assistance and treatment, limits medicine to a single provider or a limited number of refills. PREVENTING PRESCRIPTION ABUSE IN THE WORKPLACE TECHNICAL ASSISTANCE CENTER, *supra* note 12, at 3.

[96] Blue Cross Blue Shield of Massachusetts's program limits opioids to two successive fifteen-day prescriptions. To prescribe more than thirty days of such medicine within a two-month period, there must be preauthorization by the insurer. *Id.* at 12.

[97] *Id.*

[98] *Id.*

b. Treating Existing Cases of Prescription Painkiller Addiction

Insurers can also ensure that addiction treatments and other related therapies are adequately covered for those already struggling with addiction to opioids.[99] Historically, insurers have not funded addiction treatment as generously as other costly medical services like cardiac care or organ transplant.[100] Addicted patients were sometimes excluded from enrollment in insurance or charged very high premiums.[101] Some insurers also opted not to cover addiction services, or pushed the costs of these services back onto patients through very high co-pays.[102] One reason for this lack of parity between medical care and addiction services may be stigma; if addiction disorders are perceived as the fault of the addicted and not worthy of treatment, then regulators and the public will be less likely to press for equal coverage.[103] Additionally, some may believe that addiction treatment is too costly and will raise insurance premiums too significantly, placing burdens on other insureds and taxpayers.[104] However, adequately treating addiction through the healthcare system can save taxpayers dollars in other ways, such as by improving workplace productivity and reducing accidents, death, and involvement in the criminal justice system.[105]

The National Center on Addiction and Substance Abuse has published guidelines on adequate substance abuse treatment.[106] Patients must have access to adequate screening and diagnosis of addiction; withdrawal manage-

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[99] Lynn R. Webster, *Pills, Policies, and Predicaments: The Unintended Consequences of a Health Care System's Policy Toward Opioids*, 14 PAIN MED. 1439, 1439 (2013). Webster, as President of the American Academy of Pain Medicine, says that insurers can better fund access to addiction services, and better address the mental health needs of patients that can sometimes be tied to substance abuse. *See Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*, NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE ii (June 7, 2016), http://www.centeronaddiction.org/download/file/fid/1678 [https://perma.cc/K7QK-UT75] (observing that "[c]omprehensive insurance coverage for addiction, alone, will not eradicate the opioid crisis—but it is essential").

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

[101] *See id.* at 2359; *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, 570 (2014).

[102] *See* Starr, *supra* note 100, at 2323; Barnes & Worthy, *supra* note 101, at 572.

[103] *See* Starr, *supra* note 100, at 2321; Barnes & Worthy, *supra* note 101, at 557.

[104] *See* Barnes & Worthy, *supra* note 101, at 557. Additionally, it has been common practice pre-ACA for insurers to avoid covering preventive services. *See* Sara Rosenbaum, *New Directions for Health Insurance Design: Implications for Public Health Policy and Practice*, 31 J.L. MED. & ETHICS 94, 98 (2003).

[105] *See Principles of Drug Addiction Treatment: A Research-Based Guide*, NAT'L INST. ON DRUG ABUSE 13 (3d ed. 2012), https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost [https://perma.cc/J2R7-745K].

[106] *EHB Recommendations for States: Critical Addiction Prevention and Treatment Benefits for Essential Health Benefits (EHB) Benchmark Plans*, NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE (July 2013), http://www.centeronaddiction.org/sites/default/files/files/8_3%20EHB-recs-for-states.pdf [https://perma.cc/9H2A-JARQ].

ment and detoxification services; addiction treatment, including medical and psychosocial services; and long-term monitoring.[107] Insurers can improve access to addiction services by ensuring that the insurance adequately covers cutting-edge addiction services that are comprehensive, and by reducing barriers to access, including pre-authorization requirements and high cost sharing.[108] Insurers are already beginning some of these efforts to better cover addiction treatment, for example, by including state-of-the-art addiction treatments in insurance plans and following up with patients in detox programs to better coordinate their addiction care.[109] But there is a long way to go to achieve truly successful addiction care for the population.

While insurers may not seek generous addiction benefits of their own initiative, regulations and laws have gone a long way toward mandating that insurers be more generous in their coverage of addiction services. All of the reforms that have led to more generous benefits face the threat of repeal under the new Trump Administration now or in the future. Thus, these benefits should be assessed not only on the basis of the good they do now but also in terms of any harms that might attend their repeal.

Most importantly, under the ACA, substance abuse disorders can no longer be treated as a preexisting condition.[110] Insurers are not allowed to discriminate against patients who suffer from addiction[111] with respect to premiums[112] or enrollment. Those with addiction can thus purchase insurance at the same rates and eligibility as others, when they might previously have been excluded because of their addiction.

The ACA also mandates that insurers cover certain drugs and therapies as essential health benefits.[113] While many insurers may have opted to exclude these drugs in the past,[114] insurers are now mandated to cover mental health and substance abuse disorder (SUD) services as one of the ten essen-

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[107] *See id.* at 5–8.

[108] *See, e.g.*, *One Insurer's Efforts to Assist in Massachusetts' Opioid Overdose Crisis*, *supra* note 94.

[109] Becker, *supra* note 72.

[110] For a broad and introductory overview of the ACA's many reforms to the healthcare system, especially reforms of the private insurance system, see *Summary of the Affordable Care Act*, KAISER FAMILY FOUND. (Apr. 25, 2013), http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/ [https://perma.cc/QKB9-ZXND]. For the relevant provision banning discrimination by insurers on the basis of all preexisting medical conditions, including substance abuse, see Patient Protection and Affordable Care Act §§ 2702–05, 42 U.S.C. §§ 300gg-1–300gg-4.

[111] *See* 42 U.S.C. § 300gg (2012). Insurers may not also discriminate in insurance renewals. *See id.* at 300gg-1-300gg-4.

[112] *See id.* at section 300gg.

[113] *See id.* at § 18022(b)(1). EHBs require coverage of some medical care in ten key areas, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.

[114] *See* Dowell, *supra* note 75 (noting that "patient cost can be a barrier to buprenorphine treatment because insurance coverage of buprenorphine for opioid use disorder is often limited" (citation omitted)).

tial health benefits.[115] Insurers must cover at least one opioid dependence drug, like suboxone.[116] Insurers must also cover one opioid overdose reversal agent, like naloxone.[117] Naloxone and similar drugs are fast-acting opioid reversal agents that can be deployed during an opioid overdose to reverse the overdose and save the patient's life. Naloxone is widely available in pharmacies, and public servants like Emergency Medical Technicians and police officers are increasingly carrying naloxone and being trained on how to administer it.[118]

Beyond these mandates, however, insurers have discretion in which types of addiction treatments they will cover. One ongoing area of controversy is whether insurers must cover medication-assisted treatment (MAT).[119] MATs combine drugs with behavioral therapy, detox, and other methods and have been proven to enhance the likelihood of recovery from opioid addiction.[120] While the cost of a single regimen of MATs is negligible compared to many other drugs (at seventy-six dollars per week), the cumulative cost may be significant, as the population using MATs has increased significantly and will likely only increase.[121] The Department of Health and Human Services (HHS) has yet to issue definitive guidance on whether insurers are mandated to cover MATs but has discussed issuing specific MAT guidance in the future.[122] In March 2016, the Obama Administration also put forth a number of other efforts to enhance MAT access.[123] Similar debates

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[115] HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 12,203 (Mar. 8, 2016).

[116] *See* NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 99. Methadone is not explicitly required to be covered by the ACA and is not covered by Medicare Part D. *See also* Notice of Benefit and Payment Parameters for 2017, *supra* note 115, where DHHS, in its annual guidance on benefits and regulations of the insurance market, acknowledged that the EHB provision requires insurers to cover "medications to treat opioid dependence."

[117] *Id.*

[118] For arguments on the importance of naloxone as a broader policy strategy to reduce the opioid epidemic and its attending harms, see Dineen, PSYCHOL. REV., *supra* note 30, at 75–77.

[119] For a discussion of the importance of MAT as a leading evidence-based standard for addiction treatment and various policy considerations to enhance access, see Barbara Andraka-Christou, *America Needs the TREAT Act: Expanding Access to Effective Medication for Treating Addiction*, 26 HEALTH MATRIX 309 (2016).

[120] *See Medication-Assisted Treatment for Opioid Addiction*, NAT'L INST. ON DRUG ABUSE 2 (Apr. 2012), https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf [https://perma.cc/4VRE-GPVW].

[121] *See* Steven Ross Johnson, *Medication-Assisted Addiction Treatment Faces Cost and Payment Concerns*, MODERN HEALTHCARE (Dec. 30, 2015), http://www.modernhealthcare.com/article/20151230/NEWS/151239992 [https://perma.cc/6YLG-68LR].

[122] In comment periods, a mandate to cover some MATs met mixed reviews. Many commentators supported the inclusion of MATs under EHBs, citing cost-effectiveness and clinical success rates. Commentators also emphasized that insurers have placed limits on MATs through utilization review, and some states have excluded MATs from their model state plans, meaning a federal mandate could improve access. Some insurers argued against the inclusion of MATs in EHBs, worried that being locked in to any single drug therapy could prohibit them from competing with pharmaceutical companies for lower prices. *See* Notice of Benefit and Payment Parameters for 2017, *supra* note 115. Increased funding is available to both the states and community health centers to enhance availability of MATs.

[123] These include funding to community health centers and to states to enhance availability of MATs. *See Fact Sheet: Obama Administration Announces Additional Actions to Address the*

about MAT coverage have been playing out in other federal healthcare programs.[124] It is unclear what the current Trump Administration will do with respect to this issue.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) also monitors insurance coverage of addiction services.[125] The law requires group health plans to ensure that any treatment restrictions (like limits on the number of days covered, frequency of visits, etc.) and financial restrictions (copays, deductibles, out-of-pocket expenses) not be any greater for addiction services than for other medical or surgical services.[126] The final regulation also requires parity in non-quantitative treatment restrictions, like requirements for step therapy or pre-authorizations.[127] In addition, to the extent an insurer covers services in certain settings (like outpatient, inpatient, out-of-network, drug prescription, and emergency services), it must also cover addiction services in those same settings.[128] While the MHPAEA did not apply to small-group or individual insurers, the ACA extended the MHPAEA requirements to those insurers offering insurance on federal and state insurance exchanges through the EHB provisions.[129] Still, the law has been critiqued because it fails to actually mandate coverage of addiction services, instead only requiring that, if offered, they be offered in parity with other services.[130]

In practice, insurers are falling short of these mandates. In a study of all 2017 state benchmark plans which set the baseline standard for what many private insurers must cover, over two-thirds did not comply with ACA EHB requirements for substance abuse coverage.[131] Twenty states' plans did not cover an opioid reversal agent, two states' plans wrongfully imposed lifetime limits for addiction services, one plan did not cover adequate diagnosis and screening for substance abuse, and some plans did not address coverage for

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Prescription Opioid Abuse and Heroin Epidemic, THE WHITE HOUSE (Mar. 29, 2016), https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address [https://perma.cc/7TXD-FAP3].

[124] These include TRICare, the healthcare program for active duty military, and the Federal Employee Health Benefits program. *See id.*

[125] *See* Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, 122 Stat. 3765 (2008).

[126] For example, an insurer cannot impose a deductible to see an addiction therapist that is not also imposed on a diabetes patient, or place a limit of only two visits per month that is unique to addiction service and not also applicable to other non-addiction services. *Id.*

[127] 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).

[128] *See* Barnes & Worthy, *supra* note 101.

[129] *See id.* The MHPAEA does not apply to public insurers, with some exceptions for managed care elements of CHIP/Medicaid. *See Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTR. FOR CONSUMER INFO. & INSURANCE OVERSIGHT, https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html#Regulation [https://perma.cc/RBZ7-9MFV]. The states also may have their own versions of such laws that may be more stringent than the MHPAEA. *See* Barnes & Worthy, *supra* note 101, at 558.

[130] *See* Barnes & Worthy, *supra* note 101, at 568.

[131] *See* NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 99, at 11.

addiction screening for adolescents.[132] Likewise, many insurers have failed to comply with mental health parity laws.[133] Thirty-three states required prior authorization for a range of addiction services, which might delay or prevent access.[134] Some states have significant cost sharing for addiction services (as high as $500–2500 per day or $750 copayments).[135] A number of states, in their model plans, are placing limits on inpatient and outpatient addiction services only or lifetime limits on addiction services (and did not place those same limits on other clinical services).[136] Some states did not include coinsurance for addiction services as part of the annual out-of-pocket limit, leaving extra costs on the patient.[137] Eighty-eight percent of state plans did not provide sufficient detail in their policy statements for regulators to be able to see whether the plans were in compliance with EHB and mental health parity laws.[138] The reasons why these state plans are falling short may be many, but one reason may be that states are reluctant to set too high of a bar if they only have a few insurers offering insurance on their marketplaces. They may also fear that more generous coverage will result in spiked premiums, driving consumer backlash.

Insurers clearly hold great promise in their ability to change the scope of the prescription painkiller crisis. They are already changing prescribing patterns, monitoring patients for signs of abuse, intervening when necessary, and promoting plans that offer sufficient addiction services. Despite the lack of widespread federal regulation, insurers are already making various changes in a piecemeal way. The next part advocates for a broader regulatory examination of what efforts are occurring at the insurer level (public and private) and considers some of the perils if regulators fail to anticipate and address some of the goals of insurers that may run counter to the broader public health aim of resolving this epidemic.

III. The Need for Regulatory Review of Insurance Practices

As the previous parts have suggested, insurers have the power and clear incentives to curb prescription painkiller abuse, and they are acting accordingly. In some instances, insurers are acting on their own volition out of the interest of driving down healthcare costs, for example by attempting to prevent wasteful and inappropriate prescribing. In other circumstances, insurers are being forced to make changes to comply with regulations. For example, they are more generously covering addiction treatments because of the ACA and the Mental Health Parity Act.

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[132] *Id* at 26–29.
[133] *Id* at 1.
[134] *Id.* at 37–46.
[135] *Id.* at 21.
[136] *Id.* at 3.
[137] *Id.* at 32, 35.
[138] *Id.* at 1.

The federal government has yet to undertake a widespread effort to consider the role of insurers in addressing this epidemic. In doing this, regulators should take into account some key considerations and pitfalls that can arise as insurers increasingly engage this epidemic. In this part, I consider three key issues that regulators might consider. First, our insurance system is heavily fragmented, meaning that a concerted federal effort will be necessary to ensure that any changes by insurers are widespread. Second, there is a risk that insurers' strategies to reduce opioid abuse will result in discrimination against those in poor health, significantly worsening the plight of the addicted. Regulators should pay particular attention to any efforts by insurers to reduce care, and whether such efforts achieve broader health goals. They should also be aware of the need to incentivize insurers to cover costly (but health-beneficial treatments) like comprehensive addiction services. Lastly, insurers are not necessarily seeking the same goals as the public in this realm. Insurers worry about their insureds', not necessarily the wider public's, health, so enlisting them in a public health crisis requires caution and consideration for the impact on third parties.

A. Fragmentation of Health Insurance

Healthcare financing in the United States is often criticized for being highly fragmented.[139] We have different health insurance programs abiding by different laws for the elderly, the poor, veterans, active-duty military, children, employed persons, and others.[140] Yet the prescription painkiller epidemic is sweeping and widespread, and few populations appear immune to it.[141] Abusers of opioids can be found in any of the populations above.[142] To the extent that insurers are a critical element of the battle against prescription painkiller abuse, this fragmentation is problematic. There are simply too many insurers, private and public, likely resulting in inconsistent and patchwork efforts without uniform regulation.[143]

Moreover, even after the ACA, approximately ten percent of our nonelderly population remains without health insurance.[144] To the extent these individuals are obtaining and abusing opioids, they are doing so outside of

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[139] *See, e.g.*, John Noseworthy, *Overcoming Fragmentation in Health Care*, HARV. BUS. REV. (Oct. 11, 2013), https://hbr.org/2013/10/creating-a-sustainable-model-for-health-care [https://perma.cc/F6SQ-9PZ9].

[140] For an overview of where individuals get their health coverage, see *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUND., http://kff.org/other/state-indicator/total-population/?currentTimeframe=0 [https://perma.cc/6BH5-RQFJ].

[141] *See Specific Populations and Prescription Drug Misuse and Abuse*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/prescription-drug-misuse-abuse/specific-populations [https://perma.cc/KYG9-ZLP7].

[142] *See id.*

[143] *See* Sara Rosenbaum et al., *Public Health Emergencies and the Public Health/Managed Care Challenge*, 30 J.L. MED. & ETHICS 63, 64 (2002).

[144] *Key Facts About the Uninsured Population*, KAISER FAMILY FOUND. (Sept. 29, 2016), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ [https://perma.cc/TK78-GGXS].

the healthcare payment system, and many remedies by insurers cannot reach them. Worse still, these individuals will likely not have adequate access to addiction services without some form of health insurance.[145] This is particularly true in the course of rural opioid abuse, where rural residents may be without adequate access to healthcare and financing.[146] And even for those who have access to insurance, rehabilitation has frequently been inadequately covered, as earlier sections suggest.[147] This may be even more significant if the new Congress repeals the ACA or eliminates its essential health benefits provision mandating coverage of certain addiction services.[148]

Appropriate coverage of necessary pain medicine and coverage for addiction services are both critical. Regulators must consider how to more widely ensure access to these services, particularly for the uninsured, and this may prove even more difficult if the ACA is repealed and many people lose coverage.[149] Regulators may leverage the overwhelming bipartisan backing of opioid reforms (as shown in the passage of the Comprehensive Addiction and Recovery Act) to advocate for expansive coverage of addiction treatment across the uninsured and the various types of health insurance programs.

B. Health-Status Discrimination

Insurers hold a great deal of power over prescribers and patients that they can leverage to reduce abusive opioid practices, and they are already beginning to use this power to that end. However, to achieve positive public health goals of preventing and fully treating painkiller abuse, regulators must ensure that insurers use this power in a way that does not discriminate against patients, particularly on the basis of their health status.

In short, insurers are wired to avoid and minimize risk and, in the case of healthcare, risk equates with expensive healthcare consumption.[150] This is

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[145] Rosenbaum, *supra* note 104, at 96.

[146] Lisa R. Pruitt, *The Forgotten Fifth: Rural Youth and Substance Abuse*, 20 STAN. L. & POL'Y REV. 359, 388–89 (2009).

[147] In the past, people frequently had to pay out-of-pocket for treatment for addiction, or insurers have limited the number of covered days. *See* Ben Allen, *When Rehab Might Help an Addict—But Insurance Won't Cover It*, NPR (Aug. 16, 2015), http://www.npr.org/sections/health-shots/2015/08/16/430437514/when-rehab-might-help-an-addict-but-insurance-wont-cover-it [https://perma.cc/NNS8-PKXZ].

[148] Robert Pear & Thomas Kaplan, *House G.O.P. Leaders Outline Plan to Replace Obama Health Care Act*, N.Y. TIMES (Feb. 16, 2017), https://www.nytimes.com/2017/02/16/us/politics/affordable-care-act-congress.html [https://perma.cc/7PSP-4PCW].

[149] Rosenbaum has discussed how the failure to have a portion of the population with insurance is a public health threat in and of itself, as it means a failure to finance their needed healthcare in public health emergencies or epidemics. Rosenbaum, *supra* note 104, at 95.

[150] Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, U. ILL. L. REV. 1159, 1163 (2012) ("charging insureds rates based on their relative risk . . . [is] exactly what allow[s] health insurers to profit."); *see also* Wendy K. Mariner, *Health Reform: What's Insurance Got to Do With It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 441 (2010).

true for both public and private insurers, but it is particularly true for for-profit private insurers who are responsible to their shareholders to ensure profits.[151] Particularly, insurers appear to act independently in seeking to reduce harmful prescribing patterns, likely because it proves costly. But regulation has been necessary to make insurers more generous in covering addiction treatment.

The ACA has implemented a variety of insurance reforms to protect the sick from insurance discrimination.[152] For example, insurers regulated by the ACA cannot increase premiums,[153] cannot deny enrollment because of pre-existing conditions or level of healthcare usage,[154] and are limited in the amount they can require in out-of-pocket spending per annum.[155] Benefits are standardized through the essential health benefits provision so that all insurers must cover the same services, and thus cannot avoid the sick by failing to cover services they most often need.[156] This is with the aim of ensuring affordable and meaningful access to healthcare for those who need it.[157]

These changes have proven critical to protecting the access to healthcare of people with addictions.[158] The ACA's reforms prevent insurers from excluding people with addictions from their plans, or from charging them

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[151] Mariner, *supra* note 150, at 441–43. For an extensive discussion of examples of how insurers discriminated in the individual, private insurance market prior to the ACA, see generally *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?*, KAISER FAMILY FOUND. (June 2001), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf [https://perma.cc/3SEV-TPS3] (detailing wide-ranging discrimination from serious conditions like HIV to minor health conditions like hay fever, particularly in small group and individual health insurance where risk cannot be as readily pooled across groups).

[152] For a discussion of historical patterns of discrimination by insurers against the sick, see generally Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 81–108 (2005). Specifically, insurers have to adjust for adverse selection, that is, the phenomenon whereby individuals only purchase health insurance when they know that they need it. Also, insurers must adjust for moral hazard, the phenomenon where individuals, once they have insurance, are more likely to use it. Both phenomena mean that insureds will come into the market and heavily use it without having paid in. *See* Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, 20 KAN. J.L. & PUB. POL'Y 237, 242 (2011).

[153] Patient Protection and Affordable Care Act § 2701, 42 U.S.C. § 300gg (2012).

[154] *Id.* at § 300gg-1. Insurers also may not discriminate in insurance renewals. *Id.* at § 300gg-2.

[155] *See Out-of-Pocket Maximum/Limit*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ [https://perma.cc/GJD2-YR39].

[156] *See* 42 U.S.C. § 18022(b)(1). EHBs require coverage of some medical care in ten key areas, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. *See id.*

[157] Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 130, 131 (2011) (explaining that "[t]he purpose of these standards, as noted, is to ban discrimination against women, older people, and children and adults in less than perfect health").

[158] NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 99.

different premiums and copays. The ACA also mandates more equitable coverage of mental health and addiction treatments than insurers were apt to provide pre-ACA. These reforms may have some shortcomings.[159] Mainly, they require greater compliance, for example, in monitoring states to ensure that their model plans are in compliance with the ACA and the Mental Health Parity Act.[160] However, on the whole, the ACA has proven critical in reducing discrimination against the addicted by insurers.

However, the ACA is under threat, and all of these protections may be dismantled. Many of those who seek to repeal the ACA seek to reduce insurance regulation too, meaning that insurers could be free once again to discriminate against the addicted in enrollment, premiums, and benefits.

If the ACA (or some parts of it) is repealed, regulators must stand ready to assess insurers' changing practices around the opioid epidemic. Many of these efforts by insurers to reduce harmful prescribing can be powerful tools of change with ACA safeguards in place, but can quickly turn discriminatory if these protections are repealed or diminished.

Take the example of drug utilization review and patient review and restriction programs. Insurers are currently finding great cost savings in detecting and stopping abusive patients, reducing costly cases of new addiction by implementing the patient review and restriction program and drug utilization reviews that closely monitor patient drug consumption.[161] By preventing new cases of addiction, these programs can be powerful tools to control this epidemic. These programs allow insurers to quickly spot possible abuse, control the flow of opioids to these patients, and properly refer patients for addiction services, when needed.[162] Many insurers are already undertaking these programs, and regulators could easily require that all insurers, government or private, do so.

However, the same intensive monitoring that once meant help for the addicted could quickly become a snare to catch and discriminate. All of this information on patient drug abuse would now be a treasure trove of information about how to assess and avoid risk. Without the ACA's protections, information about potential drug abuse by insureds could be used to raise their premiums or cost sharing, remove them from the plan altogether, exclude

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[159] For a comprehensive overview of areas where the ACA has failed to fully eliminate health status discrimination, see generally John V. Jacobi et al., *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform*, 120 PENN ST. L. REV. 109 (2015). For an argument that the Mental Health Parity Act's limitations may inhibit its full redressing of discrimination in mental health and addiction, see generally Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U. L. REV. 179 (2013). For a discussion of how mental health parity laws and the ACA both fail to fully address addiction treatment, see generally Amanda Flood, *Substance Use Disorder Parity Under the Patient Protection and Affordable Care Act: Improvements Made, but Further Government Action Needed to Guarantee Full Parity in the Private Insurance Market*, 10 J. HEALTH & BIOMED. L. 363 (2015).

[160] *See* NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 99.

[161] *See supra* notes 89–98 and accompanying text.

[162] *See supra* notes 89–98 and accompanying text.

addiction services from their specific plans, or impose annual or lifetime limits on addiction services or other services.[163] Insurers might discriminate not just against those addicted to these drugs, but also those who are showing signs of becoming addicted.

Some may argue that this does not place the addicted in a position any worse off than they would have been pre-ACA when insurers regularly discriminated on the basis of addiction. But this argument fails to recognize that insurers have been developing new and comprehensive practices to detect addiction that were not in place prior to the ACA. With these enhanced abilities to detect addiction (or those at risk of it) and the freedom to discriminate again under an ACA repeal, we could see significantly more discrimination against those who are addicted and even those who are at risk of addiction.

As another example, while insurers acted without regulatory mandates to help spot and reduce wrongful prescribing, they likely did so because it proved financially beneficial to them without being costly in its own right. But it took regulations to make insurers cover addiction treatments more comprehensively, because, without regulations, insurers may favor minimizing that coverage so as to keep premiums low and be able to better compete for healthier enrollees. The ACA and the Mental Health Parity Act both mandate broader coverage of addiction services to treat opioid dependence. If these mandates or their regulations were repealed, insurers may opt to reduce coverage of addiction services significantly, again with an aim of risk avoidance.

Given these considerations, policymakers should begin a number of efforts. First, they must start monitoring the practices that insurers are currently engaged in to tackle this epidemic. Good practices could be implemented across all insurance, while harmful practices could be banned or monitored. Second, regulators must consider the risk of discrimination posed by these programs if the ACA is repealed. Policymakers can implement rules to ensure that insurers' drug monitoring and patient utilization review programs reduce opioid abuse without discriminating against addicted or potentially addicted patients. Lastly, regulators can monitor insurers for whether their addiction benefits are adequate. Even if the ACA remains intact, there are clear instances of lack of monitoring and enforcement than regulators can improve upon. If the ACA is repealed, policymakers should anticipate that the changes insurers have made to improve benefits will drop off. Policymakers may use the popular support around opioid addiction to advocate, again, for better coverage of addiction services.

C. Insurance as a Tool to Achieve Public Health Changes

In addition to considering the issued discussed above, policymakers and regulators should draw upon past experiences in regulating insurers during public health crises.

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[163] *See supra* notes 154–59 and accompanying text.

Past epidemics and public health crises tell us that insurers must be engaged on some level, as it is too costly to expect the government to shoulder the full price of any epidemic.[164] Certainly, there are examples of policymakers successfully leveraging insurance to obtain public health goals.[165]

Yet, there is a disconnect between health insurance and public health aims. Insurers are not focused on the health of the entire population, or even the population of those suffering from prescription painkiller abuse. They are only responsible for their own insureds, and their insureds are the only individuals whom they can reach with many of their initiatives. While insurers have incentives to combat epidemics if they lead to costly consumption of medical services, their solutions may not always advance public health goals.

Some scholars have explored the role of private insurance during other public health crises, such as floods or flu pandemics. In these contexts, scholars agree that insurers' incentives do not always align perfectly with broader public health goals and that regulation is necessary to encourage such alignment.[166] Indeed, this is because health insurance is a fundamentally different exercise from public health.[167]

This tension between the broader public health aims of policymakers seeking to address the prescription drug abuse crisis and the aims of insurers could be further exposed over time, particularly if the ACA is repealed.

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[164] Rosenbaum et al., *supra* note 143, at 65–66 ("Of course, a government may elect to bypass the issue of coverage and directly bear the costs, out of general or dedicated revenues, associated with treating a population both during and following the immediate period of a public health emergency. But while government may use direct financing for certain services and activities, public health emergencies can be expected to have costly and long-term physical and mental health consequences, thus making ongoing direct government financing through 'extra-contractual' coverage less feasible. Because the American health care system is built on an expectation that necessary medical care will be financed through insurance coverage (indeed, virtually all states, for example, now define 'prudent layperson' emergencies as a covered benefit in state-regulated managed care contracts), indefinite reliance on direct government financing would appear to be at odds with the operation of the medical care system itself. At some point, it becomes important to reconcile insurance financing and public health principles.").

[165] For example, Medicare expanded its program to cover prescription drugs under Part D to ensure that elderly patients were able to control their medical conditions affordably. Indeed, the ACA itself can arguably be described as tinkering with the insurance system to achieve a broader health aim of improving access to healthcare for the broader population. *See* J.G. Hodge et al., *Congress, Courts, and Commerce: Upholding the Individual Mandate to Protect the Public's Health*, 39 J. L. MED. & ETHICS 394, 394–96 (2011) (arguing that health reforms regulating insurance "are not simply aimed at regulating the health insurance industry or individual actors, but rather seek to advance a core public health objective of improving access to health care services"); s*ee also* Rosenbaum*, supra* note 104, at 94.

[166] *See* Rosenbaum et al., *supra* note 143, at 65. For example, the authors point to an epidemic of measles in Wisconsin in the 1980s that occurred because the state Medicaid agency was not required to cover vaccination as part of its benefits. The sheer existence of the epidemic (and any related cost of treating the disease for the state) was not enough for the state agency to act, and policies had to be later added to ensure that vaccination would be covered in the future. *See id.*

[167] *See* Rosenbaum, *supra* note 104, at 102.

Regulators must recognize this and recognize what it means—it means that insurers' goals cannot naturally be expected to align with the goals of public health. It means that regulation is necessary to bring insurers' incentives into proper alignment. Regulators can look to the past for examples of successful and unsuccessful engagement of insurers during epidemics and can consider insurers' individual interests and the ways in which they may differ from the goals of public health.

Conclusion

The potential for insurers to effect real change in the prescription painkiller epidemic is significant. Insurers are one of a few primary gatekeepers of prescription painkillers, and their position at the top of the chain means that they can control prescriber behaviors and monitor patient uptake. Their participation in regulatory efforts to combat abuse is necessary to ensure that opioids are given where appropriate and not given where inappropriate. Despite their power (and their own vested interests in combating this abuse), insurers have been under-examined by regulators as a stakeholder in the prescription painkiller epidemic and an agent for change. This is unfortunate because engaging these entities could improve patient outcomes, but also because change is already happening among insurers, and regulators must evaluate whether these changes are for the better. Regulators should consider innovations occurring on the insurance market and think critically about how best to engage insurers in the battle for our nation's recovery. Particularly if the ACA is repealed, regulators should be prepared to consider and mitigate the risk of discrimination by insurers against those struggling with addiction.