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The Varying Views of Substance Use Disorder Based on Temporal Considerations:
Preventative Sympathy v. Retroactive Condemnation

The United States of America is experiencing a crisis of dramatic proportions in the form of substance use disorder (SUD). With the rates of substance use steadily increasing in large part due to the opioid crisis, society has been pressured to come up with a response to quell the devastating effects of SUD.¹ According to the 2018 National Survey on Drug Use and Health, the percentage of Americans age 18 and older with SUD increased from 7.6% in 2017 to 7.8% in 2018.²

The impact of SUD stretches beyond those who have the disorder and has been estimated as having an overall societal economic cost of \$740 billion annually.³ This number is frightening enough without considering the detriments caused by SUD that cannot be numerically measured, such as its effect on personal relationships, missed opportunities and lost lives. With the advances in neuroscience and armed with scientific data, the country has been moving in the right direction by developing policy which seeks to alleviate the problem of SUD by providing health services for those with SUD.⁴ Yet, the percentage of Americans with SUD is still increasing and there remains work to be done.

Perhaps the largest legislative step taken toward curbing the economic and social issues created by high rates of SUD in recent history is the expansion of the Mental Health Parity and Addiction Equity Act's heightened insurance parity requirements to small business and individual

¹ See SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., 2018 NAT'L SURV. OF DRUG USE & HEALTH at Table 5.1B (2018)

² *Id.*

³ Nat'l Inst. on Drug Abuse, *Trends & Statistics*, <https://www.drugabuse.gov/related-topics/trends-statistics> (last updated April, 2007)

⁴ 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, 364-365 (2015)

plans by means of the Patient Protection and Affordable Care Act (ACA).⁵ By expanding the number of insured Americans, the ACA took an important step toward ensuring healthcare for all, including care for SUD.⁶ In addition, the ACA set up a system requiring new individual and small business health insurance plans to cover a list of Essential Health Benefits.⁷ This list includes SUD services and therefore expands the number of Americans who are entitled to access to substance misuse treatment services through their health insurance.⁸

While this step may prove to be helpful in tackling SUD, it does not fully solve the issue. The existence of further loopholes regarding private health insurance remain within the statutory framework in the form of exemptions and exceptions within the ACA.⁹ If an individual suffering SUD is terminated from employment due to their SUD, certain provisions of the Consolidated Omnibus Reconciliation Act (COBRA) could leave them vulnerable by preventing the extension of their health insurance coverage beyond termination.¹⁰ Additionally, public disability insurance through the Social Security framework still provides a hindrance to providing disability insurance for those afflicted with SUD due to portions of the Contract With America Advancement Act of 1996 (CAAA).¹¹ Reformation of the exemptions available under the Affordable Care Act, a modification of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and amendments to the Contract With America Advancement Act of 1996 would help to ensure that Americans of all backgrounds suffering SUD of all backgrounds have access to rehabilitative healthcare services.

⁵ *Id.* at 372

⁶ *Id.*

⁷ *Id.* at 381-382

⁸ *Id.*

⁹ *Id.* at 393

¹⁰ 29 U.S.C.A. § 1161 (LEXIS through Pub. L. 116-77)

¹¹ Max Selver, *Disability Benefits and Addiction: Resolving an Uncertain Burden*, 91 N.Y.U.L. REV. 954, 957 (2016)

These amendments would also reconcile the view of SUD in the policies by eliminating any potential bias based on when the SUD becomes apparent.

Throughout the article, the issues caused by SUD and the statutory structures mentioned above will be examined, in part, by following the story of John Doe. John Doe, despite his diagnosed Attention Deficit Hyperactive Disorder (ADHD), is a diligent and effective employee at a small business. After a long day at the office, John is involved in a tragic car accident during his commute which renders him with chronic pain and an undiagnosed case of Post-Traumatic Stress Disorder (PTSD). John's doctor prescribes him with opioid-based painkillers to help subdue the pain following the accident. As a means of dealing with the resulting pain, as well as easing the mental turmoil John experiences since the crash, John continues to seek out and use opioids after his prescription runs out. While John is using the illegal opioids, his employer notices a decline in John's performance due to John appearing to be distracted and distant. While John does not use opioids during work hours, he finds his PTSD severely reduces his ability to be productive. The boss subsequently discovers John is using opioids illegally outside of the workplace and fires John. John then attempts to find some alternative method of obtaining both medical care, and income. John attempts to apply for Social Security Disability Insurance (SSDI) due to his PTSD.

This article examines the potential reconciliation of the principles espoused in the expansion of SUD parity laws in private insurance regulation with public aid available through SSDI. In Part I, this essay paper details the neuroscience and statistics that support the provision of health services for SUD. Part II reveals the legal history surrounding health insurance, private and public, as it relates to SUD coverage. Part III elaborates on how the legislative schemes function in relation to SUD coverage. Part IV concludes by proposing legislative modifications to existing health insurance law relating to SUD coverage.

I. A Scientific Examination of SUD

In order to understand public policy surrounding healthcare for SUD, it is imperative to understand the neurobiology of the disorder. The first point to understand is the three stages of the addiction cycle and how they are carried out within the brain. The other vital point to examine is how genetic factors and comorbidity of other neurological disorders relate to SUD.

a. Three stages of substance use

SUD involves three stages of use, each associated with a different region of the brain: intoxication, withdrawal, and preoccupation.¹² The first of the three stages is the intoxication stage, which involves chemical changes in the basal ganglia.¹³ The intoxication stage is the point in time where the individual consumes the intoxicating substance and it produces a pleasurable effect by means of releasing neurotransmitters in the brain at higher rates than normal.¹⁴ The main neurotransmitter involved in SUD is dopamine, which is activated in our brain naturally when something good happens to serve as a reward system for our mind.¹⁵ While the use of the substance can activate dopamine and, in the use of substances such as opioids and alcohol, our opioid systems, it also conditions the mind to desire to use the substance in the future.¹⁶ This desire to continue usage in the future occurs because the brain releases smaller amounts of dopamine due to stimuli related to drug use and thus activates the reward-seeking mentality in the individual causing them to seek out that substance again.¹⁷ This phenomena is referred to by neurologists as

¹² U.S. DEP'T OF HEALTH & HUMAN SERV. ET AL., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 2-6 (U.S. Dep't of Health and Human Serv. Eds., 2016)

¹³ *Id.* at 2-8

¹⁴ *Id.* at 2-9

¹⁵ *Id.*

¹⁶ *Id.* at 2-10

¹⁷ Ann E. Kelley & Kent C. Berridge, *The Neuroscience of Natural Rewards*, 22 J. OF NEUROSCIENCE 9, (May 1, 2002), <https://www.jneurosci.org/content/22/9/3306.short>

incentive salience and is seen as a primary force behind the habitual and compulsive behavior involved in SUD.¹⁸

The second stage of substance use is referred to as the withdrawal stage and involves the extended amygdala as well as the basal ganglia.¹⁹ The withdrawal stage is a two-part process which occurs in response to removing the substance from use causing chemical reactions in the brain due to the change in behavior.²⁰ The first cause of the withdrawal phase is the detrimental effect of continued substance use on the dopamine receptors in the brain as they respond to natural stimuli.²¹ Through the use of neuroimaging technology, such as fMRI scans, researchers have found that the dopamine system in substance users becomes less sensitive to stimuli and thus releases smaller amounts of dopamine than in non-users.²² This lower sensitivity pairs with the second process, release of neurotransmitters linked to stress in the extended amygdala, to drive the individual to continue use of substances in seeking pleasure.²³ The release of neurotransmitters such as norepinephrine, dynorphin and corticotropin-releasing factor, lead to intense negative feelings of stress in the absence of the substance.²⁴ In an effort to reduce these feelings, the individual is motivated to seek out the substance.²⁵

Opioid withdrawal produces a particularly harsh physical response to cease use due to changes in the locus cereuleus' production of the chemical noradrenaline.²⁶ The brain produces more noradrenaline, which controls functions associated with alertness including breathing and blood

¹⁸ *Id.*

¹⁹ *Id.* at 2-13

²⁰ *Id.*

²¹ *Id.*

²² *Id.* at 2-14

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, SCI. & PRAC PERSP., July 2002, at 13

pressure, in an attempt to counteract the impact of opioids in reducing blood pressure and respiration rates.²⁷ When the individual ceases use of opioids, the brain continues to overproduce noradrenaline, which causes withdrawal symptoms, such as heightened anxiety and cramps.²⁸ In many instances the individual seeks out the substance and relapses in an effort to prevent withdrawal symptoms.

The third stage of the process is the preoccupation stage, during which individuals seek substances out after extended periods of sobriety.²⁹ The theory behind the preoccupation stage is that the prefrontal cortex of an individual with a history of substance use is conditioned in its cue activity to desire substances based on stimuli it associates with that substance.³⁰ This leads to the related stimuli causing a similar, yet reduced, reaction in the prefrontal cortex activity as substance use.³¹ This effect can be seen in people who have an established history of cocaine use when they observe a video containing images of cocaine use, which triggers a neural cue in the decision-making prefrontal cortex to seek out the substance.³²

b. Genetics of SUD

The neurological impact of substance use is well established, but research leaves open the question of why certain individuals are more likely to use substances in the first instance. In addition, it is unknown why certain individuals develop SUD after using a substance and others do not. This is where it is useful to understand the role that genetics play in SUD. Genetic factors contribute to between 40% and 70% of risk differences that pertain to SUD.³³ One main genetic

²⁷ *Id.* at 15

²⁸ *Id.*

²⁹ U.S. DEP'T OF HEALTH & HUMAN SERV. ET AL., *Supra* note 12, at 2-15

³⁰ Rita Z. Goldstein & Nora D. Volkow, *Dysfunction of the Prefrontal Cortex in Addiction: Neuroimaging Findings and Clinical Implications*, NATURE REV. NEUROSCIENCE, (Oct. 20, 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3462342/>

³¹ *Id.*

³² *Id.*

³³ U.S. DEP'T OF HEALTH & HUMAN SERV. ET AL., *Supra* note 6, at 2-22

factor which impacts susceptibility to SUD is an abnormal prefrontal cortex as it relates to emotion control and impulsivity as along with other biological factors such as the metabolism of substances.³⁴ The other prevalent genetic factor linked to SUD is the comorbidity of other neurological disorders.³⁵

The first area where genetics play a role in SUD is the genetic makeup of the neurological functions surrounding the effects of substance use.³⁶ This aspect of genetic predisposition to SUD is called the cognitive deficits model.³⁷ This theory heavily focuses on the prefrontal cortex, which is the brain area that controls executive functions and allows individuals to make decisions in the interest of long-term impacts despite contrary impulses.³⁸

The cognitive deficits theory posits that SUD is more prevalent in individuals with prefrontal cortexes that fail to adequately signal to the mesolimbic reward system because those individuals are less likely to have control over their impulses.³⁹ Studies have shown that this existing issue with the prefrontal cortex is then exasperated by the substance use.⁴⁰ This occurs because stimulants have been demonstrated as impacting the part of the brain responsible for communicating between the prefrontal cortex and the reward system.⁴¹ Alternatively, opioid use damages the prefrontal cortex and compounds the preexisting problems.⁴² Genetic predispositions to substance use support the notion that SUD should be viewed by the law as a health condition, with policy that comports accordingly.

³⁴ Goldstein & Volkow, *supra* note 30

³⁵ *Id.*

³⁶ Kosten & George, *supra* note 26, at 16

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

The other major genetic factor in SUD is the existence of co-occurring neurological disorders.⁴³ The co-occurrence of mental illness with SUD is a serious issue as survey data demonstrates that, out of the 9.7 million adults aged 26 to 49 who had SUD in 2018, 5 million also suffered from a mental illness (of any level of seriousness).⁴⁴ 3.2 million or 1.3% of adults aged 18 or older have been diagnosed with both a serious mental illness and SUD.⁴⁵ Neurological disorders that are often co-morbid with SUD include schizophrenia, which presents a “3- to 4-fold higher rate of tobacco smoking” indicating higher susceptibility to habitual substance use.⁴⁶ PTSD also demonstrates co-morbidity as between 30 to 60 percent of people seeking treatment for alcohol abuse demonstrate signs of PTSD.⁴⁷ This data has led researchers, who focus on the genetic conditions of individuals who exhibit signs of both mental illness and SUD, to better understand disease co-morbidity of the two. Such clinicians have discovered that conditions such as ADHD and mood disorders have a higher rate of co-morbidity with SUD.⁴⁸ While the reasons for such high comorbidity rates are still being examined, the correlation is definite.

As demonstrated by the neurobiology of SUD, SUD is an issue that extends well beyond mere choice, but rather is a biological disorder. It is imperative that SUD be viewed by lawmakers as a biological disorder in the course of setting public policy related to SUD healthcare services. The view of SUD as a lifestyle choice limited to a certain class of individuals is misguided as SUD impacts an estimated 11 million full-time workers in the United States.⁴⁹ For example, take John

⁴³ SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH at 46 (2018)

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ U.S. DEP'T OF HEALTH & HUMAN SERV. ET AL., *Supra* note 12, at 2-22 – 2-23

⁴⁷ *Id.*

⁴⁸ Nora D. Volkow & Maximilian Muenke, *The Genetics of Addiction*, HUM. GENETICS, (June 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4101188>

⁴⁹ Recovery Unplugged, *The Impact of Substance Use Disorder on Professionals and Their Employers*, CORPORATE WELLNESS, <https://www.corporatewellnessmagazine.com/article/the-impact-of-substance-use-disorder-on-professionals-and-their-employers> (last accessed Dec. 12, 2019)

Doe who, although diagnosed with ADHD, led an average life and excelled professionally until his involvement in a serious car accident. As a result of his accident, John's doctor prescribed him opioid-based painkillers. Due to the ability of the opioids in reducing his physical pain and psychological stress resulting from the trauma of the accident, he continued to use opioids past the end of his prescription. John developed a dependency on the opioids to self-treat his undiagnosed PTSD resulting from the incident. It is against this background of biological considerations that public policy must be developed.

II. Legal History of SUD Healthcare Policy

The issues caused by SUD have not been completely overlooked by American lawmakers as there have been several legislative actions directed towards addressing the issue since the 1990s. However, these legislative policies stop short of ensuring health services for all people who have a SUD. Perhaps the largest outstanding issue regarding SUD treatment that needs to be addressed is the ongoing disparity between pertinent private and public healthcare laws and policies. This section examines the history of statutory treatment of SUD. This examination will focus on statutes which regulate the provision of SUD services within private health insurance plans as well as the treatment of SUD in SSDI.

a. Mental health and substance use disorder parity in private insurance

Policies regarding mental health parity in private health insurance were first introduced with the enactment of the Mental Health Parity Act in 1996 by President Bill Clinton.⁵⁰ This bill was important because, while it neglected to address SUD, it was the first federal statute that addressed the issues of discriminatory health insurance treatment for mental health conditions and disorders.⁵¹ Prior to the enactment of the statute, employers had been hesitant to offer parity

⁵⁰ Flood, *supra* note 4, at 368

⁵¹ *Id.*

between physical injury coverage and mental health coverage due to the belief that such parity would increase costs.⁵² The increase in neurological research and access to cheaper and more effective means of treatment led to the push for parity.⁵³ The Mental Health Parity Act required employers with more than fifty employees to provide parity between physical and mental health benefits in lifetime and annual limits.⁵⁴ While this legislation was a step in the right direction towards requiring parity in health insurance, it neglected to tackle the issue of SUD which was not addressed until Representative Marge Roukema of New Jersey proposed amendments to the act to expand the parity benefits to SUD treatment.⁵⁵

The real change in legislative policy regarding SUD would come on October 3, 2008 when President George W. Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) into law.⁵⁶ The MHPAEA modified pre-existing parity legislation by expanding its coverage to SUD and increased the reach of parity.⁵⁷ The act required equal treatment of mental health and SUD coverage in terms of number of visits, cost sharing and access to in- and out-of-network services.⁵⁸ This provided a huge benefit for those working in large companies by granting them easier access to SUD resources.⁵⁹ The downside is that it did little for those with mental health and SUD issues working in small businesses or who received health insurance by means of individual plans.

⁵² *Id.* at 367

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 21 (2000)

⁵⁶ 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, 182 (2013)

⁵⁷ Flood, *supra* note 4, at 370

⁵⁸ *Id.*

⁵⁹ *Id.*

The issue of expanding mental health and SUD parity beyond large companies came as a piece of a much larger law, the Patient Protection and Affordable Care Act (ACA). The ACA was signed into law by President Barack Obama on March 23, 2010.⁶⁰ The ACA made many changes in the structure of health insurance law, but the most pertinent change for parity came in the form of implementing coverage mandates that imposed a tax penalty for those who did not carry a minimum health insurance plan either through their employer, a state-funded plan or individual plans.⁶¹ Additionally, the ACA established a requirement that plans which were not grandfathered by the act be required to provide Essential Health Benefits (EHB) which includes SUD treatment.⁶² The details of how this legislation functions in the private health insurance field will be discussed in section III of this paper.

b. Legal history of SUD in SSDI

The CAAA was hugely detrimental to securing adequate treatment for many suffering SUD resulting in a 52.4% decrease in Americans with a SUD who were eligible for SSDI upon enactment.⁶³ The CAAA was enacted in 1996 and contained a provision which prevented the term “Disability” as understood in the context of SSDI from being extended to those who had a SUD which is “material” to their disability.⁶⁴ A SUD is considered material to the disability in the event that the co-occurring disability would not be severe enough to qualify for SSDI without the existence of the SUD.⁶⁵ In many judicial circuits this causes evidentiary hurdles for claimants of

⁶⁰ *Id.* at 372

⁶¹ *Id.* at 374

⁶² 42 U.S.C. § 18022 (LEXIS through Pub. L. No. 116-77)

⁶³ *See Selver, supra* note 11, at 958

⁶⁴ Mazin A. Sbaiti, *Administrative Oversight? Towards a Meaningful “Materiality” Determination Process for Dual-Diagnosis Claimants Seeking Disability Benefits Under Titles II & XVI of the Social Security Act*, 35 COLUM. HUMAN RIGHTS L. REV. 415, 416 (2004)

⁶⁵ Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J. L. AND MED. 471, 483 (2012)

SSDI as the burden is placed upon them to bifurcate the co-occurring conditions.⁶⁶ This act resulted in the inability of those suffering with SUD from receiving SSDI to aid in seeking and paying for treatment of their disorder. While the passage of this act preceded the extension of SUD parity established by the MHPAEA and extended by the ACA, it continues to exist today despite the policy considerations favoring the provision of treatment to those with SUD evident in the ACA and MHPAEA. The mechanics of how this statute functions in determining whether an individual is able to secure SSDI is further examined in Part III below.

III. Legal Analysis of Health Care Policy Relating to SUD

The passage of legislation regulating the provision of private healthcare, such as the MHPAEA and the ACA, have made huge strides towards providing those with SUD the care that they need, but how is this accomplished and to what extent? To answer these questions requires an in-depth analysis of those law's statutory frameworks as well as an examination of what they fail to cover. Additionally, it is necessary to examine how unemployed and otherwise uninsured individuals are treated under laws such as the COBRA as well as SSDI after the passage of the CAAA.

a. SUD parity under the MHPAEA

The MHPAEA mandated SUD parity in relation to the benefits in those plans provided for physical health conditions for employers with more than fifty employees.⁶⁷ While the scope of this act was limited to large employers, it was also relatively toothless because it did not mandate any coverage at all for mental health issues or SUD as parity was only required in instances where any level of coverage was offered for mental health and SUD.⁶⁸ Furthermore, the act provided an exemption from its parity requirements if the insurer could demonstrate parity would result in a

⁶⁶ See Selver, *supra* note 11, at 967-970

⁶⁷ Tovino, *supra* note 65, at 483

⁶⁸ *Id.*

two percent or more increase in cost in the first year and one percent increase in following years.⁶⁹ With these limitations, millions of Americans who were not employed by large employers, whose employer offered no form of coverage for mental health or SUD, and whose insurers could demonstrate an increase in cost, were precluded from realizing SUD parity. As this relates to the example of John Doe, since he was working for a small business of less than fifty employees when he developed his PTSD and opioid use disorder, his employer health insurance plan through his employer would not be required to offer equal coverage to him if he sought treatment for his post-accident issues.

The reach of the MHPAEA was certainly less than satisfactory, but its provisions surrounding parity, were theoretically beneficial for setting a framework for SUD parity. The act enhanced coverage for SUD by preventing large group health plans from providing disparate coverage for SUD treatment by placing strict financial limits such as annual and lifetime spending on treatment for mental health and SUD.⁷⁰ Treatment equality was another consideration of the act as it provided insured individuals equal application of necessity determinations as well as provider access for those seeking mental health and SUD care to the quality of treatment needed to alleviate their issues.⁷¹ The financial and treatment equality standards apply under MHPAEA to six categories: (1) inpatient in-network care, (2) inpatient out-of-network care, (3) outpatient in-network care, (4) outpatient out-of-network care, (5) prescription drugs and (6) emergency care.⁷² In determining whether parity exists the limitation, service, and network involved are compared to physical benefits under the same circumstances.⁷³

⁶⁹ *Id.*

⁷⁰ Weber, *supra* note 56, at 183

⁷¹ *Id.* at 184

⁷² *Id.* at 211

⁷³ *Id.* at 212

The parity requirements under the MHPAEA are certainly favorable for ensuring equal coverage for those suffering from mental health disorders or SUD. For instance, in the event that John Doe’s employer was actually a large employer, and required to offer equal coverage for mental health and SUD, then Doe would not be required to pay a larger copayment when seeking treatment for his post-accident issues. He also would not have to worry about whether his cumulative cost of treatment exceeds an arbitrary and lesser annual cap than if he sought treatment for physical injuries received in the same accident. However, since John worked for a small business, his employer would not be required to provide parity under the MHPAEA.

b. ACA Health Care Reform

i. ACA expansion of coverage

The biggest criticism of the MHPAEA is its limited reach to large employer groups. The ACA partially remedied this issue by expanding parity to a significantly larger group of insureds by means of its shared responsibility provision, which requires a significant portion of Americans to have health insurance.⁷⁴ This ACA’s shared responsibility provision imposes a penalty on individuals who do not receive “minimum essential coverage” under a government-sponsored plan, an employer-sponsored plan, individual plans, grandfathered health plans or coverage otherwise recognized by the Secretary of Health and Human Services.⁷⁵ The ACA exempts from this penalty for certain classes of individuals.⁷⁶ The most pertinent exemptions for SUD concerns are the incarcerated, those whose contributions would represent more than eight percent of their household income and those whose household income is below the filing threshold for federal

⁷⁴ Flood, *supra* note 4, at 373

⁷⁵ 26 U.S.C.S. §5000A (LEXIS through Pub. L. No. 116-77)

⁷⁶ *Id.*

income taxes.⁷⁷ While this mandate has led to a large increase in the number of insured Americans, there were still 27.5 million Americans who did not have health insurance in 2018.⁷⁸

The ACA's shared responsibility provision also extended to Large Employer Groups (LEGs). This provision required that LEGs, which are employers with more than fifty full-time employees, to provide minimum essential coverage for their full-time employees.⁷⁹ While this expanded the requirements for health insurance significantly, it failed to reach Small Employer Groups (SEGs) which account for 96% of employers.⁸⁰ This exception for SEGs leaves a large gap in employer provided health care. The exception forces individuals employed by SEGs who do not provide health insurance to seek out alternative forms of essential minimum coverage in order to avoid penalties under the individual portion of the shared responsibility provision. John Doe is employed by a small business with less than 20 employees and would not be guaranteed health insurance provided by his employer. Assuming that John makes enough income to have to file federal income taxes each year he would suffer a penalty if he did not seek out health insurance on the individual market or from another source. This penalty would apply so long as his contribution to the insurance was less than 8% of his annual household income. John's employer did in fact provide health insurance coverage, so John does not meet the exemptions.

ii. ACA and the expansion of covered services

While the ACA's expansion of coverage was a huge difference maker, the real force of the ACA is its Essential Health Benefits (EHB) requirement, which is inclusive of ten categories of benefits, including SUD services.⁸¹ In addition to the EHB requirement, SUD parity is ensured in

⁷⁷ *Id.*

⁷⁸ EDWARD R. BERCHICK ET AL., HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018 (2019), <https://www.census.gov/library/publications/2019/demo/p60-267.html>

⁷⁹ 26 U.S.C. §§4980H (LEXIS through Pub. L. No. 116-77)

⁸⁰ Flood, *supra* note 4, at 380

⁸¹ *Id.* at 381-382

qualified health plans by expanding the application of the MHPAEA from LEGs to all qualified health plans.⁸² These two changes were monumental in expanding access to SUD services for individuals, but there are still areas where the EHB requirement does not reach.

The EHB requirement extends to individual and SEG plans that are neither grandfathered nor self-funded.⁸³ An ACA grandfathered plan includes health plans in which individuals or SEGs were enrolled on or before March 23, 2010.⁸⁴ While this may lead to some individuals not receiving the EHB services required of non-grandfathered plans, it is actually in the insurance providers' interests to utilize non-grandfathered plans so they can adapt the plans to current market conditions.⁸⁵ While the SEG grandfathered plans will reduce in number over the years due to the need to significantly alter the mechanics of the plans to keep up with changes in premiums and other considerations, there remains the issue of the self-funded plan exemption.⁸⁶ Self-funded insurance plans are where the employer provides for the medical costs of employees out-of-pocket rather than by paying premiums to an insurance company.⁸⁷ In order for non-exempt individual plans and SEG plans to meet the EHB requirement, they must meet the parity requirements provided under the MHPAEA.⁸⁸ While the EHB requirement does not extend to LEG plans, the LEGs who offer any form of mental health and SUD services are still bound by the parity requirements of the MHPAEA.⁸⁹ What this means for poor old John Doe is that since the small business which he works for utilizes a self-funded health insurance plan, his employer is not bound

⁸² 42 U.S.C.A. 18031(j) (LEXIS through Pub. L. No. 116-77)

⁸³ Flood, *supra* note 4, at 385

⁸⁴ 29 C.F.R. § 2590.715-1251(a) (LEXIS through Dec. 9, 2019 issue of Federal Register)

⁸⁵ Flood, *supra* note 4, at 384

⁸⁶ *Id.* at 385-386

⁸⁷ *Id.* at 387

⁸⁸ 45 C.F.R § 156.115(a)(3) (LEXIS through Dec. 9, 2019 issue of the Federal Register)

⁸⁹ Flood, *supra* note 4, at 390

by the EHB requirements or the parity requirements of the MHPAEA and thus does not have to afford him equal coverage of his PTSD or SUD following his automobile accident.

c. Extension and lack thereof of SUD coverage under COBRA

The next potential source of uninsured Americans with SUD comes from an examination of individuals who were covered under an employer-based insurance plan and is terminated from employment. This area of health insurance law is addressed by COBRA. COBRA mandates that a plan must continue coverage of an individual who would lose coverage due to a “qualifying event”.⁹⁰ The coverage required for the duration of the continuation must be coverage identical to the coverage provided at the time of the qualifying event (i.e. termination of employment).⁹¹ This means that after being fired, the same insurance plan must apply as applied during employment. It can be provided for a continued premium not to exceed 102 percent of the premium at the time of the qualifying event and continue for a duration of 18 months.⁹² COBRA qualifying events include termination from employment for any reason other than “gross misconduct”.⁹³ It is important to note that this continuation of coverage applies to self-insured plans, and includes a specialized determination of the applicable premium to be used in determining premiums for continuation.⁹⁴

One of the glaring issues with COBRA as it relates to SUD is the lack of clarity in analyzing whether a person being terminated from their position for their substance use outside of the workplace is considered “gross misconduct”. In the absence of clear authority governing the use of intoxicating substances outside of the workplace a view of analogous law must be utilized. The analysis of how the Americans with Disabilities Act (ADA) views the use of substances provides

⁹⁰ 29 U.S.C.A. §1161 (LEXIS through Pub. L. 116-77)

⁹¹ 29 U.S.C.A. §1162 (LEXIS through Pub. L. 116-77)

⁹² 29 U.S.C.A. §1162 (LEXIS through Pub. L. 116-77)

⁹³ 29 U.S.C.A. §1163 (LEXIS through Pub. L. 116-77)

⁹⁴ 29 U.S.C.A. §1164 (LEXIS through Pub. L. No. 116-77)

some guidance but is far from concrete. Under the ADA, employer policy enforcing employee compliance with federal laws and regulations related to drug and alcohol use is acceptable.⁹⁵ This allows employers to fire an employee with SUD who is currently using illegal drugs regardless of if they are considered as having a disability.⁹⁶ The notion of legal compliance is one which appears reasonable, but causes has the consequence of discriminating against SUD under an area of law designed to counter discrimination.

There is another analogous area of law under which clarity on whether SUD qualifies as “gross misconduct” is provided is the Service-Connected Disability Compensation Program for Veterans.⁹⁷ Under veteran service-related disability programs compensation is only granted for disabilities which do not stem from “willful misconduct”, SUD or alcoholism.⁹⁸ The pairing of “willful misconduct” with SUD and alcoholism in the law surrounding veteran benefit appears to link the group with a common thread and suggest that SUD is a form of misconduct.

Taking this into consideration, the “gross misconduct” exception to continued coverage under COBRA is likely to extend to termination for illegal drug use outside the workplace by an employee, even if that employee has SUD. This means that John Doe, if fired because his boss finds in a drug test that he has been using unprescribed opioids, could be terminated for “gross misconduct” and unable to elect for continued coverage under the employer’s plan.

d. SUD discrimination in SSDI post-CAAA

⁹⁵ U.S. COMM’N ON CIVIL RIGHTS, SHARING THE DREAM: IS THE ADA ACCOMMODATING ALL?, <https://www.usccr.gov/pubs/ada/ch4.htm#>

⁹⁶ *Id.*

⁹⁷ See Jennifer D. Oliva, *Son of Sam, Service-Connected Entitlements, and Disabled Veteran Prisoners*, 25 GEO. MASON L. REV. 302, at 312 (2018)

⁹⁸ *Id.*

The analysis of whether an individual is eligible for SSDI relies upon the determination that the individual is “disabled” according to the statute.⁹⁹ This determination of an individual’s “disability” is based on a five-step sequential evaluation.¹⁰⁰

The first step of the analysis examines whether the applicant is currently engaged in work which is considered “substantial gainful activity”.¹⁰¹ In the event that the claimant is engaged in such activity, then the Social Security Administration (SSA) will conclude that the claimant is not “disabled” and terminate the claim for SSDI.¹⁰² The SSA considers such matters as whether the work performed by the claimant is for monetary compensation, requires physical or mental activities and whether the worker can complete the work in an independent manner similarly to others in the same or similar positions.¹⁰³

The second step in the analysis is determining whether the claimant has a medical impairment that is significant enough to limit the claimant’s ability to perform basic activities.¹⁰⁴ This factor in particular is of interest in cases such as that of John Doe as it lists a series of nine categorical mental conditions which are considered to be severe medical impairments, but SUD is excluded from that list.¹⁰⁵ In the event that the claimant is discovered as not having a severe medical impairment, the SSA will not approve the claim.¹⁰⁶

The third step in the determination process is a consideration of whether the medical condition of the applicant is included on the SSA’s list of disabilities.¹⁰⁷ If a condition is not expressly listed, but is considered by the SSA to be of equivalent impairment, then the claim may

⁹⁹ 42 U.S.C.A §423(a)(1)(E) (LEXIS through Pub. L. No. 116-77)

¹⁰⁰ Selver, *supra* note 11, at 961

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id. at 962*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

be approved.¹⁰⁸ If this factor of the test is satisfactorily met by the claimant, then the analysis concludes, with the exception of the SUD consideration added by the CAAA.¹⁰⁹ If this factor is not satisfactorily met, then the analysis continues to the next stage.¹¹⁰

The fourth stage of the analysis is to determine whether the claimant's medical impairment prevents the claimant from engaging in the same manner of work as the claimant was engaged in during the past fifteen years.¹¹¹ If the conclusion is that the applicant is unable to continue work in such similar fields the analysis continues to the final step.¹¹²

The final stage is for the SSA to analyze the potential for the claimant to seek out and perform other types of meaningful work.¹¹³ This factor takes into consideration the characteristics of the claimant.¹¹⁴ Some traits the SSA will take into consideration for this determination include age, education, work experience, and ability.¹¹⁵ This stage is unique within the analysis as it requires the SSA bears the burden of demonstrating the claimant is capable of adjusting to alternative modes of work in order to deny the claim.¹¹⁶

The CAAA amends the definition of disability in 42 U.S.C.S. 423(d) to make clear that an individual cannot be classified as disabled for purposes of SSDI in the event that alcoholism or drug addiction is a material factor to the disability determination.¹¹⁷ This amendment to the definition of disability for purposes of obtaining SSDI was incredibly detrimental to alleviating the burden of SUD in America.¹¹⁸ The materiality provision effectively prevented 60% of SSI and

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 963

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ 42 U.S.C.A §423(d)(2)(C) (LEXIS through Pub. L. No. 116-77)

¹¹⁸ *See Selver, supra* note 11, at 958

SSDI recipients with SUD from requalifying between the enactment of the provision in 1996 and 1999.¹¹⁹ This leaves individuals with severe impairments suffering co-occurring mental illness and SUD from being able to meet their burden of proving disability which prevents them from engaging in meaningful employment.

This additional consideration in disability assessments is in stark contrast with the policy considerations which were catalysts for the reformation of private health insurance mental health and SUD parity demonstrated above. Regulations related to this provision state that, in making the materiality determination, the SSA will utilize medical evidence to make the decision of whether the disability would exist after removing the use of substances.¹²⁰ In the event that a claimant with SUD can meet this burden, the law requires that any SSDI benefits they are entitled to are collected on their behalf by a representative payee.¹²¹ The representative payee requirement is sensible in view of preventing misuse of benefits, but contributes yet another procedural hurdle for those already challenged with overcoming co-occurring disabilities.

The impact on John Doe is devastating. After being terminated from his job, even if his inability to work is due to his PTSD, the co-existence of his SUD would be a huge impediment to his being able to secure SSDI. In several circuits, John would have the evidentiary burden of demonstrating that his PTSD was disabling enough without his SUD contributing in a material manner. Due to the fact that his SUD began in response to the same event that caused his PTSD, it would be highly unlikely that John would be able to separate the two enough to meet the heavy burden upon him as a claimant. In the event that John is able to meet his burden, he would need a representative payee to collect the payment on his behalf.

¹¹⁹ *Id.*

¹²⁰ 20 C.F.R. 404.1535 (LEXIS through Dec. 9, 2019 issue of the Federal Register)

¹²¹ 42 U.S.C.S. §405(j)(1)(B) (LEXIS through Pub. L. No. 116-77)

IV. Suggested Amendments to Legislation Surrounding SUD Services

In reviewing the relevant legislation, it appears that there are several issues which prevent the adequate prevention and treatment of SUD in the provision of healthcare. Those issues include: (1) the lack of requirements for LEGs to provide any coverage of mental health and SUD under either the MHPAEA or the ACA, (2) the self-funded exception to the EHB requirement for SEGs, (3) the failure to require coverage from SEGs, (4) the lack of clarity in whether SUD involving the illegal use of drugs outside of the workplace falls under the gross misconduct exception to COBRA, and (5) the harsh effect of the material contribution analysis in determining a disability post-CAAA.

Perhaps the most concerning of these obstacles is the disparity in policy between the reformations made to the regulation of SUD services in private healthcare and the CAAA amendment of disability to exclude material SUD. The disparity between the views of the policies guiding healthcare related to SUD displays a change in attitude based on temporal considerations surrounding SUD. If a person with SUD is employed, and their SUD is not discovered, they are provided more right to SUD health services. Once their SUD is discovered, they may be open to termination and the ensuing discriminatory impacts of COBRA and the CAAA identified above.

The first change necessary to ensure the adequate provision of health services for SUD is to increase the breadth of the EHB requirement to apply LEGs. By expanding this requirement to the LEGs, it would ensure that not only is coverage expanded to more citizens, but also that those covered under such plans are receiving access to mental health and SUD services. A large portion of the estimated cost of SUD in America is due to lost productivity and absenteeism in the workplace as a result of SUD.¹²² If LEGs are required to provide services for SUD under the EHB

¹²² Nat'l Inst. on Drug Abuse, *supra* note 3

requirement then this number can be reduced. It would prevent companies that currently provide no coverage for mental health and SUD from future avoidance of parity for these vital health concerns. This solution is easily implemented by a simple amendment to the ACA. In 2010 and 2011 it was found that 96% of LEGs already provided some level of SUD coverage to employees.¹²³ This demonstrates that the change would not be a critically negative impact on industry while providing life-changing care for those employees suffering with SUD.

The second necessary change is to eliminate the SEG self-funded exception to the EHB requirement. The implied policy consideration underlying the EHB requirement is to prioritize care for issues which are considered to be essential to the well-being of society. In order to more adequately meet this policy goal, there must be a means of holding self-funded SEGs accountable for providing essential services. In the absence of the EHB requirement, these SEGs could provide healthcare which is severely lacking in coverage which also allows those employees covered under the plan from being penalized and driven towards the individual market where EHB is required. Alternatively, if the employees are dissatisfied with the level of coverage provided by their employer they could be forced to seek plans on the individual market in order to obtain EHB coverage. This is a large loophole in the ACA that prevents many thousands of individuals to from access to mental health and SUD services necessary for their welfare.

The third modification which is necessary to ensure proper coverage is to amend the ACA to require that SEGs provide health insurance for employee or, at the minimum, contribute to an individual plan in the form of a specified percentage of the paid premiums. Such an amendment would ensure that full-time employees receive aid in healthcare from their employers and are not left to fend for themselves in the individual plan marketplace. The national average deductible for

¹²³ Flood, *supra* note 4, at 385

SEG plans is 31% lower than the deductible for individual plans.¹²⁴ By forcing employees seeking EHB coverage to seek individual plans, the burden on the individual is multiplied.¹²⁵ This would lead to more insured individuals in general since there are certainly individuals who take the penalty for being uninsured due to not having employer-provided health insurance and not wishing to pay significantly greater amounts for individual plans.

The fourth amendment which is necessary is to shelter those with medically demonstrable SUD from COBRA's gross misconduct exception for SUD which fails to impact their productivity. As is demonstrated by the neurological facts surrounding SUD, it is and should be viewed as a disability. In the event that an employee is terminated for use of illegal substances outside of the workplace, the law should state that if the out-of-work misconduct can be attributed to a covered condition, then continuing coverage is contingent upon a showing by the claimant that they are taking remedial action in the form of rehabilitative services. The duration of such services should be required to extend for the full period of the continuation. This would allow employees terminated for illegal use of substances outside of the workplace the ability to utilize any existing SUD services covered by their employer's plan for rehabilitative purposes. This prevents the temporal disparity between providing rehabilitative services for SUD during employment and SUD services after termination.

The final proposition for the construction of a truly comprehensive SUD policy is to alleviate the impact of the CAAA amendment on the definition of disability. An amendment should be made that there be an additional provision which allows for the approval of SSDI for an individual with material SUD in the event that: (1) the claimant demonstrates the existence of a genetic

¹²⁴ *Why Is Small Group Health Insurance More Affordable Than Other Plans?*, <https://www.ehealthinsurance.com/resources/small-business/small-group-health-insurance-affordable-plans> (last updated Dec. 2, 2019)

¹²⁵ *Id.*

predisposition to SUD either through genetic properties of their brain or the existence of a co-occurring disability which heightens the rate of SUD, (2) the claimant utilizes a responsible payee pursuant to the current legislation, (3) the SSDI approval is conditioned on the demonstration by claimant that they are taking part in remedial action in the form of rehabilitative services, (4) the SSDI shall continue insofar as the claimant is disabled following the treatment of the SUD, and (5) that SSDI benefits shall be terminated after an eighteen-month safe harbor period following approval upon showing of SUD materiality by the SSA. The most important aspect of this proposal is the introduction of a safe harbor provision allowing the claimant time to mitigate the impact of SUD on the disability determination. This safe harbor is a middle ground between the CAAA's non-existent safe harbor which replaced the thirty-six month safe harbor in the Social Security Independence and Program Improvement Act of 1994.¹²⁶ This proposed change will allow those who have co-occurring conditions such as John Doe's PTSD and opioid use disorder the opportunity to utilize SSDI while taking remedial action. This allows time to gather evidence of exactly how material the SUD is to the overall disability without relying on the SSA's own speculative judgement of the disability.

In conclusion, while recent legislation has demonstrated a strong stance of treating SUD according to the neurobiological facts known about the condition, there remains work to be done to fight the great American crisis that is SUD. There still remains a temporal disparity in how SUD is viewed in healthcare law. If an individual had previous SUD in the past the law appears to welcome the provision of services. In the same vein, prophylaxis garners preferential legal consideration over treatment. If the SUD has just begun or is currently in progress, the law appears to shun the individual. With each passing day another victim in the war on drug-users slips through

¹²⁶ Sbaiti, *supra* note 64, at 435

the legal cracks into an early grave. The law should be used as a medium for implementing positive societal change rather than as a shackle upon the necks of those already imprisoned within the confines of substance abuse.