ERISA as a Solution to Insurer Abrogation of Responsibility in the Face of the Opioid Crisis

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INTRODUCTION

Even as insurance companies saw record profits during the COVID-19 pandemic, they steadfastly refused to adequately respond to the other health crisis facing America: the opioid overdose epidemic. The opioid overdose epidemic began in the 1990s with the overprescribing of prescription opioids for the treatment of pain.[1] Since then, the epidemic has advanced through at least two other stages. In 2010 the nature of the epidemic changed as overdose deaths due to heroin use surged.[2] The third wave began in 2013 and was driven by the use of synthetic opioids such as fentanyl.[3] At least one paper has since argued that the epidemic is entering a fourth wave driven by stimulant use.[4]

The background section of this Note provides an overview of the opioid epidemic's impact upon the United States, as well as a relatively recent legislative effort to address it. It also briefly examines the history of the Supreme Court's Employee Retirement Income Security Act of 1974 (ERISA) jurisprudence as it relates to the standard of review of fiduciary decisions in ERISA-regulated insurance plans. Then, the discussion section explains how the "rulification" of medical necessity standards, coupled with a permissive standard of review has hamstrung meaningful attempts at judicial oversight. This insulation is particularly concerning in the context of coverage for addiction treatment, because addiction treatment is a comparably new field of medicine that is still evolving rapidly. Next, the note analogizes existing ERISA jurisprudence to Model Rule 1.7 to highlight the policy and ethical shortcomings of existing ERISA jurisprudence. Finally, the recommendations section offers four proposals for policymakers to consider in order to realign the balance of power between insurers and plan beneficiaries.

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1. Richard A Jenkins, *The Fourth Wave of the US Opioid Epidemic and Its Implications for the Rural US: A Federal Perspective*, 152(2) PREVENTIVE MED. (2021).
2. *Id.*
3. *Id.*
4. *Id.*

I. BACKGROUND

A. THE OPIOID EPIDEMIC

The opioid overdose epidemic is ravaging communities across the United States. More than 760,000 people have died from drug overdoses since 1999.[5] Of those deaths, more than 564,000 of them were related to opioids.[6] These deaths have also imposed significant economic costs upon the country.[7] Opioid-related employment loss may have cost the United States up to $37.8 billion in lost tax revenue.[8] The healthcare costs associated with the epidemic have exceeded $215 billion.[9] At least one estimate has placed the aggregate cost of the crisis at over one trillion dollars.[10] The COVID-19 pandemic further exacerbated the overdose epidemic.[11] After slight decreases in annual opioid-related overdoses over the previous years, overdose deaths surged during the COVID-19 pandemic, likely due to the pandemic's disruption of traditional support structures and care delivery systems.[12]

Unfortunately, the insurance industry has abrogated its responsibility in addressing this crisis. When insurers cover mental health and addiction treatment, they routinely fail to cover it in a way that facilitates access to treatment. The Substance Abuse and Mental Health Services Administration ("SAMHSA") estimates that over 100,000 people needed treatment for addiction in 2018 but did not receive it either because their insurer refused to cover it or did not cover the full costs.[13] Insurers maintain addiction treatment provider networks that are far weaker than their medical and surgical provider networks, resulting in substantially more out-of-network utilization for addiction treatment.[14] Furthermore,

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5. Departments of Health and Human Services, Digital Communications Division (DCD), *Opioid Crisis Statistics*, https://www.hhs.gov/opioids/about-the-epidemic/opioid-crisis-statistics/index.html [https://perma.cc/A55F-94WT].

6. Centers for Disease Control and Preventions, *Understanding the Opioid Epidemic*, (Jun. 1, 2022), https://www.cdc.gov/opioids/basics/epidemic.html [https://perma.cc/8THJ-P7VH].

7. Joel E. Segel, Yunfeng Shi, John R. Moran, & Dennis P. Scanlon, *Revenue Losses to State and Federal Government from Opioid-related Employment Reductions*, 57 MED. CARE 494 (2019).

8. *Id.*

9. *Economic Toll of Opioid Crisis in U.S. Exceeded $1 Trillion Since 2001,* ALTARUM, (Feb. 13, 2018), https://altarum.org/news/economic-toll-opioid-crisis-us-exceeded-1-trillion-2001 [https://perma.cc/V3U5-TS8Z].

10. Feijun Luo, Mengyao Li, & Curtis Florence, *State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose — United States, 2017*, 70(15) MORBIDITY AND MORTALITY WEEKLY REPORT 541, 541 (2017).

11. Rina Ghose, Amir M Forati, & John R Mantsch, *Impact of the COVID-19 Pandemic on Opioid Overdose Deaths: A Spatiotemporal Analysis*, 99(2) J. URB. HEALTH 316, 316 (2022).

12. *Id.*

13. Substance Abuse and Mental Health Services Administration, *Results from the 2018 National Survey on Drug Use and Health: Detailed Tables*, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect7pe2018.htm#tab7-65a [https://perma.cc/76UD-FEAL].

14. Steve Melek, Stoddard Davenport, & T.J. Gray, ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: WIDENING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT 6 (The Bowman Family Foundation, 2019).

insurers reimburse addiction treatment providers at significantly lower rates than their medical and surgical treatment provider counterparts.[15]

Seeking to remedy this situation, in 2008 Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) to regulate health plans covering fifty or more employees.[16] MHPAEA mandates that those health plans which cover both medical/surgical benefits and mental health/addiction benefits must subject the mental health/addiction benefits to limitations no more stringent than the limitations placed on medical/surgical benefits.[17] The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, subsequently expanded these parity requirements to individual health plans sold on the newly established federal and state insurance marketplaces.[18]

However, perhaps in part because of weak reporting requirements and complex enforcement mechanisms, insurers largely ignored the requirements of MHPAEA until 2020, when Congress amended MHPAEA to require plans and insurers to provide comparative analysis of their non-quantitative treatment limitations to the Secretary of the Treasury, Secretary of Labor, and the Secretary of Health and Human Services.[19] Issuing its first report since this amendment, one hundred percent of the Department of Labor's (DoL) initial compliance determinations resulted in a finding of insurer noncompliance.[20] It remains to be seen if the most recent round of DoL efforts will lead to increased compliance.

B. ERISA AS A MECHANISM FOR JUDICIAL OVERSIGHT

In the face of widespread noncompliance with MHPAEA, the judiciary should leverage ERISA as a viable vehicle for judicial oversight of the insurance industry. ERISA governs employee welfare benefit plans, which includes plans established to provide employees "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death."[21] Once an employer establishes such a plan, employees may sue to recover benefits due to them under the plan when those benefits are wrongfully withheld by the plan administrator.[22] It is generally through these ERISA benefit determination lawsuits that the terms of employee welfare benefit plans are subjected to judicial review.

However, the deferential standard of review enshrined in ERISA doctrine handicaps judicial efforts to utilize ERISA to oversee insurers. ERISA, while

15. *Id.* at 6–7.

16. Abbey Derechin, *Medical Necessity of Residential Treatment for Anorexia: Can Parity be Achieved?,* 17 NW. J. L. & SOC. POL'Y 171, 178 (2022).

17. *Id.*

18. Kathleen G. Noonan, *Enforcing Mental Health Parity Through the Affordable Care Act's Essential Health Benefit Mandate*, 24 ANNALS OF HEALTH L. 252, 253 (2015).

19. DEPARTMENT OF LABOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, & DEPARTMENT OF THE TREASURY, 2022 MHPAEA REPORT TO CONGRESS 3 (2022).

20. *Id.* at 19.

21. 29 U.S.C.A. § 1002(1) (1974).

22. 29 U.S.C.A. § 1132(a)(1)(B) (1974).

recognized as an exhaustive statute, contains no provisions indicating the standard of review for courts analyzing the decisions of a plan fiduciary.[23] The Supreme Court filled this gap in *Firestone Tire & Rubber Co. v. Bruch*, where it ruled that courts should review the decisions of a plan fiduciary under a *de novo* standard of review.[24] However, where the plan language provides the fiduciary with discretionary authority to interpret ambiguous plan terms, the courts must overturn a fiduciary's decision only where it is arbitrary and capricious.[25] Since *Firestone*, language in insurance plans granting plan fiduciaries deference when interpreting the terms of the plan has become standard, functionally insulating insurers from *de novo* review.[26]

Furthermore, *Firestone* established that courts must weigh whether the fiduciary was acting under a conflict of interest as a "factor to consider" when determining whether there has been an abuse of discretion.[27] A conflict of interest sufficient to impact considerations of judicial deference under *Firestone* arises where the entity that administers the ERISA-governed plan, such as an insurance company, both determines whether an employee is eligible for benefits and also pays those benefits from its own funds.[28] However, a conflict of interest is not itself sufficient to change the standard of review from abuse of discretion to *de novo* review.[29] Therefore, under existing ERISA doctrine, even in the face of a plan administrator's conflict of interest, plan administrators may still enjoy the benefit of judicial deference.

II. DISCUSSION

A. RULIFICATION OF STANDARDS

Judicial overview of ERISA-governed health plans is further hamstrung by the "rulification" of medical necessity criteria by insurers. In the 1990s, patients won a string of legal victories in which courts ordered their plan administrators to cover access to questionably effective, expensive medical treatments.[30] In response, insurers began establishing specific medical necessity guidelines to shield themselves from having to cover judicially-ordered treatments for their beneficiaries.[31] Today, insurers rely on internally or externally developed rules of

23. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989).
24. *Id.* at 115.
25. *Id.* at 111–15.
26. Maria O'Brien Hylton, *Post-Firestone Skirmishes: The Patient Protection and Affordable Care Act, Discretionary Clauses, and Judicial Review of ERISA Plan Administrator Decisions*, 2 WM. & MARY POL'Y REV. 1, 1 (2010).
27. *Firestone*, 489 U.S. at 115.
28. Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 114 (2008).
29. *Id. at* 115. In fact, the Supreme Court in *Glenn* struck down attempts by the Circuit Courts to shift the standard to *de novo* where the insurer was subject to a conflict of interest. *Id.* Instead, the Court once again emphasized that a conflict of interest is merely a factor to be considered. *Id.* at 117.
30. Amy B. Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. REV. 423, 427 (2022).
31. *See id.*

medical necessity that define covered treatment and services in granular detail.[32] These detailed guidelines purport to be evidence-based but can fall short of generally accepted standards of care.[33] For example, insurers can permit cost considerations to inappropriately infect the guideline creation process.[34]

B. EVOLUTION OF ADDICTION MEDICINE

The speed at which addiction medicine has developed makes it uniquely unsuited to the strict rules imposed by insurers. Alcoholism was first described as a disease in the 1700s.[35] However, its recognition in the United States as a health condition did not occur until the 1930s with the founding of Alcoholics Anonymous.[36] Since then, the treatment of addiction has been heavily stigmatized, with many viewing addiction as a moral failing, rather than a complex brain disease.[37] This stigmatization continued even as the Nixon Administration recognized the high rate of addiction among returning Vietnam veterans.[38]

Organized addiction medicine came into existence in 1959, after the founding of the New York City Medical Society on Alcoholism in 1954.[39] Subsequently, in 1983, leading physicians in the addiction treatment space formed the organization that would become the American Society of Addiction Medicine in 1989.[40] In 1991, ASAM released the Patient Placement Criteria ("ASAM Criteria" or the "Criteria").[41] The ASAM Criteria is a clinical guide designed to improve assessment and outcomes-driven treatment and recovery services.[42] Critically, the Criteria are evolutionary in nature and are intended to encourage further research in the field of addiction medicine.[43]

Over the last twenty-five years, ASAM has released three different editions of the ASAM Criteria, all of which have reflected substantive changes to the field of addiction medicine. These routine updates are likely due, in part, to the fact that

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32. *See id.* at 454.
33. *Id.* at 455.
34. *Id.* at 456. See discussion of the *Wit* decision *infra* Section II.C.
35. David Smith, *The Evolution of Addiction Medicine as a Medical Specialty*, 13(12) AM. MED. J. ETHICS 900, 900 (2011).
36. *Id.*
37. Valerie A. Earnshaw et al., *Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma*, 11 INT'L J. MENTAL HEALTH ADDICTION 110, 110–11 (2013).
38. James Reston, *Nixon, Drugs, and the War*, N.Y. TIMES, June 2, 1971, at 41.
39. Smith, *supra* note 35, at 900.
40. American Society of Addiction Medicine, *Our History, 1980s*, https://www.asam.org/about-us/our-history/1980s [https://perma.cc/5S88-N3EH].
41. American Society of Addiction Medicine, *Our History, 1990s,* https://www.asam.org/about-us/our-history/1990s [https://perma.cc/K7SG-KJMJ].
42. THE AMERICAN SOCIETY OF ADDICTION MEDICINE, THE ASAM CRITERIA, TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE-RELATED, AND CO-OCCURRING CONDITIONS, X (David Mee-Lee et. al. eds. 3d ed. 2013).
43. *Id.*

addiction is a constantly evolving disease, unlike, for example, diabetes.[44] As the nature of the opioid epidemic and addiction crisis evolve, so too must our treatment standards and medical necessity guidelines. Reflecting this imperative, the number of changes to the ASAM Criteria has been significant. Between the second and third editions of the Criteria, the editors implemented changes in eight different areas of the previous edition, including updating the core framework of the Criteria, the "ASAM criteria dimensions," updating diagnostic admission criteria for the ASAM levels of care, and including substantial new information on treating patients suffering from co-occurring disorders.[45] The fourth edition of the ASAM Criteria, which is currently being developed, also contains major changes. It includes updates to at least eight major areas of addiction medicine, including updates on the use of pharmacotherapies for the treatment of addiction, encouraging usage of telehealth by addiction treatment professionals, and updating the continuum of care. [46]

Furthermore, the ASAM Criteria are updated as legislation broadens the scope of permissible treatments. In fact, the treatment of opioid use disorder in outpatient settings with the medication buprenorphine was not legal in the United States until the passage of the Drug Addiction Treatment Act of 2000 (DATA).[47] The passage of DATA finally encouraged an explosion in the discourse and analysis of addiction treatment in outpatient settings, including discussion in the third edition of the ASAM Criteria.[48] ASAM's updates to the Criteria reflect this awareness of the ever-changing nature of the pandemic, treatment for addiction, and legislative changes. But are insurers similarly fluid in their approach to medical necessity criteria for addiction treatment?

C. THE RULIFICATION OF STANDARDS COUPLED WITH ADDICTION MEDICINE'S RAPID EVOLUTION

The answer is that the public has no idea. Insurers fall into two camps. First, there are insurers who rely on medical necessity guidelines developed by a third party, such as the Milliman Care Guidelines (MCG) or the InterQual Criteria.[49]

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44. The overdose epidemic in the United States has transformed through four waves. The first wave was widespread opioid use, the second wave was heroin use, the third wave was the use of synthetic opioids such as fentanyl, and the newly emerging fourth wave is the concurrent use of stimulants and opioids. Richard A Jenkins, *The Fourth Wave of the US Opioid Epidemic and Its Implications for the Rural US: A Federal Perspective*, 152(2) PREVENTIVE MED. (2021). These different waves require different treatment methods. *Id.*

45. *Id.* at 11–13. A co-occurring disorder exists where a person struggles with both a substance use disorder and an untreated mental illness.

46. ASAM, *4th Edition Development* (2002), https://www.asam.org/asam-criteria/4th-edition-development [https://perma.cc/3XTZ-29DX].

47. Drug Addiction Treatment Act of 2000, H.R. 2634, 106th Cong. § 2(a)(2)(A) (2000).

48. THE AMERICAN SOCIETY OF ADDICTION MEDICINE, THE ASAM CRITERIA, TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE-RELATED, AND CO-OCCURRING CONDITIONS, X (David Mee-Lee et. al. eds. 3d ed. 2013).

49. *See* MCG Health, *Industry-Leading Evidence-Based Care Guidelines* (2022) https://www.mcg.com/care-guidelines/care-guidelines [https://perma.cc/K323-V9GH]; Change Healthcare, *InterQual Solution* (2022) https://www.changehealthcare.com/clinical-decision-support/interqual [https://perma.cc/F7TK-U2A3].

These third-party guidelines purport to offer an unbiased review of the latest medical data and clinical practices.[50] However, due to the proprietary nature of the guidelines, there is little oversight of their development.[51] Furthermore, the use of third-party guidelines creates another level of judicial deference to fiduciary decision-making.[52]

The second camp is insurers who rely on internally developed medical necessity guidelines. These internally developed guidelines are less likely to receive judicial deference than third-party guidelines. However, they are also only successfully challenged on rare occasions, and generally only after lengthy bench trials.[53] The premier case in this area, which has since been overturned, is *Wit v. United Behavioral Health*. In *Wit*, after a ten day bench trial, Chief Magistrate Judge Joseph C. Spero of the Northern District of California found that United Behavioral Health's internally developed medical necessity criteria violated its fiduciary duty to its beneficiaries.[54] Judge Spero conducted an overview of the relevant addiction treatment medical necessity guidelines including the ASAM Criteria, LOCUS, CALOCUS/CASII, and the CMS Manual.[55] From this overview, Judge Spero derived the following principles of addiction treatment:

> a) It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms . . . b) It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care . . . c) It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective . . . d) It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care . . . e) It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration . . . f) It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment . . . g) It is a generally accepted standard of care that the unique needs

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50. *See* MCG Health, *supra* note 49; Change Healthcare, *supra* note 49.

51. The author of this note is not aware of any supervisory body that ensures that these third-party guidelines are in fact based on an unbiased review of the latest medical data.

52. *See* Todd R. v. Premera Blue Cross Blue Shield of Alaska, Case No. C17-1041JLR, 2021 WL 2911121 at *14 (W.D. Wash. 2021).

53. Monahan & Schwarcz, *supra* note 30 at 469.

54. Wit v. United Behavioral Health, Case No. 14-cv-02346-JCS, 2019 WL 1033730 at *54 (N.D. Cal. 2019).

55. *Id.* at 14–16.

> of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders . . . h) It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.[56]

After deriving these eight principles of the generally accepted standards of care, Judge Spero applied them to United's medical necessity criteria and found that the criteria did not align with them.[57] Because the plan document stated that treatment must align with generally accepted standards of care, but United's own medical necessity criteria did not align with generally accepted standards of care, Judge Spero found that United was liable for breach of fiduciary duty and wrongful denial of benefits.[58] However, Judge Spero's decision in *Wit* represents one of the only successful, albeit temporarily so, challenges to an insurer's internally developed guidelines for addiction treatment, as the rulification of insurer medical necessity guidelines has successfully insulated benefit determinations from judicial review.[59] In conclusion, the rapid evolution of addiction treatment coupled with the changing nature of addiction as a disease makes it uniquely unsuited for strict medical necessity guidelines subject to minimal oversight by regulators or the judiciary.

D. INSIGHTS FROM THE MODEL RULES OF PROFESSIONAL ETHICS

The Supreme Court's apparent deference to a fiduciary's decision made even in the face of a conflict of interest stands in stark contrast to the ideological underpinnings of the ethical code that governs its own profession. Model Rule 1.7: Conflict of Interest: Current Clients specifically prohibits lawyers from representing clients who have a conflict of interest with another client, or the lawyer themselves.[60] Specifically, Model Rule 1.7 states that ". . . a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if: . . . (2) there is a significant risk that the representation of one or more clients will be materially limited by . . . a personal interest of the lawyer."[61] The analogous conflict of interest situation in the insurance space is when the insurer offers a fully insured plan.[62] Arguably, insurers also have a conflict of interest synonymous to that contemplated by Model Rule 1.7

56. *Id.* at 17–21.

57. *Id.* at 14–41.

58. *Id.* at 54–55.

59. Monahan & Schwarcz, *supra* note 30 at 468–69.

60. *See* MODEL RULES OF PROF'L CONDUCT R. 1.7 (2009) [hereinafter MODEL RULES].

61. MODEL RULES R. 1.7.

62. Fully insured plans are plans where employers pay a flat fee to the insurer, and then the insurer pays out of its own funds when a beneficiary requires treatment. Kaiser Family Foundation, *2018 Employer Health Benefits Survey* (2018) https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/#:~:text=Eighty-seven%20percent%20of%20covered%20workers%20in%20firms%20with,workers%20in%20small%20firms%20%2881%25%20vs.%2013%25%29.%20 [https://perma.cc/65VT-7DS9].

when they offer self-funded plans, since they have an incentive to keep costs low for their customers.[63]

Model Rule 1.7 includes an exception to this blanket prohibition when certain conditions are met, including when the client gives informed consent in writing to the representation.[64] However, this informed consent exception is justified in part based on the idea that clients should remain free to select representation of their choice, even if that representation may have a conflict of interest.[65] This freedom of choice rationale quickly falls apart when translated to the insurance context because Americans have little meaningful choice over their health insurance provider. First, Americans lack the knowledge to make educated decisions regarding their health insurance.[66] At least one study found that where consumers were asked to choose between two insurance plans where one plan was clearly inferior to the other, the consumers chose correctly less than fifty percent of the time.[67] Critically, the study participants were required to demonstrate they understood basic insurance terms, and even still they routinely made the incorrect selection.[68] This study, among others, has led to a widespread belief among experts that consumers are fundamentally unable to successfully compare insurance plans sufficient to exercise meaningful choice.[69] So unlike the ideological underpinnings of Model Rule 1.7, which permits informed consent to being represented by a lawyer with a conflict of interest, it is almost impossible for a consumer to give informed consent to be covered by an insurer with a conflict of interest because the average consumer does not understand the complexities of the issue.

Furthermore, even those consumers who have the requisite knowledge to make a meaningful choice may lack the practical opportunity. 54.4% of the population received insurance coverage through their employer in 2020.[70] These employer-sponsored plans tend to be self-funded.[71] An employee participating in a self-funded plan is at least partially shielded from the conflict-of-interest issues plaguing private insurers, as the employer, not the insurer, pays for treatment. However, a conflict still exists, as insurers are incentivized to minimize the insurance costs of

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63. Self-insured plans are plans where the insurer makes benefit determinations, but the treatment itself is paid for by the employer. Kaiser Family Foundation, *supra* note 62; *see* Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2019 WL 1033730 at *53 (N.D. Cal. 2019) (noting that insurers offering self-insured plans are incentivized to offer competitive rates to employers).

64. *See* MODEL RULES R. 1.7.

65. Alice E. Brown, *Advance Waivers of Conflicts of Interest: Are the ABA Formal Ethics Opinions Advanced Enough Themselves*, 19 GEO. J. LEGAL ETHICS 567, 570.

66. *See* Eric J. Johnson et al., *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture*, 8 PLOS ONE 1 (2013).

67. *Id.*

68. *Id.* at 3.

69. Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. Rev. 1926, 1953.

70. United States Census Bureau, *Health Insurance Coverage in the United States: 2020* (2020) https://www.census.gov/library/publications/2021/demo/p60-274.html [https://perma.cc/LYE8-USA2].

71. *See* Kaiser Family Foundation, *supra* note 62.

their customers (employers) by covering as little care as possible. Alternatively, a consumer might reject their employer's health plan and instead take their chances on the ACA-created insurance marketplace. Also known as "individual market coverage," an insurer offering individual plans absorbs the costs of healthcare that it determines are necessary based on the terms of the plan. Therefore, they suffer from a stronger conflict of interest issue than self-funded plans because each time they decide to cover medical care directly, it impacts their bottom-line. A choice between hundreds of plans, all of which suffer from a structural conflict of interest, is no choice at all. In conclusion, unlike in the legal world, where a client can simply find another lawyer to represent them if they are unwilling to sign a conflict-of-interest waiver, in the healthcare space, customers are functionally forced to pay a conflicted fiduciary, and hope the fiduciary prioritizes their wellbeing instead of profit motive.

III. RECOMMENDATIONS

A. INCREASED TRANSPARENCY OF MEDICAL NECESSITY GUIDELINES

One of the primary issues with medical necessity criteria is their lack of transparency. While some insurers make their medical necessity criteria publicly available on their websites, many others do not.[72] The DoL made some progress in this area with its final regulation implementing the recent MHPAEA amendments. This regulation requires that insurers provide the criteria to current or potential plan participants, beneficiaries, and providers.[73] However, those insurers that are unwilling to make accessing their criteria easy may make them available only upon request.[74] Furthermore, the parties to whom insurers must make their criteria available are unlikely to possess the necessary expertise to engage in the comparative analysis called for by MHPAEA, or even understand if the criteria threaten the health of the plan beneficiaries in a legally meaningful way.[75] The transparency requirements are therefore somewhat toothless. The other alternative, offering the criteria upon request to the DoL, is more promising. However, this option still hamstrings efforts from third parties, such as medical societies, that may have an interest in better understanding the criteria that bind their members' actions. Therefore, the MHPAEA final regulation should be amended to require that all insurers make their criteria publicly available and easily locatable on their websites.

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72. Monahan & Schwarcz, *supra* note 30 at 491.
73. Gerald (Jud) E. DeLoss, Laura Ashpole & Kelly Whelan, *Mental Health Parity and Addiction Equity Act Final Rules: Limited Enforcement Options Don't Overcome Unequal Treatment*, 7 J. HEALTH & LIFE SCI. L. 73, 87–88 (2014).
74. *Id.*
75. *See supra* Section III.D.

B. TIE MEDICAL NECESSITY CRITERIA DIRECTLY TO SOCIETY-DEVELOPED GUIDELINES

Another, more direct solution, would involve tying insurer medical necessity determinations to medical society-developed guidelines. This approach would limit the amount of discretion that plan administrators can exercise in the first place, minimizing the negative effect of a conflict of interest. Some states have already begun to implement this approach for the plans that they have the power to regulate, although of course this excludes some ERISA-governed plans.[76] The first state to take such an approach was California, which, inspired by the *Wit* decision, implemented legislation requiring private insurers in the state to use the ASAM Criteria when making medical necessity determinations for addiction treatment.[77] Other states require the use of the ASAM Criteria, or insurer-developed guidelines approved by the state Department of Insurance.[78] Still, others permit the use of the ASAM Criteria or other third-party developed guidelines, such as the Milliman Care Guidelines or InterQual.[79] It is true that insurers would still be incentivized, when faced with a conflict of interest, to construe these third party guidelines or ASAM Criteria in a stringent way to deny care. However, such an approach would be more easily policed by private regulators and the appropriate government agencies, as the baseline criteria applied would not themselves have been developed by a party subject to as strong of a conflict of interest incentivizing them to minimize access to care. This argument is less applicable to the MCG and InterQual though, because those third-party guidelines have an interest in establishing restrictive medical necessity guidelines so that plan administrators select them to keep costs low.[80]

C. THE EXISTENCE OF A PUBLIC HEALTH EMERGENCY SHOULD GREATLY ENHANCE THE WEIGHT OF THE CONFLICT-OF-INTEREST FACTOR

Third, the judiciary should consider the existence of a public health emergency as militating strongly towards a finding of a fiduciary abuse of discretion where a conflict of interest otherwise exists. It is true that the Supreme Court has acknowledged that the weight of each factor should be determined on a case-by-case basis.[81] While this pronouncement may counsel against the judiciary viewing the

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76. Monahan & Schwarcz *supra* note 30 at 435.

77. CAL. HEALTH & SAFETY CODE § 1374.72 (West 2021). *See also* 215 ILL. COMP. STAT. § 5/370c (West 2021) (explicitly prohibiting the use of any criteria but the ASAM Criteria for medical necessity determinations).

78. *See, e.g.*, CONN. GEN. STAT. § 38a-591c (West 2017).

79. *See, e.g.*, OR. REV. STAT. § 743A.168e (West 2022).

80. *See* Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2019 WL 1033730 at *53 (N.D. Cal. 2019). Just as insurers offering self-funded plans have an incentive to keep costs low for their customers, so too do medical necessity guideline developers have an incentive to keep their guidelines stringent so that insurers' costs remain low.

81. Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 117 (2008).

existence of a public health emergency as *per se* increasing the weight of the conflict-of-interest factor, on the other hand it offers the judiciary the necessary flexibility to engage in limited innovation in the space.

In this instance, the significant cost that public health emergencies impose upon private insurance markets strongly incentivizes a conflicted insurer to avoid paying claims where possible. The COVID-19 pandemic and opioid epidemic both serve as evidence of the significant costs that public health emergencies can impose upon an insurer.[82] In response, the private insurance industry has a well-documented history of avoiding payouts and encouraging government intervention in the face of a public health emergency.[83] If an insurer decides to cover a treatment related to the public health emergency, it exposes itself to significant costs as others affected by the health crisis seek that same treatment.[84] Plan-provided discretion grants insurers a shield, permitting them to interpret the terms of the plan in such a way as to avoid coverage. In such an instance, the judiciary should be extremely cognizant of the conflict of interest when determining whether the insurer's determination constitutes an abuse of discretion.

Critically, the existence of a public health emergency need not be a matter left to judicial interpretation. Rather, the judiciary should assign increased weight to the conflict-of-interest factor where the Department of Health and Human Services has declared a public health emergency. Such declarations are easy to find online and should not overly complicate the judicial analysis.[85] Furthermore, this additional weight added to the conflict-of-interest analysis falls well within the bounds of established trust law.[86]

D. LESSONS FROM *WIT*

Finally, the principles of effective addiction treatment as distilled in *Wit* should serve as a blueprint for future judicial analysis of insurer-created medical necessity criteria. One of the largest challenges faced by advocates concerned by insurer-developed medical necessity guidelines was the resource-intensive nature of any trial seeking to challenge medical necessity guidelines. These guidelines are, by their nature, complex and difficult to understand for people untrained in

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82. *See* Divya Kirti & Mu Yang Shin, Impact of COVID-19 on Insurers (2020). *But see* Reed Abelson, *Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic*, N.Y. TIMES, Aug. 5, 2020 (noting that the COVID-19 pandemic has actually saved insurers millions of dollars because overtaxed hospitals have delayed elective surgeries, limiting insurance payouts).

83. *See* Section I.A; Vickie J. Williams, *Fluconomics: Preserving our Hospital Infrastructure During and After a Pandemic*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 99, 145.

84. *See* Vickie J. Williams, *Fluconomics: Preserving our Hospital Infrastructure During and After a Pandemic*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 99, 145–46.

85. Department of Health and Human Services, *Declarations of a Public Health Emergency* (Jan. 9, 2023), https://aspr.hhs.gov/legal/PHE/Pages/default.aspx [https://perma.cc/KE8N-HBM5] (listing both COVID-19 and the opioid overdose epidemic as public health emergencies).

86. *See* Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 111 (2008) (explaining the weight of the conflict of interest should be based upon the circumstances of the case).

medicine.[87] Legal challenges to such guidelines result in conflicting testimony offered by expert witnesses that can be difficult for juries, and even judges, to parse.[88] Thankfully, Judge Spero navigated that difficult situation and distilled the eight principles discussed above, all of which can provide courts the critical guidance necessary to better understand medical necessity criteria challenges in the future.

Much to the consternation of every medical society in the space,[89] the Ninth Circuit reversed the *Wit* opinion in its entirety, noting that it was not unreasonable for United to refuse to cover treatment that aligned with generally accepted standards of care based on the plain language of the plan.[90] The Court of Appeals' opinion was four pages in its entirety, and the section discussing whether United abused its discretion was one page.[91] By contrast, the initial *Wit* opinion is 55 pages. Since then, the plaintiffs have filed for the Ninth Circuit to hear the case *en banc*.[92]

Even as the behavioral health community awaits the results of the *en banc* petition, plaintiffs seeking to challenge insurer benefit determinations can utilize findings "A", "D", and "F" from the *Wit* decision as a persuasive basis for their claims.[93] These three findings serve as strong compounding conclusions when coupled with an insurer conflict of interest. Regarding "A," and as with many diseases, treating the symptoms is far less expensive than treating the underlying condition. Therefore, a judge finding that an insurer's medical necessity criteria treat the symptoms but not the underlying illness strongly militates towards the insurer engaging in an abuse of discretion when interpreting the terms of the plan. Similarly, "D" reflects a decision that is made purely to save money. While the

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87. *See* THE AMERICAN SOCIETY OF ADDICTION MEDICINE *supra* note 42, at 174–244.

88. *See* Wit v. United Behavioral Health, Case No. 14-cv-02346-JCS, 2019 WL 1033730 at *14–15 (N.D. Cal. 2019).

89. American Psychological Association, *APA Takes Action After Federal Appeals Court Overturns Groundbreaking Wit Decision* (Apr. 8, 2022), https://www.apaservices.org/practice/legal/managed/court-overturns-wit-decision [https://perma.cc/B2CS-DBRF]; The Kennedy Forum, *Wit v. United Behavioral Health* (June 2022), https://www.thekennedyforum.org/wit/ [https://perma.cc/ED6U-A6X5]; National Association for Behavioral Healthcare, *NABH Issue Brief*, https://www.nabh.org/nabh-issue-brief-details-about-9th-u-s-circuit-court-of-appeals-ruling-to-overturn-wit-v-united-behavioral-health-decision/#:~:text=In%20a%20blow%20to%20parity%20this%20week%2C%20a,accepted%20standards%20of%20care%20%28GASC%29%20%E2%80%9Cwas%20not%20unreasonable.%E2%80%9D [https://perma.cc/Q6AC-QDV4].

90. Wit v. United Behavioral Health, No. 20-17363, 2022 WL 850647 (9th Cir. 2022).

91. *Id.* at 2.

92. Plaintiffs-Appellees' Petition for Panel Rehearing and Rehearing En-Banc, Wit v. United Behavioral Health, No. 20-17363, 2022 WL 850647 (9th Cir. 2022).

93. a) it is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms. . . d) It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care. . . f) It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment. Wit v. United Behavioral Health, Case No. 14-cv-02346-JCS, 2019 WL 1033730 at *17–21 (N.D. Cal. 2019).

ASAM Criteria and other medical necessity guidelines advise opting for a higher level of care where ambiguity exists, many insurance guidelines, including the United guidelines, require the opposite.[94] This less cautious approach saves money at the cost of worse health outcomes for patients. Finally, "F" is again a sign of insurers standardizing care to save money at the expense of patient outcomes. By placing clear limits on certain treatments, for example, by stating that patients presenting with signs of severe opioid addiction may only receive inpatient care for three days before being reevaluated, insurers minimize costs while potentially placing patients at the wrong level of care. Taken together, findings "A", "D", and "F" can bridge the gap between the medical world and the legal world, giving lawyers and judges a new lens through which to analyze insurer medical necessity guidelines, and hopefully, to better police flagrant insurer abuses that cost lives.

E. ISSUES WITH *WIT*

The efficacy of the *Wit* decision as a blueprint for future litigation is challenged by a few issues. First, the *Wit* decision was premised on the specific language of the United plan, which required that requested care be consistent with generally accepted standards of care.[95] This language empowered the plaintiffs to contest the meaning of the phrase "generally accepted standards of care" and opened the door to the eventual bench trial and Judge Spero's principles of generally accepted standards of care.[96] However, the language among plans can differ wildly, and ERISA requires only that the "plan administrator [] properly apply plan terms, provide a decision-making process that is reasoned and principled, and render decisions that are consistent with the purposes and goals of the subject plan."[97] This significant leeway empowers plans to avoid vulnerability to the holding in *Wit* by simply changing the terms of their plans. Instead of providing treatment at a "generally accepted standard of care" or in alignment with "national recognized care guidelines," plan language can more specifically cover medical necessity guidelines developed by the insurers themselves. Insurers have already seized upon this distinction where available to defeat plaintiff driven efforts to leverage *Wit* to improve medical necessity guidelines.[98] In the absence of state or federal legislation requiring that insurers cover treatment in alignment with "generally accepted standard[s] of care" in private insurance contracts, *Wit* will likely amount to no more than a guide to insurers on how to write their contracts to avoid paying for medically necessary care.

94. *Id.* at 19.

95. *Id.* at 13.

96. *Id.* at 53–55.

97. Silva v. Voya Services Company Employee Welfare Benefits, No. 6:19-cv-00318-DCC, 2020 WL 2537454 (D.S.C. 2020).

98. *See, e.g.,* M.F. on behalf of R.L. v. Magellan Healthcare Inc., No. 20 CV 3928, 2021 WL 1121042 (N.D. Ill. 2021); Kevin D. v. Blue Cross and Blue Shield of South Carolina, 545 F. Supp. 3d 587 (M.D. Tenn. 2021).

Courts have also rejected plaintiff efforts at utilizing the *Wit* decision through a myriad of other objections. At least one court appeared to entertain the possibility that the factual findings of Judge Spero were inadmissible hearsay.[99] That same court noted that the *Wit* decision had not yet been finalized at the time of the court's decision.[100] Of course, now that *Wit* has been overturned, its persuasive power will be further decreased. This weak persuasive power is best exemplified by the case *Josef K. v. California Physicians' Service*, in which the court indicated they would be unwilling to rule that the insurer's guidelines constituted an abuse of discretion without developing a record akin to the one in *Wit*, likely necessitating a similarly lengthy bench trial.[101] On the other hand, various courts have shown themselves willing to analogize to United's guidelines to find that an insurer has abused their discretion in denying a benefit to a beneficiary.[102] Others have taken the principles distilled by Judge Spero in *Wit* and applied them in other behavioral health contexts.[103]

IV. CONCLUSION

The path to improving access to addiction treatment services is bound to be long and circuitous, in no small part because insurer discretion has been expanding for the past thirty years, with some pushback in the form of the passage of MHPAEA and state efforts to tie insurer discretion guidelines to nationally recognized generally accepted standards of care. This note provides just a few small changes that stakeholders can make today to contribute to the balancing of power between patients and insurers. Perhaps the greatest check on the discretion of conflicted insurers is limiting that discretion in the first place by mandating the use of specific medical necessity guidelines. However, this approach is also the most resource-intensive, as insurers are adept at resisting policy change at the state level. Since the opioid epidemic has been compounded by the COVID-19 pandemic, and the cracks in our healthcare infrastructure have been thrust into the harsh light of day, now more than ever there is a chance for significant change and innovation at the federal, legislative, and judicial levels.

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99. Andrew C. v. Oracle America Inc. Flexible Benefit Plan, 474 F. Supp. 3d 1066, 1081 (N.D. Cal. 2020).

100. *Id.*

101. *See* Josef K. v. California Physicians' Service, 477 F. Supp. 3d 886, 897 (N.D. Cal. 2020).

102. Bain v. Oxford Health Insurance Inc., No. 15-cv-03305-EMC, 2020 WL 808236 at *6 (N.D. Cal. 2020); S.B. v. Oxford Health Insurance, Inc., 419 F. Supp. 3d 344, 361–62 (D. Conn. 2019).

103. Jamie F. v. United Healthcare Insurance Company, 474 F.Supp.3d 1052, 1055 (N.D. Cal. 2020).