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From Health Policy to Stigma and Back Again: The Feedback Loop Perpetuating the Opioids Crisis

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FROM HEALTH POLICY TO STIGMA AND BACK AGAIN: THE FEEDBACK LOOP PERPETUATING THE OPIOIDS CRISIS

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I. INTRODUCTION

Between 1999 and 2017, almost 400,000 people died from opioid overdoses,[1] and since 2001, the opioid crisis has cost the U.S. more than 1 trillion dollars.[2] In late 2018, the Department of Health and Human Services (HHS) Secretary opined that the country was "beginning to turn the tide" in responding to the crisis.[3] Secretary Azar's positive statements were based on preliminary CDC data that showed a national decline of 2.7 percent in drug overdose deaths from October 2017 to May 2018.[4] However, data still show over half the states posting an increase in overdose deaths[5] with a concentration of higher death rates in the upper Midwest and Appalachia.[6] Recent sobering data from CDC, also showed a national decline in life expectancy for the third year in a row.[7] A 2018 McKinsey report argued that the

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[1] *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/epidemic/index.html [https://perma.cc/GB3Y-ZLF3].

[2] *Economic Toll of Opioid Crisis in U.S. Exceeded $1 Trillion Since 2001*, ALATRUM (Feb. 13, 2018), https://altarum.org/news/economic-toll-opioid-crisis-us-exceeded-1-trillion-2001 [https://perma.cc/XL4G-D85T].

[3] *E.g.*, German Lopez, *Trump's Health Secretary Says the Opioid Epidemic May Be Turning Around. Not so Fast.*, VOX (Oct. 24, 2018), https://www.vox.com/science-and-health/2018/10/24/18015532/opioid-epidemic-overdose-deaths-2018-alex-azar-trump [https://perma.cc/VQG4-YZVT].

[4] *Id*. As of April 2019, the CDC predicts a decline of 3.2% between September 2017 and September 2018, *see Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm [https://perma.cc/9W6L-QP42] [hereinafter *Vital Statistics*].

[5] *See Vital Statistics, supra* note 4.

[6] HOLLY HEDEGAARD ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR DISEASE CONTROL & PREVENTION, NCHS DATA BRIEF NO. 329, DRUG OVERDOSE DEATHS IN THE UNITED STATES, 1999–2017, at 3 (2018), https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf [https://perma.cc/M4T9-54UK].

[7] SHERRY L. MURPHY ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR DISEASE CONTROL & PREVENTION, NCHS DATA BRIEF NO. 328, MORTALITY IN THE UNITED STATES, 2017, 6 (2018), https://www.cdc.gov/nchs/data/databriefs/db328-h.pdf [https://perma.cc/798B-84SN].

number of persons suffering from opioid use disorder ("OUD") is likely to be an underestimate with the actual number being between four and six million persons.[8] Even if the most optimistic projections about opioid overdose deaths proved correct, we will still face new dangers in fentanyl cocktails, as it is mixed with other street or diverted drugs such as Methamphetamine, cocaine, or benzodiazepines.[9] Neither is there any evidence that we are now better prepared for the next addiction crisis.

Why is it that the United States seems to have little resilience in the face of such crises? Why aren't those at risk being diagnosed earlier through preventative care? Why are so many of those suffering with OUD denied any care or are unable to find adequate treatment, coordinated care, or recovery services? An earlier article concentrated on flaws in the healthcare system, arguing that healthcare itself was a structural determinant of the continuing crisis.[10] Specifically, that article was critical of access and benefit stratification, the failure of some states to adopt Medicaid expansion (or having done so to make enrollment dependent on burdensome administrative or work requirements), persistent problems associated with fragmentation of care, sub-optimal care coordination, and the lack of wraparound services.[11]

This Article seeks to provide additional context for those structural determinants. Furthermore, this analysis extends to identifying causes that are upstream (for example, social determinants) or downstream (for example, exceptionalism) from those identified healthcare structural determinants. These causes and effects include the limitations of our federal structure, social and structural determinants, and the implications of stigma-reinforcing policymaking. Together they conspire to create a feedback loop fueled by inadequate goals, strategies, and tactics.

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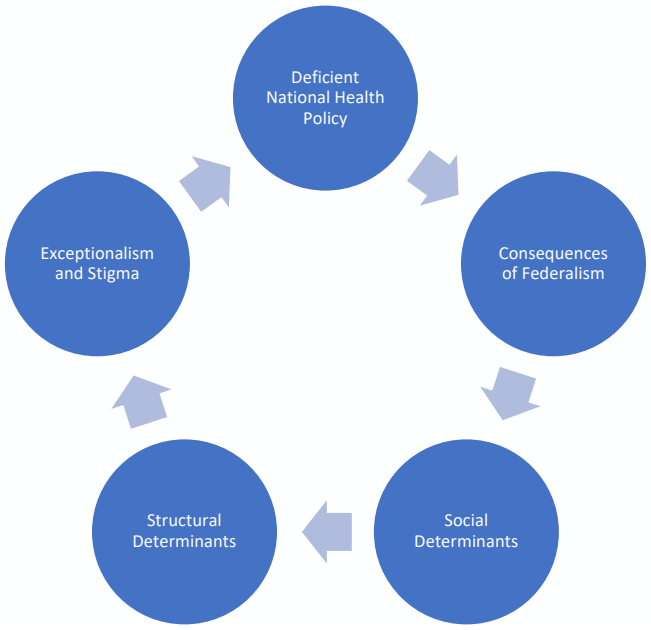
[8] Sarun Charumilind et al., *Why We Need Bolder Action to Combat the Opioid Epidemic,* MCKINSEY & COMPANY (Sept. 2018), https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/why-we-need-bolder-action-to-combat-the-opioid-epidemic [https://perma.cc/PQ5Q-92TU].

[9] *See* HOLLY HEDEGAARD ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR DISEASE CONTROL & PREVENTION, DRUGS MOST FREQUENTLY INVOLVED IN DRUG OVERDOSE DEATHS: UNITED STATES, 2011–2016 1 (2018); Rachel L. Rothberg & Katie T. Smith, *Fentanyl: A Whole New World?*, 46 J. L., MED. & ETHICS 314 (2018) (discussing the growing black market for fentanyl and the danger it presents because of its potency); *see also* Lauren B. Gerlach et al., *Factors Associated with Long-term Benzodiazepine Use Among Older Adults*, 178 JAMA INTERNAL MED. 1560, 1560 (2018) (noting that one in three older adults prescribed a benzodiazepine by a nonpsychiatric clinician progressed to risky long-term use).

[10] Nicolas Terry, *Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid*, 11 NE. U. L. REV. 315 (2019).

[11] *Id.*



Implicit in this Article is the belief that the U.S. response to the opioid overdose epidemic is and likely will continue to be fatally flawed. The explicit claim is that there are multiple causes for this failure and they, each in turn, have negative effects further downstream. Thus, the absence of a national health policy is both caused by and plays out in the impact of federalism on healthcare. Healthcare federalism is partly responsible for failing to adequately address social and structural determinants, while social determinants, such as unemployment or poverty, feed into healthcare structural determinants, such as limited access to care. Those structural barriers in turn tend to be approached with incremental reforms or exceptional "solutions" (themselves relatable to the absence of a holistic national health policy). Furthermore, the health discrimination inherent in exceptional rather than parity models feeds competing narratives (such as moral defect) about the causes of addictions. Competing narratives give rise to uneven, incomplete, or just plain bad policies; a rise in policies that perpetuate stigma, delay harm reduction strategies, and promote supply-side criminalization. Completing the feedback loop, stigma works against innovative, inclusive national (or even state) policies. The Article concludes with a brief analysis of the SUPPORT Act of 2018 and explains why this, the latest well-intentioned federal "solution" to the opioid crisis, hones true to the systemic issues outlined herein.

II. DEFICIENT NATIONAL HEALTH POLICY

Many, if not most, of the recent national,[12] regional,[13] and state[14] reports on the opioid crisis have endorsed healthcare and public health initiatives, such as broader availability of all three types of FDA-approved medication assisted treatment ("MAT") in multiple treatment settings (including in prisons and jails), the provision of wrap-around services, and efforts to tackle the social determinants of health. Remarkably, there even seems to be broad bipartisan support for these ideas as evidenced by the passage of a series of federal funding statutes between 2016 and 2018.[15] Yet, even with expanded financing from the federal government, progress has been slow. In part, this has been due to flaws in short-term financing models such as grants. However, the major problem has been in implementation.

Implementation is impeded because the U.S. lacks a coherent national health policy. Without some overarching concept and architecture for providing care, a healthcare "system" is likely to be fragmented and ill-equipped to deal with novel stressors, such as syndemics or natural disasters. As recognized by the World Health Organization, national health policies include a defined vision and policy directions together with strategies for implementation.[16] A national health policy could also influence other areas of government planning, by pursuing the "Health in All

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[12] *See e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 4-1, 4-10–11 (2016), https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf [https://perma.cc/RPC3-Y3KV]; *see also* OFFICE OF NAT'L DRUG CONTROL POLICY, THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS FINAL REPORT (2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf [https://perma.cc/73V2-34FG] (demonstrating a national effort to combat drug addiction); *Governors' Recommendations for Federal Action to End the Nation's Opioid Crisis*, NAT'L GOVERNORS ASS'N (Jan. 18, 2018), https://classic.nga.org/cms/governors-recommendations-opioid-crisis [https://perma.cc/A2MB-QCQJ] (demonstrating another national effort to combat drug addiction).

[13] *See e.g.*, APPALACHIAN REG'L COMM'N, COMMUNICATING ABOUT OPIOIDS IN APPALACHIA: CHALLENGES, OPPORTUNITIES, AND BEST PRACTICES (2018), http://operationunite.org/wp-content/uploads/2018/01/Opioid-communication-in-appalachia-ORAU-report-1-17-18.pdf [https://perma.cc/7HV4-K3J6].

[14] *See e.g.*, IND. GOVERNOR'S OFFICE , INDIANA DRUG PREVENTION, TREATMENT AND ENFORCEMENT PRELIMINARY ACTION STEPS (May 18, 2017), http://www.in.gov/gov/files/DPTE%20Preliminary%20Action%20Steps.pdf [https://perma.cc/B34R-KZ6Y]; *see also* IND. PRESCRIPTION DRUG ABUSE PREVENTION TASK FORCE, TAKING ACTION: THE FOUR YEAR REPORT 2012–2016, at 6–10 (2016), https://www.in.gov/bitterpill/files/FINAL%20Four%20Years%20In%20Action%20Report%20-%20OAG%20Coverchange%20final.pdf [https://perma.cc/5D2K-LYYZ].

[15] *See infra* note 142.

[16] *National Health Policies, Strategies, and Plans*, WORLD HEALTH ORG. (Apr. 3, 2019), https://www.who.int/nationalpolicies/nationalpolicies/en/ [https://perma.cc/A5JG-M78Z].

Polices" ("HiAP") approach to policymaking in order to correct the socioeconomic inequalities responsible for some of the social determinants of health.[17]

Obviously, the U.S. has *some* centralized healthcare regulation and management. For example, the FDA[18] and HHS-OCR[19] regulate drugs and devices and health privacy, respectively. More pertinently, Centers for Medicare & Medicaid Services ("CMS") administers Medicare that covers more than seventeen percent of the population, has its own policies, and often acts as a bellwether for private payers.[20] CMS also has been active in pulling policy levers to combat the opioid epidemic, promoting prevention, treatment, and data collection.[21] However, there are at least four reasons why centralized regulation of healthcare, even when accompanied by financing, is not the same as a national health policy. First, a true national health policy runs wider and deeper than these federal models. According to Carl Ameringer, "[t]he failure of the U.S. government to construct a national health policy that reconciles diverse priorities means that there are no overriding principles to guide health care delivery."[22] Second, Congress, the branch of government best positioned to develop health policy, is locked in divisive partisanship, which is generally and bitterly divided on healthcare reform.[23] Third, most healthcare in the U.S. is provided by private entities or persons.[24] The resulting fragmented system is paid for by a fragmented financing model; the federal and state governments pay the largest share (41%), followed by private health insurance (34%) and individuals' out-of-pocket expenses (11%).[25] Fourth, Ameringer's

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[17] *See generally Health in All Policies*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 9, 2016), https://www.cdc.gov/policy/hiap/index.html [https://perma.cc/DE9Z-LQB7] (discussing "a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities . . . .").

[18] Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 301–399i (1946).

[19] 45 C.F.R. § 164.500–164.534 (2001).

[20] *Medicare Beneficiaries as a Percent of Total Population*, HENRY J. KAISER FAMILY FOUND., https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/NU26-4MTP].

[21] *See e.g.*, CTR. FOR MEDICARE & MEDICAID SERVS., CMS ROADMAP: FIGHTING THE OPIOD CRISIS (2019), https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf [https://perma.cc/4CYJ-9ULV].

[22] CARL AMERINGER, U.S. HEALTH POLICY AND HEALTH CARE DELIVERY: DOCTORS, REFORMERS, AND ENTREPRENEURS 13 (2018).

[23] Alison Kodjak, *Democrats' Health Care Ambitions Meet the Reality of Divided Government*, NPR (Jan. 9, 2019, 11:40 AM), https://www.npr.org/sections/health-shots/2019/01/09/683055963/democrats-health-care-ambitions-meet-the-reality-of-divided-government [https://perma.cc/8X22-4ZQZ].

[24] Josh Cothran, *Infographic — US Health Care Spending: Who Pays?*, CAL. HEALTH CARE FOUND. (Apr. 6, 2018), https://www.chcf.org/publication/us-health-care-spending-who-pays/ [https://perma.cc/AX79-BTMX].

[25] CAL. HEALTHCARE FOUND., HEALTH CARE COSTS 101: A CONTINUING ECONOMIC THREAT 22 (2018), https://www.chcf.org/wp-content/uploads/2018/05/HealthCareCosts2018.pdf [https://perma.cc/NS2P-SFNE].

observations have particular salience in the opioid context: "neither the provision of care nor the financing of it targets the entire population" and that "finance and delivery are mostly separate and distinct."[26] It is likely that these issues are further exacerbated by the lack of HiAP coordination between U.S. healthcare and other federal or state social services.

Only an approximation of a national healthcare policy can be inferred from the Affordable Care Act ("ACA"):[27] that the federal government will encourage, even subsidize access to health insurance.[28] However, a true national healthcare policy requires more broadly stated goals, such as universal access to care or the adoption of the principle of solidarity.[29] In contrast, a Rand analysis of post-ACA healthcare policy instead identified a paralyzed policy environment revealing:

> tensions between many health policy goals—for example, expanding coverage versus reducing costs; targeting tax credits effectively versus incentivizing work; protecting the sickest and most expensive patients versus preserving choice among the majority of patients who may not need comprehensive coverage; and limiting the federal government's cost liability versus minimizing cost-shifting to consumers and states.[30]

A national healthcare policy also should be the place for broad-ranging, evidence-based cost-effectiveness analysis. For example, the Surgeon General's 2016 report concluded that "evaluations of Medicaid expenditures for substance use disorder treatment show that the costs of treating substance use disorders are more than offset by the accompanying savings to Medicaid in reduced health care costs, such as reductions in future substance use disorder-related hospitalizations and residential treatment costs."[31] For example, a 2008 report from Substance Abuse and Mental Health Services Administration ("SAMHSA") estimated that every dollar spent on effective school-based programs would save an estimated $18 in education and healthcare costs.[32] The National Insititute on Drug Abuse ("NIDA") estimates that "every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft.

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[26] AMERINGER, *supra* note 22, at 13.

[27] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

[28] *See, e.g.*, *Subsidized Coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/subsidized-coverage/ [https://perma.cc/XY95-X6MN].

[29] *See generally* Richard B. Saltman, *Health Sector Solidarity: A Core European Value But with Broadly Varying Content*, 4 ISR. J. HEALTH POL'Y RES. 1 (2015).

[30] *The Future of U.S. Health Care: Replace or Revise the Affordable Care Act?*, RAND HEALTH CARE, https://www.rand.org/health-care/key-topics/health-policy/in-depth.html [https://perma.cc/9GW8-DZRJ].

[31] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 12, at 6–18 .

[32] TED R. MILLER & DELIA HENDRIE, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SUBSTANCE ABUSE PREVENTION DOLLARS AND CENTS: A COST-BENEFIT ANALYSIS 2 (2008), https://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf [https://perma.cc/6VVM-5ZBT].

When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1."[33] A HiAP approach could also be implemented through reallocation of resources; for example, Ohio's "Issue 1" drug decriminalization constitutional amendment that failed in 2018 would have required the state to invest sums saved from the reduction of inmates on drug treatment, crime victim, and rehabilitation programs.[34] Finally, national policies can result in broader strategic initiatives. For example, the opioid crisis requires healthcare and public health initiatives that extend beyond harm reduction and include broader availability of all three types of FDA-approved MAT in multiple treatment settings (including in prisons and jails),[35] the provision of wrap-around services, and efforts to tackle the social determinants of health.

III. FEDERALISM

National healthcare policies tend to be associated with unitary governments.[36] To an extent, therefore, federalism is intertwined with our national healthcare policy vacuum. Furthermore, federalism reinforces the fragmentation of our healthcare system. Even after the ACA (that was viewed by some conservatives as a "usurpation" of long-standing state authority in regulating private insurance[37]), the levers of central government are quite limited, with states still responsible for exercising their police powers to protect the welfare, safety, and health of the public.

The economies of the U.S. states have recovered from the great recession.[38] However, Medicaid now absorbs more than seventeen percent of state revenue[39] and

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[33] NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 14 (3rd ed. 2018), https://www.drugabuse.gov/node/pdf/675/principles-of-drug-addiction-treatment-a-research-based-guide-third-edition [https://perma.cc/DQ4G-DXVV].

[34] *Ohio Issue 1, Drug and Criminal Justice Policies Initiative (2018)*, BALLOTPEDIA, https://ballotpedia.org/Ohio_Issue_1,_Drug_and_Criminal_Justice_Policies_Initiative_(2018) [https://perma.cc/M8RP-89FT].

[35] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 12, at 6–18.

[36] WORLD HEALTH ORG., ORGANIZATION AND FINANCING OF PUBLIC HEALTH SERVICES IN EUROPE: COUNTRY REPORTS 5, 23, 35, 49, 95 (Bernd Rechel et al. eds., 2018), http://www.euro.who.int/__data/assets/pdf_file/0011/370946/public-health-services.pdf [https://perma.cc/74GU-BQAT].

[37] EDMUND F. HAISLMAIER & BRIAN C. BLASE, THE HERITAGE FOUND., OBAMACARE: IMPACT ON STATES 1 (2010), http://thf_media.s3.amazonaws.com/2010/pdf/bg2433.pdf [https://perma.cc/9UXA-UAHP].

[38] *See generally Fiscal 50: State Trends and Analysis*, PEW (Mar. 11, 2019), https://www.pewtrusts.org/en/research-and-analysis/articles/2014/05/19/fiscal-50-state-trends-and-analysis [https://perma.cc/8DY2-S9PW].

[39] *Fiscal 50: State Trends and Analysis: More Than 17 Percent of State Revenue Goes to Medicaid,* PEW (June 20, 2018), https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2014/fiscal-50#ind7 [https://perma.cc/3X54-3MUY].

states hit hardest by the opioid epidemic are experiencing slower growth.[40] The states alone cannot fund the kind of healthcare initiatives necessitated by the opioid epidemic. Therefore, the states must look to the federal government. This implicates a legion of problems. First, until quite recently there has not been very much Congressional enthusiasm for paying for the opioid epidemic.[41] Second, when it comes to the financing of healthcare (particularly Medicaid), Congressional conservatives want to see a reduction in the uncapped flow of money to the states, preferring block grants that provide limited sums for defined purposes.[42] The other way that the federal government caps the flow of funds to the states in emergencies is by establishing federally supervised grant programs. During the opioid epidemic, this has translated into grant programs administered by SAMHSA.[43] Typically, however generous, grants are time-limited without any guarantee of renewal. Such short spending horizons can handcuff state governments who will be hesitant to build out infrastructure and capacity without having ongoing funding to service it. Third, assuming the federal appropriations process is successfully navigated,[44] there will be delays in the distribution of funds as federal and state regulators work to draft funding mechanisms and oversight regulations in advance of releasing resources to bear on the crisis.

Sometimes the downsides of federalism are spun as an opportunity, "that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."[45] However, in healthcare and particularly in responses to the opioid epidemic, the mythology surrounding state or private entity laboratories of innovation seems

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[40] Barb Rosewicz & Joe Fleming, *Look West for Strongest Growth Since the Recession*, PEW (Nov. 19, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/11/19/look-west-for-strongest-growth-since-the-recession [https://perma.cc/7RSJ-L2XX].

[41] *See* Associated Press, *U.S. Government Will Spend $4.6 Billion Fighting Opioid Crisis. Advocates Say That's Not Nearly Enough*, L.A. TIMES (Mar. 25, 2018, 4:55 PM), http://www.latimes.com/nation/nationnow/la-na-opiod-crisis-20180325-story.html [https://perma.cc/W3FA-CP75] (providing a quote from a former U.S. representative stating that "Congress needs to devote more money").

[42] Peter Sullivan, *Trump Officials Consider Allowing Medicaid Block Grants for States*, HILL (Jan. 11, 2019, 4:17 PM), https://thehill.com/policy/healthcare/424988-trump-officials-consider-allowing-medicaid-block-grants-for-states [https://perma.cc/H4PT-AVN7]; *see generally* Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does It Work and What Are the Implications?*, HENRY J. KAISER FAMILY FOUND. (May 20, 2015), https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/ [https://perma.cc/7HKQ-K4BF].

[43] *See, e.g.*, *State Opioid Response Grants*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. (Aug. 3, 2018), https://www.samhsa.gov/grants/grant-announcements/ti-18-015 [https://perma.cc/847Y-88MF].

[44] *See generally* JAMES V. SATURNO ET AL., CONG. RESEARCH SERV., R42388, THE CONGRESSIONAL APPROPRIATIONS PROCESS: AN INTRODUCTION (Nov. 30, 2016), https://www.senate.gov/CRSpubs/8013e37d-4a09-46f0-b1e2-c14915d498a6.pdf [https://perma.cc/WJ5P-VNH3].

[45] New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

defensible.[46] As Kristin Madison notes, "[f]lexibility permits but does not guarantee innovation."[47] Indeed, the federal tools intended to promote state innovation such as Section 1115[48] and Section 1332 waivers[49] increasingly are being used to undermine not improve federal health policies.[50] Furthermore, many apparent state innovations such as Washington's plans for a "public option,"[51] Minnesota's reinsurance program,[52] or Maryland's proposed individual mandate[53] are less about experimentation and more about building state moats to protect against federal neglect, sabotage, or piece-by-piece repeal of the ACA.[54]

Pockets of innovation in opioid policy or innovation are detectible and should be lauded. They include the MAT programs at Rikers Island[55] and in Rhode Island,[56]

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[46] *Cf.* Hannah J. Wiseman & Dave Owen, *Federal Laboratories of Democracy*, 52 U.C. DAVIS L. REV. 1119 (2018) (arguing that state "laboratories" are rare and that the federal government is a key driver of experimentaion).

[47] Kristin Madison, *Building A Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 776 (2014).

[48] Elizabeth Hinton et al., *Section 1115 Medicaid Demonstrative Waivers: The Current Landscape of Approved and Pending Waivers*, HENRY J. KAISER FAMILY FOUND. (Feb. 12, 2019), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/ [https://perma.cc/G8PT-HTW9].

[49] *Tracking Section 1332 State Innovation Waivers*, HENRY J. KAISER FAMILY FOUND. (Aug. 23, 2018), https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/ [https://perma.cc/V9DQ-UE74].

[50] *See, e.g.*, Timothy S. Jost, *Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State*, COMMONWEALTH FUND: TO THE POINT (Oct. 30, 2018), https://www.commonwealthfund.org/blog/2018/using-1332-state-waiver-program-undermine-affordable-care-act-state-state [https://perma.cc/74D7-4KCX].

[51] Ryan Blethen & Joseph O'Sullivan, *Inslee Proposes 'Public Option' Health-Insurance Plan for Washington*, SEATTLE TIMES (Jan. 8, 2019), https://www.seattletimes.com/seattle-news/politics/inslee-proposes-public-option-health-insurance-plan-for-washington/ [https://perma.cc/DT2A-NMXH].

[52] Christopher Snowbeck, *Minnesota Health Insurers Propose Lower Premiums*, STAR TRIB. (June 15, 2018), http://www.startribune.com/minnesota-health-insurers-propose-lower-premiums/485674372/ [https://perma.cc/39Q5-D3WK].

[53] Andrea K. McDaniels, *General Assembly Weighs Bill to Require Marylanders to Buy Health Insurance*, BALT. SUN (Feb. 20, 2018), https://www.baltimoresun.com/health/bs-hs-individual-mandate-20180216-story.html [https://perma.cc/6UQV-M39V].

[54] *See generally* Complaint for Declaratory and Injunctive Relief at 5, City of Columbus v. Trump, No. 18-cv-2364 (D. Md. Aug. 2, 2018), https://democracyforward.org/wp-content/uploads/2018/08/ACA-Complaint.pdf [https://perma.cc/6FRT-LFYX] (alleging sabotage of ACA by the Trump Administration).

[55] Christine Vestal, *At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment*, PEW: STATELINE (May 23, 2016), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/05/23/at-rikers-island-a-legacy-of-medication-assisted-opioid-treatment [https://perma.cc/8YPA-JQC2].

[56] Andrea Hsu & Ari Shapiro, *Rhode Island Prisons Push to Get Inmates the Best Treatment for Opioid Addiction*, NPR (Nov. 19, 2018), https://www.npr.org/sections/health-

the Police Assisted Addiction Recovery Initiative (PAARI) program in Gloucester, Massachusetts,[57] and Vermont's Hub-and-Spoke treatment model.[58] Overall, however, innovations in the opioid space such as safe injection sites are as likely to be faced with objections based on stigma and moral defect.[59] Equally, state programs may find themselves battling their own "federalism" problem as decentralization within the states delegates' questions, such as whether to implement a syringe exchange to smaller political entities like county departments of health.[60]

IV. SOCIAL DETERMINANTS OF HEALTH

Nowhere are the absence of a national healthcare policy and federalism felt more than in the public healthcare system. According to the Institute of Medicine,

> The fragmentation of the governmental public health infrastructure is in part a direct result of the way in which governmental roles and responsibilities at the federal, state, and local levels have evolved over U.S. history. This history also explains why the nation lacks a comprehensive national health policy that could be used to align health-sector investment, governmental public health agency structure and function, and incentives for the private sector to work more effectively as part of a broader public health system.[61]

Without a properly funded and organized public healthcare system, the U.S. will continue struggling to address the social determinants of health. Social determinants are nonmedical factors, such as "the conditions in which people are born, grow, live, work and age . . . [and] are mostly responsible for health inequities."[62] They include education, housing, employment (there are relatively few recovery-friendly workplaces[63]), and the availability of transport. Social determinants have been

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shots/2018/11/19/668340844/rhode-island-prisons-push-to-get-inmates-the-best-treatment-for-opioid-addiction [https://perma.cc/2LU4-F4Q3].

[57] *See* Davida M. Schiff et al., *A Police-Led Addiction Treatment Referral Program in Gloucester, MA: Implementation and Participants' Experiences*, 82 J. SUBSTANCE ABUSE TREATMENT 41, 42 (2017).

[58] *See infra* text accompanying note 120.

[59] Jessica Cohen, *Supervised Injection Facilities Face Obstacles, But That Shouldn't Stop Them*, HEALTH AFF.: BLOG (Nov. 29, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181127.121405/full/ [https://perma.cc/FKU5-DT26].

[60] *See e.g.*, IND. CODE § 16-41-7.5-5 (West 2019).

[61] INST. OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 97 (2003), https://www.nap.edu/read/10548/chapter/5 [https://perma.cc/J6LB-UVBX].

[62] *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/social_determinants/sdh_definition/en/ [https://perma.cc/D2TP-WDL2].

[63] *See* Lenny Bernstein, *One of the Biggest Challenges of Kicking Addiction Is Getting and Keeping a Job*, WASH. POST (Nov. 27, 2018), https://www.washingtonpost.com/national/health-science/one-of-the-biggest-challenges-of-kicking-addiction-is-getting-and-keeping-a-job/2018/11/27/87e8a168-d958-11e8-aeb7-ddcad4a0a54e_story.html?utm_term=.dc8a

extensively identified with the opioid epidemic. For example, OUD frequently is identified as a "disease of despair,"[64] similar to those detailed by Anne Case and Angus Deaton and which are characterized by an increase in mortality and morbidity among non-Hispanic white Americans without college degrees caused in part by "an increasingly difficult labor market."[65] Increasing economic inequality and other issues such as social isolation add to the picture and stoke addictions crises. In Dayna Matthew's words, "social determinants contribute to hopelessness and social trauma that 'set the stage' for opioid abuse and dependency."[66] We also know the opposite can be true, as improvements in healthcare lead to increased civic engagement such as voting.[67]

In the absence of national health and public healthcare policies, we will continue to see large geographical pockets suffer the worst of the opioid epidemic as it falls disproportionately on "Tobacco Nation,"[68] upper Midwestern, Appalachian, and Southern states that exhibit poverty, inadequate health care, underfinanced public health, and marginalized populations.[69] Comorbid substance use problems and other chronic diseases are far more likely to be found in the poor.[70] However, these high risk states tend to perpetuate structural determinants as many of them have either failed to expand Medicaid or have imperiled enrollment (and hence access) by introducing administrative or work requirements.[71] This lack of

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2d195188 [https://perma.cc/4EQU-5S2W].

[64] *See, e.g.*, Jeff Guo, *The Disease Killing White Americans Goes Way Deeper than Opioids*, WASH. POST (Mar. 24, 2017), https://www.washingtonpost.com/news/wonk/wp/2017/03/24/the-disease-killing-white-americans-goes-way-deeper-than-opioids/?noredirect=on&utm_term=.734ce9f859c2 [https://perma.cc/6Y32-Y2Y5] (internal quatations omitted); MICHAEL MEIT ET AL., WALSH CTR. FOR RURAL HEALTH ANALYSIS, APPALACHIAN DISEASES OF DESPAIR 1 (2017), https://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=139 [https://perma.cc/7VPM-68LF].

[65] Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, 2017 BROOKINGS PAPERS ON ECON. ACTIVITY 397, 399 (2017).

[66] DAYNA BOWEN MATTHEW, USC-BROOKINGS SCAEFFER INITIATIVE FOR HEALTH POLICY, UN-BURYING THE LEAD: PUBLIC HEALTH TOOLS ARE THE KEY TO BEATING THE OPIOID EPIDEMIC 4 (2018), https://www.brookings.edu/wp-content/uploads/2018/01/es_20180123_un-burying-the-lead-final.pdf [https://perma.cc/VLY2-MXCT].

[67] *See* Margot Sanger-Katz, *When Medicaid Expands, More People Vote*, N.Y. TIMES: THE UPSHOT (Nov. 8, 2018), https://www.nytimes.com/2018/11/08/upshot/medicaid-expansion-voting-increase.html [https://perma.cc/B2D4-79J8].

[68] TRUTH INITIATIVE, TOBACCO NATION: THE DEADLY STATE OF SMOKING DISPARITY IN THE U.S. 1–2 (Oct. 4, 2017), https://truthinitiative.org/sites/default/files/Tobacco-Nation-FINAL.pdf [https://perma.cc/V3PY-XUGJ].

[69] *See* Nicolas Terry & Aila Hoss, *Opioid Litigation Proceeds: Cautionary Tales from the Tobacco Settlement*, HEALTH AFF.: BLOG (May 23, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180517.992650/full/ [https://perma.cc/5CHF-ZW8R].

[70] *See* Peter J. Cunningham et al., *Income Disparities in the Prevalence, Severity, and Costs of Co-Occurring Chronic and Behavioral Health Conditions*, 56 MED. CARE 139 (2018) (noting that comorbid conditions are more prevelant among low-income people).

[71] *See infra* text accompanying note 103.

health equity, together with what sometimes appears to be a declaration of war on the poor,[72] make it hard to improve resilience to addictions crises such as by re-building the social capital that seems to protect communities from the opioid epidemic.[73]

V. STRUCTURAL DETERMINANTS

The absence of a principled national healthcare policy, the uneasy alliance between the federal government and the states on the financing of health insurance, and the fragmented delivery of healthcare through heterogeneous private entities create a breeding ground for structural determinants that adversely affect healthcare generally and opioid treatment specifically. An earlier article argued in detail that facets of the healthcare system are themselves structural determinants that obstruct the remediation of social determinants of health or perpetuate them.[74] Viewing the healthcare system as a structural determinant explains at least some of its failures to provide preventative care, treatment, and recovery service to those suffering from OUD.[75] Many of the barriers erected can be grouped as either access to healthcare or healthcare delivery.

In the U.S., access to healthcare equates with access to public or private health insurance. There is strong correlation between low rates of un-insurance and high levels of MAT.[76] In 2016, the Surgeon General's report was clear, "a fundamental way to address disparities is to increase the number of people who have health coverage [and] The Affordable Care Act provides several mechanisms that broaden access to coverage."[77] There are two principal mechanisms: lower cost individual insurance available for purchase from the marketplace exchanges[78] and Medicaid expanded to a larger population.[79] However, ACA exchange sabotage by the Trump Administration, work requirements, and other barriers to Medicaid are increasing the number of uninsured persons after the steady decline seen since the passage of the ACA.[80]

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[72] Paul Krugman, *The G.O.P.'s War on the Poor*, N.Y. TIMES: OPINION (July 16, 2018), https://www.nytimes.com/2018/07/16/opinion/republican-war-on-poverty.html [https://perma.cc/JL5Z-6DX9].

[73] Michael J. Zoorob & Jason L. Salemi, *Bowling Alone, Dying Together: The Role of Social Capital in Mitigating the Drug Overdose Epidemic in the United States*, 173 DRUG & ALCOHOL DEPENDENCE 1, 7–8 (2017), https://doi.org/10.1016/j.drugalcdep.2016.12.011 [https://perma.cc/L93Y-BCK3].

[74] Terry, *supra* note 10, at 58–59.

[75] *Id*.

[76] *America's Opioid Epidemic and Its Effect on the Nation's Commercially-Insured Population*, BLUE CROSS BLUE SHIELD (June 29, 2017), https://www.bcbs.com/the-health-of-america/reports/americas-opioid-epidemic-and-its-effect-on-the-nations-commercially-insured [https://perma.cc/RS5E-284R].

[77] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 12, at 6–15.

[78] Patient Protection and Affordable Care Act § 1311(b), 42 U.S.C. § 18001 (2018).

[79] 42 U.S.C. § 1396(a) (2019).

[80] Margot Sanger-Katz, *After Falling Under Obama, America's Uninsured Rate Looks to Be Rising*, N.Y. TIMES: THE UPSHOT (Jan. 23, 2019), https://www.nytimes.com/2019/01/

The ACA sought to make the marketplace policies premiums affordable by providing tax credits[81] and requiring insurance-companies to subsidize cost-sharing.[82] In very general terms, persons are eligible for financial assistance if their income is between 138% and 400% of the Federal Poverty Level ("FPL").[83] The exchange marketplaces showed some volatility under the administration of President Obama but latterly premiums showed signs of stabilizing and growing their enrollments.[84] However, after the 2016 election of President Trump, the markets again became volatile amidst threats of "repeal and replace,"[85] the zero-outing of the individual mandate,[86] and various administration moves to sabotage the marketplace processes and their risk pools.[87] Premiums have continued to increase modestly;[88]

23/upshot/rate-of-americans-without-health-insurance-rising.html [https://perma.cc/DGM3-Z3ME].

[81] *See generally* King v. Burwell, 135 S. Ct. 2480, 2494–95 (2015) (holding that the ACA authorized tax credits for health insurance purchased either from state or federally established exchanges).

[82] *See* BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R44425, HEALTH INSURANCE PREMIUM TAX CREDITS AND COST-SHARING SUBSIDIES 10–13 (Apr. 24, 2018), https://fas.org/sgp/crs/misc/R44425.pdf [https://perma.cc/J837-LGW4].

[83] "Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage." *Federal Poverty Level (FPL)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ [https://perma.cc/32XE-9QRG]. This percentage spread depends on whether a state has expanded Medicaid. *See generally Explaining Health Care Reform: Questions About Health Insurance Subsidies*, HENRY J. KAISER FAMILY FOUND. (Nov. 20, 2018), https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/ [https://perma.cc/PYB3-QJR6].

[84] Dan Mangan, *Obamacare Insurers See Better Financial Performance in 2017, 'No Sign of Market Collapse,'* CNBC (Jan. 4, 2018), https://www.cnbc.com/2018/01/04/obamacare-health-insurers-see-improved-financial-performance-in-2017.html [https://perma.cc/GX8J-Q6YX].

[85] Sean Sullivan, *Republicans Abandon the Fight to Repeal and Replace Obama's Health Care Law*, WASH. POST (Nov. 7, 2018), https://www.washingtonpost.com/powerpost/republicans-abandon-the-fight-to-repeal-and-replace-obamas-health-care-law/2018/11/07/157d052c-e2d8-11e8-ab2c-b31dcd53ca6b_story.html?noredirect=on&utm_term=.1ede745899d7 [https://perma.cc/UZ4W-9YMH].

[86] Sy Mukherjee, *The GOP Tax Bill Repeals Obamacare's Individual Mandate. Here's What that Means for You*, FORTUNE (Dec. 20, 2017), http://fortune.com/2017/12/20/tax-bill-individual-mandate-obamacare/ [https://perma.cc/E9L5-6DY9].

[87] *Sabotage Watch: Tracking Efforts to Undermine the ACA*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca [https://perma.cc/55M7-KZN2].

[88] Rabah Kamal et al., *How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums*, HENRY J. KAISER FAMILY FOUND. (Oct. 26, 2018), https://www.kff.org/health-costs/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/ [https://perma.cc/K4QP-7MEP].

however, enrollments are down.[89] Another related phenomenon is picking up steam in the private insurance market, this time in employer-funded group insurance: increasingly, the insured are finding themselves underinsured because of increases in out-of-pocket costs.[90]

Medicaid expansion, which became optional for the states after the Supreme Court ruling in *NFIB v. Sebelius*,[91] increased the upper level of eligibility for Medicaid. Like those with marketplace policies, the newly eligible Medicaid population are guaranteed certain essential health benefits including mental health and substance use services.[92] Beyond improving access to care, Medicaid also opens paths to reimbursement for upstream services aimed at improving social determinants of health.[93] The obvious direct result of not expanding Medicaid is maintaining a cohort of uninsured persons that likely correlates with a disease of despair population. However, there are also indirect effects. For example, Medicaid expansion correlates with reductions in uncompensated care[94] and generally positive financial performance of hospitals, and it reduces the likelihood of closure of rural hospitals.[95] Most importantly, expansion correlates with reduced rates of poverty.[96] Medicaid expansion also seems to lift all boats; according to the U.S. Government Accountability Office (GAO), "low-income adults in states that expanded Medicaid generally reported better access to health care. For example, they were less likely to

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[89] *Marketplace Enrollment, 2014–2019*, HENRY J. KAISER FAMILY FOUND., https://www.kff.org/health-reform/state-indicator/marketplaceenrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/3XBV-BMPD].

[90] Sara R. Collins et al., *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured*, COMMONWEALTH FUND (Feb. 7, 2019), https://doi.org/10.26099/penv-q932 [https://perma.cc/WE37-M4KG].

[91] 567 U.S. 519, 585 (2012).

[80] 42 U.S.C. § 18022(b)(1)(E) (2018).

[93] Enrique Martinez-Vidal et al., *Overcoming Challenges to Medicaid Investments in Social Determinants of Health*, HEALTH AFF.: BLOG (June 13, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180612.152825/full/ [https://perma.cc/U8D3-VHCV]; *see also* Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, HENRY J. KAISER FAMILY FOUND. (May 10, 2018), https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/ [https://perma.cc/6HN7-7C9X].

[94] David Dranove et al., *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal*, COMMONWEALTH FUND (May 3, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care [https://perma.cc/8D9G-BSJZ].

[95] Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFFAIRS 111, 116–18 (2018).

[96] Naomi Zewde & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions over Time*, 38 HEALTH AFFAIRS 132, 135–38 (2019).

report having unmet medical needs (such as not being able to afford their prescriptions)—whether or not they were insured."[97] Overall, the Medicaid population maps closely to the population of nonelderly adults with opioid addiction and even more so to those with low incomes.[98] For example, after Kentucky expanded Medicaid, it experienced a 700 percent increase in the utilization of substance use services.[99] Unfortunately, 14 states have still not expanded Medicaid,[100] including southern states with poorly performing healthcare systems.[101] The Obama administration was successful in persuading some states with conservative governments to expand Medicaid by approving § 1115 waivers that required enrollees to have some "skin in the game" that require compliance with administrative requirements, paying premiums, contributing to health savings accounts, or requiring healthy behaviors.[102] The Trump Administration has gone further, approving provisions such as work requirements that the prior administration rejected.[103] Studies of these additional eligibility requirements show a dramatic, negative effect on enrollment.[104] Particularly troubling are projections

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[97] *MEDICAID*: *Access to Health Care for Low-Income Adults in States With and Without Expanded Eligibility*, U.S. GOV'T ACCOUNTABILITY OFF. (Sept. 13, 2018), https://www.gao.gov/products/GAO-18-607 [https://perma.cc/8Z37-8L9N].

[98] Julia Zur & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, HENRY J. KAISER FAMILY FOUND. (Apr. 11, 2018), https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/ [https://perma.cc/E6D6-WT77].

[99] FOUND. FOR A HEALHTY KY., SUBSTANCE USE AND THE ACA IN KENTUCKY (2016), https://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final_12_16-002-.pdf [https://perma.cc/N23K-KZAN].

[100] *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAMILY FOUND., https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ [https://perma.cc/TW9M-SMKT]; *see also* Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, HENRY J. KAISER FAMILY FOUND. (June 12, 2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ [https://perma.cc/5TCP-GSCG].

[101] DAVID C. RADLEY ET AL., COMMONWEALTH FUND, 2018 SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE 3 (May 2018), https://interactives.commonwealthfund.org/2018/state-scorecard/files/Radley_State_Scorecard_2018.pdf [https://perma.cc/NPF3-PH34].

[102] *See* Seema Verma & Brian Neale, *Healthy Indiana 2.0 Is Challenging Medicaid Norms*, HEALTH AFF.: BLOG (Aug. 29, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160829.056228/full/ [https://perma.cc/VS3F-THAN].

[103] Sara Rosenbaum, *The Trump Administration Re-Imagines Section 1115 Medicaid Demonstrations — and Medicaid*, HEALTH AFF.: BLOG (Nov. 9, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171109.297738/full/ [https://perma.cc/N23K-KZAN].

[104] MaryBeth Musumeci et al., *An Early Look at Implementation of Medicaid Work Requirements in Arkansas*, HENRY J. KAISER FAMILY FOUND. (Oct. 8, 2018), https://www.kff.org/medicaid/issue-brief/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas/ [https://perma.cc/6DAM-JXKL].

about the impact of work requirements; for example, based on experiences in other states and other data, it has been estimated that Kentucky's work requirement would lead to over 100,000 persons losing their eligibility.[105] Assuming that persons with substance use disorder may have difficulty in fulfilling administrative requirements and may churn in and out of employment, it may be that those with OUD will be denied help from the program best matched to their circumstances.

Structural determinants impeding access are only half the story. Our healthcare delivery systems also exhibit negative structural determinants. Many of these issues are standard fare, describing a healthcare system that lacks an overarching policy, is hopelessly fragmented leading to inadequate care coordination and case management, and has insufficient wraparound services.[106] There is evidence that patients with multiple chronic conditions whose care is not coordinated are at far higher risk of emergency department visits.[107] As with other chronic conditions or other vulnerable populations, those in need of treatment for OUD are particularly in need of such services.[108] In particular, OUD patients are in critical need of care coordination.[109] More broadly, the current OUD treatment delivery system simply is incomplete. Reflecting the through line from the absence of a national health policy through federalism to structural determinants, just because a state program is funded, the services it requires may not be available. State healthcare systems have been overwhelmed by demand for opioid services caused by a death of treatment centers and a qualified workforce.[110] Even if a person suffering from OUD can find an outpatient treatment center, there is only a small chance that it will be suitable.[111] Non-medical detoxification and recovery models, such as 12-step programs, are used and often over-used in patients suffering from severe OUD, for whom the

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[105] Sara R. Collins et al., *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky*, COMMONWEATH FUND (Oct. 22, 2018), https://www.commonwealthfund.org/publications/2018/oct/kentucky-medicaid-work-requirements [https://perma.cc/9LPT-5BYQ].

[106] *See*, *e.g.*, FAMILIES USA, THE PROMISE OF CARE COORDINATION: TRANSFORMING HEALTH CARE DELIVERY 3 (2013).

[107] Lisa M. Kern et al., *Fragmented Ambulatory Care and Subsequent Healthcare Utilization Among Medicare Beneficiaries*, 24 AM. J. MANAGAGED CARE 278, 281–82 (2018).

[108] *See*, *e.g.*, Jingping Xing et al., *Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs*, 34 HEALTH AFF. 653, 657–59 (2015).

[109] Mark Olfson et al., *Causes of Death After Nonfatal Opioid Overdose*, 75 JAMA PSYCHIATRY 820, 824–25 (2018).

[110] Christine Vestal, *Still Not Enough Treatment in the Heart of the Opioid Crisis*, PEW: STATELINE (Sep. 26, 2016), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/09/26/still-not-enough-treatment-in-the-heart-of-the-opioid-crisis [https://perma.cc/ETM6-HB5X].

[111] Ramin Mojtabai et al., *Medication Treatment For Opioid Use Disorders in Substance Use Treatment Facilities*, 38 HEALTH AFF. 1, 1 (2019), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05162 [https://perma.cc/SB8M-4PTJ].

standard of care is MAT.[112] Indeed, many facilities remain detox-only or do not offer a full range of evidence-based MAT.[113] For example, only a small number offer all three types of MAT (6.1%) and, even if they do, not all actually will receive MAT.[114] These types of services cannot just be switched "on." They are dependent on investment, infrastructure, and workforce training. Some of the structural barriers are path dependent reminders of the unsatisfactory, stigma-laden history of treating those with behavioral health issues; segregating those suffering from substance from mainstream healthcare delivery and leaving their "treatment" to psychiatric hospitals or prisons.[115] Examples include the Institutions for Mental Diseases ("IMD") exclusion that prohibited Medicaid financing for care in mental health and substance use disorder residential treatment facilities larger than 16 beds, until it was suspended by the SUPPORT Act.[116] Limitations persist regarding Opioid Treatment Programs ("OTP"), the required location for most MAT treatments.[117] By law, OTPs must be accredited by an approved accrediting body and certified by SAMHSA.[118] Methadone can only be dispensed through an OTP certified by SAMHSA, and a few states have no such facilities. Methadone-based treatment is absent from a third of Medicaid state plans, and Medicare Part D (covering prescription drugs) does not include methadone or buprenorphine when used for treatment of opioid dependence in an opioid treatment program. Notwithstanding, innovation is possible. For example, Vermont's "Hub-and-Spoke" delivery model splits the state into four

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[112] Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, 2064–65 (2014); *see also Drugs, Brains, and Behavior: The Science of Addiction*, NAT'L INST. ON DRUG ABUSE, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/soa.pdf [https://perma.cc/E448-PPRY] ("Research shows that when treating addictions to opioids (prescription pain relievers or drugs like heroin or fentanyl), medication should be the first line of treatment, usually combined with some form of behavioral therapy or counseling.").

[113] Hannah K. Knudsen et al., *Barriers to the Implementation of Medication-Assisted Treatment for Substance Use Disorders: The Importance of Funding Policies and Medical Infrastructure*, 34 EVALUATION & PROGRAM PLAN. 375, 375–76, 379 (2011), https://doi.org/10.1016/j.evalprogplan.2011.02.004 [https://perma.cc/J3EU-MLGL]; *see also* Brendan Saloner & Colleen L. Barry, *Ending the Opioid Epidemic Requires a Historic Investment in Medication-Assisted Treatment*, 37 J. POL. ANALYSIS & MGMT. 431, 432 (2018).

[114] Mojtabai, *supra* note 111, at 18–20.

[115] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 12, at 1-19, 6-5.

[116] *See infra* note 151 and accompanying text.

[117] *Medication and Counseling Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment [https://perma.cc/XY6F-6DHJ]; *see also* U.S. DEP'T. OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS 4 (2015), https://store.samhsa.gov/system/files/pep15-fedguideotp.pdf [https://perma.cc/847Y-88MF].

[118] Opioid Treatment Program Certification, 42 C.F.R. § 8.11 (2018).

regions, each with a licensed outpatient treatment "hub" providing MAT.[119] These hubs are linked to primary care "spokes" that provide counselling and buprenorphine. Depending on their needs, patients can be transferred between hub and spokes.[120] Overall, however, in a fragmented system without centralized (including state or regional) planning it remains difficult to identify the levers or incentives that would cause providers to invest in care coordination and wrap-around services.

The opioid crisis is a wicked problem;[121] so is our healthcare system. Faced with complex, multi-faceted, interlocking problems, it is perhaps not surprising when policymakers favor tackling simpler problems and racking up an easy win. Indeed, the opioid crisis exemplifies efforts to solve macro problems with micro solutions. For example, the crisis exposed the serious asymmetry of drug supply and treatment. As with previous addictions crises, the instinctive reaction was to deal with the problem on the supply-side with micro solutions, such as limitations on prescribing,[122] reimbursement restrictions,[123] and the expansion of Prescription Drug Monitoring Programs.[124] The preferable solution would have involved confronting the other side of the asymmetry, to improve harm reduction and SUD treatment. Worse, because that was a micro-solution the prescription drug policies merely kicked the can down the road as far as tackling street opioids and the probable future undertreatment of pain.

As a recent Commonwealth Fund reported, for many, their high expectations for U.S. healthcare are not delivered on as "it places unexpected and unnecessary burdens on the sick. People struggle to obtain effective treatments and services.

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[119] John R. Brooklyn & Stacey C. Sigmon, *Vermont Hub-and-Spoke Model of Care For Opioid Use Disorder: Development, Implementation, and Impact*, 11 J. ADDICTICTION MED. 286, 286–92 (2017).

[120] RICHARD A. RAWSON, VT. CTR. ON BEHAVIOR & HEALTH, VERMONT HUB-AND-SPOKE MODEL OF CARE FOR OPIOID USE DISORDERS: AN EVALUATION 21–30 (2017), http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Hub_and_Spoke_Evaluation_2017_1.pdf. [https://perma.cc/KX93-ZF3G].

[121] *See generally* Jonathan C. Lee, *The Opioid Crisis Is a Wicked Problem*, 27 AM. J. ON ADDICTIONS 51 (2017), https://onlinelibrary.wiley.com/doi/epdf/10.1111/ajad.12662 [https://perma.cc/9M67-WXTH] (explaining how the opioid crisis meets the criteria of being considered a "wicked problem").

[122] Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, 65 CTRS. FOR DISEASE CONTROL & PREVENTION MORBIDITY & MORTALITY WKLY. REP. 1, 10–11 (2016), https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf [https://perma.cc/ZG67-NK6Z]

[123] *2019 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 1, 2018), https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-advance-notice-part-ii-and-draft-call-letter [https://perma.cc/N4PG-AW49].

[124] Rebecca L. Haffajee et al., *Mandatory Use of Prescription Drug Monitoring Programs*, 313 JAMA 891, 891–92 (2015).

Pervasive fragmentation and lack of coordination across the health system make obtaining services heavy labor for people with advanced illnesses or frailty."[125]

VI. EXCEPTIONALISM AND STIGMA

Deficiencies in policy and planning, lack of system resilience, and barriers created by structural determinants (when they are not simply denying access or impeding quality care) tend to result in incremental or piecemeal "solutions" to crises such as the opioid epidemic. Such an ecosystem (and, further, one not defined by broad national or social principles) can create differential treatment for persons (the access segmentation already discussed) or for diseases (for example, treating OUD differently from other chronic diseases such as diabetes). Some of the problems are caused by exceptional treatment of behavioral health while some of the solutions create exceptions to general rules. Upstream exceptionalism is likely explained by stigma. Downstream exceptionalism can *cause* it. And, as with deeply entrenched social determinants of health, ultimately it will be next to impossible to deal with addictions crises without eradicating stigma.

Historically, behavioral and non-behavioral healthcare developed separately. Different rules regarding treatment, location of services, and data sharing bear testimony to the policies born out of stigma that treat mental illness or substance use differently from other chronic diseases. According to the Surgeon General's report, "because substance misuse has traditionally been seen as a social or criminal problem, prevention services were not typically considered a responsibility of health care systems and people needing care for substance use disorders have had access to only a limited range of treatment options that were generally not covered by insurance."[126]

The ramifications have been serious. Although institutionalized care in psychiatric hospitals eventually gave way to community care, the latter was provided by nonintegrated treatment centers "geographically, financially, culturally, and organizationally separate from mainstream health care."[127] The result was stigmatizing separateness. SUD and mainstream healthcare even have distinct federal confidentiality regimes; SUD is subject to the Confidentiality of Substance Use Disorder Patient Records rule[128] in addition to the HIPAA Privacy Rule which

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[125] Eric C. Schneider et al., *Health Care in America: The Experience of People with Serious Illness*, COMMONWEALTH FUND, http://features.commonwealthfund.org/health-care-in-america [https://perma.cc/7HV4-K3J6].

[126] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 12, at 6-1.

[127] *Id.* at 6-5.

[128] 42 C.F.R. pt. 2 (2018); *see generally* LAURA ASHPOLE ET AL., 42 C.F.R. PART 2 IN RETROSPECTIVE: THE 30-YEAR JOURNEY OF THE ALCOHOL AND DRUG ABUSE TREATMENT CONFIDENTIALITY REGULATIONS (2017), https://www.healthlawyers.org/Members/PracticeGroups/TaskForces/BH/briefings/Documents/42_CFR_Part2_MB.pdf [https://perma.cc/YU8S-8QCE] (describing the history and reasoning that led to Part 2 being promulgated).

alone applies to patient data in most traditional healthcare environments.[129] Cabining SUD and other chronic diseases has negatively impacted the role of primary healthcare in early diagnosis and discouraged mainstream providers from prescribing MAT.[130] It has also led to exceptional policies (that are also structural determinants) not seen in the treatment of other chronic diseases, including the IMD exception, tying MAT to OTPs, and the patient limit attached to the buprenorphine waiver.[131] These differentials offer insights into both the impact of stigma and also the roots of its perpetuation.

Policymakers have attempted to close the gap between behavioral and mainstream healthcare services. That was the thrust of both the Mental Health Parity Act of 1996[132] and the Mental Health Parity and Addiction Equity Act of 2008.[133] The ACA went further, mandating substance use treatment as essential health benefits in Medicaid and marketplace plans and reducing the chance of those with mental health or substance use histories from being denied coverage by prohibiting medical underwriting.[134] However, as already discussed,[135] it does not follow that there are sufficient treatment resources to meet the demand. For example, those seeking treatment will be forced "out-of-network" at a far higher rate than those seeking other medical or surgical services[136] and half of all marketplace plans have behavioral health "narrow networks."[137]

Exceptionalism surrounding substance use prevention, treatment, or recovery perpetuates stigma. As described by Craig Lefebvre, "structural stigma consolidates and sustains stigma through the cultural norms, institutional practices and policies that constrain the opportunities and well-being of people addicted to opioids and

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[129] 45 C.F.R. pts. 160, 162, 164 (2018); *see also Covered Entities and Business Associates*, U.S. DEP'T OF HEALTH & HUMAN SERVS., https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html [https://perma.cc/R52G-GVFJ] (discussing how, in general, the HIPAA rules apply to "covered entities," including most doctors, hospitals, and treatment facilities).

[130] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 12, at 6-5, 6-6.

[131] *Apply to Increase Patient Limits*, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN. SERVS., https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits [https://perma.cc/HDL9-5JUF].

[132] Pub. L. No. 104-204, tit. VII, 110 Stat. 2874, 2944 (1996).

[133] Emergency Economic Stabilization Act of 2008, Pub. L. 110-343 tit. V sub. B, § 511, 122 Stat. 3765, 3881 (2008).

[134] 42 U.S.C. § 300gg (2019).

[135] *See supra* text accompanying notes 110–113.

[136] STEPHEN P. MELEK ET AL., ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: ANALYZING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT RATES 1 (2017), http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparity Analysis.pdf [https://perma.cc/Q2R7-2KMA].

[137] Jane M. Zhu et al., *Networks in ACA Marketplaces are Narrower for Mental Health Care than for Primary Care*, 36 HEALTH AFF. 1624, 1626 (2017).

provide a reinforcing context for stigma when practiced by individuals."[138] Stigma endorses the moral defect theory of SUD rather than viewing it as another chronic disease. And not treating it as a continuing chronic disease perpetuates the dichotomous idea that a person with SUD is either "clean" or "addicted."

Policymakers seem more comfortable with incremental moves over fundamental change. Symbolic gestures such as the appointment of commissions[139] or czars[140] are far easier than the development, financing, and implementation of complex policy solutions to a wicked problem. Those who question the value of incremental reforms often run into the "perfection is the enemy of the good" argument. However, as we face recurring addiction crises, "good" increasingly will not be good enough.[141]

VII. FEDERAL LEGISLATIVE RESPONSES

The Comprehensive Addiction and Recovery Act of 2016 ("CARA")[142] was the first major federal legislation to address the current opioid crisis. It authorized federal grants to address harm reduction and healthcare issues such as educational programs, naloxone availability, evidence-based treatment for the incarcerated, disposal sites, MAT demonstration, and Prescription Drug Monitoring Programs (PDMPs).[143] CARA directly appropriated only $181 million per year.[144] A few months later Congress passed The 21st Century Cures Act ("Cures").[145] Cures directly appropriated $1 billion in funding for the first two years of opioid-related

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[138] R. Craig Lefebvre, *The Stigma Shadow Over the Opioid Crisis*, RTI (Jan. 17, 2019), https://www.rti.org/insights/stigma-shadow-over-opioid-crisis? [https://perma.cc/P4Q2-PU84].

[139] Rachel Roubein, *Trump Appoints Opioid Commission*, HILL (May 10, 2017), https://thehill.com/homenews/administration/332871-trump-appoints-opioid-commission [https://perma.cc/7BBL-E42G].

[140] Jeremy Diamond, *Top White House Official to Leave West Wing to Become Drug Czar*, CNN (Feb. 9, 2018), https://www.cnn.com/2018/02/09/politics/jim-carroll-white-house-national-drug-control-policy/index.html [https://perma.cc/E6PP-9K4V].

[141] Nicolas P. Terry, *Reports on the Opioid Crisis Are Full of Misidentified Problems and Poorly Calibrated Solutions*, BILL OF HEALTH (July 19, 2018), https://blogs.harvard.edu/billofhealth/2018/07/19/reports-on-the-opioid-crisis-are-full-of-misidentified-problems-and-poorly-calibrated-solutions/ [https://perma.cc/Z3NG-RWJ6].

[142] Comprehensive Addiction and Recovery Act, Pub. L. No. 114-198, 130 Stat. 695 (2016).

[143] *The Comprehensive Addiction and Recovery Act (CARA)*, CADCA, https://www.cadca.org/comprehensive-addiction-and-recovery-act-cara [https://perma.cc/RLD3-KMYE].

[144] Jessica Hulsey Nickel, *Statement on the President Signing CARA into Law*, ADDICTION POL'Y FORUM (July 25, 2016), https://www.addictionpolicy.org/blog/statement-on-the-president-signing-cara-into-law [https://perma.cc/4R26-RZY2].

[145] 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

programs.[146] Subsequent appropriations bills continued or increased funding for CARA and Cures treatment, prevention, and recovery programs to more than $3 billion for FY 2017 and $4.7 billion for FY 2018.[147] For example, in April 2018, HHS released $485 million to the states under SAMHSA Opioid State Targeted Response grants authorized by the Cures Act.[148] Most recently, the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 ("SUPPORT")[149] promised approximately $9.3 billion in opioid-related funds. However, most of those funds are re-authorizations of existing programs.[150] Notwithstanding, SUPPORT did authorize a new SAMHSA grant program for establishing or operating Comprehensive opioid recovery centers.[151]

The Trump Administration has heralded these large sums designed to combat the opioid crisis.[152] However, although large, they do not map satisfactorily to a national epidemic that has caused a trillion dollars of damage to the country. According to a 2018 McKinsey report, "the opioid crisis has received less funding and research attention than other pervasive problems in the US [such as Cancer or HIV/AIDS] have received."[153] For example, while SUPPORT added $2.1 billion to Medicaid funding, that sum represents just 0.04% of total Medicaid funding.[154] Indeed, legislation proposed by Senator Elizabeth Warren and Representative Elijah

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[146] *See, e.g.*, Rachel Roubein, *Budget Deal Includes $6 Billion to Fight Opioid Abuse*, HILL (Feb. 7, 2018, 1:40 PM), https://thehill.com/policy/healthcare/372759-budget-deal-includes-6-billion-to-fight-opioid-abuse [https://perma.cc/E4XQ-L3SP].

[147] *Funding Update: Senate Funding Levels for Fiscal Year 2019*, ADDICTION POL'Y FORUM (July 19, 2018), https://www.addictionpolicy.org/blog/funding-update-senate-funding-levels-for-fiscal-year-2019 [https://perma.cc/837D-WQEH].

[148] *HHS Provides States Second Installment of Grant Awards to Combat Opioid Crisis*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Apr. 18, 2018), https://www.hhs.gov/about/news/2018/04/18/hhs-provides-states-second-installment-grant-awards-combat-opioid-crisis.html [https://perma.cc/2UL7-C2EK].

[149] SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

[150] AIDS United, *Congress Quietly Makes Progress on Its Opioid Bill and FY19 Funding*, POZ (Sept. 28, 2018), https://www.poz.com/blog/congress-quietly-makes-progress-opioid-bill-fy19-funding [https://perma.cc/BHY7-QV8B].

[151] SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 7121, 132 Stat. 3894, 4043 (2018).

[152] President Trump "called the package the 'single largest bill to combat the drug crisis in the history of our country.'" Marianna Sotomayor, *Trump Signs Sweeping Opioid Bill with Vow to End 'Scourge' of Drug Addiction*, NBC NEWS (Oct. 24, 2018), https://www.nbcnews.com/politics/congress/trump-signs-sweeping-opioid-bill-vow-end-scourge-drug-addiction-n923976 [https://perma.cc/RR3A-E2BS].

[153] Charumilind et al., *supra* note 8.

[154] Cindy Mann & Jocelyn Guyer, *Medicaid Provisions in the SUPPORT Act: An Important Step Forward in the Opioid Epidemic, But the Road Ahead Is Long*, COMMONWEALTH FUND (Nov. 13, 2018), https://www.commonwealthfund.org/blog/2018/medicaid-provisions-support-act-important-step-forward-opioid-epidemic-road-ahead-long [https://perma.cc/Z894-2YX9].

Cummings suggested $100 billion in funding over 10 years.[155] The disconnect between the country's losses caused by the opioid epidemic and the funds made available by the federal government is perhaps one explanation why so many states and counties are pinning their hopes on litigation against opioid manufacturers and others in the distributions chain.[156] Other issues with the federal grant programs have surfaced. For example, the original two-year guarantee of funding in the Cures Act was viewed as one-time money, causing states to hesitate to develop and build programs that later would not be sustainable.[157]

In addition to funding state efforts to address the opioid epidemic, the CARA Cures and SUPPORT Acts all sought to address some of the structural impediments to prevention, treatment, and recovery. These positive steps include:

- Improvements in funding for Medicaid health homes that can coordinate care.[158]
- A requirement that state Medicaid programs cover all three types of FDA-approved MAT from 2020 to 2025.[159]
- Expanded Medicare use of telehealth treatment.[160]
- Increased screening for opioid use disorder and other substance use disorders among Medicare beneficiaries.[161]
- Expanded Medicare coverage of OTP care.[162]
- An increase in the number of patients (up to 275) to whom qualified physicians may prescribe MAT.[163]
- Made permanent the MAT prescribing authority for physician assistants and nurse practitioners.[164]
- Suspended the so-called IMD prohibition for 2019–2023, allowing states to use Medicaid reimbursement for certain inpatient treatment.[165]

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[155] Rachel Roubein, *Warren, Cummings Seek $100B to Fight Opioid Epidemic*, HILL (Apr. 18, 2018), https://thehill.com/business-a-lobbying/383787-warren-cummings-seek-100b-to-fight-opioid-epidemic [https://perma.cc/AD3T-BTHD].

[156] *See generally* Nicolas Terry, *The Opioid Litigation Unicorn*, S. CAROLINA L. REV. (forthcoming 2019) (analyzing the reasoning behind state, city, county, and tribal nations investigations and or litigations against individuals and companies involved in the opioid prescription drug supply chain).

[157] Rachana Pradhan & Brianna Ehley, *Hundreds of Millions in State Opioid Cash Left Unspent*, POLITICO (Mar. 19, 2018), https://www.politico.com/story/2018/03/19/opioid-crisis-funding-unspent-468658 [https://perma.cc/E447-2HAQ].

[158] SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 1006(a) (2018).

[159] *See id.* § 1006(b).

[160] *See id.* § 2001.

[161] *See id.* § 2002.

[162] *See id.* § 2005.

[163] *See id.* § 3201(a).

[164] *See id.* § 3201(b).

[165] *See id.* § 5052.

- Established a six-year loan repayment agreements with substance use disorder treatment professionals in high need areas.[166]
- Provided resources for hospitals to develop discharge protocols that provide naloxone and connection with peer-support specialists.[167]
- Authorized a pilot program to provide persons in recovery with stable, temporary housing.[168]

These reforms, if implemented in timely manner (and grant processes followed by state implementation will create a lag), will help. Notwithstanding, too many of the projects authorized by the SUPPORT Act eschew bold, direct, and timely intervention and, for example, convene expert groups, request studies, research, or reports.[169] Other provisions tend to favor demonstration programs or pilot programs rather than long-term strategies. And, little is done to address social determinants of health or stigma. Furthermore, critics argue that the legislation takes "a scattershot approach that nibbles at the issue around the margins — and misses problems that a more comprehensive strategy or package of bills could fully address."[170] Addressing the Medicaid provisions, Cindy Mann and Jocelyn Guyer perhaps captured the SUPPORT Act's overarching limitation, arguing that it is notable "for what it does *not* include, most prominently, a major, sustained infusion of new funding to expand community-based care for substance use disorders."[171]

VIII. CONCLUSION

Wendy Parmet, discussing the healthcare of another marginalized, stigmatized, vulnerable population, observed "non-citizen immigrants are the canaries in the health care coal mine . . . they are among the most vulnerable groups in the United States. Consequently, they are often the first to experience the gaps, inefficiencies, and conflicts in our health care system."[172] So it is with those suffering from OUD. Their chronic illnesses are not the product of moral defect, but the social determinants of health that in many of our states show few signs of being addressed. When those who suffer or their families seek help, they run into a healthcare system

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[166] *See id.* § 7071.

[167] *See id.* § 7081.

[168] *See id.* § 8071.

[169] MaryBeth Musumeci & Jennifer Tolbert, *Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act*, HENRY J. KAISER FAMILY FOUND. (Oct. 5, 2018), https://www.kff.org/medicaid/issue-brief/federal-legislation-to-address-the-opioid-crisis-medicaid-provisions-in-the-support-act/ [https://perma.cc/6XEH-2AZM].

[170] German Lopez, *Congress Is Hyping Up Its Opioid Bills. But There's Not Much to Hype*, VOX (Mar. 21, 2018), https://www.vox.com/policy-and-politics/2018/3/21/17144592/congress-opioid-epidemic-bills [https://perma.cc/6R6F-3SV5].

[171] Mann & Guyer, *supra* note 154 (emphasis added).

[172] Wendy E. Parmet, *Immigration and Health Care Under the Trump Administration*, HEALTH AFF.: BLOG (Jan. 18, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180105.259433/full/ [https://perma.cc/8789-2X9D].

that is not bolstered by any comprehensive plan to provide patients with access to care, is woefully underequipped to deal with system stressors such as epidemics, lacks required services, and, even if such services do exist, is unable to deliver them because of acute fragmentation. When reforms do occur, they tend to be exceptional rather than holistic changes consistent with parity principles. As long as those suffering from OUD remain marginalized and stigmatized, a feedback loop will reduce the likelihood of meaningful changes in federal or state policies. Similar to the undocumented, those suffering in the opioid epidemic provide us a window into our healthcare policies and systems, a window that does not reveal an attractive view.