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News for policy and program decision-makers

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In This Issue...

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Leveraging public attention into treatment dollars

Never in the past 30 years has the problem of addiction gotten so much attention, from the media and from politicians. The long-awaited transition from a "war on drugs" to having public-health solutions to what is after all a disease is taking place. But in the midst of overdoses (deaths at more than 100 a day) and rampant heroin addiction, funding has stayed stagnant or been cut.

The Substance Abuse Prevention and Treatment block grant has stayed level at $1.8 billion for years, the Substance Abuse and Mental Health Services Administration has not asked for additional treatment money, and states are cutting treatment funding as well. The focus has been on providing naloxone to first responders — often police departments — to reverse overdoses, and on prescription drug monitoring programs and reducing access to prescription opioids.

As summer wanes and we look ahead toward the budget process starting up when Congress returns next month, we asked top advocates in the field how the attention currently being paid to addiction via the opioid epidemic can be translated into increased funding for treatment,

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Bottom Line...
Despite headlines and speeches about the opioid epidemic, treatment funding has not increased and has been cut; advocates discuss the need to be vocal and to work with legislators and connect with patients on the message.

The Business of Treatment

Planners of October rally in D.C. seek to spur treatment demand

The concept is being likened to 1995's Million Man March for the black community and last year's People's Climate March for environmental activism. Organizers of the October 4 UNITE to Face Addiction rally in Washington, D.C., believe their effort to bring numerous constituencies together for what they call a breaking of the silence over the national health crisis of addiction will catalyze demand for treatment, and ultimately spur efforts to increase access to services.

Given that this is a first-of-its-kind weekend of addiction-related events in the nation's capital with both entertainment and advocacy components, there are certainly many unknowns about the ultimate

See **UNITE** page 5

Bottom Line...
Organizers of UNITE to Face Addiction see the potential strength of the October 4 event's impact in its broad-based coalition of supporting groups from the recovery, treatment and associated communities.

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which for many people who are on waiting lists or unable to afford the cost is an urgent health care need.

Build relationship with legislators

Simply calling your legislators — state and federal — is one thing treatment providers can do, but it's not nearly enough, said Sara Moscato Howe, chief executive officer of the Illinois Alcoholism and Drug Dependence Association (IADDA). "Building a relationship is much more important than just making the call," she told *ADAW* last week. Whether that legislator goes to the state house or to Washington, D.C., he or she needs to know what constituents want, she said.

In addition, the community needs to value treatment, and providers can help by reaching out to the community by developing relationships with local media. Educating the media is key, she said. Citing the recent study from Roosevelt University showing that Chicago is first in the country for overdoses and last for treatment funding, she noted that the governor just days later vetoed Medicaid funding for medication-assisted treatment (see story, page 5). "This is a microcosm in terms of the state, in terms of the country," she said. "If the public doesn't understand what that study means, it doesn't go anywhere."

Howe cites Treatment Alternatives for Safe Communities (TASC) as a model group in terms of advocacy. "They have done a great job both in the state and federally," she said. "They bring a good portion of their staff down to the state capitol to check in with legislators."

'Consistent noise'

"I wish there were a neat equation that lends itself to increased dollars," said Robert Morrison, executive director of the National Association of State Alcohol and Drug Programs (NASADAD). "But it's tough. In the end, consistent noise is what's going to make the difference."

Morrison cited the events leading up to the October 4 rally (see bottom lead) will help. "The rally will be on the mall where folks are coming to D.C. to scream out the importance of prevention, treatment and recovery, not to mention saving people's lives," he said.

Contacting legislators and articulating the intensity of the need for services is essential, said Morrison. "You can't be deterred by a budgetary process that seems arcane and less anchored in the reality of what's happening on the ground, because that's still the reality of how things get done here in Washington," he said.

The bottom line, said Morrison, is to "have people look out for their interests in a way that is true to what they do, and to speak so that people who don't have a voice or are struggling to find it can be heard."

He noted that Michael Botticelli, director of the Office of National Drug Control Policy, talks about the changing nature of the HIV/AIDS issue decades ago, and how things didn't improve "until people got really vocal."

There have been some gains, said Morrison, noting the recent $100 million for opioid treatment for federally qualified health centers (see *ADAW*, August 3) and provisions in the Affordable Care Act. But the discretionary addiction money, which is what this article is about, is not increasing and is even being cut.

The right message

It may be more popular to talk about the addiction issue than to spend money on it — especially if the public doesn't want to be "soft on crime," something that veteran federal staffers are well aware of. "The question of where is the money for treatment reminds me of then-drug czar Gen. Barry McCaffrey go-

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ing on 'This Week' in the late 90s versus Sen. Orrin Hatch," who was the lead Republican on the judiciary committee, said Bob Weiner, a public policy expert who still works for McCaffrey and was at the time spokesman for the Office of National Drug Control Policy. In the green room, Senator Hatch said he was concerned about the McCaffrey strategy of adding an extra billion dollars for treatment, recalled Weiner, who responded, "Treatment isn't being soft on crime; it's being hard on crime because it stops the number of criminals." Hatch, who did not want to be accused of being a liberal big spender, said, "I can go with that," recalled Weiner. "Often the argument is just that simple."

Likewise, Rep. Steny Hoyer (D-Maryland), a centrist then as now, told Weiner: "Don't only call it a program to do good; point out it is a crime stopper. That's how it can win and appeal to everyone."

Finally, Weiner said Rahm Emanuel, then the president's crime advisor at the White House, "did his famous stand-on-his-desk in reaction to my telling him McCaffrey wanted to increase treatment money by half and exclaimed in support, 'Treatment keeps the slime off the street!'" Weiner asked if "slime" could be changed to "crime," and Emanuel said "OK."

In fact, advocates for years have couched addiction treatment as a cost-saver and a crime-reduction tool. It hasn't been working. And in addition, times have changed: the possible money is much less, and the budget process is now encumbered with caps (sequestration).

The caps

Andrew Kessler, principal of Slingshot Solutions, lives and breathes advocacy on Capitol Hill, focusing on addiction. "Every advocate is hitting a brick wall," he said. "I can only speak for substance abuse, and it's worse for us, but the budget caps are not aligned for any health needs."

Many members of Congress do want to increase funding for treatment but their hands are tied by the budget caps, he told *ADAW*. "I don't think we're going to get anywhere until we address that issue," Kessler said.

Kessler would like to see more attention paid to working with advocates across the entire health care spectrum to eliminate the caps.

> **'Every advocate is hitting a brick wall.'**
>
> Andrew Kessler

"We need to make lawmakers realize that caps hurt people in their districts — you can't find a district that isn't going to be hurt by the caps," he said.

As for the Obama administration's vision that private insurance or Medicaid will cover everyone's treatment needs — that hasn't come to fruition. Private insurance still limits access to treatment, and in many states Medicaid has not been expanded so public funding must be used for treatment. "I think we would like to see private insurance involved in substance use disorder care, especially in the age of parity," said Kessler. "But the reality is we still have to rely on public dollars."

And SAMHSA's block grant funding has "not kept up with the expanded need for treatment," said Kessler. "The block grant has been flat for years, and when you consider inflation, it's actually lose something close to $400 million. And all the while, overdose deaths go through the roof."

The budget process has become, in recent years due to gridlock, completely unpredictable, agreed NASADAD's Morrison. "Now we're seeing a 365-day budget process," he said. "For states, how do they plan when they're not sure what they're going to get each year? That's frustrating."

Morrison acknowledged that addiction is in a spotlight, but "it's on us to explain" the need for treatment. "It's complex; it's unique to each state, each county," he said. "The resource issue is not one that we have licked. That's why, now more than ever, the relationship between providers and people receiving services, and the groups that work in D.C., is vital."

But advocates can't just march into Congress and ask for more money for the block grant, he said. They have to seize the moment. "We know that winds shift," said Kessler. "We need to be aware that in this landscape, which is dominated by the sequester, dominated by the adversarial relationship between Congress and the White House, any window that opens will close pretty quickly." •

Teens with SUDs hypersensitive to aversive stimuli

Researchers have found that when adolescents with substance use disorders (SUDs) have a negative visceral sensation — in this case, a limited ability to draw a deep breath — their brain response is more exaggerated than in healthy teens, who are better able to prepare for the negative sensation. This means that SUDs could make teens hypersensitive to aversive stimuli, or that this hypersensitivity is innate and they are trying to medicate it with substances, or both.

Study details

The cross-sectional study, published in the August issue of *Addiction*, was done with 18 adolescents ages 15–17 with an alcohol or marijuana SUD, and 15 healthy controls.

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Subjects were recruited by flier from local high schools.

Subjects had never had a psychiatric disorder independent of SUD, were not currently using psychoactive medications, had no history of major medical disorder or head trauma, were right-handed, and had not been exposed to prenatal alcohol or drugs. For the SUD subjects, 27 percent had a current primary alcohol use disorder, and 73 percent a current primary marijuana use disorder. Controls had limited lifetime alcohol or marijuana use and no other subject use. Each subject was paid $180 for participation.

The study required anticipation of, via a signal, and experience of an aversive interoceptive stimulus, which in this case was the breathing load stimulus. Subjects wore a nose clip and breathed through a mouthpiece that had a valve that prevented breathing. The mouthpiece was connected to an inspiratory resistance load, which could limit the airflow through the breathing tube attached to the mouthpiece. When it's difficult to breathe in, the subject experiences discomfort. The breathing valve was closed after a signal was given that this would happen.

The subjects' fMRI was recording during the breathing load cue and the breathing load itself. There were three conditions: baseline, in which the task was performed with a blue indicator, meaning there would be no breathing load; anticipation, in which the task was performed with a yellow indicator, meaning there was a 25 percent chance of a breathing load; and breathing load, in which the subject experienced 40 seconds of loaded breathing. Response accuracy in the task was measured, along with reaction time.

Results

All subjects had greater activation in the bilateral anterior and posterior insula, the part of the brain that connects the mind and body, during activation than anticipation. However, subjects with SUDs had far greater activation during breathing load than during anticipation, compared with controls, who had greater activation during anticipation than breathing load in the left posterior insula.

The researchers had expected that teens with SUDs would have greater breathing-load activation than controls in the left middle frontal gyrus and the right inferior frontal gyrus. Teens with SUDs also had consistent modulation in these areas. And finally, the teens with SUDs rated the breathing load as more unpleasant than the controls rated it.

'I want them to be able to state out loud, "I am feeling nervous, I'm not feeling well right now," and to think of some other ways to feel better without using substances.'

Susan F. Tapert, Ph.D.

The gyri are part of the insula.

The results are consistent with other research showing that adolescents with SUDs also have heightened sensitivity to pleasant stimuli — in this case, a light stroke on the arm. In this research, published previously by the same group, there was increased striatal processing.

Teens with SUDs may not be able to predict physiological bodily changes, the researchers said. "Addiction may present a chronic imbalance of a homeostatic condition of the body, leading to maladaptive regulation of the internal state through substances," they wrote. In addition, they note that drug-seeking in people with addiction is also caused by the negative bodily experience of withdrawal, which reinforces drug-seeking in a constant vicious cycle.

Preventing relapse

Corresponding author Susan F. Tapert, Ph.D., professor of psychiatry at the University of California, San Diego, explained that the aversive stimulus is not the same as stress. "Interoceptive functioning involves our visceral reactions to things, like a gut feeling," she told *ADAW*. "We don't want to measure the pain response system or the stress response system, but something that is a little bit more subtle," she said. "The idea is to map onto different situations that can escalate someone's substance use, or, in someone in recovery, precipitate a relapse."

The healthy teens in the study seemed to be more in touch with their physical responses, she said. "The healthy teens knew what was coming and prepared for it," she said. For the teens with SUDs, "there was a little bit of 'Oh no, that thing is coming again'" seen on the fMRI, but it was "modest," she said. "There was much more activation during the unpleasant time than during anticipation" in teens with SUDs, she said. "But healthy teenagers brace for this unpleasant thing, and then there's not as much activation when it's actually happening."

The insula acts to connect the brain and body, said Tapert. "If you think of the system as homeostatic, it could be that some teens are more inclined to use alcohol and other drugs to balance it out," she said. "We don't know yet whether the hypersensitivity is in kids who had a characteristic that predated SUDs, or whether it's due to the drug effects."

"This study and our other studies suggest that substance-using youth may be more reactive," said Tapert. "Their brains are set up to be more reactive to both pleasant and unpleasant situations, including

bodily states, feeling under the weather or feeling excited about something." This hypersensitivity itself may make them inclined to use substances to "even out and regulate their state of mind," she said.

As a clinician, Tapert wants to help adolescents be able to understand how they're feeling, she said, noting that this can ward off using substances for regulating emotions. "I want them to be able to state out loud, 'I am feeling nervous, I'm not feeling well right now,' and to think of some other ways to feel better without using substances," she said.

Limitations

The study was limited by the small sample size, and by the lack of other kinds of substances in addition to alcohol and marijuana. Still, the study did suggest that adolescents with SUDs are hypersensitive to aversive stimuli, which may lead them to seek drugs.

"Under Pressure: Adolescent Substance Users Show Exaggerated Neural Processing of Aversive Interoceptive Stimuli" was supported by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. •

Report: Illinois almost last in the nation in treatment capacity

A new study by researchers at Chicago-based Roosevelt University finds that treatment capacity in Illinois fell from 28th in the nation five years ago to the third worst in the nation, behind only Tennessee and Texas. The drop in capacity comes at a time when the state is facing a heroin crisis, with 25 percent of state-funded admissions for heroin, compared to 16 percent nationally. "We can't cut treatment and expect the heroin problem to magically get better," said Kathleen Kane-Willis, director of Roosevelt's Illinois Consortium on Drug Policy and lead author of the report, "Diminishing Capacity: The Heroin Crisis and Illinois Treatment in a National Perspective." The report was funded by the Drug Policy Alliance.

The study, released August 11, found that heroin use is a problem not only in Chicago, which is ranked first in the United States for heroin-related emergency room visits, but also in the state's rural areas.

With her colleagues, Kane-Willis examined public treatment data, emergency room statistics and arrest data. They found that more young people and women in the state are using heroin.

More money now

"If we want to make the heroin problem worse, we're headed in the right direction. If we want to save money and lives, we need evidence-based policies enacted immediately," said Kane-Willis. "Illinois needs to provide more — not less — treatment, especially medication-assisted treatment. We also need to scale up naloxone access so that fewer people die, and expand syringe programs to prevent the spread of HIV and hepatitis C."

Illinois ranked first in the country for its decline in treatment capacity, which was 52 percent, according to the report. From 2007 to 2012, state general revenue funding dropped by nearly 30 percent, and Medicaid funding dropped by 4 percent, leaving state-funded addiction treatment in jeopardy, according to the study. The state's proposed FY 2016 budget includes a 61-percent cut to state-funded addiction treatment.

Kane-Willis argues that expanding treatment funding, especially medication-assisted treatment like methadone and buprenorphine would lower crime and save money. "The benefits of providing methadone for just 2,500 people could save the state up to $100 million in reduced crime and health care consequences," she said.

Governor's veto

Medicaid in Illinois does not cover methadone, and only covers buprenorphine in limited situations. "We need to change this immediately so that these drugs are more readily available," said Kane-Willis.

However, on August 24, Gov. Bruce Rauner issued a mandatory veto of a provision of a heroin bill that would have required the state's Medicaid program to pay for medication-assisted treatment for opioid dependence, saying it was too expensive. Coming on the heels of the Roosevelt report, the veto was an especially stunning blow to public health advocates. Critics of his move said it would be more costly in the long run, with people on Medicaid going to hospitals and the criminal justice system with end-stage disease. •

For the study, go to www.roosevelt.edu/CAS/CentersAndInstitutes/IMA/ICDP#publications and click on the "Diminishing Capacity" report.

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impact of the event (organizers have set an attendance goal of 50,000 to 65,000 for the Sunday rally and concert on the National Mall). Some treatment providers have signed on by spreading the word to their alumni networks and in some cases sponsoring transportation to the rally, although the treatment community's presence appears secondary to constituencies such as recovery community organizations and national advocacy groups among the nearly 550 supporting organizations that had formally joined in as of midweek last week.

Greg Williams, the campaign director for Facing Addiction, Inc., the nonprofit formed to serve as the umbrella organization for organizing UNITE to Face Addiction, said the

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event is not focused on treatment or recovery per se.

Williams, creator of the film "The Anonymous People," told *ADAW*, "We all play a role, as we seek a comprehensive public health approach across all areas."

Williams added, "I believe treatment demand will increase dramatically on October 5 and beyond with activities like this. In turn, the overt and public demand increase will in time create the political and social will to create the [treatment] supply-side increases desperately needed."

Event's origins

Planning for the event commenced in December 2013 with the formation of an advisory group. Williams says momentum for the effort started around discussions he was having as "The Anonymous People" was being shown across the country and local individuals in recovery were looking for a broader forum for delivering their message.

"I was talking to people who were telling their recovery story in the community, or were starting a recovery community center, and that just wasn't big enough for them," Williams said.

Pat Taylor, the former executive director of Faces & Voices of Recovery who is coordinating outreach efforts for the UNITE event, told *ADAW* that from her earliest days at Faces & Voices, colleagues were telling her that the field needed its own version of the Million Man March (that event attracted an official crowd estimate of 400,000 in Washington two decades ago, while the People's Climate March attracted more than 300,000 participants to New York City last fall). By enlisting outreach experts with experience mobilizing constituencies such as labor, the faith community and various demographic groups, Facing Addiction is working to bring together a diversity of constituencies that no existing organization in the field with a narrower agenda could have mobilized, Taylor and Williams say.

"This is not about building a new structure," Williams said. "It's a tent."

Part of that is being made possible, he said, because the various participating groups are coalescing around broad issues for which consensus is readily achievable, such as stigma reduction and a public health approach to the crisis (while avoiding stances on what he calls "inside baseball" issues that often serve to divide).

Williams would not give an exact figure for the event's budget but said it is in the multimillions. He said that more than $1 million has been raised in individual donations. Key developments have also included receipt of a $250,000 grant from the Hilton Foundation and commitments to participate from entertainers such as The Eagles' guitarist Joe Walsh and Aerosmith frontman Steven Tyler, which in turn have attracted other scheduled artists (performers are volunteering their participation on Oct. 4). No government money is being used for the event, Williams said.

Activities will actually be carried out over a three-day stretch, with an October 3 comedy benefit at the Warner Theatre, the October 4 rally on the Mall from 4 to 8 p.m. and a Monday advocacy event on Capitol Hill that is being coordinated by field lobbyist Carol McDaid and that coincides with the National Council for Behavioral Health's own Hill Day activities. The Sunday rally is this year's hub event for Recovery Month, purposely scheduled for October so as not to conflict with local events scheduled for dates in September.

"Some participants in the Sunday rally will also engage in advocacy efforts when they go home," Taylor said. "The relationships that will be forged as a result of the rally will carry on in the communities."

It is not yet known whether UNITE to Face Addiction will turn out to be a one-time event or an annual rally. Williams said conducting this event on the Mall carries important symbolic value, but he indicated that if there are similar activities in future years they may be held elsewhere.

Williams envisions this year's event as fueling demand culturally for help-seeking, with effects both on people in need of treatment and society at large. He refers to a statement from William Moyers that is now being used in the campaign's trailer: "Public perception drives public policy, and if we want to change public policy we have to change public perception."

Treatment centers' role

The Hazelden Betty Ford Foundation plans to have a significant presence at the UNITE rally, including an address to the crowd by Moyers as well as a pep rally before the main event. "On the one hand, the UNITE to Face Addiction event shows that decades of advocacy down in the trenches from coast to coast have finally paid off for all of us who know the power of standing up and speaking out," Nick Motu, vice president of Hazelden Betty Ford's Institute for Recovery Advocacy, told *ADAW*. "At the same time, the rally also is a launching point for advocacy on a bigger, even more collaborative scale."

Taylor said addiction treatment facilities are supporting the event by reaching out to staff and alumni to encourage their attendance and/or by sponsoring transportation to Washington to allow these individuals and members of their local communities to attend. "This is creating a bridge between the facility and the community," she said. "That's a real change."

She sees several forces that have led organizers to come together now around this rally, including the emergence of new local advocates in recent years, the urgency of the opioid addiction and overdose crises, and a growing network of constituencies with newfound influence in the community, from drug courts to recovery residences. •

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Physicians could treat 300 to 500 bupe patients 'very easily'

The debate about lifting the patient cap — 30 or 100, depending on training — for buprenorphine is entering its second official year, with one side questioning whether physicians would be able to treat a large volume of patients and the other arguing that once patients are stable, treatment is not time-consuming. In last week's issue, Mark Parrino, president of the American Association for the Treatment of Opioid Dependence, the trade association representing opioid treatment programs, pointed out that the guidelines for the use of medication-assisted treatment call for the use of best practices (see *ADAW*, Aug. 24). "If you're treating 300 to 500 patients, how do you do this?" he asked.

"Very easily," Stuart Gitlow, M.D., immediate past president of the American Society of Addiction Medicine (ASAM), wrote us. The letter from Gitlow continues below.

"Parrino, who is not a physician, may not realize that a typical outpatient physician can easily handle this volume of patients, and indeed, many more. Let's look at a less stigmatized situation first: a patient presents for first-time treatment for major depression. Symptoms are significant and the patient is functionally impaired. The intake takes some time and a combination of psychotherapy and pharmacotherapy is initiated. The patient is seen frequently at first, with significant time taken at each visit. As time passes, the patient typically improves. Psychotherapy is discontinued when the patient reaches maximum improvement from that modality. Eventually, as the patient becomes symptom-free, the patient is seen annually for renewal of medication. A typical psychiatrist in long-term private practice has quite literally hundreds of such patients.

"The outpatient addiction model is quite similar. So in my practice, after nearly ten years of prescribing buprenorphine, I have roughly 90 patients who I've been seeing for an average of seven years. They are largely symptom-free, functional in all respects, attending twelve-step meetings, demonstrating negative urine drug test results, and no longer in need of any intensive care. I see many of them every 3 to 4 months to renew their medication, just as I do my patients with well-treated schizophrenia, bipolar disorder or anxiety disorder. My total number of patients in my outpatient practice is just under 1000, and since I've been in practice for 22 years, the vast majority of these patients are stable and symptom-free. The bulk of my time, however, is spent with the minority: the patients more recently admitted into the practice.

"So when Parrino asks how could one treat 300 to 500 patients, the answer is: very easily. In fact, the number could be significantly higher. Could I, a single private practice physician, handle 300 to 500 NEW patients all at once? Of course not. There aren't the hours in the day to do that. But that's not the question. The question is whether a typical practice could accommodate greater than 100 patients taking buprenorphine. We could indeed, so long as we follow a typical course of a private practice, where new patients are gradually added as existing patients require diminishing amounts of treatment intensity. The concept of a limit is foolish; we don't have a limit with schizophrenia, a disease that arguably requires even more complexity of services over a more extended time period than addiction. Why would we possibly have a limit with addictive disease treatment?"

Legislation has been proposed that would lift or eliminate the cap. SAMHSA has not indicated which way it will go but has provided information to Sylvia Burwell, secretary of the Department of Health and Human Services, on the issue. Stay tuned. •

Florida drug-test labs sue Cigna for $10 million plus legal fees

On August 17, two drug-testing laboratories in Florida sued Cigna for $10 million plus attorney's fees and costs, charging that the Connecticut-based insurance company unlawfully withheld payment for out-of-network drug tests. The labs, BioHealth Medical Laboratory Inc. and PB Laboratories, do not have contracts with Cigna. The complaint was filed in the United States District Court for the Southern District of Florida.

"Prior to providing these services, the Laboratories confirmed with Cigna that the services were covered benefits under the applicable insurance policies," the complaint states. The labs performed the tests and submitted the claims, but Cigna has refused to pay or delayed the payment, the complaint states. So far, Cigna has failed to pay more than $10 million in claims, according to the complaint, "using false pretenses and vague excuses as a basis for denial."

The laboratories have applied to become in-network providers to Cigna, but these applications were not approved, according to the complaint.

Last month, Cigna sued Sky Labs in Florida for fraud, citing just such out-of-network claims, in which patients are not billed for deductibles or copays in "fee forgiveness" arrangements that leave the insurance company on the hook (see *ADAW*, July 27).

Lawyers comment

We asked two lawyers not connected to the case, but both very fa-

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miliar with drug testing and addiction treatment in the state, and both based in treatment-saturated Delray Beach, to comment.

When a physician requests that a lab perform a test, the lab does it, said Jeff Cohen. "Labs are supposed to be very customer-friendly and not make the life of the ordering doctor difficult," he told *ADAW*. "They get the form, do the work and report in an accurate and timely way. They never ever see a patient — they just see the form and the sample."

Labs are almost always out of network, said Cohen. Either the payer won't let them in or they pay rates that are too low to cover the cost of services.

Cohen charged that Cigna has positioned that there is a "grand conspiracy to steal from insurance companies." Cigna's theory is that if the lab doesn't collect a copay or a deductible, but rather forgives those debts, then the payer has no obligation to pay any part of the claim.

Cohen faults insurance companies for having no clear policies on toxicology services that it will cover, and on the lack of reasonable in-network contracts.

The solution to the urine-testing issue is to establish a nationally recognized standard related to toxicology screenings, said lawyer Jeffrey Lynne. While drug testing is "an important part of treatment for substance use disorder, it has been grossly overused," he said. Still, he also blames insurance companies for their focus on "keeping insurance premiums and not paying benefits." He noted that many insurance companies still fail to recognize the intent of the Mental Health Parity and Addiction Equity Act of 2008, "which was to put an end to the inequities in health care between medical and behavioral services."

What's important now is to have a "national dialogue over funding and supporting empirical scientific research into eliminating addiction as a disease," he said. "Instead, we allow treatment providers and insurance companies to spend our premiums in court to fight over profit."

Finally, Lynne pointed out that many other providers also take advantage of out-of-network benefits, billing at exorbitant rates. "I think that society is quick to judge urine testing, but turn a blind eye when it comes to the overwhelming fraud which occurs within medical health care," he said. •

Coming up…

The **Cape Cod Symposium on Addictive Disorders** will be held **September 10–13** in **Hyannis, Massachusetts**. Go to **www.ccsad.com** for more information.

NAADAC, the Association for Addiction Professionals will hold its 2015 annual conference and Hill Day **October 9–13** in **Washington, D.C.** For more information, go to **www.naadac.org/annualconference**.

The **International Nurses Society on Addictions** will hold its annual educational conference **October 21–24** in **Charlotte, North Carolina**. For more information, go to **www.intnsa.org/conference**.

The **Addiction Executives Industry Summit** will be held **January 31–February 3, 2016,** in **Naples, Florida**. Go to **www.axissummit.com** for more information.

Correction

In last week's story on opioid treatment programs (see *ADAW*, August 24), we incorrectly cited the source guidelines on medication assisted treatment. The guidelines will be coming from the American Society of Addiction Medicine, not the Substance Abuse and Mental Health Services Administration. We regret the error.

For ASAM's guidelines, which were released in June (see *ADAW*, June 15), go to www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf.

In case you haven't heard…

What are marijuana taxes used for in Colorado? First, to support the regulatory framework involved in the legal marijuana industry. Next comes education. And last comes prevention and treatment. After one-and-a-half years of sales, the state has collected more than $117 million in excise taxes, the Huffington Post reported August 26, citing data from the Colorado Department of Revenue. "Our philosophy has been that marijuana pays its own way," J. Skyler McKinley, deputy director of Colorado Gov. John Hickenlooper's (D) Office of Marijuana Coordination, told the Huffington Post. "Every dime we bring in from legalization is dedicated to the cost of legalization. That's regulatory framework first, then public education campaigns about safe and responsible use and then prevention and treatment programs." The revenue is first put into the government to support its own regulatory apparatus — including state employees like McKinley — then some to education, and at the bottom comes prevention and treatment.