AMERICAN UNIVERSITY | WASHINGTON COLLEGE OF LAW

HEALTH LAW & POLICY BRIEF

VOLUME 16 • ISSUE 2 • SPRING 2022

ARTICLES

AMERICAN UNIVERSITY WASHINGTON COLLEGE OF LAW

Acknowledgements:
We would like to thank our advisor, Lewis Grossman, for his support. We are also grateful to the American University Washington College of Law for providing a legal education that empowers us to champion what matters.

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2021 – 2022

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LETTER FROM THE EDITORS

Dear Reader:

On behalf of the Editorial Board and Staff, we proudly present Volume 16, Issue 2 of the *Health Law & Policy Brief.* Since its formation in 2007, the Brief has published articles on an array of topics in health law, food and drug law, and emerging health technologies. In this issue, our authors discuss facets of substance use, treatment, and regulation in the United States. Volume 16.2 features three articles: one examining the regulation of direct-to-consumer shipping of alcohol products, one studying health care fraud in the drug and alcohol treatment industry, and one analyzing medicinal marijuana use and employment rights.

Our first article, by Dr. Elyse R. Grossman, details the United States' historical relationship with alcohol and how it intertwines with the current legal landscape of alcohol regulations and, in particular, direct-to-consumer alcohol shipping regulations. Dr. Grossman concludes with new suggestions for states and public health and policy professionals on how to fortify and protect existing and new alcohol-related laws. Our second article, by Rachel A. Rein, examines the high rates of health care fraud in the recovery industry, provisions and financing of health care in the recovery industry, and the harmful impact of this fraud on patients. Ms. Rein recommends a cooperative strategy of developing legislative, regulatory, and enforcement tools to limit fraud and ensure necessary patient protections. Our final article, by Sarah Spardy, highlights the current federal and state regulations controlling medicinal marijuana use as it pertains to employment rights in the United States. Ms. Spardy lays out methods for providing adequate employment rights to individuals whose medicinal marijuana use allows them to cope with their medical conditions in same way federally legal medications do.

We would like to thank the authors for their insight, creativity, and cooperation in producing these pieces. We would also like to thank the *Health Law & Policy Brief's* article editors and staff members who worked so diligently on this issue.

To all our readers, we hope you enjoy this issue, that the never-ending complexities of this area of law inspire your own scholarship, and that you continue to anticipate and scrutinize the inevitable challenges that our healthcare system continues to withstand.

Sincerely,

Katherine Freitas
Editor-in-Chief

Allison Bock
Executive Editor

* * *

THE CHANGING LEGAL LANDSCAPE OF DIRECT-TO-CONSUMER SHIPPING OF ALCOHOL PRODUCTS: WHAT DOES THE FUTURE HOLD FOR PUBLIC HEALTH?

*Dr. Elyse R. Grossman**

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** Elyse R. Grossman, JD, PhD, conducts research focusing on laws related to alcohol and drugs – especially those that target prevention and youth. Dr. Grossman has a JD from the University of Maryland Francis King Carey School of Law, and a PhD in Public Policy from the University of Maryland, Baltimore County.*

INTRODUCTION

Excessive alcohol consumption is the fourth-leading preventable cause of death in the United States.[1] Alcohol use, in general, is associated with motor vehicle crashes,[2] sexual assault and other violent crimes,[3] and much more. Underage drinking – which is one type of excessive alcohol consumption – is also associated with altered brain development,[4] risky sexual activity,[5] and development of alcohol problems when older.[6] The research clearly shows a relationship between the amount of alcohol available and accessible and the harms experienced.[7] And yet, the issue of how to regulate alcohol is one that the U.S. has been struggling with for over two centuries.

As one would expect, alcohol consumption, alcohol-related harms, and the enactment of alcohol-related laws are intrinsically related. A high rate of alcohol consumption leads to increased alcohol-related harms.[8] This, in turn, often leads to the enactment of more alcohol-related laws to try to address and reduce these harms. Although not all laws are successful, from a public health perspective, alcohol regulation is both beneficial and desirable, as it protects both youth and adults.[9] Unfortunately, the alcohol industry has challenged many of these laws,[10]

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[1] Mandy Stahre et al., *Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Lost in the United States,* 11 PREVENTING CHRONIC DISEASE (2014).
[2] World Health Organization, GLOBAL STATUS REPORT ON ROAD SAFETY 2015 30 (2015).
[3] Aleksandra J. Snowden, *Violence: The Role of Neighborhood Characteristics, Alcohol Outlets, and Other Micro-Places,* 82 SOC. SCI. RSCH. 181, 183 (2019); Traci L. Toomey et al., *The association between density of alcohol establishments and violent crime within urban neighborhoods,* 36 ALCOHOLISM: CLINICAL & EXPERIMENTAL RSCH. 1468, 1470 (2012).
[4] *See, e.g.,* Marisa M. Silveri, *Adolescent brain development and underage drinking in the United States: Identifying risks of alcohol use in college populations*, 20 HARV. REV. PSYCHIATRY 189; Briana Lees et al., *Effect of Alcohol Use on the Adolescent Brain and Behavior,* 192 PHARMACOLOGY BIOCHEMISTRY & BEHAV. (2020).
[5] *See, e.g.,* Phyllis L. Ellickson, *Ten-Year Prospective Study of Public Health Problems Associated with Early Drinking*, 111 PEDIATRICS 949 (2003); Ann Stueve & Lydia N. O'Donnell, *Early Alcohol Initiation and Subsequent Sexual and Alcohol Risk Behaviors Among Urban Youths,* 95 AM. J. PUB. HEALTH 887, 887 (2005).
[6] Will Maimaris & Jim McCambridge, *Age of First Drinking and Adult Alcohol Problems: Systematic Review of Prospective Cohort Studies*, 68 J. EPIDEMIOLOGICAL CMTY. HEALTH 268, 268 (2014).
[7] Paul J. Gruenewald, *Regulating Availability: How Access to Alcohol Affects Drinking and Problems in Youth and Adults,* 34 ALCOHOL RSCH. & HEALTH 248, 248 (2011).
[8] *Id.* at 252.
[9] Kelli A. Komro & Traci L. Toomey, *Strategies to Prevent Underage Drinking,* 26 ALCOHOL RSCH. & HEALTH 5, 5 (2002).
[10] *See, e.g.*, *Bacchus Imports, Ltd. v. Dias*, 468 U.S. 263 (1984); 44 *Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996); *Sarasota Wine Market v. Schmitt*, 987 F.3d 1171 (8th Cir. 2021).

and the courts have decided their constitutionality, with what often appears to be little to no regard for the impact that these laws—and alcohol itself—have on public health.

The main legal argument that the courts have debated stems from the 21st Amendment.[11] Ratified in 1933 by the States, the 21st Amendment both ended Prohibition and granted the states the primary power over alcohol within their own borders.[12] States used the power of the 21st Amendment to license, tax, and regulate both alcohol products and those involved in the creation and sale of alcohol.[13] This included the adoption of a three-tier system for alcohol distribution, in which alcohol manufacturers sell products to wholesalers, who in turn provide these products to retailers for consumers to purchase. In addition to providing public health benefits by limiting the distribution of inexpensive and readily available alcohol, the three-tier system also provides regulatory benefits, economic benefits, and commercial benefits, described in more detail below.[14]

In recent years, the three-tier system has come under attack. Given the known harms of making alcohol more accessible to both adults and to youth,[15] it is alarming that the alcohol industry and some consumers have begun to advocate for states to broaden the ability of breweries, wineries, and distilleries to ship alcohol directly to consumers' homes.[16] Research shows that direct-to-consumer (DTC) shipping practices often result in increased underage alcohol consumption and, in turn, increased alcohol-related harms.[17] For example, young people may attempt to purchase alcohol through direct sales (e.g., online or over the phone) instead of face-to-face sales at retail outlets because they perceive that detection of their underage status is less likely. Studies have validated this concern, finding that Internet alcohol vendors use weak, if any, age verification, thereby allowing minors to successfully purchase alcohol online.[18]

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[11] U.S. CONST. amend. XXI.
[12] *Id.*
[13] *See e.g., State Bd. of Equalization of Cal. v. Young's Market Co.*, 299 U.S. 59 (1936).
[14] *See* discussion *infra* Part I.
[15] Gruenewald, *supra* note 7, at 248.
[16] *See, e.g., Mike* Pomranz, *Why Do So Few Breweries Ship Their Beer Directly to Customers?,* FOOD & WINE (Mar. 12, 2021), https://www.foodandwine.com/news/beer-direct-customer-shipping-state-laws-why-not; Brief Amicus Curiae of Wine Institute at 1, Granholm v. Heald, 540 U.S. 460 (2005) (No. 03-1116).
[17] Substance Abuse & Mental Health Services Admin., *State Performance & Best Practices for the Prevention and Reduction of Underage Drinking 2020* 1, 87-89 (2021).
[18] Rebecca S. Williams & Kurt M. Ribisl, *Internet Alcohol Sales to Minors,* 166 ARCHIVES PEDIATRICS & ADOLESCENT MED. 808, 811 (2012).

Although laws placing restrictions on DTC shipping have not yet been reviewed by the Supreme Court,[19] other recent alcohol-related Supreme Court decisions have created concern among the public health and legal communities that these laws may also be overturned on constitutional grounds. These Supreme Court decisions have already negatively impacted public health by weakening the 21st Amendment[20] and the legal infrastructure put in place post-Prohibition; how these court cases will impact DTC shipping laws—and public health in the future—is still uncertain. Before one can address how states may begin preparing to face this uncertainty, it is important to understand the United States' history with alcohol, why it is problematic, and how it intertwines with the current legal landscape related to alcohol regulation.

The reader might note that the laws and much of the case law discussed in this article were enacted or decided prior to March 2020. The authors would be remiss if they did not recognize that the COVID-19 pandemic has had and will continue to have an impact on alcohol consumption and alcohol-related behaviors and laws. Preliminary research studies have shown that alcohol consumption,[21] binge drinking,[22] and some alcohol-related harms[23] have increased during the COVID-19 pandemic. Additionally, some states have either temporarily or permanently relaxed alcohol-related restrictions, thereby allowing on-premises establishments (e.g., restaurants and bars) to deliver alcohol to consumers' homes.[24] However, given the current uncertainties about the future as it relates to COVID-19, the author chose to focus this paper on the issue of DTC shipping practices as it existed pre-pandemic, with questions and suggestions for future discussion included in the Conclusion section.

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[19] Some may argue that *Granholm v. Heald* was a case that centered on direct-to-consumer (DTC) shipping. However, as discussed in a later section, although *Granholm* involved alcohol producers, the issue in that case was whether the state could regulate out-of-state producers differently than in-state producers, not whether a state could regulate DTC shipping at all.

[20] Elyse Grossman & James F. Mosher, *Public Health, State Alcohol Pricing Policies, and the Dismantling of the 21st Amendment: A Legal Analysis,* 15 MICH. STATE UNIV. J. MED. & L. 177 (2011).

[21] *See, e.g.,* Elyse R. Grossman et al., *Alcohol Consumption During the COVID-19 Pandemic: A Cross-Sectional Survey of U.S. Adults,* 17 INT. J. ENVIRON. RES. PUB. HEALTH (2020).

[22] *See, e.g., Carolina* Barbosa et al., *Alcohol Consumption in Response to the COVID-19 Pandemic in the United States,* 15 J. ADDICT MED. 341, 342 (2021).

[23] *See, e.g.,* Michael S. Pollard et al., *Changes in Adults Alcohol Use and Consequences During the COVID-19 Pandemic in the U.S.* 3 JAMA NETWORK OPEN (2020).

[24] Elliott Davis, *States Boost Hospitality Industry with Booze Delivery and Takeout Sales*, U.S. NEWS & WORLD REP. (Mar. 19, 2020), https://www.usnews.com/news/best-states/articles/2020-03-19/more-states-offer-alcohol-delivery-and-takeout-amid-coronavirus.

I. ALCOHOL REGULATION AND CONSUMPTION IN THE U.S. THROUGHOUT HISTORY

Alcohol has been a pervasive, deep-rooted, and often problematic feature of life in the United States since before the country's founding. Early on, heavy drinking by colonists of North America was a normal part of everyday life.[25] When colonists emigrated from Europe, they brought with them "a high regard for alcoholic beverages . . . . People in all regions and of all classes drank heavily. Wine and sugar were consumed at breakfast; at 11:00 and 4:00 workers broke for their 'bitters'; cider and beer were drunk at lunch and toddies for supper and during the evening."[26] In a 1779 letter, Benjamin Franklin wrote that wine was "a constant proof that God loves us, and loves to see us happy."[27]

Eventually, alcohol began to be recognized as an "addicting and even poisonous drug" with many physical, emotional, and social harms.[28] This view would inform the development of future policies focusing on the availability of alcohol, rather than on the personal failing of the individual engaged in drunkenness. In the 19th century, however, individuals—mostly men—continued to consume large quantities of alcohol, often in saloons.[29] By the late 19th century, saloons served as gathering places and were often the location for political conventions and primaries.[30] As such, saloons rapidly multiplied across the country, and "by 1897 there were roughly a quarter of a million saloons."[31] For example, in Chicago, there were more saloons than grocery stores, meat markets, and dry goods stores combined.[32] Saloons served inexpensive alcohol and provided food for free with an

[25] Steve Olson & Dean R. Gerstein, ALCOHOL IN AMERICA: TAKING ACTION TO PREVENT ABUSE, 4-5 (1985).
[26] *Id.*
[27] The Franklin Institute, *7 Things Benjamin Franklin Never Said. (Nov. 20, 2019),* https://www.fi.edu/benjamin-franklin/7-things-benjamin-franklin-never-said (last visited Apr. 3, 2022).
[28] *See* Olson & Gerstein, *supra* note 25.
[29] *See* Royal Melendy, *The Saloon in Chicago*, 6 AM. J. SOC. 289-306 (Nov. 1900); Royal Melendy*, The Saloon in Chicago II*, 6 AM. J. SOC. 433-64 (Jan. 1901).
[30] Jon Grinspan, *The Saloons, America's Forgotten Democratic Institution,* N.Y. TIMES (Nov. 26, 2016), https://www.nytimes.com/2016/11/26/opinion/sunday/the-saloon-americas-forgotten-democratic-institution.html.
[31] *Id.*
[32] Jon M. Kingsdale, *The "Poor Man's Club": Social Functions of the Urban Working-Class Saloon,* 25 AM. Q. 472 (1973).

alcohol purchase. Increasing alcohol consumption among men led to higher rates of domestic abuse.[33]

One factor that contributed to both an increase in saloons and overall alcohol consumption was the "vertical integration" of the alcohol industry. In other words, retail establishments (such as saloons) were often owned by alcohol producers who used financial inducements, such as the extension of credit, to drive retailers to sell as much alcohol as possible.[34] In the years prior to Prohibition, "brewers owned or had controlling interests in nearly eighty percent of all saloons."[35] The saloon, "with its steady flow of cheap alcohol, exemplified the problems associated with vertical integration . . . and [in fact] came to be associated with 'political corruption, prostitution, gambling, crime, poverty and family destruction." [36] The number of alcohol-related harms stemming from the saloons was one of the influencing factors that led the U.S. to adopt the 18th Amendment and thus begin Prohibition in 1920.

Thirteen years later, the states ratified the 21st Amendment, which repealed Prohibition and granted control of alcohol regulation to the states. Given the problems with vertical integration that existed pre-Prohibition, every state chose to adopt a three-tier system post-Prohibition. Under this system, each tier was separately licensed and regulated, and the wholesalers separated the producers from the retailers. This precluded the alcohol industry from becoming vertically integrated again. The three-tier system prevents the sale of inexpensive and readily available alcohol by allowing states to raise the price of alcohol to reduce the harms of alcohol consumption.[37] In addition to providing public health benefits, the three-tier system also provides other benefits.[38] From a regulatory perspective, each tier is responsible for following all state and federal laws and regulations and for tracking alcohol products across distribution channels. This has created checks and balances, thereby preventing the broad spread of tainted alcohol products and allowing companies to quickly and effectively recall alcohol products when

[33] Mickey Lyons, *Dry Times: Looking Back 100 Years After Prohibition,* HOUR DETROIT MAG. (Apr. 20, 2018), https://www.hourdetroit.com/community/dry-times-looking-back-100-years-after-prohibition/.
[34] *See* Carole L. Jurkiewicz & Murphy L. Painter. SOCIAL AND ECONOMIC CONTROL OF ALCOHOL: THE 21ST AMENDMENT IN THE 21ST CENTURY 7 (2008).
[35] Paul Aaron & David Musto, *Temperance and Prohibition in America: A Historical Overview*, *in* ALCOHOL AND PUBLIC POLICY: BEYOND THE SHADOW OF PROHIBITION 127-81 (Mark H. Moore & Dean R. Gernstein eds. 1981).
[36] W.J. Rorabaugh, *The Origins of the Washington State Liquor Control Board, 1934,* 100 PAC. NW. Q. 159, 159 (2009).
[37] The National Alcohol Beverage Control Association, *The Three Tier System: A Modern View,* (Mar. 2015).
[38] *Id.*

needed.[39] The system also produced economic benefits to the state through the taxing of each of the tiers, which increases the total state revenue compared to a system without a taxed wholesale tier.[40] From a commercial perspective, this system allowed both large corporations and smaller manufacturers to make and sell alcohol products to consumers by equaling the playing field and preventing monopolies.[41]

Although in the early to mid-twentieth century, the Supreme Court repeatedly upheld state alcohol laws – including supporting the three-tier system – as protected by the 21st Amendment, over the last several decades, the Supreme Court's view of the importance of the 21st Amendment has shifted. The Court began to give less deference to the 21st Amendment when it conflicted with other constitutional provisions. As a result, states now have a much harder time defending their alcohol laws, and challenges to them often end with these laws being overturned.[42]

Along with changes both to alcohol laws and to how the Supreme Court evaluates and analyzes them, there have also been changes in consumption trends such as who is drinking which products and where. For example, after Prohibition ended, and with saloons gone, the alcohol industry slowly rebuilt by glamorizing liquor and targeting women.[43] And, "by the end of the 20th century, two thirds of the alcohol consumed by Americans was drunk in the home or at private parties."[44] With all these changes, the one constant has been the impact that alcohol has had on public health.

II. THE CONSEQUENCES OF ALCOHOL CONSUMPTION ON PUBLIC HEALTH

In the early 1900s, rates of alcohol production and consumption and rates of deaths attributable to alcohol (e.g., liver cirrhosis and chronic alcoholism) were extremely high and rising.[45] For example, between 1900 and 1913, the amount of alcohol consumed per capita increased by nearly 33 percent—a substantial rise for such a

[39] *Id.*
[40] *Id. at 2.*
[41] *Id.*
[42] *See* discussion *infra* Part III(B).
[43] Jack S. Blocker, *Did Prohibition Really Work? Alcohol Prohibition as a Public Health Innovation,* 96 AM. J. PUB. HEALTH 233, 241 (2006).
[44] *Id.* at 241.
[45] Angela K. Dills & Jeffrey A. Miron, *Alcohol Prohibition and Cirrhosis,* 6 L & ECON. REV. 285 (2004); E.M. Jellinek, *Recent Trends in Alcoholism and in Alcohol Consumption,* 8 Q. J. STUD. ON ALCOHOL 1, 20 (1947).

short period of time.[46] These increasing levels of alcohol consumption and alcohol-related harms was one factor that led to the enactment of Prohibition.

Prohibition lasted for thirteen years and, contrary to public opinion, it was successful from a public health perspective.[47] Saloons across the United States closed their doors, and employers reported that work productivity and the amount of money men took home to their families increased. Post-Prohibition, individuals were consuming 33 percent to 50 percent less alcohol than before Prohibition.[48] In fact, annual consumption did not surpass the pre-Prohibition peak until the early 1970s.[49] When compared to pre-Prohibition, there were also post-Prohibition declines in death rates from liver cirrhosis, in rates of individuals with "alcoholic psychosis," and in national arrest rates for drunkenness and disorderly conduct.[50] Moreover, "reports of welfare agencies from around the country overwhelmingly indicated a dramatic decrease among client population of alcohol-related family problems."[51] These positive public health outcomes continued for decades post-Prohibition.

However, with alcohol legal again, consumption and alcohol-related harms slowly grew before substantially increasing in the 1960s and 1970s.[52] Today, most of the alcohol-related harms come from excessive alcohol consumption, which according to the Center for Disease Control and Prevention (CDC), includes binge drinking, heavy drinking, and any drinking by pregnant women or people younger than age 21.[53] The CDC generally defines binge drinking[54] as consuming 4 or more drinks during a single occasion for women and as consuming 5 or more drinks during a single occasion for a man.[55] It defines heavy drinking as consuming 8 or more drinks per week for women and as consuming 15 or more drinks per week for

[46] *See* Blocker, *supra* note 43, at 235.
[47] *Id.*
[48] Aaron & Musto, supra note 35.
[49] *See* Blocker, *supra* note 43, at 240.
[50] *See* Aaron & Musto, *supra* note 35.
[51] *Id.*
[52] *See* Blocker, *supra* note 43.
[53] Centers for Disease Control and Prevention. *Fact Sheets – Alcohol Use and Your Health* (Jan. 3, 2018), Available at https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm.
[54] Agencies and organizations have different definitions of the terms "binge drinking" and "heavy drinking." For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines "heavy alcohol use" as "binge drinking on 5 or more days in the past month." *See, e.g.,* The National Institute on Alcohol Abuse and Alcoholism (n.d.). *Drinking Levels Defined*. Available at https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking.
[55] *See* Centers for Disease Control and Prevention, *supra* note 53.

men.[56] About 29 percent of the population engages in behaviors that meet the definition of excessive alcohol consumption.[57]

Underage drinking is particularly hazardous because underage drinkers consume more on a single occasion than adults, even though they consume less alcohol than adults overall.[58] Underage drinking affects the health and well-being of not only the underage people who drink but also their families, their communities, and society overall.

In the short term, consuming too much alcohol can cause harm resulting from motor vehicle crashes[59] and other unintentional injuries,[60] alcohol poisoning and overdoses,[61] and other alcohol-related fatalities such as homicides[62] or suicides.[63] Other risks related to underage drinking include altered brain development,[64] engagement in risky sexual activity,[65] and involvement with the legal system.[66] Moreover, the earlier an individual begins consuming alcohol, the greater the likelihood that he or she develops increased alcohol involvement later in life.[67] The onset of alcohol consumption in childhood or early adolescence is also associated with later use of drugs, drug dependence, and drug-related crash involvement.[68] In the long term, excessive alcohol consumption can cause chronic diseases, such as

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[56] *Id*.
[57] Tara Parker-Pope, *Most Heavy Drinkers Are Not Alcoholics*, N.Y. TIMES (Nov. 20, 2014), https://well.blogs.nytimes.com/2014/11/20/most-heavy-drinkers-are-not-alcoholics-study-finds/.
[58] The National Institute on Alcohol Abuse and Alcoholism (n.d.). *Underage Drinking*. Available at https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/underage-drinking.
[59] *See* World Health Organization, *supra* note 2.
[60] Melonie Heron, *Deaths: Leading Causes for 2010*, 62 NAT'L VITAL STATISTICS REP. (Dec. 20, 2013).
[61] Mariana Cremonte & Cheryl J. Cherpitel, *Alcohol Intake and Risk of Injury*, 74 MEDICINA (B AIRES) 287-9 (2014).
[62] Timothy S. Naimi et al., *Alcohol Involvement in Homicide Victimization in the United States,* 40 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES., 2614-21 (Dec. 2016).
[63] Maurizio Pompili et al., *Suicidal Behavior and Alcohol Abuse,* 7 INT'L. J. ENVTL. RES. PUB. HEALTH 1392-1431 (2010).
[64] Silveri et al., *supra* note 4; Lees et al., *supra* note 4.
[65] Ellickson et al., *supra* note 5; Stuevee & O'Donnell, *supra* note 5.
[66] *See, e.g.,* Thomas L. Hafemeister & Shelly L. Jackson, *Effectiveness of Sanctions and Law Enforcement Practices Targeted at Underage Drinking Not Involving Operation of a Motor Vehicle*, *in* REDUCING UNDERAGE DRINKING: A COLLECTIVE RESPONSIBILITY (Richard J. Bonnie & Mary Ellen O-Connell eds., 2004).
[67] Ralph W. Hingson et al., *Age at Drinking Onset and Alcohol Dependence: Age at Onset, Duration, and Severity*, 160 ARCHIVES OF PEDIATRICS & ADOLESCENT MED.739-46 (2006).
[68] Ralph W. Hingson et al., *Age at Drinking Onset, Alcohol Dependence, and their Relation to Drug Use and Dependence, Driving Under the Influence of Drugs, and Motor-Vehicle Crash Involvement Because of Drugs*, 69 J. STUD. ON ALCOHOL & DRUGS 192-201 (2008).

liver cirrhosis, cancer, and heart disease.[69] These short- and long-term harms have motivated much of the government regulation of alcohol over the years.

In 2020, over half of the population aged 12 or older (50 percent or 139 million people) in the United States reported consuming alcohol within the past month.[70] Nearly half of this group were binge drinkers (45 percent or 62 million people) and 13 percent (18 million people) were heavy drinkers.[71] Each day, another 13,365 individuals report first consuming alcohol and almost half of these individuals are between the ages of 12 and 17.[72] Although men are still more likely than women to report consuming alcohol or binge drinking in the past month, the gap is steadily closing as women report higher consumption rates than in prior years.[73] Caucasian individuals have the highest percentages of reported alcohol consumption, followed by American Indians or Alaska Natives, African-Americans, and Asians.[74]

Excessive alcohol consumption in general, and underage drinking specifically, are both extremely costly for the U.S.[75] In 2010, excessive alcohol consumption cost the U.S. $249 billion dollars, or about $2.05 per drink.[76] The government paid for forty percent of these alcohol-related costs.[77] Binge drinking accounted for over three-quarters of that cost ($191 billion), and underage drinking accounted for almost 10 percent of it ($24 billion).[78] Approximately 56 percent of underage drinking costs can be attributed to lost productivity arising from the premature mortality from alcohol-attributable conditions involving underage youth.[79]

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[69] Community Preventive Services Task Force, Centers for Disease Control and Prevention, *The Community Guide: What Works*. *Preventing Excessive Alcohol Consumption: Evidence-Based Interventions for Your Community*. Available at https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-Alcohol.pdf
[70] Substance Abuse and Mental Health Services Administration, KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2020 NATIONAL SURVEY ON DRUG USE AND HEALTH (Oct. 2021).
[71] *Id.*
[72] Substance Abuse and Mental Health Services Administration, KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH (Aug. 2019).
[73] Aaron White et al., *Converging Patterns of Alcohol Use and Related Outcomes Among Females and Males in the United States, 2002 to 2012*, 39 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES. 9, 1712-13 (2015).
[74] *See* Substance Abuse and Mental Health Services Administration, *supra* note 72.
[75] Jeffrey J. Sacks et al., *2010 National and State Costs of Excessive Alcohol Consumption*. 49 AMERICAN J. PREVENTIVE MEDICINE 5, e73, e73-e79 (2015).
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *Id.*

III. THE CHANGING LEGAL LANDSCAPE

As alcohol consumption and related harms have varied, so too have attempts by the government to regulate both this product and the individuals manufacturing, distributing, and selling this product. For example, alcohol is the only consumer good to have led to not one, but two, constitutional amendments as well as thousands of laws at the federal, state, and local levels. Numerous court cases have been brought challenging these laws, with several cases making it all the way to the U.S. Supreme Court. Although the 21st Amendment has been at issue in most, if not all, alcohol-related cases since its ratification, most of the judicial decisions concerning alcohol spend a significant amount of time reviewing the history and precedent from pre-Prohibition (and therefore pre-21st Amendment) to the present.

A. The Alcohol Legal Landscape Pre- and Post-Prohibition

States attempted to reduce the high rates of alcohol consumption in the 19th century by enacting a variety of regulations, including licensing requirements, age restrictions, and Sunday-closing laws.[80] The Supreme Court heard many cases challenging these laws on a variety of constitutional grounds but repeatedly upheld these laws as "'the right of the States,' in exercising their 'police power,' to 'protect the health, morals, and safety of their people.'" [81] Over time, as states prohibited the production or sale of alcohol within their borders, they found that residents were still consuming alcohol shipped in from other states and enacted laws to stop this. The Supreme Court began overturning laws that regulated or prohibited the importation of alcohol from other states as violating the dormant Commerce Clause.[82] The courts have inferred from the fact that the Constitution states that Congress can regulate interstate commerce and that, therefore, states cannot discriminate against nor unduly burden interstate commerce. This implied provision of the Constitution prohibits states from passing laws that affect interstate commerce, and particularly, laws that favor in-state businesses over out-of-state businesses.

At the request of states that wished to regulate alcohol importation from other states and other temperance advocates, Congress passed two laws to help states better regulate imported alcohol. The Wilson Act[83], enacted in 1890, required equal

[80] *See Tenn. Wine & Spirits Retailers Assoc. v. Thomas*. 139 S. Ct. 2449, 2463 (2019) (citing Clark Byse, *Alcoholic Beverage Control Before Repeal*, 7 LAW & CONTEMP. PROBS. 544, 546-51 (1940)).
[81] *Mugler v. Kansas*, 123 U.S. 623, 659 (1887).
[82] U.S. CONST. art. I, § 8, cl. 3.
[83] 27 U.S.C. § 121.

treatment for alcohol produced within and outside a State. It mandated that any alcohol transported into the State "or remaining therein for use, consumption, sale, or storage" shall upon arrival "be subject to the operation and effect of the laws of such State or Territory enacted in the exercise of its police powers, to the same extent and in the same manner as though such liquids or liquors had been produced [there]."[84] However, the Supreme Court interpreted the word "arrival" to mean delivery to the consumer, and so residents of dry states could still order and receive out-of-state alcohol. In order to close this loophole, Congress passed the Webb-Kenyon Act[85] in 1913, which prohibited the shipment or transportation of alcohol into a State in violation of that State's laws.

However, in 1919, the Webb-Kenyon Act became a moot point when the states ratified the 18th Amendment, which banned the "manufacture, sale, or transportation" of alcohol within the U.S., thus beginning Prohibition in 1920. Prohibition lasted 13 years until support for it diminished. Then, in 1933, the states ratified the 21st Amendment, which both ended Prohibition (Section 1) and granted the states' primary power over alcohol within their own borders (Section 2). The language closely followed the Webb-Kenyon Act, with Section 2 of the 21st Amendment stating that: "the transportation or importation into any State, Territory, or Possession of the United States for delivery or use therein of intoxicating liquors, **in violation of the laws thereof**, is hereby prohibited" (bolded for emphasis).[86]

States used the power granted to them by the 21st Amendment to set up individualized laws and regulations for alcohol, including the adoption of the three-tier system. Although the laws were often challenged, the U.S. Supreme Court repeatedly upheld them as constitutional under the 21st Amendment.[87] However, by the mid- to late-twentieth century, the Supreme Court's view of the importance of the 21st Amendment had shifted, and the Court began to give less deference to it when it conflicted with other Constitutional provisions such as the Free Speech

[84] *Id.*
[85] 27 U.S.C. § 122.
[86] U.S. CONST. amend. XXI.
[87] *See, e.g.*, *State Board of Equalization of California v. Young's Market Co.*, 299 U.S. 59, 64 (1936); *Joseph S. Finch & Co. v. McKittrick*, 305 U.S. 395, 398 (1939); *see also Joseph E. Seagram & Sons, Inc. v. Hostetter*, 384 U.S. 35 (1966).

Clause,[88] the Establishment Clause,[89] the Equal Protection Clause,[90] the Due Process Clause,[91] the Import-Export Clause,[92] and, of course, the Commerce Clause.[93]

B. The Recent Alcohol Legal Landscape

Over the last 30 years, the Supreme Court has decided two relevant and important alcohol-related cases. In 2005, it decided *Granholm v. Heald*, and then, in 2019, decided *Tennessee Wine and Spirits Retailers Association v. Thomas*.

Granholm v. Heald (2005). In *Granholm v. Heald*, [94] the Supreme Court answered the question of whether states may allow in-state wineries to ship alcohol directly to consumers while restricting out-of-state wineries from doing the same. Groups of wineries had separately sued Michigan and New York, arguing that laws prohibiting out-of-state wine shipments violated the U.S. Constitution's dormant Commerce Clause, resulting in a split between the federal appellate courts for the respective circuits. The U.S. Court of Appeals for the Sixth Circuit[95] struck down the Michigan law as unconstitutional because it violated the dormant Commerce Clause; the U.S. Court of Appeals for the Second Circuit[96] upheld a similar New York law as constitutional because it found that the law was a valid exercise of state power under the 21st Amendment. It was the conflicting opinions over which law should prevail that the Supreme Court was requested to resolve in *Granholm*. Therefore, the Supreme Court consolidated the cases from Michigan and New York and granted certiorari.

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[88] U.S. CONST. amend. I. **(**prohibiting the government from enacting any law that abridges an individual's freedom of speech); *see Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996).
[89] U.S. CONST. amend. I. (prohibiting the government from enacting any law that establishes an official religion or favors one religion over another); *see Larkin v. Grendel's Den, Inc*., 459 U.S. 116 (1982).
[90] U.S. CONST. amend. XIV (requiring the government to grant people equal protection under the law by treating them in the same manner as others in similar conditions and circumstances); *see Craig v. Boren*, 429 U.S. 190 (1976).
[91] U.S. CONST. amend. V (prohibiting the government from depriving a person of life, liberty, or property without due process of law); *see Wisconsin v. Constantineau*, 400 U.S. 433 (1971).
[92] U.S. CONST. art. I, § 10, cl. 2 (prohibiting states from taxing imports or exports); *see Department of Revenue v. James B. Beam Distilling Co.*, 377 U.S. 341 (1964).
[93] U.S. CONST. art. I § 8, cl. 3 (granting Congress the power to regulate interstate commerce); *see United States v. Darby Lumber Co,* 312 U.S. 100 (1941).
[94] *Granholm v. Heald*, 544 U.S. 460 (2005).
[95] *Michigan Beer & Wine Wholesalers Association v. Heald*, 541 U.S. 1062 (2004).
[96] *Swedenburg v. Kelly*, 358 F.3d 22, 24 (2nd Cir. 2004).

Sixteen parties submitted amicus curiae (i.e., "friend of the court") briefs. Six briefs supported the petitioners and argued that these laws were constitutional under the 21st Amendment. Two of these briefs were written by alcohol wholesalers associations,[97] one by organizations representing state and local government alcohol regulatory agencies,[98] and one on behalf of 33 states.[99] Lastly, one brief was written by a nonprofit association involved in the training of alcohol and drug dependency prevention and treatment providers, [100] and another by a diverse group of nonprofit organizations representing secondary school principals, women, youth, religious entities, and other concerned individuals.[101] This last brief argued that these laws were constitutional under the 21st Amendment because invalidating them "would cause a major increase in the number of alcohol-related traffic fatalities, injuries, assaults, and other crimes, especially among our youths."[102]

The ten other briefs supported the respondents and argued that these laws were unconstitutional under the dormant Commerce Clause. Three of these briefs were written by wineries, vintners, or associations representing wineries or vintners.[103] One was written by entities involved in electronic commerce,[104] and another by a trade association of interstate air and motor carriers.[105] Three briefs were written by economists or nonprofits promoting economic liberties and the elimination of

[97] *See* Brief for the National Beer Wholesalers Association as Amicus Curiae, *Granholm v. Heald*, 544 U.S. 460 (2005); Brief for the Wine & Spirits Wholesalers of America as Amicus Curiae, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[98] *See* Brief for the National Alcohol Beverage Control Association & the National Conference for State Liquor Administrators as Amicus Curiae, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[99] *See* Brief for Ohio et al. as Amicus Curiae, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[100] *See* Brief for the Illinois Alcoholism and Drug Dependence Association as Amicus Curiae, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[101] *See* Brief for the Mich. Ass'n of Secondary Sch. Principals et al. as Amicus Curiae Supporting Petitioners, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[102] *Id.* at 3, 24.
[103] *See* Brief for the Wine Inst. as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116); Brief for Wine Inst. of Am. et al. as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005); Brief for the Napa Valley Vitners, et al. as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[104] *See* Brief for the Am. Homeowners All., et al. as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[105] *See* Brief for the Cargo Airline Ass'n as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).

government burdens on commerce and trade.[106] Lastly, one brief was written by members of the U.S. Congress[107] and another on behalf of five states (California, Washington, New Mexico, Oregon, and West Virginia) that, at the time of publication, did not restrict sales by out-of-state wineries.[108]

In June of 2005, the Supreme Court issued a 5-4 decision finding that laws restricting shipments from out-of-state wineries but allowing shipments from in-state wineries were unconstitutional.[109] The decision, written by Justice Kennedy, thoroughly reviewed the case law surrounding the 21st Amendment before concluding that: 1) The 21st Amendment did not protect challenged laws from scrutiny under the Commerce Clause; and 2) when scrutinized, the states' concerns about shipments to minors and tax collection did not advance a legitimate local purpose that could not be adequately served by reasonable, nondiscriminatory alternatives.[110] However, the decision also explained that "state policies are protected under the Twenty-first Amendment when they treat liquor produced out of state the same as its domestic equivalent," and, therefore, states could still "control liquor distribution through state-run outlets or funnel sales through the three-tier system."[111] The Court also reiterated that the three-tier system itself was "unquestionably legitimate." [112]

There were two dissenting opinions filed. The first dissent was written by Justice Stevens and joined by Justice O'Connor. Justice Stevens argued that these laws would be invalid if they regulated a product other than alcohol.[113] However, the country has treated alcohol differently (i.e., by passing two amendments regulating it), and thus, the 21st Amendment's broad authority should protect these laws.[114] The second dissent was written by Justice Thomas, joined by Justices Stevens and O'Connor and Chief Justice Rehnquist. Justice Thomas provided a careful

[106] *See* Brief for the DKT Liberty Project as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116); Brief for the Goldwater Inst. as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116); Brief of George A. Akerlof, et al. as Amicus Curiae Supporting Petitioners, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[107] *See* Brief for Members of the U.S. Congress as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[108] *See* Brief for Cal., Wash., N.M., Or., & W.Va. as Amicus Curiae Supporting Respondents, *Granholm v. Heald*, 544 U.S. 460 (2005) (No. 03-1116).
[109] *See* Granholm v. Heald, 544 U.S. 460, 493 (2005).
[110] *Id.* at 490.
[111] *Id.* at 489.
[112] *Id.*
[113] *Id.* at 493.
[114] *Id.*

historical analysis demonstrating that the laws were valid under the 21st Amendment.[115]

Granholm v. Heald answered some questions but raised others. The most notable was whether the finding only applied to alcohol producers or also applied to alcohol retailers and wholesalers. The lower courts were split on this issue. For example, the U.S. Court of Appeals for the Second Circuit[116] and Eighth Circuit[117] concluded that the high level of scrutiny under the Commerce Clause mandated by the *Granholm* decision only applied when state laws discriminated against out-of-state producers or out-of-state products. However, the Fifth Circuit[118] and the Sixth Circuit[119] concluded that this high level of scrutiny also applied to state laws discriminating against out-of-state wholesalers and retailers.

After the *Granholm* decision was announced, the alcohol industry relied on the decision as legal precedence. It quickly began flooding the courts with cases challenging similar alcohol-related laws and other non-similar alcohol-related or even non-alcohol-related laws. The *Granholm* case was referenced or discussed in 228 other court decisions.[120] Of these, 196 were federal cases, including across all but one of the Courts of Appeals (not including the D.C. Circuit) and over half of the District Courts (57 out of the 94).[121] The other mentions occurred in cases in 19 state courts and Puerto Rico.[122] Although most of these cases involved laws regulating alcohol, there were some that addressed other issues such as tobacco, taxation, transportation, and environmental law.

Tennessee Wine and Spirits Retailers Association v. Thomas (2019). Given the questions left by *Granholm* and the split among the lower courts' decisions that followed, it was expected that the Supreme Court would grant certiorari in another alcohol-related case. Fourteen years later, the Supreme Court agreed to hear *Tennessee Wine and Spirits Retailers Association v. Thomas*.[123]

The issue in this case was whether a Tennessee law imposing a two-year durational residency requirement on applicants for retailer licenses was unconstitutional under

[115] *See* Granholm v. Heald, 544 U.S. 460, 497 (2005).
[116] *See Arnold's Wines, Inc. v. Boyle*, 571 F.3d 185, 189 (2d Cir. 2009).
[117] *See also S. Wine & Spirits of Am., Inc. v. Div. of Alcohol & Tobacco Control*, 731 F.3d 799, 806 (8th Cir. 2013).
[118] *See Cooper v. Tex. Alcoholic Beverage Comm'n*, 820 F.3d 730, 743 (5th Cir. 2016).
[119] *See Byrd v. Tenn. Wine & Spirits Retailers Ass'n*, 259 F. Supp. 3d 785, 793 (M.D. Tenn. 2017).
[120] *See, e.g., Anvar v. Tanner*, 549 F. Supp. 3d 235, 240 (D.R.I. 2021).
[121] *See, e.g., Heffner v. Murphy*, 745 F.3d 56, 70 (3d Cir. 2014).
[122] *See, e.g.*, *Keystone Redevelopment Partners, LLC v. Decker*, 631 F.3d 89, 107 (3d Cir. 2011).
[123] *See generally* Tenn. Wine & Spirits Retailers Ass'n v. Thomas, 139 S. Ct. 2449 (2019).

the dormant Commerce Clause or constitutional under the 21st Amendment.[124] When the State planned to give licenses to two applicants that did not meet the residency requirements, the Tennessee Wine and Spirits Retailers Association (TWSRA) threatened litigation.[125] Tennessee, in turn, sought judicial review of the state's residency requirement.[126] When both the District Court for the Middle District of Tennessee[127] and the Sixth Circuit Court of Appeals[128] found the residency requirement unconstitutional, the TWSRA appealed the decision to the Supreme Court.

Even more parties submitted amicus curiae briefs in this case than had in *Granholm*. Over two-thirds of these briefs (14 out of 22) supported the petitioners and argued that Tennessee's durational residency requirement was constitutional under the 21st Amendment. Five of the briefs were submitted by beer, wine, and spirits wholesalers,[129] one by an association representing retailers,[130] and two by organizations either representing "underrepresented consumers"[131] or "dedicated to promoting fair and competitive markets."[132] Other briefs were submitted by organizations representing state and local government alcohol regulatory associations[133] or state legislators,[134] nonprofits providing education about alcohol

[124] *Id.* at 2457.
[125] *Id.* at 2458.
[126] *Id.*
[127] *See generally Byrd v. Tenn. Wine & Spirits Retailers Ass'n*, 259 F. Supp. 3d 785, 798 (M.D. Tenn. 2017).
[128] *See id.* at 797; *see generally Byrd v. Tenn. Wine & Spirits Retailers Ass'n*, 883 F.3d 608 (6th Cir. 2018).
[129] *See* Brief for the Mich. Beer & Wine Wholesalers Ass'n as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019); Brief for the Wine & Spirits Wholesalers of Tenn. as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019); Brief for the Nat'l Beer Wholesalers Ass'n as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019); Brief for the Major Brands, Inc. as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019).
[130] *See* Brief for the Am. Beverage Licensees as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019).
[131] *See* Brief for Consumer Action as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019).
[132] *See* Brief for Open Mkt.s Inst. as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019).
[133] *See* Brief for the Nat'l Alcohol Beverage Control Ass'n & Nat'l Liquor Law Enf't Ass'n as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[134] *See* Brief for Nat'l Conf. of State Legislatures, et al. as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019).

regulation,[135] individual businesses, [136] or on behalf of 35 states and the District of Columbia.[137] The final brief came from a nonprofit that "translates alcohol policy research into public health practice to prevent and reduce alcohol-related harm in the United States" and 30 other independent organizations "comprised of public-health researchers, practitioners, and advocates devoted to studying alcohol regulations, promoting evidence-based reforms, and informing the public about the dangers of excessive alcohol and other drug consumption."[138]

The other eight amicus curiae briefs were submitted by parties supporting the respondents. They argued that Tennessee's law was unconstitutional under the dormant Commerce Clause. These briefs were submitted by alcohol retailers,[139] law and economic scholars,[140] law professors,[141] a nonpartisan public-policy research foundation "dedicated to advancing the principles of individual liberty, free, markets, and limited government,"[142] a nonprofit public interest law firm "dedicated to defending the principles of limited government, federalism, and free enterprise," [143] and on behalf of 81 wine consumers.[144]

In June of 2019, the Supreme Court—in a 7-2 decision—found that Tennessee's two-year durational residency requirement was unconstitutional.[145] Justice Alito

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[135] *See* Brief for the Ctr. for Alcohol Pol'y as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n. v.* Blair, 139 S. Ct. 2449 (2019).
[136] *See* Brief for KHBC Partners II, Ltd. as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Byrd*, 139 S. Ct. 2449 (2019).
[137] *See* Brief for 35 states and D.C. as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Bl*air, 139 S. Ct. 2449 (2019).
[138] Brief for the U.S. Alcohol Pol'y All. & Public Health Researchers and Advocates as Amicus Curiae Supporting Petitioner, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[139] *See* Brief for the Nat'l Ass'n of Wine Retailers as Amicus Curiae Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019); Brief for the Retail Litig. Ctr., Inc. as Amicus Curiae Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[140] *See* Brief for Law & Econ. Scholars as Amicus Curiae Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[141] *See* Brief for Law Professors as Amicus Curiae Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019); Brief for Alan B. Morrison Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[142] Brief for Cato Inst. as Amicus Curiae Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[143] Brief for Pac. Legal Found. as Amicus Curiae Supporting Respondents, *Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[144] *See* Brief for 81 Wine Consumers as Amicus Curiae Supporting Respondents*, Tenn. Wine & Spirits Retailers Ass'n v. Blair*, 139 S. Ct. 2449 (2019).
[145] *See Tenn. Wine & Spirits Retailers Ass'n v. Thomas*, 139 S. Ct. 2449, 2476 (2019).

wrote the decision in which the Court held that: 1) Under the dormant Commerce Clause, a state law cannot discriminate against out-of-state products or nonresidents without showing that that discrimination is narrowly tailored to advance a legitimate local purpose; 2) based on a historical analysis and a review of caselaw, even though the 21st Amendment "grants States latitude with respect to the regulation of alcohol . . . [it does not allow] the States to violate the 'nondiscrimination principle' that was a central feature of the regulatory regime that [provision two of the 21st Amendment] was meant to constitutionalize"; 3) protectionism is not a legitimate interest under provision two of the 21st Amendment if a state alcohol law burdens interstate commerce; and 4) this law "has at best a highly attenuated relationship to public health or safety" and its goals could be accomplished without discriminating against nonresidents.[146]

The Court dismissed arguments that *Granholm* only applied to out-of-state alcohol products and producers, and that Tennessee's law was constitutional because of *Granholm*'s discussion (and support) of the three-tiered model.[147] In *TWSRA*, the Court stated that "[a]lthough *Granholm* spoke approvingly of that basic model, it did not suggest that [section two of the 21st Amendment] sanctions every discriminatory feature that a State may incorporate into its three-tiered scheme."[148] Lastly, whereas the court agreed with the dissent that states can regulate the health and safety risks posed by alcohol under the 21st Amendment, it explained that the constitutionality of each law "must be judged based on its own features."[149]

Justice Gorsuch dissented, and the opinion was joined by Justice Thomas.[150] Justice Gorsuch reviewed the history behind the 21st Amendment and cited "plenty of evidence" that, under this amendment, states should be "able to regulate the sale of liquor free of judicial meddling."[151] He acknowledged that Tennessee's durational residency requirement may reduce competition by excluding nonresidents or recent arrivals, but he also recognized that "even that effect might serve a legitimate state purpose by increasing the price of alcohol and thus moderating its use, an objective States have always remained free to pursue under the bargain of the Twenty-first Amendment." [152] Justice Gorsuch also criticized the Court for overextending the *Granholm* decision to include out-of-state retailers and wholesalers.[153]

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[146] *Id.* at 2474.
[147] *Id.* at 2475.
[148] *Id.* at 2471.
[149] *Id.* at 2484.
[150] *See* Tenn. *Wine & Spirits Retailers Ass'n v. Thomas*, 139 S. Ct. 2449, 2476 (2019).
[151] *Id.* at 2481.
[152] *Id.* at 2483.
[153] *Id.*

Justice Gorsuch pointed out that although the Court claimed that states are still allowed to enact "'the measures that its citizens believe are appropriate' to address public health and safety," it dismissed the judgement of the citizens of Tennessee as "'protectionist measures with no demonstratable connection' to public health and safety."[154] Justice Gorsuch then raises several important questions:

> What are lower courts supposed to make of this? How much public health and safety benefit must there be to overcome this Court's worries about protectionism "predominat[ing]"? Does reducing competition in the liquor market, raising prices, and thus reducing demand still count as a public health benefit, as many States have long supposed? And if residency requirements are problematic, what about simple physical presence laws?[155]

As Justice Gorsuch alludes to, it is unclear how much concrete evidence a state must produce to justify a given law or what a state must show to prove that no nondiscriminatory alternatives exist.[156] Unfortunately, the Court offers very little guidance to lower courts or states moving forward.

IV. THE IMPACT OF THE CHANGING LEGAL LANDSCAPE ON DTC SHIPPING OF ALCOHOL

As discussed earlier, alcohol consumption and its related harms are intertwined with alcohol regulation.[157] Therefore, it is no surprise that the changing legal landscape has impacted both alcohol consumption trends and the alcohol industry itself.

A. The Emergence of Craft Breweries and Distilleries

In the years immediately preceding Prohibition, there were 1,300 breweries in the U.S.[158] and 318 wineries.[159] Ten years later, there were no breweries and only 27

[154] *Id.* at 2455.
[155] *See id.* at 2484.
[156] *See Tenn. Wine & Spirits Retailers Ass'n v. Thomas*, 139 S. Ct. 2449, 2484 (2019). *Id.*
[157] *See id.* at 2475.
[158] These numbers only refer to breweries that produced beer containing 0.5% or more alcohol by volume. Whereas the 18th Amendment prohibited the production, sale, and transport of "intoxicating liquors," it did not define the term. Therefore, in 1920, Congress passed the Volstead Act which defined the words "beer, wine, or other intoxicating malt or vinous liquors" to mean "any such beverages which contain one-half of 1 per centum or more of alcohol by volume." As a result, several breweries began making alcohol with less than 0.5% alcohol by volume, often referred to as "near-beer." *See* VOLSTEAD ACT, H.R. 6810, 66th Cong. (1919).
[159] *See* Jack S. Blocker Jr., *Did Prohibition Really Work? Alcohol Prohibition as a Public Health Innovation*, 96 Am. J. of Public Health 233, 236 (2006).

wineries.[160] Over the same period, the number of distilleries was cut by 85 percent, the number of liquor wholesalers was cut by 96 percent, and the number of retailers was cut by 90 percent.[161]

Within the year after Prohibition ended, 756 breweries were making beer.[162] However, the expansion of the biggest breweries slowly put smaller breweries out of business. There were 407 breweries in 1950, and by 1961, there were only 230.[163] In 1983, "one source counted only 80 breweries, run by only 51 independent companies."[164] By 2016, 72 percent of all beer in the United States was produced by two companies: Anheuser-Busch InBev and SABMiller.[165] This rapid and continuing concentration of the alcohol producers' industry also occurred among distilleries.[166]

As a likely push-back to this corporate concentration, the last three decades have seen the emergence of craft breweries and craft distilleries. This rapidly growing industry is comprised of small, independent brewers or distillers.[167] From 1994 to 2013, the number of craft breweries in the United States increased from 537 to 2,898.[168] By 2018, a mere five years later, that number had more than doubled.[169]

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[160] *See id.*
[161] *See id.* As discussed earlier in the text, alcohol in the U.S. is sold through a three-tier system of distribution. Breweries, wineries, and distilleries manufacture the alcohol. Wholesalers buy the product in bulk and sell it to retailers in smaller quantities. Retailers then sell the product directly to consumers.
[162] *See Chronology of the American Brewing Industry*, BeerHistory.com, https://beerhistory.com/library/holdings/chronology.shtml (last visited Apr. 4, 2022).
[163] *Id.*
[164] *See* Ryan Dunn*, Alexandria: Crafting a New Industry Microbreweries Rise in Northern Virginia,* The Connection Newspapers (Feb. 10, 2016), http://www.connectionnewspapers.com/news/2016/feb/10/alexandria-crafting-new-industry/?templatepreference=desktop.
[165] *See* Complaint at ¶ 39, *United States v. Anheuser-Busch InBev*, No. 1:16-cv-01483, (2016 D. D.C.).
[166] *See Stats and Data: Craft Brewer Definition*, Brewers Association, https://www.brewersassociation.org/statistics-and-data/craft-brewer-definition/ (last visited: Apr. 12, 2022).
[167] *Id.*
[168] *See Stats and Data: National Beer Sales & Production Data*, Brewers Association, https://www.brewersassociation.org/statistics-and-data/national-beer-stats (last visited: Apr. 12, 2022).
[169] *Id.*

Similarly, between 2016 and 2017, the number of craft distilleries in the United States rose by 26 percent—the total number now exceeds 1,500.[170]

These craft breweries and distilleries tend to sell alcohol products that have a higher alcohol-by-volume (ABV).[171] Individuals consuming craft beer may not realize that they are consuming an alcohol product with a higher ABV, and therefore they do not decrease their overall consumption of that product.[172] This may account for the increases in liver cirrhosis[173] and ER hospitalizations[174] observed recently, even though the data on alcohol consumption, in general, has not increased.

B. The Expansion of Laws Allowing DTC Shipping Between Craft Alcohol Producers and Consumers

Unfortunately, as the number of craft breweries and distilleries has increased, so too has the push to exempt them from the three-tier system.[175] In other words, instead of having to first sell to a wholesaler, these producers of beer and spirits can sell directly to consumers.[176] As discussed above, the three-tier system plays a crucial role in reducing alcohol-related public health harms and laws, making these beverages more affordable and accessible runs counter to that role.[177]

Prior to *Granholm*, very few states allowed alcohol producers to ship alcohol directly to consumers' homes.[178] In 1999, 5 states allowed DTC shipping of beer to consumers (see Appendix, Table 1), 32 states allowed DTC shipping of wine to consumers (see Appendix, Table 2), and 5 states allowed DTC shipping of distilled

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[170] *See* Rachel Arthur, *Number of U.S. Craft Distilleries Rises by 26%*, Beverage Daily, (Jul. 18, 2018), https://www.beveragedaily.com/Article/2018/07/18/Number-of-US-craft-distilleries-rises-by-26.
[171] *See* Bo McMillan, *Craft Beers Get Heavy… on the Alcohol*, CNBC, (Aug. 8, 2015), https://www.cnbc.com/2015/08/07/craft-beers-get-heavy-on-the-alcohol.html.
[172] *See id.*
[173] *See* Elliot B. Tapper & Neehar D. Parikh, *Mortality Due to Cirrhosis and Liver Cancer in the United States, 1999-2016: Observational Study*, BMJ (Jul. 18, 2018).
[174] *See* Aaron M. White, et al., *Trends in Alcohol-Related Emergency Department Visits in the United States: Results from the Nationwide Emergency Department Sample, 2006 to 2014*, 42 ALCOHOLISM: CLINICAL & EXPERIMENTAL RSCH. 352-59 (Feb. 2018).
[175] *See* Heather Morton, *Three-Tier Cheers! States are Calling the Shots When it Comes to Regulating Alcohol Producers, Distributors, and Retailers*, ST. LEGISLATURES MAG. (Jun. 1, 2015).
[176] *See id.*
[177] *See* Vijay Shankar, Note, *Alcohol Direct Shipment Laws, the Commerce Clause, and the Twenty-first Amendment*, 85 Va. L. Rev. 353, 356 (1999).
[178] *See id.* at 365-57.

spirits to consumers (see Appendix, Table 3).[179] However, those numbers have been growing, and by 2019,[180] they were 10, 45, and 9 states who allowed DTC shipping for beer, wine, and distilled spirits, respectively.[181] Only time can tell whether more states will use the decision from *TWRSA* as an incentive to expand their DTC alcohol shipping laws. Producers and retailers may also choose to expand their direct interstate shipment through online purchasing, which, as the research has shown, has lax age controls and routinely allows youth purchases.[182]

One factor that has led to an increased number of states now allowing DTC alcohol shipping has been the advocacy of interested parties. For example, in 2018, the Uniform Law Commission (ULC)—strongly influenced by the alcohol industry—studied whether it should draft a uniform or model law legalizing DTC shipping of beer, wine, and spirits for states to adopt.[183] The ULC is a national group of attorneys that "provides states with non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law."[184] After hearing from a variety of stakeholders, including producers, wholesalers, retailers, legislators, and public health researchers and advocates, the ULC voted to move forward and begin drafting a model law.[185] Although the alcohol producers pushed strongly for the legalization of DTC shipping for all three alcohol categories, the ULC chose to change the scope of its uniform or model law

[179] *Id.*
[180] *See 2020 Report to Congress on the Prevention and Reduction of Underage Drinking*, HHS & SUBSTANCE ABUSE AND MENTAL HEALTH SERV.S ADMIN. (2020). These reports contain data on alcohol laws for each state and the District of Columbia that have been collected and rigorously coded. The DTC shipping of beer, wine, and spirits policy topic was added to the Report to Congress in 2009.
[181] *See* Shankar, *supra* note 177. It is important to note that the interpretation of DTC laws is complex, and these numbers may vary depending on the individual(s) reviewing and coding these laws. For example, some states pre-*Granholm* allowed in-state DTC shipping of alcohol but not out-of-state, which could be coded as either having or not having a DTC law. Whereas the data from the Substance Abuse & Mental Health Services Administration's annual Report to Congress is double-coded using a specific coding protocol to ensure accuracy and agreement, the authors were not able to ascertain the process that Shankar (1999) used in his coding.
[182] *See* Williams & Ribisl, *supra* note 18.
[183] *See* Memorandum from Stephen B. Humphress to Steve Wilborn & John McGarvey, *RE: Uniform Law Commission, Consideration of Direct to Consumer ("DTC") Distilled Spirits Shipping Law* (July 15, 2018). Available at: https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=caf20e0f-2602-d502-8e4f-0c902f0d2e86&forceDialog=0
[184] *See About Us*, Uniform Law Commission, https://www.uniformlaws.org/aboutulc/overview (last visited: Apr. 12, 2022).
[185] *Id.*

slightly.[186] The ULC drafting committee's mission is now to "draft a uniform or model law addressing registration and licensing of the direct sale of wine to consumers and the prevention of illegal sales."[187] The assumption is that after the ULC drafts the law, it will provide the draft to the states and push for its nationwide enactment.

Amazon.com, Inc. is also interested in expanding alcohol shipping and sales. In April 2019, the company released a job posting looking for a "business policy and lobbying expert" to "create, execute, and manage key public policy issues related to alcohol procurement and sales."[188] Under the job description, the individual must be able to "persuade and inform" as well as "work with state government and regulatory officials, trade associations and consultants."[189] Amazon currently allows Prime members to get beer, wine, and spirits delivered to their homes in a few select cities that allow it.[190] Experts believe that this new position at Amazon would likely have responsibility for expanding Amazon's capacity to sell and ship alcohol to consumers nationwide by advocating for the removal of state and local laws prohibiting this.[191]

The legalization of DTC shipping of beer, wine, and spirits has coincided with an increase in alcohol delivery phone applications such as Drizly.[192] These phone apps allow consumers to order alcohol delivered to their homes in the same manner as one would order food to be delivered.[193] Until recently, these companies could only deliver alcohol from off-premises retail establishments (e.g., liquor stores) to the consumer. In June 2019, the Louisiana governor signed a bill into law that allows other food delivery services, such as Waitr, to "bring low alcohol content beverages

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[186] *See* Memorandum from the Steve Frost to Scope and Program Comm*., RE: Uniform Direct to Consumer Sales of Distilled Spirits Act – Study Committee Report* (June 11, 2019). Available at: https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=514e21f0-2f5c-9536-fe79-0a9aaa3d3171&forceDialog=0; *see also* Katie Robinson, *New Drafting and Study Committees to be Appointed*, Uniform Law Commission, (July 24, 2019). Available at: https://www.uniformlaws.org/committees/community-home/digestviewer/viewthread?MessageKey=bc3e157b-399e-4490-9c5c-608ec5caabcc&CommunityKey=d4b8f588-4c2f-4db1-90e9-48b1184ca39a&tab=digestviewer.
[187] *See* Robinson, *supra* note 186.
[188] *See* Jonathan Capriel, *Amazon Planning a Deeper Dive into Alcohol Sales? A D.C.-area Job Posting Suggests So*, WASHINGTON BUS. J. (Apr. 9, 2019).
[189] *See id.*
[190] *See Amazon Expands Prime Now Whole Foods Delivery*, MARKET WATCH (June 6, 2018).
[191] *See* Capriel, *supra* note 188.
[192] See Drizly, https://drizly.com (last visited: Apr. 11, 2022).
[193] *See id.*

[e.g., sealed beer and wine] along with a food order to your front door."[194] Additionally, DoorDash expanded its offerings in September of 2021 by allowing customers in select markets (currently 20 states and the District of Columbia) to order beer, wine, or spirits from restaurants, grocery stores, and retailers.[195] Given the current trend toward expansion of DTC shipping, it seems likely that more of these companies will attempt to expand their alcohol delivery services in the future. Those expansions may include advocating for changes to alcohol laws in the states where it is not currently permissible or the delivery of alcohol directly from alcohol producers (e.g., breweries, wineries, and distilleries) to the consumer.

V. What Can States Do to Regulate Alcohol Moving Forward?

For now, the decision in *Tennessee Wine and Spirits Retailers Association v. Thomas* is the latest iteration in the long debate over the relation between the 21st Amendment and the Commerce Clause. Given the Supreme Court's restricted view of the role of the 21st Amendment, this case will likely affect the alcohol-related laws states enact and continue to fight for, and it will certainly change what arguments and evidence states will need to produce if they want to have a chance of these laws being upheld by the Court. Unfortunately, there will be public health consequences if states stop enacting new laws and cease fighting for existing alcohol-related law, and if the Court continues to overturn such laws. It is highly likely that excessive alcohol consumption will increase, and with it, alcohol-related harms will also increase.

So, what can the states and public health and policy professionals do to fortify and protect existing and new alcohol-related laws? It comes down to "The 4 T's": Train, Track, Test, and Translate.

A. Train

First, there is a need for research on different types of alcohol regulation and the impact of such regulations on public health. This means that universities and colleges must continue to train people in public health, public policy, and epidemiology and in the skills necessary to conduct this research. Additionally,

[194] *See Governor Edwards Signs Legislation Allowing Beer and Wine Delivery to Homes*, Louisiana Network (June 26, 2019). Available at: https://kpel965.com/governor-edwards-signs-legislation-allowing-beer-and-wine-delivery-to-homes.
[195] *See DoorDash Expands Marketplace Offering with Alcohol On-Demand*, DoorDash (Sept. 20, 2021), https://ir.doordash.com/news/news-details/2021/DoorDash-Expands-Marketplace-Offering-with-Alcohol-On-Demand/default.aspx.

funding organizations (whether from the government, such as the National Institute on Alcohol Abuse and Alcoholism, or from the philanthropic sector, such as the Robert Wood Johnson Foundation) need to provide funding so that academic researchers in think-tanks, public policy, and similar nonprofit organizations can continue to conduct such studies.[196]

Second, the capacity of the public health community to track and analyze data at a granular level is low. There is a need for trained state epidemiologists with an understanding of substance use in order to analyze local and state data to examine the relation between these data and alcohol-related harms. Although the number of state epidemiologists in the country increased by 22 percent from 2013 to 2017, less than 5 percent work in substance abuse or mental health areas.[197] As of 2017, there were 59 such individuals working in the substance abuse field, out of 3,370 total state epidemiologists in the country.[198] Only five were alcohol epidemiologists.[199] These five individuals work in Colorado, Minnesota, Michigan, New Mexico, and Utah.[200] The Council of State and Territorial Epidemiologists (CSTE) calculated that only 48 percent of the substance abuse epidemiology demand was being met, and that there needs to be a 109 percent increase in the number of epidemiologists to meet 100 percent of this need in our country.[201] The CSTE also reported that the greatest challenge to state health departments in training, hiring, and retaining epidemiologists is funding.[202] Specifically, "more than three quarters of health department epidemiology funds were provided by the federal government . . . [and] heavy reliance on federal funds reduces flexibility, adds to insecurity in the workplace, and may affect the ability to cover core functions."[203]

Third, it is not enough for only the researchers and advocates in the public health community to understand the importance of alcohol regulations in protecting society from the harms of excessive alcohol consumption. It is equally important

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[196] *See Why Alcohol-Use Research is More Important than Ever*, NIH MEDLINEPLUS MAG., https://magazine.medlineplus.gov/article/why-alcohol-use-research-is-more-important-than-ever#:~:text=Recent.
[197] *See 2017 Epidemiology Capacity Assessment Report*, COUNCIL OF STATE & TERRITORIAL EPIDEMIOLOGISTS (Jul. 2018), https://cdn.ymaws.com/www.cste.org/resource/resmgr/eca/2017_ECA_Report_Web__5_.pdf.
[198] *See id.* at 29.
[199] *See id.* at 5.
[200] *Utah is Taking a Closer Look at How and What People Drink When it Comes to Alcohol,* DESERET NEWS (Jan. 27, 2018).
[201] *See* COUNCIL OF STATE & TERRITORIAL EPIDEMIOLOGISTS, s*upra* note 197 at 29.
[202] *See id.* at 6.
[203] *Id.*

that lawyers arguing on behalf of laws that regulate alcohol understand the history of these laws and why they are important from a public health perspective. For example, state Attorneys General (AGs) should be able to articulate this information to the courts in a passionate and meaningful way. The state AGs should also understand the role of the research and researchers and should be connected to and take advantage of these individuals in their State.

B. Track

For epidemiologists and researchers to conduct the abovementioned studies, state and local jurisdictions need to do a better job of tracking alcohol-related administrative and enforcement data. For example, a list of holders of alcohol licenses and the type of licenses held in each jurisdiction is needed. It is important that this list is current, complete, and publicly available so that it can be studied. For example, Montgomery County, Maryland tracks county-level data, including alcohol licenses, licensees' violation histories, alcohol-related crash data, alcohol-related death data, and violent crime, among other things.[204] This database currently includes several years of data and is available to anyone online.[205] This is a huge asset to the county because this data can help map the connections between alcohol licenses, outlet locations, and health and safety outcomes.

C. Test

As mentioned above, researchers must continue to study the efficacy of different alcohol laws. In the past, these studies examined both the impact of individual laws at a state- and national-level and the overall alcohol policy landscape in any given state. For example, Fell et al., using a pre-post design,[206] found that the enactment of under age 21 drinking laws (e.g., laws prohibiting youth possession or purchase or requiring underage individuals to lose their license if found drinking) reduced the number of underage drinking-and-driving fatal crashes across the U.S.[207] Holder & Wagenaar concluded that Oregon's statewide mandated training for alcohol servers significantly reduced single-vehicle nighttime alcohol-related

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[204] *See openMontgomery: Montgomery County Maryland's Digital Government Strategy*, Montgomery County Government, https://montgomerycountymd.gov/open. (last visited: Apr. 11, 2022).
[205] *See id.*
[206] In this study, the pre-post design means that the researchers collected data both before and after a law was enacted to see the specific effects of that law.
[207] *See* James C. Fell, et al., *The Impact of Underage Drinking Laws on Alcohol-Related Fatal Crashes of Young Drivers*, 33 ALCOHOLISM CLINICAL & EXPERIMENTAL RSCH. 1208 (2009).

traffic crashes.[208] Additionally, Naimi et al. developed an Alcohol Policy Scale (APS) to "measure the aggregate state-level alcohol policy environment in the U.S." and found that the states with higher APS scores, reflecting stronger policy environments, correlated with less adult binge drinking,[209] fewer alcohol-related crash fatalities,[210] and lower cancer mortality rates.[211] These studies are critical for those defending these laws, and states and other entities should partner with researchers to continue conducting this research.

The Supreme Court, however, has indicated that research on the effectiveness of a law generally, and the effectiveness of an alcohol regulation specifically, is insufficient.[212] It is no longer sufficient to cite to research from a different jurisdiction that has different laws, demographics, and customs.[213] Instead, there is a need for specific research and evaluations of individual state and local laws. Although it is unrealistic to argue that states can evaluate the effectiveness of every law within a given time period after enactment, it is both necessary and feasible for states to conduct routine assessments of their state legal framework. In particular, states should understand the impact of their laws on the public health and the burdens on law enforcement.

An example of this occurred in 2018 when the Maryland General Assembly established The Task Force to Study State Alcohol Regulation, Enforcement, Safety, and Public Health.[214] The mission of the Task Force was to examine which state agency should regulate the state alcoholic beverages industry and enforce state alcoholic beverages law by examining existing state and local alcohol laws to determine how these laws compare to other states, the enforcement of these laws, and the public health impact of alcohol in Maryland.[215] The Task Force included legislators, alcohol industry representatives, law enforcement representatives, and

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[208] *See* Harold D. Holder & Alexander C. Wagenaar, *Mandated Server Training and Reduced Alcohol-Involved Traffic Crashes: A Time Series Analysis of the Oregon Experience*, 26 ACCIDENT ANALYSIS & PREVENTION 89 (1994).
[209] *See* Timothy S. Naimi, et al., *A New Scale of the U.S. Alcohol Policy Environment and its Relationship to Binge Drinking,* 46 AM. J. PREVENTIVE MED. 10 (2014).
[210] *See* Timothy S. Naimi, et al., *Association of State Alcohol Policies with Alcohol-Related Motor Vehicle Crash Fatalities Among U.S. Adults*, 178 JAMA INTERNAL MED. 894 (2018).
[211] *See* Maha Alattas, et al., *Alcohol Policies and Alcohol-Attributable Cancer Mortality in U.S. States*, 5 CHEMICO-BIOLOGICAL INTERACTIONS 315 (2020).
[212] *See Lorillard Tobacco Company v. Reilly*, 533 U.S. 525, 600 (2001) (discussing that Massachusetts erred using a restriction on tobacco and alcohol signage based on the use of the same restriction elsewhere as "a particular regulatory scheme tends to be case specific").
[213] *See generally id.*
[214] *See* H.B. 1316, Md. Gen. Assembly (2018) (enacted).
[215] *Id.*

health care professionals.[216] The Maryland General Assembly required the Task Force to produce several recommendations to improve alcohol regulation and enforcement in the State by 2019.[217]

D. Translate

The final step in protecting existing alcohol-related laws is for the public health community to translate its findings in order to connect with policymakers and drive decision-making.[218] This requires researchers and academics to create short, oral or written, talking points. By translating the data and the research into a format that politicians and community health advocates can easily understand, the political will to continue enacting and defending alcohol-related laws and regulations will be generated.

Part of translation includes the development of tools to make the research and data more accessible. The Vermont state government worked with a local epidemiologist to develop projectRABIT, an "interactive dashboard to assist the [Vermont Department of Liquor Control] visualize, interpret, and drive decision making based on data sources with relationships to alcohol and tobacco use, criminal and civil violations, and compliance programs throughout Vermont."[219] For example, the dashboard provided a map of licensed alcohol outlets and showed which outlets had been cited for violations and were located near criminal activity.[220] Once created, the Vermont Director of Compliance and Enforcement used this dashboard to understand where the greatest needs in the state were and deploy resources more effectively.[221] Additionally, when challenges to alcohol licenses come before the Vermont Division of Liquor Control, division officials can easily access data on public health and safety concerns regarding those outlets and support its decision should it need to revoke a license.

CONCLUSION

As the country moves toward a post-*TWSRA v. Thomas* world, it will be important for state agencies and departments and the public health community to come together to generate, track, analyze, and transmit the data needed to support

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[216] *See* H.B. 1316 §1(b), Md. Gen. Assembly (2018) (enacted).
[217] *Id.*
[218] *See* NIH MEDLINEPLUS MAG., *supra* note 196.
[219] *See Compliance & Enforcement*, Div. of Liquor Control, https://liquorcontrol.vermont.gov/enforcement (last visited: Apr. 11, 2022).
[220] *Id.*
[221] *Id.*

important alcohol-related laws. The Vermont tool is just one example of what a state can do with data.[222] Ultimately, it comes back to having the resources allocated—in this case, to the state public health department and the alcohol enforcement division—to fund these types of initiatives.[223] Moving forward, if the data is insufficient, the infrastructure does not allow states to prove that challenged alcohol-related laws are evidence-based, and state Attorney Generals cannot access and supply courts with evidence, the courts may continue to overturn laws that effectively regulate alcohol sales and protect public health, which would be to everyone's detriment.

Although the major issue in enacting and upholding alcohol laws has been lawsuits initiated by the alcohol industry, the current pandemic has brought with it unique challenges. To help struggling restaurants and bars, policymakers in several states have either temporarily or permanently relaxed evidence-based laws that previously restricted alcohol access and availability.[224] Although their goal is admirable, these policymakers often overlook, or worse, ignore, the potential public health harms that may result from their actions. Therefore, the public health community needs to work together to track these new alcohol laws, test the impacts of these laws on alcohol consumption and alcohol-related harms, and translate any scientific findings into layperson materials. By doing so, it will provide policymakers with the necessary data to argue against relaxing alcohol restrictions.

[222] *Id.*
[223] *Id.*
[224] *See* Davis, *supra* note 24.

APPENDIX

Table 1. States Allowing Breweries to Ship Beer Directly to Consumers in 1999, 2009, and 2019*

States	*1999*	*2009*	*2019*
Alabama	--	--	--
Alaska	X	X	X
Arizona	--	--	--
Arkansas	--	--	--
California	--	--	--
Colorado	--	--	--
Connecticut	--	--	--
Delaware	--	--	--
District of Columbia	X	X	X
Florida	--	--	--
Georgia	--	--	--
Hawaii	--	--	--
Idaho	--	--	--
Illinois	--	--	--
Indiana	--	--	--
Iowa	--	--	--
Kansas	--	--	--
Kentucky	--	--	--
Louisiana	--	--	--
Maine	--	--	--
Maryland	--	--	--
Massachusetts	--	--	--
Michigan	--	--	--
Minnesota	--	--	--
Mississippi	--	--	--
Missouri	--	--	--
Montana	--	--	--
Nebraska	X	X	X
Nevada	X	X	X
New Hampshire	--	X	X
New Jersey	--	--	--
New Mexico	--	--	--
New York	--	--	--
North Carolina	--	--	--
North Dakota	X	X	X
Ohio	--	--	X
Oklahoma	--	--	--
Oregon	--	--	X
Pennsylvania	--	--	--

* A legal search of LexisNexis was used to calculate the 1999 data on DTC shipping of beer and distilled spirits. The 2009 and 2019 data were obtained from the Substance Abuse & Mental Health Services Administration's annual Report to Congress on the Prevention and Reduction of Underage Drinking. *See supra* note 180.

States	*1999*	*2009*	*2019*
Rhode Island	--	--	--
South Carolina	--	--	--
South Dakota	--	--	--
Tennessee	--	--	--
Texas	--	--	--
Utah	--	--	--
Virginia	--	X	X
Vermont	--	--	X
Washington	--	--	--
West Virginia	--	--	--
Wisconsin	--	--	--
Wyoming	--	--	--
TOTAL:	*5*	*7*	*10*

Table 2. States Allowing Wineries to Ship Wine Directly to Consumers in 1999, 2009, and 2019*

States	*1999*	*2009*	*2019*
Alabama	X	--	--
Alaska	X	X	X
Arizona	--	X	X
Arkansas	--	--	X
California	X	X	X
Colorado	X	X	X
Connecticut	X	X	X
Delaware	--	--	--
District of Columbia	X	X	X
Florida	X	--	--
Georgia	--	X	X
Hawaii	X	X	X
Idaho	X	X	X
Illinois	X	X	X
Indiana	--	X	X
Iowa	X	X	X
Kansas	--	--	X
Kentucky	--	X	X
Louisiana	X	X	X
Maine	--	--	X
Maryland	--	--	X
Massachusetts	X	X	X
Michigan	X	X	X
Minnesota	X	X	X
Mississippi	--	--	--
Missouri	X	X	X
Montana	--	X	X
Nebraska	X	X	X
Nevada	X	X	X
New Hampshire	X	X	X
New Jersey	X	--	X
New Mexico	X	X	X
New York	--	X	X
North Carolina	--	X	X
North Dakota	--	X	X
Ohio	X	X	X
Oklahoma	X	--	X
Oregon	X	X	X
Pennsylvania	X	--	X
Rhode Island	X	--	--

* The 1999 data on DTC shipping of wine come from Vijay Shankar, Note, Alcohol Direct Shipment Laws, the Commerce Clause, and the Twenty-first Amendment, 85 Va.L.Rev. 353, 356-57, n.20, 22, 24 (1999). *See supra* note 178. The 2009 and 2019 data were obtained from the Substance Abuse & Mental Health Services Administration's annual Report to Congress on the Prevention and Reduction of Underage Drinking. *See supra* note 180.

States	*1999*	*2009*	*2019*
South Carolina	X	X	X
South Dakota	--	--	X
Tennessee	--	--	X
Texas	--	X	X
Utah	--	--	--
Virginia	--	X	X
Vermont	X	X	X
Washington	X	X	X
West Virginia	X	X	X
Wisconsin	X	X	X
Wyoming	X	X	X
TOTAL:	*32*	*36*	*45*

Table 3. States Allowing Distilleries to Ship Distilled Spirits Directly to Consumers in 1999, 2009, and 2019*

States	*1999*	*2009*	*2019*
Alabama	--	--	--
Alaska	X	X	X
Arizona	--	--	X
Arkansas	--	--	--
California	--	--	--
Colorado	--	--	--
Connecticut	--	--	--
Delaware	--	--	--
District of Columbia	X	X	X
Florida	--	--	--
Georgia	--	--	--
Hawaii	--	--	--
Idaho	--	--	--
Illinois	--	--	--
Indiana	--	--	--
Iowa	--	--	--
Kansas	--	--	--
Kentucky	--	--	X
Louisiana	--	--	--
Maine	--	--	--
Maryland	--	--	--
Massachusetts	--	--	--
Michigan	--	--	--
Minnesota	--	--	--
Mississippi	--	--	--
Missouri	--	--	--
Montana	--	--	--
Nebraska	X	X	X
Nevada	X	X	X
New Hampshire	--	X	X
New Jersey	--	--	--
New Mexico	--	--	--
New York	--	--	--
North Carolina	--	--	--
North Dakota	X	X	X
Ohio	--	--	--
Oklahoma	--	--	--
Oregon	--	--	--
Pennsylvania	--	--	--
Rhode Island	--	--	--
South Carolina	--	--	--

* A legal search of LexisNexis was used to calculate the 1999 data on DTC shipping of beer and distilled spirits. The 2009 and 2019 data were obtained from the Substance Abuse & Mental Health Services Administration's annual Report to Congress on the Prevention and Reduction of Underage Drinking. *See supra* note 180.

States	*1999*	*2009*	*2019*
South Dakota	--	--	--
Tennessee	--	--	--
Texas	--	--	--
Utah	--	--	--
Virginia	--	--	--
Vermont	--	--	--
Washington	--	--	X
West Virginia	--	--	--
Wisconsin	--	--	--
Wyoming	--	--	--
TOTAL:	*5*	*6*	*9*

STORMS IN SUNNY STATES: FRAUD IN THE ADDICTION TREATMENT INDUSTRY

*Rachel A. Rein**

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INTRODUCTION

When 23-year-old John Baker moved into his new sober home in sunny West Palm Beach, Florida, his parents had high hopes for a bright future.[1] For six years, John had struggled with a crippling heroin addiction.[2] Now, sober living coupled with outpatient treatment seemed to offer accountability and help.[3] John's new treatment center promised to help clients like John find self-awareness and provide guidance on the path to long-term recovery.[4] With multiple treatment providers lending support, neither John nor his parents could have imagined the dark fate awaiting him.[5] Tragically, these days of treatment and drug tests would be his last.[6]

John seemed to do well for six months.[7] His drug tests during that time were all negative.[8] He made friends at his sober house.[9] He met with counselors about his recovery.[10] However, unknown to John's sober house or treatment center, he had relapsed on steroids.[11] When John's sober house managers eventually realized John had relapsed, they evicted him.[12] Three days later, John's body was discovered in a parking lot.[13] He had fatally overdosed on heroin.[14]

John fell victim not only to his addiction, but also to one of the many schemes plaguing the drug treatment and recovery industry: overutilization of urine testing.[15] First, although John's preferred drug was heroin, both his sober home and outpatient treatment center tested for "everything you could possibly buy at a

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[1] *See* David Segal, *In Pursuit of Liquid Gold*, N.Y. TIMES (Dec. 27, 2017), https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html.
[2] *See id.*
[3] *See id.*
[4] *See A New Start Inc.*, FREE REHAB CTRS., https://www.freerehabcenters.org/details/a-new-start-inc (last visited Dec. 20, 2021).
[5] *See* Segal, *supra* note 1.
[6] *See id.*
[7] *See id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Segal, *supra* note 1.
[12] *Id.* When patients relapse, sober living places can direct resident to a "higher level of care," like a residential treatment center or detox center to help them get their recoveries back on track. If they have the resources, sober living houses can also give residents second chances, creating relapse prevention plans and recovery contracts with relapsing clients where clients agree to take more steps toward their recovery or submit to enhanced accountability protocols, like earlier curfews or more required weekly twelve-step meetings.
[13] *Id.*
[14] *Id.*
[15] *See id.*

Walgreens, everything you could possibly get from a psychiatrist and a number of drugs that haven't been seen in years," according to an independent lab owner who examined John's drug testing bills after John's death.[16] Next, John's treatment center and sober house ignored evidence-based standards on how often to test and tested John far too frequently.[17] John had "passed" all his drug tests for half a year, so such frequent testing was not medically warranted.[18] To add insult to injury, after John's death, his parents were left with a $260,000 bill for the drug testing that their private insurance largely failed to cover.[19]

John is far from alone. In the wake of the opioid crisis, millions of people abuse drugs each year.[20] In fact, substance abuse costs the United States over $600 billion annually.[21] Because treatment can reduce the societal costs of addiction, drug treatment is a booming industry.[22] According to federal health and census data, addiction treatment was expected to be a nearly $50 billion industry in 2020, with almost 15,000 substance treatment facilities across the country.[23] With its rapid proliferation, the recovery industry operates with various levels of formality, regulation, and accreditation. But what happens when the treatment that is intended

[16] *See* Segal, *supra* note 1.
[17] John's parents received bills for "dozens" of urine tests from *both* John's outpatient providers and sober house after John was in treatment for just a few months. It is thus likely John was tested at least once a week (and probably much more) after his first few weeks of treatment—too often for a stabilized patient. In fact, a conservative estimate based on a calculation of John's estimated number of received tests compared to medical collection standards indicates John received at least approximately 40 more drug tests than he should have received in that period. *Id*.; *see* Robert F. Forman & Paul D. Nagy, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, U.S. DEP'T HEALTH & HUM. SERVS., 237–38 (2006) ("Collection should occur not less than once a week or more frequently than every 3 days in the first weeks of treatment. . . . Once clients are stabilized in treatment, they require less intensive monitoring of abstinence.").
[18] *See* Segal, *supra* note 1.
[19] *See id*. (noting that John's parents' insurance company, Blue Cross Blue Shield of Northeastern Pennsylvania, only covered a "small fraction" of the bill).
[20] *See Use of Selected Substances*, CDC, https://www.cdc.gov/nchs/data/hus/2019/020-508.pdf (2019).
[21] National Institute on Drug Abuse, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 11 (3rd ed, 2018).
[22] *See id.* at 11 (noting that addiction treatment can help reduce the costs of substance abuse in the nation).
[23] *See* John LaRosa*, $42 Billion U.S. Addiction Rehab Industry Poised for Growth, and Challenges*, MARKET RESEARCH BLOG, (Feb. 5, 2020) https://blog.marketresearch.com/42-billion-u.s.-addiction-rehab-industry-poised-for-growth-and-challenges. *See generally* Katrice B. Copeland, *Liquid Gold*, 97 WASH. U. L. REV. 1451, 1451 (2020); *Opioid Crisis Statistics*, HHS, https://www.hhs.gov/opioids/about-the-epidemic/opioid-crisis-statistics/index.html (last visited Dec. 20, 2021).

to help vulnerable patients and reduce societal costs ends up harming patients and costing the government millions, if not billions, of dollars?[24]

This article studies health care fraud in the drug and alcohol treatment industry:[25] what it is, how it happens, and how to stop it. The general problem that this article identifies is that the drug recovery industry is still victim to high levels of health care fraud despite recent efforts to fight fraud. As a result, vulnerable patients suffer in subpar treatment centers. The specific problems this article identifies are as follows. First, one key federal statute targeting health care fraud in the addiction industry, the Eliminating Kickbacks in Recovery Act (EKRA), is unclear and provides inadequate penalties.[26] Second, regulatory guidance for EKRA is nonexistent. Third, inconsistent accreditation and licensing standards pave the way for fraudulent providers to fly under the radar. The unique contribution of this paper is that it looks beyond fraud in residential treatment and also responds to schemes in outpatient and community care, intensive outpatient, and partial hospitalization programs.

This article argues that the solution to high health care fraud rates in the recovery industry is a combined approach. Congress should either amend EKRA or the Department of Justice (DOJ) should issue regulations or guidance to clarify EKRA, local investigators should coordinate with opioid strike forces, and Congress should pass new legislation. Part I studies the provision and financing of health care in the recovery industry, common health care fraud schemes in the industry, and the victims and impact of such schemes. Next, Part II assesses the investigation, prosecution, and enforcement of health care fraud in the recovery industry. This section initially identifies the statutes implicated in drug recovery health care fraud, and then identifies the regulators and other actors charged with investigating health care fraud in the recovery industry. This part will then offer examples of recent prosecutions and penalties, along with prevention and enforcement goals and challenges to investigation, prosecution, and enforcement. Finally, Part III reveals strategies for the future. The best chance to combat fraud in the recovery industry is to combine a cooperative strategy between local investigators and specialized forces with enhanced penalties in enforcement, regulatory guidance, and revised and new legislation. Given our country's worsening addiction problem amid the

[24] *See Principles of Drug Addiction Treatment*, *supra* note 21.
[25] Note that this article uses "drug treatment," "treatment," and "recovery" interchangeably. Alcohol is considered a drug in "drug treatment" and not excluded from discussion.
[26] *See* discussion *infra* II.A.

COVID-19 pandemic,[27] it is critical that those undergoing drug treatment receive quality care.[28]

I. BACKGROUND ON HEALTH CARE FRAUD IN THE DRUG TREATMENT INDUSTRY

Understanding the addiction treatment industry itself is key to understanding the health care fraud that permeates it. This section initially examines who provides and pays for health care in addiction treatment. Next, it describes common fraud schemes in the industry and their effect on those in treatment and on society as a whole.

A. The Provision and Financing of Health Care in the Recovery Industry

Florida alone harbors almost 3,000 sober houses, as well as countless detoxes, 28-day rehabs, and intensive outpatient programs, according to the president of the Florida Association of Recovery Residences.[29] California is home to more than 2,000 inpatient drug treatment facilities.[30] This section identifies who provides and finances health care in the addiction treatment industry in these states and beyond.

1. Provision

Health care in the recovery industry may be provided by a combination of inpatient, outpatient, and community care.[31] Sometimes treatment includes multiple steps, called a "continuum of care."[32] Hospitals, detoxes, and residential drug treatment

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[27] *See generally COVID-19 & Substance Use*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drug-topics/comorbidity/covid-19-substance-use. The plight of addicted patients who suffer some of the effects of health care fraud in the recovery industry, is exacerbated by the current COVID-19 pandemic, which has led to increased substance abuse across the nation, poorer health outcomes for addicted COVID patients, and more overdoses.

[28] This article topic is also personal. The author herself is approximately four years sober, entering recovery before attending law school. She first witnessed health care fraud in the recovery industry as a patient. Now, she has seen many law school classmates struggle with drug addiction and alcoholism. She hopes this article can contribute to their experiences with recovery being journeys of hope and progress unmarred by fraud.

[29] Cat Ferguson, *Pee Scams, Kickbacks, and Overdoses Plague South Florida Rehabs*, BUZZFEED NEWS (Sept. 15, 2015), https://www.buzzfeednews.com/article/catferguson/the-rehab-scam.

[30] Anuradha Rao-Patel et al., *Fraud's Newest Hot Spot: The Opioid Epidemic and the Corresponding Rise of Unethical Addiction Treatment Providers*, HEALTH AFFS. BLOG (Apr. 26, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20180423.449595/full/.

[31] *See Your Foundation for Lifelong Recovery*, HAZELDEN BETTY FORD FOUND., https://www.hazeldenbettyford.org/treatment.

[32] *See id.*

centers (also known as "rehabs") provide one option for treatment: inpatient care.[33] These centers provide services to patients who live, eat, and sleep where they receive treatment.[34] When patients stabilize, partial hospitalization, intensive outpatient, and outpatient centers offer programs where patients live elsewhere and travel to treatment for several hours each day or week.[35] After patients return to their own homes, community care options like 12-step Alcoholics and Narcotics Anonymous meetings lend support.[36] For patients who cannot live in their own homes, sober houses provide a healthy home base.[37] These homes occupy a liminal space in the recovery industry because, most of the time, they provide no treatment.[38] Instead, residents must travel to separate outpatient treatment centers.[39] The exceptions are that some sober houses provide a form of health care services by drug testing residents, and some sober houses provide therapy and medical care because they are owned and operated by treatment centers.[40]

Accreditation standards and requirements widely vary depending on the provider and the state in which the patient receives treatment.[41] Different states have different licensing requirements for the centers themselves and who can work in them.[42] This article cannot cover standards in all fifty states so it will focus on Florida and California, which have the highest concentration of drug treatment recovery providers in the nation.[43]

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[33] *What Are the Treatments for Alcohol Use Disorder?*, WEBMD, https://www.webmd.com/mental-health/addiction/alcohol-use-disorder-treatments#2 (last visited Dec. 21, 2021).
[34] *Id.*
[35] *See id.*
[36] *See, e.g.*, *Community Care & Addiction Recovery Services*, CCARS (2020), https://communityaddictionrecovery.com/.
[37] *See* Kaitlyn Motley, *Sober Living Homes—Halfway There: Everything You Need to Know*, AM. ADDICT. CTRS. (Oct. 8, 2020), https://drugabuse.com/blog/sober-living-homes/.
[38] *See What Are Sober Living Homes?*, THARROS HOUSE (Apr. 16, 2018), https://tharroshouse.com/what-are-sober-living-homes/.
[39] *See id.*
[40] *See, e.g., Your Foundation for Lifelong Recovery, supra* note 31. For example, Hazelden (part of the Betty Ford Foundation) operated a sober living house in Chicago in which therapists provided outpatient services to residents. A doctor also regularly provided medical care to residents in the house.
[41] *See* Brian Mann, *As Addiction Deaths Surge, Profit-Driven Rehab Industry Faces 'Severe Ethical Crisis'*, NPR (Feb. 15, 2021), https://www.npr.org/2021/02/15/963700736/as-addiction-deaths-surge-profit-driven-rehab-industry-faces-severe-ethical-cris.
[42] *See id.*
[43] *See generally* German Lopez, *She Wanted Addiction Treatment. She Ended Up in the Relapse Capital of America*, VOX (Mar. 2, 2020), https://www.vox.com/policy-and-politics/2020/3/2/21156327/florida-shuffle-drug-rehab-addiction-treatment-bri-jaynes; *see also*

Regarding accreditation standards, there is no federal definition of a "sober" home and no federal licensing or accreditation requirements specific to sober homes.[44] The Americans with Disabilities Act (ADA) and Fair Housing Act (FHA) have been implicated in the management of sober homes but do not provide specific requirements for such facilities.[45] Health care attorney Lillie Werner Singh, a consulting attorney for the Behavioral Health Association of Providers, explains that, because people in recovery are disabled under federal law, the ADA and FHA have been successfully used to circumvent laws requiring things like expensive fire code compliance and a doctor's presence on the premises 24 hours a day.[46] Strict rules and regulations, like mandating doctors on sober house premises, are often held invalid as applied under the ADA or FHA because they prevent people in recovery, a class of protected individuals, from getting the housing they need to care for their disability—their addictions.[47]

Some states regulate sober homes on the state level, though these regulations have also been subject to litigation.[48] In Florida, sober houses may obtain voluntary certification through a state-established program.[49] While certification is not mandatory, the law prohibits licensed treatment centers from referring patients to

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Office of Public Affairs, *Justice Department Announces Series of Cases to Combat Addiction Treatment Kickback Schemes in Southern California*, U.S. DEP'T OF JUST. (Dec. 16, 2021) https://www.justice.gov/opa/pr/justice-department-announces-series-cases-combat-addiction-treatment-kickback-schemes. (The U.S. Attorney for the Central District of California, Tracy L. Wilkison, said, "Driven by greed, dishonest operators of substance abuse treatment centers have invaded Southern California[.]"). Fraud in the treatment industry in Florida is so common that there is a term for it: "the Florida Shuffle." The Florida Shuffle is when patients bounce from treatment provided to treatment provider, lured by patient brokers. *See* discussion *infra* Section I.B.

[44] *See* Lee Weber, *Sober Living Options in Texas*, ADDICT. BLOG (Apr. 13, 2019), https://addictionblog.org/texas/treatment/sober-living-houses (indicating the only two federal laws surrounding sober living houses are the ADA and FHA). Neither the ADA nor FHA provide meaningful guidance for how sober houses should operate to decrease the prevalence of fraud. In fact, the rest of this paragraph shows how sober houses use both federal laws to instead escape regulation.

[45] *See* Lillie W. Singh, *Federal Law and State Sober Living Regulations Intersect*, BEHAV. HEALTHCARE EXEC. (June 19, 2018), https://www.hmpgloballearningnetwork.com/site/behavioral/article/policy/federal-law-and-state-sober-living-regulations-intersect.

[46] *Id.*

[47] *Id.*

[48] *Id.*

[49] Patricia Liverpool, *Regulating Sober Living Homes*, REGUL. REV. (Aug. 20, 2018), https://www.theregreview.org/2018/08/20/liverpool-regulating-sober-living-homes/.

sober houses that are not certified.[50] In California, the state licenses residential facilities and registers sober living houses through the California Association for Addiction and Recovery Resources.[51]

Some nonprofits offer optional accreditation and sober home standards. For example, the National Association of Recovery Residences (NARR), a nonprofit, defines a "recovery home" as a "sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems."[52] The state-level groups California Consortium of Addiction Programs and Professionals and the Florida Association of Recovery Residences are both associated with NARR.[53]

For non-medical drug abuse treatment facilities in California, the California Department of Health Care Services handles licensing and certification.[54] Within this department, the Substance Use Disorder Compliance Division Licensing and Certification Branch is responsible for ensuring the provision of quality services by licensing, certifying, regulating, and overseeing a statewide system of drug recovery treatment centers, programs, and counselors.[55] In recent years, Florida has tightened its regulation of rehabilitation programs.[56] For example, recently-enacted legislation strengthens requirements for clinical supervisors and peer specialists in Florida treatment centers.[57] The new law also mandates background checks for treatment center employees.[58] Thus, the provision of drug treatment varies widely by provider and by state.

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[50] *See id. Id.*; *HB 369 – Latest Florida Addiction Treatment Law*, FLA. HEALTHCARE L. BLOG (July 1, 2019), https://www.floridahealthcarelawfirm.com/florida-law-addiction-treatment-hb369/ (describing how Florida's, H.B. 369, enacted into law in 2019, now allows Florida sober houses to discharge a resident when doing so is necessary for the resident's welfare).
[51] *A Primer on Recovery Residences: Frequently Asked Questions*, NAT. ASS'N RECOVERY RESIDENCES, (Sept. 20 2012), https://www.opioidlibrary.org/wp-content/uploads/2019/07/Primer-on-Recovery-Residences-09-20-2012a.pdf.
[52] *See id.* at 5.
[53] *Id.*
[54] *DHCS Licensed Residential Facilities and/or Certified Alcohol and Drug Programs*, CAL. HEALTH & HUM. SERVS. (last updated Dec. 8, 2021), https://data.world/chhs/ca-licensed-residential-facili
[55] *Id.*
[56] Mann, *supra* note 41.
[57] *HB 369 – Latest Florida Addiction Treatment Law*, *supra* note 50.
[58] *Id.*

2. Financing

Providers in the recovery industry receive funding from multiple streams, including public insurance, private insurance, private investors, federal grants, and general federal and state funds.[59] For example, public substance abuse treatment programs traditionally relied on federal substance abuse block grants, Medicaid reimbursement, and state general funds.[60] But now, federal and state funding for substance abuse treatment in the "context of other services like job training, child protective services, or criminal justice" offers additional funding sources.[61]

Public and private insurance both play a large role in funding treatment centers.[62] Two federal acts, The Mental Health Parity and Addiction Equity Act and the Affordable Care Act, expanded coverage for substance use disorders under both kinds of insurance.[63] This expanded coverage has resulted in most patients paying for substance treatment with insurance instead of direct payment.[64] Private insurers that participate in the Affordable Care Act's online health care exchange must provide substance use treatment.[65] Such treatment is considered an essential

[59] This section focuses on a non-exhaustive selection of funding sources. Patients or parents of the patients themselves are also on the hook for "private pay," in which treatment centers do not accept private or public insurance. However, private pay represents only a small fraction of treatment center funding today—the majority of patients pay through insurance. Additionally, patients or their loved ones are often responsible for whatever their insurance does not cover. Finally, some patients receive scholarships by which they can attend treatment for free due to contributions from private donors, religious organizations, or the treatment center itself.
[60] *See* Substance Abuse and Mental Health Services Administration, *Integrating Substance Abuse Treatment and Vocational Services,* 38 TREATMENT IMPROVEMENT PROTOCOL (TIP) SERIES 101 (2000).
[61] *See id*. The Department of Housing and Development (HUD)'s Recovery Housing Program also offers federal funding to state agencies for sober houses for homeless patients. *RHP FAQs*, U.S. DEP'T OF HOUS. & URB. DEV. EXCHANGE, https://www.hudexchange.info/rhp/faqs/ (last visited Dec. 19, 2021); *Recovery Housing Program*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/comm_planning/rhp (last visited Dec. 14, 2021). The program allows states and the District of Columbia to provide transitional housing for individuals in recovery for no more than two years or until the person gets permanent housing. Programs funded by HUD as part of the Recovery Housing Program must, where appropriate, obtain local, state, or national accreditation. Critically, grantees do not need prior experience administering recovery programs. HUD encourages but does not appear to require grantees to establish partnerships with people and agencies knowledgeable of the recovery industry.
[62] Copeland, *supra* note 23, at 1471.
[63] *Id.* at 1469–70.
[64] *Id.* at 1471.
[65] *Id.* at 1470–71. Under the Affordable Care Act, there is one federally-run online health care exchange, HealthCare.gov, in which people shop for mandated individual insurance. As of the 2022 coverage year, 17 states and the District of Columbia run their own online exchanges. Louise

benefit, along with mental health treatment and emergency services.[66] For states that chose not to expand Medicaid, limited services are reimbursable for addicted patients.[67] For instance, only physician services and inpatient services, including medically necessary inpatient detoxification, are covered for addicted patients.[68] The impact is that, in many states, there is no Medicaid coverage for residential drug treatment at all.[69]

Medicare, on the other hand, covers residential centers, outpatient and partial hospitalization programs, and some services that patients receive while already in treatment.[70] There is no distinct Medicare benefit category for substance abuse treatment.[71] Despite the lack of a specific category, when services for substance abuse treatment are "reasonable and necessary" Medicare covers them.[72] For example, the Centers for Medicare and Medicaid Services (CMS) offers a "full range of services," including ones for substance abuse disorders.[73] For outpatient services, coverage and payment are on a service-by-service basis.[74] For instance, Medicare might pay for counseling by an enrolled licensed clinical social worker, psychologist, or psychiatrist.[75] Moreover, CMS recently finalized the expansion of Medicare coverage to cover opioid treatment programs delivering medication-assisted treatment.[76]

Private investors also own sober homes and treatment facilities.[77] Eric Cobourn, managing director for the health care mergers and acquisitions practice at a

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Norris, *Which States Run Their Own Health Insurance Exchanges?*, VERYWELL HEALTH (Nov. 18, 2021), https://www.verywellhealth.com/which-states-run-their-own-health-insurance-exchanges-5199217.

[66] 42 U.S.C. § 18022(b)(1)(E).

[67] Copeland, *supra* note 23, at 1472–73.

[68] *Id.* at 1472.

[69] *Id.*

[70] Centers for Medicare & Medicaid Services, *MLN Matters SE1606, Medicare Coverage of Substance Abuse Services* (2016), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf.

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] *Id.*

[76] *Drug Abuse Statistics*, NAT'L CTR. FOR DRUG ABUSE STAT., https://drugabusestatistics.org/ (last visited Dec. 20, 2021).

[77] Private owners can also get government grants. Olufisayo, *How to Finance a Sober Living Facility with Government Grants*, SECRETS OF ENTREPRENEURSHIP, https://www.entrepreneurshipsecret.com/sober-living-facility/ (Feb. 21, 2022) (stating that nonprofit sober houses are eligible for three types of government grant funding: contract for

financial consulting firm, notes that the recovery industry attracts private investors because of business opportunities.[78] Fragmented, old-school treatment facilities offer an opportunity for investors to consolidate, modernize, and make providers efficient.[79] Because of the actions of private investors, there has been a rise in "vertical integration." In vertically integrated companies, the same corporate family that owns a treatment center advertisement website or call center for prospective patients may also own the rehab itself, the drug-testing labs that the rehab sends its samples to, and the sober home to which the rehab discharges patients.[80]

Finally, different states have different funding streams. Narrowing in on Florida and California, Florida operates a health insurance exchange in which private insurers participate. However, Cigna, one of the country's largest private insurers, departed from Florida's exchange six years ago, blaming fraud, abuse, and out-of-network substance abuse clinics and labs.[81] In California, addicted patients who travel to the state for treatment can purchase out-of-state insurance through the Covered California program.[82] Once patients are covered, the Affordable Care Act requires the insurer to pay for addiction treatment.[83] So, in this situation, a combination of public and private actors finance drug treatment.

B. Common Health Care Fraud Schemes in the Recovery Industry

Health care fraud schemes in the recovery industry include billing for unnecessary or unprovided services, patient brokering, and providing and billing for services without required accreditation or licensing.[84] This article focuses on the former two sources of fraud.[85] This section will describe the schemes of overutilization and patient brokering, while section I.C will explore the impacts of these behaviors.

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services, government-guaranteed loans, and government grants. To get such funding, the sober house must be designated as a faith-based or community based halfway house).

[78] Teri Sforza, *Addiction Treatment: The New Gold Rush. 'It's Almost Chic*,' ORANGE COUNTY REG. (June 16, 2017), https://www.ocregister.com/2017/06/16/addiction-treatment-the-new-gold-rush-its-almost-chic/.

[79] *Id.*

[80] *Id.*

[81] Copeland, *supra* note 23, at 1481.

[82] *Id.* at 1472.

[83] *Id.*

[84] This section will describe the nature of such schemes. *See* discussion *infra* Section II.A for statutes implicated in such schemes.

[85] Providing services without necessary accreditation or licensing can occur among individual providers within a larger drug treatment facility. For example, a provider who is not licensed as a therapist or as a mental health or recovery counselor may fraudulently provide and bill for "therapy" at a drug treatment center. This scheme can also entail whole provider facilities

First, providers bill for unnecessary or unprovided services.[86] This scheme often occurs with drug testing.[87] Providers, like sober homes, bill private and public benefit programs for urine tests that are not medically warranted in order to maximize profit.[88] Recall that this is what happened to John. In John's case, however, his parents' private insurance did not cover all of the $260,000 worth of drug tests,[89] so John's parents were left to foot the rest of the bill.[90] These unwarranted tests can be too frequent—sometimes even twice per day—or for drugs that patients do not have a history of abusing.[91] Clinics and labs can charge more than $4,000 per test; as a result, shady providers have called urine "liquid gold."[92]

Addiction treatment centers in Florida and California, specifically, have billed insurance companies for millions of dollars' worth of counseling and treatment.[93] For example, one federal press release details how the medical director of a Florida drug treatment center ordered urine drug tests based on the kickbacks and bribes he received from different labs, instead of based on medical necessity.[94] Furthermore, when the director examined treatment center patients, he billed patients' insurance plans using procedure codes for longer and more complex examinations than those he performed.[95]

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operating without necessary accreditation or licensing in counties, cities, or states that require it. Operating without necessary accreditation does not always rise to the level of fraud. Sometimes it is only a regulatory violation. Discussing the details of when such provision rises to the level of fraud is outside the scope of this article.

[86] *See* Copeland, *supra* note 23, at 1477.

[87] *See id.*

[88] *See id.* at 1481.

[89] Segal, *supra* note 1.

[90] *Id.*

[91] Second Chances Sober Living in Austin, Texas, drug tests residents twice per day—once for alcohol and once for other drugs. *See* FORMAN & NAGY, *supra* note 17, at 237–38 (indicating how frequently people in recovery should receive drug tests); *see also* Copeland, *supra* note 23, at 1480 (noting some treatment centers test patients from two to four times per week).

[92] Segal, *supra* note 1 (stating that "George McNally the former owner of the defunct House of Principles, a sober home in West Palm Beach, described an anecdote he heard not long ago at an Alcoholics Anonymous meeting. 'A guy there, who works at a treatment center, was talking about how he had somehow messed up these five U.A.s," Mr. McNally recalled, using the shorthand for urinalysis tests. The man's boss had berated at him, Mr. McNally said: "Don't you know — this stuff is liquid gold?'")

[93] Copeland, *supra* note 23, at 1478.

[94] Press Release, *Doctor Sentenced in Multi-Million Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes and Alcohol and Drug Addiction Treatment Centers*, U.S. DEP'T OF JUST., U.S. ATT'YS OFF., S. DIST. OF FLA. (Nov. 9, 2017), https://www.justice.gov/usao-sdfl/pr/doctor-sentenced-multi-million-dollar-health-care-fraud-and-money-laundering-scheme.

[95] *Id.*

Is there a gatekeeper charged with preventing overutilization? Could it be a sober house manager, a lab employee, or a physician? Physicians ordering sober house drug tests often have no contact with residents and do not always actively verify medical need for urine tests.[96] And the sober house managers and employees responsible for administering drug tests often do not have medical degrees.[97] Thus, they are not subject to medical malpractice concerns from overutilization of drug testing, unlike physicians. As providers outside of the medical field, they are also unlikely to feel compelled to abide by medical professionals' ethical obligations. What about lab employees? The employees of the labs that conduct the drug testing often do not have information about individual patients in a sober house. Therefore, they are not well-positioned to decline to test these patients' urine. And if such employees are part of a vertically integrated treatment structure, where the same company owns the lab and the sober house, they may be intentional participants in the fraud.[98]

Instead, the insurance providers that reimburse for drug tests may be the best-positioned gatekeepers. These claims are expensive for insurers to compensate, so for-profit private insurers have a monetary motive to fight gratuitous compensation. However, citizens fund Medicare through taxes, and the federal government and the states fund Medicaid, so federal benefit programs may have weaker incentives to aggressively investigate the expensive drug testing claims they reimburse.

Next, with patient brokering schemes,[99] treatment centers pay kickbacks to third parties for bringing in patients.[100] The patient believes a responsible party is referring them, but the brokers and treatment centers involved only care about the

[96] *See* Kerry Nenn, *Drug Testing: How Urine Samples Turn into Big Business*, AM. ADDICTION CTRS. (Apr. 9, 2021), https://rehabs.com/blog/drug-testing-how-urine-samples-turn-into-big-business/ (noting that many physicians ordering drug tests often work with multiple sober houses or clinics). The more facilities a doctor works with, the less likely it is that the doctor is actively engaged with the treatment of all his or her individual patients.
[97] *See AmericaSober*, MISSION STATEMENT 10-13, https://americasober.com/AmericaSober_Online_Contract.pdf.
[98] *See, e.g.*, U.S. ATT'YS OFF., S. DIST. OF FLA., *supra* note 94 (indicating that defendant Mendez, an employee of vertically integrated structure, intentionally enabled fraudulent testing).
[99] These schemes are also called "body brokering" schemes. *See What is "Patient Brokering"?*, TURNING POINT TAMPA BLOG (Nov. 11, 2019), https://www.tpoftampa.com/what-is-patient-brokering.
[100] Jim Peake & Christian Morris, *Patient Brokering in the Addiction Treatment Industry*, ADDICTION-REP NEWS (Apr. 20, 2018), https://addiction-rep.com/blog/patient-brokering-in-the-addiction-treatment-industry/.

finances, not the patients.[101] Brokers first market on the internet, operating websites that advertise treatment centers.[102] They then manage call centers to connect unwitting prospective patients to treatment. Brokers sometimes offer money, cigarettes, and even luxury items to patients to persuade them to attend treatment centers that pay the brokers kickbacks.[103] Because of these marketing tactics, thousands of addicts flock to Florida from other states each year.[104]

Finally, fraudulent providers sometimes launder money in connection with their schemes.[105] These doctors provide addicted patients with large quantities of deadly opiates to profit off patients' addictions.[106]

C. Victims and Impacts

Health care fraud in the recovery industry harms patients, wastes federal resources, and negatively impacts the public. The most obvious victims are the patients themselves. When predatory sober homes keep patients in programs just to bill insurance, patients' drug addictions are often left untreated, risking patients' lives.[107] And, in the most egregious cases, providers offer drugs to patients,

[101] *Id*.; David Armstrong & Evan Allen, *The Addict Brokers: Middlemen Profit as Desperate Patients Are 'Treated like Paychecks*,*'* STAT NEWS (May 28, 2017), https://www.statnews.com/2017/0 5/28/addict-brokers-opioids/ (saying that vulnerable patients are "treated like paychecks").
[102] *See What is "Patient Brokering"?*, *supra* note 99 (describing methods by which brokers recruit patients, including online and even by loitering near sober living houses).
[103] *Father Blames "Body Broker" After Son Dies During Drug Rehab*, CBS NEWS (Nov. 8, 2018) https://www.cbsnews.com/news/drug-rehab-body-brokering-reportedly-leads-to-mans-death/ (detailing a situation in which one body broker attempted to convince a prospective patient to switch from his Florida rehab center to a California one, offering him money, cigarettes, and a gym membership to make the switch).
[104] Copeland, *supra* note 23, at 1476.
[105] *See, e.g.*, Mann, *supra* note 41 (noting that Kenneth Chatman, who owned two drug treatment centers, is now serving a 27-year federal prison sentence for health care fraud and money laundering convictions in connection with his treatment centers); *see also* U.S. ATT'YS OFF., S. DIST. OF FLA., *supra* note 94.
[106] *See, e.g.*, Press Release, Eduardo A. Chávez, *Ft. Worth Doctors Leave Patients Wasted and Dazed in a Pill Mill Operation; 49 Arrested*, U.S. DRUG ENF'T AGENCY (Sept. 24, 2020), https://www.dea.gov/press-releases/2020/09/24/ft-worth-doctors-leave-patients-wasted-and-dazed-pill-mill-operation-49 (explaining that patient brokers are sometimes connecting to opioid distribution schemes as well)*; see also* U.S. DEP'T OF JUST., OFF. OF PUB. AFFS., *supra* note 43.
[107] *See* NAT'L INST. ON DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION 16 (2020) (indicating that addiction can be fatal if left untreated); *see also* Copeland, *supra* note 23, at 1455.

potentiating fatal overdoses.[108] As this section explores, these impacts are not just isolated to the patients themselves; they often lead to federal waste and harm the public.

Starting out, unnecessary drug tests may lull recovering patients into a false sense of security. Drug testing provides the appearance of rigorous treatment. For example, a recovery home that tests residents daily appears to keep a close eye on residents. And when insurance companies reimburse claims, patients may be further reassured that the unnecessary drug tests or services identified in the claims are necessary for their recovery. Patients are then often left untreated at their sober homes and are at higher risk for relapse from their untreated addictions. They suffer from a lack of counseling, a lack of supportive sober house managers in long-term recovery, and a lack of work duties that help them stay accountable and build life skills.

Next, patient brokering harms patients by funneling them to substandard facilities. When brokers recommend drug treatment centers based on profit agreements instead of providing an independent, quality assessment, patients are not matched with quality, evidence-based treatment centers. Brokers may fail to send prospective patients to facilities that are qualified to support the large percentage of patients who are dual diagnosis.[109] Similarly, brokers may mismanage patients who have medical issues that must be monitored during treatment.[110] Some patients have even died from the predatory actions of patient brokers.[111]

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[108] *See Opioid Overdose*, WORLD HEALTH ORG. (Aug. 4, 2021), https://www.who.int/news-room/fact-sheets/detail/opioid-overdose (indicating that opioids, a common drug of abuse, can cause fatal overdoses); *see also* Copeland, *supra* note 23, at 1455.

[109] Many patients suffer from both addiction and mental illness. Their treatment centers must be qualified to provide both services to such patients unless patients' mental illness(es) are adequately stabilized beforehand. Brokers are unlikely to know about prospective patients' mental illnesses or hold the qualifications to determine what treatment centers will best serve such patients. Even if a broker happened to be qualified, there is no guarantee a broker would place a patient's wellbeing over profit.

[110] Adi Jaffe, *Alcohol, Benzos, and Opiates—Withdrawal That Might Kill You*, PSYCH. TODAY (Jan. 13, 2010), https://www.psychologytoday.com/us/blog/all-about-addiction/201001/alcohol-benzos-and-opiates-withdrawal-might-kill-you (explaining that patients detoxing from alcohol, certain opiates, or benzodiazepines must be stabilized in medical facilities or detoxes, otherwise they risk fatal health complications).

[111] *See e.g.*, *Father Blames "Body Broker" After Son Dies During Drug Rehab*, *supra* note 103 (covering the death of Alex Strickland who died after a body broker pressured him to relapse so that the broker could justify Alex's need for treatment in California). Many insurance programs will not cover treatment for prospective rehab patients unless the patients are newly sober. So, a patient that detoxes on their own before applying for treatment, or one who wishes to switch treatment centers, is less likely to be covered. They have less of a "medical need" for treatment

Further, health care fraud in the recovery industry wastes federal resources. Federal health benefit schemes waste hundreds of millions of dollars, if not more, compensating false or excessive claims. Private insurers likely waste an equivalent amount compensating false claims, given the high prevalence of private insurance funding for treatment centers. Even worse, it costs the Justice Department, regulators, and other investigators millions to investigate and prosecute crimes involved with health care fraud in the recovery industry.[112] Doing so also wastes time—time the Justice Department and other federal entities could otherwise spend deciding upon appropriate grants to prevent and respond to addiction.[113]

Finally, the public suffers. The opioid crisis is a public health crisis that directly or indirectly impacts nearly everyone in the nation. For example, people with untreated addiction often cannot contribute to the workforce and economy. In addition, increased crime and homelessness are huge costs to society. Furthermore, for every one person suffering from addiction, numerous family members and friends are impacted. And when patients receive substandard care, their addictions are likely to continue to impact those around them. Thus, not only are federal funds at stake, but also human lives and livelihoods—especially those of the patients not getting the care they need because of fraudulent providers' focus on money.

II. INVESTIGATION, PROSECUTION, AND ENFORCEMENT

In 2020, the National Drug Control Budget requested $34.6 billion for drug control functions, including treatment.[114] But what happens when health care fraud inhibits the provision of such treatment? This section studies the investigation, prosecution, and enforcement of health care fraud in the drug treatment industry, including where investigators and prosecutors do not meet their goals.

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than a prospective patient who tests positive (showing clear proof of active addiction) for drugs right before entering rehab.

[112] *See* Press Release, *National Health Care Fraud Enforcement Action Results in Charges of Over $308 Million in Intended Loss Against 52 Defendants in the Southern District of Florida*, U.S. ATT'YS OFF., S. DIST. OF FLA. (Sept. 17, 2021), https://www.justice.gov/usao-sdfl/pr/national-health-care-fraud-enforcement-action-results-charges-over-308-million-intended (George L. Piro, Special Agent in Charge, FBI Miami, as part of a recent enforcement action against fraudulent providers in the recovery industry with a $308 million loss, notes that "the FBI and its partners devote vast resources to investigate, catch and prosecute those committing this fraud. The victims are U.S. taxpayers, you and me.").

[113] *See generally* Press Release, *Department of Justice Announces More Than $341 Million in Grants to Combat America's Addiction Crisis*, U.S. DEP'T OF JUST., OFF. OF PUB. AFFS. (Oct. 16, 2021), https://www.justice.gov/opa/pr/department-justice-announces-more-341-million-grants-combat-america-s-addiction-crisis.

[114] *Drug Abuse Statistics*, *supra* note 76.

A. Statutes Implicated

When providers in the addiction treatment industry engage in patient brokering, or when they pay or receive kickbacks for services like drug testing, they risk implicating two federal criminal statutes: the Eliminating Kickbacks in Recovery Act (EKRA)[115] and the Anti-Kickback Statute (AKS).[116] Florida and California providers also risk running afoul of similar state statutes.[117] For other schemes, like billing for unnecessary testing or unprovided services, providers risk implicating two additional federal statutes: the Health Care Fraud Statute[118] and the False Claims Act.[119] This section will briefly describe these key statutes, paving the way for a later section, II.C, to discuss recent prosecutions and penalties.

EKRA prohibits kickbacks for patient brokering in the drug treatment industry, including providing bribes for patients to use lab services in connection with treatment.[120] Congress passed EKRA in 2018 as part of broader legislative efforts to promote patient access to drug treatment.[121] EKRA includes safe harbors that protect certain payment and business practices that could otherwise implicate EKRA and trigger liability.[122] Similarly, the AKS prohibits the "knowing and willful" payment of kickbacks involving patient referrals and kickbacks inducing

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[115] 18 U.S.C. § 220(a).
[116] 42 U.S.C. § 1320a–7b(b). Additionally, the physician self-referral laws (Stark Laws), 42 U.S.C. § 1395nn, may provide for civil liability. The Stark Laws implicate doctors that self-refer Medicare or Medicaid patients to institutions that the doctor (or their immediate family) has a financial connection with. *Anti-kickback Statute and Physician Self-Referral Laws (Stark Laws)*, AM. SOC'Y ANESTHESIOLOGISTS, https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/anti-kickback-statute-and-physician-self-referral-laws-stark-laws#:~:text=The%20federal%20Anti%2DKickback%20Statute,by%20federal%20health%20care%20programs (last visited Dec. 1, 2021). This article chooses to leave out discussion of the Stark Laws, because most operators and employees of sober houses are not physicians (and neither are most employees of drug treatment facilities). Moreover, most of the litigation surrounding drug treatment facility and sober house fraud that this author could find did not include Stark Law claims (likely because of the lack of physician-oversight in the industry). While Stark Law discussion could still add context to this article's statutory discussion, these laws are thus not the main laws at issue.
[117] *See* FLA. STAT. § 817.505 (2021); S.B. 823 (Cal. 2018).
[118] 18 U.S.C. § 1347.
[119] 31 U.S.C. § § 3729–3733 (civil False Claims Act); 18 U.S.C. § 287 (Criminal False Claims Act).
[120] 18 U.S.C. § 220(a). Such lab services likely include urine drug testing.
[121] Susan St. John, *EKRA and SUPPORT Act Impact: Legal Breakdown*, FLA. HEALTHCARE L. FIRM BLOG (Mar. 11, 2019), https://www.floridahealthcarelawfirm.com/ekra-support-act-anti-kickback-law-patient-referral/.
[122] *See* 18 U.S.C. § 220(a).

the furnishing or purchase of items or services payable by federal health care programs.[123] The AKS also includes numerous safe harbors.[124]

EKRA's main differences from the AKS are three-fold. First, EKRA is limited to drug treatment centers and related providers,[125] while the AKS implicates *any* health care provider (that is, any health care provider in a kickback scheme involving reimbursement by federal health care programs).[126] Next, EKRA contains only seven statutory safe harbors, whereas the AKS provides over three dozen statutory and regulatory safe harbors.[127] Finally, EKRA applies to private insurer reimbursement as well as federal health benefit reimbursement, while the AKS only applies to remuneration paid in connection with referrals of federal health benefit program beneficiaries.[128]

Compared to EKRA, state patient-brokering statutes appear both broader and narrower. Florida's Patient Brokering Act (PBA), amended in 2019 in connection with a broader effort to increase recovery treatment regulation, provides a stricter monetary penalty than EKRA.[129] Specifically, while both EKRA and the PBA make

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[123] 42 U.S.C. § 1320a–7b(b); *Anti-kickback Statute and Physician Self-Referral Laws (Stark Laws)*, *supra* note 116; *Federal and State Anti-Kickback and Inducement Laws*, BENKOFF HEALTH L., https://benkofflaw.com/practice-areas/federal-and-state-anti-kickback-and-inducement-laws/ (last visited Dec. 1, 2021) (explaining that as the AKS is an intent-based law, an AKS analysis involves the prosecution analyzing the "facts and circumstances" of a referral arrangement to determine if it involves any intent to violate the AKS).

[124] *See Fraud & Abuse Laws*, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/ (last visited Dec. 22, 2021).

[125] 18 U.S.C. § 220(a) (includes recovery homes, clinical treatment facilities, and laboratories). Under EKRA, the term 'clinical treatment facility' means a medical setting, other than a hospital, that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for substance use, pursuant to licensure or certification under State law[.] . . . [T]he term 'laboratory' has the meaning given the term in section 353 of the Public Health Service Act (42 [§] U.S.C. 263a)[.] . . . [T]he term 'recovery home' means a shared living environment that is, or purports to be, free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders. *Id.*

[126] 42 U.S.C. § 1320a–7b(b).

[127] Michael W. Paddock et al., *The Eliminating Kickbacks in Recovery Act: A Critical Analysis of an Altered Landscape for Financial Relationships with Clinical Laboratories*, 9 NAT. L. REV., at 2–3 (2019).

[128] Nick Oberheiden, *EKRA Rules, Regulations & Compliance: 5 Tips that Health Care Providers Need to Know*, JD SUPRA (Dec. 11, 2020), https://www.jdsupra.com/legalnews/ekra-rules-regulations-compliance-5-67718/. *See* discussion *infra* Section II.E for problems with EKRA's language; *see* discussion *infra* Section II.E for EKRA's lighter penalties, as compared to the Health Care Fraud Statute's penalties.

[129] *See* Jana Kolarik, *EKRA and Florida's Patient Brokering Act: Clarification Needed Amid Uncertainty*, JD SUPRA (Feb. 28, 2020), https://www.jdsupra.com/legalnews/ekra-and-florida-s-patient-brokering-98223/.

kickbacks in the drug treatment industry a felony, the PBA provides for higher fines than EKRA—up to $500,000 in cases involving twenty or more patients.[130] EKRA, on the other hand, only provides for fines up to $200,000.[131] In this way, the PBA's impact on a fraudulent provider can pack a stronger punch if the provider operates in Florida. However, unlike EKRA, the PBA is not specific to drug treatment providers or recovery houses.[132] In this way, the PBA is broader than EKRA.

California's statute, like EKRA, is specific to the recovery industry.[133] While EKRA applies to recovery homes, clinical treatment facilities, and laboratories,[134] California's statute is more narrow and applies only to state-licensed drug treatment facilities, certified programs, and counselors—not sober houses or labs in the state.[135] Additionally, California's statute offers weaker penalties than EKRA or Florida's PBA. The California statute does not specify fines, and the law only grants penalty authority to the California Department of Public Health, not prosecutors.[136] Moving to fraudulent billing practices, the Health Care Fraud Statute and False Claims Act provide liability for health care fraud schemes in the drug recovery industry, such as billing for unnecessary drug tests. The Health Care Fraud Statute implicates anyone who "knowingly and willfully" defrauds or attempts to defraud a health care benefit program or obtains health care benefit reimbursement under false or fraudulent circumstances.[137] Therefore, a provider who bills for more

[130] *Compare* FLA. STAT. § 817.505 (2021), *with* 18 U.S.C. § 220(a) (look to each statute's penalty provisions).
[131] 18 U.S.C. § 220(a).
[132] *Compare* FLA. STAT. § 817.505 (2021), *with* 18 U.S.C. § 220(a) (look to the providers each statute references).
[133] Ted Sforza, *New Rehab Laws May Revamp Addiction Treatment in California*, ORANGE COUNTY REG. (Sept. 27, 2018, updated Oct. 16, 2018), https://www.ocregister.com/2018/09/27/new-rehab-laws-may-revamp-addiction-treatment-in-california/ (referring to S.B. 1228 (Cal. 2018)).
[134] 18 U.S.C. § 220(a).
[135] *See* Ted Sforza & Tony Saavedra, *How Many Body-brokering Cases Have Been Prosecuted by the Feds Under New Law?*, DAILY DEMOCRAT (Apr. 26, 2020), https://www.dailydemocrat.com/2020/04/26/how-many-body-brokering-cases-have-been-prosecuted-by-the-feds-under-new-law/; *see also* Ted Sforza, *Body Brokering, Where Addicts Are Sold as Investments, Can Continue in Sober homes, for Now*, S. CAL. NEWS GROUP (Jan. 16, 2020), https://www.eastbaytimes.com/2020/01/16/body-brokering-where-addicts-are-sold-as-investments-can-continue-in-sober-homes-for-now/. In 2019, California Senator Pat Bates introduced a bill, S.B. 486, that would have prohibited "commercially operated recovery residences" from engaging in body brokering, with a $50,000 penalty per occurrence; however, the bill died. *Id.*; *see also* Sforza & Saavedra, *supra* note 135. ("Current California law allows the back door to be left wide open by not penalizing the sober living home owner when they are ground zero for body brokering[.]")
[136] *See* Sforza & Saavedra, *supra* note 135.
[137] 18 U.S.C. § 1347.

extensive examinations of drug treatment patients than they actually provided would likely face liability.[138]

Similarly, the civil False Claims Act prohibits providers from submitting false or fraudulent claims for payment to government programs like Medicare or Medicaid.[139] The criminal False Claims Act applies when providers *intend* to defraud a government agency or department.[140] Say a sober house intentionally submits false insurance claims to the government for drug tests they failed to administer. If the prosecution can prove knowledge and intent, the sober house may be on its way to criminal False Claims Act liability. Fraudulent addiction treatment providers thus risk liability under multiple statutes.

B. Regulators and Other Actors Charged with Health Care Fraud Control for Recovery Providers

It is beyond the scope of this article to discuss all actors charged with health care fraud control for addiction recovery providers. Therefore, this article will provide an overview of actors at various levels of government, then describe one actor in-depth: opioid strike forces.

First, on the federal level, the Federal Bureau of Investigation (FBI) and U.S. Attorney's offices in different districts often work with state and local law enforcement, like State Attorney's offices and local sheriff's departments, as well as other federal investigators and regulators. Federal regulatory authorities like the Health and Human Services Office of Inspector General (HHS-OIG) also participate in investigations and audits. For example, in one Florida sober house and treatment center health care fraud enforcement action, the U.S. Attorney's Office for the Southern District of Florida worked with the FBI's Miami Field Office, the Palm Beach County Sheriff's Office, and various agents in Inspector General Offices, among others.[141]

Second, task forces and recovery residence associations partner with investigators to control fraud. For example, Florida State Attorney for Palm Beach County, Dave Aronberg, created the Sober Homes Task Force in Florida. From July 2016 through the end of 2020, the task force made more than ninety arrests and secured thirty-six

[138] U.S. ATT'YS OFF., S. DIST. OF FLA., *supra* note 94.
[139] U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., *supra* note 124.
[140] *Id.*
[141] U.S. ATT'YS OFF., S. DIST. OF FLA., *supra* note 94.

convictions.[142] Similarly, the Florida Association of Recovery Residences works with state and federal offices to investigate treatment centers and sober houses.[143]

Finally, specialized programs like opioid strike forces or the Medicare Fraud Strike Force lend resources, support, and expertise to local, state, and federal investigators when they collaborate to find and fight fraud in addiction treatment.[144] Opioid strike forces specialize in the prosecution of illegal opioid distribution schemes.[145] These strike forces operate as part of the Appalachian Regional Prescription Opioid (ARPO) Strike Force.[146] The DOJ, FBI, HHS-OIG, Drug Enforcement Agency (DEA), and state and local law enforcement created the strike force program as a joint effort to combat health care fraud and the opioid epidemic.[147] Approximately ten U.S. Attorneys' Office districts currently partner with ARPO, which is divided into multiple teams.[148]

ARPO teams' current impact is that they are successful prosecutors of illegal opioid distribution schemes.[149] For example, in recent enforcement actions, ARPO program teams partnered with U.S. Attorneys' Offices and state law enforcement nationwide to investigate an over $845 million loss connected to substance abuse treatment facilities,[150] and an even larger loss connected in part to illegal opioid distribution.[151] Coupled with other busts within the enforcement action, the

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[142] Copeland, *supra* note 23, at 1477.
[143] Ferguson, *supra* note 29.
[144] *See, e.g.*, Thomas Sullivan, *Newly Created Appalachian Opioid Strike Force Charges 60 Defendants for Alleged Involvement in Distribution of Over 32 Million Pills*, POL'Y & MED. (last updated May 12, 2019), https://www.policymed.com/2019/05/newly-created-appalachian-opioid-strike-force-charges-60-defendants-for-alleged-involvement-in-distribution-of-over-32-million-pills.html (showing how the new Appalachian Regional Prescription Opioid (ARPO) Strike Force worked with other investigators to bring down a health care fraud scheme involving the opioid epidemic); *see also Health Care Fraud Takedown*, FED. BUREAU OF INVESTIGATION (July 13, 2017), https://www.fbi.gov/news/stories/nationwide-sweep-targets-enablers-of-opioid-epidemic.
[145] Sullivan, *supra* note 144.
[146] *Health Care Fraud Unit*, U.S. DEP'T OF JUST. (updated Aug. 6, 2021), https://www.justice.gov/criminal-fraud/health-care-fraud-unit.
[147] *Id.*
[148] *Id.*
[149] These schemes are sometimes addiction treatment schemes—for example, when a doctor claims to provide medication-assisted treatment but operates a "pill mill" instead. Or these schemes can be a part of larger criminal schemes where fraudulent providers illegally doll out opiates but also run sober homes or act as patient brokers.
[150] The investigators grouped sober houses and substance abuse treatment facilities together into one category.
[151] P.J., *Health Care Fraud and Opioid Arrests Results in Charges Against 345 Defendants Representing Over $6 Billion in Alleged Fraud*, ORLANDO MED. NEWS (Oct. 1, 2020),

investigation resulted in charges against 345 defendants.[152] In fact, since its inception in October 2018, ARPO has charged more than 90 defendants, collectively responsible for distributing over 105 million opiate pills.[153] This article will later argue that one fix for health care fraud in the recovery industry is for more local law enforcement offices to partner with such strike forces.

C. Recent Prosecutions and Penalties

Providers may face prosecution and resulting civil, criminal, and regulatory penalties for engaging in health care fraud in the drug treatment industry. For example, under the Health Care Fraud Statute, fraudulent providers face fines or imprisonment up to ten years—or more, if "serious bodily injury" or death occurs.[154] In Florida, the PBA makes patient brokering a felony with a $50,000 minimum fine.[155] This section offers a few examples of recent prosecutions and penalties to demonstrate what providers have actually faced.[156]

In January 2020, federal prosecutors in the Eastern District of Kentucky secured the first guilty plea under EKRA.[157] Theresa Merced, an office manager of a substance abuse treatment clinic, admitted to soliciting kickbacks from the Chief Executive of a toxicology lab in exchange for urine drug test referrals.[158] While Merced faced up to twenty years in prison and a fine of up to $250,000, the judge only sentenced her to five months in prison, five months in home detention, and ordered her to pay a $55,000 fine.[159] As a condition of Merced's supervised release, however, she cannot work "in any capacity in which she influences referrals for

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https://www.orlandomedicalnews.com/article/3906/health-care-fraud-and-opioid-arrests-results-in-charges-against-345-defendants-representing-over-6-billion-in-alleged-fraud.

[152] *Id.*

[153] U.S. DEP'T OF JUST., *supra* note 146.

[154] 18 U.S.C. § 1347.

[155] FLA. STAT. § 817.505 (2021).

[156] Where there are enforcement actions, there are often corporate compliance programs and integrity agreements. However, the author has primarily focused on the penalties and enforcement measures that the Justice Department and other actors have showcased in press releases.

[157] Press Release, *Jackson Woman Pleads Guilty to Soliciting Kickbacks, Making False Statements to Law Enforcement Agents, and Tampering with Records*, U.S. ATT'YS OFF., DIST. OF KY. (Jan. 10, 2020), https://www.justice.gov/usao-edky/pr/jackson-woman-pleads-guilty-soliciting-kickbacks-making-false-statements-law.

[158] *Id.*

[159] *Id.*; Press Release, *Jackson Woman Sentenced to 10 Months for Soliciting Kickbacks and Obstructing Justice*, U.S. ATT'YS OFF., DIST. OF KY. (May 11, 2020), https://www.justice.gov/usao-edky/pr/jackson-woman-sentenced-10-months-soliciting-kickbacks-and-obstructing-justice.

medical testing."[160] Since Ms. Merced's conviction, prosecutors have secured multiple convictions under EKRA.[161]

More recently, in November 2021, as part of the DOJ's Sober Homes Initiative, a federal jury in Miami convicted two brothers who owned and operated two South Florida addiction treatment centers. The jury convicted the brothers of conspiracy to commit health care fraud and conspiracy to pay and receive kickbacks, among other offenses.[162] The brothers fraudulently billed an estimated $112 million for services that were either never provided or were medically unnecessary.[163] The brothers also obtained patients for their treatment facilities through patient brokers. These brokers offered free airline tickets, cash payments, and even illegal drugs to addicted people to induce them to come to the brothers' facilities.[164] Patients were then given large, harmful quantities of illegal drugs as bribes to ensure they remained at the centers so the providers could continue to bill for services. The brothers each face a maximum of twenty years in prison for the conspiracy to commit health care fraud count and ten years for each substantive health care fraud and payment and receipt of kickbacks count.[165] They have not yet been sentenced.[166]

In 2017, the Florida doctor mentioned earlier in the article, who received kickbacks and billed for more complex examinations of addiction treatment patients than he performed, was sentenced to forty-eight months in prison, followed by a year of supervised release.[167] He was also ordered to pay restitution of over $2 million.[168]

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[160] U.S. ATT'YS OFF., DIST. OF KY., *supra* note 159.
[161] *See, e.g.*, Press Release, *Two California Men Admit Roles in Multi-State Recovery Home Patient Brokering Scheme*, U.S. ATT'YS OFF., DIST. OF N.J. (Sept. 15, 2020), https://www.justice.gov/usao-nj/pr/two-california-men-admit-roles-multi-state-recovery-home-patient-brokering-scheme (saying that two men pled guilty for conspiracy to commit health care fraud and conspiracy to violate EKRA; they engaged in an elaborate multi-state patient brokering scheme); *see also* P.J., *supra* note 151 (describing multiple cases charged under EKRA, as well as the AKS, in the Southern District of Florida).
[162] Eva Gunasekera & Renee Brooker, *Addiction Treatment Facilities' Patient Shuffling Scheme Exposed*, 11 NAT. L. REV., at 1–2 (2022).
[163] Gunasekera & Brooker, *supra* note 162, at 1–2.
[164] Press Release, *South Florida Addiction Treatment Facility Operators Convicted in $112 Million Addiction Treatment Fraud Scheme*, U.S. DEP'T OF JUST., OFF. OF PUB. AFFS. (Nov. 4, 2021), https://www.justice.gov/opa/pr/south-florida-addiction-treatment-facility-operators-convicted-112-million-addiction.
[165] *Id.*
[166] *Id.*
[167] U.S. ATT'YS OFF., S. DIST. OF FLA., *supra* note 94.
[168] *Id.*

D. Prevention and Enforcement Goals

Prevention and enforcement goals for controlling health care fraud in the recovery industry include cracking down on sober house fraud, especially in southern Florida and California, deterring fraud, and requiring better accreditation for treatment facilities. This section only aims to identify relevant goals, not evaluate them. The next section, II.E, Challenges to Investigation, Prosecution, and Enforcement,[169] includes an evaluation of whether investigators and prosecutors are meeting these goals. As the next section argues, while investigators and prosecutors have had slight successes in pursuing their goals, they have a long way to go.

First, the Justice Department wants to increase its enforcement goals by cracking down on fraud in sober houses and treatment centers in southern Florida and California.[170] Specifically, the DOJ has focused on investigating and prosecuting fraudulent urine testing and patient brokering.[171] For patient brokering cases, the DOJ aims to aggressively pursue cases under EKRA.[172]

Next, investigators, regulators, and law enforcement officers want to deter fraud in the recovery industry.[173] For example, Former Acting Attorney General of the DOJ's Criminal Division, Brian C. Rabbitt, commended investigator efforts in a sweeping nationwide enforcement action that included substance abuse treatment center fraud. Rabbitt lauded law enforcement for not only holding accountable the medical professionals and others who exploited patients for personal gain, but also for sending a "clear deterrent message."[174]

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[169] *See* discussion *infra* Section II.E (evaluating the challenges to prosecution under EKRA).
[170] *See* U.S. DEP'T OF JUST., OFF. OF PUB. AFFS., *supra* note 43 (announcing prosecutions against ten defendants for kickback schemes at substance abuse treatment facilities in Orange County, earlier this month [Dec. 2021], brought by the Sober Homes Initiative in Southern California, led by the California U.S. Attorney's Office); *see also* Gunasekera & Brooker, *supra* note 162, at 1–2 (announcing convictions last month [Nov. 2021] as part of the DOJ's Sober Homes Initiative by a federal jury in Miami of the owners of two South Florida addiction treatment facilities who engaged in health care fraud).
[171] U.S. DEP'T OF JUST., OFF. OF PUB. AFFS., *supra* note 43 ("These cases reflect the continued efforts of the Department of Justice to combat fraud by substance abuse treatment facilities and patient recruiters," according to Assistant Attorney General Kenneth A. Polite Jr. at the Criminal Division of the Justice Department.); Gunasekera & Brooker, *supra* note 162, at 1–2.
[172] Nick Oberheiden, *5 Things You Must Know About EKRA Law in 2022*, OBERHEIDEN P.C. (last updated Mar. 4, 2022), https://federal-lawyer.com/5-things-you-must-know-about-ekra-in-2022/.
[173] *See* U.S. DEP'T OF JUST., OFF. OF PUB. AFFS., *supra* note 43.
[174] P.J., *supra* note 151.

Finally, scholars have identified the need for better accreditation for drug treatment facilities.[175] This is a prevention goal that primarily implicates legislators and regulators. Legislators are usually charged with mandating accreditation and licensing in the recovery industry, while regulators are often charged with creating and administering accreditation and licensing programs. While evaluation of treatment center and sober accreditation standards is largely beyond the scope of this article,[176] the final section will suggest new federal legislation to mandate that sober houses and treatment centers obtain licensure and adhere to medical addiction treatment standards.[177]

E. Challenges to Investigation, Prosecution, and Enforcement

While investigators and prosecutors have had some success pursuing their goals, there is still much to do. Challenges to the investigation, prosecution, and enforcement of health care fraud include the following: EKRA is unclear and its penalties are too lenient, and, more importantly, inconsistent accreditation and licensing standards pave the way for fraudulent providers to fly under the radar.

First, EKRA is unclear, and agencies have not published clarification.[178] Practitioners cannot tell whether the AKS's safe harbors apply to or conflict with EKRA.[179] Subsection (d)(1) of EKRA states that EKRA "shall not apply to conduct that is prohibited" by the AKS.[180] But conduct under the AKS's safe harbors is, by definition, *not* prohibited by the AKS.[181] Consequently, conduct exempted by an AKS safe harbor may be subjected to EKRA liability.[182] Practitioners are therefore concerned about the "counter-intuitive conclusion" from EKRA's plain language that conduct permitted by the AKS may still create criminal liability under

[175] Katrice Bridges Copeland, a legal scholar, argues in favor of heightened accreditation standards to combat information disadvantages for drug treatment patients. Copeland, *supra* note 23, at 1451–1515.
[176] *See supra* Section I.A (providing a glimpse into the lack of consistent accreditation and licensing standards for sober houses and drug treatment centers nationwide).
[177] *See* discussion *infra* Section III.D.
[178] *See* Charles Dunham & Benjamin Nipper, *EKRA Prosecution: What Does this Mean for the Laboratory Industry?*, G2 INTEL. (Nov. 21, 2020), https://www.g2intelligence.com/ekra-prosecution-what-does-this-mean-for-the-laboratory-industry/ (noting that the DOJ has published no regulations clarifying EKRA); Kolarik, *supra* note 129 (revealing lawyers are worried about how federal agencies will interpret EKRA's exemption provision and administer EKRA and the AKS when the two federal laws overlap).
[179] Paddock et al., *supra* note 127, at 3.
[180] *Id.*
[181] *Id.*
[182] *Id.*

EKRA.[183] In other words, EKRA may forbid more practices that recovery industry practitioners are not used to.

Next, EKRA's penalties are too lenient. EKRA's possible ten-year prison term is more than a slap on the wrist. But other statutes provide for greater penalties, like the Health Care Fraud Statute.[184] For example, providers convicted under the Health Care Fraud Statute face up to twenty years in prison in cases of serious bodily injury, while EKRA only provides for ten years.[185] That being said, prosecutors can often stack charges, focusing on the most readily provable offenses.

The strongest evidence that EKRA's confusing provisions or comparatively lenient prison penalty poses a challenge to prosecutors is that EKRA prosecutions are few and far between.[186] Accordingly, DOJ is not meeting its enforcement goal of using EKRA to the fullest extent possible.[187] This could be because EKRA is still a relatively new statute, prosecutors are unsure how best to prosecute providers under EKRA, or it is easier to prove offenses under other similar statutes.

Finally, and most critically, inconsistent accreditation and licensing standards pave the way for fraudulent providers to engage in bad conduct. Criminals know that the recovery industry offers an easy target because there are no federal laws and few state laws mandating that residential rehabs, outpatient centers, and sober houses obtain licenses or adopt certain treatment criteria. Without the regular inspections that accreditation or licensure typically requires, fraudulent providers can trick vulnerable patients into staying in fraudulent treatment schemes for longer periods. Sometimes providers even make fraudulent claims for years before investigators catch on to their schemes.

However, investigators and prosecutors have met, if not surpassed, their goal to crack down on fraud in sober houses and treatment centers in southern Florida and California, especially for fraudulent urine testing and patient brokering. Extensive prosecutions across the nation, under statutes other than EKRA, have caught

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[183] *Id.*
[184] *See* Sforza & Saavedra, *supra* note 135 (discussing the penalties provided under the Health Care Fraud and Abuse Statute)
[185] 18 U.S.C. § 1347(a)(2); 18 U.S.C. § 220(a).
[186] *See* Sforza & Saavedra, *supra* note 135 (When referring to the lack of EKRA prosecutions, one California Representative said, "[i]t is extremely frustrating that the Department of Justice has not aggressively pursued cases where brokers treat patients as commodities[.]" He continued, "[t]here is no excuse for their failure to prosecute these cases, particularly when we desperately need an all-hands-on-deck approach to this crisis.").
[187] *See* Oberheiden, *supra* note 172 (examining the DOJ's prosecution of individuals under EKRA in 2022)

providers whose fraud caused hundreds of millions of dollar losses.[188] Unfortunately, it is unclear how effective these prosecutions have been in deterring this kind of fraudulent behavior.[189] Regardless, prosecutors' vast enforcement actions are likely to dissuade at least some drug treatment providers who were considering engaging in fraud. In conclusion, actors charged with controlling fraud in the drug recovery industry have not yet met some of their aims, though they have met at least one objective.

III. STRATEGIES FOR THE FUTURE

This section proposes and evaluates strategies for the future to prevent and control health care fraud in the addiction treatment industry.

A. Congress Should Revise and Amend EKRA

This section proposes legislative fixes and first advises that Congress clarify EKRA's relationship with the AKS safe harbors and then enhance EKRA's prison penalty.

1. Clarify EKRA's Relationship with the AKS Safe Harbors

Given the confusion surrounding EKRA's relationship with the AKS's safe harbor exceptions, Congress should clarify EKRA. This article advises two strategies, which are both legislative fixes. First, Congress could explicitly add each of the AKS's thirty-seven safe harbors to the text of EKRA. This amendment would only be appropriate if Congress intended all of the AKS safe harbors to apply to EKRA. Second, Congress could instead rewrite EKRA by adding language stating that, "irrespective of the type of health care benefit program, conduct and/or payment arrangements that comply with an exception under or otherwise do not violate the federal AKS will not be an offense."[190] The rewrite could further add that "[m]any arrangements can be structured to meet a federal AKS exception and safe harbor; however, there are some arrangements [like] percentage arrangements for sales agents or hourly arrangements for medical directors, which do not."[191] Such arrangements, ones that otherwise meet a facts

[188] *See, e.g.*, P.J., *supra* note 151.
[189] By nature, fraud deterred is fraud that does not occur, so it is inherently difficult to measure how much fraud has been deterred.
[190] Kolarik, *supra* note 129.
[191] *Id.*

and circumstances analysis under the AKS, would be allowed under a revised EKRA.[192]

Such amendments would provide clarity surrounding EKRA's confusing clause that it "shall not apply to conduct that is prohibited" by the AKS.[193] This article recommends these amendments so that prosecutors will have more clarity in prosecuting under EKRA, and also so that defense attorneys will be able to provide more consistent guidance to their provider clients. This way, providers can avoid engaging in risky actions that may subject them to liability and ultimately harm patients. These amendments could also be introduced through regulatory action, should legislative action not be possible or expedient. Because EKRA authorizes the Attorney General to promulgate regulatory safe harbors to EKRA, the Attorney General could add additional safe harbors.[194]

2. Enhance EKRA's Prison Penalty to Mirror the Health Care Fraud Statute

Congress could also amend EKRA by increasing its prison penalty to match the Health Care Fraud Statute's prison term. Specifically, given patient deaths from patient brokering, Congress should add the Health Care Fraud Statute's increased prison term for violations resulting in serious bodily injury or death to the EKRA statute.[195]

The following shows EKRA's relevant portions as if amended (changes in bold):

> (a) Offense.— Except as provided in subsection (b), whoever, with respect to services covered by a health care benefit program, in or affecting interstate or foreign commerce, knowingly and willfully—
> (1) solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient or patronage to a recovery home, clinical treatment facility, or laboratory; or
> (2) pays or offers any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—
> (A) to induce a referral of an individual to a recovery home, clinical treatment facility, or laboratory; or

[192] *Id.*
[193] Paddock et al., *supra* note 127, at 3; *see* 18 U.S.C. § 220(d)(1).
[194] Paddock et al., *supra* note 127, at 3; St. John, *supra* note 121.
[195] *See* 18 U.S.C. § 1347.

> (B) in exchange for an individual using the services of that recovery home, clinical treatment facility, or laboratory,
> shall be fined not more than $200,000, imprisoned not more than 10 years, or both, for each occurrence[.] **If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.**

These changes may make it more likely that prosecutors will charge fraudulent addiction recovery providers under EKRA. Furthermore, if Congress adds the Health Care Fraud Statute's enhancement to life in especially egregious cases, providers considering committing fraud in the addiction treatment industry—who may not otherwise have been deterred—may now think twice about offending. This article considers the potential additional deterrent effect alone a strong justification for Congress to amend EKRA.

B. The DOJ Ought to Issue Regulations or Guidance on EKRA

If Congress does not act, the DOJ could exercise its power to issue regulations or guidance clarifying EKRA.[196] The DOJ ought to disseminate a memo or agency guidance document to clarify whether EKRA applies to conduct not prohibited by the AKS or conduct that the AKS protects via a safe harbor exception.[197] The memo should further clarify whether EKRA applies to conduct that an OIG guidance or a facts and circumstances analysis under the AKS protects or does not prohibit.[198]

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[196] *See* Kolarik, *supra* note 129 (noting clarification could include (legislative) revisions of EKRA, or statements released by state agencies or federal agencies like the DOJ or HHS concerning EKRA); *see also* Dunham & Nipper, *supra* note 178 (noting that industry stakeholders have raised concerns to both Congress and the DOJ that EKRA is unclear and conflicts with the AKS's safe harbors, and that the DOJ has not yet issued any regulations or guidance on the issue); *see also* Cori R. Haper & Sarah M. Hall, *DOJ Announces First Criminal Prosecution Under EKRA*, THOMPSON HINE L.L.P. (Feb. 12, 2020), https://www.thompsonhine.com/publications/doj-announces-first-criminal-prosecution-under-ekra (indicating that Congress gave the DOJ authority to issue regulations to clarify the exceptions to EKRA, but that the DOJ has not yet proposed any such clarifying regulations).
[197] *See* Kolarik, *supra* note 129 (reiterating the lack of clarification regarding how EKRA should be applied and suggesting ways to clarify the uncertainty)
[198] *Id.*

C. Opioid Strike Forces and Other Specialized Actors Can Help Local Investigators

Next, local investigators could partner with opioid strike forces and other specialized actors when pursuing fraudulent addiction treatment providers. This is a strategy that focuses on cooperation and collaboration during investigation and enforcement. This article believes such cooperation is necessary for investigators and prosecutors to bring down criminal providers.

Opioid strike forces, for example, could investigate schemes where doctors claim to provide medication-assisted treatment but operate "pill mills" instead. As proof, one need only look to strike force teams' great success in prosecuting pill mills nationwide.[199] U.S. Attorney's Office districts who have not yet partnered with strike force teams for these kinds of prosecutions should do so.[200] Furthermore, opioid strike forces are likely to provide support in large health care fraud recovery schemes, where fraudulent providers may operate pill mills for one part of the scheme and sober house or rehab overbilling as another part of the scheme. Thus, because opioid strike forces can combat addiction treatment industry fraud, and because past collaboration has been successful, investigators and strike forces should continue to work together to fight drug treatment industry fraud.

D. Additional Legislative Measures Congress Should Take

Congress should also pass additional legislation regarding licensure and medical treatment standards in the addiction treatment industry. This article suggests this legislative fix for two reasons. First, it will put added pressure on treatment providers to provide quality care. Currently only some treatment providers are subject to similar state laws, like in California,[201] but if Congress acts, *all* drug treatment providers will have to conform. This could either be a federal accreditation scheme or a requirement that each state adopts and enforces accreditation for facilities in their state. For instance, providers in California would have to comply with both federal and state laws, further deterring them from fraud. As California is a hotbed for health care fraud in the addiction treatment industry,

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[199] *See* discussion *supra* Section II.B, which includes examples of enforcement effort successes by opioid strike forces. Section II.B. shows such strike forces work together with other law enforcement agencies to investigate and prosecute these crimes.
[200] Currently, only ten out of the 94 U.S. Attorneys' Office districts partner with ARPO.
[201] *See* Ted Sforza, *Lawmakers Vow to Push Stiffer Regulations on Addiction Treatment in California*, ORANGE COUNTY REG. (June 4, 2019), https://www.ocregister.com/2019/06/04/lawmakers-vow-to-push-stiffer-regulations-on-addiction-treatment-in-california/ (explaining how California is passing legislation to target the rehab industry)

deterring fraudulent California providers would likely put a dent in fraud in the industry. Second, passing national legislation inches the drug treatment industry closer to a world in which treatment centers are federally regulated.

Furthermore, Congress should pass legislation requiring residential rehabs, outpatient centers, and sober houses that offer treatment to adopt the American Society of Addiction Medicine's treatment criteria. Congress should also pass legislation requiring that all drug treatment centers and sober houses that operate in states with licensing options obtain proper licensure. Finally, Congress could pass legislation to ban deceptive marketing in the rehab industry. These proposed acts are modeled after recent California bills.[202] Senators or members of the House of Representatives could model their federal bills off of California's bills. By passing such provisions, Congress would pave the way for consistent, quality regulation of treatment centers across the nation, not just in a select few states.

E. Is There a Role for Heightened Compliance and Corporate Integrity?

Finally, this article asks whether there is a need for heightened compliance and corporate integrity in the recovery industry. Specifically, should the DOJ create special provisions pertaining to the recovery industry in its newly updated Evaluation of Corporate Compliance Programs manual? Or should the DOJ more harshly evaluate whether addiction treatment providers administer satisfactory compliance programs and adhere to corporate integrity agreements that they implement and sign as part of settling DOJ investigations? At present, this article answers no. This article found no evidence suggesting that the DOJ taking either action would substantially reduce fraud in the recovery industry.[203]

However, this is an area ripe for further study. A future researcher should ask what kind of compliance agreements would be useful in drug recovery facilities. As a brief, non-exhaustive answer, this article maintains that regular trainings for drug recovery providers must be a part of any drug recovery compliance program. For example, Ariana Fajardo Orshan, U.S. Attorney for the Southern District of Florida,

[202] *See, e.g.*, S.B. 823 (Cal. 2018) (requiring California state-licensed residential rehab centers to adopt the American Society of Addiction Medicine's treatment criteria as their minimum standards of care); *see also* S.B. 325 (Cal. 2019) (This bill, if it had succeeded, would have required California outpatient centers in the drug treatment industry get licensed and meet evidence-based treatment standards); S.B. 589 (Cal. 2019) (This bill, if it had succeeded, would have ended deceptive marketing in the drug rehabilitation industry). S.B. 823 has been signed into California law. S.B. 325 died. The Governor of California vetoed S.B. 589, and the California Senate sustained the veto.

[203] The author could not locate any information to suggest that the DOJ implementing more harsh corporate compliance agreements would substantially reduce fraud in the recovery industry.

recommends that, in order to administer and implement effective compliance, businesses must fully educate themselves and their employees on the ramifications of accepting and spending public funds.[204] For recovery providers specifically, this means documenting how and why the center spends money reimbursed from federal benefit programs. The center must document the frequency and medical justification for patient drug tests when it submits them for reimbursement in case the DOJ investigates the center's expenditures. Furthermore, the recovery provider ought to document how they recruit patients. If a center is not sure whether its recruitment reimbursement model may subject them to patient brokering liability, the center should seek counsel.

Even with a comprehensive compliance program, bad actors in the treatment industry may still choose to engage in fraud and suffer the consequences. However, with robust corporate compliance programs and strict corporate integrity agreements, the DOJ may help providers that have instead made a mistake stay in line.

CONCLUSION

John Baker never saw justice in his lifetime. A New Start, the outpatient center that overbilled John and his parents, still operates in West Palm Beach.[205] The center's owner, Moshe Dunoff, is serving time in prison, but on unrelated fraud charges.[206] And while Moshe will see the light of day upon his release, John and countless others who fell victim to fraud in the drug recovery industry will not, all because of health care providers who cared more about profiting from pee than about patient lives.

But future patients in the drug recovery industry may have a more hopeful outlook if legislators, investigators, and agencies take note of proposed solutions. If these actors crack down on fraud in the recovery industry by using a combination of legislative, regulatory, and enforcement tools, hopefully patients may focus on their recovery and brighter days ahead.

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[204] Wifredo A. Ferrer et al., *Federal and Florida Officials Discuss Enforcement Priorities and How Corporations Can Minimize Risk*, HOLLAND & KNIGHT (Nov. 12, 2020), https://www.hklaw.com/en/insights/publications/2020/11/federal-and-florida-officials-discuss-enforcement-priorities.
[205] *See A New Start Inc.*, *supra* note 4.
[206] Segal, *supra* note 1.

MEDICINAL MARIJUANA AND *[THE LACK OF]* EMPLOYMENT RIGHTS

*Sarah Spardy**

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The views, thoughts, and opinions expressed in this text belong solely to the author, and not necessarily to the author's employer, organization, committee, or other group or individual.

INTRODUCTION

Imagine you spent the last year fighting a medical diagnosis, such as cancer. You underwent aggressive treatment, major surgery, and intense rehabilitation. Now, every day you take a dose of a medicinal marijuana product that your doctor recommended to you. After trying a variety of treatments and therapies, this is the only treatment that makes your discomfort subside—you are now able to operate comfortably during everyday activities. You return to your job at a federal agency only to fail a random drug test. As a result, you are fired for violating your company's "drug-free" policy. While searching for a new job in your field, applications ask whether you have consumed marijuana in the past 'x' number of years—instructing you to check yes or no. You answer honestly and are denied interviews for jobs that your education and experience make you a qualified candidate for. When you seek feedback, the employers cite your admission of "consuming illegal substances," noting how they are drug-free workplaces, so they are unable to consider you as a candidate. While this seems unfair considering you are consuming marijuana for medical reasons under the supervision of a physician, you have no legal recourse because marijuana is federally illegal—employers are permitted to have zero-tolerance policies against marijuana use, medicinal and recreational alike, regardless of its medical benefits. You could narrow your job search to positions that do not inquire about marijuana use. But should you have to?

Despite medicinal marijuana's wide acceptance and legal status in many states, this individual's experience is a real possibility for current and prospective employees in the United States because marijuana is still federally illegal under the Controlled Substances Act (CSA). With conflicting federal and state laws regarding the legality of medicinal marijuana use, the legal protections available to employees and applicants depend largely upon the type of employer they have. For example, a federal agency can fire an employee for failing a drug test because of medicinal marijuana use, but a local business owner could not fire that same employee if the business's state had an anti-discrimination law protecting that employee. As states continue to legalize medicinal marijuana use, Congress should work to more adequality protect employees' ability to pursue appropriate medical treatments. Congress can enact this change on a federal level through amendments to the CSA, the Americans with Disabilities Act (ADA), and the Drug-Free Workplace Act (DFWA). States can continue to enact this change at the state level through the implementation of anti-discrimination laws that protect individuals who use medicinal marijuana under the supervision of a medical professional.

The goal of this paper is to provide recommendations on how to extend these anti-discriminatory protections to employees and job applicants at both the state and federal levels. This paper does not assert that employers must allow employees to be intoxicated at work.[1] Instead, it lays out methods for providing adequate employment rights to qualified individuals whose medicinal marijuana use allows them to cope with their medical conditions the same way that federally legal medications, such as over-the-counter medication and prescription painkillers, help individuals cope with illness or discomfort.

This paper will be broken down into three sections: one introducing The Controlled Substance Act (CSA), another regarding state public employment law, and the final section regarding employment law for federal employees and contractors. The first section will briefly discuss the CSA, marijuana's classification under it, and why that makes it difficult for employees who use medicinal marijuana to obtain certain employment rights. The second section will discuss the current trend toward state public employment law protections, compare select state statutes, and provide a recommendation to states on how to avoid federal preemption when drafting those statutes. The third section will then analyze the ADA and the Drug-Free Workplace Act to provide recommendations on how to amend their language and implementation to provide more appropriate protections in employment matters.

I. THE CONTROLLED SUBSTANCE ACT

The CSA categorizes "drugs, substances, and certain chemicals used to make drugs"[2] into five schedules of controlled substances based on their medical benefits and dangers. The Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) are the bodies responsible for adding or removing drugs and substances from different schedules.[3] The fives schedules range from the most restrictive Schedule I drugs and substances to the least restrictive Schedule V drugs and substances.[4] Once a drug is listed as a controlled substance under one of the five Schedules, it is then federally regulated based on which schedule it falls under.[5]

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[1] In fact, individuals who use medicinal marijuana often do not have a "high" sensation associated with it because medicinal marijuana typically contains a high CBD content, which does not produce "psychoactive effects." Recreational marijuana use usually results with that sensation based on its higher level of THC. *See What is the Difference Between Medical vs. Recreational Marijuana?*, DOCMJ (June 5, 2017), https://docmj.com/2017/06/05/difference-medical-recreational-marijuana/.

[2] *Drug Scheduling*, DRUG ENF'T ADMIN., https://www.dea.gov/drug-scheduling (last visited Apr. 3, 2022); *see also* 21 U.S.C.A. § 812 (2018).

[3] *See infra* note 50.

[4] *See generally Drug Scheduling*, *supra* note 2.

[5] 21 U.S.C.A. § 812 (2018).

Currently, marijuana is listed under the most restrictive classification— Schedule I. Meaning, it qualifies as having a high potential for abuse, no currently accepted medical use for treatment in the United States, and a lack of accepted safety use under medical supervision.[6] Marijuana is classified as a Schedule I drug alongside substances like heroin, and at a more restrictive level than Schedule II drugs, such as cocaine and methamphetamine.

Schedule I drugs are strictly regulated and can only be produced and possessed for use in scientific studies that are federally approved on a limited basis.[7] Even though its classification as a Schedule I drug restricts the ability for robust research of its medical benefits, small studies and personal anecdotes have indicated that medicinal marijuana does have benefits as a medical treatment. For example, the American Cancer Society recognizes studies that have found medicinal marijuana helpful for combatting certain cancer symptoms, such as nausea, and improving appetite.[8] While still emphasizing the need for more research, the American Cancer Society also notes that recent studies even show that components within marijuana may be able to slow certain cancer cells from growing.[9]

II. STATE PUBLIC EMPLOYMENT LAW

Despite marijuana's classification under the CSA, thirty-seven states and four territories have legalized the use of medicinal marijuana.[10] The state laws permitting medicinal marijuana use conflict with the CSA, so there is a need to reconcile them for federal employees to also benefit from this legalization. Employers do not need to tolerate employees consuming federally illegal drugs that will reduce their ability to effectively fulfill their responsibilities at work. However, should employers need to allow, and accommodate for, their employees' use of physician-recommended medicinal marijuana? The answer should be yes.

Thirteen state governments have passed anti-discrimination protections for employees who use medicinal marijuana, and the courts have upheld these

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[6] *Id.* § 812(b)(1).
[7] *See* Joanna R. Lampe, CONG. RSCH. SERV., R45948, THE CONTROLLED SUBSTANCES ACT (CSA): A LEGAL OVERVIEW FOR THE 117TH CONGRESS 7 (2021) (citing 21 U.S.C. 823(f)).
[8] *Marijuana and Cancer*, AM. CANCER SOC'Y (last updated Aug. 4, 2020), https://www.cancer.org/treatment/treatments-and-side-effects/treatment-types/complementary-and-integrative-medicine/marijuana-and-cancer.html.
[9] *Id.*
[10] *State Medical Cannabis Laws*, NAT'L CONF. STATE LEGS. (Feb. 3, 2022), https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx; *Map of Marijuana Legality by State*, DISA GLOB. SOLS. (last updated Mar. 2022), https://disa.com/map-of-marijuana-legality-by-state.

statutes.[11] The following discussion of two court decisions illustrates how states that have not yet implemented such provisions can bolster protections for employees.

A. State Anti-Discrimination Laws versus Broad Medicinal Marijuana Laws

The U.S. Constitution's Supremacy Clause deems federal law superior to state law, so state legislatures must use caution when drafting statutes regarding marijuana consumption so as to not be preempted because of its illegal status under the CSA. There are several ways federal preemption can occur, including field preemption, impossibility preemption, and obstacle preemption.[12] Thus, if a state legislature wants to issue an anti-discrimination law for employees who use medicinal marijuana, it needs to specifically state that its intent is to prohibit adverse employment action on that basis. If the statute fails to do this and instead only includes broad language about medicinal marijuana use not being criminalized within the state, it will not prohibit employers from taking adverse action on the basis of medicinal marijuana use. If an employee brings a claim pursuant to that law, the court will determine that the CSA prevails and rule in favor of the employer.

The cases discussed below, *Noffsinger v. SSC Niantic Operating Co.*[13] and *Emerald Steel Fabricators, Inc. v. Bureau of Lab. & Indus.*, [14] focus on two different statutes—one that survived federal preemption and another that other did not. Connecticut's Palliative Use of Marijuana Act (PUMA), which the court in *Noffsinger* determined withstood federal preemption, explicitly protected individuals from discriminatory adverse employment actions for using medically prescribed marijuana while off-the-job.[15] Oregon's Medical Marijuana Act (OMMA), which the court in *Emerald Steel* deemed federally preempted, broadly authorized individuals to use marijuana for medicinal purposes without criminal repercussions. However, it failed to specifically prohibit adverse employment

[11] *Medical Marijuana Laws and Anti-Discrimination Provisions*, MARIJUANA POL'Y PROJECT (last updated Feb. 7, 2022), https://www.mpp.org/issues/medical-marijuana/medical-marijuana-laws-anti-discrimination-provisions/.
[12] SYKES & VANATKO, CONG. RSCH. SERV., R45825, FEDERAL PREEMPTION: A LEGAL PRIMER 17, 23–24 (2019). Field preemption occurs when a state law pertains to a field of regulation that has such thorough federal regulation, it is reasonable to conclude that "Congress left no room for States to supplement it." *Id.* at 17. Impossibility preemption occurs when "it is impossible for regulated parties to comply with both sets of laws." *Id.* at 23–24. Obstacle preemption occurs when state laws "pose an obstacle to the 'full purposes and objectives' of Congress.'" *Id.*
[13] 273 F. Supp. 3d 326, 326 (D. Conn. 2017).
[14] 230 P.3d 518, 518 (Or. 2010).
[15] CONN. GEN. STAT. ANN. § 21a-408p (West 2012).

actions against employees who use medicinal marijuana.[16] The relevant provisions of each statute are as follows:

PUMA:

> CT ST § 21a-408p. Treatment of student, tenant or employee due to status as a qualifying patient
> (b) Unless required by federal law or required to obtain federal funding:
> . . .
> (3) No employer may refuse to hire a person or may discharge, penalize or threaten an employee solely on the basis of such person's or employee's status as a qualifying patient or primary caregiver under sections 21a-408 to 21a-408n,[17] inclusive. Nothing in this subdivision shall restrict an employer's ability to prohibit the use of intoxicating substances during work hours or restrict an employer's ability to discipline an employee for being under the influence of intoxicating substances during work hours.

CONN. GEN. STAT. ANN. § 21a-408p (West 2012).

The lower court in *Emerald Steel* explains the original OMMA[18] in a footnote as follows:

> The Oregon Medical Marijuana Act (OMMA), ORS 475.300–475.346, allows the use of marijuana, under some circumstances, to mitigate the symptoms of a debilitating medical condition. If an attending physician documents that a person has been diagnosed with a debilitating medical condition and that the medical use of marijuana will mitigate the symptoms or effects of that condition, a registry identification card may be issued to that person. ORS 475.309. After registration, a person who is engaged in the medical use of marijuana is partially exempt from the state's criminal laws proscribing marijuana possession. ORS 475.316; ORS 475.319; ORS 475.342.

[16] *Emerald Steel*, 230 P.3d at 518.
[17] These are statutes within Connecticut's General Statutes Annotated under Chapter 420f regarding palliative use of marijuana. *See* CONN. GEN. STAT. ANN. § 21a-408 (West 2012).
[18] *See Oregon Medical Marijuana Act*, PROCON.ORG, https://medicalmarijuana.procon.org/wp-content/uploads/sites/37/ors.pdf (last visited Apr. 4, 2022) (providing complete copy of the original OMMA discussed by *Emerald Steel*).

Noffsinger and *Emerald Steel* illustrate the different analyses courts go through when determining whether the CSA preempts state law regarding marijuana use. The difference in the courts' analyses is as follows.

In *Noffsinger*, a doctor recommended that a Connecticut employee (plaintiff) use medicinal marijuana as treatment for posttraumatic stress disorder (PTSD).[19] The plaintiff subsequently registered with the state Department of Consumer Protection as a qualified patient under PUMA so he would then be permitted to consume medicinal marijuana to treat his PTSD while off work, per his doctor's recommendation.[20] By registering under PUMA, the plaintiff would not be jeopardizing his job prospects by consuming the recommended dosage.[21] However, the plaintiff brought suit when his employer (defendant) rescinded his job offer when his drug screening results returned positive for cannabis.[22] In response to the suit, the defendant challenged PUMA's validity, asserting that the CSA preempted it.[23] The court held in the plaintiff's favor, and clarified that the CSA does not preempt the state of Connecticut from implementing and enforcing PUMA because:

> The CSA . . . does not make it illegal to employ a marijuana user. Nor does it purport to regulate employment practices in any manner. It also contains a provision that explicitly indicates that Congress did not intend for the CSA to preempt state law "unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together. 21 U.S.C. § 903.
>
> Defendant argues that PUMA stands as an obstacle to the CSA because it affirmatively authorizes the very conduct—marijuana use—that the CSA prohibits. But this argument is overbroad and overlooks the operative provision of PUMA that is at issue in this case: the specific provision of PUMA that prohibits an employer from discriminating against authorized persons who use medicinal marijuana. Plaintiffs contend that the defendants have violated this particular provision . . . Accordingly, I must focus on PUMA's specific anti-employment discrimination provision rather than the statute as a whole, because in preemption cases, "state law is displaced only to the extent that it actually conflicts with federal Law," and "a federal court

[19] *Noffsinger v. SSC Niantic Operating Co*., 273 F. Supp. 3d 326, 331 (D. Conn. 2017).
[20] *Id*.
[21] *Id*.
[22] *Id.* at 332.
[23] *Id.* at 333.

> should not extend its invalidation of a statute further than necessary to dispose of the case before it."[24]

When the *Noffsinger* court was going through its analysis to determine whether CSA preempts PUMA, the court noted that it was dealing with the specific issue regarding *anti-discrimination on the basis of medicinal marijuana* use rather than a broader question regarding *the legality* of that medicinal marijuana use, as discussed in *Emerald Steel*. In *Emerald Steel*, there was an employee (plaintiff) who needed to pass a drug test to earn a permanent position at the workplace. Before submitting to the drug test, the plaintiff informed the employer (defendant) of his medical marijuana use pursuant to his registry identification, which enabled him to legally consume medicinal marijuana under Oregon law,[25] and provided the defendant with a physician-signed statement detailing that he had a "debilitating medical condition" which marijuana might be able to mitigate.[26] The defendant fired the plaintiff one week later despite OMMA's authorization of individuals to use marijuana for medicinal purposes without criminal repercussion so long as they obtain a registry identification card to do so.[27]

The *Noffsinger* court uses *Emerald Steel* as a comparison because the defendant in *Emerald Steel* relied on similar facts and federal preemption to base his argument regarding preemption of PUMA on. The *Noffsinger* court's comparison to OMMA in *Emerald Steel* included:

> Although state and federal courts around the country have evaluated other States' medical marijuana statutes—including in the employment context—many of those cases are of limited value here, because the statutory provisions at issue in those cases are not analogous to the anti-discrimination provision of [PUMA].
>
> For example, defendant relies heavily on *Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus.,* 348 Or. 159, 230 P.3d 518 (2010), in which the Oregon Supreme Court determined that Oregon's medical marijuana statutes was preempted by the CSA. Factually, the context in *Emerald Steel* is quite similar to this case: a plaintiff was fired by his employer one week after disclosing his status as a state-law- authorized user of medical marijuana. Legally, however, *Emerald Steel* is different, because Oregon's

[24] *Id.* at 334.
[25] Referring to OMMA.
[26] *Emerald Steel Fabricators, Inc. v. Bureau of Lab. & Indus*., 230 P.3d 518, 520 (Or. 2010).
[27] *Id.* at 521.

> medical marijuana statute contains no provisions explicitly barring employment discrimination.[28]

Based on these slight, yet key, factual differences between the statutes at issue, the Court determined that the defendant employer's reliance on *Emerald Steel* failed. The court reasoned that:

> The very different question presented in *Emerald Steel* was whether the CSA more generally preempted a provision of Oregon law that authorized the use of medical marijuana. Here, by contrast, the question is whether the CSA preempts a provision that prohibits an employer from taking adverse action against an employee on the basis of the employee's otherwise state-authorized medicinal use of marijuana.[29]
>
> So *Emerald Steel* is distinguishable, because it did not concern a statutory anti- discrimination-against-use-of-medical-marijuana provision. . . . Although most cases dealing with the CSA's preemption of state medical marijuana statutes have come out in favor of employers, these cases have not concerned statutes with specific anti-discrimination provisions. . .
>
> [The section of PUMA at issue in this case] regulates the employment relationship, an area in which States "possess broad authority under their policy powers to regulate.'" . . . Given that the CSA nowhere prohibits employers from hiring applicants who may be engaged in illegal drug use, defendant has not established the sort of "positive conflict"[30] between

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[28] *Id*. at 334–35.

[29] The opinion includes a footnote further explaining why the issue in *Emerald Steel* was different than the issue in *Noffsinger*:

> "The plaintiff in *Emerald Steel* brought his claim under ORS 659A. 112, a state law that protects employees against discrimination on the basis of disability. The defendant argued that it had no obligation to accommodate the plaintiff's medical marijuana use, because the law provided an exemption to the protection of ORS 659A.112, for cases in which the employer takes action based on an employee's illegal use of drugs. The decision in *Emerald Steel* turned on whether the plaintiff's use of medical marijuana constituted "the use of illegal drugs," and therefore it turned on whether the use of medical marijuana was "lawful." The Oregon Supreme Court held that it was not lawful, because the provision of Oregon's medical marijuana act that authorized the use of medical marijuana was preempted by the CSA."

[30] The "positive conflict" the court mentions is based on § 903 of the CSA, which reads:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates,

> [PUMA] and the CSA that is required for preemption under the very terms of the CSA. *See* 21 U.S.C. § 903.[31]

A key aspect of the court's preemption consideration was § 903 of the CSA.[32] This section essentially confirms that states may issue marijuana use laws that are able to survive preemption.[33] However, the provision goes on to warn that even though the contents within the CSA are not preempted through field preemption, courts can still preempt them based on the impossibility or obstacle preemption theories.[34] The courts illustrate these analyses.

In *Emerald Steel,* the court determined the OMMA was preempted through a two-prong analysis of § 903. The court analyzed (1) whether the statute could be preempted under impossibility preemption and (2) whether it could be preempted based on obstacle preemption.[35] While it determined that there was no "actual conflict" under the first prong because individuals could follow both laws by simply not using medicinal marijuana, the court gave the second prong's analysis more weight. It ultimately concluded that the CSA preempts OMMA based on the theory of obstacle preemption because OMMA affirmatively authorizes marijuana use with no criminal repercussions, making it a direct obstacle to the "implementation and execution" of the Congress' objectives to criminalize marijuana use under the CSA.[36]

On the other hand, the court in *Noffsinger* determined that the CSA does not preempt PUMA because the CSA neither (1) makes it illegal to employ someone who uses marijuana nor (2) seeks to regulate state employment practices or preempt state law.[37]

> including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together. 21 U.S.C.A. § 903

[31] *See Noffsinger v. SSC Niantic Operating Co*., 273 F.Supp.3d 326, 335–36 (D. Conn. 2017).
[32] *See supra* note 30.
[33] *Id*. (detailing that "no provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law . . . .").
[34] *Id.*
[35] *Emerald Steel*, 230 P.3d at 528.
[36] *Id*. at 529.
[37] *Supra* note 30.; *Noffsinger v. SSC Niantic Operating Co*., 273 F. Supp. 3d 326, 334 (D. Conn. 2017).

B. Judicial Remedies for Injured Patients

As long as marijuana remains federally illegal, every state with a medical marijuana legalization statute should include an anti-discrimination provision that explicitly prohibits employers from taking adverse employment actions against individuals on the basis of medicinal marijuana use. Although marijuana remains a Schedule I drug under the CSA, *Noffsinger* proves that states have the power to allow citizens to participate in medicinal marijuana therapy, per physician recommendation, without having to forfeit job opportunities and economic stability. All states should strive for such inclusivity.

To do this, state legislatures need to avoid preemption by ensuring there is no (1) "positive conflict" or (2) "impermissible obstacle to the basic purpose of the CSA."[38] State legislatures need to include specific language that prohibits discrimination against employees *on the basis of their medicinal marijuana use*. For example, as seen in PUMA, "[n]o employer may refuse to hire a person or may discharge, penalize or threaten an employee solely on the basis of such person's or employee's status. . ." as a medicinal marijuana patient.[39] The courts will focus their analysis on whether the employer took adverse action against the employee on the basis of their marijuana use when analyzing a statute with that language. On the other hand, if the statute is written more like OMMA to simply not criminalize medicinal marijuana use, courts are likely to defer to the CSA and uphold the employer's actions when employees try to base their discrimination claims on the state statute.

Nonetheless, even if every state successfully drafted and implemented anti-discrimination statutes for employees who use medicinal marijuana, there would still be many individuals in the United States who are not afforded this protection or peace of mind: employees, contractors, and applicants at the federal government level.

III. [THE LACK OF] MEDICAL RIGHTS AT THE FEDERAL LEVEL

State-level anti-discrimination provisions regarding medicinal marijuana do not apply to federal employees. This leaves many individuals at risk of experiencing discrimination in the workplace and job application processes for simply choosing a medical treatment that their doctor recommended to manage their medical

[38] *Id*. at 333, 336.
[39] CONN. GEN. STAT. ANN. § 21a-408a (a)(1)-(4).

condition.[40] However, there are existing federal laws that, if amended, afford those federal employees and applicants protection against that kind of discrimination.

A. The Controlled Substances Act

Currently, the biggest setback to protecting these federal employees in the workplace is marijuana's classification as a Schedule I substance in the CSA. Among other consequences, this classification prohibits medical professionals from prescribing it,[41] severely restricts research on its potential medical uses,[42] and bars its use as a reasonable accommodation under the ADA.[43]

If marijuana were rescheduled to even a Schedule II substance, medical professionals could legally prescribe medicinal marijuana as treatment for their patients.[44] Jobs that require screenings for illegal drug use in their application processes could no longer eliminate applicants based on medicinal marijuana use as prescribed by a medical professional. For example, when job applicants are asked whether they have participated in illegal drug use over the past few years, someone who only consumed marijuana as prescribed by their doctor would be able to answer no. If an office requires drug testing as part of their screening process, applicants could prove that their marijuana use was legal and for medical purposes with a written prescription. Similarly, employees who are bound by drugfree workplace policies could use their written prescription as proof that their consumption was legal and for a medical purpose as prescribed by their doctor. Further, medicinal marijuana consumption while on the job could more easily be

[40] The Congressional Research Service issued data indicating that there were 4,253,133 United States federal employees in 2020. *See* Julie Jennings & Jared C. Nagel, CONG. RSCH. SERV., R43590, FEDERAL WORKFORCE STATISTICS SOURCES: OPM AND OMB 6 (2021).
[41] 21 U.S.C.A. § 829 (2016) (discussing the parameters by which scheduled drugs may be prescribed pursuant to their scheduling, with Schedule II substances being the most restricted schedule that physicians may prescribe from).
[42] *See* Lampe, *supra* note 7, at 31 (citing 21 U.S.C.A. § 823(f)).
[43] While a more thorough discussion of the ADA takes place in the following section, *see* 42 U.S.C.A. § 12210(c)(d)(1) (2009) (stating "[t]he term "illegal use of drugs" means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substance Act. Such term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act. . . ."; 21 U.S.C.A. § 829(a) (2016).
[44] § 829(a). It is important to note that pursuant to § 829(a), prescriptions for Schedule II drugs may not be refilled without a practitioner. As such, if marijuana cannot be unscheduled, rescheduling it to at least a Schedule III substance would be more effective for individuals who benefit most from its treatment on a longer-term basis.

classified as a reasonable accommodation under the ADA so long as it does not inhibit the employee's functionality and efficiency.[45]

However, it is important to note that while reducing marijuana's classification to a Schedule II substance would make these improvements, they would come with a notable limitation: prescriptions for Schedule II substances may not be refilled.[46] As such, rescheduling marijuana to at least a Schedule III drug would be more beneficial for individuals who benefit most from medical marijuana treatment on a longer-term basis.

Although rescheduling marijuana from the list of Schedule I substances seems like a reasonable step,[47] and numerous discussions have already occurred regarding this topic,[48] changing its status is not likely to be a swift process.[49] In fact, the DEA, which is the entity with authority to schedule and reschedule substances and drugs based on specific criteria set forth in the CSA,[50] denied a petition to reschedule marijuana relatively recently based on the CSA's strict requirements.[51]

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[45] *See supra* note 43 and accompanying text; 21 U.S.C.A. § 829(a) (2016) (permitting practitioners to dispense Schedule II substances through written prescriptions and particular emergency situations).

[46] 21 U.S.C.A. § 829(a) (2016).

[47] "As of December 2020, 15 states and the District of Columbia have passed laws removing state prohibitions on medical and recreational marijuana use by adults age 21 or older. An additional 33 states have passed laws permitting medical use of marijuana or the marijuana-derived compound cannabidiol (CBD). However, marijuana remains a Schedule I controlled substance under federal law, and state legislation decriminalizing marijuana has no effect on that status." Lampe, *supra* note 7, at 25–26 (citations omitted).

[48] For a discussion from the past year regarding marijuana's rescheduling, *see* Jesse Mondry, *Cannabis Litigation: Second Circuit Could Force DEA to Re-or Deschedule Marijuana*, HARRIS BRICKEN (June 1, 2019), https://harrisbricken.com/cannalawblog/cannabis-litigation-second-circuit-could-force-dea-to-re-or-deschedule-marijuana/.

[49] *See* 21 U.S.C. § 811 (2018) (discussing the process the Attorney General must follow to reschedule a drug).

[50] While the CSA gives the Attorney General the authority to add a drug or substance to the schedules (21 U.S.C. 811(a)(1)) or remove any drug or substance from the schedules (21 U.S.C. 811(a)(2)) pursuant to specific criteria (21 U.S.C. 811), the Attorney General delegated this authority to the DEA. *See* 28 C.F.R. Section 0.100(b). For an overview of the scheduling process, *see generally*, Lampe, *supra* note 7.

[51] In a 2016 Federal Register, the DEA discusses its denial of a petition to initiate proceedings to reschedule marijuana. In this discussion, the DEA explains that "in accordance with section 811(d)(1) [of the CSA, which requires the DEA to schedule marijuana based on what is most appropriate "to carry out the U.S. obligations" under international treaties], DEA must place marijuana in either schedule I or schedule II." In the 2016 decision, the DEA rejects a schedule II classification for marijuana because "the available evidence is not sufficient to determine that marijuana has an accepted medical use," thus requiring the DEA to maintain marijuana's status as

Additionally, Congress has the authority to amend the CSA and reschedule marijuana from its Schedule I classification through its legislative process,[52] but this has not successfully been achieved. Meanwhile, federal employees, contractors, and hopeful applicants are being put in a position to choose between valid medical treatment and employment opportunities every day. Alternative avenues to address this issue thus warrant consideration. These options include amending the ADA and the Drugfree Workplace Act to mitigate the restrictions that these statutes present to employees attempting to access medical marijuana to treat their medical conditions, as discussed in the following two sections.

B. The Americans with Disabilities Act (ADA)

If courts were able to slightly alter their analysis of matters regarding the ADA and medicinal marijuana use, the federal employees, contractors, and hopeful applicants who are at risk of workplace discrimination because of medicinal marijuana use would not need to rely solely on a CSA amendment for protection from that discrimination. The ADA is grounded in promoting individuals' inherent right to live equally without the threat of discrimination based on their disability. With the authority to accept qualified individuals' use of medicinal marijuana, courts could enhance the ADA's function as a tool to protect these individuals against discrimination.

Title I of the ADA prohibits "private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities."[53] The ADA's protections were not applicable to all federal employees and contractors until the Equal Employment Opportunity Commission (EEOC) amended section 501 of the Rehabilitation Act—an act that prohibits discrimination against federal employees and contractors on the basis of

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a schedule I drug. *See* Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 81 Fed. Reg. 156 (Aug. 12, 2016); *see also* Joanna R. Lampe, CONG. RSCH. SERV., LSB10655, DOES THE PRESIDENT HAVE THE POWER TO LEGALIZE MARIJUANA? (2021) (noting that CSA § 811(d)(1) "directing DEA to schedule controlled substances as 'required by United States obligations under international treaties' may limit the agency's authority to relax controls of marijuana").

[52] *See* Joanna R. Lampe, *supra* note 51, at 2-3.

[53] *Employment (Title I)*, ADA.GOV, https://www.ada.gov/ada_title_I.htm. (last visited Apr. 10, 2022). The ADA has five sections: Title I for employment, Title II for public entities and public transportation, Title III for public accommodations and commercial facilities, Title IV for telecommunications, and Title V for miscellaneous provisions. *See generally* 42 U.S.C. § 12101 (2018).

disability—to cross-reference the ADA as its standard for applying the act.[54] Thus, because federal employers are bound by the ADA based on that cross-reference, this section focuses on Title I of the ADA and ways to expand its protections.[55] While this expansion would be applicable to all employees in the United States, the primary focus of this section is to ensure that federal government employees are afforded adequate protections because state laws legalizing medicinal marijuana use do not apply to their employment. Although not an exhaustive list, two sections that provide instances where the authority to complete an altered analysis would achieve this expansion to the use of medicinal marijuana are § 12210 and § 12112.

1. The ADA's Background

When President H.W. Bush signed the ADA into law in 1990, he said the "ADA would ensure individuals with disabilities 'the opportunity to blend fully and equally into the rich mosaic of the American mainstream.'"[56] The ADA was written to provide individuals with disabilities legal recourse to redress discrimination in critical aspects of life, such as "employment, housing, public accommodations, education, transportation, communication, recreation institutionalization, health services, voting, and access to public services."[57] While physical or mental disabilities do not diminish individuals' rights and abilities to fully participate in every aspect of society, discrimination can reduce this ability if gone unaddressed. Discrimination against individuals with disabilities, preventing them from exercising their right to fully participate in all of society, was a "serious and

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[54] *Fact Sheet: Disability Discrimination*, U.S. EEOC, https://www.eeoc.gov/eeoc/publications/fs-ada.cfm (last visited Apr. 10, 2022); *The Rehabilitation Act*, Southwest ADA Center, http://www.southwestada.org/html/guide_to/sect501_503.html (last visited Apr. 10, 2022) (noting that:

> "When Title I of the ADA (employment provisions) was enacted, some of the legal requirements of the ADA differed from the Rehabilitation Act, even though the two laws shared the same purpose: ending employment discrimination based on disability. Congress subsequently amended the Rehabilitation Act, applying the ADA standards to federal employment. This EEOC final regulation continues the movement towards full integration of individuals with disabilities into the Federal workforce by clarifying the application of the employment provisions of the Americans with Disabilities Act of 1990 (ADA) to federal government workers.")

[55] While this expansion would be applicable to all employees, the primary purpose of including this section in this paper is to ensure that federal employees are afforded adequate protections since the state anti-discrimination laws are not applicable at the federal level. *See generally* U.S. Const. Art. VI. cl. 2 (establishing that federal laws supersede conflicting state laws).

[56] *The Americans With Disabilities Act of 1990-ADA*, OLMSTEAD RIGHTS, https://www.olmsteadrights.org/about-olmstead/item.6460-The_Americans_with_Disabilities_Act_of_1990_ADA (last visited Apr. 10, 2022).

[57] 42 U.S.C.A. § 12101(a)(3)–(4) (2009).

pervasive social problem" at the time the ADA was signed into law.[58] The legislatures who wrote the ADA intended to combat that issue.[59]

2. Title I of the ADA and Qualifying Disabilities

When it comes to disability rights and employment, Title I of the ADA prohibits employers from discriminating against employees, contractors, or applicants on the basis of disability.[60] This applies throughout job application procedures, hiring, advancement or discharge of employees, employee compensation, job training, and other conditions and privileges of employment.[61] To qualify as a disability, an individual's medical condition must (1) be a physical or mental impairment that substantially limits one or more of the individual's major life activities, (2) have record showing the existence of such impairment, and (3) result in the individual being regarded as having such impairment.[62]

Major life activities include, but are not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."[63] The operation of a major bodily function, such as functions of the immune system, neurological, or brain functions, can also constitute a major life activity.[64] Only one major life activity needs to be limited to fulfill this requirement,[65] and an impairment that is in remission or episodic is still a disability if, when active, it would substantially limit a major life activity.[66] However, even if all of the aforementioned qualifications are met, the impairment does not qualify as a disability under the ADA if it is "transitory or minor," meaning the impairment only lasts, or is expected to last, for six months or less.[67]

To determine whether an individual's disability qualifies under the ADA, courts must (1) establish whether the physical or mental condition qualifies as an "impairment," (2) identify and establish the major life activity that the impairment limits, and (3) determine whether the impairment substantially limits that major life activity. Impairments can impact individuals differently, so there is no set list of

[58] § 12101(a)(2).
[59] § 12101(b).
[60] § 12112(a).
[61] § 12112(b)(1)–(7).
[62] 42 U.S.C.A. § 12102 (1)(A)–(C) (2009).
[63] § 12102(2)(A).
[64] *Id*. at (2)(B).
[65] § 12102(4)(C).
[66] *Id*. at (4)(D).
[67] § 12102(3)(B).

disabilities that qualify under the ADA. Instead, whether a disability qualifies is determined on a case-by-case basis.[68]

Once an individual's impairment does qualify as a disability under the ADA, that individual is afforded the protections of the ADA. However, the ADA is currently not interpreted to include protections for medicinal marijuana use to treat a disability. This gap provides room for discriminatory practices masked as responses to "illegal drug use." An employer can discriminate against employees and applicants based on their disability but blame it on the medicinal marijuana they use to treat that disability. This eliminates qualified applicants from consideration and forces qualified employees to choose between their employment and participating in what could be the most beneficial medical treatment for them.

3. § 12210 Illegal Use of Drugs

Section 12210 of the ADA specifies that individuals who engage in the illegal use of drugs are not included in the ADA's definition of "individual with a disability."[69] The 'illegal use of drugs' includes "the use of drugs, the possession of, and distribution of which is unlawful under the Controlled Substances Act."[70] In other words, an employer may take adverse employment action against an employee without violating the ADA on the basis of them using, for example, cocaine or abusing prescription drugs.[71] However, this provision includes an exception for drugs that are "taken under supervision by a licensed health care professional."[72]

Federal courts have decided that § 12210 does not protect medicinal marijuana use, even with a physician recommendation,[73] because it is federally illegal. Meaning, that even if an individual is using medicinal marijuana while off-duty per a medical professional's recommendation solely for the purpose of treating an ADA-qualifying disability, an employer may still take adverse actions against them based on their marijuana use without violating the ADA. Although dissenting judges sought to include medicinal marijuana to fall under § 12210, the majority in *James v. City of Costa Mesa* opted against its inclusion.

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[68] *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 2162 (1999).
[69] 42 U.S.C. § 12210(a) (2009).
[70] § 12210(d)(1).
[71] *Sharing the Dream: Is the ADA Accommodating All?*, U.S. COMM'N ON CIV. RTS., https://www.usccr.gov/pubs/ada/ch4.htm#_ftnref7. (last visited Apr. 10, 2022).
[72] § 12210(d)(1).
[73] As discussed previously, the CSA prohibits physicians from prescribing Schedule I substances. *See* 21 U.S.C. § 829 (2016).

The plaintiffs in *James v. City of Costa Mesa* were California residents who had severe disabilities that could not be alleviated with traditional medical services, drugs, or other medications.[74] To manage their pain, the plaintiffs obtained a recommendation from their doctors to use marijuana. This recommendation was pursuant to the California law that suspended state-law penalties for marijuana possession and cultivation for California residents who were (1) seriously ill and (2) obtained recommendation or approval from a physician even though the CSA federally prohibited doing so.[75] However, the cities that had the dispensaries from which the plaintiffs were getting their marijuana were adopting ordinances to prohibit the operation of marijuana dispensing facilities within their city limits.[76] In response to these zoning plans, which would prevent access to the medicinal marijuana that they relied on, the plaintiffs brought suit. In an action for preliminary injunctive relief in federal district court to enjoin the cities from implementing these ordinances, the plaintiffs based their claim on ADA violations.[77] The court ultimately denied the action, ruling against the plaintiffs, because "the ADA does not protect against discrimination on the basis of marijuana use, even medical marijuana use supervised by a doctor in accordance with state law."[78] This is one example of medicinal marijuana use not being considered to fall under the ADA's § 12210(d)(1) illegal drug exclusion.

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[74] *James v. City of Costa Mesa*, 700 F.3d 394, 396 (9th Cir. 2012). Although this section of the paper is focused on rights for federal employees and these plaintiffs are not federal employees, the court's interpretation here of the ADA is applicable to all employees because the ADA applies to federal and non-federal employees. For additional discussion on this, *see generally supra* notes 54 & 56 and accompanying text.

[75] *See* CAL. HEALTH & SAFETY CODE § 11362.5(d) (West 1996) ("Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.").

[76] *James*, 700 F.3d at 396; *see infra* note 87 (discussing the requirements of President Reagan's Drug-Free Workplace Act of 1988 which restricted the awarding of federal contracts to contractors who took specific measures to keep workplaces drug-free).

[77] *James*, 700 F.3d at 396.

[78] *Id.* at 397; A particularly striking excerpt from the *James* opinion reads:

> "We recognize that the plaintiffs are gravely ill, and that their request for ADA relief implicates not only their right to live comfortably, but also their basic human dignity. We also acknowledge that California has embraced marijuana as an effective treatment for individuals like the plaintiffs who face debilitating pain. Congress has made clear, however, that the ADA defines "illegal drug use" by reference to federal, rather than state, law, and federal law does not authorize the plaintiffs' medical marijuana use. We therefore necessarily conclude that the plaintiffs' medical marijuana use is not protected by the ADA."

Id.

However, the court includes a footnote that states they do not hold that "medical marijuana users are not protected by the ADA in any circumstance," but instead they hold that "the ADA does not protect medical marijuana users who claim to face discrimination on the basis of their marijuana use."[79] The Equal Employment Opportunity Commission (EEOC) explained that the reason for this distinction is because medical marijuana use does not qualify as a disability under the ADA, so an individual cannot bring a discrimination claim under the ADA for it. The footnote further explains by example, stating that an individual can have a qualifying disability under the ADA and also be a compulsive gambler in violation of Section 12211(b)(2). If their employer takes adverse employment action against them because of their compulsive gambling and they subsequently bring an ADA violation claim based on discrimination, their claim will fail because compulsive gambling is not a disability under the ADA.

4. Recommended Changes to § 12210

While the reasoning behind the holding in *James* may be justified in the context of the illegal activity Section 12210 was intended to regulate, it should be a different analysis when the "illegal" activity is in the context of a medically-prescribed treatment, with widely-accepted medical uses and benefits, taken under the supervision of a medical professional.[80] The court itself states:

> We recognize that the plaintiffs are gravely ill, and that their request for ADA relief implicates not only their right to live comfortably, but also their basic human dignity. We also acknowledge that California has embraced marijuana as an effective treatment for individuals like the plaintiffs who face debilitating pain. Congress has made clear, however, that the ADA defines "illegal drug use" by reference to federal, rather than state, law, and federal law does not authorize the plaintiffs' medical marijuana use. We therefore necessarily conclude that the plaintiffs' medical marijuana use is not protected by the ADA.[81]

To discriminate against someone based on the treatment they use to treat their disability is to discriminate against someone based on their disability. For example, if an individual who has cancer that qualifies them as having a disability under the

[79] *Id.* at 397 n.3.
[80] *See id.* at 397; *supra* note 7 (discussing how studies determined that while marijuana should not be used alone to treat cancer, it can help ameliorate cancer symptoms including: treating nausea and vomiting from chemotherapy, improving food intake, and reducing the need for pain medicine).
[81] *James*, 700 F.3d at 397.

ADA uses medicinal marijuana to combat nausea and vomiting so they can attend work, their work product is not being negatively impacted. In fact, the treatment is likely making it more manageable for them to fulfill their responsibilities. They are consuming the marijuana in response to their ADA-qualifying disability; they would not have marijuana in their bloodstream if it were not for their disability. Thus, adverse action against them for their marijuana use should be considered adverse action against them as a result of their disability. When an employee experiences this kind of discrimination, they can assert that the employer's adverse actions were made based on the employee's disability instead of asserting that the adverse actions were a violation of the ADA like the plaintiffs did in *James*. Discriminating against a *qualifying disability* is a violation of the ADA—the marijuana use stems from the disability. Thus, discriminating against them for the therapy they use to treat that disability is discriminatory.

Second, while removing marijuana from its classification as a Schedule I drug under the CSA would make courts' decision to permit medicinal marijuana use the clearest, the federal legislature also has the power to amend Section 12210(c)(1)'s exception to achieve a similar outcome. This amendment can more easily occur because it would not require specifically "legalizing marijuana," which can be a substantial hurdle for some legislators. The amendment could expand the exception to include 'illegal drug use' when that drug use is under a *medical professional's supervision* and it is the individual's *last-resort option* for treatment with *no reasonable alternatives*.[82] This expanded exception could co-exist with the CSA because it is recognizing that without that drug use, the individual with a disability would be "precluded from [their right to fully participate in all aspects of society]" because of their disability,[83] which is one of the main issues the ADA exists to combat.

5. § 12112 Discrimination

Section 12112 of the ADA prohibits employers from discriminating against qualified individuals on the basis of a disability "in regard to job application procedures, the hiring, advancement, or discharge of employees, employee

[82] Take, for example, a man who suffered from seizures to the point that he "couldn't function properly." After extensive testing and trying different medications, "his seizures continued, no matter which treatment he was given." He was only able to control the seizures, and function better as a result, once he began using medicinal marijuana to treat them. *See Pioneering Treatment Options: How Medical Cannabis Improves Patients' Lives*, SANDOZ https://dev.sa.sandoz.com/stories/access-medicines/pioneering-treatment-options-how-medical-cannabis-improves-patients%27-lives (Nov. 5, 2018) (discussing this example).
[83] 42 U.S.C.A. § 12101(a)(1).

compensation, job training, and other terms, conditions, and privileges of employment."[84]

> Discriminating on the basis of disability includes, in relevant part:
>
> (1) limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee;
>
> (5)(A) not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity;

42 U.S.C.A. § 12112 (b)(1), (5)(A) (2009).

If an employer violates § 12112 requirements, an employee can bring a claim alleging that the employer failed to reasonably accommodate their disability by showing that the employee (1) has a disability under the ADA, (2) the employer was aware of the disability, and (3) the employee was otherwise qualified for the job.[85] If an employer fails to provide reasonable accommodations to an employee who the employer knows needs reasonable accommodations because of their ADA-qualifying disability, the employer is responsible for committing unlawful discrimination unless they can show the accommodation imposed an undue hardship.[86]

Although this sounds like a relatively straightforward process, it is notably more complicated for employees who are seeking medicinal marijuana use as their reasonable accommodation because of its status under the CSA.

6. Recommended Changes to § 12112

Medicinal marijuana use should be classified as a reasonable accommodation under Section 12112(b)(5)(A) when the use does not negatively interfere with an employee's ability to complete the duties they were hired for. This accommodation would still allow employers to enforce drug-free workplace policies against

[84] 42 U.S.C.A. § 12112(a) (2009).
[85] *Hammer v. Bd. of Educ. of Arlington Heights Sch. Dist. No. 25*, 955 F. Supp. 921, 925 (N.D. Ill. 1997).
[86] *Dutton v. Johnson Cnty. Bd. of Cnty. Com'rs*, 859 F. Supp. 498, 505 (D. Kan. 1994).

employees participating in illegal drug use recreationally. However, it would also permit individuals with ADA-qualifying disabilities to participate in medicinal marijuana treatment if their medical professionals recommend it. This accommodation would move the United States closer to achieving the ADA's purpose in the workplace.

This accommodation would be reasonably straightforward to implement by requiring (1) an individual to have an ADA-qualifying disability and (2) written proof confirming that their medical professional recommended medicinal marijuana for treatment of that disability. It is important to note, however, that this accommodation is likely to rise to the level of an undue hardship for federally-funded employers without an amendment to another law—the Drug-Free Workplace Act—which requires workplaces to remain drug-free to receive federal funding.

C. The Drug-Free Workplace Act

In 1986, President Ronald Reagan issued Executive Order 12564 in response to the alleged adverse effects of the use of illegal drugs on the national workforce.[87] The executive order notes that federal employees who use illegal drugs are often "less productive, less reliable, and prone to greater absenteeism."[88] The purpose of the executive order was to emphasize the risks to national security, public safety, and law enforcement that come with certain federal employees using illegal drugs. President Reagan reasoned that the drug use indicated insufficient "reliability, stability, and good judgment" needed for access to the sensitive information those federal employees worked with.[89] As a result, President Reagan ordered the Drug-Free Workplace Act of 1988 (DFWA) to prohibit federal employees from using illegal drugs for the federal agencies and contractors to receive federal funding of $100,000 or more.[90] Despite the legalization of marijuana use in many states and the measures those states have taken to protect employees who use medicinal marijuana from discrimination since then, there is still explicit prohibition of marijuana use for federal department and agency employees and contractors in order for those entities to comply with the DFWA.[91]

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[87] *See* Exec. Order No. 12564, 51 Fed. Reg. 32889 (1986).
[88] *Id*. at 32889.
[89] *Id*.
[90] 41 U.S.C.A. § 8102.
[91] Memorandum from Katherine Archuleta, Director, Off. of Pers. Mgmt., to Heads of Executive Departments and Agencies (May 26, 2015), https://www.chcoc.gov/content/federal-laws-and-policies-prohibiting-marijuana-use (setting out guidance clarifying that marijuana is still a federally illegal Schedule I drug within the CSA, the DFWA's requirements prohibit its use, and that involvement with marijuana may impact suitability determinations for covered positions).

The DFWA[92] requires federal contractors (defined as the "department, division, or other unit of a person responsible for performance under the contract") receiving federal grants to make a good faith effort to maintain a drug-free workplace by implementing certain measures in the workplace.[93] If these measures are not taken, the federal contractors cannot receive federal grants. [94] One measure, for example, requires the grant recipient to notify employees that they are prohibited from using or possessing any unlawful controlled substances in the workplace.[95] The notification must specify that action will be taken against the employees for any violations.[96] While the DFWA does not specifically require the federal agencies and contractors to drug test employees, it does require them to: publish a statement notifying employees about what actions will be taken if they use or possess unlawful illegal controlled substances at work; establish a drug-free awareness program; give every employee a copy of the grant statement that prohibits unlawful drug use or possession; and notify employees that their employment is conditioned upon abiding by the terms of the grant statement.[97]

If the federal agency granting the funding determines that the recipient has violated any of these listed requirements, or that a number of the recipient's employees have been convicted for violating criminal drug statutes indicating the recipient is not making a "good faith effort to provide a drug-free workplace," then the grantor may suspend or terminate the grant.[98] Even worse, the grantor also has the ability to debar the recipient which would prohibit the recipient from maintaining the current grant received and from receiving further grants from federal agencies for up to five years.[99]

In instances where a recipient is at-risk of suspension of grant payments, termination of the contract, or disbarment, the head of the grantor agency has the option to waive the suspension, termination, or disbarment if they determine either that any of these actions would "severely disrupt the operation of the agency to the detriment of the Federal Government or the general public," or that the repercussion would be against public interest in general.[100]

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[92] 41 U.S.C.A. § 8101(a)(1).
[93] *See* § 8102.
[94] *Id*.
[95] *Id*. § 8103(a)(1)(A).
[96] *Id.*
[97] *Id.* § 8103(a)(1)(A)-(D).
[98] 41 U.S.C.A. § 8103(b)(1).
[99] *See id.* § 8103(b)(2).
[100] *See id*. § 8105(a).

The DFWA does not specify how workplaces should enforce company policies, but court decisions and interpretations have determined that the DFWA does not require recipients to drug test employees and applicants.[101] However, random drug testing is a reliable method used as a deterrent from illegal drug use to ensure compliance with the drug-free requirements.[102] The Substance Abuse and Mental Health Administration (SAMSHA), which is a branch within the Department of Health and Human Services, has guidelines for federal workplace drug testing that require federal agencies to drug test and ensure that they test each specimen for marijuana.[103] Once the specimen is collected, a Medical Review Officer (MRO) in an HHS-certified laboratory conducts the necessary drug screenings. If the specimen is negative, the MRO will report the results to the agency. If the specimen is positive, the MRO must contact the employee to determine if there is a "legitimate medical explanation for the invalid result."[104] If the employee provides a legitimate medical explanation and proper documentation to corroborate their medical situation, then the MRO reports a negative test result to the agency.[105] Neither "passive exposure to marijuana" nor "ingestion of food products" are considered legitimate medical explanations for positive test results.[106]

One example of how agencies implement and enforce DFWA requirements is visible through the Department of Homeland Security's procedures. When an individual is applying for a position as a Transportation and Security Officer (TSO), the initial application has them indicate whether they have used marijuana in the

[101] *See* Parker v. Atlanta Gas Light Co., 818 F. Supp. 345, 348 (S.D. Ga. 1993) ("[T]he Act itself contains no mandate requiring defendant to administer drug tests to its employees.").
[102] *Drug Testing Resources*, SAMHSA (last updated Oct. 14, 2021), https://www.samhsa.gov/workplace/resources/drug-testing.
[103] Mandatory Guidelines for Federal Workplace Drug Testing Programs, 82 Fed. Reg. 7920-01 (Jan. 23, 2017); *see also* David Evans, Mandatory Guidelines for Federal Workplace Drug Testing Programs, in 2 DRUG TESTING LAW TECH. & PRAC. APP. B-2.10 (Jan. 2017) (citing 82 Fed. Reg. 7920-01) (discussing in Section 3.1 how each specimen must be tested for marijuana and cocaine in addition to other controlled substances). While government entities can modify the guidelines to better fit their own specifications, these guidelines are a good example of the process for drug testing employees of federal departments and agencies.
[104] Mandatory Guidelines for Federal Workplace Drug Testing Programs, 82 Fed. Reg. 7920-01, 7929 (Jan. 23, 2017) (discussing section 13.5(d) of the revised section and further explaining and clarifying the process that occurs when the MRO determines there is a positive specimen).
[105] *Id.* at 7929 (discussing § 13.5(d)(1)).
[106] David Evans, Mandatory Guidelines for Federal Workplace Drug Testing Programs, in 2 DRUG TESTING LAW TECH. & PRAC. APP. B-2.10 (Jan. 2017) (citing 82 Fed. Reg. 7920) (noting that pursuant to § 13.5(d)(1)(i)–(ii), neither "passive exposure to marijuana" nor "ingestion of food products" are considered legitimate medical explanations for positive test results.

past seven years by checking 'yes' or 'no.'[107] Once their application is submitted and screened, they are notified of an upcoming medical examination and drug test. If they pass the medical examination and the drug test comes back negative, they then interview for the position. Once they are offered the position, they sign paperwork indicating that they agree to be subjected to random drug testing. On that form, they must provide a signature agreeing that if they refuse to take a drug test or fail a drug test, their employment will be terminated.[108] Once they are fully employed and trained, drug testing occurs at random. A supervisor will get a phone call requesting one of the TSOs to report for a drug test at a specific time that day.

1. Recommended Changes to the Drug-Free Workplace Act

Currently, there are many qualified individuals who are disqualified from working for federal grant recipients at the very start of the application process simply for checking "yes" to having used marijuana in the past few years. There is no room for explanation in the application process for those who have a valid reason for using medicinal marijuana, such as a recommendation from a medical professional to treat a disability.[109] Further, as seen in the way TSA enforces its drug-free workplace policies, there is no room for explanation when an employee who made it through the application process subsequently tests positive during a random drug screening. While these measures are conducted in an effort to maintain a 'drug-free' status in compliance with the DFWA, this does not need to be the only acceptable way to maintain that status.

There are two reasonable steps that would enable these grant recipients to maintain their funding while also not eliminating qualified individuals on the basis of previous, or even current, medicinal marijuana use.

The first, and most important, change is the implementation of medical waivers that employees and applicants have the option to apply for. These waivers would be available to applicants in the application process and to employees when they are subjected to random drug screening. Application paperwork would include the option to attach a signed form from a medical professional indicating their recommendation that the applicant use medicinal marijuana to treat a medical

[107] The information explaining details about the TSA procedures was gathered through a conversation with an individual who was a TSO after applying to the position in 2018. She stated that random drug testing is not uncommon. If they test positive, they lose their job.
[108] The same TSO noted that when certain CBD products were FDA-approved, they were notified via email to use caution if they choose to use the products because CBD-use will not be an excuse for a positive drug test.
[109] For example, the aforementioned TSO stated there was no option to explain why you selected "yes" to using marijuana.

condition. This will permit applicants to distinguish their marijuana consumption from recreational drug use.

Second, current employees should have the option to provide a medical waiver to the MRO who reports their drug tests back to the employee's agency. The medical waiver would align with the processes MROs use to verify other controlled substances that show up as positive in drug screenings, including proof that a medical professional recommended the employee use medicinal marijuana to treat a disability. By having these waivers, positive drug results would never even make it back to the agency because upon verification that the individual had a legitimate medical explanation for their positive test result, the MRO would report a negative test result to the agency. Thus, the grant recipient will be able to maintain its drug-free status and thus maintain its funding, but qualified individuals will no longer be excluded from those workplaces on the basis of their medicinal marijuana use.

CONCLUSION

There were approximately 3,099,934 people within the United States and its territories who were legally permitted to use medicinal marijuana pursuant to their state laws in 2018.[110] Those of which who are employed or seeking employment should not be able to be discriminated against for this personal medical decision. If an individual meets all of the qualifications for a job, it should make no difference whether they consume medicinal marijuana to treat a medical condition while off-duty. Nonetheless, current laws permit discrimination against them for doing so. There are solutions to this issue, though, including: removing marijuana from its Schedule I classification under the CSA, issuing state-level anti-discrimination laws, expanding the ADA's coverage, and permitting medical waivers for employees of federal grant recipients subject to the DFWA. Any one of these solutions would make progress toward more equitable employment rights for all.

[110] *Supra note* 10.