Engaging Disability Rights Law to Address the Distinct Harms at the Intersection of Race and Disability for People with Substance Use Disorder

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Abstract: This article examines the unique disadvantages experienced by Black people and other people of color with substance use disorder in health care, and argues that an intersectional approach to enforcing disability rights laws offer an opportunity to ameliorate some of the harms of oppression to this population.

I. Introduction

The unethical, separate, and unequal system of health care for people with substance use disorder (SUD), a condition effecting approximately 20 million people each year,[1] is the product of long standing and mutually reinforcing systems of racism and ableism in the U.S.[2] Addiction exceptionalism in health care access, coverage,[3] and treatment[4] devastate the health and wellbeing of people with SUD and disproportionately harm people of color.[5] Beyond traditional health care settings, the experiences of daily life for people with SUD — especially people of color with SUD — are informed by profound epistemic, racial, and disability injustice that compound these harms. Legal norms that further this injustice include prohibitionist drug policies that selectively criminalize drug use and possession;[6] racist policing, enforcement, and sentencing in the criminal legal system;[7] refusals by drug courts and in carceral setting to allow appropriate medical care for people with SUD;[8] child welfare law enforcement targeting Black pregnant women who use drugs;[9] and continued efforts to block harm reduction services that effectively reduce morbidity and mortality from drug use made risky by prohibition.[10] Across these settings, tools of structural oppression combine to subjugate people, especially Black, Latinx, and Indigenous people who use drugs, including those with SUD.[11]

Over 30 years ago, Kimberlé Crenshaw coined the term "intersectionality" to capture forms of oppression that overlap and compound across multiple identi-

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ties.[12] Disability studies scholars have combined critical theories of race, gender, and disability in interesting ways, often with a focus on education and school discipline.[13] A growing number of legal scholars have explored race and disability discrimination using different approaches.[14] An intersectional scholarly approach focuses on the unique and compounded harms of oppression experienced by people who are members of two or more marginalized groups (e.g., a Black woman with a disability). Rather than addressing each marginalized identity separately,[15] this approach employs critical theories to explore "how race and disability were co-constituted, informed and motivated by the intent to not only to uphold racial hierarchy/white supremacy, but also uphold the related racial project of ableism."[16] For example, scholars and advocates have engaged disability critical race theory (DisCrit) to explore unique disadvantages at the intersection of race and disability in education[17] police encounters,[18] prison litigation,[19] immigration law,[20] and employment discrimination.[21] Less academic attention has been paid to the unique disadvantages at the intersection of race and disability in health care. This may be due in part to a lack of information and data. A 2019 report published by the National Academies, *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, summarized the available evidence while noting that "research on health and health disparities at the intersection of disability and race/ethnicity is very limited."[22]

Here, we examine the unique disadvantages experienced by Black people and other people of color with SUD in health care,[23] and argue that the intersectional approach we describe above to enforcement of disability rights laws offers an opportunity to ameliorate some of the harms of oppression to this population.[24] Although disability rights law does not explicitly address intersectional discrimination, specific features of the laws are well-suited to address the particular forms of discrimination and disadvantage experienced by people of color with SUD. These laws extend to individuals who are excluded or denied health care services based on SUD, as well as individuals who are victims of widespread but incorrect and often racialized assumptions about SUD or stigma based on a past SUD. These laws consistently require individualized assessment based on objective medical or scientific evidence which has the potential to interrupt racial and ableist bias and assumptions related to SUD. Finally, disability laws can be used to challenge multiple modes of discrimination, including intentional discrimination, segregation, and failure to accommodate people, as well as policies and practices that have a disparate impact on people of color with SUD.

A small but growing body of research highlights specific compounded disadvantages experienced by people of color with disabilities, people who are "multiply marginalized." We know that intersections with race, ethnicity, gender, LGBTQIA+ status, and other characteristics intensify certain health inequities experienced by people with disabilities … These intersectional health inequities are reflected in the disproportionate harms during the COVID-19 pandemic, including among multiply marginalized people with SUD. There is a need for additional research focusing on the health care experiences and outcomes of people with disabilities in disadvantaged racial and ethnic groups, as well as further interrogation of the relationship between white supremacy, ableism, and the treatment of people with SUD.

II. Structural Racism, Ableism, and Health Inequities for People with SUD

Racism and ableism have long worked together as symbiotic oppressive forces, centering and empowering white non-disabled persons and resulting in significant health inequities for people who are members of underserved racial and ethnic groups[25] and for people with disabilities.[26] Structural forces also work to *create* disability, and scholars have examined social disablement for many who are Black, Latinx, Indigenous, or other people of color.[27]A small but growing body of

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research highlights specific compounded disadvantages experienced by people of color with disabilities,[28] people who are "multiply marginalized."[29] We know that intersections with race, ethnicity, gender, LGBTQIA+ status, and other characteristics intensify certain health inequities experienced by people with disabilities; for example, although more research is needed, several studies indicate that people of color with disabilities experience greater inequities in health status and access to health care.[30] These intersectional health inequities are reflected in the disproportionate harms during the COVID-19 pandemic,[31] including among multiply marginalized people with SUD.[32] There is a need for additional research focusing on the health care experiences and outcomes of people with disabilities in disadvantaged racial and ethnic groups,[33] as well as further interrogation of the relationship between white supremacy, ableism, and the treatment of people with SUD.[34]

The racism that fuels the ongoing "war on drugs" enables serious inequities for people of color with SUD in accessing treatment at all, much less standard of care treatment.[35] The mutually reinforcing systems of white supremacy and ableism created and support constructions of people who use drugs, especially people of color who use drugs, as deviant and damaged to justify their segregation, criminalization, surveillance, and denials of legal protections.[36] If they manage to access care, racialized minorities who use drugs report high levels of interpersonal discrimination in health care settings.[37] They are more likely to become entangled with law enforcement than offered tools for safe drug use, medical care, or community supports. Exclusion from civil rights protections of laws like the Fair Housing Act and the Americans with Disabilities Act (ADA) is also common, negatively impacting social determinants of health.[38]

In fact, U.S. drug policy is a centuries long white supremacy project,[39] and the Controlled Substances Act and its progeny has disproportionately harmed Black communities and other communities of color.[40] This is by design.[41] Despite equivalent rates of drug use and SUD among racialized groups, non-white individuals are disproportionately arrested, sentenced, and incarcerated, [42] and incarceration itself keeps multiply marginalized individuals from completing community-based SUD treatment at disproportionate rates.[43]

Entanglement in the criminal legal system may in fact cause more substance use, harm, and even death. According to Taleed El-Sabawi and Jennifer Carroll,

> Among individuals with a history of substance use, for example, law enforcement interaction is known to be positively associated with the initiation of substance injection. Incarceration is known to be positively associated with both fatal and non-fatal overdose, and the growing evidence base is congruent with the hypothesis that this relationship is *causal* (meaning that incarceration most likely causes new overdose events directly, not simply that people more likely to overdose are also more likely to become incarcerated at some point).[44]

Racism in SUD treatment access and quality persists in the criminal legal system, and non-evidence-based approaches dominate.[45] Among the people with opioid use disorder (OUD) in diversionary programs who get "referred" for treatment, less than five percent receive the standard of care treatment, i.e., medication for opioid use disorder (MOUD).[46] Even then, one study found that white defendants were more than twice as likely as Black defendants to have their treatment paid for by the court.[47]

Incarceration and post-incarceration periods are also dangerous for multiply marginalized people with SUD. In addition to a lack of access to treatment, harm reduction, and the increased infectious disease risks while incarcerated,[48] the period after incarceration can be deadly.[49] Those with OUD who do not receive MOUD or are released with no treatment continuation die at rates as high as 129-fold that of the general population in the two weeks following release.[50] As Jamelia Morgan has explained, however, that while carceral settings are "particularly dangerous and damaging for people with disabilities, it is precisely because of the their disability that the [ADA], where enforced, has the potential to protect them."[51] A handful of recent legal victories have opened the door to more appropriate treatment of some people with SUD in carceral settings;[52] however, involvement in the criminal legal system almost universally continues to harm people with SUD.

The criminal legal system also intrudes into the regulation of medicine and combines with institutional and individual discrimination in health care to produce serious and deadly consequences for multiply marginalized people with SUD as well as those perceived to have a SUD, such as those with persistent pain who may benefit from prescription opioids. The care of people with SUD is legally segregated from and more extensively regulated than the rest of medicine, including enhanced criminal surveillance of health care providers and patients alike.[53] MOUD treatment is governed by distinct regulatory regimes — where methadone is dispensed only through separate Opi-

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oid Treatment Programs (also known as methadone clinics)[54] and the prescription of buprenorphine for addiction is less regulated but still requires additional prescribing permissions (known as a DATA waiver), patient limits, and data collection.[55] Interestingly, the *exact same medications,* at the same or even higher doses, can be prescribed in the same way as any other drugs as long as they are being prescribed for a condition *other than addiction*, such as persistent pain. Even then, white patients are far more likely to receive appropriate treatment with prescription medications for their pain. For example, in a recent meta-analysis, Black patients and Hispanic patients were 36% and 30% less likely to receive treatment for acute pain in the emergency department than similarly situated white patients.[56] For those on long-term opioids for persistent pain, Black patients are more likely than white patients to be surveilled with regular urine drug testing and more likely to have their medications unilaterally discontinued following a concerning drug test.[57] Practically, the expansion of prescribing surveillance and law enforcement scrutiny make these providers and patients targets as well.

Providers willing to treat people with SUD or persistent pain are operating at the boundary of health care and criminal law. They do so with tangible personal risk, as prescribers in several federal circuits may face imprisonment for nothing more than mistaken or negligent prescribing for pain or SUD.[58] The "lucky" few patients who manage to access medical care for these conditions are subjected to trickle-down surveillance as a condition of receiving care because of myriad legal requirements combined with providers' overzealous compliance and risk management practices.[59]

The deterrent effect of prescribing surveillance and the salience of the recent "opioid crisis" combine powerfully with other mutually reinforcing systems of discrimination to leave people with SUD[60] and persistent pain discounted, mistreated, and untreated across a range of settings,[61] a reality even more common for multiply marginalized people of color with these conditions.[62] People die as a result. For example, the extensive non-evidence-based laws and policies to curtail only *prescription* opioid use resulted in provider abandonment and avoidance of people with persistent pain and SUD, shifting many to the much riskier illicit supply, with an overall *increase* in overdose deaths, albeit from illicit rather than prescription substances.[63] Despite constructions of opioid-related overdoses as harming mostly white people, overdose rates among Black people have increased by approximately 40 percent while rates among other populations have remained stable,[64] a trend that continued during the COVID-19 pandemic.[65] Others died by suicide — a problem significant enough to prompt new warnings for prescribers from the Food and Drug Administration against too rapid and involuntary discontinuations of prescribed opioids.[66]

At the same time, health care providers routinely ignore SUD and related treatment needs. While SUD is highly treatable and affects upwards of 20 percent of patients in many health care setting,[67] most patients are never screened, assessed, or treated for SUD.[68] In acute care settings, even those hospitalized *because of drug use* are simply treated for the complications of drug use while their underlying SUD is ignored. For example, people with SUD who are hospitalized with injection drug-related infections (e.g., endocarditis) are typically left to suffer through painful withdrawal,[69] while providers treat only the infection. There is some limited evidence of racial bias in these treatment decisions as well.[70]

Health care providers often surveil and stigmatize hospitalized patients with SUD,[71] center the patient as the cause of their own suffering, and characterize them as irrational and defective — leading to disproportionate numbers of people with SUD leaving the hospital against medical advice.[72] Even the majority of people hospitalized for a life-threatening overdose are discharged without treatment or referral for SUD treatment, and the rates are even worse for women and Black and Hispanic patients.[73] Instead, only the immediate physical instability is addressed, usually by treating the life-threatening respiratory depression with an opioid antagonist (e.g., Naloxone),[74] and the patient is observed and discharged without any SUD receipt or referrals for standard of care treatment (e.g., MOUD).[75] This is not only a missed opportunity to provide appropriate care. It is also a deadly practice. The reversal agent corrects the respiratory depression by displacing the opioids from the patient's opioid receptors, placing the recipient in painful withdrawal,[76] setting them up to use again to relieve the symptoms. People who survive an overdose have a rate of death in the following year 24 times higher than the general population,[77] and about a quarter of people discharged from the emergency department die within a month — with the highest risk of death within 48 hours of discharge.[78] Initiation of methadone or buprenorphine can cut the mortality risk in half,[79] which nearly every prescriber can administer for up to 72 hours,[80] even without a DATA waiver or special certificate of registration to dispense methadone.[81]

Thanks to structural, institutional, and individual discrimination, most health care providers do not see those with SUD as whole people worthy of respect and

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patient-centered care. They certainly do not regard treating a SUD as their problem thanks to the legal isolation of addiction medicine from the rest of health care, which impacts the multiply marginalized people with SUD profoundly. The de-medicalization of addiction and the segregation of addiction care began in earnest after the passage of the Harrison Narcotic Act in 1914 and subsequent Supreme Court cases declared addiction treatment was not the "legitimate practice of medicine."[82] This quickly left people with SUD without professional treatment options outside of a few government run "narcotic farms" that targeted marginalized groups.[83] The void was filled by individuals and organizations offering "treatments" ranging from self-help groups with limited evidence of effectiveness,[84] to much more malicious and unregulated practices with a trail of traumatized and even dead former "clients."[85] For example, people with SUD who receive rapid detoxification or pay tens of thousands of dollars for abstinence only treatments for opioid and polysubstance use disorders are at higher risk of death after these "treatments" than if they had received no "treatment" at all.[86]

In the case of people with OUD, the lucky 20 percent of people who manage to access appropriate care are presented with extraordinary barriers to initiation and continuation that are designed to cause "failures," especially for the multiply marginalized.[87] People of color are less likely to receive MOUD, and those that do are less likely than white people with OUD to receive buprenorphine,[88] which has fewer barriers to access and retention in treatment than methadone. Multiply marginalized groups are also more likely to live in areas without adequate access to buprenorphine prescribers.[89] These are not benign differences. Both methadone and buprenorphine are extremely effective treatments — more effective than the best available therapies for many other health conditions.[90] However, receiving methadone requires people with OUD to meet far more stringent criteria for access and retention in therapy, an active SUD for a full year prior to enrollment with few exceptions,[91] random drug screenings,[92] required counseling and detoxification,[93] and daily visits to the clinic for supervised medication ingestion — regardless of their access to transportation or conflicting work or caregiving responsibilities.[94] Methadone also carries more drug risks and produces more severe withdrawal symptoms than buprenorphine for patients who miss doses. Of the available MOUDs, methadone is the most stigmatized, and has a troubling history as a purported means of control of multiply marginalized people with SUD.[95] For these populations, the intersection of the disability of SUD and race, among other marginalized identities, creates significant harms for which structural changes are required.

III. Distinctive Features of Disability Law and the Compound Disadvantages of People of Color with SUD

Federal civil rights laws have been used to address racial discrimination in health care over the last 60 years. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance.[96] Title VI has been used to challenge forms of intentional discrimination in health care, such as the explicit exclusion of minorities from hospitals and racial segregation in hospital wards.[97] However, it has been less effective at challenging practices or policies with a discriminatory effect or instances of implicit racial bias in the absence of intentional discrimination. This is due, in part, to the Supreme Court's decision in *Sandoval* which requires private plaintiffs to show discriminatory intent, as well as a lack of consistent and robust enforcement by the Office for Civil Rights (OCR).[98]

Years later, the ADA was enacted to address widespread discrimination against people with disabilities and to ensure integration and equal opportunity in all areas of American life.[99] Title II of the ADA applies to state and local government services, including state Medicaid programs and health care services provided by public hospitals and clinics.[100] Title III covers places of public accommodations, which include private physician's offices, private hospitals, private nursing homes, and private SUD treatment programs open to the public, regardless of federal funding.[101] The ADA expands the protections of the Rehabilitation Act of 1973, which similar to Title VI prohibits disability discrimination in federal employment and in programs and activities that receive federal financial assistance such as SUD treatment programs, hospitals and health clinics, pharmacies, contracted service providers, medical and dental providers, and nursing homes.[102]

Section 1557 of the Affordable Care Act amends the Rehabilitation Act to provide additional protections in certain health care programs, activities, and settings[103] although the scope of its protections is uncertain.[104] Because Section 1557 extends the reach of multiple existing nondiscrimination laws, it has the potential to recognize intersectional discrimination. For example, the 2016 final rule issued by HHS under the Obama Administration noted that Section 1557's prohibition of discrimination reaches multiple bases of discrimi-

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nation, for example, "discrimination against an African-American woman could be discrimination on the basis of both race and sex."[105] The acknowledgement of a distinct and intersectional form of discrimination based on multiple characteristics — a whole that is greater and different than the sum of its parts — echoes judicial decisions under Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, religion, sex, and national origin.[106] For example, in *Jefferies v. Harris County Community Action Ass'n,* the 5th Circuit recognized that discrimination could exist against the plaintiff based on her distinct experiences in the workplace as a Black woman, regardless of whether those experiences were shared by Black men or white women.[107] However, as observed by civil rights attorney Alice Abrokwa, now Senior Counsel of OCR, courts "have offered little guidance on how to articulate and prove the [Title VII] claims."[108] Similarly, the mechanism for addressing intersectional claims — as opposed to addressing multiple claims each based on a single characteristic — under Section 1557 or the laws it amends has not been developed.

As we continue to develop approaches consistent with the view of intersectional discrimination we describe here, strong and consistent enforcement of disability nondiscrimination laws can be used to remove barriers to treatment in health care services and programs and other areas of persistent discrimination against people with SUD, especially those that are multiply marginalized. This section examines specific features of the laws that are particularly well-suited to addressing the distinct forms of discrimination and disadvantage experienced by people of color with SUD.

A. SUD as an Actual and Socially Constructed Disability

The ADA protects individuals with a physical or mental impairment that substantially limits a major life activity, those with a history of an impairment, and those who are regarded as having an impairment.[109] Amendments to the ADA in 2008 clarified the definition of disability should be construed in favor of broad coverage of individuals.[110] Recent guidance from the HHS OCR affirmed that people with SUD are protected under the ADA, Rehabilitation Act, and Section 1557 when the condition substantially limits a major life activity (which includes major bodily functions such as neurological and brain functions).[111] Recognition of SUD as an actual disability under the first part of the definition sends an important message that SUD is both a medical condition and a socially constructed disability,[112] and that people with SUD are worthy of the same protections and care we are obligated to provide to people with other disabilities.

Recent guidance from the HHS OCR affirmed that people with SUD are protected under the ADA, Rehabilitation Act, and Section 1557 when the condition substantially limits a major life activity (which includes major bodily functions such as neurological and brain functions). Recognition of SUD as an actual disability under the first part of the definition sends an important message that SUD is both a medical condition and a socially constructed disability, and that people with SUD are worthy of the same protections and care we are obligated to provide to people with other disabilities.

The ADA extends protections to individuals who are victims of widespread but incorrect assumptions about SUD or stigma based on a past SUD, reflecting the social model of disability which recognizes disability as a social construct rather than simply a biological trait of the individual. It is a rejection of what Morgan describes as the centering of the harms experienced by people with SUD "in the bodies and minds of the [individual]... rather than in the systems and structures that contribute to their disablement."[113] The "regarded as" prong protects people who are incorrectly assumed to be using unlawful drugs (but who are not in fact using drugs),[114] as well as people taking lawfully prescribed opioids for treatment of persistant pain or another medical condition who are incorrectly assumed to have a SUD — both common errors supported by racialized and ableist framing of drug use and drug users.[115] The ADA's protections for people

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with a history of SUD are reinforced by a new nondiscrimination provision in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) [116] that prohibits discriminatory use by recipients of disclosed SUD treatment information in areas including health care; employment and receipt of worker's compensation; rental or sale of housing; access to courts; and social services and benefits funded by federal, state, or local governments.[117]

Of course, this expansive view of protections for people with SUD is undercut by the ADA's explicit exclusion of individuals who are currently engaged in the illegal use of drugs,[118] itself a form of structural discrimination that further compounds existing racism in drug policy. Some scholars (including the authors) have argued that the harmful and unnecessary exclusion for current illegal use of drugs should be removed from the ADA and other nondiscrimination laws.[119] Fortunately, under the Rehabilitation Act, current illegal use of drugs is not a basis to deny health services in hospitals and outpatient facilities or services provided in connection with drug rehabilitation, vocational rehabilitation programs and services, and other covered programs and services funded if the individual is otherwise entitled to such services.[120] In addition, as we have written elsewhere, there is no statutory exclusion of current illegal substance users in the new CARES Act protections for individuals whose patient records reveal or appear to reveal current or past SUD.[121]

B. Requirement of Individualized, Evidence-Based Assessments

The ADA's consistent focus on individualized assessment has the potential to interrupt explicit and implicit biases at the intersection of race, disability, and SUD. For example, the ADA allows employers to ask about an employee's disability if that employee poses a "direct threat" to workplace health and safety, which is defined as a "significant risk of substantial harm to the health or safety of others" that cannot be eliminated or reduced by a reasonable accommodation.[122] Recent enforcement actions by the Equal Employment Opportunity Commission (EEOC) against employers for discrimination against applicants or employees being treated with MOUD or prescription opioids underscore the requirement that employers engage in an individualized assessment of what, if any, impact the medication has on the individual's ability to perform the job safely, rather than relying on stereotypes or assumptions.[123] The Supreme Court in *Bragdon v. Abbott* established that assessment of a direct threat must rely on analysis of objective medical scientific evidence, rather than stereotypes or misconceptions, even if held in good faith.[124] EEOC guidance for employers[125] and for health care providers[126] on existing legal protections in the workplace for individuals who are using opioids or individuals with a current or former SUD place similar emphasis on these requirements.

We think of people with SUD as patients, but they are also providers. In health care settings, health care providers with a SUD are often viewed with suspicion and as incapable of performing their professional roles. In many instances, physicians and other professionals are forced to choose between their profession and effective treatment for their own SUD. Participation in physician health programs or similar programs is often a condition of maintaining state licensure and employment for professionals with SUD.[127] However, many of those organizations maintain blanket prohibition of medication as part of treatment (including MOUD) under the unexamined presumption that those medications render these providers less safe, an assumption based on the enduring legacy of stigma and addiction exceptionalism rather than available evidence.[128] MOUD is also associated with lower employee health care and productivity costs for employers in other settings.[129] Not only are these bans expensive for all involved, the alternative "treatments" require near constant surveillance of the provider — in the form of frequent random drug screenings and even full time "monitors" in the workplace. Several scholars have noted that the programs' blanket MOUD prohibitions and other practices violate the ADA,[130] but this has yet to be tested in practice.

Decisions about accommodation of disability in health care settings also calls for individualized assessment. The ADA and the Rehabilitation Act require health care providers, systems, and institutions to make reasonable "accommodations" to ensure that people with disabilities have equal opportunities to benefit from health care programs, services, and facilities.[131] A reasonable accommodation for an individual with a SUD in long-term care might include, for example, making arrangements with the patient's Opioid Treatment Program or the patient's DATA waived buprenorphine prescriber to avoid an interruption in their MOUD therapy.[132] In acute care settings, hospitals should have, at a minimum, DATA waivered clinicians available to offer and continue MOUD and ideally, an addiction medicine consult service to provide appropriate, individualized care. Accommodation decisions should be collaborative, focused on the patient's specific needs, and should always include consideration of patient preferences and perspectives.[133] Focus on the patient's specific needs, preferences and perspectives provides space to consider

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the role of race, gender, and other characteristics in formulating an appropriate response.[134] However, the first national study of physician knowledge of the ADA suggests that less than one-third of practicing physicians know who is responsible for making decisions about disability accommodations.[135]

C. Multiple Modes of Discrimination

The ADA provides tools to address different forms of discrimination that obstruct access to health care services and programs and cause needless suffering for people with SUD. The ADA addresses disparate treatment, or intentional discrimination because of disability, as health care providers and institutions cannot exclude or deny services to people based on disability.[136] Studies of practicing physicians suggest that most physicians understand this obligation,[137] although we know that exclusions and refusals to treat based on SUD and other disabilities persist. Recent DOJ settlements with primary care providers,[138] specialists,[139] skilled nursing facilities,[140] and organ transplant programs[141] illustrate the persistence of refusals to provide health care services to patients who are receiving MOUDs.

The ADA also requires that people with SUD be treated in integrated settings. The Supreme Court's decision in *Olmstead v. L.C.*[142] established that unnecessary segregation of people with disabilities constitutes discrimination in violation of Title II of the ADA. This means that people with SUD cannot be shunted into separate health care settings or programs unless a separate setting is the most integrated setting appropriate to the needs of the patient. As noted above, people with SUD can also use disability nondiscrimination laws to challenge failure to accommodate their disability-related needs as a justification for segregation.

Disability nondiscrimination laws can also be used in the absence of evidence of intentional discrimination to challenge policies and practices with a disparate impact on people with SUD. The Supreme Court in *Alexander v. Choate* assumed the availability of disparate impact claims under the Rehabilitation Act.[143] However, it further held that the requirements of the law are met when individuals with disabilities are provided "meaningful access" to programs, services, and activities.[144] There is also uncertainty as to whether a claim of disparate impact based on disability requires a showing of intent (e.g., "deliberate indifference"). Some courts have borrowed the analysis of intent from Title VI, while others have not.[145]

D. Enforcement Efforts and Education

Disability nondiscrimination laws are powerful tools to address stigma and discrimination against people with SUD, but enforcement of these laws, including public enforcement of the nondiscrimination requirements of the ADA, Rehabilitation Act, Section 1557, and the CARES Act must be robust and equitable. Many experts claim that the ADA and Section 504 are underenforced, and the promises of these laws have yet to be realized, especially in health care settings.[146] Others have described how the ADA's enforcement has not led to "equal access, social inclusion, and freedom from discrimination … particularly[for] multiply marginalized disabled People of Color."[147] We note that outside of the employment context, enforcement of the ADA for discrimination against people with SUD was nonexistent until a few years ago, despite the long-standing protections in the law. Anything but robust and equitable enforcement of disability nondiscrimination laws furthers able-bodied and white supremacist ideologies.[148] The recent trend toward enforcement of protections for people with SUD must continue.

Enforcement efforts must include education. The DOJ has worked to provide education about the protection of people with SUD under existing law in health care settings.[149] In 2018, OCR launched a public education campaign[150] aimed at increasing access to evidence-based treatments, including MOUD, by clarifying the federal civil rights protections[151] for people with SUD and providing specific guidance in the context of OUD.[152] Continued educational initiatives about the pervasive discrimination faced by people with SUD and new and existing nondiscrimination requirements are needed. In particular, health care providers, institutions, and systems need education about SUD as a disability, barriers to care for people with SUD, and compounded inequities for multiply marginalized people with SUD, along with the existing civil rights protections that protect and promote accessible health care for individuals with disabilities.[153]

Finally, collecting better data at the federal, state, local, and health systems level that can be disaggregated by disability, race, and other characteristics is critical to understand and address inequities experienced by people with SUD at the intersection of these identities.[154]

IV. Conclusion

The compound disadvantages conferred upon people of color with disabilities by the function of structural, institutional, and individual discrimination is an area deserving of more scholarly attention. For people of color with SUD in health care settings, the structural

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forces of existing criminal, health care, and even disability nondiscrimination laws create profound disadvantages and barriers to humane and appropriate treatment. Nothing short of foundation changes in the criminal legal system, drug policy, and myriad other laws — including removing the exclusion from protection disability nondiscrimination laws of those "currently using illegal drugs" — will afford justice to multiply marginalized people with SUD. In the interim, we have suggested that intersectionality-conscious and robust enforcement of existing protections in the ADA, Rehabilitation Act, Section 1557, and the CARES Act offer the best opportunity for just outcomes for people of color with SUD in health care.

Note

The authors have no conflicts to disclose.

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1. *See* Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, HHS Publication No. PEP20-07-01-001, NSDUH Series H-55 (2020).
2. There is very little work on the intersection of gender, race, and disability status specific to people with substance use disorders outside of people who are pregnant and women who have children. See, e.g., A.J. Gunn et al., "'That's Not Me Anymore': Resistance Strategies for Managing Intersectional Stigmas for Women with Substance Use and Incarceration Histories," *Qualitative Social Work* 17, no. 4 (2018): 490-508. Although worthy of more attention, the scope of this article is limited to intersections of race and disability.
3. *See* S.A. Tovino, "State Benchmark Plan Coverage of Opioid Use Disorder Treatments and Services: Trends and Limitations," *South Carolina Law Review* 70 (2019) 764-949.
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9. *See, e.g.,* D.E. Roberts, "Unshackling Black Motherhood," *Michigan Law Review* 95 (1997): 938-964.
10. *See, e.g.,* L. Beletsky and J. Goulka, *Letter to Scott County Commissioner Re: Litigation Risk of Terminating the Syringe Service Program in Scott County, Indiana*, *available at* <https://www.dropbox.com/s/vajr98qop3qyy8a/Litigation%20risk%20of%20terminating%20Scott%20County%20SSP%20copy.pdf?dl=0> (last visited December 30, 2021).
11. People of color who use drugs for enjoyment and those who use drugs as part of a SUD are structurally harmed by the white and able-bodied supremacy of drug policy. Contrary to the hysteria that attends the "just say no" and other approaches to drug use, many people use drugs without developing a substance use disorder. *See* C.L. Hart, *Drug Use for Grown-Ups: Chasing Liberty in the Land of Fear* (New York: Penguin Random House, 2021). Prohibition, for example, creates demand for an illicit supply of drugs with inconsistent and unknown contents and quality, drives people to use alone or in unsafe conditions, deters people from seeking help for fear of imprisonment, and contributes to infectious disease by denying access to sterile injection supplies. *See generally*, L. Beletsky and C.S. Davis, "Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited," *International Journal of Drug Policy* 46 (2017): 156-159.
12. K. Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color," *Stanford Law Review* 43 (1991): 1241-1299; K. Crenshaw, N. Gotanda, G. Peller, and K. Thomas, *Critical Race Theory: The Key Writings That Formed the Movement* (New York: The New Press, 1996).
13. *See, e.g.,* A. Asch, "Critical Race Theory, Feminism, and Disability: Reflections on Social Justice and Personal Identity," *Ohio State Law Journal* 62 (2001): 391-423; F.A. Kumari Campbell, "Exploring Internalized Ableism Using Critical Race Theory," *Disability and Society* 23 (2008): 151-162.
14. J.E. Harris, "Reckoning with Race and Disability," *Yale Law Journal Forum* 130 (2021): 916-958 (review of recent scholarship on race and disability).
15. A. Frederick and D. Shifrer, "Race and Disability: From Analogy to Intersectionality," *Sociology of Race and Ethnicity* 5 (2019): 200-214 (arguing that "centering the positionality of disabled People of Color demands not analogy but intersectional analyses that illuminate how racism and ableism intertwine and interact to generate unique forms of inequality and resistance").
16. J.N. Morgan, "Toward a DisCrit Approach to American Law," *DisCrit Expanded: Inquiries, Reverberations & Ruptures* (Forthcoming 2022): 1-29.
17. S. Ancy Annamma, B.A. Ferri, and D.J. Connor, "Disability Critical Race Theory: Exploring the Intersectional Lineage, Emergence, and Potential Futures of DisCrit in Education," *Review of Research in Education* 42 (2018): 46-71 (summarizing research).
18. C.A. Nelson, "Racializing Disability, Disabling Race: Policing Race and Mental Status," *Berkeley Journal of Criminal Law* 15 (2010): 1-64.
19. J.N. Morgan, "Reflections on Representing Incarcerated People with Disabilities: Ableism in Prison Reform Litigation," *Denver Law Review* 96 (2019): 973-991.
20. M.B. Kashyap, "Toward a Race-Conscious Critique of Mental Health-Related Exclusionary Immigration Laws," *Michigan Journal of Race and Law* 26 (2021): 87-111.
21. A. Abrokwa, "'When They Enter, We All Enter': Opening the Door to Intersectional Discrimination Claims Based on Race

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and Disability," *Michigan Journal of Race and Law* 24 (2018): 15-74 at 48.

22. S. Yee, et al., "Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity," *The National Academies of Sciences, Engineering, and Medicine* (2019): 1-177, at 69. There are some empirical studies that tangentially address the intersection of race and SUD as disability without explicitly describing it as such. *See, e.g.,* W.C. Goedel, et al., "Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States," *JAMA Network Open* 3, no. 4 (2020): e203711 (correlating geographic areas with more non-white residents with methadone treatment availability only and the lower burden buprenorphine access with areas with high numbers of white residents); G. Pro and N. Zaller, "Interaction Effects in the Association Between Methadone Maintenance Therapy and Experiences of Racial Discrimination in U.S. Healthcare Settings," *PLOS ONE* 15, no. 2 (2020): e0228755 (finding that patients who were Black, Hispanic/Latino, or American Indian and who had a history of receiving methadone to treat their substance use disorder were more likely to experience racism in the health care setting than those who had never received methadone).
23. Although intersectionality is not directly engaged in their public policy statement, the American Society of Addiction Medicine has explicitly detailed the ways in which racism has and continues to disproportionately harm people of color with SUD. See American Society of Addiction Medicine, "Public Policy Statement on Advancing Racial Justice in Addiction Medicine," 2021, *available at* <https://www.asam.org/docs/default-source/public-policy-statements/asam-policy-statement-on-racial-justiced7a33a9472bc604ca5b7ff000030b21a.pdf?sfvrsn=5a1f5ac2_2> (last visited December 30, 2021).
24. J.N. Morgan has argued along similar lines. *See* Morgan, *supra* note 16, at 11 ("[a]n intersectional approach to disability [demonstrates] how disability and historically marginalized identities and statuses interact to render some disabled persons even more vulnerable to disability discrimination, and how recognizing that cuts in favor of strengthening legal protections under the ADA.")
25. See, e.g., *2019 National Healthcare Quality and Disparities Report*, December 2020, *available at* <http://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html> (last visited December 30, 2021); Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003), *available at* <https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care> (last visited December 30, 2021).
26. E. Pendo and L.I. Iezzoni, *The Role of Law and Policy in Achieving Healthy People's Disability and Health Goals around Access to Health Care, Activities Promoting Health and Wellness, Independent Living and Participation, and Collecting Data in the United States*, Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2020, *available at* <https://www.healthypeople.gov/sites/default/files/LHP_Disability-Health-Policy_2020.03.12_508_0.pdf> (last visited December 30, 2021); Yee, et al., *supra* note 18.
27. *See e.g.,* K. Paul-Emile, "Blackness as Disability?" *Georgetown Law Journal* 293 (2018): 293-364; Frederick and Shifrer, *supra* note 15; Morgan, *supra* note 19.
28. *See* National Disability Institute, *Race, Ethnicity and Disability: The Financial Impact of Systemic Inequality, National Disability Institute* (August 2020), *available at* <https://www.nationaldisabilityinstitute.org/reports/research-brief-race-ethnicity-and-disability/> (last visited December 30, 2021). *See also,* E.H. Mereish, "The Intersectional Invisibility of Race and Disability Status: An Exploratory Study of Health And Discrimination Facing Asian Americans with Disabilities," *Ethnicity and Inequalities in Health and Social Care* 5, no. 2 (2012): 52-60 (AAPI individuals with a disability reported more experiences of everyday discrimination than AAPI individuals without a disability in the study).
29. This terminology emerged from the DisCrit literature and reflects the compound disadvantage experienced by people who are members of multiple groups that are historically and currently subjugated. *See, e.g.,* S. Mac Dougall, "Over-the-Counter Access to Oral Contraception: Reproductive Autonomy on Pharmacy Shelves or A Political Trojan Horse?" *Columbia Journal of Gender & Law* 30 (2015): 204 -253, at n. 6 (explaining the meaning of multiply marginalized).
30. Yee et al., *supra* note 22.
31. *See generally* R. Yearby and S. Mohapatra, "Law, Structural Racism, and the COVID-19 Pandemic," *Journal of Law and the Biosciences* 7, no. 1 (2020): 1-20; P. Chandan et al., "Demonstrating the Vital Role of Physiatry Throughout the Health Care Continuum: Lessons Learned from Impacts of the COVID-19 Pandemic on the Disability Community," *American Academy of Physical Medicine and Rehabilitation* 13 (2021): 589-598.
32. *See, e.g.,* U.G. Khatri et al., "Racial/Ethnic Disparities in Unintentional Fatal and Nonfatal Emergency Medical Services–Attended Opioid Overdoses During the COVID-19 Pandemic in Philadelphia," *JAMA* 4, no. 1 (2021): 1-4 (detailing significant and disproportionate increases in drug overdoses among Black people during the pandemic in Philadelphia).
33. Yee et al., *supra* note 22, at 47.
34. Morgan, *supra* note 16.
35. *See, e.g.,* American Society of Addiction Medicine, *supra* note 23. *See also,* P.A. Lagisetty et al., "Buprenorphine Treatment Divide by Race/Ethnicity and Payment," *JAMA Psychiatry* 76 no. 9 (2019): 979-980 (finding white and higher-income individuals receive standard of care treatment at disproportionate rates).
36. *See* S. Mendoza et al., "Re-racialization of Addiction and the Redistribution of Blame in the White Opioid Epidemic," *Medical Anthropology Quarterly* 33 (2018): 242-262.
37. C. McKnight et al., "Perceived Discrimination among Racial and Ethnic Minority Drug Users and the Association with Health Care Utilization," *Journal of Ethnicity in Substance Abuse* 16, no. 4 (2017): 404-419.
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39. Racism has consistently served as the foundation for U.S. drug policy, including the de-medicalization and criminalization of addiction. For a historical account of the anti-Chinese, anti-Mexican, and anti-Black racism that has fueled drug laws in this country, *see, e.g.,* D.M. Provine, *Unequal Under Law: Race in the War on Drugs* (Chicago: University of Chicago Press, 2008).
40. *See, e.g.,* Davis, *supra* note 7, at 284; A. Akbar, "Toward a Radical Imagination of Law," *New York University Law Review* 93 (2018): 405-479.
41. *See, e.g.,* D. Baum, "Legalize It All: How to Win the War on Drugs," *Harper's Magazine*, April 2016 (interviewing Nixon's former domestic policy advisor who said "The Nixon White House had two enemies: the antiwar left and Black people … We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did"); B. Andraka-Christou, "Addressing Racial and Ethnic Disparities in the Use of Medications for Opioid Use Disorder," *Health Affairs* 40, no. 6 (2021): 920-927.
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62. *See, e.g.,* J.D. Oliva, "Dosing Discrimination," *supra* note 53; K.K. Dineen, 'Opioid Prescribing in Stigmatized and Special Populations,' in J. Peppin, J. Coleman, K.K. Dineen, & A. Ruggles, eds., Prescription Drug Diversion and Pain: History, Policy, and Treatment, (Oxford University Press, 2018): 190-204 (reviewing the undertreatment of people of color in acute pain from sickle cell crisis).
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92. 42 C.F.R. §8.12 (f)(6).
93. 42 C.F.R. §8.12 (f)(5) (counseling); 42 C.F.R. § 8.12(e)(4) (detoxification).
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104. The Biden Administration has signaled that it will propose a new final rule reversing many of the limitations imposed by the Trump Administration's 2020 revised final rule. See M. Musumeci et al., "Recent and Anticipated Actions to Reverse Trump Administration Section 1557 Non-Discrimination Rules," Kaiser Family Foundation, June 9, 2021, *available at* <https://www.kff.org/racial-equity-and-health-policy/issue-brief/recent-and-anticipated-actions-to-reverse-trump-administration-section-1557-non-discrimination-rules/> (last visited January 1, 2022).
105. U.S. Department of Health & Human Services, "Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act," 45 C.F.R. Part 92, 81 Fed. Reg. 31376, 31405 (May 18, 2016).
106. 42 U.S.C. § 2000e.
107. *Jefferies v. Harris County Community Action Ass'n,* 615 F.2d 1025, 1032 (5th Cir. 1980).
108. Abrokwa, *supra* note 21, at 15.
109. 42 U.S.C. § 12102(1).
110. *Id.* at §12102(4)(A).
111. *See* Office for Civil Rights, U.S. Department of Health & Human Services, *Fact Sheet: Drug Addiction and Federal Disability Rights Laws* (October 25, 2018), *available at* <https://www.hhs.gov/sites/default/files/drug-addiction-aand-federal-disability-rights-laws-fact-sheet.pdf> [https://perma.cc/7WT2-TUCY] (last visited January 1, 2022); U.S. Department of Health & Human Services, *Nondiscrimination and Opioid Use Disorders Fact Sheet* (October 25, 2018), *available at* <https://www.hhs.gov/sites/default/files/fact-sheet-non-discrimination-and-opioid-use.pdf> [https://perma.cc/Z2Z4-MU5Y] (last visited January 1, 2022).
112. *See* Frederick and Shifrer, *supra* note 15, at 204 ("People of Color and those from lower socioeconomic backgrounds have disproportionately experienced the harm that comes from medical coercion and surveillance of disabled people, the very forms of medical injustice that have driven the rejection of the medical model. But these groups also commonly experience lack of access, or denial of access, to quality medical care that middle-class white Americans are less likely to endure. In other words, there is a privilege in being able to call for a distancing from the biomedical regime, a privilege not enjoyed by those whose oppression has included denial of medical care").
113. Morgan, *supra* note 16, at 13.
114. 42 U.S.C. § 12114(b)(3); *see also Nielsen v. Moroni Feed Co.*, 162 F.3d 604, 610 (10th Cir. 1998) ("[T]he ADA protects

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employees who are erroneously regarded as being current illegal drug users.").
115. *See* Hart, *supra* note 11.
116. CARES Act, Pub. L. No. 116-136, § 3221, 134 Stat. 281, 375–79 (2020) (codified at 42 U.S.C. § 290dd-2).
117. K.K. Dineen and E. Pendo, "Substance Use Disorder Discrimination and the CARES Act: Using Disability Law to Inform Part 2 Rulemaking," *Arizona State Law Journal* 52 (2021): 1143-1165.
118. 42 U.S.C. § 12114(a); *see also* 29 U.S.C. § 705(20)(C)(i) (Rehabilitation Act); 42 U.S.C. § 3602(h) (FHA).
119. L. Francis, "Illegal Substance Abuse and Protection from Discrimination in Housing and Employment: Reversing the Exclusion of Illegal Substance Abuse as a Disability," *Utah Law Review* 2019, no. 4 (2019): 891-913; E.G. Aoun and P.S. Appelbaum, "Ten Years After the ADA Amendment Act (2008): The Relationship between ADA Employment Discrimination and Substance Use Disorders," *Psychiatric Services* 70 (2019): 596-603. *See also* M.J. Egan, Comment, "When Does 'Currently' Using No Longer Apply? The Americans with Disabilities Act, the Opioid Crisis, and a Search for the Solution," *George Mason Law Review* 27 (2019): 307-344.
120. *See* Office for Civil Rights, *supra* note 79.
121. Dineen and Pendo, *supra* note 117.
122. 42 U.S.C. § 12113(a)-(b), 42 U.S.C. § 12111(3); 29 C.F.R. § 1630.2(r).
123. *Id.*, at 3; *Breaux v. Bollinger Shipyards*, LLC, No. 16-2331, 2018 WL 3329059, at *12 (E.D. La. July 5, 2018); *Pollard v. Drummond Co.*, No. 12-CV-03948, 2015 WL 5306084, at *7 (N.D. Ala. Sept. 10, 2015); *Equal Emp. Opportunity Comm'n v. Hussey Copper Ltd.*, 696 F. Supp. 2d 505, 517–18 (W.D. Pa. 2010). *See also*, "Cases Involving Discrimination Based on Treatment with Medication for Opioid Use Disorder (MOUD)," 2020, *available at* <https://perma.cc/RFJ6-3UZQ> (last visited January 1, 2022).
124. *Bragdon v. Abbott*, 524 U.S. 624 (1998).
125. U.S. Equal Employment, Opportunity Commission EEOC–NTVA–2020–2, "Use of Codeine, Oxycodone, and Other Opioids: Information for Employees," 2020, *available at* <https://www.eeoc.gov/laws/guidance/use-codeine-oxycodone-and-other-opioids-information-employees> [https://perma.cc/S2NJ-EMUM] (last visited January 1, 2022).
126. U.S. Equal Employment Opportunity Commission, EEOC–NTVA–2020–1, "How Health Care Providers Can Help Current and Former Patients Who Have Used Opioids Stay Employed," 2020, *available at* <https://www.eeoc.gov/laws/guidance/how-health-care-providers-can-help-current-and-former-patients-who-have-used-opioids> [https://perma.cc/AB5J-MYAU] (last visited January 1, 2022).
127. L. Beletsky et al., "Practicing What We Preach—Ending Physician Health Program Bans on Opioid-Agonist Therapy," *New England Journal of Medicine* 381 (2019): 796-798.
128. *Id.*
129. *See* R. Mosher Henke et al., "Opioid Use Disorder and Employee Work Presenteeism, Absences, and Health Care Costs," *Journal of Occupational and Environmental Medicine* 62, no. 5 (2020): 344-349.
130. Beletsky, et al., *supra* note 127.
131. General Prohibitions Against Discrimination, 28 C.F.R. § 35.130(b) (2016); Prohibition of discrimination by public accommodations, 42 U.S.C. § 12182(b)(2)(A) (1990).
132. *See, e.g.,* Mass. Bureau of Health Care Safety and Quality, Circular Letter: DHCQ 16-11-662-Admission of Residents on Medication Assisted Treatment for Opioid Use Disorder (November 15, 2016), *available at* <https://www.mass.gov/circular-letter/circular-letter-dhcq-16-11-662-admission-of-residents-on-medication-assisted-treatment-for-opioid-use-disorder> (last visited January 3, 2021).
133. Title II entities are required to give primary consideration to patient preferences, while Title III entities are encouraged to consult patients and emphasize their needs. General, 28 C.F.R. § 35.160(b)(2) (2011); Auxiliary Aids and Services, 28 C.F.R. § 36.303(c)(2) (2017). *See also,* Civil Rights Division, Department of Justice, ADA Requirements Effective Communication, 2014, *available at* <https://www.ada.gov/effective-comm.htm> (last visited January 3, 2021).
134. Abrokwa, *supra* note 21, at 71.
135. L.I. Iezzoni et al., "What U.S. Practicing Physicians Know About the Americans with Disabilities Act and Accommodating Patients with Disability," *Health Affairs* 38, no. 4 (forthcoming 2022).
136. General Prohibitions Against Discrimination, 28 C.F.R. § 35.130(b) (2016); Activities, 28 C.F.R §36.202(a) (1992).
137. *See, e.g.,* N.D. Agaronnik et al., "Knowledge of Practicing Physicians about Their Legal Obligations When Caring for Patients with Disability," *Health Affairs* 38 (2019): 545-553.
138. Department of Justice, DJ No. 202-80-64, Settlement Agreement between the United States of America and Selma Medical Associates, Inc. Under the Americans with Disabilities Act (2019), *available at* <https://www.ada.gov/selma_medical_sa.html> [https://perma.cc/DH9W-J3JW] (last visited January 3, 2022).
139. Department of Justice, DJ No. 202-36-319, Settlement Agreement between the United States of America and New England Orthopedic Surgeons under the Americans with Disabilities Act (2021), *available at* <https://www.ada.gov/neos_sa.html> (last visited January 3, 2022).
140. Department of Justice, DJ No. 202-36-306, Settlement Agreement Between the United States of America and Charlwell Operating, LLC Under the Americans with Disabilities Act (2018), *available at* <https://www.ada.gov/charlwell_sa.html> [https://perma.cc/J8X6-E4Y3] (last visited January 3, 2022); Department of Justice, DJ No. 202-36-308, Settlement Agreement Between the United States of America and Athena Health Care Systems Under the Americans with Disabilities Act (2019), *available at* <https://www.ada.gov/athena_healthcare_sa.html> [https://perma.cc/866L-7P3M] (last visited January 3, 2022).
141. Department of Justice, DJ No. 202-36-304, Settlement Agreement Between the United States of America and Massachusetts General Hospital Under the Americans with Disabilities Act (2020), *available at* <https://www.ada.gov/mass_gen_hosp_sa.html> [https://perma.cc/BK9K-NKL2] (last visited January 3, 2022).
142. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 592 (1992).
143. *Alexander v. Choate*, 469 U.S. 287 at 292-93 (1985). The U.S. Supreme Court agreed to hear a case during the 2021-2022 term on the question of whether Section 504, and by extension Section 1557, provides a disparate-impact cause of action for plaintiffs alleging disability discrimination. The case was withdrawn pursuant to a joint stipulation on November 12, 2021. *CVS Pharmacy v. Doe*, U.S. (July 2, 2021).
144. *Id.*, at 301, 304. For a discussion of "meaningful access" in the context of health care, *see* L. Francis and A. Silvers, "Debilitating Alexander v. Choate: 'Meaningful Access' to Health Care for People with Disabilities," *Fordham Urban Law Journal* 35 (2008): 447-477.
145. For a discussion *see id.*, M.C. Weber, "Accidentally on Purpose: Intent in Disability Discrimination Law," *Boston College Law Review* 56 (2015): 1417-1464.
146. *See e.g.,* "The Current State of Health Care for People with Disabilities," National Council on Disability (September 30, 2009).
147. Morgan, *supra* note 13, at 3.
148. R. Yearby, "Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States due to Structural Racism," *American Journal of Economics and Sociology* (2018): 1113-1152.
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153. *See* N.D. Agaronnik et al., "Knowledge of Practicing Physicians about Their Legal Obligations When Caring for Patients with Disability," *Health Affairs* 38 (2019): 545-553.
154. *See* Pendo and Iezzoni, *supra* note 26.

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