

# From Stigma to Treatment: The HIV/AIDS Epidemic and the Opioid Epidemic

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*Like in the early years of HIV/AIDS, when homophobia led to responses of blame and fear, addiction is seen as a social problem rather than a defined disease. At the crux of another public health crisis, we need to take responsibility as a community, as providers, as human beings, for those who are living with addiction . . . . This epidemic is a crisis that knows no geographic or economic boundaries. And the impact of it is felt across racial and ethnic minorities, and especially in disadvantaged populations. Like the HIV/AIDS epidemic, addiction touches just about every family in the U.S.<sup>1</sup>*

## I. INTRODUCTION

Like countless others, Cristin was prescribed OxyContin after a car accident left her with painful injuries at eighteen years old.<sup>2</sup> It was

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1. *The Intersection of HRSA's Ryan White HIV/AIDS Program and the Opioid Epidemic*, HRSA'S RYAN WHITE HIV/AIDS PROGRAM 1 (2019), <https://hab.hrsa.gov/sites/default/files/hab/Publications/factsheets/opioid-executive-summary-report.pdf> (quoting Sylvia Trent-Adams, Ph.D., R.N., F.A.A.N., Principal Deputy Assistant Secretary for Health).

2. *Overcoming Opioid Addiction: A Woman Shares Her Story*, YALE MED. (Feb. 28, 2017), <https://www.yalemedicine.org/stories/overcoming-opioid-addiction/>. The article does not note Cristin's race, but it is important to note the difference in media presentation of rural white opioid users compared with presentation of urban Black opioid users (this Note uses "Black" as an umbrella term to include those who identify as "African American" and/or "Black" in the United States). Opioid misuse is often reported as a white rural or suburban problem. See Julie Netherland & Helena B. Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, 40 CULTURE, MED., & PSYCHIATRY 664, 671–76 (2016), [https://www.med.upenn.edu/timm/assets/user-content/Netherland-Hansen2016\\_Article\\_TheWarOnDrugsThatWasnTWastedWh.pdf](https://www.med.upenn.edu/timm/assets/user-content/Netherland-Hansen2016_Article_TheWarOnDrugsThatWasnTWastedWh.pdf) (analyzing press articles from 2001 to 2011 to contrast coverage of white non-medical opioid users with Black heroin users). Stories about white people struggling with addiction often explain how the person became addicted, and while stories about Black people struggling with opioid addiction are rare, they focus on arrest reports and are silent as to the details of how they became addicted. *Id.* at 671–72. This presentation highlights the "assumption that drug use is to be expected in poor, ethnic minority urban communities, but not in suburban and rural white America . . . . [T]he fact that drug use is now happening in white communities (or so we are told) is precisely what is newsworthy." *Id.* at 672.

1998 and opioid prescriptions were on the rise.<sup>3</sup> Cristin took the medication as prescribed, until her physician refused to order another refill after a full year.<sup>4</sup> By then, it was too late—Cristin was addicted.<sup>5</sup> Cristin’s OxyContin prescription ended, but her pain did not.<sup>6</sup> She turned to heroin to mitigate the pain.<sup>7</sup> It was the beginning of a decades long journey through opioid addiction.<sup>8</sup>

Years later, Cristin enrolled in a rehabilitation program that provided medication-assisted treatment (MAT)<sup>9</sup> rather than abstinence-only psychological care.<sup>10</sup> Doctors prescribed Cristin methadone and

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3. *Overcoming Opioid Addiction: A Woman Shares Her Story*, *supra* note 2; see also *Opioid Overdose: Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 17, 2021), <https://www.cdc.gov/drugoverdose/epidemic/index.html> (describing the “first wave” of opioid overdose deaths following an increase in prescription opioids in the 1990s). By this time, the manufacturer of OxyContin, Purdue Pharma, was aware the drug was highly addictive. Eric Levitz, *Purdue Pharma Knew its Opioids Were Widely Abused by Late '90s*, INTELLIGENCER (May 29, 2018), <https://nymag.com/intelligencer/2018/05/purdue-knew-its-opioids-were-widely-abused-by-late-90s.html>. Purdue Pharma nevertheless advertised the drug as posing a minimal risk of addiction. *Id.*

4. *Overcoming Opioid Addiction: A Woman Shares Her Story*, *supra* note 2.

5. *Id.*

6. *See id.*

7. *Id.* Dependence on prescription opioids is “associated with a 40-fold increased risk of dependence on or abuse of heroin.” *Prescription Opioids and Heroin Research Report*, NAT’L INST. ON DRUG ABUSE 8 (2018), <https://www.drugabuse.gov/download/19774/prescription-opioids-heroin-research-report.pdf?v=fc86d9fdda38d0f275b23cd969da1a1f>. Heroin is cheaper and more widely available than prescription opioids. *Id.* at 10–11.

8. *Overcoming Opioid Addiction: A Woman Shares Her Story*, *supra* note 2.

9. *Id.* Experts widely consider MAT for opioid use disorders as the “gold standard” of treatment. Hilary Smith Connery, *Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions*, 23 HARV. REV. PSYCHIATRY 63, 64 (2015), [https://journals.lww.com/hrpjournal/Fulltext/2015/03000/Medication\\_Assisted\\_Treatment\\_of\\_Opioid\\_Use.2.aspx](https://journals.lww.com/hrpjournal/Fulltext/2015/03000/Medication_Assisted_Treatment_of_Opioid_Use.2.aspx) (reviewing the strength of evidence behind MAT). “Medication for Addiction Treatment” also may describe MAT.

10. Abstinence-only psychological care remains the majority treatment for rehabilitation from opioid addiction, despite growing evidence that MAT combined with psychological treatment is superior. See AM. SOC’Y OF ADDICTION MED., THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE 27 (2020), [https://www.asam.org/docs/default-source/quality-science/npq-jam-supplement.pdf?sfvrsn=a00a52c2\\_2](https://www.asam.org/docs/default-source/quality-science/npq-jam-supplement.pdf?sfvrsn=a00a52c2_2) (stating that “the use of

buprenorphine to manage her addiction and mitigate withdrawal symptoms.<sup>11</sup> For the first time in her adult life, she was free to focus on her career; she is now a certified phlebotomist.<sup>12</sup> Access to methadone and buprenorphine saved her life.<sup>13</sup> Cristin’s story is all too familiar, except for the ending—patients with opioid addiction receive MAT less than twenty percent of the time.<sup>14</sup>

The United States is in the midst of an opioid epidemic.<sup>15</sup> More Americans die each year from opioid overdose than from motor vehicle accidents and firearms.<sup>16</sup> In 2017, more than 47,000 people died from opioid overdose, and 1.7 million people lived with an opioid use disorder (OUD).<sup>17</sup> In 2018, 128 people died each day from opioid

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medications . . . is superior to psychosocial treatment” alone in its 2020 practice guide for clinicians treating patients with opioid use disorder). The practice guide goes on to state that medication and psychosocial treatments combined is the standard of care. *Id.*

11. *Overcoming Opioid Addiction: A Woman Shares Her Story*, *supra* note 2 (“Medications such as methadone and buprenorphine can stimulate the opioid receptors enough to eliminate the drug cravings, without getting a patient high. ‘The goal is to help patients feel normal,’ Dr. Marienfeld says. Then they can focus on other aspects of their lives, such as working or parenting.”).

12. *Id.*

13. *Id.*

14. See Brendan Saloner, Emma E. McGinty, Leo Beletsky, Ricky Bluthenthal, Chris Beyrer, Michael Botticelli, & Susan G. Sherman, *A Public Health Strategy for the Opioid Crisis*, 133 PUB. HEALTH REPS. 24S, 26S (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6243441/> (“In 2004–2013, only one-fifth of people with opioid use disorder received treatment.”).

15. Opioids include prescription pain killers, heroin, and synthetic opioids such as fentanyl. See *Opioids*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drug-topics/opioids> (last visited Sept. 25, 2021).

16. See Sarah E. Wakeman, Traci C. Green, & Josiah D. Rich, *From Documenting Death to Comprehensive Care: Applying Lessons from the HIV/AIDS Epidemic to Addiction*, 127 AM. J. MED. 465, 465 (2014), <https://www.amjmed.com/action/showPdf?pii=S0002-9343%2814%2900027-8> (noting that opioid overdose “kills more Americans than motor vehicle crashes or firearms”). In 2019, firearms killed 12.1 people per 100,000 population, motor vehicle crashes 11.5, and opioid overdose 15.2. *National Center for Health Statistics: All Injuries*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 1, 2021), <https://www.cdc.gov/nchs/fastats/injury.htm>.

17. See *Opioid Overdose Crisis*, NAT’L INST. ON DRUG ABUSE (Mar. 11, 2021), <https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis> (explaining the rise in opioid use disorder). It is worth noting that the American Society of Addiction Medicine encourages use of the term “addiction involving” opioid use rather

overdose,<sup>18</sup> and more than 10.3 million people over the age of twelve misused opioids.<sup>19</sup> Moreover, the economic burden of OUD is approximately \$78.5 billion a year.<sup>20</sup> Opioid overdose deaths also increased in 2020, likely due to COVID-19-related hardships and disruptions in care.<sup>21</sup>

In the mid-1990s, HIV and AIDS mortality rates declined rapidly because of antiretroviral therapy and a large-scale, comprehensive public health response.<sup>22</sup> Included in that public health response was the Ryan White CARE Act (RWCA)—federal legislation focused on providing HIV care and treatment services to uninsured or underserved people living with HIV.<sup>23</sup> Some have argued that the response to the AIDS epidemic offers a blueprint to guide the response to other

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than “opioid use disorder,” but because the DSM and the bulk of literature use “opioid use disorder,” this Note will do the same. See AM. SOC’Y ADDICTION MED., *supra* note 10, at 7 (encouraging use of “addiction involving” but acknowledging that the DSM and other literature use “opioid use disorder”).

18. *Opioid Overdose Crisis*, *supra* note 17.

19. SUBSTANCE ABUSE AND MENTAL HEALTH DISORDER SERVS. ASSOC., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH 23 (2019), <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.

20. See *Opioid Overdose Crisis*, *supra* note 17 (discussing the extent of the opioid crisis, including the total economic burden).

21. *Overdose Deaths Accelerating During COVID-19*, CTRS. FOR DISEASE CONTROL & PREVENTION, (Dec. 17, 2020), <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>. Overdose deaths were already increasing in 2019, but the increase has accelerated during the pandemic. *Id.* The CDC did not explain the specific disruptions but warned of “unintended consequences” and “[t]he disruption to daily life due to the COVID-19 pandemic.” *Id.* Other commentators have pointed to COVID-19-related job loss, increased anxiety and depression, and limited social interaction as contributing to a “perfect storm” to trigger someone into relapse. Chris Sweeney, *A Crisis on Top of a Crisis: COVID-19 and the Opioid Epidemic*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (Feb. 16, 2021), <https://www.hsph.harvard.edu/news/features/a-crisis-on-top-of-a-crisis-covid-19-and-the-opioid-epidemic/>.

22. Caroline M. Parker, Jennifer S. Hirsch, Helena B. Hansen, & Charles Branas, *Facing Opioids in the Shadow of the HIV Epidemic*, 380 NEW ENG. J. MED. 1 (2019), <https://www.nejm.org/doi/full/10.1056/nejmp1813836>.

23. See 42 U.S.C. § 300ff (2018).

emerging epidemics.<sup>24</sup> As our nation reckons with a growing opioid drug-overdose death toll, set to surpass that of AIDS at its peak,<sup>25</sup> the response to the opioid epidemic should be informed by the relative success in combatting the scourge of HIV/AIDS.

This Note will demonstrate the need to apply lessons from the HIV/AIDS epidemic to combat the opioid crisis. The federal government should use the legislative response to the HIV/AIDS epidemic as a blueprint for a large-scale response to the opioid epidemic. The legislation should mirror the RWCA<sup>26</sup> and provide increased access to MAT, decrease the cost of care, and fund comprehensive support services for marginalized populations struggling with opioid use disorder. Part II of this Note will discuss the specific public health policies and legislation that led to a dramatic decline in HIV/AIDS incidence and mortality rates. Part III will analyze the current state of the opioid epidemic and the flawed policies that led to this point. Part IV will argue that Congress should allocate funding to combat the opioid crisis in a manner like the RWCA. Finally, Part V will conclude that the current opioid response is not strong enough and is not rooted in evidence-based practice. The opioid epidemic is a disease, not a moral failure, and legislation should mirror that reality.

## II. HISTORY OF THE HIV/AIDS EPIDEMIC AND THE OPIOID EPIDEMIC

The HIV/AIDS crisis began in the early 1980s, and nearly a decade of fear and tragic deaths passed before a comprehensive federal legislative response emerged.<sup>27</sup> The United States is more than a decade into the opioid crisis and still lacks a comprehensive, public health-

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24. Arthur Robin Williams & Adam Bisaga, *From AIDS to Opioids—How to Combat an Epidemic*, 375 NEW ENG. J. MED. 813, 814 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5517310/>.

25. See Puja Seth, Rose A. Rudd, Rita K. Noonan, & Tamara M. Haegerich, *Quantifying the Epidemic of Prescription Opioid Overdose Deaths*, 108 AM. J. PUB. HEALTH 500 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5844400/> (“[A]n estimated 32,445 prescription opioid-involved deaths occurred in 2016.”). At its peak in 1995, HIV/AIDS caused 50,877 deaths. Dennis H. Osmond, *Epidemiology of HIV/AIDS in the United States*, HIV INSITE (2003), <http://hivinsite.ucsf.edu/InSite?page=kb-01-03>.

26. See 42 U.S.C. § 300ff (2018).

27. See *supra* Part II(A)(1) (showing that the CDC first reported HIV-related deaths in 1981, and the RWCA did not become law until 1990).

focused response.<sup>28</sup> Now is the time for a response to the opioid crisis that mirrors the legislative response to the HIV/AIDS crisis.

### A. *The HIV/AIDS Epidemic*

The HIV/AIDS crisis has taken an enormous toll—more than 700,000 people in the United States have died from AIDS since the epidemic emerged.<sup>29</sup> From the origins of the disease to today, the response has largely shifted from one rooted in fear, stigmatization, and criminal punishment, to one rooted in public health and human rights.<sup>30</sup> The road to progress has not been smooth, nor is the result perfect, but policymakers should look to this previous epidemic for insight.

#### 1. From Stigmatization to Public Health

HIV (human immunodeficiency virus) is a virus that attacks and destroys immune cells.<sup>31</sup> The virus is incurable but may be controlled through Anti-Retroviral Therapy (ART).<sup>32</sup> The most severe stage of HIV infection is known as AIDS (acquired immunodeficiency syndrome).<sup>33</sup> Clinicians first recognized cases of severe immune deficiency in 1981.<sup>34</sup> The CDC identified clusters of diseases, rare in those with normal immune systems, in otherwise healthy, young, gay men.<sup>35</sup>

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28. Corey S. Davis, *The SUPPORT for Patients and Communities Act—What Will it Mean for the Opioid-Overdose Crisis?*, 380 NEW ENG. J. MED. 3, 3 (Jan. 3, 2019), <https://www.nejm.org/doi/full/10.1056/NEJMp1813961>.

29. *The HIV/AIDS Epidemic in the United States: The Basics*, KAISER FAM. FOUND. (June 7, 2021), <https://www.kff.org/hiv/aids/fact-sheet/the-hiv-aids-epidemic-in-the-united-states-the-basics/>.

30. Jamie Enoch & Peter Piot, *Human Rights in the Fourth Decade of the HIV/AIDS Response*, 19 HEALTH & HUM. RTS. J. 117, 118–20 (Dec. 29, 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739363/>.

31. *About HIV*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 1, 2021), <https://www.cdc.gov/hiv/basics/whatishiv.html>.

32. *Id.*

33. *Id.*

34. *A Timeline of HIV and AIDS*, HIV.GOV, <https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline> (last visited Sept. 30, 2021).

35. See INST. OF MED. OF THE NAT'L ACADS., MEASURING WHAT MATTERS: ALLOCATION, PLANNING, AND QUALITY ASSESSMENT FOR THE RYAN WHITE CARE ACT 41 (2004), <https://www.nap.edu/read/10855/chapter/4> (giving an overview of the HIV/AIDS epidemic).

One of those diseases is Kaposi's sarcoma, an unusually aggressive cancer associated with severe immune deficiency.<sup>36</sup> Reporters coined it the "gay cancer."<sup>37</sup>

By the end of the year, the CDC identified over 337 cases of the then-novel AIDS disease—130 of those infected died within the same year.<sup>38</sup> By 1989, HIV/AIDS surpassed heart disease, cancer, suicide, and homicide to be the second leading cause of death among men twenty-five to forty-four years of age.<sup>39</sup> Incidence of HIV/AIDS was largely perceived as a gay man's disease, evidenced by its first official name: GRID, or Gay-Related Immunodeficiency Disease.<sup>40</sup>

The initial response by the government was rooted in stigmatizing groups perceived to be at a high risk for contracting and spreading HIV infection.<sup>41</sup> The CDC famously declared four risk-factors for HIV, the four H's: "homosexuals, heroin users, hemophiliacs, and Haitians."<sup>42</sup> Because these groups were already marginalized, the government initially took a "law and order" approach that created a culture of "fear, blaming, shaming, and isolation."<sup>43</sup>

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36. *Id.*

37. *Id.*; see, e.g., Lawrence K. Altman, *New Homosexual Disorder Worries Health Officials*, N.Y. TIMES (May 11, 1982), <https://www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html> (referring repeatedly to the new immune system disorder affecting "primarily male homosexuals" as GRID).

38. See *A Timeline of HIV and AIDS*, *supra* note 34.

39. *Current Trends Mortality Attributable to HIV Infection/AIDS—United States, 1981–1990*, 40 CTRS. FOR DISEASE CONTROL & PREVENTION: MORBIDITY & MORTALITY WKLY. REPORT 41 (Jan. 25, 1991), <https://www.cdc.gov/mmwr/preview/mmwrhtml/00001880.htm>.

40. *A Timeline of HIV and AIDS*, *supra* note 34.

41. See Enoch & Piot, *supra* note 30 (describing the historical shift from stigmatization to public health interventions). Groups perceived to be high risk included "men who have sex with men (MSM) and Haitian immigrants in the United States." *Id.*

42. Robert Bazell, *Research Rewrites First Chapter of AIDS in U.S.*, NBC NEWS (Nov. 6, 2007, 2:55 PM), <https://www.nbcnews.com/id/wbna21653369>.

43. Enoch & Piot, *supra* note 30. For example, Haitians living in the United States were often fired from their jobs due to AIDS stigma. Bazell, *supra* note 42. Modern access to care for HIV/AIDS patients is still "affected by discriminatory attitudes toward such dimensions as sexual practices, sexually transmitted infections, homosexuality, prostitution, and the use of hard drugs." Oscar Labra & Daniel Thomas, *The Persistence of Stigma Linked with HIV/AIDS in Health-Care Contexts: A Chronic*



As HIV/AIDS-related research continued, an understanding of the disease's transmission catalyzed an unprecedented public health response.<sup>44</sup> Researchers and the general public quickly caught on that this novel immune disease affected people of all nationalities and sexualities, including people like Ryan White.<sup>45</sup> Though the government's response was shamefully slow in the early years of the epidemic, the public health approach shifted towards a then-novel concept—human rights.<sup>46</sup> The World Health Organization initiated the shift in framing HIV/AIDS from deviant behavior to a matter of fundamental human rights.<sup>47</sup> In the United States, this shift culminated in the RWCA.<sup>48</sup>

In 1984, in Central Indiana, a thirteen-year-old with hemophilia contracted HIV after a blood transfusion.<sup>49</sup> His name was Ryan White, and doctors told him he had six months to live.<sup>50</sup> His middle school expelled him after parents took their children out of school in protest.<sup>51</sup>

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*Social Incapacity, in HIV/AIDS – CONTEMPORARY CHALLENGES* 125, 126 (Nancy Dumais ed., 2017), <https://www.intechopen.com/books/hiv-aids-contemporary-challenges/the-persistence-of-stigma-linked-with-hiv-aids-in-health-care-contexts-a-chronic-social-incapacity>.

44. See Wakeman, Green, & Rich, *supra* note 16 (comparing the efficacy of the HIV/AIDS response with the response to the opioid crisis).

45. See *infra* notes 51–54 and accompanying text (describing Ryan White's story).

46. Wakeman, Green, & Rich, *supra* note 16.

47. Enoch & Piot, *supra* note 30, at 118.

48. 42 U.S.C. § 300ff (2018). Of course, the stigma associated with an HIV/AIDS diagnosis still exists and aspects of living with HIV/AIDS remain criminalized. See, e.g., Kim Shayo Buchanan, *When is HIV a Crime? Sexuality, Gender and Consent*, 99 MINN. L. REV. 1231, 1232–34 (2015) (discussing existing HIV criminalization); Stephen Frost, Comment, *HIV Criminalization Laws: A Poor Public Policy Choice in the New Era of PrEP*, 6 WAKE FOREST J. L. & POL'Y 319, 321 (2016) (discussing the ineffectiveness of HIV criminalization laws). To acknowledge the progress made is not to ignore the progress yet to happen, nor to minimize the hardships experienced by people living with HIV or AIDS.

49. *Who Was Ryan White?*, HEALTH RES. & SERVS. ADMIN., <https://hab.hrsa.gov/about-ryan-white-hivaids-program/who-was-ryan-white> (last modified Oct. 2016).

50. *Id.*

51. See Dirk Johnson, *Ryan White Dies of AIDS at 18; His Struggle Helped Pierce Myths*, N.Y. TIMES, (Apr. 9, 1990), <https://timesmachine.nytimes.com/timesmachine/1990/04/09/344690.html?pageNumber=60> (describing Ryan White's experience with HIV). A parent who organized the group opposing Ryan said, "I don't want that boy hurt any more than he has been, but my daughter is

Little was known about the quickly emerging epidemic, and the parents feared that Ryan could infect their children by mere casual contact.<sup>52</sup> Use of the misnomer GRID was also common at this time.<sup>53</sup> Ryan was lambasted by his neighbors—according to whom, Ryan must be gay, and the disease was God’s punishment for his sin.<sup>54</sup>

The next year, Ryan and his family successfully fought in court for his right to go to school.<sup>55</sup> He became a household name. But teenagers can be cruel and so can parents. Students vandalized his locker, cursed him in the hallways, slashed the tires on his family’s car, and shattered the windows of his home.<sup>56</sup> Nevertheless, Ryan quickly became something of a celebrity. He was the poster child for anti-AIDS discrimination—if a nice, quiet teenager like Ryan could get AIDS, then maybe discrimination was unjustified.<sup>57</sup> But it should not have taken a middle-class white teenager to open the eyes of the nation.<sup>58</sup>

In 1990, Ryan White died from an AIDS-related illness at eighteen after fiercely advocating for improved AIDS treatment and education. Four months later, Congress passed the Ryan White CARE Act, a massive, federally funded, HIV and AIDS care system.<sup>59</sup>

## 2. The Ryan White CARE Act—Legislation

The RWCA is a comprehensive federal aid program passed in 1990.<sup>60</sup> The primary goals of the RWCA are to: (1) reduce the cost of

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never going to school with someone I know has AIDS.” Michael Specter, *AIDS Victim’s Right to Attend Public School Tested in Corn Belt*, WASH. POST (Sept. 3, 1985), <https://www.washingtonpost.com/archive/politics/1985/09/03/aids-victims-right-to-attend-public-school-tested-in-corn-belt/8ffb6ac0-93cc-4c6f-88da-f3bb23664294/>.

52. *A Timeline of HIV and AIDS*, *supra* note 34.

53. *Id.*

54. *Who Was Ryan White?*, *supra* note 49.

55. Johnson, *supra* note 51.

56. *Id.*

57. *See id.* (describing Ryan White’s experience with HIV).

58. *See supra* notes 37–43 and accompanying text (describing how the HIV/AIDS crisis was originally framed as a problem facing only sexual minorities, drug users, or Haitian immigrants). The national reckoning came after researchers discovered transmission follows behavior, not sexuality or nationality.

59. *A Timeline of HIV and AIDS*, *supra* note 34.

60. *See* Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 U.S.C. § 300ff-47 (repealed 2000) (setting out the RWCA). The Health Resources

inpatient care, (2) increase access to care for underserved populations, and (3) improve quality of life for persons living with HIV/AIDS.<sup>61</sup> Congress has reauthorized the program four times since its inception: 1996, 2000, 2006, and 2009.<sup>62</sup>

The program acts as a payer of last resort, filling in gaps for those who are uninsured or underinsured.<sup>63</sup> The RWCA is more than a health insurance program; it resembles a comprehensive safety net for people with HIV/AIDS. In addition to funding HIV care facilities, “the program funds a wide variety of services, including primary care, training programs for health care practitioners, assistance in identifying sources of care, access to medications, transportation to care sites, and provision of the necessary documentation to insurers and health care practitioners.”<sup>64</sup> The legislation is divided into several parts.<sup>65</sup>

Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides funds for areas most severely impacted by the HIV epidemic.<sup>66</sup> To qualify for the funds, areas must meet a threshold

and Services Administration (HRSA) of the Department for Human Services (HHS) runs the Ryan White Program. KAISER FAM. FOUND., *The Ryan White HIV/AIDS Program: The Basics* (Oct. 22, 2020), <https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/>.

61. See Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 U.S.C. § 300ff-47 (repealed 2000) (listing the goals of the Act). The purpose of the Act was to “provide emergency assistance to localities that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost[-]efficient systems for the delivery of essential services to individuals and families with HIV disease.” *Id.*

62. KAISER FAM. FOUND., *supra* note 60; see, e.g., Ryan White HIV/AIDS Treatment Extension Act of 2009, Pub. L. No. 111-87, 123 Stat. 2285 (2009) (extending the RWCA).

63. KAISER FAM. FOUND., *supra* note 60.

64. Tamar Ginossar, John Oetzel, Lindsay Van Meter, Andrew A. Gans, & Joel E. Gallant, *The Ryan White HIV/AIDS Program After the Patient Protection and Affordable Care Act Full Implementation: A Critical Review of Predictions, Evidence, and Future Directions*, 27 TOPICS ANTIVIRAL MED. 91, 92 (Sept. 27, 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6892620/>.

65. Ryan White HIV/AIDS Treatment Extension Act of 2009, Pub. L. No. 111-87, 123 Stat. 2285 (2009).

66. See § 2, 123 Stat. at 2285; 42 U.S.C. § 300ff-19 (describing the disbursement of funds for eligible metropolitan areas and transition areas).

population size and reported AIDS cases.<sup>67</sup> The funds are awarded to the city or county chief elected official who “designates a lead agency to administer funds,” and the funds are used to provide holistic medical and social services for people living with HIV/AIDS.<sup>68</sup> Medical services include the following: early intervention services, home health care, hospice services, nutrition therapy, mental health services, and oral health services, among others.<sup>69</sup> Support services include medical transportation, aid for caregivers of people living with HIV, residential services, and linguistic services.<sup>70</sup> Approximately \$655.9 million grants were distributed through Part A in 2020.<sup>71</sup>

Part B of the RWCA effectuated Congress’s intent for the Act to function as a “payer of last resort”<sup>72</sup> through the AIDS Drug Assistance Program (ADAP).<sup>73</sup> ADAP provides funding to all fifty states to cover HIV treatments for uninsured or underinsured people living with HIV.<sup>74</sup> The awards are based on the number of confirmed persons with HIV living in the state.<sup>75</sup> The program positions the federal government as a payer of last resort for low-income persons with limited coverage from private insurance, Medicaid, or Medicare.<sup>76</sup> In fact, the

67. *Part A: Grants to Eligible Metropolitan and Transitional Areas*, HEALTH RES. & SERVS. ADMIN., <https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-a-grants-emerging-metro-transitional-areas> (last modified Oct. 2020). Among the grant recipients are Memphis, TN; Detroit, MI; Baltimore, MD; and Miami, FL. *Id.*

68. *Id.*

69. *Id.*

70. *See id.* (“Support services under Part A must be linked to medical outcomes . . .”).

71. HEALTH RES. & SERVS. ADMIN., HRSA’S RYAN WHITE HIV/AIDS PROGRAM: PART A 2 (2020), <https://hab.hrsa.gov/sites/default/files/hab/Publications/factsheets/program-factsheet-part-a.pdf>.

72. INST. OF MED. OF THE NAT’L ACADS., *supra* note 35, at 3.

73. Ryan White HIV/AIDS Treatment Extension Act of 2009, Pub. L. No. 111-87, 123 Stat. 2285 (2009). The Extension Act extended the original RWCA. The original provision is found at 42 U.S.C. § 300ff-25.

74. *Part B: AIDS Drug Assistance Program*, HEALTH RES. & SERVS. ADMIN., <https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-b-aids-drug-assistance-program> (last modified Oct. 2020).

75. U.S. DEP’T OF HEALTH & HUM. SERVS., RYAN WHITE HIV/AIDS PROGRAM: PART B MANUAL 25 (2015), <https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/habpartbmanual2013.pdf>. ADAP funds make up most of the spending under the Act. *Id.*

76. *Id.*

RWCA is the third largest payer for HIV/AIDS health care, behind Medicaid and Medicare.<sup>77</sup>

Part F of the RWCA sets up the AIDS Education and Training Program (AETC).<sup>78</sup> The AETC conducts training for a diverse group of health care providers in treating people living with HIV, training an average of 83,000 providers each year.<sup>79</sup> The stated mission of the program is “to improve the quality of life of persons with or at-risk of HIV through the provision of high-quality professional education and training.”<sup>80</sup> The program increases the number of health care providers competent to treat people living with HIV.<sup>81</sup> The AETC Program is a national network of HIV experts who provide education and consultation to healthcare professionals and organizations.<sup>82</sup> Specifically, AETC directs training to “providers who serve marginalized and resource-poor populations of high HIV prevalence.”<sup>83</sup> This reflects the statute’s language that explicitly gives preference to projects which will train professionals who care for minority populations and for minority health professionals.<sup>84</sup>

### 3. The Ryan White CARE Act—Impact

The RWCA has largely been successful in providing services to people living with HIV/AIDS. At its worst, the American HIV/AIDS

77. INST. OF MED. OF THE NAT’L ACADS., *supra* note 35, at 27.

78. See 42 U.S.C. § 300ff-111 (setting up the AETC program). The Ryan White HIV/AIDS Treatment Extension Act of 2009 extended the RWCA for following years. *Part F: AIDS Education and Training (AETC) Program*, HEALTH RES. & SERVS. ADMIN., <https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-aids-education-and-training-centers-aetc-program> (last modified Oct. 2020).

79. *Part F: AIDS Education and Training (AETC) Program*, *supra* note 78; *AETC Program Mission and History*, AETC NAT’L COORDINATING RES. CTR., <https://aidsetc.org/page/aetc-program-mission-and-history> (last modified June 4, 2021).

80. *About the AIDS Education and Training Center Program*, AETC NAT’L COORDINATING RES. CTR., <https://aidsetc.org/about> (last modified Dec. 30, 2020). AETC priorities include reducing new HIV infections, increasing access to care for people with HIV, improving health outcomes, reducing health disparities, and reducing duplicative efforts. *Id.*

81. See 42 U.S.C. § 300ff-111 (describing the AETC Program).

82. *Part F: AIDS Education and Training (AETC) Program*, *supra* note 78; *AETC Program Mission and History*, *supra* note 79.

83. *Id.*

84. Public Health Service Act, 42 U.S.C. §§ 300ff-111(a)(2)(A)–(C).

epidemic killed nearly 50,000 people per year.<sup>85</sup> Fifteen years after the CDC identified the first cases of HIV/AIDS, the disease had reached its peak and death rates declined sharply, largely due to increased access to health care, including ART.<sup>86</sup> And the RWCA has been a crucial part of mitigating the HIV/AIDS epidemic. In 2014, more than half of the people living with HIV received services provided by the Act.<sup>87</sup> While it also comes with a hefty price tag—the program cost \$2.39 billion in 2020<sup>88</sup>—the Act has made significant steps towards its goal of increasing access to HIV care for underserved populations.<sup>89</sup> Most individuals receiving services under the RWCA are “low-income, male, people of color, and sexual minorities.”<sup>90</sup>

The response to the HIV crisis was not an unqualified success. It took nearly a decade of HIV-related deaths and confusion before the government passed the RWCA.<sup>91</sup> Even then, the push for significant legislation was motivated largely by the reality that HIV is not limited to gay men and intravenous drug users.<sup>92</sup> It took a middle class, white

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85. See Lucia Torian, Mi Chen, Phillip Rhodes, & H. Irene Hall, *HIV Surveillance—United States, 1981–2008*, 60 *CTRS. FOR DISEASE CONTROL & PREVENTION: MORBIDITY & MORTALITY WKLY. REP.* 689, 689–90 (2011), <https://www.cdc.gov/mmwr/pdf/wk/mm6021.pdf> (summarizing HIV morbidity and mortality from 1981–2008).

86. *Id.* at 690–91. It is worth noting that the global HIV/AIDS response has been less successful, mired in setbacks and politicization of globalized human rights. See Enoch & Piot, *supra* note 30, at 117 (“HIV continues to cause almost two million infections each year, and the ‘end of AIDS’ by 2030 remains elusive.”).

87. *About the Ryan White HIV/AIDS Program*, HEALTH RES. & HUM. SERVS. ADMIN., <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/about-ryan-white-hiv-aids-program> (last updated Dec. 2020).

88. *Id.* The cost rose to \$2.5 billion in 2020, largely because of supplemental funds related to the coronavirus pandemic. KAISER FAM. FOUND., *supra* note 60.

89. See *Part F: Minority AIDS Initiative*, HEALTH RES. & SERVS. ADMIN., <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-f-minority-aids-initiative> (last updated Sept. 2021) (explaining how the Minority AIDS Initiative provides additional funding under the RWCA to “improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV”).

90. KAISER FAM. FOUND., *supra* note 60. In 2018, 61% had an income at or below the federal poverty level, 72% are male, 74% are people of color, and 50% are gay or bisexual men. *Id.*

91. See *supra* Part II(A)(1) (showing that the CDC first reported HIV-related deaths in 1981 and the RWCA did not become law until 1990).

92. See Enoch & Piot, *supra* note 30, at 117 (explaining that the shift to a human rights based public health response followed recognition that disease transmission was tied to behavior, not to certain populations).

teenager to motivate the nation. Despite its shortcomings, experts have called for the response to the HIV crisis to serve as a blueprint for a response to other emerging epidemics.<sup>93</sup>

### B. *The Opioid Epidemic*

The number of persons who meet the clinical definition of OUD continues to rise,<sup>94</sup> as do opioid overdose deaths. The American Society of Addiction Medicine (ASAM) defines addiction as ““a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.””<sup>95</sup> Opioid addiction, in particular, is increasingly common and often develops after a seemingly harmless prescription for painkillers.<sup>96</sup> From 2010 to 2018, opioid overdose deaths increased by 120% in the United States.<sup>97</sup> The CDC describes the rise in opioid overdose deaths over the past thirty years in three waves.<sup>98</sup> First, the boom in prescription opioids in the 1990s resulted in a rise in prescription opioid overdose deaths.<sup>99</sup> Second, 2010 saw a massive increase in deaths caused by heroin overdose.<sup>100</sup> Third, 2013 brought a steep increase in deaths caused by synthetic opioids such as fentanyl.<sup>101</sup> The federal government started out behind in the 1990s, and has yet to catch up

93. See, e.g., Parker, Hirsch, Hansen, & Branas, *supra* note 22 (arguing that the HIV response should inform the response to the opioid crisis).

94. Rebecca L. Haffajee, Amy S.B. Bohnert, & Pooja Lagisetty, *Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment*, 54 AM. J. PREV. MED. S230, S231 (Jan. 13, 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6330240/pdf/nihms-1004715.pdf>.

95. AM. SOC’Y OF ADDICTION MED., *supra* note 10, at 3.

96. See Jeffrey Juergens, *10 Most Common Addictions*, ADDICTION CTR. <https://www.addictioncenter.com/addiction/10-most-common-addictions/> (last updated Sept. 30, 2021) (listing addiction to painkillers as the fourth most common addiction, following tobacco, alcohol, and marijuana).

97. *Opioid Overdose*, WORLD HEALTH ORG. (Aug. 4, 2021), <https://www.who.int/news-room/fact-sheets/detail/opioid-overdose>.

98. *Opioid Overdose: Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/epidemic/index.html> (last updated Mar. 17, 2021).

99. *Id.*

100. *Id.*

101. *Id.*

with the dynamic opioid epidemic and changing medical understanding of addiction as a disease.

### 1. From Stigmatization to Public Health

The policy approach to OUD is slowly shifting from criminalization to public health. This policy shift was likely catalyzed by the shifting demographics of OUD—from urban, nonwhite men to rural, white men and women.<sup>102</sup> As noted above, the CDC describes the “first wave” of the opioid crisis as beginning in the 1990s.<sup>103</sup> In reality, the first opioid epidemic was the heroin crisis of the 1960s and 70s.<sup>104</sup> The original heroin epidemic primarily affected low-income, urban, minority populations.<sup>105</sup> Heroin use has since increased, alongside an increase in opioid prescriptions, but modern users are increasingly affluent suburban and rural white people.<sup>106</sup>

Commentators have highlighted the dramatically different response to the modern opioid crisis and the crack cocaine epidemic in the 1990s.<sup>107</sup> One critic profoundly summed up the disparate treatment:

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102. Theodore J. Cicero, Matthew S. Ellis, Hilary L. Surrat, & Steven P. Kurtz, *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA PSYCHIATRY 821, 821–26 (2014), <https://pubmed.ncbi.nlm.nih.gov/24871348/>. In the 1960’s, 82.8% of those who started abusing opioids were men, compared with a nearly equal number by 2010. *Id.* at 823. By 2010, those with OUD were usually in rural or suburban areas. *Id.* at 824.

103. *See supra* notes 98–101 and accompanying text (describing the CDC’s “three-wave” description of the opioid crisis progression).

104. *See* Cicero, Ellis, Surrat, & Kurtz, *supra* note 102, at 823.

105. *Id.* at 823–24; *see also* Keturah James & Ayana Jordan, *The Opioid Crisis in Black Communities*, 46 J.L., MED. & ETHICS 404 (2018) (discussing the heroin epidemic).

106. *See* Cicero, Ellis, Surrat, & Kurtz, *supra* note 102, at 825.

107. Crack cocaine use reached epidemic proportions in the 1980s. Alyssa L. Beaver, Note, *Getting a Fix on Cocaine Sentencing Policy: Reforming the Sentencing Scheme of the Anti-Drug Abuse Act of 1986*, 78 FORDHAM L. REV. 2531, 2538 (2010) (noting that, “[b]etween 1983 and 1985, crack cocaine usage among African American and Hispanic populations doubled”). The Anti-Drug Abuse Act of 1986 famously instituted sentencing guidelines at a one-hundred-to-one ratio of powder cocaine, associated with white people, to crack cocaine, associated with minorities. *Id.* at 2545. Racial inequities in arrests and sentencing for cocaine remain—police arrested Black people at a rate more than twice that of white people in 2016, even though most users are white. *Racial Double Standard in Drug Laws Persists Today*, EQUAL JUST. INITIATIVE (Dec. 9, 2019), <https://eji.org/news/racial-double-standard-in-drug-laws-persists-today/>.



Thirty years ago, America was facing a similar wave of addiction, death and crime, and the response could not have been more different. Television brought us endless images of thin, black, ravaged bodies, always with desperate, dried lips. We learned the words crack baby. Back then, when addiction was a black problem, there was no wave of national compassion. Instead, we were warned of super predators, young, faceless black men wearing bandannas and sagging jeans . . . . White heroin addicts get overdose treatment, rehabilitation, and reincorporation. Black drug users got jail cells and just say no.<sup>108</sup>

In the wake of urban heroin overdose deaths, states passed harsh criminal statutes.<sup>109</sup> There was little to no emphasis on treatment and rehabilitation. Highlighting the disparate responses in no way negates the importance of shifting the dialogue of addiction to public health over criminalization. To move the needle towards a human rights-based public health response to all addiction diseases, the public must recognize the disparate responses. A comprehensive public health response must consider the impact of poverty and racism.

The response to the opioid crisis must account for the rising tide of opioid misuse and overdose deaths in Black communities. To tell

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108. Judy Woodruff, *There Was No Wave of Compassion When Addicts Were Hooked on Crack*, PBS NEWS HOUR (Mar. 29, 2016, 8:06 PM), <https://www.pbs.org/newshour/show/there-was-no-wave-of-compassion-when-addicts-were-hooked-on-crack> (transcribing Cardozo Law Professor Ekow Yankah's discussion of the modern approach to the opioid crisis compared with the approach to the crack cocaine crisis).

109. See James & Jordan, *supra* note 105, at 412 (discussing New York's Rockefeller Drug Laws and stating, "[t]his practice of employing a public health strategy for white middle-class groups, but a crime-control agenda in urban minority communities is deeply entrenched in American political culture"); see also SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., THE OPIOID CRISIS AND THE BLACK/AFRICAN AMERICAN POPULATION: AN URGENT ISSUE 3 (2020), [https://store.samhsa.gov/sites/default/files/SAMHSA\\_Digital\\_Download/PEP20-05-02-001\\_508%20Final.pdf](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf) ("Three decades ago, when opioids and crack cocaine were devastating Black/African American communities, the national response was 'The War on Drugs.'") [hereinafter AN URGENT ISSUE]. The lasting effects of the War on Drugs are clear—Black Americans represent 12% of the population but 39% of those incarcerated for drug-related offenses. *Id.* Moreover, "80% of those who are convicted for heroin trafficking are either Black or Latino, even though whites use opioids at higher rates than other groups." James & Jordan, *supra* note 105, at 409.

the story of the opioid crisis as a rural white problem overlooks communities of color that have been profoundly affected. Opioid overdose deaths among the Black community increased 40% from 2015 to 2016, compared with 21% for the overall population.<sup>110</sup> Despite a lack of media attention, Black communities are amid an opioid epidemic.<sup>111</sup> Communities of color face a similar, albeit exacerbated, hurdle to healing—lack of access to adequate OUD treatment.<sup>112</sup>

OUDs are chronic medical conditions that require treatment.<sup>113</sup> Three crucial drugs for effective treatment of OUD are methadone, buprenorphine, and naltrexone (also called naloxone).<sup>114</sup> MAT uses such medications to treat OUD and is administered alongside psychosocial treatment.<sup>115</sup> MAT works to normalize a patient's brain chemistry to relieve physiological cravings while blocking the euphoric high associated with opioid use.<sup>116</sup> Methadone and buprenorphine interact with the same brain receptors as opioids without creating the high.<sup>117</sup> These drugs allow patients to focus on achieving sobriety without

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110. AN URGENT ISSUE, *supra* note 109, at 4 (“The opioid misuse rate among non-Hispanic Blacks is similar to the national population rate, about 4 percent.”).

111. *See* Netherland & Hansen, *supra* note 2, at 665–66 (analyzing media coverage of opioid addiction by race).

112. *See generally* Marilyn C. Daley, *Race, Managed Care, and the Quality of Substance Abuse Treatment*, 32 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 457, 458–59 (2005), <https://link.springer.com/content/pdf/10.1007/s10488-004-1670-3.pdf> (finding access to MAT worse for minorities than whites).

113. Andrew W. Dick, Rosalie L. Pacula, Adam J. Gordon, Mark Sorbero, Rachel M. Burns, Douglas Leslie, & Bradley D. Stein, *Growth in Buprenorphine Waivers Increased Potential Access to Opioid Agonist Treatment, 2002–11*, 34 HEALTH AFFS. 1028, 1028 (2015), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1205>.

114. John Kip Cornwell, *Opioid Courts and Judicial Management of the Opioid Crisis*, 49 SETON HALL L. REV. 997, 1007 (2019). Other MAT includes naloxone, suboxone, clonidine, and lofexidine. AM. SOC'Y OF ADDICTION MED., *supra* note 10, at 34.

115. AM. SOC'Y OF ADDICTION MED., *supra* note 10, at 27.

116. *Medication Assisted Treatment (MAT)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment> (last updated Sept. 16, 2021).

117. NAT'L INST. ON DRUG ABUSE, *MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT 3* (2018), <https://www.drugabuse.gov/download/21349/medications-to-treat-opioid-use-disorder-research-report.pdf?v=99088f7584dac93ddcfa98648065bfbe> (describing how MAT works to treat OUD).

experiencing withdrawal and its dangers.<sup>118</sup> Naloxone binds to the same opioid receptors and can rapidly reverse an opioid overdose.<sup>119</sup> Opioid overdose deaths are preventable, moreover, if the person receives timely naloxone.<sup>120</sup>

Scientists and practitioners widely recognize MAT as the “gold standard” for OUD.<sup>121</sup> The World Health Organization includes the methadone and buprenorphine on their Model List of Essential Medicines<sup>122</sup> and the U.S. Department of Health and Human Services considers MAT the most effective available treatment for OUD.<sup>123</sup> Combining MAT with psychosocial therapy allows patients to address the psychosocial concerns underlying their disease while reducing cravings and withdrawal symptoms.<sup>124</sup> Without MAT, eighty to ninety percent of people in treatment relapse.<sup>125</sup> The U.S. Department of Health and Human Services acknowledges that MAT works.<sup>126</sup>

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118. *See id.*

119. NAT'L INST. ON DRUG ABUSE, NALOXONE DRUG FACTS 5 (2021), <https://www.drugabuse.gov/download/23417/naloxone-drugfacts-.pdf>.

120. *See Opioid Overdose, supra* note 97. Recognizing the benefits and relatively limited risks of naloxone, some countries allow over-the-counter sales of the medication, including Canada, the UK, and Australia. *Id.*

121. *See Connery, supra* note 9, at 64.

122. *See* WORLD HEALTH ORG., WORLD HEALTH ORGANIZATION MODEL LIST OF ESSENTIAL MEDICINES 49 (21st ed. 2019), <https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf>.

123. *See Executive Summary: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths*, OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, <https://aspe.hhs.gov/opioid-abuse-us-hhs-actions-address-opioid-drug-related-overdoses-deaths> (last visited Oct. 2, 2021) (describing actions to address the opioid crisis).

124. AM. SOC'Y OF ADDICTION MED., *supra* note 10, at 48.

125. *Id.*

126. *See Medication Assisted Treatment (MAT), supra* note 116 (noting that MAT is shown to “[i]mprove patient survival, [i]ncrease retention in treatment, [d]ecrease illicit opiate use and other criminal activity among people with substance use disorders, [i]ncrease patients’ ability to gain and maintain employment, [and] [i]mprove birth outcomes among women who have substance use disorders and are pregnant.”).

## 2. Lack of Access to MAT

MAT treatments such as buprenorphine, methadone, and extended-release naltrexone are the standard of care to treat OUD.<sup>127</sup> Treatments for OUD are well-established but under-utilized, and untreated OUD takes an enormous toll.<sup>128</sup> Estimates for the annual burden of opioid addiction range from \$78.5 billion to \$696 billion.<sup>129</sup> Only twenty percent of people with OUD receive any treatment, and most are not treated with MAT.<sup>130</sup> Patients face challenges with MAT accessibility and clinicians face barriers to prescribing MAT.<sup>131</sup> Despite direct guidance from ASMA that MAT is superior to psychosocial treatment alone, the majority of people suffering from OUD continue to not receive MAT as part of their recovery.<sup>132</sup>

### *i. Barrier One: Provider Limitations*

The lack of providers willing and able to prescribe MAT to those who need it is a significant barrier to patient's receiving adequate medical treatment.<sup>133</sup> Less than four percent of physicians can prescribe

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127. See AM. SOC'Y OF ADDICTION MED., *supra* note 10, at 27 (“[T]he combination of pharmacotherapy and psychosocial treatments, tailored to the individual’s needs, is the recommended standard of care.”).

128. Sarah E. Wakeman & Josiah D. Rich, *Barriers to Medication for Addiction Treatment: How Stigma Kills*, 53 SUBSTANCE USE & MISUSE 330, 330 (2018) <https://www.tandfonline.com/doi/abs/10.1080/10826084.2017.1363238?journalCode=isum20>.

129. AM. SOC'Y OF ADDICTION MED., *supra* note 10, at 17. These calculations include costs related to health care, lost productivity, addiction treatment, and criminal justice costs. *Id.*

130. Saloner, McGinty, Beletsky, Bluthenthal, Beyrer, Botticelli, & Sherman, *supra* note 14, at 26S.

131. Andrew S. Huhn, J. Gregory Hobelmann, Justin C. Strickland, George A. Oyler, Cecilia L. Bergeria, Annie Umbricht, & Kelly E. Dunn, *Differences in Availability and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States*, 3 JAMA NETWORK OPEN 1, 2 (Feb. 7, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760443>. The same study concluded that Black patients and patients referred from the criminal justice system were even less likely to receive MAT, showing reduced access to MAT in disadvantaged populations. *See id.*

132. AM. SOC'Y OF ADDICTION MED., *supra* note 10, at 27. The guidance goes on to recommend methadone and buprenorphine over withdrawal management alone to reduce opioid use and reduce mortality. *Id.*

133. Haffajee, Bohnert, & Lagisetty, *supra* note 94, at S235.

buprenorphine, and forty-seven percent of counties do not have a single physician able to prescribe the drug.<sup>134</sup> Over thirty million people live in one of these counties.<sup>135</sup>

The reasons for the provider shortage are complex and multifaceted, but two key issues are inadequate education and training as well as regulatory and structural restrictions.<sup>136</sup> The lack of education and experience with MAT enables provider stigma, as many providers still view MAT as trading one addiction for another.<sup>137</sup> A majority of physicians in both primary care and addiction specialty settings cite insufficient training and education as a prominent barrier to prescribing MAT.<sup>138</sup> Regulatory restrictions limit the number of providers able to prescribe MAT even further. Only providers with a special waiver may prescribe MAT. For example, the FDA approved buprenorphine as a treatment only if the prescribing provider completed a special course and received a waiver from the Drug Enforcement Administration (DEA).<sup>139</sup> As the number of waivers provided to physicians increase, the number of counties with an opioid treatment shortage decrease.<sup>140</sup> The connection between prescription waivers and the DEA speaks to the continued perception of opioid addiction as a criminal matter rather than a health crisis. Experts have proposed the elimination of waiver requirements for providers already licensed to prescribe controlled substances.<sup>141</sup>

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134. *Id.* at S231.

135. Wakeman & Rich, *supra* note 128, at 330.

136. Haffajee, Bohnert, & Lagisetty, *supra* note 94, at S231. Other factors include provider stigma, lack of institutional support, insufficient insurance reimbursement, and poor care coordination. *Id.*

137. Christine Hancock, Heidi Mennenga, Nikki King, Holly Andrilla, Eric Larson, & Pat Schou, *Treating the Rural Opioid Epidemic*, NAT'L RURAL HEALTH ASS'N 2 (Feb. 2017), [https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic\\_Feb-2017\\_NRHA-Policy-Paper.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic_Feb-2017_NRHA-Policy-Paper.pdf). Another aspect of provider stigma is the belief that the OUD “patient population, is difficult, deceitful, untrustworthy, [and] noncompliant with therapy.” Haffajee, *supra* note 94, at S236.

138. Haffajee, Bohnert, & Lagisetty, *supra* note 94, at S235–36.

139. Dick, Pacula, Gordon, Sorbero, Burns, Leslie, & Stein, *supra* note 113, at 1029.

140. *Id.* It should come as no surprise that more prescribing physicians results in more prescriptions.

141. Haffajee, Bohnert, & Lagisetty, *supra* note 94, at S239.

State-enacted prescribing barriers further limit access to MAT. States without expanded Medicaid as well as prescribing restrictions offered MAT significantly less than states without expanded Medicaid and without prescribing restrictions.<sup>142</sup> The same is true for states with expanded Medicaid.<sup>143</sup> Prescribing restrictions consistently limit MAT accessibility.<sup>144</sup> Strict restrictions together with limited provider education and training contribute to MAT accessibility.

*ii. Barrier Two: Insurance*

People with OUD also face financial challenges to receiving the appropriate treatment. Problems with insurance coverage and the high cost of long-term treatment prevent patients from receiving the care they need. Methadone treatment costs \$126.00 per week, buprenorphine costs \$115.00 per week, and naltrexone costs \$294.13 per week.<sup>145</sup> Household annual expenditures for MAT exceeds that for diabetes and chronic kidney disease.<sup>146</sup> Without comprehensive insurance coverage, these treatments are simply out of reach for most Americans.

Insurance coverage for MAT is insufficiently comprehensive. Until 2020, MAT was not a mandated benefit under Medicaid and Medicare insurance programs, resulting in little to no insurance coverage.<sup>147</sup> The SUPPORT for Patients and Communities Act changed that when it added a category for MAT services for treating OUD.<sup>148</sup> MAT is now a mandated benefit under state Medicaid and Medicare programs.<sup>149</sup> Nevertheless, proper coverage is scarce. State-level

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142. Huhn, Hobelmann, Strickland, Oyler, Bergeria, Umbricht, & Dunn, *supra* note 131, at 9.

143. *Id.*

144. *Id.*

145. *How Much Does Opioid Treatment Cost?*, NAT'L INST. ON DRUG ABUSE (June 2018), <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost>.

146. *Id.*

147. See SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2020) (mandating Medicaid and Medicare to provide coverage for MAT).

148. *See id.*

149. *Id.*

restrictions on Medicaid consistently limit accessibility to MAT.<sup>150</sup> States that resisted Medicaid expansion following the Patient Protection and Affordable Care Act have lower rates of MAT treatment than states that expanded coverage.<sup>151</sup> In 2017, only 17.7% of residential treatment facilities located in states that expanded Medicaid coverage used MAT.<sup>152</sup> In states that did not expand coverage, a shocking 1.9% of residential treatment facilities offered MAT.<sup>153</sup> Insurance coverage is directly linked to MAT accessibility.

### 3. Current Federal Approach

The federal response to the opioid crisis started slowly but is gaining steam due to the massive death count and huge body of research identifying opioid addiction as a medical condition, not a criminal failing. Former President Trump declared the opioid epidemic a national emergency in October 2017 and created a commission to research and make recommendations about how to approach the crisis.<sup>154</sup> On September 4, 2019, the Trump Administration announced \$1.8 billion for the U.S. Department of Health and Human Services (HHS) to distribute to states.<sup>155</sup> A patchwork of federal programs within the HHS direct federal dollars dedicated to the opioid crisis in the form of grants.<sup>156</sup>

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150. Huhn, Hobelmann, Strickland, Oyler, Bergeria, Umbricht, & Dunn, *supra* note 131, at 2. States that did not expand Medicaid had reduced access to MAT. *Id.* at 5–8. State-level Medicaid policy “continue[s] to restrict the treatment community’s response to the opioid crisis.” *Id.* at 8.

151. *See id.* at 5–8.

152. *See id.*

153. *Id.*

154. Dan Merica, *Trump Declares Opioid Epidemic a National Public Health Emergency*, CNN: POLITICS (Oct. 26, 2017, 5:59 PM), <https://www.cnn.com/2017/10/26/politics/donald-trump-opioid-epidemic/index.html>.

155. *Trump Administration Announces \$1.8 Billion in Funding to States to Continue Combating Opioid Crisis*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Sept. 4, 2019), <https://www.hhs.gov/about/news/2019/09/04/trump-administration-announces-1-8-billion-funding-states-combating-opioid.html>.

156. *HHS Grant Funding to Address the U.S. Opioid Crisis*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/about-the-epidemic/opioid-crisis-statistics/opioids-grants-dashboard/index.html> (last visited Oct. 3, 2021). The top five programs include SAMHSA, HRSA, the NIH, and the CDC. *Id.*

The HHS has a five-point strategy to combat the opioid crisis. The goals are: “better addiction prevention, treatment, and recovery services; better data; better pain management; better targeting of overdose reversing drugs; and better research.”<sup>157</sup> From 2016 to 2019, over nine billion dollars of grants were given to states and local communities to combat the epidemic.<sup>158</sup> Funds dedicated to training providers for opioid overdose total \$44.7 million.<sup>159</sup> A closer glance at these grants shows they are narrow—the grants fund training for first responders and naltrexone use only, not MAT broadly.<sup>160</sup> Only \$35 million of the Trump Administration’s \$1.8 billion allotted to the opioid crisis is allocated to expand access to MAT.<sup>161</sup> Approximately 1.27 million Americans receive MAT,<sup>162</sup> but in light of the staggering 10.3 million who misuse opioids and the two million with diagnosed OUD,<sup>163</sup> it is clear that more is needed.

Yet another effort to combat the opioid crisis, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), was signed into law in October of 2018.<sup>164</sup> The SUPPORT Act is a large-scale legislative response to the opioid crisis “designed to address widespread overprescribing and abuse of opioids.”<sup>165</sup> The SUPPORT Act

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157. *5-Point Strategy to Combat the Opioid Crisis*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/index.html> (last updated Jan. 21, 2021).

158. *See Opioid Crisis Statistics*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/about-the-epidemic/opioid-crisis-statistics/index.html> (last updated Feb. 12, 2021) (describing grants provided to combat the opioid crisis).

159. *See id.*

160. *See SP-17-005 Individual Grant Awards*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/grants/awards/2017/SP-17-005> (last visited Oct. 3, 2021) (describing grant award recipients and project goals).

161. *Better Prevention, Treatment & Recovery Services*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/better-access/index.html> (last updated Sept. 1, 2020).

162. *See Opioid Crisis Statistics*, *supra* note 158 (listing statistics about the opioid crisis).

163. AM. SOC’Y OF ADDICTION MED., *supra* note 10, at 7. The DSM-5 sets out the diagnostic criteria for OUD. *Id.* The true number is likely much larger—an unknown number of people who meet the OUD diagnostic criteria have never been diagnosed.

164. ELAYNE J. HEISLER ET AL., CONG. RSCH. SERV., R45423, PUBLIC HEALTH AND OTHER RELATED PROVISIONS IN P.L 115-271, THE SUPPORT FOR PATIENTS AND COMMUNITIES ACT 1 (2018), <https://crsreports.congress.gov/product/pdf/R/R45423>.

165. *Id.*



is the largest federal legislative response to combat the opioid crisis to date.<sup>166</sup> Two key goals of the SUPPORT Act are to expand the number of MAT providers and expand insurance coverage for MAT.<sup>167</sup> Despite this, the SUPPORT Act has been critiqued for not going far enough.<sup>168</sup>

Opioid use disorder and overdose deaths are still increasing, despite the federal government's increased funding.<sup>169</sup> Small decreases in overdose deaths from 2017 to 2018 were reversed in 2020.<sup>170</sup> The number of overdose deaths increased 18.2% from June 2019 to May 2020—approximately 81,230 people died of opioid overdose.<sup>171</sup> The coronavirus pandemic and related economic recession have led to more addiction, more overdose deaths, and less treatment.<sup>172</sup> The federal government has taken small steps to adapt its opioid policies to the

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166. See Davis, *supra* note 28 (noting that neither the 2016 Comprehensive Addiction and Recovery Act nor the 21st Century Cures Act “substantially altered the federal policy landscape . . . and overdose-related deaths have continued to increase”).

167. *Id.*

168. See *infra* Part III (discussing the insufficiency of the federal response to the opioid crisis); see also, Davis, *supra* note 28 (criticizing the SUPPORT Act).

169. See *Overdose Deaths Accelerating During COVID-19*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 17, 2020), <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html> (discussing the increase in overdose deaths in 2020). The number of drug overdose deaths in 2020 was “the highest number of overdose deaths ever recorded in a 12-month period.” *Id.*

170. *Opioid Crisis Statistics*, *supra* note 158. Overdose deaths decreased 4.1% between 2017 and 2018. *Id.* Even still, overdose deaths in 2018 were four times higher than in 1999. See *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/epidemic/index.html> (last updated Mar. 17, 2021).

171. *Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 17, 2020, 8:00 AM), <https://emergency.cdc.gov/han/2020/han00438.asp>. The increase in this twelve-month period began in 2019, even before the coronavirus pandemic took hold and is driven by synthetic opioids such as fentanyl. *Id.*

172. Letter from Thomas W. Prevoznik, Deputy Assistant Adm’r, U.S. Dep’t of Just., to DEA-Registered Narcotic Treatment Program Registrant, (Apr. 7, 2020), [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-025\)\(DEA078\)\\_Off-site\\_OTP\\_delivery\\_method\\_\(Final\)+\\_esign.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-025)(DEA078)_Off-site_OTP_delivery_method_(Final)+_esign.pdf). Opioid treatment programs have dealt with staffing-shortages, and some have closed permanently due to the pandemic. *Id.* A survey of people with OUD showed 34% of respondents faced a change in addiction treatment and services. Jamie Osborne, L. Casey Chosewood, & John Howard, *The COVID-19 Pandemic and the Opioid Overdose Epidemic: A Perfect Storm for Workers?*, CTRS. FOR DISEASE CONTROL & PREVENTION; NIOSH SCIENCE BLOG (Sept. 14, 2020), <https://blogs.cdc.gov/niosh-science-blog/2020/09/14/covid-19-and-oud/>.

COVID-19-related boom, including waiving the requirement that providers meet with patients in person before initiating buprenorphine treatment.<sup>173</sup> These steps have not slowed the tide of rising opioid overdose deaths nor have they significantly increased access to MAT.<sup>174</sup>

### III. THE INSUFFICIENT RESPONSE TO THE OPIOID CRISIS

Journalists have called the opioid crisis “[t]his generation’s AIDS crisis.”<sup>175</sup> Still, there are major differences between the HIV/AIDS epidemic and the opioid epidemic, yet the similarities are striking.<sup>176</sup> Both epidemics were, and are, perceived as affecting only a certain type of person. For HIV/AIDS, the archetypal patient was gay.<sup>177</sup> For opioid addiction, the archetypal patient is rural, uneducated, and weak-minded.<sup>178</sup> Both stereotypes are wrong and breed stigmatization of people groups.<sup>179</sup> The early years of HIV/AIDS were rife with homophobia and judgment against infected people.<sup>180</sup> Ryan White’s story is representative of the larger issue—he was subjected to hateful speech and actions based on his diagnosis of HIV.<sup>181</sup> Similarly, politicians and the broader public responded to the original heroin epidemic of the 1960s and 70s with criminalization and stigma but only

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173. *COVID-19 Information Page*, U.S. DEP’T OF JUST., <https://www.dea-division.usdoj.gov/coronavirus.html#TELE> (last visited Oct. 13, 2021). The DEA has also partnered with SAMHSA to allow take-home doses of MAT. Prevoznik, *supra* note 172.

174. *Overdose Deaths Accelerating During COVID-19*, *supra* note 169.

175. Andrew Sullivan, *The Opioid Epidemic is This Generation’s AIDS Crisis*, INTELLIGENCER (Mar. 16, 2017), <https://nymag.com/intelligencer/2017/03/the-opioid-epidemic-is-this-generations-aids-crisis.html>.

176. *See supra* Part II (describing the HIV/AIDS crisis and the opioid crisis).

177. *See supra* Part II(A)(1) (discussing the origins of the HIV/AIDS crisis as rooted in homophobia); Labra & Thomas, *supra* note 43 (discussing the “moral panic” associated with the “gay plague” and resulting mass media alarmist reporting of the disease infecting homosexual men).

178. *See generally* Lexy Gross, Note, *The Opioid Epidemic & Rural America: Why the USDA Should Lead the Response*, 10 KY. J. EQUINE, AGRIC., & NAT’L RESOURCES L. 257, 263–69 (2018) (discussing the impact of the opioid crisis and surrounding stigma).

179. *Id.* at 269.

180. *See supra* Part II(A)(1) (describing the beginning of the HIV/AIDS epidemic).

181. *See supra* notes 51–54 and accompanying text.

recently has the response shifted to public health.<sup>182</sup> Once the nation recognized HIV/AIDS as an epidemic, a shift to mobilize public health resources, improve research funding, and reduce stigma took place.<sup>183</sup> Compared to the large-scale, coordinated approach to the HIV/AIDS epidemic, the federal response to the opioid crisis is glaringly deficient.<sup>184</sup> If the response to the HIV/AIDS crisis grew to a waterfall, the current response to the opioid crisis is a leaky faucet. The human toll of opioid addiction requires an effective policy change at the highest levels. The SUPPORT Act was a step in the right direction but nowhere near enough.<sup>185</sup> Critics have argued that the opioid crisis “requires a comprehensive, integrated, and public health-oriented response” that the SUPPORT Act fails to provide.<sup>186</sup> One critic wrote:

[The SUPPORT Act] represents a positive step towards curbing the opioid epidemic. It is, however, an incremental step rather than a silver bullet, and critics argue that it falls significantly short of what is needed to solve a crisis of this magnitude. Many called for sustained, robust funding like the Ryan White HIV/AIDS program enacted to combat an epidemic of similar size, and this bill is far from that.<sup>187</sup>

Congress should look to the relative success of the legislative response to the HIV/AIDS epidemic to inform the response to the opioid crisis. The current federal response does not go far enough to expand access to MAT, provide support services, or to reach marginalized communities.<sup>188</sup>

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182. See *supra* Part II(B)(1) (describing the different approach to the inner-city heroin crisis of the 60s and 70s with the response to the modern opioid crisis).

183. See Wakeman, Green, & Rich, *supra* note 16 (describing the arc of the HIV/AIDS public health response).

184. Gross, *supra* note 178, at 276.

185. Billy Wynne & Dawn Joyce, *The 660-Page Opioids Bill is Now the Law. Here's What's Inside*, CAL. HEALTH CARE FOUND. (Nov. 1, 2018), <https://www.chcf.org/blog/the-660-page-opioids-bill-is-now-the-law-heres-whats-in-it/>.

186. Davis, *supra* note 28.

187. Wynne & Joyce, *supra* note 185.

188. See *infra* Part III(A)–(B) (explaining what is lacking in the current federal response to the opioid crisis).

*A. Increased Access to MAT*

The medical understanding of MAT is more advanced than public policy reflects. Instead of evidence-based practice, public policy has largely taken an abstinence-only approach to addiction recovery.<sup>189</sup> Most people with an OUD never receive MAT despite it being the standard of care.<sup>190</sup> Of the \$1.8 billion allocated to combat the opioid epidemic by the Trump Administration, a paltry 0.019% is allocated to expand access to MAT.<sup>191</sup> While other federal programs also allocate funds to expand MAT access, the allocation of the Trump Administration funds speaks to the federal government's perception of MAT. MAT funding makes up a fraction of the federal opioid dollars despite proof of its success and inaccessibility. It is not that the federal dollars are going to waste—they fund research, statistical analysis, and mental health programs.<sup>192</sup> The problem is that opioid addiction is a disease and proven treatments are not being adequately funded.

Legislation that purports to combat the opioid epidemic without significantly boosting access to MAT is akin to HIV/AIDS legislation that does not provide funds for ART. Congress recognized the national interest in providing funding for antiretroviral therapeutics to people with HIV when it passed the RWCA. Through the AETC Program and the ADAP Program, the Act ensured that providers had the education to treat HIV and that low-income persons with HIV had coverage to afford it.

Similarly, programs like AETC and ADAP will increase accessibility to MAT. The lack of physician education and training for MAT is a barrier to physicians effectively treating patients with OUD. Funding for MAT is essentially useless if physicians are unable or unwilling to utilize these medications. A comprehensive provider education program, like AETC, is a crucial part of expanding access to MAT. Like the AETC, the program should focus its training on underserved and marginalized populations.

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189. See Wakeman, Green, & Rich, *supra* note 16.

190. See *supra* Part II(B)(1) (describing the role of MAT and the barriers to access).

191. See *supra* Part II(B)(2) (describing the current federal approach to the opioid crisis).

192. *Better Prevention, Treatment & Recovery Services*, U.S. DEP'T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/better-access/index.html> (last updated Sept. 1, 2020).

There are significant gaps and restrictions in insurance coverage for MAT through Medicaid, Medicare, and private insurance. Insurance coverage is directly linked to MAT accessibility,<sup>193</sup> and MAT is the standard of care for OUD.<sup>194</sup> Increasing insurance coverage is especially crucial to ensure that Black patients with OUD have access to treatment, as more Black people are uninsured or utilize public insurance than white people.<sup>195</sup> Congress should establish an ADAP-like program to set the federal government as a payer of last resort for MAT to plug the holes in existing insurance programs and ensure equitable access to MAT.

### B. Comprehensive Support Services

A holistic response to the opioid crisis requires funds for comprehensive support services. Effective treatment involves more than prescribers and insurance coverage, though those are essential. For example, people with OUD must have transportation services to reach their treatment center, yet 47% of counties do not have a single buprenorphine-waivered provider.<sup>196</sup> Support for medical transportation can help alleviate the burden on patients and their families. The current federal response provides minimal support services, and, even then, only for specific people groups.<sup>197</sup>

## IV. USING THE RYAN WHITE CARE ACT AS A MODEL FOR THE OPIOID

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193. See *supra* Part II(B)(2)(ii) (explaining how poor insurance coverage affects MAT use).

194. See AM. SOC'Y OF ADDICTION MED., *supra* note 10.

195. James & Jordan, *supra* note 105, at 414 (2018) (“In 2015, 44.1% of Blacks relied on Medicaid in comparison to 35.3% of whites, but only 60% of counties have one or more outpatient substance use disorder treatment facilities that accept Medicaid.”). The article continues, noting that “[i]n 2015, 11.1% of Blacks were uninsured compared to 6.7% of whites.” *Id.* The problem of public insurance extends to the type of MAT Black patients receive—they are “more likely to receive methadone, under DEA surveillance in stigmatized methadone clinics, than to receive buprenorphine, which is pharmacologically similar to methadone but can be prescribed in the privacy of a doctor’s office and taken at home.” Netherland & Hansen, *supra* note 2, at 669.

196. Haffajee, Bohnert, & Lagisetty, *supra* note 94, at S231.

197. *Better Prevention, Treatment & Recovery Services*, *supra* note 192. The HHS allocated \$49 million to support services for women and their children in residential substance abuse treatment facilities. *Id.*

## CRISIS

To combat the opioid epidemic, Congress must pass comprehensive legislation on par with the magnitude of the opioid crisis. The legislation needs to respond to the limited access to MAT,<sup>198</sup> provide funds for health coverage for uninsured and underinsured people and provide comprehensive support services to persons with OUD.

*A. Increased Access to MAT*

Congress should pass legislation that increases access to MAT by increasing provider training and instituting the government as a payer of last resort for MAT costs. For example, Congress could mobilize resources to increase the number of providers able to prescribe MAT by mirroring Part F of the RWCA.<sup>199</sup> A provision might read:

The Secretary may make grants and enter into contracts to assist public and nonprofit private entities and schools and academic health science centers in meeting the costs of projects: (1) to train health personnel in the diagnosis, treatment, and prevention of OUD, including the use of MAT; (2) to train the faculty of schools of, and graduate departments or programs of, medicine, nursing, osteopathic medicine, public health, and mental health practice to teach health professional students to provide for the health care needs of individuals with OUD; and (3) to develop and disseminate curricula and resource materials related to the care and treatment of individuals with OUD, including MAT.<sup>200</sup>

This language mirrors the provision of the RWCA setting up the AETC Program, which has been largely successful at increasing the number of providers able to treat HIV/AIDS.

An AETC-like program more effectively accomplishes the goal of increasing the number of MAT providers than the steps taken by the

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198. *See supra* notes 93–98 and accompanying text (discussing limited access to MAT).

199. *See supra* notes 57–63 and accompanying text (discussing Part F of the RWCA).

200. *See* 42 U.S.C. §§ 300ff–111(a)(1)(A)–(C).

SUPPORT Act alone.<sup>201</sup> The SUPPORT Act included provisions designed to expand the number of practitioners able to proscribe MAT.<sup>202</sup> These provisions permanently authorized qualified nurse practitioners and physician assistants to prescribe MAT.<sup>203</sup> The public health response to the opioid crisis requires effective treatment, but medications reach people with OUD exclusively through a waived practitioner. Like the SUPPORT Act, this provision mirroring the RWCA's AETC Program moves the needle to expand the scope of available practitioners. But instead of simply granting nurse practitioners and physician assistants the *ability* to prescribe MAT, an AETC-like program would train and educate providers, including physicians, to *actually* receive a waiver and prescribe MAT to patients.<sup>204</sup>

Congress should also institute the federal government as a payer of last resort for MAT. Financial constraints for uninsured and underinsured persons frequently bar them from the treatment they need simply because of policy coverage limits and strict insurance regulations. With the federal government available as a payer of last resort, more people would have access to MAT. For example, Congress could pass legislation that mirrors Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009. An ADAP-like program for MAT would increase access for low-income persons and ensure that persons with OUD are treated with evidence-based therapeutics. A provision might read:

A State shall use a portion of the amounts provided under a grant to establish a program to provide therapeutics to treat OUD or prevent the serious deterioration of health arising from OUD. To be eligible to receive assistance, an individual shall: (1) have a medical diagnosis of OUD; and (2) be a low-income individual, as defined by the State. The State shall: (1) provide assistance for the purchase of treatments including MAT; (2) provide outreach to individuals with OUD, and as appropriate to the families of such individuals; (3) facilitate access to treatments for such individuals; and (4) encourage, support,

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201. See *supra* Part II(B)(3) (describing the steps taken by the SUPPORT Act).

202. See SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 3201(b) (describing grants intended to increase substance use provider capacity).

203. *Id.*

204. See *supra* Part II(B)(3) (describing the steps taken by the SUPPORT Act).

and enhance adherence to and compliance with treatment regimens.<sup>205</sup>

An ADAP-like program for MAT would ensure that poor insurance coverage does not deny low-income people with OUD access to life-saving MAT. The SUPPORT Act reflects the federal government's policy to expand insurance coverage of MAT, evidenced by provisions expanding Medicare and Medicaid coverage of MAT.<sup>206</sup> Insurance coverage is directly related to adequate treatment for OUD.<sup>207</sup> This sample provision purports to build on the SUPPORT Act by filling the remaining gaps in Medicaid, Medicare, and private insurance coverage. Moreover, an ADAP-like program for MAT would provide open-ended, long-term funding for MAT coverage, unlike the temporary coverage set up by the SUPPORT Act.<sup>208</sup> Establishing the government as payer of last resort for MAT would provide comprehensive, guaranteed coverage for MAT. In practice, this would result in increased provider willingness to prescribe MAT and increased access to MAT for people with OUD.<sup>209</sup>

### *B. Comprehensive Support Services*

Congress should pass legislation that funds support services for people with OUD. For example, Congress could draft legislation that mirrors Part A of the RWCA to provide funds to regions with high need. Support services would increase access to treatment and improve health outcomes for people with OUD. Legislation might include the provision of grant funds for transitional areas that meet a threshold reported number of opioid overdose deaths or people diagnosed with OUD. The provision providing funds for support services might read:

Funds shall be allocated for core medical services, meaning: (A) outpatient and ambulatory health services; (B) Opioid Treatment Programs; (C) OUD pharmaceutical assistance; (D) oral health care; I early intervention

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205. See 42 U.S.C. 300ff-25 (a)–(c) (setting up the ADAP program).

206. See SUPPORT for Patients and Communities Act § 5061.

207. See Huhn, Hobelmann, Strickland, Oyler, Bergeria, Umbricht, & Dunn, *supra* note 131.

208. See SUPPORT for Patients and Communities Act § 1006.

209. See Huhn, Hobelmann, Strickland, Oyler, Bergeria, Umbricht, & Dunn, *supra* note 131.



services; (F) home health care; (G) medical nutrition therapy; (H) hospice services; (I) home and community-based health services; (J) mental health services; and (K) medical case management. Funds shall also be allocated for support services, meaning services that are needed for individuals with OUD to achieve their medical outcomes, such as respite care for persons caring for individuals with OUD, outreach services, medical services, linguistic services, and referrals for health care and support services.<sup>210</sup>

Funds for core medical services and support services will improve health outcomes for patients with OUD and increase access to MAT.<sup>211</sup> Marginalized, high need populations require support services to facilitate adequate treatment.<sup>212</sup> The SUPPORT Act demonstrates the urgency of reducing disparity in access to treatment—the Act requires HHS to issue guidance to states for MAT and allows telehealth prescriptions.<sup>213</sup> While the SUPPORT Act correctly identified the underlying policy of reducing disparity, it failed to provide concrete funding for comprehensive social services.<sup>214</sup> This sample provision mirroring the RWCA would provide crucial services to high need regions to facilitate access to treatment and retention in treatment programs.

## V. CONCLUSION

The opioid epidemic is a public health crisis. Our nation's response of stigmatization and criminalization will only exacerbate the problem. Opioid addiction is a medical disease and should be treated according to medical guidelines and standards of care—meaning that MAT should be accessible. This Note argues that the parallel HIV/AIDS and opioid epidemics deserve a parallel response. Congress should use the RWCA as a blueprint for a comprehensive federal

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210. This provision is modeled after 42 U.S.C. §§300ff-14 (c)(3)–(d)(1).

211. See *supra* Part III(B) (describing the impact of comprehensive support services).

212. See *supra* Part III(B).

213. SUPPORT for Patients and Communities Act § 1009; see also Davis, *supra* note 28 (discussing how the SUPPORT Act attempts to reduce disparities in treatment access).

214. Davis, *supra* note 28, at 5.

response to the opioid crisis. The legislation should mobilize funds to expand access to MAT, provide adequate care for underserved populations, and fund support services provided to people living with opioid addiction.