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Blind Spot in Plain Sight: The Need for Federal Intervention in the Sober Living Home Industry and the Path To Making It Happen

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BLIND SPOT IN PLAIN SIGHT: THE NEED FOR FEDERAL INTERVENTION IN THE SOBER LIVING HOME INDUSTRY AND THE PATH TO MAKING IT HAPPEN[†]

ABSTRACT

The United States federal government is fighting the nation's addiction epidemic harder than ever before. Billions of federal dollars are invested each year in substance use disorder treatment and prevention in amounts that have more than doubled over the last decade—yet addiction is still winning, and winning big. Substance use disorder claimed the lives of a record-breaking nearly 160,000 Americans in 2019. One of the epidemic's biggest obstacles has turned out to be within the nation's substance use disorder treatment industry itself: fraudulent treatment providers are getting rich quick off a broken, unregulated system. This Comment discusses the sober living home industry, a place in the substance use disorder continuum of care where fraud and abuse are not only most pervasive, but also almost entirely beyond the bounds of government regulation. In 88% of states, anyone can legally open a sober living home facility with zero inspection or oversight. A rapidly growing influx of bad players takes advantage of this blind spot by luring in potential residents with patient brokering schemes, pocketing residents' cash, and hiking up their insurance bills with excessively expensive and unnecessary drug tests.

This Comment asserts that current federal and state attempts to intervene in the sober living industry have no teeth. Moreover, despite federalism-based objections, federal efforts, as opposed to solely-state based efforts, offer the only effective solution for meaningful intervention in the sober living industry. Yet, the anti-commandeering doctrine of the Tenth Amendment significantly hinders the federal government's ability to regulate the industry. This Comment makes the case that the Commerce Clause provides an unusual, but not unheard of, path for the federal government to step into state health care sectors to eliminate the sober living industry's bad players. Pursuant to its Commerce Clause authority, Congress can, and should, enact a federal law that creates minimum quality standards and accreditation requirements for operating a sober living home in the United States.

[†] This Comment received the Mary Laura “Chee” Davis Award for Writing Excellence.

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INTRODUCTION

The federal government is spending an unprecedented amount of money in its battle against drug addiction, more than doubling its funding over the last decade.¹ So, why is the government still losing this battle, worse than ever before? Last year, drug overdose death rates reached an all-time high—94,134 Americans fatally overdosed.² Currently, an average of 95,000 deaths per year

¹ See NAT’L CTR. DRUG ABUSE STAT., DRUG ABUSE STATISTICS (2020), <https://drugabusestatistics.org/>. Federal spending on addiction treatment and prevention totaled to \$17.6 billion for the year 2020, compared to \$8.5 billion in 2008. *Id.* The overall requested National Drug Control budget for 2020 totaled \$34.6 billion. *Id.*

² CTR. DISEASE CONTROL & PREVENTION, *12 Month-Ending Provisional Counts and Percent Change of Drug Overdose Deaths*, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm> (last visited Sept. 2, 2021). Compare *id.* (reporting provisional number of reported overdoses over a 12-month period ending in January 2021), with NAT’L INST. DRUG ABUSE, *Overdose Death Rates*, <https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates> (last visited Sept. 2, 2021) (reporting 38,329 overdose deaths in 2010).

are attributable to alcoholism.³ Death is not the only factor in this battle: life for the 20.4 million Americans suffering from substance use disorder (SUD)⁴ is wrought with devastating impacts on physical and mental well-being and ability to function in society,⁵ the effects of which are felt by a SUD patient's entire family.⁶ In addition to its impact on human life, SUD costs the nation's economy an estimated average of \$740 billion annually.⁷

There is little mystery as to why addiction keeps winning. The federal government recognizes that a major obstacle to progress in the SUD epidemic, the "treatment gap," has remained persistent despite federal efforts. The treatment gap refers to the staggering deficit of individuals with SUD who are not receiving the treatment they need. In the words of the Office of National Drug Control Policy's director Jim Carroll, "only 12 percent of people with [SUD] are getting the treatment they need. . . . [I]n context . . . the treatment gap is about 18.2 million people."⁸ This gap is not situated between a SUD patient and *some* form of SUD treatment, but between a SUD patient and *effective* SUD treatment. A key feature of the treatment gap is that many individuals with SUD receive poor quality, clinically inappropriate, or fraudulent treatment.⁹

This Comment will focus on the sober living home industry, where fraudulent, unethical, and clinically inappropriate SUD treatment is not only the most apparent, but also remains largely beyond the reach of federal regulation.

³ NAT'L CTR. DRUG ABUSE STAT., ALCOHOL ABUSE STATISTICS (2019), <https://drugabusestatistics.org/>.

⁴ KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2019 NATIONAL SURVEY ON DRUG USE AND HEALTH 3 (2020), <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDHTML/2019NSDUHFFR090120.htm>. SUD is an umbrella diagnosis that includes all specific drug use disorders and alcohol use disorder. *Id.*

⁵ See, e.g., NAT'L INST. DRUG ABUSE, *Health Consequences of Drug Misuse: Introduction* (June 9, 2020), <https://www.drugabuse.gov/drug-topics/health-consequences-drug-misuse/introduction>.

⁶ See, e.g., Laura Lander, Janie Howsare, & Marilyn Byrne, *The Impact of Substance Use Disorders on Families and Children: From Theory to Practice*, 28 SOC. WORK PUB. HEALTH 194 (2013) (analyzing effects of SUD on families).

⁷ Nat'l Inst. Drug Abuse, *Costs of Substance Abuse* (2020), <https://www.drugabuse.gov/drug-topics/trends-statistics/costs-substance-abuse#supplemental-references-for-economic-costs> (estimating annual cost of alcohol, illicit and prescription drug abuse in relation to healthcare, lost work productivity, and crime).

⁸ Press Release, American Presidency Project, Remarks by ONDCP Director Jim Carroll, Turning the Tide: Improving Access to Addiction Care and Overcoming Obstacles to Parity (Sept. 9, 2019) (transcript available at <https://www.presidency.ucsb.edu/documents/press-release-remarks-ondep-director-jim-carroll-turning-the-tide-improving-access>).

⁹ OFF. NAT'L DRUG CONTROL POL'Y, NATIONAL DRUG CONTROL STRATEGY: NATIONAL TREATMENT PLAN FOR SUBSTANCE USE DISORDER 2020, at 12 (2020), <https://www.opioidlibrary.org/wp-content/uploads/2020/02/2020-NDCS-Treatment-Plan.pdf>.

Sober living homes,¹⁰ colloquially known as halfway houses,¹¹ may be described as a step-down means of care from rehabilitation treatment centers.¹² They are substance-free, safe, healthy living environments that promote recovery from SUD, help recovering individuals reintegrate to daily life, and establish a foundation for long-term recovery.¹³ Typically, sober living homes are an individual's "last step" in the continuum of care for SUD¹⁴—most individuals enter sober living homes either after completing residential rehabilitation treatment, during and after outpatient rehabilitation treatment, or following a stay in a hospital detox¹⁵ center.¹⁶

Although ethically-run sober living homes are valuable to lasting SUD recovery, in the past decade there has been a rapid increase of "bad players" that capitalize on the growing industry to pocket residents' cash or insurance payments.¹⁷ In forty-four of the fifty U.S. states, any individual or entity may legally open a sober living home without undergoing any formal certification and may operate a facility without any regulation.¹⁸ This influx of bad players is

¹⁰ There are a variety of terms used to refer to sober living homes. *See, e.g.*, Substance Use—Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT Act"), Pub. L. No. 115–271, § 7031, 132 Stat. 3894, 4014 (2018) (using term "recovery housing"); NAT'L ASSOC. OF RECOVERY RESIDENCES (NARR), A PRIMER ON RECOVERY RESIDENCES (2012), <https://narronline.org/wp-content/uploads/2014/06/Primer-on-Recovery-Residences-09-20-2012a.pdf> (using the term "recovery residence"); *Sober Living Homes*, ADDICTIONCENTER.COM, <https://www.addictioncenter.com/treatment/sober-living-homes/> (last visited Sept. 2, 2021) (using the term "sober living"). For purposes of clarity and consistency, this Comment will use the term "sober living."

¹¹ Although they offer similar services, the term "halfway house" differs from "sober living" in that halfway houses typically only accept recently incarcerated individuals. *E.g.*, *Is There a Difference Between a Sober House and a Halfway House?*, HARRIS HOUSE (Sept. 3, 2019), <https://www.harrishousestl.org/is-there-a-difference-between-a-sober-house-and-a-halfway-house/>.

¹² *See* NAT'L INST. ON DRUG ABUSE, TREATMENT APPROACHES FOR DRUG ADDICTION (2019) (recovery housing often serves a transitional purpose following "other types of inpatient or residential treatment").

¹³ *See* NARR, *supra* note 10, at 5 (defining basic attributes of sober living homes).

¹⁴ NAT'L COUNS. FOR BEHAV. HEALTH, BUILDING RECOVERY: STATE POLICY GUIDE FOR SUPPORTING RECOVERY HOUSING 2 (2018), https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolkit_5.3.2018.pdf?dof=375ateTbd56 (describing sober living's role in the larger continuum of addiction treatment).

¹⁵ "Detox" refers to the "[m]edically supervised withdrawal" from drugs or alcohol which takes place at either a hospital's regular medical ward, a specialized inpatient detox unit, or an outpatient service under close medical supervision. *Treatment Options*, FINDTREATMENT (Oct. 2019), <https://findtreatment.gov/content/treatment-options/what-happens-next/>.

¹⁶ NARR, *supra* note 10, at 15 ("Studies to date of [sober living homes] reveal that the vast majority of . . . residents have a history of inpatient or outpatient addiction treatment.")

¹⁷ *See infra* Part I.B.

¹⁸ ERIC MARTIN, KRISTI MCKINNEY, MICHAEL RAZAVI, & VAN BURNHAM, NATIONAL OVERVIEW OF RECOVERY HOUSING ACCREDITATION, LEGISLATION AND LICENSING 5–6 (2020), https://mhaebo.org/media/filer_public/2e/fd/2efd1a20-9558-4329-8683-0e2367cbb2b/nationaloverview-recoveryhousingjanuary2020.pdf. As of January 2020, only six states have licensure requirements for sober living homes: Arizona, Hawaii, Maryland, Utah, and Wyoming require licensing for all sober living homes,

pushing back against the government's efforts to close the treatment gap and putting the lives of an untold number of SUD patients at risk.¹⁹

This Comment will argue for the following: (1) federal, as opposed to solely state-based, intervention in the sober living industry is needed; (2) present federal efforts to eradicate bad players from the industry fall short of meaningful impact; (3) even if present efforts improve, federalism-based constraints further limit meaningful federal intervention; and (4) a federalism-friendly solution for meaningful intervention may be achieved by enacting, pursuant to Congress's authority under the Commerce Clause, a federal law that sets minimum standards and accreditation requirements for operating a sober living home in the United States.

This Comment will proceed in five parts. Part I shows why there is a need for federal intervention in the sober living industry. It first elaborates upon the importance of sober living homes in the SUD continuum of care. It next demonstrates the prevalence of fraud, abuse, and inadequate care in the sober living industry and highlights two bad practices: urinalysis drug testing and patient brokering.

Part II explains why present federal efforts to intervene in the sober living industry under provisions of the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act) have no teeth.²⁰ First, implementation of the "Ensuring Access to Quality Sober Living" provision of the SUPPORT Act identifies, but does little to solve, the industry's problems.²¹ Moreover, the Department of Health and Human Services (HHS) and Substance Abuse and Mental Health Services Administration (SAMHSA), the agencies charged with administering the provision, failed to adequately realize their statutory duties. Second, the bulk of the sober living industry's bad players fall outside the scope of the Federal Trade Commission's (FTC) SUPPORT Act authority.²²

while Arkansas requires licensing of sober living homes only if they provide post-prison housing. *Id.* Twenty-seven states encourage sober living homes to seek certification from a third-party non-profit organization, but do not require third-party certification. *Id.*

¹⁹ This number is quite literally untold, as "[t]o date, there has been no systematic inventory" of sober living homes in the United States—a result of the industry's widespread lack of federal and state oversight. *See* NARR, *supra* note 10, at 9.

²⁰ Substance Use—Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT Act"), Pub. L. No. 115–271, 132 Stat. 3894, 4014 (2018).

²¹ SUPPORT Act § 7031 (codified as amended at 42 U.S.C.A. § 290ee–5).

²² These provisions include the "Opioid Addiction Recovery Fraud Prevention Act of 2018" and "Eliminating Kickbacks in Recovery Act." *Id.* §§ 8021–8023 (codified as amended at 15 U.S.C.A. § 45(d)); *Id.* § 8122 (codified at 18 U.S.C.A. § 220).

Part III analyzes two major Tenth Amendment-based objections to meaningful federal intervention. The first objection—that absent a compelling need for the federal government to step in, intervention in the sober living industry should be left to the states out of respect for federalism principles—is not valid for three reasons: (1) there is no regulatory diversity among the few states that have acted; (2) allowing states to regulate on their own timelines has prompted a spread of bad players to new regions; and (3) uniform nationwide measures are necessary for achieving meaningful intervention. However, the second objection—that federal regulation of the sober living industry violates the doctrine of anti-commandeering—does prevent the federal government from compelling states to regulate the sober living industry in accordance with federal intent, absent the authority of one of its other constitutionally enumerated powers. While use of congressional spending powers would typically provide the federal government a loophole at this anti-commandeering crossroad, sober living homes fall outside the scope of spending powers authority because they seldom accept government insurance.

Part IV proposes a federalism-friendly solution for meaningful federal intervention in the sober living industry that is unusual, but not unheard of. The federal government can regulate the sober living industry within the bounds of the Tenth Amendment by enacting minimum standards and accreditation requirements pursuant to Congress’s Commerce Clause authority. Although this kind of legislation necessarily requires regulation of an intrastate activity, where Congress’s commerce powers are most constrained, such legislation would nevertheless comply with the Court’s Commerce Clause jurisprudence because (1) the operation of sober living homes constitutes an economic, as opposed to non-economic, activity; (2) Congress can rationally conclude that operating a sober living home belongs to a class of activities that, when aggregated in all instances, substantially affects interstate commerce; and (3) although setting a minimum accreditation requirement would regulate legitimate sober living homes in addition to those run by bad players, such a requirement would nonetheless constitute a reasonable method for eliminating the negative effects of sober living homes on interstate commerce. Moreover, the Commerce Clause has been used to regulate in the intrastate health care sector before with the enactment the Mammography Quality Standards Act (MQSA),²³ under circumstances strikingly similar to those of the sober living industry.

Finally, Part V provides general recommendations for how the federal legislation proposed by this Comment should be structured.

²³ Mammography Quality Standards Reauthorization Act of 1998, 42 U.S.C.A. § 263b.

I. THE NEED FOR FEDERAL INTERVENTION IN THE SOBER LIVING INDUSTRY

The following Part demonstrates why federal intervention in the sober living industry is necessary. It first explains the crucial role that sober living homes play in establishing long-term recovery from SUD, followed by a depiction of the fraud, abuse, and poor quality of care besetting the sober living industry. It then highlights the two most prevalent bad practices plaguing the industry's efficacy and endangering the lives of its customers: (1) fraudulent urinalysis drug testing and (2) patient brokering.

A. *The Role of Sober Living Homes in the SUD Continuum of Care*

A scientific explanation of the symptoms and long-term effects of SUD illustrates the significance of sober living homes in the SUD continuum of care. A lasting alteration of brain wiring explains the strong probability that a SUD patient will relapse long after they terminate substance use—more than 60% of SUD patients relapse within the first year after discharge from an inpatient or outpatient treatment center.²⁴ The degree to which these brain changes reverse and the length of time any reversal would take remains unknown, although studies indicate that an increased risk of relapse persists for many years.²⁵

The Diagnostic and Statistical Manual of Mental Disorder (DSM-5) identifies the essential feature of SUD as “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using [a] substance despite significant substance-related problems.”²⁶ A crucial characteristic of SUD is that, over time, misuse of a substance may affect underlying changes in a patient's brain circuits, rewiring the brain's chemistry and behavior in a manner that persists long after a substance has been detoxified from a patient's system.²⁷ Recently, “[w]ell-supported scientific evidence” led the medical community to recognize SUD as a chronic brain disease that (1)

²⁴ HEALTH AND HUMAN SERVICES (HHS), *FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, & HEALTH* ch. 2, at 2 (2016) (first citing A. T. McLellan, C. P. O'Brien, & H. D. Kleber, *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 25 J. AM. MED. ASSOC. 1689, 1689–95 (2000); then citing R. L. Hubbard, S. G. Craddock, & J. Anderson, *Overview of 5-Year Follow-up Outcomes in the Drug Abuse Treatment Outcome Studies*, 25 J. SUBSTANCE ABUSE TREATMENT 125, 125–34 (2003)).

²⁵ *Id.* (first citing Y.-I. Hser, V. Hoffman, C. E. Grella, & M. D. Anglin, *A 33-Year Follow-Up of Narcotics Addicts*, 58 ARCHIVES GEN. PSYCHIATRY 503, 503–08 (2001); then citing G.E. VAILLANT, *THE NATURAL HISTORY OF ALCOHOLISM REVISITED* (1995)).

²⁶ AM. PSYCHIATRIC ASSOC., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDER (DSM-5)* 483 (5th ed. 2013).

²⁷ *Id.*

“enable[s] substance-associated [stimuli] to trigger substance seeking”; (2) “reduces sensitivity of brain systems involved in the experience of pleasure or reward”; (3) heightens the brain’s stress systems; and (4) “reduce[s] functioning of executive control systems,” which weakens the ability to regulate impulses, actions, emotions, and decision-making skills.²⁸ In short, SUD significantly diminishes the capacity to voluntarily control substance use and significantly impairs health and social functioning.²⁹

The nature of SUD as a chronic brain disease illuminates the importance of sober living homes. Although 60% of SUD patients relapse within the first year after discharge from an inpatient or outpatient treatment program, research demonstrates that residing in a (non-corrupt) sober living home following a more intensive form of treatment decreases the likelihood of relapse.³⁰ In addition to simply prolonging the length of time spent in a substance-free environment, legitimate sober living homes help individuals build what is known as “recovery capital.”³¹ Recovery capital is “the accumulation of financial, social, human, and cultural resources” recognized as essential to the initiation, stabilization, and sustainment of long-term recovery from SUD.³² Moreover, studies show a correlation between sober living home residency and other positive outcomes, such as lower incarceration rates,³³ increased employment,³⁴ higher income,³⁵ and “[i]mproved family functioning.”³⁶

²⁸ HHS, *supra* note 24, at ch. 2, at 1–2.

²⁹ *Id.* at ch. 2, at 1.

³⁰ *See, e.g.*, Amy Mericle, Elizabeth Mahoney, Rachael Korcha, Kevin Delucchi, & Douglas L. Polcin, *Sober Living Home Characteristics: A Multilevel Analyses of Factors Associated with Improved Outcomes*, 98 J. SUBSTANCE ABUSE TREATMENT 28, 28 (2019); Douglas Polcin, Gantt P. Galloway, & Rachael Korcha, *What Did We Learn from Our Study on Sober Living Houses and Where Do We Go from Here?*, 42 J. PSYCHOACTIVE DRUGS 425, 425 (2010); Leonard A. Jason, Margaret Davis, & Joseph R. Ferrari, *The Need for Substance Abuse After-Care: Longitudinal Analysis of Oxford House*, 32 ADDICTIVE BEHAV. 803 (2007); Leonard A. Jason, Joseph R. Ferrari, & Bradley Olson, *Communal Housing Settings Enhance Substance Abuse Recovery*, 96 AM. J. PUB. HEALTH 1727, 1727–29 (2006).

³¹ *See, e.g.*, Mericle et al., *supra* note 30, at 29; NAT’L COUNCIL BEHAV. HEALTH, RECOVERY HOUSING ISSUE BRIEF: INFORMATION FOR STATE POLICYMAKERS 2 (2017). *See generally* William White & William Cloud, *Recovery Capital: A Primer for Addictions Professionals*, 9 COUNS. 22, 24 (2008) (providing a conceptual overview of “recovery capital”).

³² Mericle et al., *supra* note 30, at 29. *See generally* White & Cloud, *supra* note 31, at 22 (providing conceptual overview of “recovery capital”).

³³ NAT’L COUNCIL BEHAV. HEALTH, RECOVERY HOUSING ISSUE BRIEF: INFORMATION FOR STATE POLICYMAKERS, *supra* note 31, at 2 (citing Jason et al., *Communal Housing Settings Enhance Substance Abuse Recovery*, *supra* note 30, at 1727–29).

³⁴ *Id.* (citing Polcin et al., *Sober Living Home Characteristics: A Multilevel Analyses of Factors Associated with Improved Outcomes*, *supra* note 30).

³⁵ *Id.* (citing Amy Mericle, Jennifer Miles, & Fred Way, *Recovery Residences and Providing Safe and Supportive Housing for Individuals Overcoming Addiction*, 45 J. DRUG ISSUES 368 (2015)).

³⁶ *Id.* (citing Leonard A. Jason, Darrin M. Aase, David G. Mueller, & Joseph R. Ferrari, *Current and*

B. Fraud, Abuse, and Inadequate Care in the Sober Living Industry

The sober living industry is unique in the SUD continuum of care because it has no watchdogs. Unlike inpatient and outpatient treatment providers, sober living homes are rarely covered by insurance.³⁷ Treatment providers at earlier stages in the SUD continuum of care and general healthcare industry, by virtue of insurance coverage and Medicare funding, are policed by private insurers, states, and sometimes the federal government.³⁸ In 2010, the passage of the Affordable Care Act (ACA) required that all insurers cover SUD services and treatment.³⁹ Sober living homes, however, do not fall within the ACA's mandatory coverage requirement because they are not medical "treatment facilities."⁴⁰ Furthermore, due to lack of state licensing, sober living homes are expected to be financially independent in most states, and subsequently will rarely accept private or state health insurance.⁴¹

Because the sober living industry operates outside of more regulated healthcare systems, the industry attracts unscrupulous providers that manipulate weaknesses of the industry itself, and of countless unknowing SUD patients seeking long-term recovery.⁴² In recent years, media investigations brought attention to bad practices plaguing the industry.⁴³ The nationwide prevalence of these issues is further evidenced by the federal government's explicit recognition

Previous Residents of Self-Governed Recovery Homes: Characteristics of Long-Term Recovery, 27 ALCOHOLISM TREATMENT QUARTERLY 442 (2009)).

³⁷ NAT'L COUNCIL BEHAV. HEALTH, BUILDING RECOVERY: STATE POLICY GUIDE FOR SUPPORTING RECOVERY HOUSING, *supra* note 14, at 10.

³⁸ See generally NAT'L CONF. STATE LEGIS., *Combating Health Care Fraud and Abuse*, NO. 11 ISSUE BRIEFS STATE LEGIS. (2010) (providing overview of how federal, state, and private entities prevent health care fraud and abuse).

³⁹ 42 U.S.C.A. § 18022(b)(1)(E) (West).

⁴⁰ Laura Close, *Does Insurance Pay for Sober Living?*, AM. ADDICTION CTRS., <https://www.greenhousetreatment.com/sober-living/insurance/> (last updated Sept. 2, 2021); see also NAT'L COUNCIL BEHAV. HEALTH, BUILDING RECOVERY: STATE POLICY GUIDE FOR SUPPORTING RECOVERY HOUSING, *supra* note 14, at 11 (noting although sober living homes may provide peer-led support and connect residents to outpatient treatment, sober living homes themselves do not provide direct medical addiction services).

⁴¹ Close, *supra* note 40 (citing Polcin, et al., *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes*, *supra* note 30).

⁴² See NAT'L COUNCIL BEHAV. HEALTH, BUILDING RECOVERY: STATE POLICY GUIDE FOR SUPPORTING RECOVERY HOUSING, *supra* note 14, at 2; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RECOVERY HOUSING: BEST PRACTICES AND SUGGESTED MINIMUM GUIDELINES 10 (2019).

⁴³ See, e.g., Francie Diep, *The New Proposed Federal Guidelines for Sober Homes Are Disappointing, Observers Say*, PAC. STANDARD (Apr. 12, 2019), <https://psmag.com/social-justice/the-feds-have-proposed-new-guidelines-for-sober-homes-and-observers-are-deeply-disappointed> (reporting "several recent and devastating investigations" revealed bad practices that included astronomically overbilling for low quality services, providing free drugs, and in some cases, assaulting residents); NAT'L COUNCIL BEHAV. HEALTH, BUILDING RECOVERY: STATE POLICY GUIDE FOR SUPPORTING RECOVERY HOUSING, *supra* note 14, at 2.

of and efforts to eliminate them.⁴⁴ Two major unscrupulous practices in the sober living industry that have arisen due to the current lack of meaningful regulation are (1) urinalysis drug testing and (2) patient brokering.

1. *Urinalysis Drug Testing: How Pee in a Cup Becomes Liquid Gold*

Urinalysis drug testing is a long-standing practice in the sober living industry.⁴⁵ The American Society of Addiction Medicine (ASAM) advises sober living facilities to drug test residents a maximum of once a week.⁴⁶ The ASAM further instructs that sober living homes should only use drug testing to (1) verify an individual resident’s abstinence and use a positive test result to revise a resident’s support plan and (2) maintain “the integrity of the facility as a safe recovery environment” for all residents.⁴⁷ Traditionally, SUD care providers performed urine tests with common dipstick tests where a “change[] [in] color . . . reflect[s] a positive or negative reading, costs some five dollars and can be done anywhere.”⁴⁸

However, insurance coverage changes over the past decade transformed this once cheap and beneficial practice into a “liquid gold rush”⁴⁹ for bad players.⁵⁰ The ACA introduced a new requirement that insurers cover “laboratory services,” including laboratory-run urinalysis drug testing, as an essential health benefit.⁵¹ When the ACA took effect in 2014, bad players began a scheme of charging insurers thousands of dollars for laboratory tests of sober living residents’ urine.⁵² SAMHSA identifies three main tactics employed by bad players to exploit the ACA’s laboratory coverage: (1) “[t]esting for quantitative levels on negative samples”; (2) “[c]harging exorbitant amounts that are over

⁴⁴ See *infra* discussion in Part II.

⁴⁵ Katrice Bridge Copeland, *Liquid Gold*, 97 WASH. U. L. REV. 1451, 1478 (2020) (citing AM. SOC’Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON DRUG TESTING AS A COMPONENT OF ADDICTION TREATMENT AND MONITORING PROGRAMS AND IN OTHER CLINICAL SETTINGS 1 (2010), <https://perma.cc/AYN2-2WHL>). See generally AM. SOC’Y ADDICTION MED., DRUG TESTING: A WHITE PAPER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE (2013) (providing historical overview of drug testing in the SUD industry).

⁴⁶ ADDICTION MED., *supra* note 45, at 54.

⁴⁷ *Id.* at 52.

⁴⁸ Colton Wooten, *My Years in the Florida Shuffle of Drug Addiction*, NEW YORKER (Oct. 14, 2019), <https://www.newyorker.com/magazine/2019/10/21/my-years-in-the-florida-shuffle-of-drug-addiction>.

⁴⁹ The term “liquid gold” was first coined by reporter David Segal in his article *In Pursuit of Liquid Gold*, N.Y. TIMES (Dec. 27, 2017), <https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html>. “Liquid gold” is also the title of law professor Katrice Bridge Copeland’s seminal scholarly article on exploitation in the addiction treatment industry. See Copeland, *supra* note 45.

⁵⁰ Wooten, *supra* note 48.

⁵¹ 42 U.S.C.A. § 18022(b)(1)(H); Copeland, *supra* note 45, at 1471–72.

⁵² SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42, at 10; *What Is the Florida Shuffle?*, <https://www.fixthefloridashuffle.com/florida-shuffle> (last visited Sept. 2, 2021).

and above standard costs for” laboratory testing; and (3) testing residents with excessive frequency.⁵³ Unscrupulous providers may test residents two to four times a week to maximize profits,⁵⁴ in great excess of ASAM’s once a week maximum.⁵⁵ Some bad players strike deals with laboratories themselves to run additional, unrelated, and expensive chemical tests on a urine sample, driving up the insurance bill for a single drug test “from hundreds of dollars to thousands of dollars.”⁵⁶

Over the past few years, federal prosecutions and media reports have shed light on fraudulent drug testing in the sober living industry. In August 2020, Michael Ligotti, a doctor who acted as medical director for fifty Florida sober living homes and treatment centers, was “charged with masterminding a \$681 million scheme to bill private insurers and Medicare for unnecessary laboratory testing and undelivered [SUD] services.”⁵⁷ In 2017, Florida’s Kenny Chatman pleaded guilty to collecting \$16 million in insurance reimbursements for urine testing by operating a string of fraudulent sober living homes and treatment services.⁵⁸ Chatman’s sober living homes not only provided inadequate services, but actively encouraged clients to relapse, thus keeping clients from leaving “treatment” and ensuring they continue to take urine tests.⁵⁹

The fraud committed by Ligotti and Chatman was neither unique nor limited to “a few bad apples” that might be expected to crop up in most major industries. Rather, evidence suggests there may be more bad apples than good in the sober living industry. In 2018, SAMHSA assembled an expert technical panel to examine the prevalence of fraudulent laboratory drug testing in the sober living industry.⁶⁰ The results of the panel overwhelmingly confirmed that unscrupulous providers exploit urine testing at a shocking frequency.⁶¹ For example, *Fair Health*, a non-profit that analyzes consumer insurance statistics, examined laboratory test claims data and found that “costs associated with urine testing increased by *more than 900%* between 2011 and 2014,”⁶² a timeline that mirrors

⁵³ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42, at 7.

⁵⁴ Copeland, *supra* note 45, at 1480.

⁵⁵ AM. SOC’Y OF ADDICTION MED., *supra* note 45, at 54.

⁵⁶ Copeland, *supra* note 45, at 1481.

⁵⁷ Jodine Mayberry, *Florida Doctor Charged in \$681 Million Addiction Services Fraud*, 26 No. 3 W.J. HEALTH CARE FRAUD 4, 4 (2020).

⁵⁸ Scott Cohn, *Opioids’ Hidden Epidemic—Fraudulent Drug Treatment Centers*, CNBC (June 29, 2018, 10:06 AM), <https://www.cnbc.com/2018/06/06/opioids-hidden-epidemic-fraudulent-drug-treatment-centers.html>.

⁵⁹ *Id.*

⁶⁰ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42, at 10.

⁶¹ *See id.*

⁶² *Id.* (emphasis added).

the enactment of the ACA's lab coverage requirement through its first year in effect.⁶³

2. Patient Brokering

Patient brokering is a form of fraud where a third-party, the patient broker, recruits a SUD patient to an unethical sober living home in exchange for a financial kickback.⁶⁴ Patient brokers recruit individuals suffering from SUD by posting deceptive internet advertisements;⁶⁵ prowling outside twelve-step recovery meetings, drug courts, and inpatient treatment centers;⁶⁶ or even infiltrating treatment centers themselves.⁶⁷ Brokers may lure individuals to an unethical facility with promises of discounted rent, free plane tickets to an out-of-state facility, or other incentives such as gym memberships, cigarettes, and cellphones.⁶⁸ Brokers are typically paid either on a “per-head” basis, “ranging from \$500 to \$5,000” for each bed filled, or at a monthly rate that requires brokers to meet a quota of recruits.⁶⁹ While the recruited individual “believes they are being referred by a responsible party who has their best interest at heart,” patient brokers and the facilities that pay them are focused on financial gain.⁷⁰ The issue of patient brokering is largely unique to the SUD care system, as opposed to the general health care system, because most health care sectors do not possess the SUD industry's inordinate potential for repeat customers.⁷¹ The fact that sober living homes lack the oversight of private insurers and

⁶³ 42 U.S.C.A. § 18022(b)(1)(H); *Timeline: Affordable Care Act*, AFFORDABLE HEALTH CAL., <http://affordablehealthca.com/timeline-obamacare/> (last updated Jan. 2020).

⁶⁴ E.g., *Examining Concerns of Patient Brokering and Addiction Treatment Fraud: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Com.*, 115th Cong. (2017) [hereinafter *Patient Brokering Hearing*] (statement of Gregg Harper, Rep. Mass.); Jim Peake & Christian Morris, *Patient Brokering in the Addiction Treatment Industry*, ADDICTION-REP (Apr. 20, 2018), <https://addiction-rep.com/blog/patient-brokering-in-the-addiction-treatment-industry/>.

⁶⁵ Copeland, *supra* note 45, at 1475–76.

⁶⁶ *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.).

⁶⁷ *What is Patient Brokering?*, 499 RECOVERY (July 23, 2018), <https://www.449recovery.org/what-is-patient-brokering/>.

⁶⁸ *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.); John Pacenti, *Patient Brokering: A Festering Wound for the Recovery Community*, PALM BEACH POST, <https://www.palmbeachpost.com/news/local/patient-brokering-festering-wound-for-recovery-community/hTxetVZpD2Lud2kV4evoM/> (last updated Oct. 30, 2016, 1:15 AM).

⁶⁹ David Armstrong & Evan Allen, *The Addict Brokers: Middlemen Profit as Desperate Patients Are ‘Treated Like Paychecks’*, STAT (May 28, 2017), <https://www.statnews.com/2017/05/28/addict-brokers-opeioids/> (interviewing ex-patient brokers).

⁷⁰ Peake & Morris, *supra* note 64.

⁷¹ *Id.* When a treatment or surgery for most medical maladies concludes, it does not need to be “redone,” whereas the strong likelihood of relapse for SUD patients creates the expectation for repeat customers. *Id.*

Medicare providers that exists for other health care services exacerbates the industry's draw to patient brokers.⁷²

Sober living homes profit from patient brokering by accumulating fees clients privately pay to reside in their facility while providing little to no SUD recovery services,⁷³ pocketing insurance reimbursements for urinalysis testing,⁷⁴ and collaborating with an unethical inpatient or outpatient treatment center.⁷⁵ In the third scenario, once an individual with SUD is in a sober living home, they are incentivized with free drugs or other inducements to relapse, thereby restarting another use cycle, which requires another referral *back* to inpatient or outpatient treatment.⁷⁶ Either the sober living home itself or a third-party patient broker will then receive a kickback from the treatment center for the return referral.⁷⁷

The rapid rise of patient brokering and overuse of urinalysis drug testing among unethical sober living homes have exploited and compromised the important role of sober living homes in the SUD continuum of care. Federal intervention that meaningfully remedies these issues is needed to address the nation's SUD epidemic and protect the well-being of SUD patients and their families.

II. PRESENT FEDERAL EFFORTS TO INTERVENE IN THE SOBER LIVING INDUSTRY HAVE NO TEETH

In October 2017, the Acting Secretary of HHS declared the opioid crisis a public health emergency.⁷⁸ One year later, President Trump signed the SUPPORT Act, a bipartisan bill that primarily sought to address the opioid crisis and shaped current federal response to all other subclassifications of SUD as well.⁷⁹ The Act incorporated and expanded upon prior legislative efforts to

⁷² See *supra* Part I.B.

⁷³ *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.).

⁷⁴ See Cohn, *supra* note 60.

⁷⁵ U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-315, INFORMATION ON RECOVERY HOUSING PREVALENCE, SELECTED STATES' OVERSIGHT, AND FUNDING 8 n.16 (2018). Sober living homes may also partner with drug testing laboratories in patient brokering schemes. *Id.*

⁷⁶ *Patient Brokering Hearing*, *supra* note 64 (Statement of Gregg Harper, Rep. Mass.).

⁷⁷ See *id.*

⁷⁸ OFF. OF SEC'Y, HHS: DETERMINATION THAT A PUBLIC HEALTH EMERGENCY EXISTS (2017); Press Off., HHS: *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis* (Oct. 26, 2017), <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html>.

⁷⁹ See SUPPORT Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018); *The SUPPORT for Patients and Communities Act (H.R. 6)*, AM. SOC'Y ADDICTION MED., <https://www.asam.org/advocacy/the-support-for->

confront SUD issues, including the 21st Century Cures Act of 2018 and the Comprehensive Addiction and Recovery Act of 2016.⁸⁰ The SUPPORT Act's sweeping design imposes duties across a wide range of federal agencies.⁸¹ The Act also comprised the first ever targeted federal effort to eliminate bad practices and bad players in the sober living industry.⁸²

Although the SUPPORT Act signifies the federal government has turned its attention to issues of fraud and abuse in the sober living industry, in practice, it does not achieve much beyond memorializing federal attention. This Part explains why the three SUPPORT Act provisions relevant to the sober living industry have failed to provide meaningful intervention. While Subtitle D of the Act, which imposes duties on HHS and SAMHSA to facilitate best practices and indicators of fraud in the sober living industry, does identify the industry's issues, it does not solve them.⁸³ Subtitles B and J, which enable the FTC to prosecute certain instances of fraud within the SUD industry in general, are both subject to restrictions that negate their ability to address fraud in the sober living industry, specifically.⁸⁴

A. The Federal Government's Implementation of the "Ensuring Access to Quality Sober Living" SUPPORT Act Provision Identifies but Does Little to Solve the Industry's Problems

Subtitle D, "Ensuring Access to Quality Sober Living," imposes two duties upon HHS.⁸⁵ First, HHS must establish best practices for the operation of sober living homes.⁸⁶ The Act further states this may include "model laws for implementing suggested minimum standards" and that the Secretary of HHS shall consult with a variety of outside stakeholders as appropriate.⁸⁷ The Act

patients-and-communities-act-(h.r.-6) (last visited Sept. 2, 2021). A majority of the Act's provisions apply to SUD generally. See SUPPORT Act, Pub. L. No. 115–271, 132 Stat. 3894 (2018).

⁸⁰ ELAYNE J. HEISLER & JOHNATHAN H. DUFF, PUBLIC HEALTH AND OTHER RELATED PROVISIONS IN P.L. 115–271, THE SUPPORT FOR PATIENTS AND COMMUNITIES ACT (2018), <https://fas.org/sgp/crs/misc/R45423.pdf>.

⁸¹ *Id.* The Cures Act, Pub. L. No. 114–255, 130 Stat. 1013 (2018), primarily "focused on medical innovation," and the CARA Act, Pub. L. No. 114–198, 130 Stat. 695 (2016), targeted SUD issues through broad public health and law enforcement measures. *Id.*

⁸² Diep, *supra* note 43.

⁸³ SUPPORT Act § 7031 (codified as amended at 42 U.S.C.A. § 290ee–5).

⁸⁴ *Id.* §§ 8021–8023 (codified as amended at 15 U.S.C.A. § 45(d)); *id.* § 8122 "Eliminating Kickbacks in Recovery Act" (codified at 18 U.S.C.A. § 220).

⁸⁵ *Id.* § 7031 (codified as amended at 42 U.S.C.A. § 290ee–5).

⁸⁶ National Recovery Housing Best Practices, 42 U.S.C.A. § 290ee–5(a)(1). The Act does not further elaborate upon the meaning of "best practices." See *id.*

⁸⁷ *Id.* § 290ee–5(a)(1)–(b)(1).

explicitly lists a variety of such stakeholders, including federal and state agencies, non-governmental entities, and individuals.⁸⁸ Second, HHS must identify or facilitate “development of common indicators that could be used to identify potentially fraudulent recovery housing operators” in collaboration with outside stakeholders.⁸⁹ HHS must also keep in mind how these common indicators can actually prove useful to law enforcement, insurers, individuals with SUD, and the public as a whole in identifying bad players.⁹⁰ In codifying this provision, HHS delegated both of these duties to SAMHSA.⁹¹

HHS and SAMHSA’s measures fail to help states and other stakeholders ensure access to quality sober living homes. In 2019, SAMHSA endeavored to carry out its SUPPORT Act duties by publishing a ten-page document proposing “best practices and suggested guidelines” for recovery housing facilities.⁹² SAMHSA’s guidelines are wanting in many respects. First, despite SAMHSA’s statutory directive to identify best practices, the document provides little substantive guidance on the operation of effective sober living homes.⁹³ It provides a brief description of the different levels of care found in sober living homes as identified by the National Alliance of Recovery Residences (NARR), but fails to reference any specific operating policies or procedures.⁹⁴ The guidelines instead focus on big-picture principles such as respect for all beliefs, races, and cultures, and ensuring operators recognize SUD patients often have co-occurring mental disorders.⁹⁵ The National Council for Behavioral Health (NCBH), NARR, and other industry stakeholders criticized SAMHSA for neglecting to collaborate with NARR constituents and excluding the detailed standards for operating procedures published by NARR.⁹⁶

⁸⁸ *Id.* § 290ee–5(a)(2)(A)–(D).

⁸⁹ *Id.* at (b)(1).

⁹⁰ *Id.* at (b)(3)(A).

⁹¹ § 290ee–5 is under Public Health and Welfare Code’s subchapter III–A, which codifies the duties of SAMHSA. *See id.*

⁹² *See* SAMHSA, *supra* note 42.

⁹³ 42 U.S.C.A § 290ee–5(a); *see* Memorandum from David Sheridan, NARR President to the Substance Abuse and Mental Health Servs. Admin, Comments on draft, “Recovery Housing: Best Practices and Suggested Minimum Guidelines,” (Apr. 12, 2019), <https://narronline.org/wp-content/uploads/2019/04/SAMHSA-proposed-recovery-housing-guidelines-NARR-response.pdf> (implying SAMHSA has misconstrued its SUPPORT Act directives).

⁹⁴ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42, at 2–3 (citing NARR).

⁹⁵ *Id.* at 4, 8; Diep, *supra* note 43.

⁹⁶ Memorandum from the Nat’l Council Behav. Health to the Honorable Elinore McCance-Katz, Assistant Sec’y for Mental Health and Substance Abuse, Recovery Housing Proposed Guidelines Overall Comments (Apr. 12, 2019), https://www.thenationalcouncil.org/wp-content/uploads/2019/04/National-Council_Recovery-Housing-Proposed-Guidelines_Overall-Comments_4.12.2019.pdf?daf=375ateTbd56; Sheridan, *supra* note 93, at 3.

Stakeholders also objected to SAMHSA’s use of stigmatizing language and pejorative tone when discussing individuals with SUD.⁹⁷ Moreover, SAMHSA attempted to provide a catch-all guide for a diverse range of audiences without clarifying upon which audience a given responsibility should fall.⁹⁸ In trying to reach insurers, sober living home operators, law enforcement, state legislatures, and regulatory agencies all at once, expectations for how each stakeholder should implement SAMHSA’s principles are unclear, and concepts familiar to one audience are confusing to another.⁹⁹

Instead of offering guidance on how states can eliminate problems of fraud in the sober living industry, SAMHSA simply identifies what these problems are. The guidelines provide a basic, one-paragraph definition of patient brokering, followed by instruction that “[r]ecover house operators should be well aware of the existence of these types of practices and should understand [they] are unacceptable and unethical practices.”¹⁰⁰ Although SAMHSA explains that bad players abuse urinalysis testing by “excessive[ly]” drug testing and charging “over and above the standard costs for lab tests,” it does not elaborate on how much testing is excessive or when a laboratory bill is unusually high.¹⁰¹ Rather than helping states and law enforcement crack down on unethical sober living homes, SAMHSA merely directs ethical sober living operators to be aware of something they already know is threatening their industry. Lastly, SAMHSA advises states to “adopt a process of certification to assure program quality” but provides no instructions for how states can do so.¹⁰² States should at the least be provided with information on reputable certifying organizations and accrediting bodies. All in all, HHS and SAMHSA have failed to adequately realize their SUPPORT Act duties.

B. The Bulk of the Sober Living Industry’s Bad Players Fall Outside the Scope of the FTC’s SUPPORT Act Authority

Subtitle B of the SUPPORT ACT, the “Opioid Addiction Recovery Fraud Prevention Act of 2018,” enacts civil penalties for unfair or deceptive acts by

⁹⁷ Nat’l Council Behav. Health, Recovery Housing Proposed Guidelines Overall Comments, *supra* note 96; Sheridan, *supra* note 93; Diep, *supra* note 43.

⁹⁸ For example, the guidelines consistently use the pejorative term “addict” to refer to SUD patients and provides a sensationalized depiction of SUD as a “lifestyle” filled with networks of dealers on corners, rather than a recognized brain disease. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42, at 2–4; *see* Nat’l Council Behav. Health, Recovery Housing Proposed Guidelines Overall Comments, *supra* note 96.

⁹⁹ Sheridan, *supra* note 93; *see* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42.

¹⁰⁰ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 42, at 6–7.

¹⁰¹ *Id.* at 7.

¹⁰² *Id.*

SUD “treatment services” for first-time offenders and assigns its enforcement to the FTC.¹⁰³ This provision does nothing to address fraud in the sober living industry. The Act defines SUD “treatment services” as services purporting “to provide *referrals* to treatment or recovery housing.”¹⁰⁴ Therefore, the Act has no application to fraudulent or deceptive actions committed by an actual sober living home. Although patient brokers sometimes pose as referral services in online advertisements,¹⁰⁵ this provision does not reach the in-person recruiting tactics employed by many patient brokers.¹⁰⁶

Subtitle J, entitled “Eliminating Kickbacks in Recovery Act” (EKRA), makes it a felony to knowingly and willfully pay or receive kickbacks in return for referring a patient to a recovery home, clinical treatment facility, or laboratory, but only if a service “is covered by a healthcare benefit program.”¹⁰⁷ Thus, in order to fall within EKRA’s scope, a service must be covered by public or private health insurance.¹⁰⁸ Although EKRA may help prosecute laboratories that bill fraudulent drug tests to a customer’s insurance,¹⁰⁹ EKRA has no impact on sober living homes because they are rarely covered by public or private health insurance.¹¹⁰

While the three SUPPORT Act provisions discussed above are a step in the right direction, their actual impact on fraud and abuse in the sober living industry proves practically nonexistent.

¹⁰³ SUPPORT Act, Pub. L. No. 115–271, §§ 8021–8023 (codified as amended at 15 U.S.C.A. § 45(d)).

¹⁰⁴ *Id.* § 8022 (emphasis added).

¹⁰⁵ Copeland, *supra* note 45, at 1475–76.

¹⁰⁶ See *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.); *What is Patient Brokering?*, *supra* note 67; Pacenti, *supra* note 69. These tactics include prowling outside twelve-step recovery meetings, drug courts, and inpatient treatment centers, and infiltrating treatment centers themselves. *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.).

¹⁰⁷ SUPPORT Act § 8122(a)(2) “Eliminating Kickbacks in Recovery Act” (codified at 18 U.S.C.A. § 220).

¹⁰⁸ 18 U.S.C.A. § 220(a), (c)(3); *id.* § 24(b) (defining “health care benefit program” as a “public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual”).

¹⁰⁹ There has yet to be any prosecution directly based upon EKRA since the Act’s passage. A. Lee Bentley III & Jason P. Mehta, *Beyond the False Claims Act: The Government’s Untraditional Tools in Health Care Fraud Prosecutions*, 13 J. HEALTH & LIFE SCI. 90, 100 (2020).

¹¹⁰ Close, *supra* note 40 (citing Polcin et al., *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes*, *supra* note 30). EKRA has also been criticized for applying to all laboratories in general, not just those involved with drug testing. Copeland, *supra* note 45, at 1498; Bentley & Mehta, *supra* note 109, at 100. This technically allows any laboratory that hires a sales representative, even if for ordinary, ethical purposes, to be prosecuted. Copeland, *supra* note 45, at 1500–01. There are concerns that EKRA will be used by the government in prosecutions that have nothing to do with its purpose of protecting the SUD treatment industry. *Id.* at 1501. Although this concern has yet to be confirmed, it appears the DOJ may be using EKRA to build cases against cancer and genetic testing laboratories. Bentley & Mehta, *supra* note 109, at 101.

III. TENTH AMENDMENT OBSTACLES TO MEANINGFUL INTERVENTION

Tenth Amendment-based principles of federalism¹¹¹ and the doctrine of anti-commandeering¹¹² pose obstacles to meaningful federal intervention in the sober living industry. The Tenth Amendment dictates that powers not specifically delegated to the federal government by the Constitution are reserved to the states.¹¹³ The Amendment affords states chief authority to regulate the health, safety, and general welfare of their populations, collectively known as a state’s “police powers.”¹¹⁴ Authority to regulate in the health care sector, including authority to enact accreditation requirements and mandatory operating standards, has historically belonged to states as a function of their police powers.¹¹⁵ Accordingly, a federal law requiring minimum standards and accreditation for the operation of sober living homes faces Tenth Amendment-based obstacles.

This Part addresses two imminent obstacles. The first is a federalism-based objection that, absent a compelling need for the federal government to step in, intervention in the sober living industry should be left to the states out of respect for federalism principles. This objection is disproven by three overarching arguments for the necessity of federal involvement. However, additional Tenth Amendment obstacles under the doctrine of anti-commandeering prohibit the federal government from compelling states to regulate the sober living industry. Therefore, the only possible path by which Congress can regulate the industry without violating anti-commandeering principles is through the Commerce Clause, as elaborated in Part IV.¹¹⁶

¹¹¹ Generally, federalism principles recognize the “states and the federal government . . . as dual sovereigns, constraining the federal government from exerting federal power in areas that the Constitution reserves to the states.” *Federalism and Powers Reserved to States*, 16A AM. JURIS. 2D CONST. L. § 214 (first citing *Sossamon v. Texas*, 563 U.S. 277 (2011); then citing *United States v. Walker*, 490 F.3d 1282 (11th Cir. 2007)).

¹¹² The doctrine of anti-commandeering “prohibits the federal government from compelling the states to enact or administer a federal regulatory program.” *Basic Rule of Noninterference Between State and Federal Governments: Anticommandeering Principle*, 16A AM. JURIS. 2D CONST. L. § 224 (citing *State v. Dep’t Just.*, 951 F.3d 84 (2d Cir. 2020)).

¹¹³ U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”).

¹¹⁴ H. Benjamin Harvey & Pari V. Pandharipande, *The Federal Government’s Oversight of CT Safety: Regulatory Possibilities*, 262 RADIOLOGY 391, 392 (2012).

¹¹⁵ *Id.*

¹¹⁶ See James Buchwalter, Lonnie E. Griffith, Jr., Janice Holben, Stephen Lease, Jeffrey J. Shampo, & Barbara J. Van Arsdale, *Federal Action Not Invading State Powers*, 81 C.J.S. STATES § 57 (2020) (federal action “within the states which are valid under the commerce power cannot be an invasion of the sovereignty of the states in violation of the Tenth Amendment”) (first citing *Hodel v. Va. Surface Min. & Reclamation Ass’n, Inc.*, 452 U.S. 264 (1981); then citing *Mont. Caregivers Ass’n v. United States*, 841 F. Supp. 2d 1147 (D. Mont.

A. *Federal vs. Solely State-Based Intervention Objections*

A possible federalism-based objection to federal intervention in the sober living industry is that federal involvement “would prevent states from acting as laboratories of experimentation and developing their own requirements for” SUD treatment “because it would standardize care.”¹¹⁷ This objection derives from the theory that our federalism system of government works best “when the federal government steps out of the way” and allows states to experiment with “diverse approaches to addressing social problems.”¹¹⁸ Arguments surrounding the role of states as laboratories in the health care sector arose in the early 1990’s in response to conflict between state health care reform attempts and the Federal Employee Retirement Income Security Act.¹¹⁹ Supporters of the position that health care regulation should be the exclusive subject of state laboratories contend that examples of differing yet independently successful state reforms in retirement health care coverage demonstrated the utility of experimentation.¹²⁰

Three overarching arguments prove regulation of the sober living industry cannot be left solely to states as laboratories. First, there is a deficiency of meaningful and varied state approaches to regulation. Second, allowing states to freely experiment with regulation has resulted in an “exodus of bad players” from states that have cracked down on oversight in their sober living industries to new, vulnerable states.¹²¹ Third, even if all states were to hypothetically implement bolstered regulation, successful intervention in the sober living industry nevertheless necessitates the institutionalization of nationwide, uniform standards of quality and transparency, which only the federal government can supply.

2012), *aff’d*, 526 F. App’x 756 (9th Cir. 2013)).

¹¹⁷ Cf. Copeland, *supra* note 45, at 1512 (citing Marina Lao, *Discrediting Accreditation?: Antitrust and Legal Education*, 79 WASH. U. L.Q. 1035, 1076–78 (2002)) (discussing this objection in the context of national accreditation of residential SUD treatment centers). The “state laboratory” concept originated from Justice Brandeis’ 1932 dissenting opinion in *New State Ice Co. v. Liebmann*. There, Justice Brandeis advanced that a benefit of the United States’ system of government derives from the ability of individual states to experiment with novel approaches to social problems. While states possess the *ability* to experiment, the Court retains power to limit or prevent such experiments. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

¹¹⁸ Michael A. Livermore, *The Perils of Experimentation*, 126 YALE L.J. 636, 648 (2017).

¹¹⁹ 29 U.S.C. § 1001; *see, e.g.*, Angelo A. Stio II., *State Government: The Laboratory for National Health Care Reform*, 19 SETON HALL LEGIS. J. 322, 324 (1994); Fernando R. Laguarda, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, 170 (1993).

¹²⁰ Stio, *supra* note 119, at 373.

¹²¹ Tony Saavedra, *Florida Prosecutor Dave Aronberg Sees Parallels in Rogue Rehabs in Florida and Southern California*, ORANGE CNTY. REG. (Mar. 27, 2018, 5:00 AM), <https://www.ocregister.com/2018/03/27/florida-prosecutor-dave-aronberg-sees-parallels-in-rogue-rehabs-in-florida-and-southern-california/> (interviewing Dave Aronberg).

1. *Absence of Variance in State Approaches and Lack of State Approaches Overall*

The present lack of state intervention serves as an initial indicator that the federal government must act to fill in the gaps. Despite widespread recognition of the sober living industry's problems, an overwhelming majority of states have not intervened.¹²² Therefore, there are no examples of differing yet independently successful state approaches to eradicating bad players.¹²³ Florida, the leading and perhaps only state to successfully crack down on bad players, has advocated for urgent adoption of its same approach by other states,¹²⁴ nationalization of standards, and federal intervention.¹²⁵ As of January 2020, only six states have licensure requirements for sober living homes.¹²⁶ Arizona, Hawaii, Maryland, Utah, and Wyoming require licensing for all sober living homes, and Arkansas requires licensing of sober living homes only if they provide post-prison housing.¹²⁷ Twenty-seven states *encourage* sober living homes to seek certification from a third-party non-profit organization, and one state, Maine, requires third-party certification.¹²⁸

Industry leaders suggest the absence of state regulation may be attributable in part to the fact that, historically, states did not view SUD care as part of the health care system.¹²⁹ Until the 1970s, SUDs were viewed “as social problems, best managed at the individual,” family, and faith-based levels.¹³⁰ Although the DSM-II declared SUD a medical disorder in 1965,¹³¹ the Surgeon General

¹²² Only six of the fifty states require some form of licensure, accreditation, or other certification to operate a sober living home. Martin et al., *supra* note 18, at 5–6; *see infra* notes 124–128 and accompanying text.

¹²³ *Cf. supra* note 120 and accompanying text (suggesting that examples of differing yet independently successful state reforms in health care demonstrate the utility of experimentation).

¹²⁴ Florida State Attorney Dave Aronberg, who heads Florida's Sober Homes Task Force and considered a “national expert” on SUD care fraud, is credited with responsibility for Florida's anti-broking statute, as well as playing a major role in the three SUPPORT ACT provisions that address the sober living industry, discussed in *supra* Section II. *See* Saavedra, *supra* note 121; *How to Fix the Florida Shuffle*, FIX THE FLA. SHUFFLE, <https://www.fixthefloridashuffle.com/issues> (last visited Sept. 2, 2020). Aronberg has counseled states seeing an influx of bad players to enact legislation and policies similar to Florida's while they await hopeful federal intervention. *See id.*

¹²⁵ *See* Saavedra, *supra* note 121; *How to Fix the Florida Shuffle*, *supra* note 124; *Patient Brokering Hearing*, *supra* note 64 (statement of Dave Aronberg, State Att'y, Fla.) (“[Florida is] offering our assistance to jurisdictions throughout the country . . . but local and state law enforcement cannot solve this problem alone. We need the federal government to fix federal laws and regulations . . .”).

¹²⁶ Martin et al., *supra* note 18, at 5–6.

¹²⁷ *Id.*

¹²⁸ *Id.* at 5–6, 22.

¹²⁹ Diep, *supra* note 43.

¹³⁰ HHS, *supra* note 24, at ch. 1, at 19.

¹³¹ Sean M. Robinson & Bryan Adinoff, *The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations*, 6 BEHAV. SCI. (SPECIAL ISSUE) 18, 29 (2016).

reported in 2016 that virtually all of the SUD treatment system remained separate from mainstream health care at the financial, administrative, regulatory, cultural, and organizational levels until as recently as the last decade.¹³² Ongoing integration of the SUD treatment and general health care systems only began taking shape following enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the ACA in 2010.¹³³ The MHPAEA restricted group health plans and insurers from imposing less favorable limitations on SUD benefits than those imposed on medical and surgical benefits.¹³⁴ The ACA then expanded MHPAEA requirements to individual insurance providers.¹³⁵ Sober living homes, however, do not fall within the ACA's mandated insurance requirements.¹³⁶ Notwithstanding how the MHPAEA and ACA signify progress in the integration of the SUD and general health care systems, the sober living industry continues to lag behind.

In sum, not only is there no diversity of state experimentation in regulating the sober living industry, but also most states have yet to experiment at all. The state laboratory objection therefore has no merit in context of sober living industry regulation.¹³⁷

2. *Allowing States to Freely Experiment Has Spawned an Exodus of Bad Players*

The “exodus of bad players” that takes place after a state cracks down on sober living home regulation evidences that solely state-based regulation can only disperse, not dispel, bad players.¹³⁸ If a state or local government enacts legislation that threatens to, or actually does, shut down bad player-owned sober living homes, bad players will simply leave that state and open a new facility in a state with weaker oversight.¹³⁹ These new states may be unaware of and

¹³² HHS, *supra* note 24, at ch. 1, at 19.

¹³³ 42 U.S.C.A. § 18022; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110–343, §§ 511, 512, 122 Stat. 3765, 3881; *see* HHS, *supra* note 26, at ch. 1, at 20 (identifying MHPAEA and ACA's enactments as when “[t]he longstanding separation of substance use disorders from the rest of health care began to change”).

¹³⁴ Pub. L. No. 110–343, §§ 511, 512(a)(1)(3)(A), 122 Stat. 3765, 3881.

¹³⁵ 42 U.S.C.A. § 18022.

¹³⁶ *Id.*; Close, *supra* note 40.

¹³⁷ *Cf.* Stio, *supra* note 119, at 373 (arguing the many, diverse, and successful state approaches to health insurance reforms justify a state laboratory approach).

¹³⁸ Saavedra, *supra* note 121 (interviewing Dave Aronberg).

¹³⁹ Julia Lurie, “*Mom, When They Look at Me, They See Dollar Signs*”, MOTHER JONES (Mar.–Apr. 2019), <https://www.motherjones.com/crime-justice/2019/02/opioid-epidemic-rehab-recruiters/>.

unprepared for an unscrupulous operator's bad practices.¹⁴⁰ Bad players may change a facility's name, switch to a new laboratory to cash out on urinalysis drug testing, or employ other measures to shield themselves from oversight.¹⁴¹ Therefore, only intervention at the federal level can disrupt this pattern of unethical sober living home owners keeping their schemes alive by moving from state to state.¹⁴²

While it is possible that such "new" states may eventually catch up to an influx of bad players and "serve as . . . laborator[ies]"¹⁴³ for novel regulatory measures, we cannot afford to wait. The consequences of bad players' actions can be a matter of life and death. An estimated average of 501 individuals die from SUD every day in the United States.¹⁴⁴ At best, SUD patients in bad player-owned sober living homes miss out on the adequate care, support, and relapse prevention tools they could receive from an ethical sober living. At worst, bad players provide vulnerable SUD patients with drugs and their relapse to keep patients trapped in the profitable cycle of addiction.¹⁴⁵ Moreover, the lag between the arrival of bad players in a new state and the new state's regulatory response gives bad players time to create and perfect new fraudulent tactics. States that exhibit success in cracking down on bad players, such as Florida, not only readily demonstrate promising models of intervention, but also actively beseech the federal government to intervene.¹⁴⁶ In short, there is no time for states to experiment in the midst of a nationwide SUD crisis.¹⁴⁷

¹⁴⁰ See, e.g., *What is the Florida Shuffle?*, *supra* note 52 (expressing concern that success of Florida's Sober Homes Task Force is sending bad players to other states); Christine Vestal, *Opioid Treatment Scam May Be Coming to Your State*, STATELINE (Oct. 7, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/10/07/opioid-treatment-scam-may-be-coming-to-your-state>.

¹⁴¹ Lurie, *supra* note 139.

¹⁴² See Copeland, *supra* note 45, at 1512.

¹⁴³ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

¹⁴⁴ This average is based on the combination of provisional reported drug overdoses over a 12-month period ending in January 2021 and yearly average of deaths attributable to alcoholism, a subclassification of SUD not reported in overdose deaths. CTR. DISEASE CONTROL & PREVENTION, *supra* note 2 (estimating 94,134 Americans fatally overdosed in 2020); NAT'L CTR. DRUG ABUSE STAT., *supra* note 3 (reporting an average of 88,000 deaths per year are attributable to alcoholism).

¹⁴⁵ See *supra* notes 75–77 and accompanying text for discussion of how bad players collaborate with unethical inpatient treatments providers.

¹⁴⁶ See, e.g., *What is the Florida Shuffle?*, *supra* note 52 ("Local and state law enforcement cannot solve this problem alone. This is a national crisis that deserves a federal response. Together, we can and will convince the federal government to [intervene].").

¹⁴⁷ Cf. Copeland, *supra* note 45, at 1512 (arguing that state laboratory objections to national accreditation requirements for residential treatment carry "less weight in the face of a nationwide opioid crisis").

3. *Even if All States Attempted to Strengthen Sober Living Industry Oversight, Uniform Nationwide Measures Are Nevertheless Necessary for Achieving Meaningful Intervention*

Objections to federal, in lieu of solely state-based, intervention in the sober living industry prove inviable when considering the nationwide parameters of the industry's issues and the inability of states to confront these issues alone. Meaningful intervention in the sober living industry necessitates the institutionalization of nationwide, uniform standards of quality and transparency, which only the federal government can provide. This necessity exists for two reasons. First, because there are no common industry standards, there is no way for SUD patients to evaluate and compare the quality of sober living homes. This creates an environment where bad players can thrive. Second, the sober living industry has an unusually mobile character because residents frequently travel to out-of-state facilities. A reliable mechanism for evaluating quality and transparency must function at a nationwide level.

Without a set of nationwide, uniform standards for quality and transparency, there is no way for prospective sober living home residents to reliably evaluate and compare different facilities. At present, there is no common basis for assessing the quality and effectiveness of even *ethical* sober living homes.¹⁴⁸ It is an industry norm for SUD providers to offer minimal objective data on the “success” and quality of their programs.¹⁴⁹ Additionally, even if a facility wanted to provide such information, there is no recognized standard against which to reference their services.¹⁵⁰ This lack of industry uniformity is a major reason why the sober living industry is an environment where bad players can thrive. Because there is no feasible mechanism for SUD patients to gauge quality of service, there is in turn no incentive for bad players to provide quality services.¹⁵¹ Moreover, because even legitimate sober living home operators are not expected to provide potential residents with evidence to support their facility's quality, it is easy for bad players to mislead potential customers without raising any red flags.¹⁵² In the eyes of potential residents, the ethical

¹⁴⁸ See NARR, AN INTRODUCTION AND MEMBERSHIP INVITATION TO THE NATIONAL ASSOCIATION OF RECOVERY RESIDENCES 9 (2011), <https://narronline.org/wp-content/uploads/2013/09/NARR-White-Paper-111006-final.pdf>.

¹⁴⁹ Copeland, *supra* note 45, at 1490 (citing Teri Sforza, Tony Saavedra, Scott Schwebke, Lori Basheda, Mindy Schauer, Jeff Gritchen, & Ian Wheeler, *How Some Southern California Drug Rehab Centers Exploit Addiction*, ORANGE CNTY. REG. (May 21, 2017, 5:55 AM), <https://www.ocregister.com/2017/05/21/how-some-southern-california-drug-rehab-centers-exploit-addiction/>).

¹⁵⁰ *Id.* (citing Teri Sforza et al., *supra* note 149).

¹⁵¹ *Id.* at 1491 (citation omitted).

¹⁵² *Id.*

sober living home on one side of town looks the same as the unethical sober living home on the other.

The unique nature of the industry's consumers, newly sober SUD patients, further confounds the consequences of this lack of uniform standards. There is little chance an individual with SUD who is brand new to recovery, physically and mentally vulnerable, and lacking recovery capital can accurately judge the quality of SUD care during or even after they receive it.¹⁵³ Additionally, federalized standards are necessary because at present, no uniform terminology exists to describe practices across the industry.¹⁵⁴ This lack of common language within the industry itself contributes to the misunderstood, confused efforts to create a cross-regional framework for ethical providers to communicate and collaborate on critical issues.¹⁵⁵

The second major reason necessitating federal intervention is the mobile character of the SUD treatment industry. Unlike typical health care patients, SUD patients frequently travel out-of-state for treatment.¹⁵⁶ Because so many sober living home residents, often lured by brokers, travel to other states, there must be a reliable mechanism to provide transparency of quality at a nationwide level.¹⁵⁷ This cross-state mobility makes the SUD industry's issues a national problem.¹⁵⁸ Organizations of SUD professionals have stressed the unique pressures of the industry's mobile character in making pleas for federal standards.¹⁵⁹ In 2019, the Association for Addiction Professionals released a statement "urg[ing] Congress to work with" itself and other industry stakeholders to create national credentials and standards to account for the cross-state mobility of individuals seeking recovery services.¹⁶⁰ The Association asserted that variation among state licensing and credentialing requirements functions "as a barrier to entry, advancement, and retention" of workers that play a critical role in addressing the nation's SUD crisis.¹⁶¹

¹⁵³ *See id.* at 1490–91. A SUD patient lacks the expertise to determine whether, or to what degree, a relapse resulted from inadequate care or from their own insufficient engagement with the services provided. *See id.*

¹⁵⁴ NARR, *supra* note 148, at 9–10.

¹⁵⁵ *Id.*

¹⁵⁶ Copeland, *supra* note 45, at 1506.

¹⁵⁷ *Patient Brokering Hearing*, *supra* note 64 (statement of Eric Gold, Chief, Mass. Att'y Gen. Health Care Div.).

¹⁵⁸ *Id.* (statement of Eric Gold, Chief, Mass. Att'y Gen. Health Care Div.).

¹⁵⁹ ASSOC. ADDICTION PRO., ADDICTION PROFESSIONAL CREDENTIALING: THE NEED FOR NATIONAL STANDARDS (2019), <https://www.naadac.org/assets/2416/2019-aina-addiction-professional-credentialing-need-for-national-standards.pdf>. The statement called for national standards across the SUD continuum of care, including sober living homes. *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

The above concerns demonstrate that even if all states experimented with regulating sober living homes, state efforts alone would not be sufficient to address the industry's problems. The need for nationalized standards of quality and transparency can only be met by federal intervention.

B. The Anti-Commandeering Doctrine of the Tenth Amendment

Although the federalism-based objections discussed above are unfounded, federal intervention in the sober living industry remains severely limited by the doctrine of anti-commandeering. A product of Supreme Court jurisprudence, the doctrine of anti-commandeering asserts that because the Tenth Amendment prescribes separation of powers, the federal government cannot “commandeer” state powers by forcing state governments to enact federal laws.¹⁶² Under the anti-commandeering principles in *New York v. United States* and *Murphy v. National Collegiate Athletic Association*, the federal government cannot compel state governments to legislate or regulate in the sober living industry in accordance with federal directives without the authority of a constitutionally enumerated federal power.¹⁶³ Under *South Dakota v. Dole*, the federal government can avoid anti-commandeering violations by attaching conditions to a state's receipt of federal funds, but this avenue proves futile in the context of the sober living industry because sober living homes are rarely entwined with federal dollars.¹⁶⁴

I. Anti-Commandeering Limits: New York and Murphy

Under *New York*, Congress cannot regulate the sober living industry absent authority from one of its constitutionally enumerated powers.¹⁶⁵ Anti-commandeering principles prevent Congress from compelling states to administer a federal regulatory scheme or enact legislation to establish nationalized minimum standards in the sober living industry.¹⁶⁶ In *New York*, the Court invalidated a provision of a federal law that required states to carry out a

¹⁶² Caleb Seckman, *Anti-Commandeering: A Modern Doctrine for a Modern World*, 13 N.Y.U. J.L. & LIBERTY 150, 152 (2019) (first citing THE FEDERALIST NO. 28, at 149 (Alexander Hamilton) (Clinton Rossiter, ed., 1961); then citing *Printz v. United States*, 521 U.S. 898 (1997)).

¹⁶³ *Murphy v. Nat'l Collegiate Athletic Assoc.*, 138 S. Ct. 1461, 1477 (2018) (holding Congress cannot commandeer state legislatures); *New York v. United States*, 505 U.S. 144, 188 (1992) (holding “[t]he Federal Government may not compel the States to enact or administer a federal regulatory program”).

¹⁶⁴ See *South Dakota v. Dole*, 483 U.S. 203 (1987).

¹⁶⁵ *New York*, 505 U.S. at 188.

¹⁶⁶ *Murphy*, 138 S. Ct. at 1477 (holding Congress cannot commandeer state legislatures); *New York*, 505 U.S. at 188 (holding “the Federal Government may not compel the States to enact or administer a federal regulatory program”).

federal regulatory scheme for the disposal of nuclear waste.¹⁶⁷ The law required state governments to either enact legislation that conformed with federal instructions for regulating disposal of low-level nuclear waste or, alternatively, take possession of all nuclear waste in their state.¹⁶⁸ The provision did not provide states an option to decline administering the federal guidelines.¹⁶⁹ The Court explained that while Congress could have achieved its regulatory intent if it enacted the waste provision under the authority of a constitutionally enumerated congressional power, Congress could not simply commandeer a state's police powers by forcing it to regulate.¹⁷⁰

The Court has consistently applied its holding in *New York* in cases where a federal regulatory scheme clashes with anti-commandeering principles. In *Printz v. United States*, the Court held that Congress cannot side-step state police powers by compelling state officials and local governments to administer a federal regulatory scheme.¹⁷¹ In the recent case of *Murphy v. National Collegiate Athletic Association*, the Court invoked its precedent from *New York* in holding that the federal government cannot force states to enact or refrain from enacting legislation to achieve federal regulatory interests.¹⁷²

Although intervention in the sober living industry must take place on a nationwide level to have a meaningful impact, anti-commandeering jurisprudence makes clear that “[n]o matter how powerful” or urgent a federal interest may be, “the Constitution simply does not give Congress the authority to require the states to regulate.”¹⁷³

2. *Loopholes: Surviving Dole Still Fails to Reach the Sober Living Industry*

Because sober living homes rarely take insurance, Congress cannot utilize the Taxing and Spending Clause “loophole” in the anti-commandeering doctrine to achieve meaningful federal intervention. Found in Article I of the U.S. Constitution, the Taxing and Spending Clause authorizes Congress to spend federal funds in pursuit of the “[g]eneral [w]elfare of the United States.”¹⁷⁴ Under *Dole*, Congress's spending power authorizes it to incentivize states to carry out a federal regulatory scheme by attaching “conditions on the receipt of

¹⁶⁷ *New York*, 505 U.S. at 153–54, 188 (citing 42 U.S.C.A. § 2021(e)(d)(2)(c)).

¹⁶⁸ *Id.* at 153–54 (citing 42 U.S.C.A. § 2021(e)(d)(2)(c)).

¹⁶⁹ *Id.* at 177.

¹⁷⁰ *Id.*

¹⁷¹ *Printz v. United States*, 521 U.S. 898, 935 (1997).

¹⁷² *Murphy v. Nat'l Collegiate Athletic Assoc.*, 138 S. Ct. 1461, 1477 (2018).

¹⁷³ *New York*, 505 U.S. at 178.

¹⁷⁴ U.S. CONST. art. I, § 8, cl. 1.

federal funds,” provided the condition is “in pursuit of ‘the general welfare.’”¹⁷⁵ The Court in *Dole* upheld a federal law that withheld a percentage of a state’s federal highway funding if a state declined to raise its legal drinking age to twenty-one.¹⁷⁶ The Court reasoned Congress could incentivize states to carry out the federal regulatory interest because the purpose of Congress’s regulatory scheme—addressing the dangers of young people drinking and driving on interstate highways—furthered the nation’s general welfare.¹⁷⁷ Additionally, the condition on the highway funds was sufficiently related to the dangers of drunk drivers on highways.¹⁷⁸

The federal government has had success regulating within state health care sectors via its spending powers by attaching conditions on the receipt of Medicare funds.¹⁷⁹ Such regulations differ from the highway condition in *Dole* in that instead of applying to states, these regulations apply to private medical providers that receive Medicare funding or take Medicare payments from clients.¹⁸⁰ This provides an indirect route for the federal government to regulate in the health care sector without having to compel state governments to carry out federal goals. Fraud and abuse in the sober living industry could likely be considered a threat to the general welfare, like the dangers of drunk driving were in *Dole*.¹⁸¹ However, Congress cannot use this loophole to regulate the sober living industry because sober living homes rarely take Medicare or other government provided insurance.¹⁸²

Although federal, rather than solely state-based, intervention is crucial to eliminating bad players from the sober living industry, Tenth Amendment concerns severely shrink the federal government’s options for regulating the industry within the bounds of its constitutional authority.

¹⁷⁵ South Dakota v. Dole, 483 U.S. 203, 212 (1987).

¹⁷⁶ *Id.* at 205 (citing 23 U.S.C. § 158 (1982 ed., Supp. III)).

¹⁷⁷ *Id.* at 208.

¹⁷⁸ *Id.*

¹⁷⁹ Harvey & Pandharipande, *supra* note 114, at 393 (first citing CONG. BUDGET OFF., THE LONG-TERM BUDGET OUTLOOK (2010); then citing Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006)).

¹⁸⁰ *Id.* (first citing CONG. BUDGET OFF., *supra* note 179; then citing Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006)).

¹⁸¹ *Dole*, 483 U.S. at 208.

¹⁸² Close, *supra* note 40 (citing Douglas Polcin et al., *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes*, *supra* note 30).

IV. A FEDERALISM-FRIENDLY SOLUTION FOR MEANINGFUL FEDERAL INTERVENTION: MANDATORY ACCREDITATION REQUIREMENTS PURSUANT TO CONGRESS'S COMMERCE CLAUSE POWER

This Part asserts that (1) meaningful, Tenth Amendment friendly federal intervention can be achieved by enactment of a federal law that sets minimum quality standards and accreditation requirements for operating a sober living home; and (2) such legislation would have proper constitutional authority under Congress's Commerce Clause powers, and thus would not violate the federalism-based concerns described in Part III. Federal regulation of the operation of a sober living home meets the necessary requirements to qualify as an exercise of congressional Commerce Clause powers under Supreme Court jurisprudence. This contention is supported by analysis of six major decisions in Commerce Clause jurisprudence.¹⁸³ This Part concludes by showing that support for the constitutionality of federal regulation of sober living homes is more than theoretical. One of the few federal laws regulating intrastate aspects of the health care sector is the Mammography Quality Standards Act (MQSA), which sets minimum accreditation requirements for the operation of a mammography screening center, the same measures for federal intervention proposed by this Comment. The MQSA was enacted pursuant to Congress's commerce powers to remedy issues strikingly similar to those affecting the sober living industry.

A. Congress's Commerce Clause Power in General

The Commerce Clause grants Congress the power “[t]o regulate [c]ommerce with foreign [n]ations, and among the several states, and with the Indian tribes.”¹⁸⁴ The Court first broached the meaning of the Commerce Clause in *Gibbons v. Ogden*.¹⁸⁵ There, Justice Marshall clarified the meaning of “commerce” as stretching beyond literal traffic to “the commercial intercourse between nations, and parts of nations” and vesting in Congress the authority to prescribe the rules by which such intercourse may be carried out.¹⁸⁶ Subsequent decisions made clear Congress may exercise its Commerce Clause power to regulate incidents of interstate commerce in areas traditionally regulated under

¹⁸³ See *Wickard v. Filburn*, 317 U.S. 111 (1942); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964); *Perez v. United States*, 402 U.S. 146 (1971); *United States v. Lopez*, 514 U.S. 549 (1995); *United States v. Morrison*, 529 U.S. 598 (2000); *Gonzales v. Raich*, 545 U.S. 1 (2005).

¹⁸⁴ U.S. CONST. art. I, § 8, cl. 3.

¹⁸⁵ *Lopez*, 514 U.S. at 553 (citing *Gibbons v. Ogden*, 22 U.S. 1 (1824)) (identifying *Gibbons* as where the Court “first defined the nature of Congress’s commerce power”).

¹⁸⁶ *Gibbons*, 22 U.S. at 189–90, 196.

an individual state's police powers.¹⁸⁷ The Commerce Clause serves as a recurrent basis for the constitutionality of federal legislation and provides one of the broadest authorities for congressional exercise of power.¹⁸⁸ Although the Court's interpretation of Congress' power to regulate interstate commerce has expanded over time, it is not unrestricted.¹⁸⁹

In *United States v. Lopez*, the Court condensed its prior jurisprudence to establish a three-part framework for determining when Congress exceeds the scope of its Commerce Clause powers.¹⁹⁰ For a federal law regulating interstate commerce to be upheld as a constitutional exercise of congressional commerce powers, it must fall within at least one of three broad categories of regulatory activity: (1) laws regulating "the use of the channels of interstate commerce"; (2) laws "regulat[ing] and protect[ing] [the] instrumentalities of interstate commerce, or persons or things in interstate commerce"; or (3) laws regulating an activity that "substantially affects interstate commerce."¹⁹¹

Federal regulation of the sober living industry falls into the third *Lopez* category of congressional power: activities that "substantially affect interstate commerce."¹⁹² Regulation of sober living homes cannot fall into the first or second *Lopez* categories because the operations of sober living homes are often confined within the borders of a single state. Thus, the activity is "intrastate," not interstate.¹⁹³ The first two *Lopez* categories—"channels of interstate commerce" and instrumentalities, "persons, or things in interstate commerce"—

¹⁸⁷ *United States v. Darby*, 312 U.S. 100, 114 (1941) ("It is no objection to the assertion of the power to regulate interstate commerce that its exercise is attended by the same incidents which attend the exercise of the police power of the states.").

¹⁸⁸ KENNETH R. THOMAS, *THE POWER TO REGULATE COMMERCE: LIMITS ON CONGRESSIONAL POWER* 1–2 (2014). Over 700 federal statutory provisions directly refer to "interstate" or "foreign" commerce in regulating a wide range of issues, from civil rights to child pornography. *Id.*

¹⁸⁹ *Lopez*, 514 U.S. at 556–57 (quoting *Maryland v. Wirtz*, 392 U.S. 183, 196 (1968), *overruled on other grounds* by *Nat'l League of Cities v. Usery*, 426 U.S. 833 (1976)).

¹⁹⁰ *Id.* at 558.

¹⁹¹ *Id.* at 558–59 (citing *Darby*, 312 U.S. at 113; *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 256 (1964); *Houston, E. & W. Tex. Ry. Co. v. United States*, 234 U.S. 342 (1914); *S. Ry. Co. v. United States*, 222 U.S. 20, 32 (1911); *Perez v. United States*, 402 U.S. 146, 150 (1971); *NLRB v. Jones & Laughlin Steel*, 301 U.S. 1, 37 (1937); *Wirtz*, 392 U.S. at 196 n.27). The first two categories do not apply to this Comment's argument. Briefly explained, "channels of interstate commerce" consist of the actual interstate channels of transportation commodities travel through, such as roads and railways. *See Lopez*, 514 U.S. at 559. Regulations that protect instrumentalities, persons, and things in interstate commerce are those that attend to safety and accessibility of modes of interstate transportation. Thomas, *supra* note 188, at 8 (citing *Preseault v. United States*, 494 U.S. 1 (1990)).

¹⁹² *Lopez*, 514 U.S. at 558–59.

¹⁹³ *See, e.g., Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 530, 537 (1985) (describing a transit system operating within a state's borders as "engaged in intrastate commercial activity").

necessarily require that a regulated activity is interstate in character, involving commerce between multiple states.¹⁹⁴

B. Congress Can Regulate the Sober Living Industry Under the Commerce Clause Because the Operation of Sober Living Homes Constitutes an Economic Activity that Has a Substantial Effect on Interstate Commerce

Operation of a sober living home constitutes an activity that may be regulated under the third *Lopez* category for two main reasons. First, operation of a sober living home is part of a “class of activities” that have a substantial effect on interstate commerce, as demonstrated in *Wickard v. Filburn*, *Heart of Atlanta Motel v. United States*, *Perez v. United States*, and *Gonzales v. Raich*.¹⁹⁵ Second, the more scrutable analysis of the limits on Congress’s commerce power to regulate intrastate activities established in *Lopez* and *United States v. Morrison* does not apply to the regulation of the sober living industry because operation of a sober living home is an economic activity.¹⁹⁶ The development of the Court’s Commerce Clause jurisprudence, explicated below, illustrates the requirements for when Congress may constitutionally regulate an intrastate activity in the third *Lopez* category.

I. Wickard v. Filburn and the Aggregation Theory

The Court in *Wickard* established the initial test for whether an intrastate activity substantially affects interstate commerce: an activity’s effect on commerce is measured by the aggregated effect of *all instances* of the activity, not the individual effect of a particular instance before a court.¹⁹⁷ For example, if a plaintiff who operates one vending machine was before a court, the court would consider the combined effect of *all* vending machines in *all* states in measuring the impact of operating a vending machine on interstate commerce.

¹⁹⁴ *Lopez*, 514 U.S. at 558 (citing *Darby*, 312 U.S. at 113; *Heart of Atlanta*, 379 U.S. at 256; *Houston*, 234 U.S. 342; *S. Ry. Co.*, 222 U.S. at 32; *Perez*, 402 U.S. at 150).

¹⁹⁵ See *Gonzales v. Raich*, 545 U.S. 1, 17 (2005) (holding “[o]ur case law firmly establishes Congress’ power to regulate purely local activities that are part of an economic ‘class of activities’ that have a substantial effect on interstate commerce”); *Wickard v. Filburn*, 317 U.S. 111 (1942); *Heart of Atlanta*, 379 U.S. 241; *Perez*, 402 U.S. 146.

¹⁹⁶ *Lopez*, 514 U.S. at 558–59; see *United States v. Morrison*, 529 U.S. 598, 610 (2000) (clarifying that the characterization of an activity as economic vs. non-economic was “central” to *Lopez*’s holding in striking down a statute regulating non-economic activity).

¹⁹⁷ See *Wickard*, 317 U.S. at 127–28 (holding that although an individual instance of an activity may have a trivial impact on interstate commerce, it falls under federal regulations when its impact is “taken together with that of many others similarly situated”); Thomas, *supra* note 188, at 9–10 (explaining the rationale of combining the effects of all individual instances to find a substantial impact on interstate commerce is now recognized as “aggregation theory”).

In *Wickard*, a wheat farmer challenged the constitutionality of a federal statute that allowed the Secretary of Agriculture to limit the amount of wheat individual farmers could grow in a year.¹⁹⁸ Congress enacted the statute to control the volume of wheat “moving in interstate . . . commerce in order to avoid surpluses and shortages.”¹⁹⁹

The farmer argued that because his wheat production was for personal consumption and strictly local sale, his activities did not exert the requisite “substantial” effect on interstate commerce, and therefore Congress’s commerce power did not apply.²⁰⁰ The Court rejected this argument, finding that while the impact of farmer’s own contribution on the nationwide wheat demand “may be trivial by itself,” his crop nonetheless fell within federal regulation because, when “taken together with [the contributions] of many [other wheat farmers] similarly situated” to the individual farmer, the activity’s impact was “far from trivial.”²⁰¹ The Court therefore upheld the statute as a constitutional exercise of congressional commerce powers.²⁰²

2. *Post-Wickard Jurisprudence*

Post-*Wickard* decisions afforded Congress considerable deference in regulating intrastate activities deemed to affect interstate commerce.²⁰³ As long as Congress both (1) possesses a rational basis for concluding an activity substantially affects interstate commerce and (2) selects a reasonable means for eliminating the activity’s negative effects, a law is a constitutional exercise of Congress’s commerce powers.²⁰⁴ Whether Congress possesses a rational basis is determined by a review of the challenged law’s legislative history.²⁰⁵ Congress retains considerable discretion in selecting its means for eliminating the negative activity and whether Congress could have chosen other reasonable methods is irrelevant to judicial scrutiny.²⁰⁶

¹⁹⁸ *Wickard*, 317 U.S. at 115–17, 119 (discussing the Agricultural Adjustment Act of 1938, 52 Stat. 31, codified as amended at 7 U.S.C.A. § 1281 *et seq.*).

¹⁹⁹ *Id.* at 115 (first citing 26 U.S.C. § 331, then citing 7 U.S.C. § 1331).

²⁰⁰ *Id.* at 119.

²⁰¹ *Id.* at 127–28.

²⁰² *Id.* at 128–29.

²⁰³ Thomas, *supra* note 188, at 10 (first citing *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964); then citing *Perez v. United States*, 402 U.S. 146 (1971)).

²⁰⁴ See, e.g., *Heart of Atlanta*, 379 U.S. at 258–59 (explaining “[t]he only questions are: (1) whether Congress had a rational basis for finding that racial discrimination by motels affected commerce, and (2) if it had such a basis, whether the means it selected to eliminate that evil are reasonable and appropriate” in evaluating a statute regulating intrastate activity).

²⁰⁵ See *id.* at 249, 261–62; *Perez*, 402 U.S. at 155–57.

²⁰⁶ *Heart of Atlanta*, 379 U.S. at 261–62.

Two post-*Wickard* decisions—*Heart of Atlanta* and *Perez*—demonstrate specific intrastate activities Congress may regulate under the Commerce Clause. These cases provide analogous support for the constitutionality of federal regulation of sober living homes.

a. Heart of Atlanta: Lodgings for Transient Guests

The Court in *Heart of Atlanta* upheld a federal statute regulating inns and hotels catering to interstate guests as a permissible use of Congress’s power to regulate an intrastate economic activity.²⁰⁷ The plaintiff motel challenged Title II of The Civil Rights Act of 1964, which prohibited any hotel, inn, motel, or other establishment that “provides lodging to transient guests” from practicing discrimination on the basis of race, religion, or national origin.²⁰⁸ The Act stated that any establishment offering lodging for transient guests has a “per se effect” on interstate commerce.²⁰⁹ Other private establishments, such as restaurants, only affect interstate commerce if they actually serve interstate guests or purchase goods from other states.²¹⁰

The motel claimed it was outside the scope of Congress’s power to regulate intrastate activities affecting interstate commerce because its operation was “of a purely local character.”²¹¹ The Court explained that even if the motel truly exclusively serviced local guests, an intrastate activity is one where, generally, “interstate commerce . . . feels the pinch, it does not matter how local the operation [is that] applies the squeeze.”²¹² Motels *in general* affect interstate commerce, and thus whether the individual motel only affected local commerce was irrelevant.²¹³ The Court then proceeded through the remaining third *Lopez* category requirements. First, it held Congress could have rationally concluded intrastate incidents of discrimination by establishments lodging transient guests substantially effected interstate commerce.²¹⁴ Second, the Court deferred to Congress’s judgment in selecting Title II as its means for addressing this activity’s obstruction on interstate commerce.²¹⁵

²⁰⁷ *Id.* at 258, 261–62.

²⁰⁸ *Id.* at 242–44, 247 (citing Pub. L. No. 88–53, §§ 201–207, 78 Stat. 241 (1964) (prior to 1978 amendment)).

²⁰⁹ *Id.* at 247–48 (citing Pub. L. No. 88–53, §§ 201, 78 Stat. 241 (1964) (prior to 1978 amendment)).

²¹⁰ *Id.* (citing Pub. L. No. 88–53, §§ 201, 78 Stat. 241 (1964) (prior to 1978 amendment)).

²¹¹ *Id.* at 258.

²¹² *Id.* (quoting *United States v. Women’s Sportswear Mfg. Ass’n*, 336 U.S. 460, 464 (1949)).

²¹³ *See id.* (quoting *Women’s Sportswear Mfg. Ass’n*, 336 U.S. at 464).

²¹⁴ *Id.* at 258.

²¹⁵ *Id.* at 261–62.

b. *Perez: Classes of Evil Activities*

In *Perez*, the Court held that provisions of a federal statute regulating intrastate incidences of “loan sharking” constituted “a permissible exercise” of Congress’s Commerce Clause powers.²¹⁶ Loan sharks are individuals who employ threats, violence, or other criminal means to extort repayment of a credit extension.²¹⁷ The loan shark provision raised constitutional and federalism concerns because it “occup[ied] the field of general criminal law,” which states traditionally regulate under their police powers.²¹⁸ The only way the statute would not violate the Tenth Amendment was if it satisfied the test of the third *Lopez* category.²¹⁹

The Court applied its holding from *Heart of Atlanta*, dubbing this standard “the class of activities test.”²²⁰ Under this test, Congress could have rationally determined that purely intrastate instances of loan sharking belonged to a class of activities that, as a whole, substantially effects interstate commerce.²²¹ The second requirement that Congress select a reasonable means raised an additional problem: the law would likely regulate many legitimate credit loan providers in addition to the extortionate loan sharks it was meant to target.²²² The Court dismissed this concern, finding that “when it is necessary in order to prevent an evil[,]” a law may regulate areas which “embrace more than the precise” evil it intends to target.²²³ In other words, Congress is permitted to regulate more than the specific, undesirable activity affecting interstate commerce if it is not logistically possible to only regulate the targeted harmful activity.

3. *Lopez and Morrison: Limits on When Congress May Regulate Intrastate Non-Economic Activity*

The expansive post-*Wickard* conception of the Commerce Clause power persisted until 1995, when the Court in *Lopez* struck down a federal statute on the sole grounds that it exceeded congressional commerce powers for the first time in nearly six decades.²²⁴ *Lopez* and *Morrison* are regarded as splitting

²¹⁶ *Perez v. United States*, 402 U.S. 146, 146–47, 150 (1971) (citing Consumer Credit Protection Act, Pub. L. 90–321, § 202(a), 82 Stat. 160 (1968)).

²¹⁷ *Id.* at 147 (citing 18 U.S.C. § 891 (Supp. V 1964)).

²¹⁸ *Id.* at 149 (citing 114 CONG. REC. 1610 (1968) (statement of Rep. Robert Eckhardt)).

²¹⁹ *See id.* at 152.

²²⁰ *Id.* at 153 (internal quotation marks omitted) (citing *Heart of Atlanta*, 379 U.S. 241).

²²¹ *Id.* at 154–55.

²²² *Id.*

²²³ *Id.* at 154 (quoting *Westfall v. United States*, 274 U.S. 256, 259 (1927)).

²²⁴ *United States v. Lopez*, 514 U.S. 549, 552 (1995); Thomas, *supra* note 188, at 6 (citing Herman

judicial review of a federal statute regulating in the third *Lopez* category into two paths of analysis: one path for economic activities and a separate path of heightened scrutiny for non-economic activities.²²⁵ If the activity regulated by a statute is non-economic, then (1) a court may not aggregate the effects of all instances of the activity in measuring whether it substantially affects interstate commerce; and (2) Congress is afforded less deference in evaluating whether it could have rationally concluded the activity substantially affects interstate commerce.²²⁶ The regulated activity must exhibit a conspicuous connection to interstate commerce for a court to find Congress's conclusion was rational.²²⁷

Lopez struck down a statutory provision that made it a felony “for any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone.”²²⁸ The Court contrasted the firearm provision with several statutory provisions regulating intrastate activities that had been upheld in prior cases, specifically citing its holdings in *Wickard*, *Heart of Atlanta*, and *Perez*.²²⁹ The last two cases presented a clear pattern: where an economic activity is determined by Congress to “substantially affect[] interstate commerce, legislation regulating that activity will be sustained.”²³⁰ In contrast, the firearm possession statute in *Lopez* regulated an activity that “by its terms” intrinsically had nothing to do with commerce or any kind of economic operation.²³¹ Therefore, analysis of whether Congress could have rationally concluded that the possession of a firearm in school zones substantially affects interstate commerce (1) required greater scrutiny, and (2) its effect on interstate commerce could not be measured by an aggregation of all its instances.²³² The Court found that the government's arguments for a connection between intrastate firearm possession and interstate commerce were too attenuated to fall within Congress's commerce powers and struck down the statute.²³³

Schwartz, *Court Tries to Patrol a Political Line*, LEGAL TIMES 25 (May 8, 1995)) (stating prior to *Lopez*, the Court had not struck down a statute solely due to finding it exceeded the Commerce Clause since 1937).

²²⁵ See *United States v. Morrison*, 529 U.S. 598, 610–11 (2000) (distinguishing the more complicated analysis of a statute regulating non-economic activity from a statute regulating economic activity).

²²⁶ Mark A. Corroero, *The Lopez/Morrison Limitation on the Commerce Clause—Fact or Fabrication?*, 14 NAT'L ITALIAN AM. BAR ASS'N L.J. 17, 18 (2006).

²²⁷ *Id.*

²²⁸ *Lopez*, 514 U.S. at 551–52 (citing and quoting 18 U.S.C. § 922(q)(1)(A) (Supp. V 1998)).

²²⁹ *Id.* at 551, 559–61 (citing *Perez v. United States*, 402 U.S. 146, 150 (1971); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 256 (1964); *Wickard v. Filburn*, 317 U.S. 111, 128 (1942)).

²³⁰ *Id.* at 551, 560 (first citing *Perez*, 402 U.S. at 150; then citing *Heart of Atlanta*, 379 U.S. at 256).

²³¹ *Id.* at 561 (citing 18 U.S.C. § 922(q)(1)(A) (Supp. V 1998)).

²³² *Id.* at 561–64.

²³³ *Id.* at 567–68.

The extent to which the Court intended *Lopez* to influence its Commerce Clause doctrine in future cases remained unclear until five years later, when the Court reaffirmed *Lopez*'s holding in its *Morrison* decision.²³⁴ There, Chief Justice Rehnquist made clear that *Lopez*'s holding carried to all future Commerce Clause analyses where an activity regulated in the third *Lopez* category was non-economic.²³⁵ Rehnquist emphasized that this distinction between economic and non-economic activity was central to the *Lopez* decision and plays a crucial role in any Commerce Clause analysis.²³⁶

Uncertainties regarding whether *Morrison* and *Lopez* signaled greater judicial restriction on the scope of Congress's power to regulate *economic* intrastate activities were put to rest in the Court's 2005 *Gonzales v. Raich* decision.²³⁷ There, the Court applied the "class of activities test" to uphold a federal statutory provision that regulated intrastate production and manufacturing of marijuana, including marijuana grown for personal use.²³⁸ An individual and local instance of intrastate marijuana production belonged to an economic "class of activities" that, when aggregated in all instances, substantially affected interstate commerce.²³⁹ The Court clarified that the limitations established in *Lopez* do not apply to economic activities, noting that "[u]nlike those at issue in *Lopez* . . . , the activities regulated" by the marijuana provision were "quintessentially economic."²⁴⁰

The Court further emphasized the disparity between analyses of economic and non-economic activities, "stress[ing] that the task before [it] is a modest one" when assessing the scope of Congress's authority to regulate economic activity.²⁴¹ The Court reiterated that its determination did not concern whether the aggregate of an economic activity "substantially affects interstate commerce *in fact*, but only whether a 'rational basis' exists" for Congress to have reached this conclusion.²⁴² Moreover, in meeting this deferential standard of review,

²³⁴ United States v. Morrison, 529 U.S. 598 (2000); David M. Crowell, *Gonzales v. Raich and the Development of Commerce Clause Jurisprudence: Is the Necessary and Proper Clause the Perfect Drug*, 38 RUTGERS L.J. 251, 273–76 (2006). The *Morrison* Court struck down a statutory provision that created a federal civil rights remedy for victims of gender-motivated violence as an unconstitutional exercise of congressional commerce powers. *Morrison*, 529 U.S. at 601–02 (citing 42 U.S.C.A. § 13981).

²³⁵ *Morrison*, 529 U.S. at 602 (citing United States v. Lopez, 514 U.S. 549, 551–60 (1995)).

²³⁶ *Id.* at 610–12 (citing *Lopez*, 514 U.S. at 551).

²³⁷ *Gonzales v. Raich*, 545 U.S. 1 (2006); see Crowell, *supra* note 234, at 283.

²³⁸ *Raich*, 545 U.S. at 7–9 (citing 21 U.S.C.A. § 801).

²³⁹ *Id.* at 17, 19–20 (quoting *Perez v. United States*, 402 U.S. 146, 151 (1971)).

²⁴⁰ *Id.* at 25 (first referencing *Lopez*, 514 U.S. 549; then citing *Morrison*, 529 U.S. 598).

²⁴¹ *Id.* at 22.

²⁴² *Id.* (emphasis added) (quoting *Lopez*, 514 U.S. at 557) (citing *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276–80 (1981); *Perez*, 402 U.S. at 155–56; *Katzenbach v. McClung*, 379 U.S.

Congress is not required to procure any particularized findings to conclude an economic activity sufficiently affects interstate commerce and is never expected “to legislate with scientific exactitude.”²⁴³

4. *Federal Regulation of Sober Living Homes Satisfies the Supreme Court’s Requirements for Regulating Intrastate Activity Under Congress’s Commerce Clause Powers*

Sober living homes may be regulated in the third *Lopez* category because (1) they constitute an economic, as opposed to a non-economic, activity; (2) Congress can rationally conclude that operating a sober living home belongs to a class of activities that, when aggregated in all instances, substantially affects interstate commerce;²⁴⁴ and (3) although a law setting minimum standards and accreditation requirements would regulate legitimate sober living homes in addition to those run by bad players, it nevertheless constitutes a reasonable method for eliminating the negative effects of the sober living industry on interstate commerce.²⁴⁵

a. *Operation of a Sober Living Home Is Not Limited by Lopez and Morrison Because It Is an Economic Activity*

As confirmed by the Court in *Raich*, limitations on Congress’s power to regulate intrastate activities under *Lopez* do not apply to economic activities.²⁴⁶ The operation of a sober living home clearly constitutes an activity of an economic nature. The Court in *Lopez* distinguished the firearm provision statute from the statutes in *Heart of Atlanta* and *Perez* because possessing a firearm “by its terms” did not intrinsically involve any economic or commercial enterprise.²⁴⁷ Unlike the activity in *Lopez*, the operation of a sober living home plainly involves economic enterprise because sober living homes provide a service to residents for a monetary fee, whether paid privately or through a resident’s insurance coverage.²⁴⁸ Moreover, a federal law regulating sober living

294, 299–301 (1964); *Heart of Atlanta Motel, Inc. v. United States* 379 U.S. 241, 251–53 (1964)).

²⁴³ *Id.* at 17, 21 (first citing *Lopez*, 514 U.S. at 562; then citing *Perez*, 402 U.S. at 156). The Court did state that Congress might need to present particularized findings when a regulation implicates a special constitutional concern, such as interference with the right to free speech. *Id.* (citing *Turner Broad. Sys., Inc. v. FCC*, 512 U.S. 622, 664–68 (1994) (plurality opinion)).

²⁴⁴ *Perez*, 402 U.S. at 153–55 (citing *Heart of Atlanta*, 379 U.S. 241).

²⁴⁵ *Heart of Atlanta*, 379 U.S. at 258–59 (requiring the means Congress selects to eliminate the negative effects of an activity be reasonable).

²⁴⁶ *Raich*, 545 U.S. at 25.

²⁴⁷ *Lopez*, 514 U.S. at 561 (citing 18 U.S.C. § 922(q)(1)(A) (Supp. V 1998)).

²⁴⁸ Close, *supra* note 40 (citing Douglas Polcin et al., *Sober Living Houses for Alcohol and Drug*

homes would be similar to the statute in *Heart of Atlanta*.²⁴⁹ The statute there regulated “any inn, hotel, motel, or other establishment which provides lodging to transient guests.”²⁵⁰ Similar to the former establishments, providing individuals with temporary lodging is arguably the most basic characteristic shared by all sober living homes, including facilities run by bad players.²⁵¹

Because sober living homes constitute an economic activity, the next step in this analysis turns on whether Congress could rationally determine that the operation of a sober living home substantially affects interstate commerce. As shown below, Congress can rationally make this determination.

b. Congress Can Satisfy a Rational Basis Review of the Conclusion that Operating a Sober Living Home Belongs to a Class of Activities that, When Aggregated in All Instances, Substantially Affects Interstate Commerce

A court should find Congress could have rationally concluded that the operation of sober living homes substantially affects interstate commerce. A court’s analysis turns on whether a rational basis *could have existed* for Congress’s conclusion, not on whether a rational basis exists in fact.²⁵² Furthermore, Congress may aggregate the combined effects of all sober living homes in the nation in measuring their effect on interstate commerce.²⁵³ Lastly, Congress is not required to make findings of a connection between sober living homes and interstate commerce with exactitude to reach this conclusion.²⁵⁴

As an initial matter, even without aggregating the combined effects of all sober living homes on interstate commerce, the industry in general possesses an interstate character. Sober living home residents frequently travel to out-of-state

Dependence: 18-Month Outcomes, supra note 30).

²⁴⁹ *Heart of Atlanta*, 379 U.S. at 247 (referencing Pub. L. No. 88–53, §§ 201–207, 78 Stat. 241 (1964) (prior to 1978 amendment)).

²⁵⁰ *Id.* (quoting Pub. L. No. 88–53, § 201(b)(1), 78 Stat. 241 (1964) (prior to 1978 amendment)).

²⁵¹ See, e.g., NAT’L INST. DRUG ABUSE, *supra* note 12 (defining recovery housing as “short-term housing for patients, often following other types of inpatient or residential treatment”); NARR, *supra* note 10, at 5; *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.) (explaining that bad player sober living homes profit from the fees residents pay to stay in their facilities, regardless of whether they provide any recovery supporting services).

²⁵² *Gonzales v. Raich*, 545 U.S. 1, 22 (2006) (emphasis added) (quoting *United States v. Lopez*, 514 U.S. 549, 557 (1995)) (citing *Hodel v. Va. Surface Mining & Reclamation Ass’n*, 452 U.S. 264, 276–80 (1981); *Perez v. United States*, 402 U.S. 146, 155–56 (1971); *Katzenbach v. McClung*, 379 U.S. 249, 299–301 (1964); *Heart of Atlanta*, 379 U.S. at 251–53).

²⁵³ See *id.* at 17–20 (reiterating Congress may aggregate effects of all instances of an economic activity).

²⁵⁴ *Id.* at 17.

facilities.²⁵⁵ While in some instances this is directly due to patient brokers luring residents to other states, SUD treatment as a whole is a markedly mobile industry.²⁵⁶ The exodus of bad players to new states, discussed in Part III, further demonstrates the interstate nature of the sober living industry.²⁵⁷ Bad players who once operated sober living homes in states that have cracked down on industry fraud are now moving their operations across state lines.²⁵⁸

Still, these general characterizations of the industry as one that brings in customers from other states, standing alone, could fail to provide a rational basis for the law proposed by this Comment because there are no black and white statistics to support these characterizations. To date, there has never been a “systematic inventory of [sober living homes] in the United States,” a shortcoming that ironically is considered a result of the industry’s lack of government oversight.²⁵⁹ Because the number of sober living homes in the United States remains unknown, there is no way to verify the perceived frequency of individuals crossing state-lines to live in them.²⁶⁰ Although Supreme Court precedent does not require Congress to present particularized findings in order to satisfy a rational basis review, this objection should be noted.²⁶¹

However, Congress could nevertheless rationally conclude that the operation of a sober living home affects interstate commerce by aggregating the effects of all its instances. Like the motel that claimed it operated on a solely local basis in *Heart of Atlanta*, an individual sober living home, even if it exclusively services local customers, nonetheless belongs to a class of activities where “interstate commerce . . . feels the pinch.”²⁶² As previously noted, SUD costs the national economy an estimated average of \$520.5 billion each year.²⁶³ The impact of poor

²⁵⁵ Copeland, *supra* note 45, at 1505–06; *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.).

²⁵⁶ Copeland, *supra* note 45, at 1505–06; *Patient Brokering Hearing*, *supra* note 64 (statement of Gregg Harper, Rep. Mass.).

²⁵⁷ See *supra* Part III.A.2.

²⁵⁸ Saavedra, *supra* note 121 (interviewing Dave Aronberg); see *What is the Florida Shuffle?*, *supra* note 52 (expressing concern that success of Florida’s Sober Homes Task Force is sending bad players to other states); Vestal, *supra* note 140.

²⁵⁹ NARR, *supra* note 10, at 9.

²⁶⁰ See *id.*

²⁶¹ *Gonzales v. Raich*, 545 U.S. 1, 21 (2006) (first citing *United States v. Lopez*, 514 U.S. 549, 562 (1995); then citing *Perez v. United States*, 402 U.S. 146, 156 (1971)).

²⁶² *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 258 (1964) (quoting *United States v. Women’s Sportswear Mfg. Ass’n*, 336 U.S. 460, 464 (1949)).

²⁶³ NAT’L INST. DRUG ABUSE, COSTS OF SUBSTANCE ABUSE *supra* note 7 (estimating annual cost of alcohol and drug abuse in relation to costs of healthcare, lost work productivity, and crime).

quality and fraudulent sober living homes exerts far more pressure than a pinch on this figure. Rather, the industry's issues serve as a key contributor to the SUD treatment gap, one of the federal government's largest barriers in its battle against SUD.²⁶⁴ Moreover, analysis of the MQSA below demonstrates Congress has regulated local instances of intrastate economic activity under its commerce powers, under remarkably similar circumstances, in the past.²⁶⁵

c. Enacting Minimum Accreditation Requirements for Operation of a Sober Living Constitutes a Reasonable Means for Congress to Address the Negative Impacts of the Sober Living Industry on Interstate Commerce

The final requirement for a federal law to prove constitutional under the third *Lopez* category is that it constitutes a reasonable means for addressing an activity's negative impact on interstate commerce.²⁶⁶ Federal legislation setting minimum accreditation requirements for operating a sober living home would unquestionably meet this final prong.

Congress would be afforded substantial discretion in choosing its method for removing the industry's obstructions on commerce because operating a sober living home constitutes an economic activity.²⁶⁷ Moreover, whether Congress could have selected other reasonable methods for addressing the sober living industry's issues would not factor into this portion of the Court's analysis.²⁶⁸ As noted by the Court in *Lopez*, legislation regulating an economic activity will virtually always be upheld as reasonable.²⁶⁹ The minimum accreditation requirements chosen by Congress to address the negative impacts of mammography centers in the MQSA, discussed below, demonstrate that the similar means proposed by this Comment would be found reasonable in the context of the sober living industry.²⁷⁰

A possible challenge to the reasonableness of the legislation proposed by this Comment is refuted by examination of the *Perez* opinion.²⁷¹ One could

²⁶⁴ Carroll, *supra* note 8; OFF. NAT'L DRUG CONTROL POL'Y, *supra* note 9, at 12; *see supra* Introduction for discussion of the treatment gap.

²⁶⁵ 42 U.S.C.A. § 263(B); *see infra* Part IV.C.

²⁶⁶ *Heart of Atlanta*, 379 U.S. at 258–59.

²⁶⁷ *See id.* at 261–62 (“How obstructions in commerce may be removed—what means are to be employed—is within the sound and exclusive discretion of the Congress.”).

²⁶⁸ *Id.* at 261.

²⁶⁹ *United States v. Lopez*, 514 U.S. 549, 560 (1995).

²⁷⁰ 42 U.S.C.A. § 263(B); *see infra* Part IV.C.

²⁷¹ *Perez v. United States*, 402 U.S. 146 (1971).

object that a law requiring the accreditation of all sober living homes would necessarily regulate all legitimate sober living homes, in addition to those run by bad players. As exemplified by the loan sharking statute in *Perez*, reasonable methods may sometimes necessitate regulations that “embrace more than the precise” evil a regulation was created to target to effectively address a problem in interstate commerce.²⁷²

C. The Mammography Quality Standards Act: Use of the Commerce Clause Power to Regulate Ancillary Health Care Services

Although use of Commerce Clause authority to regulate in the health care sector is unusual, the legislation proposed by this Comment would not be the first time Congress has used this authority to regulate intrastate health care activities. Enacted pursuant to Congress’s commerce powers in 1992, the MQSA requires all mammography centers in the nation to meet minimum quality standards and obtain accreditation from an approved accrediting body to operate.²⁷³ Similarities between the need for the MQSA’s enactment and the need for federal intervention in sober living industry further evidence that the MQSA provides strong precedent for the legislation this Comment proposes.

The circumstances that led to the MQSA’s passage arose in the 1980s amidst an effort by public and private health organizations to increase the utilization of mammography screenings for early detection and prevention of breast cancer.²⁷⁴ Free-standing mammography screening centers rapidly proliferated across the country with little oversight as demand for mammography screenings increased.²⁷⁵ Much like the recent public response to issues in the sober living industry, concerns regarding the quality and legitimacy of mammography screening practice in the United States garnered the attentions of media outlets and professional radiology organizations.²⁷⁶ Problems of poor quality screening

²⁷² *Id.* at 154–55 (quoting *Westfall v. United States*, 274 U.S. 256, 259 (1927)).

²⁷³ Mammography Quality Standards Act of 1992, Pub. L. No. 102–539, 106 Stat. 3574 (1992) (codified at 42 U.S.C.A. § 263b); Harvey & Pandharipande, *supra* note 114, at 392 (citing 42 U.S.C.A. § 263b); Brian Monnich, *Bringing Order to Cybermedicine: Applying the Corporate Practice of Medicine Doctrine to Tame the Wild Wild Web*, 42 B.C. L. REV. 455, 483 n.254 (2001) (citing 42 U.S.C.A. § 263b); see S. REP. NO. 102–448, at 12 (1992) (asserting power to regulate interstate commerce as MQSA’s constitutional authority).

²⁷⁴ S. REP. NO. 102–448, at 3–4; Florence Houn, Kathleen A. Franke, Charles A. Finder, & Roger L. Burkhart, *The Mammography Quality Standards Act of 1992: History and Process*, 50 FOOD & DRUG L.J. 485, 486 (1995).

²⁷⁵ S. REP. NO. 102–448, at 5.

²⁷⁶ Houn et. al, *supra* note 274, at 486 (citing *Chicagoland*, CHI. TRIB., May 7, 1990, at 7; *A Cancer Unseen: Misdiagnosed and Dying, Victim Warned Other Women*, BOS. GLOBE, Feb. 7, 1993, (Metro. Region) at 1; B. J. Conway, O. H. Suleiman, F. G. Rueter, R. G. Antonsen, & R. J. Slayton, *National Survey of Mammographic Facilities in 1985, 1988, and 1992*, 191 RADIOLOGY 323 (1994); B.M. Galkin, S. A. Feig, & H.

equipment, substandard screening procedure, false negative results, and fraudulent representations of professional certification by providers spread throughout the industry.²⁷⁷

One decade later, Congress determined that comprehensive, national legislation was needed to replace the then “patchwork of federal, state and private voluntary standards for mammography quality assurance.”²⁷⁸ The first major effort to remedy issues in the mammography industry came from the nonprofit American College of Radiology (ACR).²⁷⁹ The ACR created a voluntary mammography accreditation program and disseminated resources that promoted standards for quality assurance.²⁸⁰ Much like how NARR has been limited in its ability to promote best practices and voluntary accreditation in the sober living industry, ACR was unable to provide sufficient oversight on its own.²⁸¹ The poor quality and fraudulent facilities causing the mammography industry’s problems were those least likely to voluntarily seek accreditation, and ACR had no authority to close substandard or illegitimate facilities.²⁸²

Prior to utilizing its Commerce Clause authority to enact the MQSA, federal regulation was limited to a fraction of mammography centers receiving Medicare funds.²⁸³ Although some state governments attempted to fill in the gaps, only approximately 20% of states had adopted comprehensive legislation to prohibit operation of poor quality mammography facilities prior to the passage of the MQSA.²⁸⁴ Currently, only 12% of states have adopted legislation that comprehensively regulates the operation of sober living homes.²⁸⁵ Federal

D. Muir, *The Technical Quality of Mammography in Centers Participating in a Regional Breast Cancer Awareness Program*, 8 RADIOGRAPHICS 133 (1988); L. Fintor, M. H. Alciati, R. Fischer, *Legislative and Regulatory Mandates for Mammography Quality Assurance*, 18 J. PUB. HEALTH POL’Y 81 (1995); R. Edward Hendrick, *Quality Assurance in Mammography: Accreditation, Legislation, and Compliance with Quality Assurance Standards*, 30 RADIOLOGIC CLINICS N. AM. 243 (1992).

²⁷⁷ S. REP. NO. 102–448, at 5–6; Houn et. al, *supra* note 274, at 486 (citing *Chicagoland*, CHI. TRIB., May 7, 1990, at 7; *A Cancer Unseen: Misdiagnosed and Dying, Victim Warned Other Women*, BOS. GLOBE, at 1; Conway et al., *supra* note 276).

²⁷⁸ H. R. REP. NO. 102–889, at 14 (1992).

²⁷⁹ *What is ACR?*, RADIOLOGICAL SOC’Y OF N. AM., <https://www.radiologyinfo.org/en/info.cfm?pg=about-acr#:~:text=The%20American%20College%20of%20Radiology,medical%20physicists%20and%20radiation%20oncologists> (last updated Jan. 6, 2020).

²⁸⁰ Houn et. al, *supra* note 274, at 486.

²⁸¹ *Id.* Although 2,500 sober living homes are NARR accredited, this represents only a portion of the mostly unaccounted for number of sober living homes in the United States. NARR, *About Us*, <https://narronline.org/about-us/> (last visited Sept. 2, 2020); NARR, *supra* note 10, at 9.

²⁸² S. REP. NO. 102–448, at 13 (1992).

²⁸³ H. R. REP. NO. 102–889, at 14, 17.

²⁸⁴ *Id.* at 14–15.

²⁸⁵ Six states have laws requiring licensure, accreditation, or other certification for operating a sober living home. Martin et al., *supra* note 18, at 5–6.

Medicare oversight in the sober living industry is also severely limited because sober living homes seldom take government or private insurance.²⁸⁶

The patchwork system of voluntary, state, and federal regulation that necessitated meaningful federal intervention in the mammography industry is the same system that is failing the sober living industry today. The MQSA demonstrates that while employing commerce powers to regulate in the health care sector is unconventional, the issues plaguing the sober living industry necessitate an unconventional solution.

V. PRACTICAL RECOMMENDATIONS FOR FEDERAL LEGISLATION

This Part provides recommendations for how a piece of federal legislation setting minimum standards and accreditation requirements for operation of a sober living home could be structured and implemented. The MQSA and the regulations that administer it supply a helpful blueprint for the legislation proposed by this Comment.²⁸⁷

In general, federal legislation should establish clear, uniform standards of quality and transparency that a sober living home must comply with to operate. Such standards should provide SUD patients a mechanism for evaluating quality and transparency that is reliable even when a patient is considering an out-of-state facility. Additionally, these standards should specifically address and prohibit the overutilization of drug testing and patient brokering.

Federal legislation must ensure non-government stakeholders have a hand in developing these standards. The expertise of outside stakeholders is needed to facilitate the sort of informed, substantive, and specific operating policies and procedures that SAMHSA's current sober living home guidelines lack.²⁸⁸ One way that legislation could ensure stakeholder collaboration is by mandating creation of a formal stakeholder advisory committee. The MQSA took this measure in creating the National Mammography Quality Assurance Advisory Committee, a group of outside stakeholders that advises HHS in developing

²⁸⁶ Close, *supra* note 40 (citing Douglas Polcin et al., *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes*, *supra* note 30).

²⁸⁷ Under the MQSA, a mammography facility must be both accredited by a Food and Drug Administration (FDA) approved accrediting body and pass inspection by FDA or FDA-approved inspectors. 42 U.S.C.A. § 263b(d)(1); Requirements for Certification, 21 C.F.R. § 900.11 (2018). HHS delegated administration of the MQSA to the FDA. *See* 21 C.F.R. ch. I, sub. ch. I, pt. 900 (assigning MQSA duties to FDA). A facility must comply with federal quality standards for procedure, equipment, and personnel to pass inspection. 42 U.S.C.A. § 263b(d)(1).

²⁸⁸ *See supra* discussion in Part II.A.

quality mammography standards and approving accrediting bodies.²⁸⁹ While the SUPPORT Act gave HHS discretion to consult outside stakeholders “when appropriate” in developing sober living home guidelines, creating a formal mechanism for collaboration *guarantees* stakeholder expertise is heard.²⁹⁰ Stakeholders such as NARR, NCBH, and the Association for Addiction Professionals have made clear they are willing to collaborate in federal endeavors.²⁹¹ Stakeholders possess an arsenal of comprehensive quality standards and policies for deterring unethical drug testing and patient brokering, which they are more than ready to bring to the table.²⁹²

Regarding accreditation, NARR is a clear example of an entity that could serve as an approved accrediting body. The ACR, which played a role similar to NARR as a leading voluntary accreditation provider prior to the MQSA, is now one of three FDA-approved MQSA accrediting bodies.²⁹³ However, the legislation proposed by this Comment could also allow for state health departments to apply for approval as accrediting bodies. Under the MQSA, a state can serve as an accrediting body for mammography facilities in its borders if it enacts and enforces “laws that are at least as stringent as the” MQSA.²⁹⁴ Allowing states a similar opportunity to accredit their sober living homes could help alleviate any lingering federalism-based opposition to federal intervention. Lastly, the legislation proposed by this Comment should make clear that states

²⁸⁹ 42 U.S.C.A. § 263b(n).

²⁹⁰ National Recovery Housing Best Practices, 42 U.S.C.A. § 290ee-5(a)(2).

²⁹¹ See ASSOC. ADDICTION PRO., *supra* note 159, (urging “Congress to work with NAADAC and other stakeholders in the addiction workforce to support national credentials”); Memorandum from Linda Rosenberg, President & CEO of the Nat’l Council Behav. Health to the Honorable Elinore McCance-Katz, Assistant Secretary for Mental Health and Substance Abuse, Proposed Recovery Housing Guidelines (Apr. 12, 2019), https://www.thenationalcouncil.org/wp-content/uploads/2019/04/National-Council_Recovery-Housing-Proposed-Guidelines_Overall-Comments_4.12.2019.pdf?dof=375ateTbd56 (recommending SAMHSA utilize its and NARR’s resources for developing sober living home guidelines).

²⁹² See, e.g., NAT’L COUNCIL BEHAV. HEALTH, BUILDING RECOVERY: STATE POLICY GUIDE FOR SUPPORTING RECOVERY HOUSING, *supra* note 14 (providing detailed sober living home quality standards in collaboration with NARR); NARR, ETHICAL POLICIES REGARDING DRUG TESTING (2018), <https://narronline.org/wp-content/uploads/2019/03/NARR-Drug-Testing-Policy.pdf>; NARR, ETHICAL POLICIES REGARDING INDUCEMENTS (2018), <https://narronline.org/wp-content/uploads/2019/03/NARR-Ethics-Policy-Statement-2018-Inducements.pdf> (providing policies for addressing patient brokering).

²⁹³ FDA, *MQSA: Accreditation Bodies*, <https://www.fda.gov/radiation-emitting-products/facility-certification-and-inspection-mqsa/mqsa-accreditation-bodies> (last visited Jan. 28, 2021); see *infra* Part IV.C (comparing ACR and NARR).

²⁹⁴ Suzanne V. Cocca, *Who’s Monitoring the Quality of Mammograms? The Mammography Quality Standards Act of 1992 Could Finally Provide the Answer*, 19 AM. J.L. & MED. 313, 343 (1993); 42 U.S.C.A. § 263b(q). Currently, divisions of the Arkansas and Texas health departments are approved MQSA accrediting parties. FDA, *supra* note 292.

are free to regulate their sober living industries more stringently than federal regulations if they wish.

CONCLUSION

The relationship between the law and SUD has made incredible strides in keeping with the shift in the public's understanding of SUD as a stigmatized social problem to a treatable medical disorder.²⁹⁵ Yet, the sober living industry persists as a life-threatening regulatory blind spot. The federal government must expand its legislative approach to the SUD epidemic by undertaking innovative measures to regulate aspects of SUD treatment. If the federal government wants to close the 18.2 million person-wide treatment gap, then it must enact meaningful regulation of the sober living industry, where the poor quality, clinically inappropriate, fraudulent SUD services widening the treatment gap are most prominent.²⁹⁶

There is no time to wait for the states to take action. An estimated 501 individuals die from SUD each day in the U.S., yet in 88% of states, bad players remain free to profit off this life and death crisis.²⁹⁷ States that have taken action are actively calling upon the federal government to take the reins.²⁹⁸ Although Tenth Amendment concerns pose obstacles to federal intervention, these obstacles can be, and should be, overcome. The federal government must get creative and utilize its Commerce Clause powers to enact meaningful intervention in the sober living industry.

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²⁹⁵ Sean M. Robinson & Bryan Adinoff, *The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations*, 6 BEHAV. SCI. (SPECIAL ISSUE) 18, 29 (2016).

²⁹⁶ OFF. NAT'L DRUG CONTROL POL'Y, *supra* note 9, at 12.

²⁹⁷ This average is based on the combination of recorded drug overdoses in 2019 and yearly average of deaths attributable to alcoholism. CTR. DISEASE CONTROL & PREVENTION, *supra* note 2 (estimating 95,200 Americans fatally overdosed in 2020); NAT'L CTR. DRUG ABUSE STAT., *supra* note 3 (reporting an average of 88,000 deaths per year is attributable to alcoholism); Martin et al., *supra* note 18, at 5–6 (showing that in forty-four out of fifty states, anyone can legally open a sober living home without any inspection or regulation).

²⁹⁸ See, e.g., *What is the Florida Shuffle?*, *supra* note 52 (declaring “[l]ocal and state law enforcement cannot solve this problem alone. This is a national crisis that deserves a federal response. Together, we can and will convince the federal government to [intervene]”).

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