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**PAINFULLY PRESCRIBED: COULD TAKING OPIOIDS AS LEGAL
TREATMENT RESULT IN DISCRIMINATION UNCOVERED BY
THE ADA?**

ABSTRACT

Amended in 2008, the Americans with Disabilities Act (ADA), with its sole mission to protect individuals with disabilities, is still gaping with holes in coverage due to recent court interpretations. One such interpretation is the lack of protection for patients being treated with legally prescribed medications. With widespread misconceptions about opioid use and its effects, employers take adverse action upon their employees seeking necessary treatment. This paper will discuss the harmful consequences of courts narrowly interpreting the ADA against coverage of these patients, as well as the potential revitalization of the ADA's mission in pending actions.

I. INTRODUCTION

Cindy, a mother of three from the Midwest, struggled with lower back pain for years after developing arthritis. Cindy tried relieving the pain through physical therapy, Tylenol, muscle relaxants, and Aspirin. However, the sharp, stabbing pain continues to keep her awake at night, prevents her from taking her usual walks with her husband, and makes watching her son's basketball games difficult. After conducting a risk assessment on Cindy, Dr. Edmondson, Cindy's physician, prescribes Cindy hydrocodone, a short-acting, non-Schedule II opioid with a 1 Morphine Equivalent Conversion Factor/mg of Opioid (MME), to be taken for the next twelve weeks with biweekly check-ups. Though Cindy sometimes feels nauseated, dizzy, and drowsy after taking the medication, she is no longer in severe, stabbing pain. About a month into her treatment period, Cindy, who has been a tax accountant for twenty-three years, is drug tested by her employer. When Cindy tests positive for hydrocodone, her employer, who read about the opioid epidemic online, terminates Cindy, saying he will not tolerate someone disrupting his drug-free workplace environment. With employment at-will and lack of statutory protection, Cindy has no legal recourse for her termination.

The Americans with Disabilities Act (ADA), amended in 2008, sought to protect disabled Americans, including individuals struggling with substantially limiting impairments, having a history of such impairments, or being regarded as impaired.¹ Nevertheless, while the amendment was intended to cover a greater number of disabled individuals, court interpretations continue to leave a gap in coverage protection. Though courts have definitively ruled on ADA coverage of past addiction as a disability, they have not included the use of drugs, nor their effects, for legally prescribed treatment in the statutory definition of "disability." Thus, discrimination while using legally prescribed drugs is still possible under the Act.²

With the growing awareness of opioid abuse and its effects on physical and mental capabilities, courts have developed clear interpretations that dependence and past addiction are covered by the Americans with Disabilities Act Amendments Act (ADAAA).³ Yet, when opioids are used as legally prescribed, despite the increased knowledge of their positive treatment results, courts have been unclear in their interpretations of the ADAAA regarding short-term, legal

1. Americans with Disabilities Act of 1990, 42 U.S.C. § 12102(2) (2006) (amended 2008).

2. U.S. DEP'T OF JUST., *Questions and Answers: The Americans with Disabilities Act and Hiring Police Officers*, ADA.GOV (March 2017), <http://www.ada.gov/copsq7a.htm>. See, e.g., *Bates v. Dura Auto. Sys., Inc.*, 650 F. Supp. 2d 754, 759, 761, 767–69, 772 (M.D. Tenn. 2009); *Ferrari v. Ford Motor Co.*, 96 F. Supp. 3d 668, 675 (E.D. Mich. 2015).

3. *Is Addiction Considered A Disability By ADA?*, KM&A, <https://lawkm.com/addiction-disability-by-ada/> (last visited July 21, 2019).

opioid use.⁴ Particularly, courts have traditionally said such use is not covered under the ADA and, based on recent holdings, could find they are not covered under the now broader amendments to the ADA as well.⁵ This misapplication of the ADA's purposes could lead to a gap in coverage, where individuals with serious pain and legally prescribed opioids to handle such pain could be terminated from their jobs after a drug test or medical consultation. Whereas, if these individuals failed to undergo their prescribed treatments and continued to struggle with chronic pain, or if the treatment developed into an addiction, they would be covered. To incentivize patients to follow prescribed treatments and preclude their potential termination or other adverse action for doing so, courts should find legally prescribed opioid use, even absent dependence or addiction, is a disability under the ADA based on the established side effects and generalized misperceptions of use.

This paper will first focus on legally prescribed opioid use (as opposed to abuse, dependence, or addiction), its negative and beneficial consequences, and the opioid addiction epidemic's impact on misperceptions, even regarding legally prescribed use. Section III will discuss how coverage has been interpreted under the ADA and how the statute's amendments have broadened coverage. The following section will analyze how courts have been wrongly interpreting coverage even after the ADA was adopted. Section IV will also suggest a remedy for these interpretations to align with congressional intent of broader coverage in a case recently filed by the Equal Employment Opportunity Commission (EEOC). The paper will conclude with a discussion on the potential consequences of lack of coverage under the ADA for employees seeking pain relief or addiction-ending treatment.

II. THE INCREASING AWARENESS AND MISPERCEPTIONS OF OPIOID USE

Opioids are “a class of drugs naturally found in the opium poppy plant” and are typically used as medicine to relieve “moderate to severe pain.”⁶ Common prescription opioids include: hydrocodone, like Vicodin; oxycodone, like Oxycontin or Percocet; oxymorphone, like Opana; morphine; codeine; and fentanyl.⁷ With an estimated 116 million Americans struggling with chronic pain, such as migraines, neck pain, or knee pain, and the \$560 to \$630 billion annual cost of these chronic aches, pain relievers, including opioids, have proven useful for the past five thousand years.⁸

4. See, e.g., *Bates*, 650 F. Supp. 2d at 759, 761, 767–69, 771–72; *Ferrari*, 96 F. Supp. 3d at 675.

5. *Bates*, 650 F. Supp. 2d at 767–69, 771–72; *Ferrari*, 96 F. Supp. 3d at 675–76.

6. NAT'L INST. ON DRUG ABUSE, *Prescription Opioids*, DRUGABUSE.GOV 1 (June 2019), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-prescriptionopioids.pdf>.

7. *Id.*

8. Corey S. Davis & Derek H. Carr, *The Law and Policy of Opioids for Pain Management, Addiction Treatment, and Overdose Reversal*, 14 IND. HEALTH L. REV. 1, 2–3 (2017).

Today, patients in the United States use opioids for treatment of acute postoperative pain, surgery-related chronic pain, severe cancer pain, pain in individuals with HIV or AIDS, and opioid addiction itself.⁹ Although there was a nineteen percent reduction “in annual prescribing rate from 2006 to 2017,” the prescribing rate in 2017 was still high—fifty-eight percent.¹⁰ To gauge the commonality of prescription opioids, consider that, in 2012, providers wrote 259 million prescriptions for opioids, which was enough for each individual American adult to have a bottle of opioid pills.¹¹ As a result, by 2015, a third of Americans had opioid prescriptions, and now, one in every ten employees is generally under some dosage of opioids at work.¹² Prescriptions are more common in smaller communities with more uninsured or unemployed individuals and patients with diabetes, arthritis, or disabilities.¹³

Generally, when prescribed by a doctor for short-term use, prescription opioids are safe.¹⁴ The Centers for Disease Control and Prevention recommends such treatment in combination with nonpharmacologic therapy when the expected benefits would likely outweigh the risks to the patient.¹⁵ Assessing the risk includes reviewing the history of the patient to assess likelihood that the patient would abuse the drug.¹⁶ While long-term use can be safe if effectively monitored in some conditions, such as refractory severe nociception or neuropathic pain, long-term use is only appropriate for a rare number of cases and will not be the focus of this Comment.¹⁷ Given the established benefits of short-term opioid use, opioids as a secondary short-term treatment for relieving pain may be embraced as long as this treatment is monitored and accurately

9. *Id.* at 5.

10. *Prescription Opioid Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/prescribing.html> (last updated Dec. 19, 2018) (defining MME as “a way to calculate the total amount of opioids, accounting for differences in opioid drug type and strength”). See also *Calculating Total Daily Dose of Opioids for Safer Dosage*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf (last visited July 20, 2019) (considering twenty to fifty MME per day as “relatively low dosages”).

11. Dawn J. Lanouette, *Opioid Addiction Enters the Workplace*, ABA (Mar. 14, 2018), <https://www.americanbar.org/groups/litigation/committees/woman-advocate/articles/2018/opiate-addiction-workplace/>.

12. *Id.*; Jack Benton, “*Opioid Addiction at Work is a Major Challenge for Employers*,” EHS SAFETY NEWS AMERICA (Aug. 1, 2017), <https://ehssafetynewsamerica.com/2017/08/01/opioid-addiction-at-work-is-a-major-challenge-for-employers-opioid-addiction-safety/>.

13. *Prescription Opioid Data*, *supra* note 10.

14. NAT’L INST. ON DRUG ABUSE, *supra* note 6, at 1.

15. Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*, MORBIDITY & MORTALITY WKLY. REP., Mar. 18, 2016, at 1, 17.

16. *Id.* at 18, 25.

17. See generally Jerome Schofferman, *Long-Term Use of Opioid Analgesics for the Treatment of Chronic Pain of Nonmalignant Origin*, 8 J. PAIN & SYMPTOM MGMT. 279 (1993).

assessed.¹⁸ For this reason, best prescribing practices are that the use of opioids should be temporary or episodic with periodic reviews.

Just as with other drugs, prescription opioids may have side effects. Some opioid side effects include: “drowsiness, confusion, nausea, constipation, euphoria, [and] slowed breathing.”¹⁹ One source found “[a]s many as 80% of patients taking opioids experience at least one side effect.”²⁰ The most common side effects of opioids as treatment are “gastrointestinal, like constipation, nausea, and vomiting.”²¹ Opioids, however, also impact the central nervous system through impaired concentration and memory problems, as well as causing dry mouth and loss of appetite.²² While most side effects tend to fade away with time, “[l]ong-term opioid use can lead to respiratory depression.”²³ With this slowed breathing, hypoxia may develop from lack of oxygen in the brain, possibly leading to “coma, permanent brain damage, or death.”²⁴

While these side effects affect patients differently based on the prescription, some studies have shown that opioid treatment can have severe impacts on bodily functions. One of the most prevalent side effects, constipation, is experienced by forty to forty-five percent of patients, sometimes becoming so severe that patients have to be hospitalized.²⁵ In addition, seventy-five percent of patients who have been taking opioids for six months or more have sleep apnea.²⁶

Side effects of opioids are compounded when opioids are misused, such as taking the medicine longer or in a higher dosage than prescribed, taking another’s prescription, or taking opioids solely for the high effect.²⁷ Misuse can cause dependence or addiction, which are distinct in scientific terminology.²⁸ When an individual repeatedly uses a drug, causing his or her neurons to function normally only if the drug is consumed, that individual develops a drug dependence, whereas “[d]rug addiction is a chronic disease characterized by compulsive, or uncontrollable, drug seeking and use despite harmful consequences and long-lasting changes in the brain.”²⁹ Though addiction and

18. Dowell et al., *supra* note 15, at 8.

19. NAT’L INST. ON DRUG ABUSE, *supra* note 6, at 2.

20. Allie Lemco Toren, *Weighing the Benefits and Side Effects of Opioids*, HEALTHGRADES (last reviewed Feb. 3, 2018), <https://healthguides.healthgrades.com/treating-opioid-induced-constipation/weighing-the-benefits-and-side-effects-of-opioids>.

21. *Id.*

22. *Id.*

23. *Id.*

24. NAT’L INST. ON DRUG ABUSE, *supra* note 6, at 2.

25. AnGee Baldini et al., *A Review of Potential Adverse Effects of Long-Term Opioid Therapy: A Practitioner’s Guide*, 14 PRIMARY CARE COMPANION CNS DISORDERS (June 14, 2012).

26. *Id.*

27. NAT’L INST. ON DRUG ABUSE, *supra* note 6, at 1.

28. *See id.* at 3–4.

29. *Id.* at 3.

dependence are not the focus of this Comment, misconceptions about those behaviors are sometimes wrongly conflated with legal prescription drug treatment.³⁰

With the growing awareness of opioid misuse in the United States, the United States Department of Justice recognizes the pattern of abuse and fatalities as an “epidemic.”³¹ In fact, the United States “consumes more than 80% of the world’s opioids,” but only makes up for less than five percent of the world’s population.³² In 2017, the United States saw approximately 11.4 million people over twelve years old misuse opioids, which included approximately 7.3 percent of people between eighteen and twenty-five years old.³³ According to the Substance Abuse and Mental Health Services Administration, prescribed pain relievers, which also included non-opioids in a particular study, were misused by 11.1 million people in 2017. The study’s results provided that hydrocodone products were the most commonly misused drugs.³⁴ Although the “epidemic” is only related to the misuse of opioids, such as addiction or dependence, misconceptions based on the generalized term “opioid epidemic” cause “stigmatization and inappropriate treatment” of those using opioids as legally prescribed.³⁵

While the growing awareness of the opioid epidemic is helpful at addressing addiction as a major public health issue, both employers and courts continue to hold misconceptions about opioid use for legal treatment based on societal stereotyping of opioids as misused substances. In a press release by the EEOC, EEOC Philadelphia District Director Jamie R. Williamson stated,

As the country grapples with an opioid addiction crisis, unfortunately there are many myths and biases about people recovering from drug addiction and the treatments for it. Under the ADA, employers may test for illegal drug use, but medically prescribed suboxone or methadone are not illegal drugs. Rather, they are common and effective treatments for individuals recovering from drug addiction, and many side effects of those treatments must be assessed on an individualized basis.³⁶

30. See Kelly Dineen, *Addressing Prescription Opioid Abuse Concerns in Context: Synchronizing Policy Solutions to Multiple Complex Public Health Problems*, 40 L. & PSYCHOL. REV. 45–46 (2016) (explaining how the broad term “opioid epidemic,” instead of opioid-related overdoses, has caused doctors to discourage positive or value neutral pain treatment because all opioid prescriptions are mistaken as causing addiction).

31. DRUG ENF’T ADMIN., 2015 NATIONAL DRUG THREAT ASSESSMENT SUMMARY iii (2015).

32. Davis & Carr, *supra* note 8, at 5–6.

33. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2017 NATIONAL SURVEY ON DRUG USE AND HEALTH 19 (2018).

34. *Id.* at 18, 20.

35. Dineen, *supra* note 30, at 3–4.

36. Press Release, EEOC, EEOC Sues Appalachian Wood Products, Inc. for Disability Discrimination (Oct. 9, 2018).

Nick Szubiak, the Director for Clinical Excellence in Addictions within the National Council for Behavioral Health, described how society perceives addiction as a “moral failing” or “character defect.”³⁷ Therefore, tying opioid use to addiction initiates the repercussion that society will misperceive those who use opioids, even for legally prescribed treatment, as not “clean” because society conflates all opioid use with addiction.³⁸ One result could be regarding those who take opioids for pain relief, such as after surgery or for diabetes, as having a “moral failing” simply for getting relief and treating them as if they are addicted to the drug, rather than simply experiencing side effects. This societal conflation causes unfair discrimination for those legally taking opioids for medical purposes.

III. THE IMPLEMENTATION OF THE ADA

The ADA, signed into law on July 26, 1990, was passed in order to prohibit discrimination against individuals with disabilities, as well as end surrounding stereotypes and set enforceable standards of care.³⁹ According to Title I of the Act, “[n]o covered entity shall discriminate on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.” This requirement of the Act particularly focuses on terms of employment.⁴⁰ A qualified individual is “an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.”⁴¹ A “disability” means that there is a “physical or mental impairment that substantially limits one or more major life activities,” there is a record of an impairment, or an individual is regarded as having an impairment.⁴²

Under the ADA, coverage for legal prescription drug use has been construed narrowly, not covering employees, even when employees produce evidence of a prescription. For example, in *Bates v. Dura Automotive Systems, Inc.*, seven former employees of a glass window manufacturing company, Dura, challenged a drug testing policy, which prohibited the use of legal prescription drugs, such as Xanax, Lortab, and Oxycodone, “if such use adversely affected safety, company property or job performance.”⁴³ This type of policy was generally acceptable under the ADA in that it reinforced the employer’s ability to remove

37. Nick Szubiak, *Discrimination & the Opioid Crisis* 10 (presentation available at <https://ccsme.org/wp-content/uploads/2017/03/2017-03-01-Discrimination-and-the-Opioid-Crisis.pdf>).

38. *Id.* at 30.

39. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101(b) (2006) (amended 2008).

40. *Id.* § 12112(a).

41. *Id.* § 12111(8).

42. *Id.* § 12102(1).

43. *Bates v. Dura Auto. Systems, Inc.*, 650 F. Supp. 2d 754, 758–59, 761 (M.D. Tenn. 2009).

employees who directly threaten the work environment, as will be discussed later in this section.⁴⁴

If an employee tested positive for one or more of the twelve tested medications, Dura compared the adverse warnings of that drug or drugs with whether there was a listed danger in operating equipment or machinery.⁴⁵ If there was a warning, Dura sent a letter to the employee that he or she would be placed on a thirty-day leave of absence and the employee had to transition to a different drug or stop using the drug.⁴⁶

After seven employees tested positive, they produced letters from their doctors that the drugs would not affect their work performance and refused Dura's request that they take other medications.⁴⁷ Dura did not consider the letters, despite acknowledging that the positive tests were a result of their taking legal, properly prescribed prescription drugs, and the employees, who continued taking the prescribed medication, sued under the ADA after they were terminated.⁴⁸

The trial court applied the original rule under the ADA, rather than the amended version, because the ADA was in place at the time the conduct occurred.⁴⁹ The court found that the employees' conditions did not "qualify [them] as disabled." The court reasoned that the employees did not fall under the first prong of having an impairment, as a result of their underlying physical or mental pains, that substantially limited a major life activity.⁵⁰ The court reasoned that the only potentially impacted major life activity was "working," but this was not actually impacted because the employees were able to work.⁵¹

This is important in the context of legally prescribed drugs specifically because, similar to *Bates*, employers typically discover the use of opioids through drug testing and may respond to positive drug tests by retaliating against employees because they could pose a danger to the workplace environment.⁵² Once an employee tests positive for a drug test and the employer seeks to take actions against the employee, the employee must, under the first prong, show that he or she has an impairment that limits a major life activity.⁵³

44. ADA Amendments Act of 2008, 42 U.S.C. § 12113(b) (2017).

45. *Bates*, 650 F. Supp. 2d at 759–60.

46. *Id.* at 760.

47. *Id.*

48. *Id.* at 760, 763.

49. *Id.* at 767 n.3.

50. *Bates*, 650 F. Supp. 2d at 767.

51. *Id.*

52. NAT'L SAFETY COUNCIL, THE PROACTIVE ROLE EMPLOYERS CAN TAKE: OPIOIDS IN THE WORKPLACE 4 (2019).

53. ADA Amendments Act of 2008, 42 U.S.C. § 12102(1)(A) (2017).

Originally, under the ADA, what constituted a “major life activity” was construed narrowly.⁵⁴ Employees could try to claim the impacted major life activity was working, but this raised the question of whether they were unqualified for their job positions with reasonable accommodation and could therefore be terminated.⁵⁵ Under the narrow interpretation, claiming other major life activities was difficult, and even if those were claimed, the employer could still show the employee was not qualified because he or she could not perform the essential functions of the job.⁵⁶ Employees, like those in *Bates*, may test positive for a drug test even if work is not impaired. After these employees test positive to a drug that has a list of negative side effects, employers may put employees’ qualifications and ability to do the job at issue.

For example, prior to the drug test, employees may not have been impaired in their functioning. Once employees are tested, employers argue that the side effects—the warnings on the drug labels, such as difficulty while operating heavy machinery—impact work safety. If the employee wants to claim a major life activity is affected, he or she must also show he or she is qualified, which the employer has already questioned through the positive drug test and adverse warning label. In *Bates*, one plaintiff stated she was able to clean, shop, cook, and walk, and she never had any safety violations while on prescribed medications.⁵⁷ Therefore, because she was taking the prescribed medication, she was able to do most of her daily activities, but in order to protect herself under the ADA from termination, she argued she was still in pain that affected her work, which was difficult because she was taking the medication in order to avoid being in pain at work. Essentially, she was faced with two options. Her first option was to not follow treatment recommendations and to therefore be protected as having an underlying impairment (chronic pain) that affected her work. Her second option was to take the medication to relieve her pain and to argue that she is still impaired in some fashion, either by the underlying pain or the side effects of the medication. Since work qualifications were put at issue with the drug test and the definition of “major life activities” was narrowly construed by courts, arguing that she was not impaired at work, but rather in another major life activity, would be difficult, and arguing she was impaired at work could conflict with her ability to qualify for the job position.

Precedent under the ADA required a higher standard for “working” as a major life activity, so the plaintiff needed to show he or she could not work in a

54. See *ADAAA Rules Expand Definition of Working as Major Life Activity*, PARKERPOE (Oct. 9, 2009), <https://www.parkerpoe.com/news/2009/10/adaaa-rules-expand-definition-of-working-as-major>.

55. ADA Amendments Act of 2008, 42 U.S.C. § 12113(a)–(b) (2017).

56. *Id.*; see *ADAAA Rules Expand Definition of Working as Major Life Activity*, *supra* note 54.

57. *Bates v. Dura Auto. Sys., Inc.*, 650 F. Supp. 2d 754, 760 (M.D. Tenn. 2009).

class of jobs.⁵⁸ In *Bates*, the plaintiffs “were all able to perform their jobs at the time they were terminated.”⁵⁹ Those plaintiffs were able to show the reason they were on medication, such as for general ailments, diabetes, or asthma, impacted a major life activity. Still, the court did not find the plaintiffs to “qualify as disabled” because the medical conditions needed to be more specific to a class of jobs.⁶⁰ For example, one plaintiff’s asthma did not constitute a disability in working because she could perform other job positions, just not the task of priming.⁶¹

In *Bates*, the plaintiffs also argued under the second prong of ADA coverage that they had “histor[ies] of diagnosed medical impairments, have suffered injuries on the job, or have taken leave under the Family Medical Leave Act.”⁶² The plaintiffs only occasionally missed work for surgeries or accidents, but there was no evidence of “continuing, long-term impairment,” so the court found there was no record of impairment covered under the second prong.⁶³

With a greater understanding on legal opioid treatment, the Centers for Disease Control and Prevention has stated that “[t]he effectiveness of short-term opioid therapy has already been established.”⁶⁴ For example, opioids are useful, as previously mentioned, for short-term treatment of opioid addiction or chronic pain, like the treatment prescribed to the plaintiffs in *Bates*.⁶⁵ By not considering this type of pain as a history of impairment simply because the incidents were “isolated,” rather than “long-term,” the court seems to suggest that the plaintiffs who seek legal, short-term opioid treatment are in a less favorable legal position than if they had not followed the treatment because they may potentially lose their jobs following drug testing. The court seems to suggest that plaintiffs who suffer through addiction or chronic pain are in a better legal position because their job positions would be protected under those circumstances. As will be discussed, post-ADAAA statutory language suggests that legislative intent would prefer a different outcome by suggesting that those with “episodic” pain should be considered disabled and protected under the Act.⁶⁶

In *Bates*, the plaintiffs also failed under the third prong because, though *Dura* regarded the plaintiffs as a safety risk, the ADA required the plaintiffs to be regarded as “disabled” from a class of jobs, which the court found was the not case.⁶⁷ However, the facts seem to suggest that the employer did not consider

58. *See id.* at 767.

59. *Id.*

60. *Id.*

61. *Id.* at 768.

62. *Bates*, 650 F. Supp. 2d at 768.

63. *Id.*

64. Dowell et al., *supra* note 15, at 8.

65. Davis & Carr, *supra* note 8; *Bates*, 650 F. Supp. 2d at 762.

66. ADA Amendments Act of 2008, 42 U.S.C. § 12102(4)(D) (2017).

67. *Bates*, 650 F. Supp. 2d at 768–69.

individual employee records, nor the doctors' notes that the drugs would not impact ability to work, suggesting the employer did, in fact, generalize employee capability purely based his or her use of opioids. Today, the same plaintiffs would be less likely to face the same outcome because the purpose of the ADA is to diminish stereotyping.⁶⁸ Because of the difficulty in meeting the "class of jobs" standard, the ADAAA broadened the scope of the third prong and removed the requirement that it needed to apply to a broad class of jobs.⁶⁹ Additionally, the "regarded as" prong no longer requires that the disability impact a major life activity.⁷⁰ Based on these changes, we would expect plaintiffs to be in a better position to argue for coverage under the ADAAA.

Because of interpretations like *Bates*, where the ADA was construed narrowly and did not provide intended coverage, Congress rejected narrow decisions and EEOC regulations by amending the ADA.⁷¹ The ADAAA was signed into law on September 25, 2008 to expand coverage and promote successful claims under the ADA.⁷² While the ADAAA did not change the definition of disability under the law, it modified the application of the ADA by advising the EEOC to redefine "substantially limits," by expanding the list of "major life activities" to include more activities and bodily functions, by clarifying that episodic impairments could be disabilities, by changing the definition of "regarded as" to not include "major life activity," and by not entitling claims under the "regarded as" prong to reasonable accommodation.⁷³ For the purposes of this Comment, we will focus on the expansion of "major life activities," episodic impairments, and the reclassification of "regarded as."

68. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101(b) (2006) (amended 2008); see *Bates*, 650 F. Supp. 2d at 771–72.

69. See ADA Amendments Act of 2008 § 12102(4)(C).

70. See *id.* § 12102(3)(A).

71. See *id.* § 12101(b); U.S. EQUAL EMP'T OPPORTUNITY COMM'N., NOTICE CONCERNING THE AMERICANS WITH DISABILITIES ACT (ADA) AMENDMENTS ACT OF 2008; *Comparison of the ADA (as Construed by the Courts) and the ADA Amendments Act in the House (H.R. 3195) and as Passed by the Senate (S. 3406)*, DSPSSOLUTIONS 1, 1 http://www.dspssolutions.org/sites/default/files/resources/differencesbetweenadaandadaaa_001.pdf (last visited July 22, 2019).

72. See ADA Amendments Act of 2008 § 12101(b); U.S. EQUAL EMP'T OPPORTUNITY COMM'N., *supra* note 71; *Comparison of the ADA (as Construed by the Courts) and the ADA Amendments Act in the House (H.R. 3195) and as Passed by the Senate (S. 3406)*, *supra* note 71, at 1.

73. See ADA Amendments Act of 2008 § 12102(1–4); U.S. EQUAL EMP'T OPPORTUNITY COMM'N., *supra* note 71; *Comparison of the ADA (as Construed by the Courts) and the ADA Amendments Act in the House (H.R. 3195) and as Passed by the Senate (S. 3406)*, *supra* note 71, at 3.

A. *The ADAAA Changed Testing Points to Expand Disability Coverage*

1. The Expansion of “Major Life Activities”

Under the first prong, the plaintiff must show he or she is substantially impaired in a major life activity.⁷⁴ In the case of legally prescribed opioids, users are likely taking the medication to reduce chronic pain.⁷⁵ This underlying chronic pain could potentially be protected as an impairment under the ADAAA definition of disability. However, by taking prescription opioids, individuals should be improving their health, considering that they are taking the medication for pain relief. Because of this mitigating effect, patients may instead argue that the effect of using opioids in itself is an impairment. As mentioned above, opioids can have serious effects on users, such as drowsiness, nausea, and slowed breathing.⁷⁶ If patients are experiencing side effects that impact a major life activity or the underlying chronic or intermittent pain is substantially limiting in itself, then they should be considered impaired in one or more major life activities for the first or second prongs.

As mentioned above, given the nature of drug testing, employees previously did not have as much flexibility in what they argued as major life activities because the meaning of “major life activity” was construed narrowly and an employer, by drug testing employees, claimed these employees were not qualified.⁷⁷ Employees could argue they were either not substantially impaired in their work, thus not falling under the ADA’s first or second prongs unless arguing a different major life activity, or that they were substantially impaired in work as a major life activity, either based on the underlying condition or the medication’s side effects.

The term “major life activit[y]” was expanded when the ADAAA added a list to further define “major life activities” as “includ[ing], but...not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.”⁷⁸ In addition to this non-exhaustive list, general “major bodily functions,” including immune system, neurological, and circulator functions, could also fall under the new ADAAA definition.

Recall, though, that the ADA, and now the ADAAA, only applies to qualified individuals, who are individuals that can “perform the essential

74. ADA Amendments Act of 2008 § 12102(1)(a).

75. NAT’L INST. ON DRUG ABUSE, *supra* note 6, at 1, 3.

76. *Id.* at 2.

77. See *ADAAA Rules Expand Definition of Working as Major Life Activity*, *supra* note 54.

78. ADA Amendments Act of 2008 § 12102(2); *The ADA Amendments Act of 2008 Frequently Asked Questions*, U.S. DEP’T LABOR, <https://www.dol.gov/ofccp/regs/compliance/faqs/ADAfaqs.htm#content> (last visited Jan. 12, 2019).

functions of the employment position that such individual holds or desires.”⁷⁹ Thus, if employees argue they are substantially impaired by the use of opioids, such as with drowsiness or decreased cognitive ability, they have to show the impairment is affecting a major life activity. Employees have to address whether they are able to perform the essential functions of their jobs or they can do so by reasonable accommodation without being a direct threat. If employers claim employees are not qualified after a positive drug test of an opioid with a safety warning, employees run the risk of not being classified as “qualified individuals” because they cannot perform the essential functions of the job, especially if their job positions are safety-intensive, such as operating heavy machinery, and the drug side effects could impact such tasks.⁸⁰ By conducting drug testing, employers put such side effects of opioids at issue for employees who take prescription opioids for purposes deemed medically necessary.

The likelihood that the same plaintiffs as those in *Bates* could make the same argument today, but be covered under the ADAAA, is higher because the ADA’s amendment was passed in order to expand the definition of “major life activity.”⁸¹ With an expanded definition, plaintiffs could better argue that there were other major life activities impacted rather than just working. Even if employers claim plaintiffs are not qualified to work after a positive drug test, the plaintiffs can argue they are not impacted at work but are impacted in other areas of their lives. With the non-exhaustive list in the ADAAA, the definition of “major life activity” is broadened. The broad definition is less likely to conflict with job qualifications than a narrow definition of major life activities, such as simply working.

The purpose of the ADAAA was to expand protection by broadening the list of “major life activities.” Opioids impact major life activities, such as sleeping, performing tasks, or breathing. Thus, if employees argued they were not impaired at work and there were no safety complaints about the employees’ work like in the *Bates* case, the employees could argue they have impairments outside of work. In such a case, there would be little likelihood of contradicting job qualifications. Under the expanded definition of the ADAAA, plaintiffs would be in a better position to argue impairment of a major life activity outside of work based on the effects experienced from opioid treatment.

79. ADA Amendments Act of 2008 § 12111(8).

80. Matthew S. Effland, *Disability Accommodation Under the ADA*, AMERICAN BAR, https://www.americanbar.org/content/dam/aba/events/labor_law/am/2014/1h_disability_accommodation.pdf (last visited July 22, 2019).

81. ADA Amendments Act of 2008 § 12102(2); *The ADA Amendments Act of 2008 Frequently Asked Questions*, *supra* note 78.

2. The Addition of Episodic Disability Coverage

The ADAAA added any episodic impairment that “substantially limit[s] a major life activity when active” to the definition of disability.⁸² Episodic impairments do not have to be present all the time, but only have to be recurring, such as epilepsy, hypertension, or major depressive disorder.⁸³ Since episodic chronic pain is decidedly covered by the ADAAA, this section focuses on the episodic use of legally prescribed opioids and its episodically experienced side effects.⁸⁴ Because of the nature of prescription medication, employees may not be constantly influenced by the side effects of opioids. To ensure that employees are not under the influence while at work, employers conduct drug tests.⁸⁵

If prescription drugs are used off-site, there may still be side effects if, at the time the employee was tested, the drug is still in his or her system. Whether the employee tests positive depends on the type of testing, the type of opioid, and how the drug was used.⁸⁶ The active ingredients of opioids only remain in blood for a few hours, so instead of blood tests, immunoassay urine tests are used to detect certain drugs days after use.⁸⁷ The immunoassay test, though, cannot distinguish between legal and illegal use of opioids.⁸⁸ In fact, simply eating enough poppy seeds can result in a positive immunoassay result.⁸⁹

Therefore, because the nature of drugs is unique in that they can be detected in blood or urine samples, even if a user is not experiencing any side effects, the user will once again be put in a situation where qualification to work is at issue if the test is positive. This is the case even if the employee’s work has not been claimed as “impaired.” Since the employer’s drug test only measures use, rather than impairment, and mere use can result in a positive drug test, the prescription drug patient may have felt the side effects episodically, though at times of the day other than work. By extending coverage to episodic impairments, the ADAAA should cover the gap that would be felt if periodic effects were not covered.

82. ADA Amendments Act of 2008 § 12102(4)(D).

83. *Questions and Answers on the Final Rule Implementing the ADA Amendments Act of 2008*, U.S. EQUAL EMP. OPPORTUNITY COMM’N, https://www.eeoc.gov/laws/regulations/ada_qa_final_rule.cfm (last visited July 22, 2019).

84. *See Eastman v. Research Pharm., Inc.*, No. 12-2170, 2013 WL 3949236, at *1, 8–9 (E.D. Penn. Aug. 1, 2013).

85. Frieda Paton, *Managing Opioids in the Workplace*, WORKPLACE TESTING (Oct. 30, 2018), <https://www.workplacetesting.com/2/4050/occupational-health-and-safety/managing-opioids-in-the-workplace>.

86. *See Opioids*, 237 HR SERIES POLICIES & PRAC. 11 (Jan. 2019).

87. *Id.*

88. *Id.*

89. *Id.*

3. The New Standards of the “Regarded As” Clause

To fall under the ADAAA protections, an employee only has to fall under one of the three prongs. An employee can avoid having to show that a major life activity was impaired by claiming he or she falls under the third prong, rather than the first or second prongs, of the definition of disability.⁹⁰ If a plaintiff argues that he or she has a claim under the third prong, the plaintiff must show that he or she is regarded as having an impairment.⁹¹ The impairment does not have to impair a major life activity, unlike the other two prongs, thus the third prong may provide a more encouraging route for some employees who claim they are not literally impaired, but rather are perceived as such, while at work.⁹² However, this prong does not apply to impairments that are “transitory and minor.”⁹³ These include impairments “with an actual or expected duration of 6 months or less.”⁹⁴ To show this prong, the employee must show that the employer thought or would expect the impairment to last at least six months. This lowered the previous standard, where plaintiffs had to show that they were regarded as impaired in a major life activity.

B. An Employer’s Defense: How the ADAAA Provides Tools to Employers’ Benefit

Though the ADAAA broadened coverage, the ADA and its amendments still protect employers by limiting certain drug use in the workplace that could impact productivity and safety. Recent studies suggest that costs of opioids are a large factor of employer concern, since opioid abuse costs employers about ten billion dollars annually to lost productivity and absenteeism.⁹⁵ As many as “one-third of prescription painkillers paid for by employer-funded plans are being abused.”⁹⁶ But, disability coverage does not extend to the use of illegal drugs.⁹⁷ “[I]llegal use of drugs” does not include “the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law.”⁹⁸ Also, in the Code of Federal Regulations, this statutory language has been interpreted to mean that legal use of prescribed drugs does not deprive a person of protection

90. ADA Amendments Act of 2008, 42 U.S.C. § 12102(1)(C) (2017).

91. *Id.*

92. *See id.* at § 12102(3)(A).

93. *Id.* at § 12102(3)(B).

94. *Id.*

95. Riia O’Donnell, *As Opioids Hit the Workforce, Employers are Forced to Improvise*, HRDIVE (Aug. 17, 2017), <https://www.hrdiver.com/news/as-opioids-hit-the-workforce-employers-are-forced-to-improvise/449471/>; Benton, *supra* note 12.

96. O’Donnell, *supra* note 95.

97. *See* Americans with Disabilities Act of 1990, 42 U.S.C. § 12111(6)(A) (2006) (amended 2008).

98. *Id.*

under the ADA; yet, the Code does not specify whether such use is protected, just that the use is not excluded.⁹⁹ Thus, the regulation leaves open the possibility that legal prescription drug use could be covered by the ADAAA, but does not specifically cover it, so it can still be excluded if interpreted as such.

High costs of abuse and the lack of statutory protection heighten employer concerns of detecting drug abuse in the workplace, thus increasing the use of drug tests. Employers may still require drug testing to promote a drug-free workforce of prescription medications.¹⁰⁰ Employers conduct drug testing, including those of legally prescribed drugs, in order to address danger of injuries, lost productivity, and potential liability.¹⁰¹ Their argument is that the opioid side effects of “drowsiness, poor memory and confusion, [and] decreased cognitive functioning” can “lead to altered judgement as well as slower movement and reaction time in the workplace.”¹⁰² If the employee tests positive for prescription medications, the employer should ask the employee to provide his or her prescription.¹⁰³

If employees are covered by the ADAAA after the upcoming case, *EEOC v. Appalachian Wood Products, Inc.*, then upon learning an applicant or employee uses opioids, an employer may need to consider its practices and procedures for drug testing, terminations, and transfers. Employers may also have the added cost of drug use as a reasonable accommodation, a policy development that has been hindered by “lack of understanding and adequate support.”¹⁰⁴ Before taking adverse employment action, employers must conduct an individualized assessment of whether the treatment affects job performance with reasonable accommodation.¹⁰⁵ This means that employers cannot have “blanket” policies forbidding any exceptions, like prescription drugs.¹⁰⁶ Without blanket prohibitions, employers have less flexibility and efficiency in adverse employment decisions because the decisions must be specific. Yet, the individualized assessment also ensures that employers do not take “adverse employment action against employees or applicants based on any prejudice,

99. 29 C.F.R. § 1630.3(a)(2) (2018); Tiffanie Benfer et al., *Addiction Under the Americans with Disabilities Act*, AM. B. 1, 11 https://www.americanbar.org/content/dam/aba/events/labor_law/2017/11/conference/papers/Kuczynski-ADDICTION-UNDER-THE-AMERICANS-WITH-DISABILITIES-ACT.authcheckdam.pdf (last visited on Sept. 29, 2018).

100. David L. Johnson, *Managing Issues Posed by Opioids in the Workplace*, TENN. EMP. L. LETTER, 2017, at 3.

101. Paton, *supra* note 85.

102. *Id.*

103. *Id.*

104. Benjamin E. Widener, *Opioid Accommodation: Overview, Case Study and Recommendations*, N.J. L. JOUR. (Aug. 10, 2018), <https://www.law.com/njlwjournal/2018/08/10/opioid-accommodation-overview-case-study-and-recommendations/?slreturn=20190019123417>.

105. *Id.*

106. *Id.*

misperception or lack of information about the employee's lawful use of prescription drugs."¹⁰⁷

Even if an employee can show he or she has a disability and he or she can perform the essential functions of the job, the employer can still discriminate against the employee if the employee poses a "direct threat."¹⁰⁸ This defense allows employers to fire, refuse to hire, demote, etc., employees who present a significant risk of substantial harm to the health or safety of that employee or others, which cannot be eliminated or reduced by a reasonable accommodation.¹⁰⁹ If the opioid treatment is affecting workplace safety, such as in a situation where a patient taking prescription opioids is operating heavy machinery or doing physical labor for his/her job, the employee may be transferred or terminated, and the employer will still be in compliance with the law.¹¹⁰ This allows employers to maintain the same protections they currently have—that if they truly have an issue with the employee in terms of safety, the direct threat defense will protect employer workplace decisions.

Furthermore, the direct threat defense also allows employers to stay aware of safety threats to the workplace, hire employees who can perform their job functions, and still terminate employees who are illegally abusing prescription drugs. To avoid liability, employers can simply have a specialized process for employees who test positive for legally prescribed drugs, have written job descriptions that detail what would be a safety concern and what is essential for the job, and focus on employee performance rather than history of abuse.¹¹¹ Though employers are losing some ability to terminate at-will those employees who are taking legally prescribed opioids, they are in turn gaining employees who, hopefully, are in less chronic pain, recovering from a history of addiction, or benefitting from one of the other short-term effects that could increase productivity through legally prescribed treatment.

With employer protections in place as well, based on the current statutory language, though it may be difficult, employees who are being discriminated against based on their legally prescribed use of opioids can show that major life activities are affected or that there was a sustained perception of being regarded as disabled. As mentioned earlier, Congress passed the amendment to broaden the scope and application of the ADA, so, when faced with this language, courts should construe the "major life activity" and "regarded as" classifications as in line with our understanding of opioid use, treatment and prescribing behavior, and employer misperceptions.

107. *Id.*

108. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12111(3), 12113(a)–(b) (2006).

109. *Id.*

110. *See id.*

111. Widener, *supra* note 104.

IV. CORRECTING THE APPLICATION OF THE ADA AND THE ADAAA IN LEGAL OPIOID PRESCRIPTION USE

Despite the legislative and regulatory intent to broaden statutory coverage for disabled individuals, courts continue to misapply a narrow interpretation that could in a way allow for legal prescription drug use to fall outside of coverage.¹¹² In a recently filed suit, *EEOC v. Appalachian Wood Products, Inc.*, a district court has the opportunity to correctly apply broader coverage for those seeking treatment through legal opioid use.¹¹³

As the potential widespread misapplication of anti-discrimination law looms, the EEOC filed a lawsuit on September 27, 2018 against a cabinet supplier, Appalachian Wood Products, Inc., claiming testing of legally prescribed drugs is a violation of the ADA and the ADAAA.¹¹⁴ According to the complaint, Appalachian Wood Products, Inc. did not hire job applicants when prescription use was disclosed to the employer's contracted medical provider.¹¹⁵ One applicant, Daub, was taking prescribed Suboxone to treat his seven-year opioid addiction following a back injury.¹¹⁶ The use of opioids "interfered with major life activities such as eating, sleeping and interacting with others."¹¹⁷ However, on his job application, Daub responded that he was not taking medication that impaired his cognitive ability or motor function skills because he had not experienced either of those specific impairments as a result of his prescription.¹¹⁸ After Daub disclosed the prescribed treatment to the employer's chiropractor, the employer withdrew its offer of employment.¹¹⁹ The complaint claims, "Defendant refused to hire Daub on the basis of his record of a disability, past drug addiction, drug addiction recovery and related medical treatment, and because he was regarded as disabled"¹²⁰

This is the first case filed in which the plaintiff specifically argued that legal opioid prescription use is a disability under the ADA and the ADAAA through side effects felt outside of work. Based on court interpretations of legal opioid treatment under the ADA and surrounding dicta on the ADA and the ADAAA, however, we should be concerned about how courts may interpret the recent filing. We can use these

112. See Brynn Stylinski, *Narrow Definitions: The Courts' Resistance to the ADA Amendments Act*, UNIV. CIN. L. REV. (May 14, 2015), <https://uclawreview.org/2015/05/14/narrow-definitions-the-courts-resistance-to-the-ada-amendments-act/>.

113. See generally Complaint at 1, *EEOC v. Appalachian Wood Prods., Inc.*, No. 18-00198 (D. Pa. Sept. 27, 2018); Press Release, *supra* note 36.

114. Complaint at 5–6, *supra* note 113; Press Release, *supra* note 36.

115. Complaint at 5, *supra* note 113.

116. *Id.* at 4.

117. *Id.*

118. *Id.*

119. *Id.* at 5.

120. Complaint at 5, *supra* note 113.

concerns to frame arguments for greater protection of those using opioids for legal treatment.

A. An Individual Legally Using Opioids Can Be Considered Actually Disabled

In order to meet the definition of “disabled,” an individual who claims he or she faced adverse action in the workplace based solely on use of legally prescribed opioids may first argue that his or her impairment “substantially limits one or more major life activities.”¹²¹ However, even after the intended expansion of coverage under the ADAAA, district courts in the same jurisdiction as *Bates* and affirmed by the Sixth Circuit continue to misapply the law against individuals legally using prescribed drugs.¹²² In *Ferrari v. Ford Motor Company*, after the plaintiff suffered a neck injury in 2000, he took pain medications and obtained a placement in human resources as a reasonable accommodation.¹²³

After his neck pain improved in late 2012 and wanting a new position without restrictions, the plaintiff sought for his restrictions to be lifted by the company physician, Dr. Brewer.¹²⁴ Dr. Brewer met with the plaintiff’s treating physician, Dr. Kole, regarding the removal of the neck-related physical restrictions and the plaintiff’s use of Valium and morphine documented as of January 7, 2013.¹²⁵ Although the plaintiff was not restricted by the neck pain, the dependence on opioids was determined as a restriction, and Dr. Kole found that the “plaintiff could physically perform the duties in the RMI position description, but would require three months to be weaned off of his pain medications.”¹²⁶ There was conflicting evidence on whether the plaintiff was actually still taking the opioids, but regardless, the plaintiff was not transferred to the desired position.¹²⁷

The plaintiff filed a discrimination suit, claiming his disability was his neck injury under the ADA, which the court misapplied, rather than applying the ADAAA.¹²⁸ Though the court found that the underlying disability, the neck injury, was a disability and covered by the ADA, the court still analyzed whether the plaintiff’s use of opioids was a disability because the use was the “stated basis for defendant’s adverse employment decision.”¹²⁹ As in *Bates*, the court

121. See ADA Amendments Act of 2008, 42 U.S.C. § 12102(1)(A) (2017).

122. See generally *Ferrari v. Ford Motor Co.*, 96 F. Supp. 3d 668, 668, 678–79 (E.D. Mich. 2015).

123. *Id.* at 670–71.

124. *Id.* at 671.

125. *Id.*

126. *Id.*

127. *Ferrari*, 96 F. Supp. 3d at 671–72.

128. *Id.* at 672, 674.

129. *Id.* at 675.

wrongly used the employer's basis for termination, limitations on work because of legally prescribed drugs, rather than the employee's actual claim to analyze the definition of disability. The court reasoned, then, that opioid use "cannot serve as the basis for an actual disability" because it cannot limit a major life activity.¹³⁰ The court cited a case finding that addiction can only be a disability through the second and third prongs, conflating the plaintiff's legal opioid treatment with the rule for "drug-addicted individuals."¹³¹ Given our knowledge of the uses and effects of legal prescription opioid use, this generalized bar on protection is an improper application of the ADAAA.

The conflation of legally prescribed treatment with addiction should not be used to categorically exclude those seeking treatment from the protections of the first prong of the ADAAA. The congressional intent of the ADA's amendment was greater protection. Thus, if a plaintiff can show a major life activity is substantially limited, the plaintiff should be able to show the first prong, even if as a result of legal drug use.¹³² As mentioned earlier, we are becoming increasingly aware of opioid side effects, such as drowsiness, altered eating habits, and behavioral changes, and the way such effects impact various life activities outside of work.¹³³ Therefore, as a matter of public policy, as well as following congressional intent, the courts should broaden the interpretation of "major life activities" to mirror our knowledge of legal opioid use side effects, rather than categorically exclude and conflate legal prescription drug use with addiction.

This expansion could be applied in *EEOC v. Appalachian Wood Products, Inc.* if the plaintiffs avoid claiming that "work" is the impaired major life activity and, instead, argue that the effects of their legal opioid prescription impair other areas of their lives, such as sleeping or eating. In the upcoming EEOC case, the plaintiffs first argue that the class of applicants was discriminated against based on their "actual disabilities."¹³⁴ One of the applicants, Daub, who was legally taking prescribed Suboxone to treat a previous addiction, argued he had a disability from the effects of the prescription that substantially limited major life activities, such as eating, sleeping, and interacting with others.¹³⁵ Based on the expanded definition of "major life activity," which includes eating and sleeping, the court should find these impacts constitute a disability under the first prong.

As mentioned earlier, the employer's drug testing or application questions may put at issue whether the impairments also limit work ability. Therefore, the employee should not be hired because he or she cannot perform the essential

130. *Id.*

131. *Id.*

132. See *The ADA Amendments Act of 2008 Frequently Asked Questions*, *supra* note 78.

133. NAT'L INST. ON DRUG ABUSE, *supra* note 6.

134. Complaint at 1, *supra* note 113.

135. *Id.* at 4.

functions of the job and is therefore not qualified.¹³⁶ However, the plaintiffs do not have to argue work is the impaired major life activity, thus reducing the likelihood that they might be deemed unqualified. Assuming cognitive ability and motor function skills were questioned in the job application because they are essential functions of the job, the court should find the plaintiffs are able to perform the essential functions of the job because, for example, plaintiff Daub answered that he had not experienced “either impaired cognitive ability or impaired motor function skills as a result of his use of Suboxone.”¹³⁷ In answering this way, Daub has already remarked that he is a qualified individual who can perform the essential job functions, while still being able to argue other major life activities are impaired.

B. An Individual Legally Using Opioids May Have a History of an Impairment

Under the second prong of having a record of a disability, plaintiffs must show they were discriminated against because they had a history of an impairment, such as recurring chronic pain or a history of addiction, which substantially limited a major life activity.¹³⁸ In *Ferrari*, the court found the plaintiff did not have a record that the plaintiff’s opioid use constituted an injury in the past.¹³⁹ The court’s conclusory analysis does not take into account the plaintiff’s underlying condition, which was considered a disability under the first prong, nor the length of time the plaintiff had taken opioids. Considering the opioid use was acknowledged as his medical history in his medical record and this is the reason the plaintiff was not transferred, the court should have spent more time considering whether the plaintiff’s medical history of opioid use was the reason for his discrimination.

Although opioids may not traditionally be prescribed long-term due to their addictive side effects,¹⁴⁰ short-term treatment through opioids may be listed on medical records, similar to history of addiction. This listing could be harmful for employment if employees are only protected based on history of addiction, not history of legally prescribed medications. In *EEOC v. Appalachian Wood Products, Inc.*, the plaintiffs argue they were also discriminated against based on history of drug use.¹⁴¹ Indeed, only after the chiropractor told the defendant

136. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101(b) (2006) (amended 2008).

137. Complaint at 4, *supra* note 113.

138. See ADA Amendments Act of 2008, 42 U.S.C. § 12102(1)(B) (2017).

139. *Ferrari v. Ford Motor Co.*, 96 F. Supp. 3d 668, 675 (E.D. Mich. 2015).

140. *But see Information About Medication-Assisted Treatment (MAT)*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm> (last updated Feb. 14, 2019) (explaining how buprenorphine, methadone, and naltrexone, when partnered with psychosocial support, can be safe and effective at treating opioid use disorders and dependency on a continuing basis).

141. Complaint at 4, *supra* note 113.

about Daub's history of Suboxone use was his application revoked.¹⁴² Because addiction itself is protected by the ADAAA, Daub would be in a better legal position under the second prong if he had struggled with a past opioid addiction (which, coincidentally, he did) than if he was legally taking opioids pursuant to a prescription. This is because a history of addiction is protected, while a history of legal prescription drug use is not.

As noted earlier, with the raised awareness of opioid use also comes grave misperceptions that all use will lead to addiction when, in reality, short-term use can have positive results for patients.¹⁴³ If employers discriminate based on medical records, such as in *Ferrari*, plaintiffs will continue to be discriminated against for legally prescribed treatment or may hide important medical information from their record to avoid discrimination. This is a policy issue where plaintiffs would be in a better legal position to abuse the drugs than to take them as prescribed because, if drug use or its effects are written on patients' records in the future, recovery from addiction would be covered while prescribed use would not. If the court finds this is not in violation of the ADAAA, the consequence could hinder an employee's ability to seek treatment or disclose legally prescribed drug use to other doctors, fearing that doing so could lead to discrimination. To encourage free flow of information between doctors and patients and to ensure compliance with legal usage of opioids, the court should protect medical records in terms of drug history, including prescribed treatment.

Taking this into consideration, courts should apply the second prong to protect medical records that include histories of legally prescribed treatments. Additionally, the second prong requires that the plaintiff show an impacted major life activity, thus facing the same problem as under the first prong.¹⁴⁴ To avoid this barrier, the plaintiff may instead have a stronger argument under the third prong.

C. *An Individual Legally Using Opioids May Be Regarded as Disabled*

With the prevalence of employer misperceptions, if a plaintiff cannot meet one of the above prongs because he or she cannot show a substantial limitation of a major life activity, the third prong is likely the strongest argument. Historically, though, plaintiffs have still faced issues under this prong.

Even under *Ferrari*, the court held the plaintiff was not regarded as disabled because the impairment was only transitory.¹⁴⁵ Because the plaintiff could be weaned off the opioids within three to four months, the legal treatment was not protected as a disability.¹⁴⁶ According to Paragraph (3)(B) of Section 12102 of

142. *Id.* at 5.

143. Szubiak, *supra* note 37, at 10.

144. ADA Amendments Act of 2008, 42 U.S.C. § 12102(1)(A)–(B) (2017).

145. *Ferrari v. Ford Motor Co.*, 96 F. Supp. 3d 668, 675 (E.D. Mich. 2015).

146. *Id.*

the Act, the third prong does not apply to “impairments that are transitory and minor,” which means the duration is six months or less.¹⁴⁷ The court did not consider whether the opioid use would be protected as an episodic disability, nor did it explain why the impairments were considered “minor” if they were sufficient to prevent work. The court’s interpretation, in limiting protection to those who use legally prescribed opioids for over six months, might encourage users to prolong use to be regarded as disabled. The decision might also discourage following treatment by not taking prescribed opioids in order to prevent being regarded as a drug user and still not being covered by the ADAAA because the use is transitory.

Under *EEOC v. Appalachian Wood Products, Inc.*, the plaintiffs argue the defendant failed to hire job applicants that were regarded as disabled under the third prong.¹⁴⁸ In fact, the complaint says, “Defendant regarded Daub as having a disability by disqualifying him and denying him hire because of his non-transitory and non-minor impairment, past drug addiction, drug addiction recovery and related medical treatment.”¹⁴⁹ In this way, the plaintiffs are trying to avoid the *Ferrari* reasoning by arguing the past addiction and current legal use are not simply transitory, particularly by arguing the plaintiff abused drugs for years and was using Suboxone, which does not affect just minor impairments, for treatment. By making this argument, the plaintiffs are more in line with our current understanding of legal treatment—that the positive effects of legal treatment are established for short-term use and such use can be incredibly beneficial to diminish long-term pain.

Additionally, as a matter of public policy, courts should interpret drug use as episodic, rather than transitory, to avoid prolonged use for better legal standing and disability protection. Even if the use was under six months, given the misperceptions of opioid treatment, it is possible that the defendant falsely classified the plaintiffs as current recurring illegal drug users and did not, at the time of revoking the offer, regard the plaintiffs as having “transitory” use of legal treatment. Therefore, the court should find that the use was not regarded as transitory.

V. CONCLUSION AND POLICY CONSIDERATIONS

If *EEOC v. Appalachian Wood Products, Inc.* does not find in favor of the plaintiffs, but rather, the court finds for the ability to discriminate based on legal opioid treatment, the effect could deter employees from seeking relieving treatment. These employees may be incentivized to hide such treatment from important resources, such as employer physicians. If patients are deterred from using opioids as treatment because of lack of protection from adverse

147. ADA Amendments Act of 2008 § 12102(3)(B).

148. See Complaint at 3, *supra* note 113.

149. *Id.* at 4.

employment actions, they may instead face chronic pain, addiction, pain from cancer treatment, or many of the health issues legal opioid treatment is prescribed to diminish.

Based on our new understandings of opioid side effects, the potential relief for patients needing short-term use, the danger in incentivizing long-term use, and common misconceptions that could lead to more adverse employment decisions, courts should embrace the ADAAA's more expansive disability definition to cover legal opioid treatment. By doing so, the judicial system would offer protection for medically-prescribed use in a way that would be monitored by physicians. Even though it may add a small upfront cost to employers, expanding the ADA's definition of disability would reduce employee pain and drug abuse while improving work productivity and long-term treatment results.

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