RESOLUTION

RESOLVED, That the American Bar Association urges federal, state, local, territorial and tribal governments and other public entities involved in the current opioid litigation to use proceeds from settlements of the litigation to address the harm resulting from the epidemic directly, by:

(1) expanding treatment services for opioid use disorder,

(2) creating additional transitional and extended housing programs to support those in treatment,

(3) fostering community social service resources and harm-reduction/overdose prevention efforts,

(4) furthering research on treatment and enhancing education and training of healthcare professionals,

(5) educating patients and the public on the use and misuse of opioids,

(6) reducing the stigma associated with having an opioid use disorder, and

(7) improving healthcare infrastructure, especially at the community level, so as to increase the capacity of healthcare professionals to treat patients with opioid use disorder.
INTRODUCTION

The opioid epidemic is likely the greatest public health emergency to face this country in the past hundred years. While the number of deaths attributable to opioid overdoses is smaller than the figure for those lost to tobacco use, the annual number grows ever closer to one hundred thousand and now exceeds the number of Americans lost in the entire Vietnam War. Notwithstanding fatality rates alone, the impact of the epidemic on our nation is, in many respects, greater. This is largely the result of the disastrous effects of opioid addiction on human functioning and social cohesion as well as on health. The costs of the epidemic extend well beyond the expense of treating those enmeshed in the epidemic, to include the impact on the criminal justice and social support systems, not to mention the economic losses associated with millions of people with opioid use disorder, many of whom are not able to function as members of the workforce or as parents. Finally, the damage relating to the destruction of families, as well as individual lives, is incalculable.

It is widely understood that the tobacco litigation of the 1990s produced mixed results in terms of its direct impact on reducing the burden of tobacco-related disease on the public. In many states and other jurisdictions, little, if any, of the money resulting from the settlements, was used to pay the costs of tobacco-related disease or for tobacco-cessation programs. Instead, the money often went into the state’s general fund and was used for such purposes as tax or debt reduction or infrastructure projects. If the harm caused by the epidemic is to be addressed effectively, the proceeds of the opioid litigation must be directed to programs that address the harm created.

SUMMARY OF HARM

The nation’s opioid epidemic affects the public health, social well-being and the economic welfare of all Americans. Overdose and death related to prescription opioids, heroin and illicit fentanyl is having an historic negative impact on our life expectancy, as overdose deaths are now the leading cause of death among people under the age of 50 in the U.S. Overdoses cause more deaths annually than AIDS during the peak of that epidemic—and even more than the Vietnam, Iraq and Afghanistan wars combined. The rise in fatal drug overdoses is almost entirely responsible for the growth in mortality rates for white, non-Hispanic people between the ages of 22 and 56 in recent years. People of all ethnicities have shown an increase in opioid-related deaths.

The federal government reports that on average, drug-related overdoses claim the lives of 130 Americans each day, although not all of those drugs were obtained by prescription. In 2017, there were 70,237 deaths, a dramatic and tragic six-fold increase

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2 https://www.cdc.gov/mmwr/volumes/67/wr/mm6712a1.htm?s_cid=mm6712a1_w
from 16,849 deaths in 1999.³ Over the next 10 years, opioids could kill over a half million more, two-thirds from heroin and one-third from prescription pills.⁴

The human cost—the emotional toll on individuals suffering from opioid use disorder (“OUD”), and that on their families and communities, is substantial. The opioid epidemic has devastated community life, isolating families and residents who are struggling with its effects. Nationwide, at least two million people live with untreated OUD. Of those, about 17 percent, or 340,000, are uninsured.⁵ The misuse of prescription opioids and use of illicit opioids and other drugs may have serious, enduring, and costly consequences, including automobile crashes, sexual violence, child abuse and neglect, suicide attempts and fatalities, strokes, and overdose deaths. Other harms include the rising incidence of neonatal abstinence syndrome due to opioid use and misuse during pregnancy, and the spread of infectious diseases including HIV and hepatitis C.⁶

The costs of the opioid crisis are borne by individuals in the form of lost wages; by the private sector in lost productivity and healthcare costs; and by federal, state and local governments in lost tax revenue and additional spending on healthcare, social services, education and criminal justice. The opioid epidemic costs the U.S. hundreds of billions annually in healthcare, criminal justice and national productivity, with estimates ranging from $504 billion⁷ to $740 billion.⁸

Stigma and the frustration individuals with a substance use disorder experience when trying to obtain care cause additional harm. Stigma, which most typically manifests itself as equating opioid use disorder with a “moral failing” or similar pejorative, provides negative incentive for someone to seek or remain in treatment and is a significant barrier in state policy development. For example, while the medical community relies on medication-assisted treatment (“MAT”) to treat patients with opioid use disorder, MAT is criticized by some as “trading one addiction for another.” This is akin to considering diabetes patients “insulin addicts.”

There is also harm when a patient is ready to seek care and start treatment, but the patient’s health insurer or other payer does not have the resources available for the patient. For example, if a patient experiences an overdose, and says he or she wants to see an addiction medicine or other specialist while in the Emergency Department, it’s very possible the patient’s health insurance network will not have one available. Even though the patient has paid value for an insurance product, the services the patient needs are not available. Also, the patient may lose hope and interest in receiving treatment and

return to using opioids. This scenario would be extremely unlikely for a patient who suffers a heart attack, yet it is the reality all too frequently encountered by patients who experience opioid-related overdoses.

THE TOBACCO LITIGATION

In 1998 the landmark legal settlement between the states and the tobacco industry (the Master Settlement Agreement or MSA) required the tobacco companies to pay $246 billion over 25 years to the states as compensation for tobacco-related healthcare costs, mostly for states to recoup Medicaid losses.9

However, despite these significant successes, concern has been expressed that a far smaller percentage of the MSA payments were used for tobacco-related causes, or healthcare in general, than was anticipated.

While the Attorneys General involved in the MSA strongly suggested, and recitals under the MSA included, that MSA funds be used to address tobacco-related issues, including cessation programs and other health initiatives, the funds were ultimately paid into state treasuries and subject to state legislative appropriations. Funds subjected to legislative processes were designated for many purposes, including non-health related projects such as education, infrastructure and budget deficits.

In an attempt to compel funds to be directed at health-related issues, some state legislatures passed restrictions on “supplantation,” prohibiting MSA funds from replacing existing smoking and healthcare programs. Still other states attempted to use the ballot box by allowing voters to vote on referendums requiring the use of MSA funds for healthcare. Nonetheless, much of the MSA funds has been used for non-health related purposes, leading former Mississippi Attorney General Michael Moore to say that “The tragedy of the tobacco cases is that we had a chance to dramatically improve public health and save lives, but we let that opportunity slip by.”10 The lessons to be learned from the use, or misuse, of the MSA funds can and should be applied to the opioid cases currently being litigated.

OPIOID-RELATED LITIGATION

Our nation’s opioid epidemic has been under way since the early 1990s and has occurred in three waves.11 The first wave started in 1991 when opioid overdose deaths rose sharply due to increased prescribing of opioids for both acute and chronic pain.12

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9 National Public Radio https://www.npr.org/2013/10/13/233449505/15-years-later-where-did-all-the-cigarette-money-go
12 The prescription increase was influenced by a New England Journal of Medicine letter to the editor titled “Addiction Rare in Patients Treated with Narcotics.” However, that “study” was of opioid prescriptions among patients at the authors’ hospital, and had no bearing on outpatient use. Nonetheless, reassurances were given to prescribers by pharmaceutical companies and medical
By 1999, 86% of patients using opioids were using them for non-cancer pain. The second wave began around 2010 with a rapid increase in deaths from heroin abuse resulting from efforts to decrease opioid prescribing, making heroin a cheap, readily available alternative. The third wave manifested in 2013 with an increase in deaths resulting from the increasing use of illicit, synthetic opioids, such as fentanyl. The sharpest rise in drug-related deaths occurred in 2016 with over 20,000 deaths from fentanyl and related drugs.

In recent years there have been numerous local, state and federal governmental actions and measures taken to combat the opioid epidemic, including an ever increasing number of lawsuits to recover monetary damages from those entities deemed to be responsible for manufacturing, marketing, distributing and selling prescription opioids. An early example is the 2007 decision by the U.S. Department of Justice to bring criminal charges against Purdue Pharma for its allegedly misleading advertising of OxyContin, which resulted in the payment of $634.5 million in criminal and civil fines.

More recently, within months after President Trump declared the opioid epidemic a public health emergency in December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated what now amounts to nearly 1,500 opioid-related cases into multidistrict litigation in the U.S. District Court for the Northern District of Ohio. The consolidated suits are against dozens of prescription drug manufacturers for misleading and aggressive marketing and advertising; against distributors for shipping large amounts of opioids to wholesalers and retailers when distribution patterns suggested significant overprescribing and diversion and then failing to report that pattern to the DEA; and against large retailers for “turning a blind eye” to overprescribing and the misuse of opioids by their customers. Representative plaintiffs include states, counties and local governments, Native American tribes, hospitals, third-party payers, and individuals throughout the country. The Justice Department has filed a statement of interest, emphasizing the government’s “substantial costs and significant interest in addressing the opioid epidemic.”

In late 2017, a coalition of 41 states’ attorneys general served major opioid manufacturers, including Endo, Janssen, Teva, Cephalon, Allergan and Purdue Pharma, with investigative subpoenas seeking information about opioid marketing and sales techniques. The coalition is also demanding documents and information from major distributors, including AmerisourceBergen, Cardinal Health and McKesson, tied to
distribution practices. In many cases, the attorneys general have filed lawsuits against these defendants.

In a recent development in March 2019, Purdue Pharma settled with the state of Oklahoma for $270 million in the state’s suit against it for misleading and aggressive marketing of OxyContin that allegedly fueled that state’s opioid epidemic. In the same month, more than 600 cities, counties and Native American tribes from 28 states filed a federal lawsuit in New York against members of the Sackler family, the owners of Purdue Pharma, alleging that the Sacklers created the opioid addiction crisis through their company’s misrepresentations and misleading marketing of OxyContin.

While a budget bill signed by President Trump in early 2018 authorizes $6 billion for two years of opioid prevention programs and law enforcement, experts opine that it would cost between $45 billion to $60 billion over 10 years to remedy the harm resulting from the opioid crisis. A White House report issued in November 2017 said that the overdose epidemic cost the U.S. economy more than $500 billion in 2015. The President’s Commission on Combatting Drug Addiction and the Opioid Crisis issued its final report in the same month, recommending, among other things, the establishment of nationwide drug courts that would place opioid addicts in treatment facilities rather than in prison.

Where will the money come from to help those harmed? How will funding become available for prevention, treatment interventions, transitional housing, education, research and infrastructure? In large part, governments should earmark the revenue derived from opioid-related litigation for these purposes. This Resolution directly addresses that need.

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23 https://thehill.com/policy/healthcare/372759-budget-deal-includes-6-billion-to-fight-opioid-abuse
RECOMMENDATIONS ON HOW THE PROCEEDS FROM THE OPIOID SETTLEMENT SHOULD BE USED

To avoid the misdirection of funds that occurred following the tobacco litigation, where the settlement proceeds frequently went to the states’ general coffers as opposed to being earmarked for smoking prevention, cessation, and harm-reduction efforts, the policy of the ABA should be to encourage federal, state, and local governments and tribal entities to use proceeds obtained from the current and pending opioid lawsuits to address the harm resulting from the opioid epidemic by: (1) expanding treatment services for OUD, (2) creating additional transitional and extended housing programs to support those in treatment and early recovery, (3) fostering community social service resources and harm-reduction/overdose prevention efforts, (4) furthering research on treatment and enhancing education and training of healthcare professionals, (5) educating patients and the public on the use and misuse of opioids, (6) reducing the stigma associated with having OUD, and (7) improving healthcare infrastructure, especially at the community level, so as to increase the capacity of healthcare professionals to treat patients with OUD. Each of these proposals for best utilizing the proceeds obtained through the opioid lawsuits is addressed in more detail below.

A. Expanding Treatment for Opioid Use Disorder

The current system of addiction treatment in the United States pre-dates the major scientific advances that have shown addiction to be a preventable and treatable chronic medical disease. Although there are many good individual treatment providers, they are operating within a fundamentally broken and under resourced system. OUD is a chronic and disabling health condition that requires serious effort and significant funding to address effectively and sufficiently the holistic treatment, prevention and educational efforts required to battle this epidemic, which has destroyed individuals, families and communities.

Addiction is best treated like other chronic illnesses with an emphasis on outpatient care that is tailored to the specific needs of the patient, is proactive in nature, and includes regular clinical monitoring to predict and avert potential relapses. Such an approach requires well-trained professionals who have the skills and ability to provide the evidence-based medications, therapies and social supports necessary to attack this epidemic.

While research has proven MAT to be an effective treatment for opioid use disorders, access to such care is limited due to regulatory restraints. MAT can utilize buprenorphine and buprenorphine/naloxone combinations as primary pharmacotherapies combined with non-pharmacologic therapies, and can be provided conveniently in outpatient office-based practices. Unfortunately, the use of buprenorphine is currently restricted under federal regulations to physicians who must attain national waiver status and pass required training to become eligible prescribers. The national program itself limits the number of active patients that any single physician can treat, thereby further

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limiting the number of potentially eligible individuals who can receive this medication. These restrictions create an access gap between this effective treatment and the much larger number of patients who could benefit from this therapy. Improving the availability of MAT for patients will require not only changes in the law, but also large expenditures to fund the required training in its use.

Community health clinics (“CHCs”) and community mental health centers (“CMHCs”), are front-line treatment centers for many underinsured and uninsured patients with OUD. These centers are typically funded through combinations of county, state, and some federal sources—funding that can be increased by using funds derived through the opioid litigation. As many of these centers are situated directly in the communities where individuals affected with OUD live, they are ideally suited to provide immediate, direct care to individuals.

Governments must channel funding from the opioid settlements to these critically situated centers that deal with affected persons on a direct, face-to-face and day-to-day level. While some academic centers have established research departments and publication track records in substance use disorders, they are not always located in areas where those with OUD live and work. Monies from the settlement must be earmarked specifically to reach the communities that work directly with affected peoples.

B. Creating Additional Transitional and Extended Housing Programs to Support Those in Treatment and Early Recovery

In addition to treatment focused on the addiction itself, those suffering from an OUD will frequently require interventions, including peer and other recovery support services, that address other areas of their lives including:

- housing
- transportation
- mental health treatment
- education, including GED programs
- parenting and family counseling
- job training and employment counseling
- access to affordable medical care
- case-management and relapse-prevention support services

Settlement proceeds should be used to address the items listed above, as they are vital to individuals getting their lives back on track and sustaining success.

C. Fostering Community Social Service Resources and Harm Reduction/Overdose Prevention Efforts

Settlement proceeds can be used to invest in data-driven prevention interventions and strategies. Such monies can be used to identify the most pressing issues and the most “at risk” populations to develop targeted prevention and treatment strategies on group and individual levels. Community social service organizations are notoriously
underfunded and will require significant financial support if they are to respond effectively to the epidemic. Similarly, additional funding to address adolescents with OUDs is needed to prevent the progression of early opiate experimentation into full OUD.

Settlement proceeds can also be used to establish and fund a State Prevention office.29 Such an office should commission a statewide review of school-based prevention to ensure that schools are properly trained, organized and equipped to deliver evidence-based prevention interventions. Prevention should be a significant part of the school curriculum every year of middle and high school and be addressed in multiple courses. Students, even if not personally using opioids, can be educated to identify OUD problems in their homes and schools, and facilitate referral of affected family members to proper treatment.30

D. Furthering Research on Treatment and Enhancing Education and Training of Healthcare Professionals

Settlement dollars can be directed to CHCs and CMHCs that are implementing conventional pharmacologic therapies in combination with newer psychosocial modalities such as Assertive Community Treatment outreach teams, telemedicine, in-home monitoring, and clinical visitation at community-based locations such as adult day-care centers. Abstinence and reduced opiate-use outcomes can be measured when these modalities are combined with established pharmacologic protocols to determine if abstinence rates are further increased in comparison to current treatments alone.

The CHCs and CMHCs provide research settings that are “real-world” in that they treat individuals in the home community context. Environmental and cultural triggers that can precipitate relapses in patients can be better identified and addressed by these centers since they are situated in the patient’s community.31 CHCs and CMHCs have a head start in exploring environmental-trigger research, especially if they already have established case-management services that provide enhanced monitoring of the patients’ behaviors and lifestyles in their own communities.

Research opportunities at the CHCs and CMHCs can also explore other non-opiate pharmacologic treatment protocols. For patients with minimal or no current opiate withdrawal symptoms, naltrexone can be an effective agent when coupled with counseling, cognitive behavioral therapy, and other supportive measures. Studies have shown superiority of the long-acting-injectable (“LAI”) form of naltrexone over daily oral tablets for some substance use disorders including OUDs.32 Moreover, in a community-based research protocol, naltrexone LAI can be further studied in the CMHC setting when administered via home healthcare visits or telemedicine services in the patient’s home or

30 Id.
at the CMHC itself, to determine whether greater abstinence periods can be achieved than with conventional clinic-only visits.

In addition, a state can use opioid settlement proceeds to establish a State Screening and Brief Intervention program to educate, train and incentivize healthcare professionals to understand and use proven methods for identifying risk factors and promoting positive behavioral change, particularly in pediatric and school healthcare settings.

E. Educating Patients and the Public on the Use and Misuse of Opioids

Attempting to get help or accurate information for OUD can be a confusing and overwhelming task for many individuals and families. Accordingly, state and local governments should promote public and professional educational efforts, and opioid settlement funds should be used to create and improve policies and programs that show measurable evidence of greater public awareness and involvement in drug-related issues.

As an example, the Addictions Solutions Campaign has recommended that city and state investments in general public education should focus on:

- Implementing public awareness campaigns focused on parents that highlight proven and effective strategies to help protect their children: An emphasis in these public awareness campaigns should address differences among substance use, misuse and addiction — and how to reduce risk factors and promote protective factors.

- Investing in data-driven policies: States and cities differ dramatically in the nature and amount of drug use and drug risks. Cities should, therefore, partner with colleges and universities to analyze available data to identify the most pressing issues and the most “at risk” populations in order to develop local prevention and treatment strategies.

- Implement evidence-based prevention and early intervention strategies to reduce substance misuse and related harmful behaviors: Addiction is a developmental disorder that frequently begins in adolescence. Research shows that the at-risk years for substance misuse are 12-25 and that over 80% of all addictions begin during this period.  


F. **Reducing the Stigma Associated with Having an OUD**

Stigma and the resulting misperceptions serve to perpetuate bad policies and ineffective solutions. Addiction historically has been conceptualized as a sign of weak character, a personality disorder, or the consequence of a habitual series of bad personal choices. As a result, stigma and lack of education are often the largest barriers to treatment.

G. **Improving Healthcare Infrastructure to Increase the Capacity of Healthcare Professionals to Treat Patients with an OUD**

Settlement proceeds can be used to increase the availability of MAT, which combines psychological/behavioral therapy and FDA-approved medications, including methadone, buprenorphine, naltrexone, is the most effective means of treating OUDs and preventing opioid overdose. Despite its proven effectiveness, fewer than ten percent of patients with opioid addiction receive MAT.

Settlement proceeds can be used for the following purposes:

- Increasing treatment capacity by addressing the shortage of physicians trained to treat addiction and those specializing in addiction medicine and to provide funding to support internships and fellowships in addiction medicine;

- Training physicians, nurse practitioners and other prescribers in the safe prescribing of opioids (e.g., using the lowest effective dosage for the shortest duration for the treatment of acute pain); and

- Providing education and training for clinicians in the usage of non-pharmacologic pain-reducing strategies (such as physical therapy, yoga or meditation) to minimize, or as an alternative to, prescription opioid use in the treatment of both acute and chronic pain.

Opioid settlement funds could be used to promote and incentivize expansion of evidence-based primary care and specialty treatment and clinically functional organizational linkages between healthcare systems and better addiction treatment programs.

**RELATED ABA POLICY**

The ABA has a long history of policies that address the needs of persons seeking to recover from mental health and/or substance abuse disorders:

At the 1972 Midyear Meeting, the House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, a model law drafted by the National Conference of Commissioners on Uniform State Laws, which provides for treatment of
alcoholics and intoxicated persons instead of subjecting such persons to criminal penalties; establishes facilities and machinery for treatment of such persons; and, provides for voluntary commitment to a treatment facility or involuntary commitment by court order. 72M90

At the 1975 Midyear Meeting, the ABA reaffirmed its support for the Uniform Alcoholism and Intoxication Treatment Act, and urged states that had not already done so to utilize the newly available federal funding (P. L. No. 93-282) to implement its provisions. The ABA also generally reaffirmed its support for the principle of decriminalization of alcoholism. 75M116

At the 1994 Midyear Meeting, the House of Delegates approved a policy supporting development of a comprehensive, systemic approach to addressing the needs of criminal defendants with drug and alcohol problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service and education systems and the community and urged the courts to adopt certain treatment-oriented, diversionary drug court programs as one component of a comprehensive approach. The policy urges bar associations to facilitate the development of such programs that result in dismissal of drug-related charges upon the completion of drug rehabilitation. 94M100

At the 1995 Annual Meeting, the House of Delegates endorsed the U. S. Sentencing Commission’s proposal to amend federal sentencing guidelines to eliminate differences in sentences based on drug quantity for offenses involving crack versus powder cocaine, and assign greater weight in drug offense sentencing to other factors that may be involved in the offense, such as weapons used, violence, or injury to another person. 95A129

At the 1995 Annual Meeting, the House of Delegates also approved a policy urging bar associations to join the ABA in developing and encouraging initiatives aimed at preventing inhalant abuse. 95A106

At the 1997 Annual Meeting, the House of Delegates approved a policy supporting the removal of legal barriers to the establishment and operation of approved needle-exchange programs that include drug counseling and drug treatment referrals, in order to further scientifically-based public health objectives to reduce HIV infection and other blood-borne diseases, and in support of the ABA’s long-standing commitment to promoting effective substance abuse prevention and treatment. 97A106B

At the 2004 Annual Meeting, the House of Delegates approved a policy urging federal, state, territorial and local governments to eliminate policies that sanction discrimination against people seeking treatment or recovery from alcohol or other disease, including specific recommendations in the area of public benefits. 04A112

At the 2005 Annual Meeting, the House of Delegates approved a policy urging all state, territorial and local legislative bodies and governmental officials to repeal laws and discontinue practices that permit insurers to deny coverage for alcohol or drug related injuries or losses that otherwise would be covered by accident and sickness insurance
policies covering hospital, medical and surgical expenses. The policy also supports the 2001 Amendment by the National Association of Insurance Commissioners to its model law, the Uniform Accident and Sickness Policy Provision law, permitting coverage for injuries or illness involving alcohol or drugs. 05A105

At the 2006 Annual Meeting, the House of Delegates approved a policy urging all federal, state, territorial and local legislative bodies and governmental agencies to adopt laws and policies that require health and disability insurers who provide coverage for the treatment of both abuse of and dependence on drugs and alcohol to do so in a manner based on the most current scientific protocols and standards of care, so as significantly to enhance the likelihood of successful recovery for each patient. 06A109

At the 2007 Annual Meeting, the House of Delegates affirmed the principle that dependence on alcohol or other drugs is a disease, supported the principle that insurance coverage for the treatment of alcohol and drug disorders should be at parity with that for other diseases, and urged that: (1) all federal, state, territorial, tribal and local legislative bodies and governmental agencies repeal laws and discontinue policies and practices that allow health and disability insurers to provide coverage for the treatment of such disorders that is not at parity with coverage for other diseases; (2) states with mandated benefit laws that do require coverage for treatment of such disorders that is at parity with coverage for other diseases should establish policies and practices that ensure such laws are enforced; and (3) the federal government should require ERISA-regulated health and disability insurers to provide coverage for treatment of such disorders in a manner that is at parity with coverage for other diseases and consistent with state laws, without limiting the scope of their coverage. 07A106A

At the 2009 Annual Meeting, the House of Delegates approved a policy supporting federal legislation that would ensure every American access to quality healthcare regardless of the person’s income, and without regard to the payor system, eliminating the specific payor system characteristics embodied in the recommendations adopted by the House of Delegates in 1990 and 1994. 09A10A

At the 2010 Midyear Meeting, the House of Delegates approved a policy that supports the development of comprehensive, systemic approaches to address the special needs of veterans within civil and criminal court contexts, including but not limited to proceedings involving veterans’ service-related injuries, disorders, mental health and substance abuse needs, through programs that connect veterans to appropriate housing, treatment and services through partnerships with the local Veterans Affairs Medical Centers, community-based services and housing providers. The policy urges state, local, and territorial courts to facilitate the development of Veterans Treatment Courts, including but not limited to, specialized court calendars or the expansion of available resources within existing civil and criminal court models focused on treatment-oriented proceedings. 10M105A
At the 2011 Annual Meeting, the House of Delegates approved a resolution that the American Bar Association urges Congress to amend the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA” or “the Act”), 38 U.S.C. §§ 4301–4335, by adding provisions to require employers to provide certain reasonable accommodations for returning veterans with combat injuries that may not manifest themselves until after a return to work. The policy urges Congress to: (1) amend the USERRA to provide authority for the award of comprehensive attorneys’ fees, costs, and damages to redress violations of the Act; (2) amend the USERRA to make unenforceable any clause of any agreement between an employer and an employee that requires arbitration of a dispute under the Act; and (3) authorize the U.S. Department of Labor to initiate investigation and prosecution of appropriate claims to address patterns and practices of USERRA violations that rise to the level of a nationally compelling interest.

At the 2013 Annual Meeting, the House of Delegates approved a resolution supporting the rights of all Americans, particularly our nation’s veterans, to access adequate mental health and substance use disorder treatment services and coverage, and urges States, in implementing the essential health benefits provisions of the Patient Protection and Affordable Care Act, to provide fully and adequately for mental health and substance use disorder coverage. The resolution also provided that the ABA urge Congress, the federal Departments of Labor, Health and Human Services and the Treasury, and state and territorial legislative, regulatory and administrative bodies, to ensure that, in the implementation of the health insurance parity requirements of the Mental Health Parity and Addiction Equity Act of 2008 and in the essential health benefits provisions of the Patient Protection and Affordable Care Act, a uniform, plain-language disclosure of the terms of coverage and criteria used in making coverage decisions is required across all insurance plans and public benefit plans, to ensure that all individuals are able to make informed, appropriate choices in accessing coverage of mental health and substance use disorder treatment services at parity with other health benefits coverage.

At the 2019 Midyear Meeting, the House of Delegates approved a resolution that the American Bar Association urges federal, state, local, territorial, and tribal courts, governmental entities, bar associations, public health agencies, lawyer assistance programs, lawyer regulatory entities, institutions of legal education, and law firms to implement the recommendations and action points in the report, Experienced Lawyers, American Families, and the Opioid Crisis—Report of the Opioid Summit May 2018.

CONCLUSION

For these reasons, the American Bar Association urge states, counties, tribes and local governments to enact legislation to ensure that any proceeds that they receive from the current opioid litigation be used for remedying the harm resulting from the opioid epidemic.
Respectfully submitted,

Alexandria Hien McCombs
Chair, Health Law Section
August 2019
GENERAL INFORMATION FORM

Submitting entities: Health Law Section
Submitted by: Alexandria McCombs, Chair
Health Law Section

1. **Summary of Recommendation.**

The Resolution urges states, counties, tribes and local governments to enact legislation to ensure that any proceeds that they receive from the current opioid litigation be used for remedying the harm resulting from the opioid epidemic.

2. **Approval by Submitting Entities**

The Council of the Health Law Section approved the filing of this Resolution and Report on May 4, 2019.

3. **Has this or a similar resolution been submitted to the House or Board previously?**

There has not been a similar resolution filed.

4. **What existing Association policies are relevant to this resolution and how would they be affected by its adoption?**

There are no known Association policies directly relevant to this Resolution. The Resolution would encourage governmental entities to commit to using the proceeds of the litigation for the purpose of remedying the harm caused by the epidemic through (1) expanding treatment services for opioid use disorder, (2) creating additional transitional and extended housing programs to support those in treatment, (3) fostering community social service resources and harm-reduction/overdose prevention efforts, (4) furthering research on treatment and enhancing education and training of healthcare professionals, (5) educating patients and the public on the use and misuse of opioids, (6) reducing the stigma associated with having an opioid use disorder, and (7) improving healthcare infrastructure, especially at the community level, so as to increase the capacity of healthcare professionals to treat patients with opioid use disorder.

5. **If this is a late report, what urgency exists which requires action at this meeting of the House?**

N/A

6. **Status of Legislation. (If applicable)**
7. **Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates.**

The sponsoring entities will work with the ABA Governmental Affairs Office to actively engage in federal and state legislative activities related to this issue.

8. **Cost to the Association. (Both direct and indirect costs)**

There are no known costs to the Association.

9. **Disclosure of Interest. (If applicable)**

There are no known conflicts of interest.

10. **Referrals.**

    By copy of this form, the Resolution will be referred to the following entities:

    Section of Administrative Law and Regulatory Practice
    Business Law Section
    Section of Civil Rights and Social Justice
    Section of State and Local Government Law
    Section of Science and Technology Law
    Section of Litigation
    Law Practice Division
    Law Student Division
    Senior Lawyers Division
    Solo, Small Firm and General Practice Division
    Young Lawyers Division
    Commission on Law and Aging
    Commission on Lawyer Assistance Programs
    Commission on Disability Rights
    Commission on Women in the Profession
    Standing Committee on Ethics and Professional Responsibility
    Standing Committee on Lawyers’ Professional Liability
    Standing Committee on Legal Aid and Indigent Defendants
    National Association of Bar Executives
    National Bar Association Inc.
    National Conference of Bar Presidents

11. **Contact Name and Address Information.**

    Alexandria McCombs, Chair
    ABA Health Law Section
    Signify Health
12. **Contact Name and Address Information.** (Who will present the report to the House? Please include name, address, telephone number, cell phone number, and e-mail address.

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EXECUTIVE SUMMARY

1. **Summary of the Resolution.**

The Resolution urges states, counties, tribes and local governments to enact legislation to ensure that any proceeds that they receive from the current opioid litigation be used for remedying the harm resulting from the opioid epidemic.

2. **Summary of the Issue that the Resolution Addresses.**

The United States faces an opioid crisis of epidemic proportions that will require many tens of millions of dollars to remedy the harm to the public resulting from the epidemic. Over one thousand lawsuits primarily brought by states, counties, tribes and local governments have been filed. Past experience with the tobacco litigation suggests that in the absence of governmental commitment to spending the proceeds on remedying the resulting harm, much of the money will be spent for purposes unrelated to the epidemic, which will inevitably lead to insufficient resources to provide the care required by the millions of people affected by the epidemic.

3. **Please Explain How the Proposed Policy Position will Address the Issue?**

The Resolution would encourage governmental entities to commit to using the proceeds of the litigation for the purpose of remedying the harm caused by the epidemic through (1) expanding treatment services for opioid use disorder, (2) creating additional transitional and extended housing programs to support those in treatment, (3) fostering community social service resources and harm-reduction/overdose prevention efforts, (4) furthering research on treatment and enhancing education and training of healthcare professionals, (5) educating patients and the public on the use and misuse of opioids, (6) reducing the stigma associated with having an opioid use disorder, and (7) improving healthcare infrastructure, especially at the community level, so as to increase the capacity of healthcare professionals to treat patients with opioid use disorder.

4. **Summary of Minority Views.**

No minority views or opposition have been identified.