IN THE ARIZONA SUPREME COURT

CVS PHARMACY, INC. and CVS ARIZONA, LLC,

Petitioners,

v.

THE HONORABLE JANET C. BOSTWICK, Judge of the SUPERIOR COURT OF ARIZONA, in and for the County of PIMA,

Respondent Judge,

TUCSON MEDICAL CENTER,

Real Party in Interest.

Arizona Supreme Court
No. CV-20-0120-PR

Court of Appeals
Division 2
No. 2 CA-SA 2020-0012

Pima County Superior Court
Case No. C20184991

AMICUS BRIEF OF THE ARIZONA HOSPITAL AND HEALTHCARE ASSOCIATION

FILED WITH WRITTEN CONSENT OF ALL PARTIES

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STATEMENT OF AMICUS CURIAE

Amicus curiae Arizona Hospital and Healthcare Association ("AzHHA") is Arizona's largest and most influential statewide trade association for hospitals, health systems, and affiliated healthcare organizations. AzHHA's 64 hospital members, and 14 healthcare members are united in the common goal of improving healthcare delivery in Arizona and advocating for issues that affect the quality, affordability, and accessibility of healthcare for Arizona patients and communities.

AzHHA's hospital members and their surrounding communities have been severely affected by the opioid crisis. Our members spend substantial resources and human capital providing unreimbursed and under-reimbursed healthcare to patients suffering from opioid overdoses, other opioid-related emergencies, and other inflictions made more challenging to treat because of opioid use. Arizona hospitals have also devoted substantial resources toward abating the opioid crisis and play a vital role in addressing the opioid epidemic.

AzHHA files this brief in support of its member—Real Party in Interest Tucson Medical Center ("TMC"). For the reasons set forth herein, AzHHA urges the Court to uphold the trial court's ruling, which was based on the specific circumstances of Defendant's alleged role in fueling the opioid epidemic and the harm that conduct has caused not only to patients (as well as their families and

communities), but specifically to Arizona hospitals. Significantly, the Court need not, and should not, recognize new liability rules to affirm the ruling below.

Indeed, as explained herein, CVS' conduct as alleged in the Complaint has directly caused specific and unique harm to TMC for which TMC has a right to compensation irrespective of the insurance status of the patients it serves. CVS allegedly marketed and distributed its addictive opioid in an irresponsible and even illegal manner that directly led to hospital emergency departments ("EDs") being flooded with patients suffering from opioid use disorder. Hospitals have unique federal statutory obligations to welcome these patients into their EDs and treat their conditions—even if it means giving them further addictive pain killers.

The cost of accepting large numbers of uniquely distressed and sometimes unstable or violent patients—whose addictions were fueled by pharmaceutical marketing practices—into the safety of an ED is not contemplated by Medicare or private insurance reimbursement models. Nor is the harm to hospitals mitigated by whether CVS merely distributes its products to its participating pharmacies. Rather, the harm is caused by the large number of residents within a hospital's service area becoming addicted, regardless of the opioid distribution network, and presenting at hospitals for emergency treatment and pain relief that hospitals have no legal choice but to provide.

This case can and should be resolved on the narrow grounds of these facts and in favor of finding a duty to hospitals by those who irresponsibly market and distribute addictive opioids to hospitals to compensate hospitals for the unique harm that their marketing and distribution has caused.

INTRODUCTION

Every day, at least 130 people die from opioid overdoses.[1] But death statistics do not capture the full extent of the opioid crisis. In 2016 there were almost 198,000 ED visits for opioid-related poisonings throughout the United States.[2] One recent national study estimated that the opioid epidemic cost $179.4 billion in 2018.[3] This estimate reflects mortality, lost productivity, child and family assistance, and criminal justice system involvement.[4] It also reflects the opioid epidemic's staggering burden on healthcare systems and their communities.

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[1] *What is the U.S. Opioid Epidemic,* U.S. DEP'T HEALTH AND HUMAN SERV., https://www.hhs.gov/opioids/about-the-epidemic/index.html (last updated Sept. 4, 2019).

[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, 2019 ANNUAL SURVEILLANCE REPORT OF DRUG-RELATED RISKS AND OUTCOMES—UNITED STATES SURVEILLANCE SPECIAL REPORT (Nov. 1, 2019), accessed from https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf.

[3] S. DAVENPORT ET AL., SOCIETY OF ACTUARIES ECONOMIC IMPACT OF NON-MEDICAL OPIOID USE IN THE UNITED STATES: ANNUAL ESTIMATES AND PROJECTIONS FOR 2015 THROUGH 2019 5 (2019), accessible at https://www.soa.org/globalassets/assets/files/resources/research-report/2019/econ-impact-non-medical-opioid-use.pdf.

[4] SOCIETY OF ACTUARIES, *supra* note 3, at 25–34.

Analysts now believe that the opioid epidemic generated $204.6 billion in healthcare costs from 2015 to 2018.[5] Opioid ***overdoses alone*** cost U.S. hospitals specifically $11 billion per year.[6]

Arizonans shoulder much of the opioid crisis's heavy burden. Over 431 million doses of opioids entered the state in 2016—the equivalent of a two-and-a-half-week supply for every resident.[7] Arizona experienced a 74 percent increase in opioid overdoses between 2013 and 2017.[8] From June 2017 to January 2018 alone, Arizona endured 5,202 suspected opioid overdoses, 812 deaths, and 455 babies born addicted to opioids.[9] These troubling developments prompted Arizona's Governor to declare a state of emergency due to the opioid epidemic.[10] Still, the deaths continued, with over 1,100 in-state deaths attributed to opioid misuse in 2018.[11] Arizona's Department of Health Services has estimated that

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[5] SOCIETY OF ACTUARIES, *supra* note 3, at 5.
[6] https://www.premierinc.com/newsroom/press-releases/opioid-overdoses-costing-u-s-hospitals-an-estimated-11-billion-annually

[7] *Arizona Opioid Epidemic Act*, Office of the Arizona Governor, available at https://azgovernor.gov/sites/default/files/relateddocs/arizona_opioid_epidemic_act_policy_primer.pdf) (last accessed Oct. 22, 2020) (hereafter *Arizona Opioid Epidemic Act*).
[8] S.B. 1001, 53rd Leg., 1st Spec. Sess. (AZ. 2018).
[9] *Arizona Opioid Epidemic Act*, *supra* note 6.
[10] *Declaration of Emergency and Notification of Enhanced Surveillance Advisory*, Office of the Arizona Governor (June 5, 2017), available at https://azgovernor.gov/sites/default/files/related-docs/opioid_declaration.pdf.
[11] *Arizona: Opioid-Involved Deaths and Related Harms*, NAT'L. INST. ON DRUG ABUSE (Apr. 3, 2020), https://www.drugabuse.gov/drug-topics/opioids/opioid-

opioid-related encounters generate over $340 million in healthcare costs in the state,[12] notwithstanding Arizona's investment of $265 million a year in substance abuse treatment and prevention.[13]

The opioid crisis will also have serious and long-lasting effects on Arizona's economy. Healthcare is a major industry in the state.[14] Arizona hospitals have become popular destinations for out-of-state patients.[15] If the opioid crisis continues to overburden Arizona's healthcare facilities and workers, the state's healthcare and medical tourism industries will also be negatively impacted –

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summaries-by-state/arizona-opioid-involved-deaths-related-harms; *see also* Arizona State Senate, 53rd Leg., 1st Special Session, Fact Sheet for S.B. 1001/H.B. 2001, available at https://www.azleg.gov/legtext/53leg/1S/summary/S.100_ASENACTED.pdf (explaining how more than two Arizonans died each day in 2016 due to the opioid epidemic).

[12] *Opioid Epidemic*, AZ. DEP'T OF HEALTH SERV., https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php (last updated Oct. 9, 2020) (estimating that opioid-related encounters at Arizona hospitals generated $341.5 million in costs in 2015).

[13] *See Arizona Opioid Epidemic Act*, *supra* note 6, at 4.

[14] *Employment Projections*, AZ. COMMERCE AUTH., available at https://www.azcommerce.com/oeo/labor-market/employment-projections/ (last accessed on Oct. 22, 2020) (stating that the healthcare support industry grew by four percent last year); *see Quick Facts: Arizona,* U.S. CENSUS, available at https://www.census.gov/quickfacts/fact/table/AZ/PST045219 (last accessed on Oct. 22, 2020) (over 17 percent of the state's population is 65 or older).

[15] *See, e.g.*, *Mayo Clinic in Arizona*, MAYO CLINIC, https://www.mayoclinic.org/patient-visitor-guide/arizona (last visited Oct. 26, 2020).

especially if out-of-state hospitals are allowed to recover their damages from opioid marketers and Arizona hospitals are not.

Hospitals serve on the front lines of the opioid crisis, and their EDs are often the primary destinations for opioid overdose victims. In addition to incurring costs while caring for patients in EDs, Arizona hospitals experience costs when opioid-affected individuals develop dangerous infections, experience organ failure, feign illness to obtain medication, demonstrate mental health needs, or require follow-up or long-term treatment.[16] Each of these opioid-specific events cost hospitals additional dollars to treat, but none of them are reimbursable. Hospitals get the same rate for treating opioid-addicted patients as others experiencing the same underlying condition, despite the increased cost related to their addicted state.

DSICUSSION

I. The Opioid Epidemic is a *Sui Generis* Event that Significantly Harmed AzHHA's Members.

CVS argues (Petition at 1) that in Arizona, "a party who wrongfully injures another has no duty in tort to the healthcare provider who treats the injured

[16] *See* S. Simmons-Duffin, *The Real Cost Of the Opioid Epidemic: An Estimated $179 Billion In Just 1 Year*, NAT. PUB. RADIO (Oct. 24, 2019), https://www.npr.org/sections/health-shots/2019/10/24/773148861/calculating-the-real-costs-of-the-opioid-epidemic; S. Luthra, *Opioid Epidemic Fueling Hospitalizations, Hospital Costs*, KAISER HEALTH NETWORK (May 2, 2016), https://khn.org/news/opioid-epidemic-fueling-hospitalizations-hospital-costs/ (describing the rise in endocarditis and septic arthritis infections among opioid victims).

person." And for most tortious conduct, this is true. But the opioid crisis is different. TMC has alleged, and other AzHHA members have reported, that opioid patients frequently present themselves to hospital EDs in a dangerous, irrational, and drug-addicted condition. Those patients pose an immediate threat to themselves, healthcare professionals, and other patients. As set forth below, hospitals are required by the Emergency Medical Treatment and Active Labor Act of 1986, 42 U.S.C. § 1395dd ("EMTALA"), to accept these patients and treat them. Caring for more opioid patients places a disproportionate burden on hospitals, especially rural ones.[17] The costs of doing so are not confined to reimbursable professional fees, medical supplies, and medications. Rather, they include unique and expensive additional direct costs such as new and additional staff, training, security, as well as indirect costs associated with the additional time and resources needed to safely treat and discharge these patients. A 2017 study found that as of 2015:

> The average cost of a patient with opioid abuse or dependence was ***more than 500 percent higher*** than the cost for a patient without these conditions. The drain on resources affects hospitals and health systems across the country as they try to meet the demands of a rapidly growing problem..[18]

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[17] *See* J. Foutz, *The Role of Medicaid in Rural America*, KAISER FAM. FOUND. (Apr. 25, 2017), https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/ (explaining how rural areas contain higher Medicaid and uninsured populations).

[18] K. Susman, *The Opioid Crisis: Hospital Prevention and Response*, Essential Hospitals Research Brief (June 2017) at 4 (emphasis added).

These costs are not reimbursed by public or private insurers, and they are incurred as a direct and foreseeable result of irresponsible marketing and sales of highly addictive opioids.

A. AzHHA Members Are Legally Obligated to Treat Every Patient.

Hospitals, like TMC, that participate in the Medicare program and provide emergency services are required by EMTALA to provide services to patients who come to the ED seeking care, irrespective of their ability to pay. The hospital must provide a medical screening examination and if it is determined that the patient has an "emergency medical condition," the hospital must "stabilize" the patient's emergency medical condition prior discharge.

Relevant to the opioid crisis, an "emergency medical condition" is defined as a "medical condition manifesting itself by acute symptoms of sufficient severity *(including severe pain, psychiatric disturbances and/or symptoms of substance abuse)* such that the absence of immediate medical attention could reasonably be expected to result in - (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part…" 42 CFR § 489.24(b) (emphasis added).

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https://www.carilionclinic.org/sites/default/files/2019-07/Essential_Hospitals_Opioid-Brief_OCR.pdf (last visited November 2, 2020).

Although the existence of psychiatric disturbances and symptoms of substance abuse may be more apparent, there is no way to objectively measure a patient's "severe pain." Severe pain is (1) subjective, and (2) based solely on the patient's representations. Untreated severe pain may in itself be sufficiently debilitating such that it can cause or contribute to serious impairment of the patient's bodily functions or serious bodily dysfunction. If the patient claims to have severe pain, the hospital must conduct tests and provide additional assessments to rule out an emergency medical condition before the patient can safely be discharged. If the patient's pain meets the definition of an emergency medical condition, the hospital must stabilize that pain until it is no longer "severe" based on the patient's representations. This treatment typically requires administration of pain medications.

It is sometimes difficult for hospital EDs to determine whether a patient is in fact in severe pain, has a lower threshold of pain due to opioid abuse or addiction, or is seeking opioids due to a chemical dependency. If the hospital makes the wrong determination and does not stabilize a patient's severe pain, the hospital risks liability under EMTALA. The penalties for violating EMTALA include civil monetary penalties up to $50,000 per violation and exclusion from participation in the Medicare and Medicaid programs. Patients may also directly sue the hospital for damages associated with EMTALA violations.

During the opioid crisis, hospitals have seen large numbers of patients who are either dependent upon or "demand" opioids. Such a patient may report that their pain is not sufficiently addressed by alternative medications or treatments; and a hospital could be put in a position to continue a patient's treatment until the patient subjectively agrees that the severe pain has been sufficiently addressed. As a result, patients who present to hospital EDs complaining of severe pain are unique—there are few other medical conditions in which the patient may both (1) subjectively determine the existence of an emergency medical condition, and (2) subjectively determine the sufficiency of any treatment provided, even if such treatment may conflict with a physician's independent medical judgment.

Here, CVS' alleged violations illegal and improper promotion of addictive opioids, when combined with hospitals' unique obligations under EMTALA, have resulted in a situation in which hospitals are not just required to treat patients, but pressed to administer them more opioids. And as described below, hospitals have paid the price.

B. <u>Hospitals are not fully reimbursed for their care.</u>

Although hospital participation in Medicaid is voluntary, not-for-profit hospitals must care for Medicaid beneficiaries in order to receive a federal tax

exemption.[19] Most states reimburse hospitals through a combination of Medicaid base payments and supplemental payments.[20] Medicaid base payment rates are set by state Medicaid agencies for specific patient services.[21]

The Medicaid Reimbursement Gap

Because payment rates are not set through private negotiations, they are often below hospitals' costs of providing patient care. For example, a visit to an Arizona hospital's ED for a life-threatening issue will be reimbursed for $322.[22] Yet, the average cost of a visit to an ED visit for an opioid overdose is more than $500 for care alone.[23] Considering that Medicare and Medicaid patients account

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[19] *Underpayment by Medicare and Medicaid Fact Sheet—January 2019*, AMER. HOSP. ASSOC., https://www.aha.org/factsheet/2019-01-02-underpayment-medicare-and-medicaid-fact-sheet-january-2019 (last visited Oct. 20, 2020).

[20] *See, e.g.*, MEDICAID AND CHIP ACCESS COMMISSION, MEDICAID BASE AND SUPPLEMENTAL PAYMENTS TO HOSPITALS (Mar. 2020), accessible at https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/.

[21] P. Cunningham et al., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, KAISER FAM. FOUND. (Jun. 9, 2016), https://www.kff.org/medicaid/issue-brief/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes/.

[22] *Final FFS Hospital-Based Freestanding Emergency Department Rates*, AZ HEALTH CARE COST CONTAINMENT SYS., (Oct. 1, 2020), available at https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/hospitalbasedfreestandingemergencydepartments.html.

[23] *Opioid Overdoses Costing U.S. Hospitals an Estimated $11 Billion Annually*, PREMIER INC., (Jan. 03, 2019), https://www.premierinc.com/newsroom/press-releases/opioid-overdoses-costing-u-s-hospitals-an-estimated-11-billion-annually#:~:text=Opioid%20Overdoses%20Costing%20U.S.%20Hospitals%20an%20Estimated%20%2411,better%20management%20of%20care%20for%20patients%20who%20overdose.

for more than 60 percent of all care provided by hospitals, shortfalls from Medicaid base payments add up quickly.[24] Although supplemental payments help account for these shortfalls, the availability and amount of these payments are determined by state legislatures, not hospitals.[25] Moreover, hospitals may wait for up to three years before receiving a supplemental payment for a certain service.[26] As a result, most hospitals experience annual "Medicaid reimbursement gaps" of between 10 and 15 percent.[27] Put another way, hospitals receive on average 87 cents for every dollar spent on Medicaid patients generally and just 64 cents for every dollar spent on opioid patients.[28]

The opioid crisis has compounded Medicaid shortfalls for hospitals by increasing the number of Medicaid beneficiaries receiving hospital care. The Centers for Medicare & Medicaid Services estimates that 8.7 of every 1,000 Medicaid beneficiaries have been diagnosed with opioid use disorder.[29] Medicaid

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[24] *Underpayment by Medicare and Medicaid Fact Sheet*, *supra* note 26.
[25] *See, e.g.*, MEDICAID AND CHIP ACCESS COMMISSION, *supra* note 27.
[26] B. Broom et al., ENSURING FINANCIAL SUSTAINABILITY WHILE SERVING A GROWING MEDICAID POPULATION, MCKINSEY & CO. (Jul. 2019), accessible at https://healthcare.mckinsey.com/ensuring-financial-sustainability-while-serving-growing-medicaid-population.
[27] Broom, *supra* note 33; *see also* R. Rudowitz, *Medicaid Enrollment & Spending growth: FY 2020 & 2021*, KAISER FAM. FOUND. (Oct. 14, 2020) (predicting that Medicaid enrollment numbers—and, thus, Medicaid-related shortfalls—will increase as the current coronavirus epidemic continues to affect the economy).
[28] *Id.*
[29] CTRS. FOR MEDICARE & MEDICAID SERV., OPIOID MISUSE STRATEGY 2016 (Jan. 5, 2017), accessible at https://www.cms.gov/Outreach-and-

beneficiaries are often prescribed opioids at higher rates than non-Medicaid patients and have a higher risk of overdose.[30] Studies suggest that 81 percent of the hospital costs for neonatal abstinence syndrome were generated by patients "covered" by state Medicaid programs.[31] In Arizona, Medicaid beneficiaries account for over half of all opioid-related ED visits.[32] Because state Medicaid reimbursement plans do not usually reflect these increased costs, hospitals are experiencing unprecedented Medicaid shortfalls while serving on the front lines of the opioid crisis.[33]

Education/Outreach/Partnerships/Prescription-Drug-Information-for-Partners-Items/CMS-Opioid-Misuse-Strategy-2016.

[30] A. Bernstein & N. Minor, *Medicaid Responds to the Opioid Epidemic: Regulating Prescribing and Finding Ways to Expand Treatment Access*, HEALTH AFFS. (Apr. 11, 2017), accessible at https://www.healthaffairs.org/do/10.1377/hblog20170411.059567/full/.

[31] Patrick et al., *Increasing Incidence and Geographic Distribution of Neonatal Abstinence Syndrome: United States 2009 to 2012*, J. PERINATOL. (2015), accessible at https://pubmed.ncbi.nlm.nih.gov/25927272/.

[32] A. Bernstein & N. Minor, *supra* note 37.

[33] Despite CVS' mischaracterizations, *Ansley v. Banner Health Network*, 248 Ariz. 143 (2020), is entirely distinguishable. In that case, hospitals recorded and attempted to enforce liens, pursuant A.R.S. §§ 33-931(A) and 36-2903.01(G)(4), against tortfeasors for the cost of medical treatment for the plaintiffs—Medicaid patients who had been treated at the hospitals—that exceeded the Medicaid reimbursement for the services. *Id*. at 145. This Court held that federal law preempted the hospital claims and that the liens statute was unconstitutional as applied. *Id*. at 152. In this case, TMC is not attempting to enforce liens pursuant A.R.S. §§ 33-931(A) and 36-2903.01(G)(4), thus *Ansley*'s holding is inapplicable here.

Hospital Service Pricing

One common misconception is that hospitals can simply raise their service prices to account for any Medicaid shortfalls or unique costs, including those incurred while caring for opioid-affected patients. This reasoning ignores the economic realities surrounding hospitals' relationships with Medicaid programs and patients. Hospitals do not engage in reimbursement negotiations with state Medicaid agencies and do not directly influence these legislative decisions. Because a hospital's decision to raise service prices does not necessarily result in higher Medicaid reimbursement rates, raising prices for Medicaid-patient services is not a viable option. Nor is raising prices for non-Medicaid patient services. This practice, known as cost shifting, is not available to most hospitals.[34] Moreover, when faced with a decline in revenue from Medicaid payments, it often makes more business sense for hospitals to *reduce* prices charged to private insurers in order to be included in more private insurance networks.[35] Such price reductions further intensify losses from the opioid crisis.

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[34] *See* A. Frakt, HOW MUCH DO HOSPITALS COST SHIFT?, 89 MILBANK QUARTERLY 1, 90–130 (2011); T. Coughlin et al., *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*, KAISER FAM. FOUND. (May 30, 2014), https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/.

[35] A. Frakt, *Hospitals Don't Shift Costs from Medicare or Medicaid to Private Insurers*, JAMA HEALTH FORUM (Jan. 04, 2017), https://jamanetwork.com/channels/health-forum/fullarticle/2760166.

C. TMC seeks to recover damages beyond uncompensated care.

To be sure, the burden of uncompensated and undercompensated care has grown substantially with the opioid epidemic and such costs are a portion of hospital damages. Only 36 percent of opioid-addicted nonelderly adults have private insurance, whereas 38 percent have Medicaid and 18 percent are uninsured.[36] But uncompensated and undercompensated care is only a portion of the harm to hospitals. As set forth below, and contrary to CVS' assertions, TMC also seeks to recover specific damages that are unique to the opioid crisis and occur regardless of the patient's insurance status.

i. Security and Staffing Costs

Opioid-related ED visits increased 99.4% between 2005 and 2014,[37] and that trend has continued. The flood of opioid-addicted patients has forced hospitals across the country to invest in new security systems and personnel to protect hospital staff and other patients. In 2016 alone, over 50 percent of hospitals surveyed had to increase their security budgets.[38] Such costs include more security

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[36] K. Orgera and J. Tolbert, *Key Facts About Uninsured Adults with Opioid Use Disorder*, KAISER FAM. FOUND. (Jul. 15, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-uninsured-adults-with-opioid-use-disorder/.

[37] Susman, *supra* n. 18 at 4.

[38] *Balancing Hospital Security Needs and Costs*, Healthmanagement.org (Oct. 16, 2016), https://healthmanagement.org/c/hospital/news/balancing-hospital-security-needs-and-costs (last visited November 2, 2020).

personnel, electronic access controls, and video surveillance systems.[39] Similarly, hospitals have had to invest specifically in more addiction treatment personnel and training for their existing staff. A 2017 US Surgeon General's Report on the opioid crisis identified healthcare worker shortages and inadequate training as two of the most significant challenges facing the healthcare system.[40] These costs are unique to the opioid crisis and individual hospitals that have borne them should be allowed to recover them from irresponsible opioid marketers.

ii. Opportunity Costs

Moreover, every dollar that hospitals must invest in infrastructure, personnel and training to respond to the opioid epidemic is one they cannot spend on other needs crucial to their missions, including cancer research, diabetes awareness, abatement programs, and overall wellness education. These, in turn, affect public health in the community and result in more patients presenting at hospital EDs with preventable diseases or in worse health than might have been the case if hospitals had had the resources to better educate their communities regarding health trends and general wellness. When patients present to hospitals with more serious

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[39] Id.

[40] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Spotlight on Opioids.* (September 2018) at 9, https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf (last visited November 2, 2020).

conditions, the cost of caring for them is even higher and because of the reimbursement gap, hospital losses continue to spiral.

D. Arizona Hospitals Should not be Disadvantaged vis-à-vis Hospitals in Other States.

Another reason why Arizona hospitals must be able to assert direct claims against third parties in this case is that hospitals in other states are receiving direct recovery in opioid litigation efforts. Arizona hospitals are part of a nationwide multidistrict litigation proceeding that has survived motions to dismiss and they are also participating as claimants in the federal bankruptcies of at least three opioid manufacturers.[41] Any ruling by this Court that impairs the ability of Arizona hospitals to receive their share of these recovery efforts—which is already in the millions of dollars—would put Arizona hospitals at a unique disadvantage to other

[41] *In re Nat'l Prescription Opiate Litig*., 452 F. Supp. 3d 745 (N.D. Ohio 2020) (Order Denying Mot. to Dismiss Hospital Bellwether Complaint*); Southwest Miss. Reg'l Med. Cntr., et al. v. AmerisourceBergen Drug Corp., et al*., Complaint, No. 5:17-cv-00145-KS-MTP (S.D. Miss Nov. 30, 2017) (original hospital class action complaint being litigated as part of the multi-district litigation); *In re Insys Therapeutics, Inc., et al.*, Order Approving Stipulation Establishing Hospital Class Claim Procedures, No. 19-11292-JTD (Bankr. D. Del. Dec. 4, 2019); *In re Purdue Pharma, L.P. et al.*, Second Am. Verified Statement of Hospital Ad Hoc Committee, No. 19-23649 (RDD) (Bankr. S.D.N.Y July 29, 2020); *In re Purdue Pharma, L.P., et al.*, Motion for Permission to File Hospital Class Proof of Claim, No. 19-23649 (RDD) (Bankr. S.D.N.Y July 2, 2020); *In re Mallinckrodt PLC, et al.*, Notice of Appointment of Opioid Related Claimants Committee, no. 20-12522 (JTD) (Bankr. D. Del. Oct. 27, 2020).

hospitals in the country. This Court should not place the economic interests of out-of-state entities above those of Arizona hospitals serving Arizona's communities.

Hospital participation in recoveries against opioid manufacturers and distributors also enables them to participate more effectively in opioid abatement programs. Hospitals are the experts on opioid recovery and abatement. Hospitals around the nation with the resources to do so have funded thei own successful opioid abatement programs. For example, the American Hospital Association has developed an evidence-based opioid epidemic toolkit for hospitals and health systems.[42] AzHHA offers similar toolkits for Arizona hospitals and outpatient clinics.[43] TMC in particular has formed the Southern Arizona Hospital Alliance to further address the opioid crisis and opened an annex within its Neonatal Intensive Care Unit to provide specialized care to opioid-addicted mothers and their babies.[44] Abatement efforts such as these have real promise; but they are costly and difficult to implement without additional resources. Recovery

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[42] *Stem the Tide: Addressing the Opioid Epidemic & Taking Action*, AMER. HOSP. ASSOC., https://www.aha.org/guidesreports/2017-11-07-stem-tide-addressing-opioid-epidemic-taking-action (last visited Oct. 26, 2020).

[43] *Arizona Opioid Compliance Toolkit for Hospitals and Outpatient Surgery Centers*, AZ. HOSP. AND HEALTHCARE ASSOC., https://www.azhha.org/compliance_toolkit_hospitals_and_outpatient_surgery_centers (last visited Oct. 26, 2020).

[44] Tucson Medical Center, *Southern Arizona Hospital Coalition Addresses Opioid Misuse in Rural Areas*, TMC NEWS (Jul. 14, 2017), https://tmcaznews.com/tag/southern-arizona-hospital-alliance/.

for opioid-related damages would help Arizona hospitals and their experts continue to develop successful opioid abatement and recovery strategies.

By contrast, government actions against mass tortfeasors have proven ineffective in addressing hospital damages or abating the fundamental problem. Tobacco settlements illustrate the danger of excluding private parties like hospitals from opioid litigation. In 1998, 46 states settled cases involving damage to Medicaid programs against tobacco companies.[45] States received over $206 billion in settlement funds over the next 25 years.[46] Although the expectation—and promise[47]—was that these funds would be used to curb tobacco use, states quickly diverted them to unrelated efforts. In the first year of settlement, only 9.2 percent of settlement funds were spent on tobacco abatement.[48] Today, fewer than two cents of every tobacco settlement dollar is spent on abatement and treatment.[49]

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[45] *Who Is Really Benefiting from the Tobacco Settlement Money*, AM. LUNG ASS'N (Feb. 3, 2016), https://www.lung.org/about-us/blog/2016/02/who-benefit-tobacco-settlement.html (last updated Nov. 19, 2018).

[46] Crystal Phend, *Tobacco Settlement Money Being Burned on Unintended Uses*, MEDPAGE TODAY (Sept. 6, 2011), https://www.medpagetoday.com/primarycare/smoking/28358.

[47] *State Spending of Tobacco Settlement Revenues: Hearing Before the S. Comm. on Commerce, Sci. & Transp.*, 108th Cong. 1015 (2003) (prepared statement of Matthew Myers, President, Campaign for Tobacco-Free Kids).

[48] *See* John Dunbar, *Tobacco Settlement Helps Everyone but Smokers: States Spending Little to Help Kick the Habit*, CTR. FOR PUB. INTEGRITY (Dec. 8, 2000), https://publicintegrity.org/health/tobacco-settlement-helps-everyone-but-smokers/ (last updated May 19, 2014).

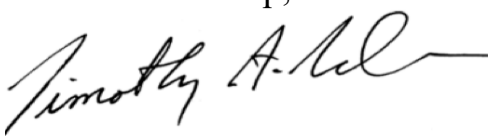
[49] *State Spending of Tobacco Settlement Revenues: Hearing Before the S. Comm. on Commerce, Sci. & Transp.*, 108th Cong. 1015 (2003) (prepared statement of Dr. Cheryl G. Healton. President and CEO, Am, Legacy Found.); *Who Is Really*

CONCLUSION

The opioid crisis has not only devastated patients and their families, but fundamentally threatened the financial viability of Arizona's struggling hospitals. Treating patients with opioid use disorder involves unique and identifiable costs that are not compensated by Medicare, Medicaid, or most private insurers. Without a remedy from the people who market and distribute these dangerous opioids, Arizona's hospitals face catastrophic losses that threaten healthcare generally in Arizona and Arizona's economic wellbeing. In light of the unique and narrow facts of this case, AzHHA respectfully requests that the Court to uphold the decisions below.

Respectfully submitted this 4th day of November, 2020.

The Nelson Law Group, PLLC



By: _____
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Benefiting from the Tobacco Settlement Money; see also Broken Promises to Our Children, Arizona, CAMPAIGN FOR TOBACCO-FREE KIDS (last updated Oct. 26, 2020), https://www.tobaccofreekids.org/what-we-do/us/statereport/arizona.

I hereby certify that on November 4, 2020, I caused the foregoing document to be e-filed with the Clerk's Office using Turbocourt and a transmittal of a Notice of Electronic Filing to be sent to the following persons:

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