PRINCIPLES TO GUIDE SPENDING OF OPIOID LITIGATION SETTLEMENT FUNDS IN ARKANSAS

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Introduction

The opioid and illicit drug epidemic began with misleading marketing and overprescribing of opioids in the 1990s, eventually leading to Arkansas having the second-highest opioid prescription rate in the nation today. The flood of opioids and subsequent addiction led to an influx of heroin and now synthetic opioids, particularly those involving the synthetic opioid fentanyl, which is frequently illicitly mixed with many street drugs and used in counterfeit prescription pills.

Arkansans continue to be directly and indirectly affected by the misuse of and addiction to opioids — including prescription pain relievers, heroin, and synthetic opioids such as fentanyl. These impacts include overdose deaths among Arkansas families, addiction impacting individual and familial functionality, lost productivity and community stability, criminal justice involvement, and costs to the public and private healthcare systems. States and local governments have actively pursued public nuisance and other legal theories through the courts to hold accountable opioid manufacturers, distributors, and retailers that are proving successful.

Opioid Litigation Settlement

As part of a nationwide settlement with Johnson & Johnson, an opioid manufacturer, and three opioid distributors, McKesson, AmerisourceBergen, and Cardinal Health, Arkansas anticipates receiving approximately $216 million. Pursuant to the settlement agreement, payments to the state, municipalities, and counties will be made over a period of 18 years beginning in late 2022 or 2023.

The Arkansas Opioids Memorandum of Understanding (MOU) is an agreement among the parties to the litigation that limits how the settlement funds will be used and allocates one-third of the settlement funds to each party — the state, municipalities, and counties. The MOU defines approved uses for settlement proceeds, including opioid intervention, treatment, education, and recovery services. In general, the approved uses in the MOU align with the Arkansas Center for Health Improvement Health Policy Board's position that settlement proceeds should be earmarked for programs, services, and other efforts to abate the current opioid epidemic and prevent future substance use disorder epidemics.

The specificity in the MOU is a welcome shift from litigation against tobacco companies in the 1990s that resulted in a nationwide settlement which provided no direction to states for use of the funds to address the damage cause by tobacco through illness, death, and lost productivity. Consequently, in the 20 years after the tobacco settlement, less than 3% of all settlement proceeds and generated funds from tobacco taxes nationally had been allocated toward the funding of state and local tobacco control programs. While no state currently funds tobacco

prevention programs at the level recommended by the Centers for Disease Control and Prevention (CDC), Arkansas is the only state to have dedicated all tobacco settlement funds to health-related initiatives.

While the specificity in the MOU for "approved uses" of opioid settlement funds is certainly an advantage, the distributed method for disbursement of funds — as opposed to the centralized disbursement of tobacco settlement funds to the state — creates the potential for investment in initiatives that without adequate coordination may be duplicative, insufficiently supported, or lacking evidence of effectiveness. That is why it is important for the state, municipalities, and counties to adopt a shared framework to guide funding decisions in order to seize this critical opportunity to address the opioid epidemic in Arkansas.

Extent of the Opioid Epidemic

Arkansas has made considerable policy progress in response to the opioid epidemic. For example, the state has established a prescription drug monitoring program (PDMP) and legislatively requires healthcare providers to check the PDMP database prior to writing an opioid prescription, adopted rules limiting the number and strength of opioids that doctors can prescribe, and invested in medication-assisted treatment programs. In addition, policymakers have enacted numerous policies to expand access to naloxone, the life-saving overdose reversal medication (Figure 1).

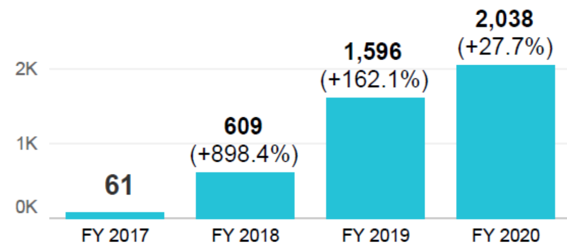
FIGURE 1: TIMELINE OF NALOXONE LEGISLATION IN ARKANSAS

Year	Legislation
2015	**Act 1222** The Naloxone Access Act allows a healthcare professional to prescribe (directly or by standing order) and dispense naloxone to: a person at risk of experiencing an opioid-related overdose; a pain management clinic; a harm reduction organization; an emergency medical services technician; a first responder; a law enforcement officer or agency; or a family member or friend of a person at risk of experiencing an opioid-related overdose. The act also provides immunity from civil or criminal liability and professional sanctions. **Act 1114** The Joshua Ashley-Pauley Act provides immunity to a person seeking medical assistance for his or her own drug overdose or another person experiencing a drug overdose.
2017	**Act 70** Authorizes healthcare professionals to prescribe opioid antagonists to employees of the State Crime Lab, adding to the list first identified under Act 1222 of 2015. **Act 284** Authorizes pharmacists to administer and dispense naloxone.
2019	**Act 964** Prohibits healthcare insurers, including Medicaid, from requiring prior authorization for a patient to obtain naloxone or imposing any other requirement other than a valid prescription. A healthcare insurer utilizing a tiered drug formulary must place at least one naloxone product on the lowest-cost benefit tier. **Act 1222** Requires the development of law enforcement training to identify an overdose of a controlled substance and understand the role of naloxone in certain opioid overdose situations.
2021	**Act 651** Requires healthcare professionals to coprescribe naloxone when prescribing or dispensing an opioid for a person who does not have an existing prescription. It also requires healthcare professionals to provide counseling and patient education.

This progress has resulted in a decline in opioid prescriptions for Arkansans with Medicaid or private insurance coverage by 38% from 2017 to 2020. Over the same period, the number of Arkansans with high-dose opioid prescriptions of 50 or more morphine milligram equivalents (MME) per day who also received a naloxone prescription increased (Figure 2). Unfortunately, the percentage of people who received both high-dose opioid and naloxone prescriptions was less than 5% of people who had a high-dose opioid prescription, and while the opioid prescribing rate in Arkansas has declined, it remains well above the national average. Arkansas still ranks second among all states for opioid dispensing rates at 75.8 prescriptions dispensed per 100 people.

FIGURE 2: HIGH-DOSE OPIOID AND NALOXONE CO-PRESCRIPTIONS OVER TIME IN ARKANSAS

The number of Arkansans who received naloxone prescriptions with their high-dose opioid prescriptions of 50 MME or more per day increased each year from state fiscal years 2017 to 2020.



The COVID-19 pandemic has derailed progress and exacerbated the opioid epidemic. While drug overdose deaths in the U.S. were already increasing prior to the pandemic as synthetic opioids such as fentanyl flooded the illicit drug supply, overdose deaths exceeded 100,000 nationally for the first time during the 12-month period ending in April 2021, according to the National Center for Health Statistics. That's a 28.5% increase from the 78,056 overdose deaths that occurred in the same period the year before. An analysis by The Commonwealth Fund found that Arkansas is one of 10 states where overdose deaths increased by more than 40% in 2020 compared to 2019.

In addition to the individual health impact from opioid misuse and abuse and the death toll from overdoses, the opioid epidemic places a tremendous burden on families, communities, and our healthcare system. There is a rising incidence of newborns experiencing withdrawal syndrome due to opioid use and misuse during pregnancy. There is a significant strain on law enforcement officers and first responders as they encounter increasingly complex problems associated with synthetic opioid use. Child welfare and foster care systems are overburdened as more children and youth enter care as a result of their parents' drug use and criminal justice system involvement. The opioid crisis is associated with increasing rates of injection drug use, which contributes to the spread of infectious diseases such as HIV and hepatitis C. The CDC estimates that the economic burden of prescription opioid misuse alone in the U.S. is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.

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Principles for Use of Funds

Many medical, public health, academic, and advocacy organizations, including the American Public Health Association and the American Medical Association, have endorsed the following principles to help guide state and local spending of opioid litigation settlement funds.

1. Spend the money to save lives.

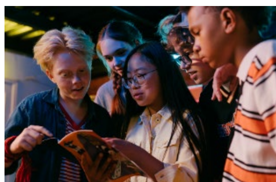
To implement this principle, states and localities should:

- Establish a dedicated fund in which to place the funds.
- Use the funds to supplement rather than supplant existing funding.
- Not spend all the money at once and avoid the temptation to exchange future payments for an up-front lump sum payment.

2. Use evidence to guide spending.

To Implement this principle, states and localities should:

- Prioritize funding of programs that are supported by evidence.
- Ensure that sufficient funds are allocated for evaluation of effectiveness if they decide to fund demonstration or pilot programs that have not been studied.
- Eliminate policies that may hinder adoption of treatment modalities or programs that work, such as syringe service programs for harm reduction.
- Build data collection capacity to coordinate and evaluate programs, ensure that they are meeting the needs of low-income communities and communities of color, provide transparency into expenditures, and conduct surveillance for ongoing or emerging substance use issues.



3. Invest in youth prevention.

To implement this principle, state and localities should:

- Direct funds toward interventions that address individual risk factors and strengthen protective factors.
- Address prevention at the family and community levels.

4. Focus on racial equity.

To implement this principle, states and localities should:

- Invest in communities affected by discriminatory policies.
- Support diversion from arrest and incarceration by:
  - Utilizing diversion programs with strong case management and linking participants to community-based services.
  - Funding harm reduction programs that provide support options and referral to promote health and understanding.
  - Increasing equitable access to treatments.
- Fund anti-stigma programs.
- Involve community members in solutions.

5. Develop a fair and transparent process for deciding how to spend the funding.

To implement this principle, state and localities should:

- Identify existing funding sources for current programs and conduct a needs assessment.
- Ensure that there is diversity in representation, with inclusion of people with lived experience of the opioid epidemic, and gather input from groups that are touched by different parts of the epidemic to develop a plan.
- Identify and develop strategies to ensure that less populated or geographically isolated communities benefit from prevention and treatment strategies.

Conclusion

State and local officials are beginning to prepare for an influx of opioid settlement dollars. Relying on these principles will help ensure that the funds are used to save the most lives. As officials implement these principles in Arkansas, however, they should also consider available resources and capacity, which in rural areas may result in regional approaches requiring combined funding efforts to reach economies of scale. They should also consider multiple braided funding streams, including the use of American Rescue Plan funds to augment opioid settlement investments. As part of the needs assessment prior to allocating funds, state and local officials should consider the scope of substance use issues, including any polysubstance abuse that may be impacting people in their area. Finally, ongoing and future litigation against additional manufacturers, distributors, and retailers is expected to increase the amount of proceeds available for these investments, and these principles should equally guide management and distribution of those funds as they are received by the state and localities.