Preemption and Privatization in the Opioid Litigation

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ABSTRACT

The upsurge of litigation against opioid manufacturers, distributors, and sellers currently proceeding through the US court system—with nearly 3,000 state and local governments as plaintiffs—raises a number of complex legal, political, and strategic issues. Although offering a wide array of legal theories, most of the local government lawsuits have been consolidated in a multi-district litigation currently overseen by a federal judge in Ohio. The state government lawsuits are mostly proceeding separately in state courts. The multiplicity of theories, plaintiffs, and jurisdictions may lead to conflict and competition between plaintiffs, as state and local governments compete to control the legal strategy deployed in the cases and the resources that may be garnered from successful rulings or settlements.

This article explores the implications of conflict between state and local governments as the opioid lawsuits proceed. Some state attorneys general have already tried to halt, influence, or take control of local government claims. Understanding the dynamics of this situation requires an analysis of two key factors: preemption and privatization. State authority to preempt local government powers—a strategy increasingly used to constrain local public health initiatives—may provide a justification for state intervention in the local opioid lawsuits. Likewise, the increasing privatization of public health functions—and the fact that most of the local government opioid lawsuits are being handled by private trial attorneys—creates political and strategic concerns about incentives, resource allocation, and legal authority.

Introduction

The opioid crisis has taken a significant toll on the health and well-being of people across the United States. Over the past two decades, opioid use has been implicated in nearly 450,000 deaths in the United States.[1] Prescription opioid medications introduced in the 1990s hit the market with an aggressive marketing campaign that coincided with a spike in opioid use disorders and opioid-related overdose deaths.[2] Overdose-related mortality increased substantially between 2010 and 2018, driven by growth in the use of illicit heroin and fentanyl.[3] The surge in deaths related to opioid overdoses and the substantial medical, legal, and social hurdles facing people with substance use disorder present one of the great public health challenges of our time.[4] Scholars and policy-makers have chronicled these challenges,[5] and while the problems persist, the nature of the crisis and the factors driving it have morphed and shifted over time. Proposals for legal interventions to mitigate the scope and impact of the crisis abound,[6] and the impact of these proposals varies considerably. Nevertheless, the impacts of the opioid crisis—and of polysubstance use disorders[7]—on our society

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1 Nana Wilson et al., *Drug and Opioid-Involved Overdose Deaths – United States, 2017-2018*, 69 Ctrs. For Disease Control Morbidity & Mortality Wkly. Rep. 290, 291 (2020).

2 Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 Am. J. Pub. Health 221, 222, 224 (2009).

3 Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 Am. J. Pub. Health 182, 182 (2018) (outlining the phases of the opioid overdose epidemic).

4 Among the challenges faced by people with opioid use disorders are legal barriers to accessing treatment and criminalization of harm reduction strategies. *See generally* Joanne Csete, *Criminal Justice Barriers to Treatment of Opioid Use Disorders in the United States: The Need for Public Health Advocacy*, 109 Am. J. Pub. Health 419 (2019); Corey Davis et al., *Changing Law from Barrier to Facilitator of Opioid Overdose Prevention*, 41 J.L. Med. & Ethics 33 (Supp. 2013).

5 *See generally* Anne Case & Angus Deaton, Deaths of Despair and the Future of Capitalism (2020).

6 *See generally, e.g.*, Leo Beletsky et al., Temple Univ. Sch. of Law Ctr. for Health Law, Policy & Practice, Conference Report, Closing Death's Door: Action Steps to Facilitate Emergency Opioid Drug Overdose Reversal in the United States (2009); Corey Davis et al., *State Approaches to Addressing the Overdose Epidemic: Public Health Focus Needed*, 47 J.L. Med. & Ethics 43 (Supp. 2 2019); Mariano-Florentino Cuellar & Keith Humphreys, *The Political Economy of the Opioid Epidemic*, 38 Yale L. & Pol'y Rev. 1 (2019); Scott Burris, *Where Next for Opioids and the Law? Despair, Harm Reduction, Lawsuits, and Regulatory Reform*, 133 Pub. Health Reps. 29 (2018); Andrew M. Parker et al., *State Responses to the Opioid Crisis*, 46 J.L. Med. & Ethics 367 (2018).

7 Polysubstance use disorder refers to concurrent use of opioid and non-opioid substances. Theodore J. Cicero et al., *Polysubstance Use: A Broader Understanding of Substance Use During the Opioid Crisis*, 110 Am. J. Pub. Health 244, 244, 247 (2020).

persist and will continue to demand deliberate, creative, and compassionate responses.

As often occurs during and after public health crises, even while we push ahead and grasp at policy changes that will solve ongoing problems, we simultaneously look back to seek accountability. Allocating responsibility for harm caused is never a simple and linear task in public health, and doing so for the opioid crisis is no different.[8] Numerous attempts are now in progress to hold opioid manufacturers, distributors, and sellers legally liable for the harms caused by their products and their respective roles in contributing to the spike in opioid-related deaths, using litigation,[9] legislation,[10] and regulations.[11] Other government interventions are also underway to mitigate the public health impact of the crisis.[12]

Thousands of claims have been filed in an effort to use civil litigation to accomplish these goals.[13] Litigation creates the potential for unusual dynamics between the thousands of plaintiffs that are currently bringing these lawsuits, most of whom are state and local governments.[14] Because the

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8 Indeed, the impetus to seek accountability and blame specific actors or causes may itself be an unfortunate diversion of effort. *See* Nicolas P. Terry, *The Opioid Litigation Unicorn*, 70 S.C. L. REV. 637, 651–55 (2019) (critiquing the retrospective "blame frame" used by the tort model).

9 *See, e.g.*, Richard C. Ausness, *The Current State of Opioid Litigation*, 70 S.C. L. REV. 565, 566 (2019); Abbe R. Gluck et al., *Civil Litigation and the Opioid Epidemic: The Role of Courts in a National Health Crisis*, 46 J.L. MED. & ETHICS 351, 351 (2018) (exploring the history of and legal issues implicated by the opioid litigation); Rebecca L. Haffajee & Michelle M. Mello, *Drug Companies' Liability for the Opioid Epidemic*, 377 NEW ENG. J. MED. 2301, 2301 (2017) (analyzing the legal theories being advanced in the lawsuits against opioid manufacturers).

10 *See, e.g.*, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

11 *See, e.g.*, Management of Quotas for Controlled Substances and List I Chemicals, 84 Fed. Reg. 56,712 (Oct. 23, 2019) (to be codified at 21 C.F.R. pt. 1303, 1315).

12 The U.S. Department of Health and Human Services declared the opioid crisis a public health emergency in October 2017. *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis*, U.S. DEP'T. HEALTH & HUM. SERVS. (Oct. 26, 2017), https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html; *see also* Rebecca L. Haffajee & Richard G. Frank, *Making the Opioid Public Health Emergency Effective*, 75 JAMA PSYCHIATRY 767, 767 (2018).

13 Terry, *supra* note 8, at 656–57; *see generally, e.g.*, Conditional Transfer Order No. 178, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-2804 (N.D. Ohio Oct. 27, 2020), ECF No. 3543 (identifying over two thousand cases consolidated for pretrial proceedings in federal court).

14 Rebecca L. Haffagee, *The Public Health Value of Opioid Litigation*, 48 J.L. MED. & ETHICS 279, 279 (2020).

interests of these respective plaintiffs overlap, the ongoing litigation raises the possibility of competition and tension between state and local governments over strategic, legal, and resource decisions.

This tension arises from the nature and complexity of the opioid-related lawsuits. The sheer number of individual lawsuits creates an inherently complicated and unwieldy landscape upon which to proceed. The multiplicity of parties raises the explicit potential for jurisdictional conflict and competition as state and local governments bring separate legal claims in different courts.[15] Consequently, the litigation spans multiple judicial jurisdictions, with forty-eight state-level lawsuits advancing in their respective state courts, while thousands of local lawsuits are concurrently proceeding in federal court.[16] The local opioid lawsuits have been consolidated into a multidistrict litigation (MDL) headed by Judge Dan Aaron Polster in the Northern District of Ohio.[17] MDLs are inherently complex,[18] but the size and scope of this MDL exceed even the normal challenges that face a court attempting to coordinate such a large and disparate group of cases.

Another challenging factor arises from the variety of legal theories being advanced in the lawsuits and in the potentially overlapping damages claims being pursued. State and local governments have spent substantial sums to address the consequences of the opioid overdose epidemic and have incurred distinct economic harms that they seek to recover in court.[19] Nevertheless, there will likely be disagreements over the applicability and relative severity of harms, and parsing these distinctions will be very difficult, whether across multiple hearings or in a large consolidated settlement. The resolution of these potential disagreements and disputes has important implications for which jurisdictions will receive any damages generated

15 *See* Gluck et al., *supra* note 9, at 355.

16 Molly Stubbs, *States Claim $2 Trillion+ in Damages from OxyContin Maker Purdue Pharma*, Expert Inst. (Sept. 1, 2020), https://www.expertinstitute.com/resources/insights/states-claim-2-trillion-in-damages-from-oxycontin-maker-purdue-pharma/#:~:text=The%20filings%2C%20which%20were%20made,risk%20of%20addiction%20or%20overdose; Tom Hals, *U.S. Regions Hard Hit by Opioids to Ditch Class Action, Pursue Own Lawsuits*, Reuters (Dec. 3, 2019), https://www.reuters.com/article/us-usa-opioids-litigation/u-s-regions-hard-hit-by-opioids-to-ditch-class-action-pursue-own-lawsuits-idUSKBN1Y72C6.

17 *See, e.g.*, Transfer Order, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-02804 (J.P.M.L Dec. 12, 2017), ECF No. 1.

18 Elizabeth Chamblee Burch & Margaret S. Williams, *Repeat Players in Multidistrict Litigation: The Social Network*, 102 Cornell L. Rev. 1445, 1526 (2017). *See generally* Elizabeth Chamblee Burch, Mass Tort Deals: Backroom Bargaining in Multidistrict Litigation (2019).

19 Elizabeth Weeks & Paula Sanford, *Financial Impact of the Opioid Crisis on Local Government: Quantifying Costs for Litigation and Policymaking*, 67 U. Kan. L. Rev. 1061, 1061–62 (2019).

by lawsuit judgments or settlements in these cases. Likewise, the outcome of state/local conflicts over this litigation may affect the balance of power between state and local governments and set influential precedents for future attempts of governments to use civil litigation as a tool to protect public health.

While many aspects of the opioid litigation are indeed unique, the potentially rivalrous position that state and local governments find themselves in has parallels in other situations that arise when governments have conflicting priorities related to public health challenges and other policies.[20] The inter-jurisdictional struggles playing out within the opioid litigation mirror the debates over preemption and privatization that often divide state and local governments when addressing other public health issues.[21]

This article explores the implications of conflict between state and local governments as the opioid lawsuits proceed. Some state attorneys general have already tried to halt or take control of local government claims, although without much success.[22] Understanding the dynamics of this situation requires an analysis of how preemption and privatization shape the relationship between state and local governments. The use of state authority to preempt local government powers—a strategy increasingly employed to constrain local public health initiatives—may form the basis for state efforts to intervene, take over, and/or extinguish local opioid lawsuits. Likewise, the increasing privatization of public health functions—and the fact that most of the local government opioid lawsuits are being handled by private trial attorneys—creates political and strategic concerns about incentives, resource allocation, and legal authority.

Part I of the article traces the history of public health litigation and situates the current opioid litigation within this complicated and growing history. The opioid litigation builds on legal theories, practices, and strategies from the successful tobacco Master Settlement Agreement from the 1990s,[23] but the contemporary opioid cases differ from the tobacco cases in some important ways. This discussion highlights how the complexity inherent in the opioid litigation renders the resolution of these lawsuits even more challenging than previous mass tort litigation.

20 *See infra* Part I.

21 *See infra* Parts II and III.

22 Sara Randazzo, *In the Opioid Litigation, It's Now States v. Cities*, WALL ST. J. (Aug. 6, 2019), https://www.wsj.com/articles/in-the-opioid-litigation-its-now-states-v-cities-11565123075.

23 Derek Carr et al., *Reducing Harm Through Litigation Against Opioid Manufacturers? Lessons from the Tobacco Wars*, 133 PUB. HEALTH REP. 207, 207–13 (2018).

Part II of the article analyzes the differential role that privatization of government services plays in the context of the opioid litigation as opposed to other contexts. The increasing privatization of public health functions—and government functions more broadly—is an accepted reality of modern governance.[24] Privatization of government services raises many potential concerns, including the concern that private entities performing government functions may not have the best interests of the public as their foremost goal and will not be democratically accountable for their actions and decisions. Many of the opioid lawsuits filed on behalf of local governments are handled by private trial attorneys, a fact that has generated scrutiny and criticism.[25] Entrusting these public lawsuits to private attorneys presents multifaceted legal, political, and strategic concerns about incentives, resource allocation, and legal authority. Ultimately, though, these concerns are balanced by the opportunities they present for local governments to hold defendants responsible for the harm they caused through their actions.

Part III of the article examines how the developing landscape of the opioid litigation reveals interesting parallels between state preemption of local public health initiatives in the legislative and judicial settings. State governments often try to limit the discretion of local jurisdictions to enact laws and policies that conflict with the preferences of state-level officials. The opioid litigation has given rise to state preemption of a different sort—in the context of litigation rather than legislation or executive orders. As the following discussion demonstrates, while state preemption of local litigation is motivated by many of the same goals as state preemption of local law or policymaking in other contexts, the authority of state governments to intervene and preempt local government lawsuits is less clear and less likely to be pursued. Indeed, collaborative strategies between state and local government plaintiffs could be mutually beneficial.

The opioid litigation provides an opportunity for state and local governments to reclaim some of the losses incurred from the opioid crisis and to attempt to hold some of those who've contributed to this harm to account. Yet the complexity of these lawsuits and the adversarial incentives between plaintiffs create an unprecedented situation that has the potential to cause divisions and disputes between state and local governments.

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24 Sarah E. Gollust & Peter D. Jacobson, *Privatization of Public Services: Organizational Reform Efforts in Public Education and Public Health*, 96 Am. J. Pub. Health 1733, 1734 (2006).

25 Daniel Fisher, *Latest Wave of State Opioid Lawsuits Shows Diverging Strategies and Lawyer Pay Scales*, Forbes (May 29, 2018), https://www.forbes.com/sites/legalnewsline/2018/05/29/latest-wave-of-state-opioid-lawsuits-shows-diverging-strategies-and-lawyer-pay-scales/#374c88a86d1d.

I. THE OPIOID LITIGATION

Public health problems like the opioid crisis defy easy fixes, in part, because direct interventions through legislative or regulatory changes often encounter structural or political obstacles. Public health is historically underfunded, and policies to address drug dependency are often framed as issues of individual responsibility and criminalized behavior.[26] The fact that programs to reduce opioid dependency have gained as much political support as they have in recent years is somewhat astonishing given these historical obstacles. But many of the policies in place to address the opioid crisis remain problematic, inappropriately criminalizing drug use and disincentivizing harm reduction strategies.[27]

Nevertheless, the political will to intervene and support people with opioid and polysubstance dependency, as well as the scale of resources needed to adequately fund such programs, falls far short of the need.[28] Litigation can serve as a tool to move public policy forward and simultaneously procure resources to support a more robust set of interventions to address the opioid crisis. Still, litigation for public health comes with its own shortcomings, limitations, and challenges.

A. *Public Health Litigation as a Public Policy Tool*

It is indisputable that public health litigation can be a powerful tool to achieve some measure of accountability for industries that produce harmful products. Litigation—whether brought by individuals, classes, organizations, or government entities—can advance the traditional tort law goals of providing a means to pursue compensation for those injured by harmful products and to achieve deterrence against future harm by incentivizing the makers and distributors of such products to make them safer.[29] In some circumstances, tort litigation can be democratizing when private individuals or entities bring civil claims to redress harms that the government won't address.[30] In other cases, the government itself can be the

26 Matthew D. Lassiter, *Impossible Criminals: The Suburban Imperatives of America's War on Drugs*, 102 J. AM. HIST. 126, 126–29 (2015); Terry, *supra* note 8, at 652–55.

27 *See* Leo Beletsky & Corey S. Davis, *Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited*, 46 INT'L J. DRUG POL'Y 156, 158 (2017).

28 Brendan Saloner et al., *A Public Health Strategy for the Opioid Crisis*, 133 PUB. HEALTH REP. 24S, 31S (2018).

29 *See* Timothy D. Lytton, *Using Litigation to Make Public Health Policy: Theoretical and Empirical Challenges in Assessing Product Liability, Tobacco, and Gun Litigation*, 32 J.L. MED. & ETHICS 556, 556–59 (2004).

30 For example, tort claims can provide recourse for people harmed in under-regulated

plaintiff, using its *parens patriae* power and bringing suit to redress harms on behalf of the public.[31]

Civil litigation can bolster additional public health policy goals by facilitating the disclosure of important information through the discovery and trial processes. Litigation can shed light on how defendants have acted to prioritize economic gain over protecting people from potential harm.[32] The information gleaned from and publicity given to pending litigation can highlight the risks of products or the behaviors of people using those products and can result in altered product design or drive behavior modifications among manufacturers or consumers. For example, evidence suggests that the widespread publicity given to tobacco company documents revealed during tobacco litigation in the 1990s solidified the public perception of the harm posed by cigarette smoking and helped to reduce smoking rates.[33] In addition, litigation can serve as a catalyst for political change, providing support for future legislative or regulatory interventions.[34] Indeed, some legislative and regulatory responses to the opioid crisis arguably stem from the ongoing opioid litigation, including the expanded use of prescription drug monitoring systems to track opioid prescriptions.[35]

The tort system has many limitations as a means to advance public policy. Monetary remedies are often inadequate in amount or in-

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fields and later spur the government to regulate. Litigation related to motor vehicle injuries was a major driver in changes to vehicle design and the subsequent adoption of regulatory standards for vehicle safety. *See* Jon S. Vernick et al., *Role of Litigation in Preventing Product-Related Injuries*, 25 Epidemiologic Reviews 90, 91–93 (2003); *see also* Melissa Mortazavi, *Tort as Democracy: Lessons from the Food Wars*, 57 Ariz. L. Rev. 929, 975 (2015).

31 The *parens patriae* doctrine allows a state to sue on behalf of its citizens. *See* Alexander Lemann, *Sheep in Wolves' Clothing: Removing* Parens Patriae *Suits Under the Class Action Fairness Act*, 111 Colum. L. Rev. 121, 122 (2011).

32 Jon S. Vernick et al., *How Litigation Can Promote Product Safety*, 32 J.L. Med. & Ethics 551, 553–54 (2004). *But see* Jennifer D. Oliva, *Opioid Multidistrict Litigation Secrecy*, 80 Ohio St. L.J. 663, 664–65 (2019) (describing how, so far, the MDL court has kept discovery under seal, effectively "undermin[ing] the public health promoting outcomes such litigation aims to achieve").

33 Peter D. Jacobson & Soheil Soliman, *Litigation as Public Health Policy: Theory or Reality*, 30 J.L. Med. & Ethics 224, 234 (2002); Walter J. Jones & Gerard A. Silvestri, Commentary, *The Master Settlement Agreement and Its Impact on Tobacco Use 10 Years Later: Lessons for Physicians About Health Policy Making*, 137 Chest J. 692, 693 (2010).

34 *See, e.g.*, Stephen P. Teret & Michael Jacobs, *Prevention and Torts: The Role of Litigation in Injury Control*, 17 L. Med. & Health Care 17, 17 (1989); Tom Christoffel, *The Role of Law in Reducing Injury*, 17 L. Med. & Health Care 7, 9 (1989).

35 *See generally* Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 Ind. Health L. Rev. 139 (2018); Jennifer D. Oliva, *Prescription Drug Policing: The Right to Protected Health Information Privacy Pre- and Post-Carpenter*, 69 Duke L.J. 775 (2019).

commensurate to the actual harm caused, particularly if the harm is death.[36] Further, tort litigation requires harm as a precondition of finding fault.[37] Consequently, tort claims provide retrospective remedies in most cases and, therefore, have limited potential for anticipatory interventions to prevent harm. In the opioid context, the retrospective approach of tort litigation means that lawsuits geared toward holding opioid manufacturers and distributors accountable for their marketing practices and callous indifference to the widespread overuse of prescription opioid medications occur after many of those practices have already ceased as a response to media or litigation pressure.[38] The locus of the opioid epidemic, while initially driven by the challenged practices of the opioid litigation defendants, has evolved to now primarily involve overdose deaths from illicit heroin and fentanyl.[39] Plaintiffs in public health tort claims often struggle to overcome the evidentiary thresholds of causation in making their cases or are overwhelmed by the sophisticated and well-financed strategic defenses raised by corporate defendants.[40] Complex litigation like the opioid lawsuits generates additional challenges, such as the calculation and disposition of damages that may be awarded through adjudication or settlement of a civil claim.[41]

Public health law scholars have robustly debated how public health litigation can or should contribute to advancing public health policies or goals.[42] While litigation can support public health policy change and will occasionally drive this change, the effectiveness of litigation is often context-specific and constrained by structural and practical limitations. Litigation is usually retrospective and applies to specific cases and controversies rather than prospective policy development, relegating most policy changes to the political branches.[43] Other commentators demonstrate significant resistance to the notion of litigation becoming a driver of public health policy, expressing concerns about judicial activism and the lack of democratic accountability.[44]

36 *See* Douglas Laycock, *The Death of the Irreparable Injury Rule*, 103 HARV. L. REV. 687, 709 (1990).

37 DAN B. DOBBS ET AL., HORNBOOK ON TORTS 311 (2d ed., 2016).

38 *See* Terry, *supra* note 8, at 649–52.

39 *Id.* at 651.

40 Peter D. Jacobson & Soheil Soliman, *supra* note 33, at 231–34.

41 *See* Weeks & Sanford, *supra* note 19, at 1063.

42 *See* Lytton, *supra* note 29, at 556; *See also* Wendy E. Parmet & Richard A. Daynard, *The New Public Health Litigation*, 21 ANN. REV. PUB. HEALTH 437,441–43 (2000).

43 Peter D. Jacobson & Kenneth E. Warner, *Litigation and Public Health Policy Making: The Case of Tobacco Control*, 24 J. HEALTH POL. POL'Y & L. 769, 795–97 (1999).

44 *See, e.g.*, Jonathan Turley, *A Crisis of Faith: Tobacco and the Madisonian Democracy*, 37 HARV. J. LEGIS. 433, 436–37 (2000); R. Shep Melnick, *Tobacco Litigation: Good for the Body but Not the Body Politic*, 24 J. HEALTH POL. POL'Y & L. 805, 807–08 (1999).

Despite the evident limitation and scholarly critiques, public health litigation has—and should—play an important role in advancing public health policy. Litigation can be particularly impactful to push back against powerful industries that are less susceptible to legislative and regulatory constraints due to their political influence. Moreover, public health litigation can meaningfully influence the broader public policy conversation by shedding light on factors driving public health crises. Both of these functions have appeared as the opioid litigation has unfolded.

B. *Governments as Plaintiffs*

The use of public health litigation by state and local governments raises additional issues. For example, when should governments use litigation to pursue public health goals as opposed to regulating directly? Often the circumstances and politics surrounding the public health concern at issue dictate the answer to this question. Litigation may be a particularly preferred approach when governments have sustained a clearly identifiable injury from the defendants' activities or when political gridlock or preemption prevents direct legislative or regulatory action.

The 1998 tobacco Master Settlement Agreement (MSA) provides the most prominent example of state government plaintiffs successfully using litigation to address a major public health concern and also provides an interesting—if not completely analogous—template for the pending opioid litigation.[45] State governments had been severely restricted in regulating tobacco products due to judicial interpretations of federal tobacco legislation that preempted most state tobacco regulation and litigation.[46] In *Cipollone v. Liggett Inc.*, however, the Supreme Court ruled that claims against tobacco companies on some state law tort theories were not preempted.[47] This case provided a turning point and opened the door for additional state litigation. The state lawsuits that followed sought damages for medical expenses incurred by the state related to smoking-induced illnesses.[48] After substantial

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45 *See generally* Micah L. Berman, *Using Opioid Settlement Proceeds for Public Health: Lessons from the Tobacco Experience*, 67 Kan. L. Rev. 1029 (2019).

46 *See, e.g.*, Roysdon v. R.J. Reynolds Tobacco Co., 623 F. Supp. 1189, 1190 (E.D. Tenn. 1985) (holding that the common law claim of failure to warn was preempted by federal legislation); *see also* Federal Cigarette Labeling and Advertising Act of 1965, Pub. L. No. 89-92 §§ 4-5, (1965); Public Health Cigarette Smoking Act of 1969, Pub. L. No. 91-222, § 5, 84 Stat. 87 (1970) (codifying labeling requirements and imposing restrictions on cigarettes in federal law while preempting more stringent state standards and restrictions).

47 Cipollone v. Liggett Grp., 505 U.S. 504, 530–31 (1992).

48 *See, e.g.*, Jon S. Vernick et al., *Public Health Benefits of Recent Litigation Against the Tobacco*

negotiation between the plaintiff states and the tobacco industry, the MSA resolved all of the pending litigation between forty-six states and the major tobacco companies, providing billions of dollars to states while imposing significant restrictions on tobacco advertising, marketing, and other conduct.[49]

Several public health litigation lessons can be taken from the MSA. First, it demonstrated that states could push for public health change through litigation against major industries producing harmful products—and could potentially obtain a significant amount of money in damages through such litigation. Government plaintiffs, including those currently pursuing opioid litigation, have since adopted many of the same legal arguments and strategies that succeeded in the tobacco litigation. Second, though the funds from the MSA were meant to reimburse the plaintiff states for medical expenses related to smoking and to underwrite future programs to reduce tobacco use, very little of the settlement money seems to have gone to tobacco cessation programs or public health initiatives.[50] Consequently, public health advocates have recommended that future mass tort settlements be more directive as to how settlement funds are used to improve public health.[51] Third, in some respects, the tobacco companies represented the perfect defendant for a substantial tort settlement: a huge, profitable industry making a clearly harmful product with a strong incentive to settle once their decades-long record of success against lawsuits began to fracture. Other industries—including the opioid manufacturers and distributors currently facing thousands of civil claims—do not have the same magnitude of resources for a large enough settlement to satisfy thousands of claimants or a similarly clear set of inducements to enter into an analogous settlement agreement.[52]

Another important issue pertaining to governments as plaintiffs in public health litigation arises when state and local government plaintiffs

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Industry, 298 JAMA 86, 87 (2007).

49 *Master Settlement Agreement*, PUB. HEALTH L. CTR., https://publichealthlawcenter.org/sites/default/files/resources/master-settlement-agreement.pdf (last visited Nov. 19, 2020).

50 Most states used the MSA funds for initiatives other than tobacco prevention, with some rare exceptions. A report from the Campaign for Tobacco-Free Kids estimated that in fiscal year 2020, states will spend only 2.7% of the MSA revenue on tobacco-related programming. *A State-by-State Look at the 1998 Tobacco Settlement 21 Years Later*, CAMPAIGN FOR TOBACCO-FREE KIDS, https://www.tobaccofreekids.org/what-we-do/us/statereport (last updated Jan. 16, 2020); Terry, *supra* note 8, at 656.

51 Micah L. Berman, *Using Opioid Settlement Proceeds for Public Health: Lessons from the Tobacco Experience*, 67 U. KAN. L. REV. 1029, 1052–58 (2019).

52 *See* Terry, *supra* note 8, at 655–64.

bring public health lawsuits simultaneously. State governments have the authority, resources, and standing to bring claims in their own states' courts, while the capacity of local governments to act as plaintiffs is much more varied and limited.[53] The authority of cities and counties to bring lawsuits on behalf of their residents varies by state, and the resources available to support litigation will almost always be greater at the state level.[54]

This would tend to suggest that public health litigation initiated and pursued by state attorneys general is more likely to succeed. Indeed, the two most successful public health mass-tort lawsuits brought by government plaintiffs—related to harms from tobacco and asbestos—were led primarily by state governments.[55] Public health litigation efforts initiated by local governments against manufacturers and sellers of firearms and lead paint have had much less success due to procedural, substantive, and political factors, including preemption by federal and state law.[56] Nevertheless, local governments may suffer distinct harms that lend themselves to redress, and not all of these claims can, or will, be pursued at the state level. Moreover, state-level settlements will rarely be shared with local jurisdictions, a lesson that local governments learned well after the tobacco MSA.[57] If local governments rely on states to pursue litigation on their behalf, local interests are likely to be neglected and local damages ignored. Therefore, it is imperative that local governments continue to pursue litigation when possible to vindicate the harms incurred by those local governments and their residents.

C. *Opioid Lawsuits: An Evolving Landscape*

The opioid crisis has generated thousands of lawsuits.[58] The earliest of these were largely filed by individuals seeking damages from opioid manufacturers for marketing their product in fraudulent and misleading ways or from individual physicians for prescribing opioids in the first place.[59] In these lawsuits, dubbed the "first wave" by Gluck and others, plaintiffs were nearly uniformly unsuccessful.[60] Manufacturers and physician defendants

53 *See* Sarah L. Swan, *Plaintiff Cities*, 71 Vand. L. Rev. 1227, 1271–76 (2018).
54 *Id.* at 1271, 1275.
55 *Id.* at 1233–34.
56 *Id.* at 1234–39.
57 *See* Jones & Silvestri, *supra* note 33, at 695–97.
58 Terry, *supra* note 8, at 656–57.
59 Gluck et al., *supra* note 9, at 353.
60 *Id.* at 353 (exploring the history of and legal issues implicated by the opioid litigation); *see also*, Richard C. Ausness, *The Role of Litigation in the Fight Against Prescription Drug Abuse*, 116 W. Va. L. Rev. 1117, 1122 (2014).

were able to portray the fact that plaintiff consumers were continuing to take excess opioids and that other physicians were continuing to prescribe them to patients as intervening illegal conduct, obviating any liability on the part of the defendants.[61] These defenses mirrored the strategy used successfully by tobacco defendants for decades against individual tort claims.[62]

Federal and state officials also began to pursue civil and criminal actions against opioid manufacturers, which culminated in a 2007 Purdue Pharma agreement to pay a $600 million settlement to the federal government plus approximately $20 million to twenty-six states and the District of Columbia for violating the Food, Drug, and Cosmetic Act[63] by introducing a misbranded drug.[64] As in the earlier tobacco litigation, state governments acting as plaintiffs were able to reach a settlement, although a fairly limited one. Whether any of the settlement money that went to the states actually funded programs related to the opioid crisis is unclear.[65] As a result, the first wave of litigation had a modest effect on the overall dynamics of the prescription opioid industry.

The success of the federal and state settlements provided a roadmap for future government litigants, however. Subsequent lawsuits, primarily filed by state and local governments, have adopted and expanded the legal theories and strategies of the earlier opioid cases and have also drawn from the successful litigation strategies and tort theories that led to the tobacco MSA.[66] The government plaintiffs allege that the effects of opioid dependency and overuse have imposed substantial costs on their budgets.[67] The lawsuits contain a wide variety of legal theories, ranging from public nuisance, negligence, unjust enrichment, violations of state consumer protection, racketeering, and Medicaid fraud to failure to follow Drug Enforcement Administration (DEA) regulations under the Controlled Substances Act[68] and analogous state regulations to "monitor, detect, investigate, refuse and

61 Gluck et al., *supra* note 9, at 353.

62 Berman, *supra* note 45, at 1032–33.

63 21 U.S.C. § 301 (2018).

64 United States v. Purdue Frederick Co., 495 F. Supp. 2d 570, 570–73 (W.D. Va. 2007); Gluck et al., *supra* note 9, at 353.

65 Gluck et al., *supra* note 9, at 353–54 (noting that in Connecticut most of the settlement money apparently went to cover attorneys' fees and general fund expenditures).

66 Berman, *supra* note 45, at 1033–34.

67 *See* Weeks & Sanford, *supra* note 19, at 1064–66. Claims using unjust enrichment and statutory consumer protection provisions to recover health care costs were first used successfully by states in the tobacco MSA. *See* Robert L. Rabin, *The Tobacco Litigation: A Tentative Assessment*, 51 DEPAUL L. REV. 331, 337 (2001).

68 21 U.S.C. § 801 (2018).

report suspicious orders of prescription opioids."[69] Fundamentally, though, the lawsuits center on claims that the defendant manufacturers excessively and inappropriately marketed and promoted opioid medications, and defendant distributors and sellers did not appropriately keep track of or report excessive orders.[70]

The number of government lawsuits quickly expanded and continued to grow. As of September 2020, forty-nine states had filed claims against opioid manufacturers.[71] State-level claims were brought, for the most part, by state attorneys general in lower courts, alleging violations of state law and invoking the states' *parens partriae* powers.[72] The multiplicity of claims presented jurisdictional and practical challenges for the parties and the courts. Among other things, states have sought damages to compensate for expenditures on opioid-related harms under Medicaid and other programs.[73] While there has been coordination among states in their settlement negotiations with opioid manufacturers and other defendants, the state-level opioid cases have proceeded independently and at varying speeds.[74]

As the state lawsuits were emerging, local jurisdictions simultaneously began to file distinct opioid-related lawsuits.[75] The proliferation of local suits has many causes. Many cities and counties—and their residents—were suffering significant harm from opioid-related deaths and dependency.[76] In times of inadequate local budgets, seeking redress for these harms through

69 *See* Gluck et al., *supra* note 9, at 355–56. Some pending lawsuits also include claims against the Joint Commission—the independent entity that accredits hospitals—for collusion with manufacturers in developing accreditation standards that favored opioid overprescribing. *Id.* at 356–57.

70 *See* Terry, *supra* note 8, at 639 (helpfully categorizing the pending lawsuits into claims of "overpromotion" and "diversion").

71 Stubbs, *supra* note 16.

72 Michelle L. Richards, *Pills, Public Nuisance, and* Parens Patriae*: Questioning the Propriety of the Posture of the Opioid Litigation*, 54 U. Rich. L. Rev. 405, 440, 443, 445 (2020).

73 *Id.* at 453.

74 Most of these state cases are still pending and moving forward slowly. State litigation against Purdue Pharma has been halted while federal bankruptcy proceedings occur. *See generally* Voluntary Petition for Non-Individuals Filing for Bankruptcy, *In re* Purdue Pharma, Inc., No. 19-23649 (Bankr. S.D.N.Y. Sept. 15, 2019), ECF No. 1. The state of Oklahoma is an exception to this trend, having negotiated a $270 million settlement with Purdue Pharma in 2019 and winning a favorable verdict against Johnson & Johnson for $572 million after the court found that the company had engaged in misleading marketing and created a public nuisance. *See* State *ex rel.* Hunter v. Purdue Pharma L.P., No. CJ-2017-816, 2019 Okla. Dist. LEXIS 3486 (Okla. Dist. Ct. Aug. 26, 2019) (entering judgment after non-jury trial).

75 *See* Richards, *supra* note 72, at 405–06.

76 *See* Dasgupta et al., *supra* note 3, at 182–83.

the tort system provided an opportunity to recoup local expenditures related to opioid use and to fund future efforts to respond to the crisis. Damages sought by local jurisdictions were distinct from state harms, and therefore not likely to be covered in a state settlement with opioid manufacturers or distributors.[77] Moreover, local governments had not shared in the settlement money from the tobacco MSA, which further incentivized local governments to pursue their own lawsuits related to opioids rather than to rely on the states to look out for their interests.[78]

Local government opioid lawsuits also received strong support and encouragement from private sector attorneys, many of them experts at representing plaintiffs in mass tort litigation.[79] These litigators offered more than just their expertise, sophistication, and connections; they also brought local officials the promise of a contingency fee arrangement.[80] Local governments typically do not have the capacity—in terms of money or personnel—to bring complex litigation against well-funded industries. But with assistance from outside counsel working on contingency, there was nothing for the local governments to lose in filing an opioid claim.

The Judicial Panel on Multidistrict Litigation consolidated forty-six local opioid litigation claims pending in federal courts into a single multidistrict litigation (MDL) on December 12, 2017, and appointed Judge Dan Aaron Polster of the Northern District of Ohio to preside over the case.[81] MDLs are a procedural mechanism authorized under federal law that allows for the consolidation and coordination of pretrial proceedings in cases with similar claims, as determined by the Judicial Panel on Multidistrict Litigation.[82] MDLs are often touted as a procedural mechanism that is both flexible and efficient, allowing for the collected plaintiffs and defendants

77 *See* Weeks & Sanford, *supra* note 19, at 1111–13.

78 *See generally* Berman, *supra* note 45, at 1035.

79 Andrew D. Bradt & D. Theodore Rave, *It's Good to Have the "Haves" on Your Side: A Defense of Repeat Players in Multidistrict Litigation*, 108 Geo. L.J. 73, 75, 94 (2019); Tom Hals & Nate Raymond, *Opioid Companies Say Lawyers' Fee Demand Threatens Settlement Talks*, Reuters (Feb. 27, 2020), https://www.reuters.com/article/us-usa-opioids-litigation/opioid-companies-say-lawyers-fee-demand-threatens-settlement-talks-idUSKCN20L2PK.

80 Burch, *supra* note 18, at 20.

81 Transfer Order, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-02804 (J.P.M.L Dec. 12, 2017), ECF No. 1.

82 While MDLs are a mechanism for consolidating multiple similar tort claims, they are not the same as class actions. The court overseeing the MDL cannot resolve the individual claims, which must be remanded back to the federal district court where they were filed. MDLs also do not have the requirements or plaintiffs' protections that are built into class actions. *See* Burch, *supra* note 18, at 12–17.

to work out common issues across cases in a consolidated format.[83] Critics have argued, however, that the MDL mechanism prioritizes efficiency over fairness and transparency, incentivizes settlement over adjudication, and forces individual litigants to cede their control over their claims to a centralized process headed by a small set of representative counsels.[84]

While initially encompassing only a few hundred cases, the opioid MDL has grown to include approximately 2,500 opioid lawsuits from local and tribal jurisdictions.[85] These suits propose a range and diversity of legal theories, as well as a wide range of defendants named in the suits.[86] This may pose a challenge to finding a common resolution for damages in settlement negotiations, although the consolidation of claims in the MDL could have the opposite effect and streamline the negotiation process. Moreover, the breadth and scope of the legal theories give rise to a different challenge: calculating damages that can reasonably approximate the losses that the plaintiffs are claiming.[87]

Litigation initiated by state and local government plaintiffs changes the nature of the applicable tort claims in some important ways. These claims have more likelihood of success compared with earlier claims filed by individuals against opioid manufacturers because government plaintiffs can avoid defenses that successfully cast blame and responsibility on consumers and prescribers for misuse in the earlier suits filed by individual plaintiffs.[88] Additionally, by focusing on the population-level effects of the defendants' actions, the government plaintiffs can better measure the scope of harm allegedly caused by these actions. If pursued in coordination, these government lawsuits could create a stronger position from which to negotiate a substantial settlement, as was done with the tobacco MSA. Finally, the availability of different causes of action may facilitate government plaintiffs' success. Public nuisance claims, for example, have "standards of fault and causation that are less rigorous than those applied in personal

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83 *See generally*, Burch, *supra* note 18.

84 *See, e.g.*, *id.* at 24–30; Howard M. Erichson, *MDL and the Allure of Sidestepping Litigation,* 53 Ga. L. Rev. 1287, 1289 (2019); Roger Michalski, *MDL Immunity: Lessons from the National Prescription Opiate Litigation*, 69 Am. U. L. Rev. 175, 213–14, 227–29 (2019); David L. Noll, *MDL as Public Administration*, 118 Mich. L. Rev. 403, 426, 452, 454–56 (2019).

85 Sara Randazzo, *Last-Minute Opioid Deal Could Open Door to Bigger Settlement*, Wall St. J. (Oct. 21, 2019), https://www.wsj.com/articles/four-drug-companies-reach-last-minute-settlement-in-opioid-litigation-11571658212 (noting that there are 2500 pending lawsuits consolidated in the MDL).

86 Gluck et al., *supra* note 9, at 353–57.

87 *See generally* Weeks & Sanford, *supra* note 19 (discussing the challenges with calculating damages incurred by local jurisdictions from the opioid crisis).

88 *See* Haffajee & Mello, *supra* note 9, at 2304 (analyzing the legal theories being advanced in the lawsuits against opioid manufacturers).

injury claims[,]"[89] which could increase their likelihood of success vis-à-vis individual negligence claims.

Judge Polster has adopted an aggressive approach to managing the MDL, stating at the outset that he intended to urge the parties to agree to a rapid global settlement agreement that prioritized forward-looking initiatives that would help address the ongoing toll of the opioid crisis. In his initial comments to the litigants, he indicated that the federal court needed:

> to try and tackle [the opioid crisis, since] the other branches of government, federal and state, have punted. . . . So my objective is to do something meaningful to abate this crisis and to do it in 2018. . . . [W]hat I'm interested in doing is not just moving money around, because this is an ongoing crisis. What we've got to do is dramatically reduce the number of the pills that are out there and make sure that the pills that are out there are being used properly. . . . [W]e don't need a lot of briefs and we don't need trials. They're not going to—none of them are—none of those are going to solve what we've got.[90]

This approach explicitly seeks to influence national opioid policy, using litigation procedure in a prescriptive—rather than retrospective and reactive—way.[91]

Judge Polster's ambition for a rapid and prescriptive settlement for the opioid MDL has not come to fruition. Shepherding so many disparate plaintiffs and defendants through such a large and varied number of claims has presented an impossibly complex task, and with thousands of motions filed over the past two and a half years, a global settlement remains elusive. Two "bellwether" trials—selected initial trials meant to test the parties' legal theories in court and to set precedent and standards for the other pending cases—were settled just before these cases were scheduled to proceed in October 2019.[92]

Judge Polster continued to push the procedural envelope to pursue

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89 Lindsay F. Wiley, *Rethinking the New Public Health*, 69 Wash. & Lee L. Rev. 207, 236–37 (2012).

90 *See* Transcript of Proceedings of January 9, 2018 at 4, 9, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-2804 (N.D. Ohio Jan. 12, 2018), ECF No. 71.

91 Gluck et al., *supra* note 9, at 359–60. Scholars of MDL procedure have noted the inherent flexibility of this model to allow for judicial innovation in resolving complex, multiparty cases, but Judge Polster's approach is unique even by MDL standards. *See* Noll, *supra* note 84, at 412–13, 440–42; Burch & Williams, *supra* note 18, at 1447–48.

92 Brian Mann & Colin Dwyer, *Opioid Trial: 4 Companies Reach Tentative Settlement With Ohio Counties*, NPR (Oct. 21, 2019), https://www.npr.org/sections/health-shots/2019/10/21/771847539/opioid-trial-4-companies-reach-tentative-settlement-with-ohio-counties.

a global settlement by certifying a negotiation class.[93] The negotiation class is a "novel" use of class action procedures that creates a class that encompasses all of the cities and counties across the United States for purposes of negotiating a "global" opioid settlement that would apply to all potential local government claims against the opioid defendants.[94] This class certification would have allowed the plaintiffs' leadership team to negotiate settlement terms with opioid litigation defendants on behalf of all of these jurisdictions,[95] even though only about ten percent of the 34,000 potentially eligible jurisdictions have brought claims that have been consolidated in the MDL. Like with other class action lawsuits, state and local officials who do not want to participate in the class—whether they may want to preserve a right to pursue a trial or settlement separately in the future or not—can opt out.[96] This ruling, issued by Judge Polster in September 2019, was both innovative and controversial; indeed, both state government plaintiffs and many of the defendants opposed the formation of the negotiation class.[97] The negotiation class could have had implications for the likelihood of a global opioid settlement. The opposition of both defendants and rival state plaintiffs indicates that the existence of a negotiation class potentially puts local government plaintiffs (or potential plaintiffs) in a stronger position to negotiate favorable settlement terms. However, in September 2020, the Sixth Circuit Court of Appeals reversed Judge Polster's negotiation class certification and remanded this issue back to the lower court for further proceedings, likely reducing the leverage of local jurisdictions in ongoing settlement negotiations.[98]

MDL proceedings have also been delayed by bankruptcy filings by some of the larger defendants, including Purdue Pharma and members of the Sackler family who own Purdue Pharma.[99] The United States Bankruptcy

93 *See In re* Nat'l Prescription Opiate Litig., 332 F.R.D. 532, 537 (N.D. Ohio 2019) (granting parties' motion for certification).

94 *Id.* at 537, 543.

95 *Id.* at 547, 551, 556.

96 *Id.* at 540–41, 551.

97 *See* Memorandum of Certain Defendants in Opposition to Plaintiffs' Renewed and Amended Motion for Certification of Rule 23(b)(3) Cities/Counties Negotiation Class, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-2804 (N.D. Ohio July 23, 2019), ECF No. 1949; Letter from National Association of Attorneys General as Amici Curiae Opposing Plaintiffs' Renewed and Amended Motion for Certification of Rule 23(b)(3) Cities/Counties Negotiation Class, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-2804 (N.D. Ohio July 23, 2019), ECF No. 1951.

98 *In re* Nat'l Prescription Opiate Litig., 976 F.3d 664, 667 (6th Cir. 2020).

99 *See* Notice of Eighth Amended Bankruptcy Court Order Granting Injunction Against Continuation of Proceedings as to Related Parties to Debtor Purdue Pharma L.P. & Affiliated Debtors, *In re* Nat'l Prescription Opiate Litig., No.1:17-md-2804 (N.D. Ohio

Court for the Southern District of New York has enjoined the MDL claims and other litigation pending the resolution of the bankruptcy.[100]

The immense size and novelty of the opioid litigation provide an unwieldy situation, the outcome of which remains uncertain. Yet, even as the story of these lawsuits continues to unfold, we are faced with the unusual inter-jurisdictional dynamics that have arisen from so many state and local jurisdictions simultaneously bringing overlapping lawsuits against the same set of defendants. The tension between government plaintiffs—especially between state and local governments within the same state—can give rise to unexpected and competing interests. Driven by the legacy of the tobacco MSA and concern about the influence of sophisticated plaintiffs' attorneys at the local level, states have contemplated using preemption authority to limit local litigation, as the underlying dynamics of privatization play out through litigation strategy and incentives.

Apr. 2, 2020), ECF No. 3251.

100 *Id.* In October 2020, Purdue Pharma agreed to plead guilty to federal criminal charges related to opioid sales and marketing tactics and to pay an $8.3 billion settlement of criminal and civil penalties to the federal government. This settlement does not include the MDL cases or other pending state litigation. *See* Katie Benner, *Purdue Pharma Pleads Guilty to Role in Opioid Crisis as Part of Deal with Justice Dept.*, N.Y. TIMES (Nov. 24, 2020), https://www.nytimes.com/2020/11/24/us/politics/purdue-pharma-opioids-guilty-settlement.html.

II. Privatization and Public Health Litigation

The expansion of opioid lawsuits filed by both state and local governments created more than just logistical complexity. These suits created the potential for conflicting interests between states and local governments. Once the local government lawsuits were consolidated into the MDL, the potential for conflict became even more pronounced. The MDL mechanism gave the local government plaintiffs a much stronger bargaining position against the defendants by aggregating their negotiating power and providing a coordinated and expedited procedure designed to advance settlement talks quickly. The state plaintiffs, concerned that the local plaintiffs were now on the fast track to settlement with the assistance of Judge Polster, faced the possibility that the defendants would be depleted of resources by a global MDL settlement, leaving no money to cover the states' claims against them.[101] But states retain a great deal of power and control over the activities of local governments, and some states have sought to use that authority to preempt local opioid lawsuits or to limit efforts by local government to utilize private attorneys to assist with their opioid-related legal claims.[102]

This part discusses the issues that arise when governments privatize public health services and activities generally. It also addresses the analogous contemporary conversations surrounding the use of private attorneys to bring public lawsuits on behalf of government plaintiffs. The politics underlying these two types of privatization often generate controversy and may give rise to positions that are diametrically opposed. Progressive advocates and policymakers often offer a trenchant critique of the principles that underlie privatization of government services, while conservative advocates and policymakers often suggest a similarly strong critique of the privatization of litigation practice.[103] Privatization—and specifically the role of private attorneys as key players in the local government opioid lawsuits—has exacerbated some of the tensions between state and local governments related to opioid litigation and provided a convenient target for states interested in criticizing—or intervening in—local litigation. And while privately led public litigation poses concerns about accountability, incentives, and contingency fees, all of these concerns can be adequately addressed through the application of existing legal mechanisms. Moreover, the downsides of private involvement in public litigation are outweighed by the benefits of allowing private counsel to be involved in opioid litigation.

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101 Randazzo, *supra* note 22.

102 See *infra* Sections II(B) and III(B).

103 *See generally* Ronald A. Cass, *Privatization: Politics, Law and Theory*, 71 Marq. L. Rev. 449 (1988).

A. *Privatization and Public Health*

The privatization of government responsibilities and services represents a longstanding trend in the United States, although one that has ebbed and flowed over time.[104] The substantial expansion of government, beginning with the New Deal in the 1930s through World War II and then the Great Society programs of the 1960s, gave way to the deregulatory and small government-oriented policies of the Reagan Administration in the 1980s.[105] The deregulatory movement that gained prominence during the Reagan era and has remained salient since then has provided a template for reducing the size of government as well as loosening regulations on the private sector, not only at the federal level but also across state and local jurisdictions.[106] Outsourcing governmental responsibilities and services to private contractors has become commonplace, especially in areas such as private schools and private prisons,[107] raising concerns about whether privatized public services can remain accountable to the public.[108]

"Privatization, [broadly speaking,] is the transfer of decision-making authority, delivery, or financing from a public to a private entity."[109] Privatization often merely involves contracting with private organizations to provide government services, but it may involve more extensive delegation of responsibility and even government powers.[110] It also encompasses public-private partnerships and external funding programs that frequently support state and local public health initiatives.[111] Several factors drive privatization: a desire for smaller government operations and responsibility; an interest in efficiency, flexibility, competition, or innovation; and an ideological commitment to private sector or market-based mechanisms in certain areas

104 *See generally* Jeffrey R. Henig, *Privatization in the United States: Theory and Practice*, 104 Pol. Sci. Q. 649 (1989–1990).

105 *Id.* at 649.

106 Florencio López-de-Silanes et al., *Privatization in the United States*, 28 RAND J. Econ. 447, 448–53, 468 (1997).

107 Jody Freeman, *The Contracting State*, 28 Fla. St. U. L. Rev. 155, 165, 185–86 (2000).

108 *See* Martha Minow, *Public and Private Partnerships: Accounting for the New Religion*, 116 Harv. L. Rev. 1229, 1230 (2003). *But see* Michael J. Trebilcock & Edward M. Iacobucci, *Privatization and Accountability*, 116 Harv. L. Rev. 1422, 1422 (2003).

109 Gollust & Jacobson, *supra* note 24, at 1734.

110 *See* David M. Lawrence, *Private Exercise of Governmental Power*, 61 Ind. L.J. 647, 647–48 (1986).

111 *See generally* Jonathan H. Marks, The Perils of Partnership, Industry Influence, Institutional Integrity, and Public Health (2019) (using one example of a privatized public health initiative—federal food and nutrition policies—to examine the inherent ethical questions and potential risks to the public of systemic privatization at this scale).

of society, among others.[112] While both state and local governments under leadership from both political parties have supported privatization, the delegation of government functions to non-governmental entities is more commonly pursued by small government-favoring conservative politicians and advocates.[113]

State and local governments are the primary drivers of public health governance, and the privatization of public health has followed contemporary trends in government privatization. However, while the scholarly literature and analysis of privatization generally are quite robust, the study and analysis of public health sector privatization specifically are sparse. A detailed study done approximately 20 years ago determined that nearly three-quarters of local health departments had privatized some of their public health services.[114] It is likely that the current scope of public health privatization is even higher, as state and local budgets have not recovered to prior levels after the 2008 economic downturn.[115] Privatization of public health services is often driven by a desire to achieve efficiency and flexibility, as well as to obtain expertise and capacity ordinarily not available to public health departments internally.[116] This latter incentive is especially important as a factor in local health department decisions to outsource services and functions.[117] Services may also be privatized in response to state law or policy requiring privatization.[118]

From a public health perspective, the policy and functional impact

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112 *See* Cass, *supra* note 103, at 466–68.

113 Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. Rev. 543, 567–68, 594 (2000).

114 Christopher Keane et al., *Privatization and the Scope of Public Health: A National Survey of Local Health Department Directors*, 91 Am. J. Pub. Health 611, 612 (2001).

115 *See, e.g.*, *A Funding Crisis for Public Health and Safety: State-by-State Public Health Funding and Key Health Facts*, Trust for America's Health 14–15 (Mar. 19, 2019), https://www.tfah.org/report-details/a-funding-crisis-for-public-health-and-safety-state-by-state-and-federal-public-health-funding-facts-and-recommendations/ (outlining trends and challenges in public health budgeting); Karen DeSalvo et al., *Developing a Financing System to Support Public Health Infrastructure*, 109 Am. J. Pub. Health 1358, 1359–60 (2019) (providing recommendations for expanding financing for public health infrastructure). State health agency expenditures have decreased by 15.6% since 2016. *See State Public Health Resources and Capacity*, Ass'n St. & Territorial Health Officers 1 (Mar. 23, 2020), https://www.astho.org/Research/Data-and-Analysis/Data-Brief-on-State-Public-Health-Resources-and-Capacity/. The COVID-19 pandemic will have a substantial effect on constraining state and local health department budgets for the foreseeable future.

116 Keane et al., *supra* note 114, at 613.

117 *Id.*; *see also* Christopher Keane et al., *Perceived Outcomes of Public Health Privatization: A National Survey of Local Health Department Directors*, Milbank Q., March 2001, at 115.

118 Keane et al., *supra* note 114, at 613.

of privatization are mixed. Privatization may have both positive and negative implications for public health and the functioning of government entities charged with the protection of public health. Privatization may allow public health agencies to expand capacity or to address public health problems or provide services that are outside the capability of their permanent workforces.[119] However, privatization raises concerns about oversight, accountability, priorities, and resource allocation.[120] Will private contractors and partners feel accountable, and can they be held accountable, either to government agencies or to the public at large? Will private contractors adequately uphold public health goals or reject these goals for other values, specifically economic and profit considerations? In other words, will the best interests of the public or their own interests take precedence in their actions? Will bringing in private contractors to conduct public health work be effective and efficient? Will the work done by these private contractors be worth the financial costs, opportunity costs, and trade-offs with direct democratic accountability?

The trend of privatization has engendered much debate, critique, and analysis. Frequently, opponents of privatization come from the political left.[121] Progressives and left-leaning public health advocates often raise well-founded concerns that with privatization comes an intermingling of market approaches and public health goals, which can only serve to dilute those goals and undermine the values and mission of public health.[122] The incorporation of profit-seeking motives into public health could result in initiatives less consistent with public health goals, expectations, and outcomes. In addition, privatizing public services can undermine the possibility of democratic accountability for the actions of private actors operating in lieu of the government. Alternatively, however, the debate over privatization can spur more attention for the need to support public sector capacity.[123]

As state and local budgets have decreased, privatized approaches to litigation have become integral to government lawsuits, particularly at the local level.[124] While government agencies have historically brought in outside legal expertise for a variety of reasons, state and local governments partnering with plaintiff-side attorneys in mass tort litigation has become

119 Gollust & Jacobson, *supra* note 24, at 1734.

120 *Id.* at 1736.

121 *See* Cass, *supra* note 103, at 453–54 (describing the models of privatization advanced by conservative political leaders).

122 *See* Gollust & Jacobson, *supra* note 24, at 1735 (discussing public health goals in the context of privatization).

123 *Id.* at 1736–37.

124 Margaret H. Lemos, *Privatizing Public Litigation*, 104 Geo. L.J. 515, 532–33 (2016).

more frequent over the last thirty years.[125] The use of private attorneys for public litigation shares many of the potential benefits and raises some of the same concerns about practicality, accountability, and legitimacy that occur in discussions about the privatization of public services more generally. The opioid litigation provides a meaningful contemporary example of how these concerns also can lead to disputes between government plaintiffs over the use of outside counsel to support public litigation.

B. *Privatization and the Opioid Litigation*

The opioid litigation provides an enticing landscape for representation by private attorneys for several reasons. First, state and local governments do not typically have the legal expertise or resources to staff, formulate, or develop complex tort litigation on behalf of the state or the city or county.[126] Consequently, private plaintiffs' attorneys offer an attractive alternative. Outside counsel can promise experience and expertise in complex litigation generally and in cases against industry defendants representing government plaintiffs specifically. These attorneys possess sophisticated understandings of court procedure and strategy, as well as a track record of success in similar cases.[127] Many of the plaintiffs' attorneys involved in the opioid litigation have participated in prior large-scale mass tort litigation on behalf of government plaintiffs.[128] Local government plaintiffs in the opioid litigation have a particularly strong incentive to retain experienced outside counsel to navigate the complexities of an unprecedentedly-large MDL.[129]

Second, government plaintiffs face significant resource limitations in terms of both personnel and expenditures. Budgets and staff capacity are limited, and gaining access to the additional resources needed to mount a complex, multi-year lawsuit is often difficult or impossible.[130] Contingency fee arrangements—in which the private attorneys do not take payment for their legal work unless and until the case is favorably concluded with a judgment for the plaintiffs or a settlement—allow for mass tort lawsuits like those in the opioid litigation to proceed without resources being allocated

125 *See generally* David A. Dana, *Public Interest and Private Lawyers: Toward a Normative Evaluation of* Parens Patriae *Litigation by Contingency Fee*, 51 DePaul L. Rev. 315 (2001) (examining the rise of private counsel support for state attorneys general during the tobacco litigation); Swan, *supra* note 53, at 1244–46, 1280–84 (noting the increased use of private counsel by local government plaintiffs in cases related to public health).

126 Lemos, *supra* note 124, at 532–33, 539, 555.

127 *Id.* at 532–33.

128 Bradt & Rave, *supra* note 79, at 75.

129 *See id.* at 94–98.

130 *See id.* at 95.

up front by government plaintiffs.[131] This approach, in turn, gives executive officials more flexibility in pursuing litigation without the explicit sanction of legislators[132] who may be reticent to acquiesce to litigation for economic or political reasons. Thus, contingency fee arrangements pose a minimal economic risk to local officials and the communities they represent and may be politically advantageous.

Both of these justifications—capacity building and expertise bolstering—provide strong positive incentives to both state and federal governments considering the retention of private counsel in relation to mass torts like the opioid litigation. Indeed, many governments at both levels have retained private counsel to support their lawsuits against the opioid defendants.[133] Private attorneys have become especially integral to the local governments' opioid claims. Many of the local government plaintiffs have retained outside counsel, while only some of the state government plaintiffs have done so.[134]

The proliferation of outside counsel representing local governments can be explained, in part, by a third potential benefit of private attorney representation in the opioid litigation: the fact that private attorneys are representing thousands of jurisdictions simultaneously in the MDL proceedings[135] and that this coordinated effort provides local government plaintiffs with greater clout to negotiate a better settlement from the opioid defendants than they would have alone. Indeed, private plaintiffs' attorneys actively sought additional local government clients to represent in opioid lawsuits, and the core group of private attorneys representing the plaintiffs in the MDL were instrumental in filing the motion that led to Judge Polster's approval of the negotiation class, which has since been overturned.[136]

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131 *See* Dennis E. Curtis & Judith Resnik, *Contingency Fees in Mass Torts: Access, Risk, and the Provision of Legal Services When Layers of Lawyers Work for Individuals and Collectives of Clients*, 47 DePaul L. Rev. 425, 425–26 (1998). *See also* Stewart Jay, *The Dilemmas of Attorney Contingent Fees*, 2 Geo. J. Legal Ethics 813, 830 (1989) (noting that "asbestos cases closed between 1980 and 1982 had average fees and costs of 39%"); Daniel Capra & Lester Brickman, *The Tobacco Litigation and Attorneys' Fees*, 67 Fordham L. Rev. 2827, 2828 (1999) (noting that plaintiffs' attorneys involved in the tobacco litigation in Texas, Mississippi, and Florida received around one quarter of the total settlement).

132 Dana, *supra* note 125, at 319–20 (speculating that state attorneys general retained private counsel on a contingency basis during the tobacco litigation, in part, to avoid legislative funding limits).

133 Fisher, *supra* note 25.

134 *Id.*

135 Daniel Fisher, *Cities vs. States: A Looming Battle for Control of High-Stakes Opioid Litigation*, Forbes (Mar. 28, 2018), https://www.forbes.com/sites/legalnewsline/2018/03/28/cities-vs-states-a-looming-battle-for-control-of-high-stakes-opioid-litigation/#35da8d3e4b5d.

136 *See In re* Nat'l Prescription Opiate Litig., 332 F.R.D. 532, 556 (N.D. Ohio 2019)

Government plaintiffs that have retained outside private counsel for the opioid litigation have received some criticism, particularly on the issues of contingency fees and accountability. Two state attorneys general sought to intervene in local opioid lawsuits in their states and invoked the involvement of private attorneys in these local suits as a justification for their need to intervene.[137] The Arkansas Attorney General filed for a writ of mandamus, citing the potential for damages to go to private attorneys rather than the state as the basis for this attempted intervention, as well as the concern that "out-of-state attorneys . . . stand to claim *significant* damages (in excess of the contingency fee caps set forth in Arkansas law) that would otherwise go to the State to address the opioid epidemic."[138] Further, the petition argued that private attorneys were not accountable, and their participation violated "principles of good government and public policy."[139] Similarly, in an effort to stop local government litigation against opioid defendants, Tennessee's Attorney General alleged that local governments had retained outside counsel inappropriately, without first receiving permission from the state.[140]

Contingency fees represent a vexing ethical issue in this ongoing litigation. Contingency fee arrangements have been vehemently criticized in the past, particularly in cases where large class action or multidistrict litigation awards ended up significantly enriching the plaintiffs' attorneys—some would say at the expense of the actual plaintiffs.[141] In response to this perception, some state legislatures—including those in Arkansas and Tennessee—have separately passed legislation to limit when private attorneys are allowed to bring claims on behalf of public sector entities, imposed approval requirements to limit the discretion of government officials, or capped fees for outside representation.[142]

(certifying negotiation class); *In re* Nat'l Prescription Opiate Litig., 976 F.3d 664, 667 (6th Cir. 2020) (reversing certification of negotiation class).

137 *See infra* Section III(B) for a detailed discussion of these state attempts to preempt local government opioid lawsuits.

138 Emergency Petition for Writ of Mandamus at 2–3, Arkansas v. Ellington, No. CV-18-296 (Ark. Apr. 2, 2018) (emphasis in original).

139 *Id.* Ironically, perhaps, the state of Arkansas is also using private attorneys to oversee their state-level opioid lawsuits. Response to Emergency Petition for Writ of Mandamus at 3, Arkansas v. Ellington, No. CV-18-296 (Ark. Apr. 4, 2018).

140 Letter from Herbert Slatery III, Attorney Gen. of Tenn., to Tenn. Dist. Attorneys Gen. (Mar. 15, 2018), https://jnswire.s3.amazonaws.com/jns-media/06/5c/792254/FromSlatery.pdf.

141 *See* Burch, *supra* note 18, at 60–71 (explaining plaintiffs' attorneys' incentives in mass tort litigation).

142 *See* Fisher, *supra* note 25. *See, e.g.*, Ark. Code Ann. § 25-16-714 (2015) (establishing a contingency fee cap for private counsel working with the attorney general); Tenn. Code Ann. § 8-6-106(a) (2016) (requiring approval of the governor or attorney general

Moreover, state attorneys general also raised the issue of private attorneys' fees in their letter opposing the negotiation class. While recognizing that outside counsel has the right to seek fair compensation for their work, they note that "it is also a reality that Defendants will likely provide a finite amount of money to resolve all the cases, and any grant of excess compensation to Plaintiffs' counsel would unnecessarily lessen the funds available to abate the crisis."[143]

Another relevant concern is that the centralization of these hundreds of local government cases in the hands of a small number of private attorneys could lead to pressure to agree to a premature settlement that works toward the interests of private counsel but not, ultimately, the best interest of the local governments.[144] However, the interests of outside counsel and local governments will not necessarily diverge, especially when plaintiffs are seeking monetary rather than injunctive remedies as they are in the opioid litigation.[145] Given the dynamics of the case and the looming bankruptcy proceedings for some of the more prominent defendants, a more rapid settlement may be preferable for all parties.

On balance, the arrangement between local governments and outside counsel is justifiable in the opioid lawsuits. Without the assistance of outside counsel, local governments would not be able to pursue opioid claims. Most local jurisdictions have neither the subject matter expertise nor the capacity to pursue these claims without outside assistance. By contrast, private attorneys provide a means to allow local governments to advance their claims against the opioid defendants and have a chance to recover some of their damages. Even though their ultimate damage award will be reduced by contingency fees paid to these outside counsels upon victory—likely to be between 20% and 35% of the total award—the remaining amount will be far in excess of what they could have won without the assistance of outside counsel.

Representation of local governments by outside counsel in the opioid litigation has a distinct advantage in fostering greater coordination among the various litigants, which offers strategic benefits as well as efficiency, although such benefits may come at the expense of the state government plaintiffs. If local governments are able to recoup any of their losses through a settlement facilitated by the MDL process, it will largely be the doing of these private attorneys.

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before retaining outside counsel to represent the state).

143 Letter from National Association of Attorneys General, *supra* note 97, at 9.

144 Burch & Williams, *supra* note 18, at 1445–46.

145 *See* Lemos, *supra* note 124, at 548–49.

III. Preemption and Public Health Litigation

This section examines the parallels between state actions to preempt local public health initiatives through legislation—which is common—and state attempts to preempt local government lawsuits—which is much rarer. The paucity of litigation preemption by states stems from the political comity between government plaintiffs that often accompanies mass tort lawsuits like the opioid litigation.

A. *State Preemption of Local Public Health Initiatives*

Preemption has become an increasingly popular approach for states to exert control and influence over local regulation and public policy. State legislatures generally have the authority to determine the scope of power granted to local governments and the power to override local laws by enacting general or specific limitations.[146] The historical default rule governing the power relationship between state and local governments was Dillon's Rule (named after an influential 19th Century judge), which only allowed local jurisdictions to govern in topical areas expressly granted by the state.[147] Over time, some states enacted a "home rule" through legislation or constitutional amendments, which gave local jurisdictions more control to enact laws without prior approval from the state.[148] States, however, can legislatively preempt local laws in most cases, even in home rule jurisdictions.[149]

Preemption of local laws and policies has become especially common in circumstances when state officials want to limit the authority of cities or counties that are intent on implementing progressive policies that state-level leaders oppose.[150] Local public health departments have

146 David J. Barron, *Reclaiming Home Rule*, 116 Harv. L. Rev. 2257, 2261 (2005).

147 Clayton P. Gillette, *In Partial Praise of Dillon's Rule, or, Can Public Choice Theory Justify Local Government Law?*, 67 Chi.-Kent L. Rev. 959, 963 (1991); Barron, *supra* note 146, at 2285.

148 *See, e.g.*, Barron, *supra* note 146, at 2290, 2292; Jesse J. Richardson, Jr. et al., Is Home Rule the Answer? Clarifying the Influence of Dillon's Rule on Growth Management 10–12 (2003), https://perma.cc/EP5E-MD65.

149 Richardson et al., *supra* note 148, at 25. In some jurisdictions with strong home rule provisions, state legislative preemption of local regulations may be disallowed if the state isn't itself regulating the issue but merely prohibiting the local government from doing so. *See, e.g*, Cleveland v. State, 2013-Ohio-1186, 989 N.E.2d 1072, 1082 (2013) (overturning a state law prohibiting local governments from banning trans fats in restaurant food). But most states have less robust home rule provisions than Ohio and would not similarly be limited in imposing this type of restriction on local governments. Richardson et al., *supra* note 148, at 17–25.

150 *See* Richard Briffault, *The Challenge of the New Preemption*, 70 Stan. L. Rev. 1995, 1997–98

been active in pushing public health initiatives and innovations, recognizing that many public health concerns are best understood and addressed at the local level.[151] In response, some state legislators have employed preemption vigorously to limit the authority of local government to enact public health laws or policies. Evidence suggests that state preemption of local government through legislation has become increasingly common, particularly in response to local government public health efforts.[152] State legislators in numerous states, often prompted by lobbying from industry groups, have passed laws that preempt local regulation of a variety of areas that impact public health, including firearm safety, fracking, environmental protections, increased minimum wage laws, and paid sick leave.[153] Preemption initiatives may draw support from state legislators seeking to protect influential business interests who may oppose the local regulations that would impose costs on business operations or otherwise reduce profitability.[154] Businesses also may advocate for state preemption of local regulation on the basis of efficiency and convenience, for example, to avoid having to comply with multiple standards across local jurisdictions.[155]

Another area where states have pursued preemption against local governments is in the protection of rights for sexual orientation and gender identity minority groups, with several states preempting local law providing protection from discrimination for LGBTQ+ individuals.[156] These preemption efforts—initiated by state governments controlled by conservative politicians—can undermine important civil rights protections and have been linked to hate crimes and negative health outcomes.[157]

(2018); Richard C. Schragger, *The Attack on American Cities*, 96 TEX. L. REV. 1163, 1165 (2018); Erin Adele Scharff, *Hyper Preemption: A Reordering of the State and Local Relationship?*, 106 GEO. L.J. 1469, 1471–73 (2018).

151 Paul A. Diller, *Why Do Cities Innovate in Public Health? Implications of Scale and Structure*, 91 WASH. U. L. REV. 1219, 1221, 1256–57, 1265–66 (2014).

152 *See* James G. Hodge, Jr. et al., *Public Health "Preemption Plus,"* 45 J.L. MED. & ETHICS 156, 156 (2017).

153 Jennifer L. Pomeranz & Mark Pertschuk, *State Preemption: A Significant and Quiet Threat to Public Health in the United States*, 107 AM. J. PUB. HEALTH 900, 901 (2017); *see also* Jennifer L. Pomeranz et al., *State Preemption: Threat to Democracy, Essential Regulation, and Public Health*, 109 AM. J. PUB. HEALTH 251, 251 (2019).

154 *See* Diller, *supra* note 151, at 1233, 1268–69, 1280.

155 Similarly, justifications of efficiency and consistency are used to support federal preemption of state law.

156 *See* Jennifer L. Pomeranz, *Challenging and Preventing Policies That Prohibit Local Civil Rights Protections for Lesbian, Gay, Bisexual, Transgender, and Queer People*, 108 AM. J. PUB. HEALTH 67, 67 (2018).

157 *Id.* at 67–68; *see also* Mark L. Hatzenbuehler et al., *State-level Policies and Psychiatric Morbidity in Lesbian, Gay, and Bisexual Populations*, 99 AM. J. PUB. HEALTH 2275, 2275 (2009). While the U.S. Supreme Court concluded that employment discrimination

Some state governors have also tried using executive orders to control local responses to public health emergencies. During the initial stages of the COVID-19 outbreak, many local jurisdictions acted quickly to impose limitations on social interactions, closing non-essential businesses and asking people to stay at home to reduce the spread of the disease.[158] In Mississippi, Governor Tate Reeves issued an executive order that broadly defined essential activities to include all offices and departments stores and explicitly preempted local government orders from enacting more stringent limitations.[159] Similarly, Florida's governor enacted an executive order designed to override local restrictions on religious services, defining "essential activities" to include "[a]ttending religious services conducted in churches, synagogues and houses of worship" and explicitly superseding contradictory local restrictions.[160] These preemptive state actions directly undermine public health.

Notably, state preemption of local regulation need not be anti-public health.[161] Some states responded to COVID-19, for example, by suspending state laws that would allow preemption of local public health efforts or imposing state-mandated minimum protections, allowing localities to implement greater, but not lesser, protections.[162] The proliferation of states using preemption to undercut local public health policy innovation remains a significant concern for public health advocates.

The rise of state preemption of local government action has

based on LGBTQ+ status violates Title VII, other forms of discrimination may still persist. *See* Bostock v. Clayton Cty., 140 S. Ct. 1731, 1734 (2020).

158 *Coronavirus State Actions*, Nat'l Governors Ass'n, https://www.nga.org/coronavirus-state-actions-all/ (last visited Nov. 1, 2020).

159 Miss. Exec. Order No. 1463 at 2–3 (Mar. 24, 2020); *see also* Bob Moser, *How Mississippi's Governor Undermined Efforts to Contain the Coronavirus*, New Yorker (Apr. 7, 2020), https://www.newyorker.com/news/news-desk/how-mississippis-governor-undermined-efforts-to-contain-the-coronavirus.

160 Fla. Exec. Order No. 20-91 at 4–5 (Mar. 19, 2020). Texas pursued a similar policy. *See* Tex. Exec. Order No. GA-18 at 5 (Apr. 27, 2020) (lifting statewide restrictions on movement and activities, stating that the order "shall supersede any conflicting order issued by local officials in response to the COVID-19 disaster, but only to the extent that such a local order restricts essential services or reopened services allowed by this executive order. . .").

161 *See* Derek Carr et al., *Equity First: Conceptualizing a Normative Framework to Assess the Role of Preemption in Public Health*, 98 Milbank Q. 131, 131 (2020).

162 *See, e.g.*, Cal. Exec. Order No. 28-20 (Mar. 16, 2020) (suspending state law provisions that would preempt local government powers to impose limitations on residential or commercial evictions); N.C. Exec. Order No. 138 § 8 (May 5, 2020) (prohibiting local governments from disregarding the minimum standards of protection against COVID-19 required by the state, while allowing additional, but not lesser restrictions to be imposed at the local level).

primarily focused on legislative and regulatory activity. The use of preemption by states to influence or undermine local litigation has been much less common.[163] When preemption of local litigation does occur, it takes the form of preemptive settlements of ongoing lawsuits initiated by local jurisdictions, legislative action at the state level to ban local suits, or the use of state powers to intervene in local lawsuits.[164] Preemptive settlements—usually at the initiation of the state attorney general—preclude subsequent similar claims by local entities based on the theory that the state has already resolved the issue on behalf of the local government entity. Tobacco company defendants successfully invoked this theory to dismiss county and city lawsuits filed after the tobacco MSA was completed.[165] From a local perspective, such preemption was devastating. Local jurisdictions were deprived of bringing claims for their own tobacco-related damages and not allocated any of the resources procured by the states in the MSA.[166] Targeted legislation passed by a state legislature can explicitly end ongoing litigation and can even prohibit future claims, as some states have done related to lead paint and gun lawsuits.[167] The final approach—direct intervention in local government-initiated litigation by state government—has been the model of litigation preemption used by states related to the opioid lawsuits so far.

B. *State Attempts to Preempt Local Opioid Lawsuits*

Most state governments that have pending lawsuits against opioid-related defendants have not taken overt actions to influence local government lawsuits concurrently pending against the same defendants. As the opioid litigation has proceeded, however, at least two states—Tennessee and Arkansas—have explicitly attempted to stop local governments from proceeding with lawsuits against opioid manufacturers and other related defendants.[168]

In March 2018, Tennessee Attorney General Herbert Slatery moved to intervene in lawsuits filed by forty-seven Tennessee counties

163 Sarah L. Swan, *Preempting Plaintiff Cities*, 45 FORDHAM URB. L.J. 1241, 1241 (2018) (examining preemption of local government litigation by states).

164 *See id.* at 1246–57.

165 *Id.* at 1247–48. A Wayne County, Michigan lawsuit against tobacco companies was dismissed in 2002 on these grounds. *In re* Certified Question from U.S. Dist. Court for E. Dist. of Michigan, 638 N.W.2d 409, 409, 411, 415 (Mich. 2002).

166 *See* Fisher, *supra* note 25.

167 Swan, *supra* note 163, at 1250–56.

168 *Id.* at 1249–50, 1259. It is worth noting that some commentators have argued that state and local lawsuits could be preempted by federal law. *See* Catherine M. Sharkey, *The Opioid Litigation: The FDA is MIA*, 124 DICK. L. REV. 101, 101 (2020).

against opioid manufacturers.[169] The counties, represented by a group of local district attorneys who collaborated on the filings, had brought claims in state court against opioid manufacturers on theories of public nuisance and violation of a state statute meant to create liability for drug dealers. The lawsuits alleged that defendants "knowingly participated in the diversion of opioids."[170] Attorney General Slatery objected to the district attorneys bringing claims on behalf of the state, stating that "the Office of the Attorney General is in the best position both to represent the interests of the State *and* to obtain the best possible monetary recovery for key governmental stakeholders."[171] Further, the Attorney General argued that these local claims impeded his "ability to prosecute all of the opioid litigation implicating the State's interests" and complicated the State's efforts to "seek relief for the State and its political subdivisions through a global resolution" as part of a "larger multistate effort."[172] Once Slatery formally moved to intervene in the case, the local district attorneys voluntarily dismissed the nuisance claims and statutory claims on behalf of the state but moved ahead with other claims that are still pending.[173] A Tennessee state appellate court later found that the local district attorneys did have standing to pursue statutory claims against the opioid manufacturers on behalf of the political subdivisions they represent.[174]

In another example, the Arkansas Attorney General filed a writ of mandamus in April 2018 to attempt to invalidate local government lawsuits against opioid manufacturers.[175] The local lawsuits asserted a number of common law and statutory claims on behalf of the state.[176] As in Tennessee, the Arkansas Attorney General argued in the filing that the prosecuting attorney for the local jurisdiction did not have the authority to bring a lawsuit on behalf of the state and that the suit "impaired the State's sovereignty and threaten[ed] to hamstring our statewide, constitutional officers' ability to carry out the will of the people."[177] The local prosecutor defended his right

169 *Statement on Opioid Litigation*, Tenn. Att'y Gen. (Mar. 21, 2018), https://www.tn.gov/attorneygeneral/news/2018/3/21/pr18-09.html; Swan, *supra* note 163, at 1259.

170 Effler v. Purdue Pharma L.P., No. 16596, 2019 Tenn. App. LEXIS 452, at *1 (Tenn. Ct. App., Sept. 11, 2019); Drug Dealer Liability Act, Tenn. Code Ann. § 29-38-101-116 (2005).

171 Letter from Herbert H. Slatery III, Tenn. Attorney Gen., *supra* note 140, at 1 (emphasis in original).

172 *Id.*

173 *Effler,* 2019 Tenn. App. LEXIS 452, at *3.

174 *Id.* at *14.

175 Emergency Petition for Writ of Mandamus at 2–3, Arkansas v. Ellington, No. CV-18-296 (Ark. Apr. 2, 2018).

176 *Id.* at 8–11.

177 *Id.* at 3, 6.

to bring the claims, and the Arkansas Supreme Court denied the mandamus request, ruling that the local lawsuit could proceed.[178]

The most prominent attempt by state actors to thwart local lawsuits came along just as the potential for a formidable local negotiation bloc became a possibility. Throughout the initial stages of the MDL, contention between states and local governments with claims in the MDL was minimal. State lawsuits were largely proceeding through their state court systems, and consequently, state attorneys general seemed to have little initial overt concern with the MDL.[179] At least one state official, in fact, openly supported the MDL proceedings as complementary to state litigation efforts against opioid defendants.[180] As the MDL gathered a critical mass of thousands of plaintiffs and the settlement negotiations picked up momentum, this state-level ambivalence began to change.

A particularly relevant turning point came with the proposal to establish a negotiation class. In 2019, Ohio Attorney General Dave Yost led efforts of state attorneys general to challenge the creation of a nationwide local jurisdiction negotiating bloc, with Yost's office arguing that state legislatures and attorneys general are best suited to "ensure the money goes to where the harm really is."[181] This state effort sought to functionally preempt the ability of local jurisdictions to use their collective efforts to pursue a more favorable settlement position, based on the argument that local governments were usurping the states' *parens patriae* powers by bringing these lawsuits.[182] The states further argued that state-level actors—as opposed to local governments—were best positioned to represent the interests of the state effectively and efficiently and should, therefore, control the allocation of any settlement funds that are awarded against these common defendants.[183] Judge Polster rejected this challenge and moved forward with implementing

178 Wesley Brown, *AG Rutledge Loses 'Writ of Mandamus' Request, Second Opioid Lawsuit May Proceed with 'State Actor,'* TALK BUS. & POL. (April 6, 2018), https://talkbusiness.net/2018/04/ag-rutledge-loses-writ-of-mandamus-request-second-opioid-lawsuit-may-proceed-with-state-actor/. These local-initiated lawsuits are still proceeding in state court as of November 2020 and have not been removed to federal court and the MDL.

179 *See* Jef Feeley, *Opioid Judge's Settlement Push Praised by Ohio Attorney General*, BLOOMBERG NEWS (Jan. 31, 2018), https://www.bloomberg.com/news/articles/2018-01-31/opioid-judge-s-settlement-push-praised-by-ohio-attorney-general (describing then-Ohio Attorney General, now Governor, Mike DeWine's support for the MDL and Judge Polster's handling of local cases).

180 *Id.*

181 Randazzo, *supra* note 22.

182 *See* Letter from National Association of Attorneys General, *supra* note 97, at 2–3.

183 *Id.*

the negotiation class,[184] although his ruling was later overturned on appeal.[185]

It is difficult to draw any strong conclusions from these examples or to infer much from the fact that these attempts by states to intervene in local government opioid lawsuits have been rare. Yet even these sparse efforts indicate potential fault lines between state and local governments that could lead to conflict as these cases proceed and as settlements are considered. If these lawsuits reach the stage where a verdict or settlement is likely and money could be available, the pressure for states to again try to intervene will increase.

These explicit attempts by state officials to intervene by preempting or co-opting local government litigation can be analogized to legislative preemption efforts that have challenged local public health initiatives. Upon examination, however, the analogy is intriguing but imperfect.

State governments can make reasonable and defensible arguments to seek to control law and policy decisions that affect the residents of the entire state. Likewise, the potential benefits of coordination and strategic consistency may support a centralized approach at the state level. In light of these arguments, as well as the recognized legal authority that states retain over local powers, there are strong legal and practical arguments supporting states' interests in maintaining control over local government policy and resources related to public health. These arguments apply to both legislative preemption and litigation preemption.

Local government claims to greater autonomy—whether through regulatory action or litigation—rest on the notions that local concerns may not be consistent state-wide, and local actions and interventions are more likely to address these more targeted concerns than state-level action.[186] For example, local jurisdictions may have a greater interest than states to regulate or prohibit fracking due to the disproportionate health impacts and environmental harms posed by this activity on local residents.[187]

In the context of the opioid litigation, states' logistical and practical

184 *See In re* Nat'l Prescription Opiate Litig., 332 F.R.D. 532, 556 (N.D. Ohio 2019). The negotiation class uses a novel procedural theory, based on Rule 23 class action principles, that would allow any city or county in the United States to participate in the negotiation class, while retaining rights to bring separate claims against the MDL defendants before a class settlement is reached. *Frequently Asked Questions*, In re: National Prescription Opiates Litig., https://www.opioidsnegotiationclass.info/Home/FAQ.

185 *In re* Nat'l Prescription Opiate Litig., 976 F.3d 664, 676–77 (6th Cir. 2020).

186 *See generally* Paul Diller, *Why Do Cities Innovate in Public Health? Implications of Scale and Structure*, 91 Wash. U. L. Rev. 1219, 1283–85 (2014).

187 *See* Shaun A. Goho, *Municipalities and Hydraulic Fracturing: Trends in State Preemption*, 64 Plan. & Envtl. L. 3, 3–5 (2012).

motivations for seeking to preempt local litigation can be explained by similar incentives. Centralized coordination of all opioid lawsuits within a particular state at the state level could have strategic value in managing lawsuits with this level of complexity. Allowing local jurisdictions the capacity and authority to bring these claims separately could undermine the hegemony of state-level officials in making policy decisions related to public health. Likewise, states may prefer to control and focus on the legal arguments and legal strategy being advanced in these cases, a goal that may be impeded by concurrent local litigation. However, these concerns may be less relevant in this instance because the state plaintiffs have mostly filed their claims in state court while the local plaintiffs' cases are primarily consolidated in the MDL and have been removed to federal court. Moreover, there is little distinction between the legal arguments and positions of the state and local government plaintiffs. They differ not on the legal basis of the harm caused by the defendants but rather on the questions of who was harmed, who deserves recovery, and what legal theories are applicable.

Another legal distinction must be made between legislation and litigation as well. While the lines of legal authority for state legislatures to preempt local ordinances and regulations are clear, the authority of state executive branch officials to exert authority over litigation filed by or on behalf of local governments is much less clear. Given this uncertainty and the relative cohesion of interests between state and local governments engaged as plaintiffs in opioid lawsuits, the parties may be better served by pursuing joint settlement negotiations with the defendants.

Public health litigation against corporate defendants, however, changes the balance of interests between state and local actors. For instance, the political incentives for state officials to try and intervene in local action differ between legislative and litigation preemption. Unlike the pro-corporate influence that often underlies state intervention by legislative preemption, state and local officials alike share the political interests of holding the opioid defendants accountable.[188] Similarly, litigation preemption is less common in mass tort public health cases compared with the more partisan patterns seen in many efforts at legislative preemption. Many examples of legislative preemption involve conservative state legislators rejecting attempts to expand progressive policies by more left-leaning localities. The opioid litigation is focused on obtaining resources to pursue public health goals, but the litigation itself does not necessarily pursue any progressive policies. This unusual comity between state and local jurisdictions that normally would have been at odds may come down to the potential for financial gain

188 Swan, *supra* note 163, at 1241.

by all parties involved. The potential for large damages awards may act as the "lubricant for this litigative flexibility,"[189] at least until the settlement proceeds need to be divided up between government plaintiffs.

Thus, the most significant factor influencing the dynamic between state and local governments is potential access to money, a resource in short supply for both state and local governments. Concerns by states about overriding local policy choices to limit variability predominate in examples of legislative preemption, while fiscal motivations—primarily the desire to control the resources that will arise from any settlement or ruling against the many defendants—underlie state efforts to preempt local litigation.

The stakes in the opioid litigation are unmistakable. All of the plaintiffs, whether state or local, recognize that there are limited resources available to be split between the many plaintiffs currently suing opioid defendants. Early movers through trial or settlement may end up being the only parties who actually receive damages, as the defendants may become insolvent or receive bankruptcy protection for their assets. Both local and state governments have reasonable concerns that they will be left out of any settlement agreed to by the other group of plaintiffs. Events in late 2019, including a court judgment and settlement by the state of Oklahoma, and the bankruptcy filing and October 2020 settlement agreement with the federal government by Purdue Pharma, have ratcheted up this pressure, as litigants see their chances of recovery diminishing.[190] These pressures may spur state-level efforts to maintain control over the resolution of these cases and to seek to minimize the influence of local government plaintiffs.

The overlapping interests between state and local government plaintiffs need not result in rivalry. State and local plaintiffs have common interests in procuring settlements for their overlapping communities. A strategic alliance between the state and local plaintiffs would be beneficial to both sets of parties, allowing them to coordinate settlement negotiations from a position of combined strength while simultaneously assuring that all

189 *Id.* at 1284.

190 After the Oklahoma Attorney General settled a case with Purdue Pharma that directed the majority of the proceeds to the creation of an addiction research center at a state university, the state legislature passed legislation that future state settlements must go into the state general fund. *See* Lenny Bernstein, *In Oklahoma, Opioid Case Windfall Starts Winners Squabbling*, Wash. Post (June 20, 2019), https://www.washingtonpost.com/health/in-oklahoma-opioid-case-windfall-starts-winners-squabbling/2019/06/20/92ce0f60-92bb-11e9-b570-6416efdc0803_story.html. *See* Notice of Eighth Amended Bankruptcy Court Order Granting Injunction Against Continuation of Proceedings as to Related Parties to Debtor Purdue Pharma L.P. & Affiliated Debtors, *In re* Nat'l Prescription Opiate Litig., No. 1:17-md-2804 (N.D. Ohio Apr. 2, 2020), ECF No. 3251. *See* Benner, *supra* note 100.

parties receive a part of any resulting settlement. Such an approach, while logistically complicated, would be strategically smart and could redound to the benefit of all government plaintiffs currently pursuing opioid litigation.

Conclusion

The opioid crisis remains a significant public health threat to the United States. The ongoing opioid litigation has the potential to hold some of the relevant actors accountable for worsening the epidemic of opioid overdoses that has plagued the country.[191] Yet concluding these lawsuits in a way that both holds the defendants accountable for their actions and provides sufficient compensation to the injured parties will require resolve and creativity. Judge Polster's controversial and innovative approach to the opioid MDL takes the opioid crisis seriously and attempts to move the many litigants steadily and inexorably toward settlement. But even this determined effort has yet to significantly advance a resolution to these issues for most of the parties to the case.

This article considered two previously under-examined facets of the opioid litigation landscape: how privatization and preemption factor into the incentives, relationships, and tactics used by various government plaintiffs, who have understandably approached these lawsuits as something of a zero-sum game. The realization that the defendants may not have sufficient resources to satisfy judgments or settlements on all of the outstanding claims would seem to create incentives for early settlements by individual plaintiffs.[192] Despite these dynamics, however, few jurisdictions have reached rapid settlements with, or judgments against, opioid manufacturers.[193]

The pressures facing government plaintiffs in such a large litigation also favor substantial rivalry between plaintiffs, as they position themselves vis-à-vis one another to procure what is sure to be a limited availability of the damages they are seeking. Yet this has not been uniformly the case. State attorneys general have collaborated with each other in settlement talks with opioid defendants while their individual cases proceed in state court.[194] While

191 Of course, even if the litigation is resolved to the satisfaction of the many plaintiffs involved, most of the factors driving the current contours of the opioid epidemic will remain unresolved. *See* Terry, *supra* note 8, at 651–53.

192 Defendants, however, would have a contrary incentive, similar to mass tort defendants in earlier cases, to delay the cases through procedural obstacles.

193 Aside from the state of Oklahoma's settlements and the two bellwether county settlements discussed *supra*, the rest of the thousands of pending lawsuits remain unresolved at the time of this writing.

194 Jan Hoffman, *Opioid Settlement Offer Provokes Clash Between Cities and States*, N.Y. Times (Mar. 13, 2020), https://nyti.ms/2W6iSCe; Jared S. Hopkins, *21 States Reject $18 Billion Offer From Drug Wholesalers to Settle Opioid Litigation*, Wall St. J. (Feb. 14, 2020), https://www.wsj.com/articles/21-states-reject-18-billion-offer-from-drug-wholesalers-to-settle-opioid-litigation-11581692527 (referring to a joint letter by 20 state attorneys general rejecting the settlement offer).

these negotiations continue, state plaintiffs have remained cohesive in these efforts. Similarly, local government plaintiffs and their attorneys have mostly presented a united front in advancing their negotiations with defendants through the MDL process, with the exception of Cuyahoga and Summit Counties, who settled with a number of the opioid defendants just before the MDL bellwether trials were scheduled to begin in October 2019.[195]

Nevertheless, the competition between state and local government plaintiffs persists, as competing settlement negotiations continue. With so much at stake, it is somewhat surprising that states have not more aggressively used their potential powers of preemption to usurp local control over litigation or to seek to dictate the dispersal of settlement agreement funds like the Oklahoma legislature attempted.[196] Perhaps this can be explained by the lack of success of previous preemption attempts, but given the scope of state power in this area, direct intervention remains an option.[197]

As the parties to the opioid litigation enter what is likely to be the final phase of the current lawsuits, several important issues should remain at the forefront as the parties seek to resolve the disputes. First, a fair global settlement, including all parties, with an opportunity for plaintiff opt-outs, would be the ideal outcome of settlement negotiations. This model could resemble the negotiation class model that looks out for the collective interests of local jurisdictions but would also include state litigants to ensure that all of the plaintiffs receive a fair share of the damages from the opioid litigation. Such a global settlement would need to account for the variety of damages suffered by the respective plaintiffs and would need to realistically and fairly allocate damages among the defendants without completely undermining access to their products, which still have legitimate and necessary uses. This approach, however, would face serious challenges in coming together given the multiple and complex issues that would have to be resolved.

Second, any settlement that results from the opioid litigation—whether global or piecemeal—should be structured to apply settlement monies prospectively to solve ongoing problems related to opioid use disorder and related public health conditions. A key lesson learned from the MSA was that unless the settlements are carefully structured, they will not be used as proposed and instead be diverted opportunistically to cover state budgetary items unrelated to public health.[198] This insight should drive efforts to ensure that clear expectations are built into any settlement to guarantee that the

195 Jan Hoffman, *Johnson & Johnson Reaches $20.4 Million Settlement in Bellwether Opioids Case*, N.Y. TIMES (Oct. 1, 2019), https://nyti.ms/2pcwWf5.

196 *See* Bernstein, *supra* note 190.

197 *See* Swan, *supra* note 163, at 1268–69.

198 *See* Berman, *supra* note 45, at 1042.

funds are used as intended and shared across state and local jurisdictions.

Third, while legitimate concerns exist about using private counsel to represent government plaintiffs in tort litigation, these concerns can be mitigated with deliberate policy decisions. Democratic accountability for outside counsel can be achieved by outlining expectations through contract and maintaining consistent government oversight of the performance of outside counsel. Strategic incentives for litigation settlements must be monitored by government officials to ensure that public goals are being pursued. Contingency fees should remain reasonable but sufficient to compensate outside counsel for their work. Ceding control of local public health litigation to private litigators is not ideal, but realistically it is the only way to reliably advance complex mass tort litigation for resource-limited jurisdictions.

Fourth, preemption of local litigation or efforts to divert the proceeds from opioid lawsuits filed by local jurisdictions should not be pursued even if the states arguably have the power to do so. Local jurisdictions have suffered real harm from the opioid crisis, and fairness dictates that their injuries are compensated through this process and not circumvented by state action. Furthermore, cooperation between state and local plaintiffs could yield a mutually beneficial settlement available to all parties.

Finally, all communities faced with the ongoing challenges of the opioid crisis need to face the reality that litigation proceeds will not solve the bulk of the problems the crisis created. As opioid manufacturers grapple with bankruptcy, the likelihood of large damages awards or settlement payouts decreases. The COVID-19 pandemic will decimate state and local budgets, further imperiling their capacity to provide public health services.

The opioid litigation only addresses some of the underlying causes of the opioid crisis, and the resolution of these lawsuits will not reverse the harm already caused. But litigation can do more than compensate for loss; it can also catalyze change and seed future efforts to build a better society. The road forward demands that any litigation proceeds be put to use to support people who continue to face opioid use disorder and similar health challenges while building and maintaining a robust public health infrastructure.