Using Law to Improve Public Health: The Example of Tobacco Regulation

By Kathleen Hoke Dachille

Tobacco use has been the leading cause of preventable death in the United State for decades[1] yet public health advocates have struggled to secure legislation effectively regulating tobacco products and their use. This is largely due to the role tobacco played in the economic development of the United States, particularly in the southern states, and the power tobacco companies wielded with Congress.[2] Although tobacco use has declined significantly in recent decades and our country no longer relies on tobacco crops for economic stability, tobacco products still maintain a prominent place in American culture, often serving as the straw man in debates over how public health regulation threatens the concept of American freedom.[3] Understanding the successes and challenges of the tobacco regulation movement may benefit public health officials and advocates seeking to address other public health issues.

Public health professionals have rallied against tobacco use for many years, employing traditional public health practices. Public health researchers studied the health impacts of smoking and exposure to secondhand smoke, the dynamics of addiction and cessation, the impact of tobacco marketing on prevalence of use in certain segments of the population, and much more. Important research on these issues continues today. Public health practitioners at state and local health departments and philanthropic organizations used this research to design and implement public education campaigns that inform consumers of the dangers of tobacco use and exposure to secondhand smoke, discouraging initiation and encouraging cessation. Moreover, the research aided in the development of drugs and counseling programs used to assist in tobacco cessation. State and local health departments play a critical role in offering cessation drugs and services to smokers. Yet public health officials long ago recognized that public education and health services alone could not resolve the profound negative impact of tobacco use on the public's health. These officials turned to public health policy, primarily in the form of statutes and regulations, to attack the leading cause of preventable death in the United States.

Development of the modern discipline of public health law coincided with the growing need to address tobacco use with more than the traditional tools of public health professionals. To be sure, using laws to protect and preserve the public's health is not a modern or novel concept; boards of health with plenary regulatory power have been in existence for well over a century.[4] But the drive to reduce the toll of tobacco use through law provides unique and important insight into the role that lawyers and the legal system can play in improving public health.

This article explores some areas of tobacco regulation that demonstrate how law has been used to advance public health; the article is by no means comprehensive as decades of tobacco regulation could not fit neatly into any one article. It is my hope that this discussion will not only serve to reinforce those working in tobacco regulation but that it will also provide inspiration to those working on other areas of public health in which legislation or other policy change may be helpful.

Local Tobacco Regulation as a Key to Success

History and current experience show that fundamental changes in public health regulation in the United States often start at the local level; this is particularly true with respect to tobacco control.[5] For decades, the tobacco industry exercised tremendous power at the federal level, securing exemptions from many federal statutes, such as the Consumer Product Safety Act, the Fair Packaging and Labeling Act, and the Comprehensive Drug Abuse Prevention and Control Act, among others.[6] Similarly, the industry exerted significant control over state legislatures. "[T]he tobacco lobby prefers to lobby at the state level, rather than the local level where it loses many political battles. Local venues are often better for public health...."[7] For this reason, much of what is now widely accepted as sound public policy in tobacco control developed at the local level.

Clean Indoor Air laws, which prohibit smoking in public places and workplaces, may be the best example of sound tobacco control policy that started at the local level. While today all states have some indoor workplace smoking restrictions and at least 23 states have passed comprehensive Clean Indoor Air laws,[8] in many jurisdictions—including California and Massachusetts—the statewide laws were passed after a majority of local jurisdictions had already passed comprehensive clean indoor air ordinances.[9] At the state level, the restaurant industry, often fueled and funded by the tobacco industry, exerted sufficient power to fend off such laws.[10] At the local level, however, public health advocates were able to secure the protective ordinances. Ultimately, when a significant

portion of the population is covered by a local clean indoor air law, even the restaurant industry stops fighting a statewide law. The local approach to clean indoor air regulation is still working today—in South Carolina there is no statewide law, yet nearly 30 local jurisdictions have passed comprehensive clean indoor air ordinances; the same is true for West Virginia.[11] To preserve this local power, public health officials and their attorneys must be aware of any attempts to preempt local power to regulate indoor smoking. Many of the jurisdictions with weak state laws also face state preemption[12] as the industry is aware that local power is far more likely to be exercised in a comprehensive and effective manner.

Similarly, and likely more helpful to current efforts in other areas of public health, local jurisdictions have passed ordinances restricting tobacco advertising. In 1987, the City of Amherst, Massachusetts, passed an ordinance prohibiting cigarette advertising on public transportation.[13] Perhaps because the Amherst ordinance was not challenged by the tobacco industry in court, in the early 1990s, a handful of other local jurisdictions imposed similar restrictions and others passed ordinances regulating outdoor cigarette advertising in proximity to schools and playgrounds.[14] Again, no legal challenges were filed. The tobacco industry was ultimately provoked into filing litigation in 1994 when the City of Baltimore passed a ban on cigarette (and alcohol) advertising on billboards in residential areas.[15] Ultimately Baltimore City prevailed in the Fourth Circuit Court of Appeals, which found that the City's interest to "protect children who are not yet independently able to assess the value of the message presented" was sufficiently related to the ban on billboard advertising of tobacco products to survive First Amendment scrutiny.[16] Baltimore City's success inspired similar regulations at the local level across the country.[17] All of this local legislative action flourished despite a federal law preempting state and local regulation of cigarette advertising and marketing, the Federal Cigarette Labeling and Advertising Act (FCLAA).[18] Local jurisdictions, supported by aggressive and bright municipal attorneys, carefully crafted their laws to avoid the preemption issue.

It remains true today that the most dynamic and effective tobacco regulation is taking place at the local level, in some respect instigated and supported by federal policy. The Family Smoking Prevention and Tobacco Control Act (FSPTCA),[19] passed by Congress in 2009, gives the Food and Drug Administration (FDA) regulatory power over tobacco products. Interestingly, the Act also repeals most of the state and local preemption language that previously appeared in FCLAA[20] and makes clear that the new provisions are, for the most part, not preemptive of more rigorous state or local regulation. Many public health professionals—and surely public health lawyers—consider this an important change that will allow local regulation to grow more aggressively than was possible under the stronger FCLAA provisions. Indeed, through American Recovery and Reinvestment Act (ARRA) and Affordable Care Act Public Health Fund Community Transformation grants, state and local jurisdictions have received federal funding to support tobacco regulation efforts. A fair interpretation of this federal action is that even with the FSPTCA and a federal agency responsible for reducing the public health harm from tobacco use, the federal government is looking to state and local jurisdictions to take the lead in novel and aggressive tobacco regulation.

Local jurisdictions have taken on the challenge with verve. While the FSPTCA bans the sale of flavored cigarettes, local jurisdictions have taken the bold step to restrict the sale of flavored non-cigarette tobacco products, such as cigars and smokeless tobacco. New York City's ordinance banning flavored tobacco products recently survived a legal challenge[21] and shortly thereafter the City of Providence, Rhode Island, imposed a comparable restriction (now the subject of litigation).[22] Similarly, FDA regulations under the FSPTCA prohibit the sale of cigarettes in packages of less than 20, and local ordinances have imposed a minimum pack size on cigars. Baltimore City[23] and Prince George's County,[24] Maryland, have imposed a 5-per-pack minimum for cheap cigars popular among youth; the provisions are currently stayed pending legal challenge. Undeterred by the threat of litigation, the Boston Public Health Commission[25] recently imposed a 4-per-pack minimum on cigars and other local jurisdictions around the country are considering such action. Public health professionals working in tobacco regulation are aware that cheap, flavored cigars have become the product of choice for young people. While the FDA slowly determines how to use its vast and complex regulatory power, local jurisdictions are taking action today.

In addition to the packaging and flavored provisions, public health attorneys are currently exploring additional approaches to regulating tobacco advertising and marketing, with an emphasis on what local jurisdictions may lawfully impose. The Tobacco Control Legal Consortium published a series of factsheets after the passage of the FSPTCA detailing state and local action that may be possible under the new law[26] and recently published toolkits that clearly explain how local jurisdictions may regulate tobacco advertising and placement.[27] And New York's Center for Public Health and Tobacco Policy has developed helpful materials on regulation of the tobacco sales environment that may be used by state and local public health officials across the country.[28] Local jurisdictions with the interest and willingness to adopt innovative tobacco regulation have the resources and support of ex-

perienced public health attorneys as they approach these issues.

Lastly, any article explaining how local jurisdictions are leading the charge in tobacco regulation should mention the unique contributions of the City of San Francisco. In 2008, San Francisco passed a law prohibiting the sale of tobacco products at pharmacies on the basis that the health-supporting mission of pharmacies was undermined by the sale of the product contributing to the leading cause of preventable death.[29] Several local jurisdictions in Massachusetts, including Boston and Needham, have passed similar provisions.[30] And in 2009, San Francisco imposed a 20¢ fee on each pack of cigarettes as the cost of clean-up associated with cigarette debris.[31] These are fine examples of the type of novel and impactful regulations we can expect to see from local governments.

Taxation as Health Policy

One issue that may not be addressed by local governments is tobacco tax increases as a means to reduce tobacco use. Because many states preempt local jurisdictions from imposing taxes, state law is generally the source of health policy through tobacco taxation. In most states, tobacco products are subject to excise taxes in addition to any state sales tax. The federal government imposes a $1.01 tax per pack of cigarettes.[32] Every state imposes a tax on cigarettes, varying from 17¢ per pack in Missouri to $4.35 per pack in New York.[33] Most states also tax non-cigarette tobacco products, known as "other tobacco products" or "OTP." State taxation of OTP varies greatly in that some states impose an ad valorem tax—typically a certain percentage of the wholesale price of the product—and others impose a weight-based tax. Many states impose a cap regardless of which approach is employed.[34] Within OTP, products may be taxed differently as well. For example, in Connecticut, snuff is taxed at $1.00 per ounce, chewing tobacco at 50% of wholesale price and cigars at 50% of wholesale price with a cap of 50¢ per cigar.[35] Federal taxes on OTP are product-based as well.[36] Some local jurisdictions not preempted by state law impose additional taxes on tobacco products—such as New York City's $1.50 per pack tax on cigarettes.[37]

Taxation of cigarettes as health policy started in the 1980s when economists demonstrated that, despite the fact that cigarettes are highly addictive, cigarette price increases would result in reduced demand. In the 30 years since, states have successfully used tax increases as health policy to deter smoking initiation and encourage cessation.[38] Today there is little doubt that raising tobacco taxes decreases tobacco use. Although cigarette taxes have been the focal point of this policy movement, a recent trend shows states seeking to increase the tax on OTP for the same reasons. For example, the Maryland General Assembly recently increased the tax on cigars from 15% of wholesale price to 70% of wholesale price.[39] This follows data showing that as cigarette use declined in Maryland, the use of OTP, specifically cheap cigars, increased, particularly among young people.[40]

In addition to reaping the benefits of reduced tobacco use, public health officials have sought or supported tobacco tax increases for the purpose of funding important tobacco control programs, such as public education, enforcement of youth sales prohibitions, counter marketing, and access to cessation resources.[41] This is the ultimate win-win for public health—use of the dangerous product declines at the same time that public health professionals are provided more resources to prevent initiation and assist in cessation. Moreover, increasing the tobacco tax, particularly in support of public health programming, is politically palatable as smokers make up a minority of the population and taxes on non-essential items are generally better received by the public.

Although not all public health issues can be addressed through taxation, there may be products that contribute significantly to public health problems that could be subject to a tax scheme designed to increase price, decrease consumption or use and fund relevant public health programs. For example, a tax on tanning services might eliminate some younger, more price-sensitive consumers and could fund educational efforts related to skin cancer prevention. Those looking at taxation as a potential public health policy ought to examine or develop sound economic studies to determine the potential impact of the tax. As with any health policy, a sound evidence base is necessary. Public health professionals ought to consider requiring those taxes be set aside for programs designed to address the particular public health problem to which the taxed product contributes. That may make an otherwise unpopular tax increase (as if there are any popular tax increases) more politically palatable and hence more likely to pass. More importantly, such an approach ensures funding for critical programming to continue to address the public health problem. There is no reason that tobacco should be unique in using tax policy to address public health problems.

Legal Issues of Concern in Public Health Generally

A few legal issues that frequently arise in tobacco regulation warrant specific mention here as these issues permeate public health law more broadly as well. As mentioned above, preemption has played a role in preventing state and local tobacco regulation.[42] For decades, FCLAA preempted state and local regulation of cigarette advertising or promotion if that regulation was based on health. Although some local laws survived FCLAA scru-

tiny—such as the Baltimore City billboard ban—many were struck down as preempted. At the same time, states passed laws restricting local jurisdictions from tobacco regulation, specifically related to indoor smoking, enforcement of youth sales restrictions and tobacco advertising. Recognizing the stifling impact of these laws, a goal of the Center for Disease Control's *Health People 2020* initiative is elimination of state preemption of local tobacco regulation. The CDC recently reported that while progress has been made in alleviating preemption of local regulation of indoor smoking, no progress has been made in lifting preemption of local regulation on youth access or tobacco advertising.[43] In states with strong preemption, much of the local regulation touted in the first section of this article is impossible to achieve. In those states, local public health professionals and their lawyers must first seek repeal of preemption before they can embark upon innovative tobacco control policy.

Recognizing the negative impact of preemption on public health policy, the Robert Wood Johnson Foundation funds Preemption Watch to provide technical assistance to public health professionals seeking to secure the repeal or prevent the imposition of preemptive provisions that restrict local public health regulation.[44] Resources available on the Preemption Watch website are easily adapted for use in any jurisdiction and for any issue of public health regulation. Public health attorneys must be adept and vigilant at recognizing the potential preemptive impact of federal and state legislative proposals and advise their local public health officials accordingly.

Public health attorneys must also familiarize themselves with First Amendment jurisprudence to ensure public health legislation is drafted and supported to best survive challenge. As mentioned above, local jurisdictions have been encouraged to consider new restrictions on tobacco advertising in light of the repeal of FCLAA's broad preemption. Public health officials may be looking to similar restrictions with respect to other products or services that impair public health. Yet recent case law cautions that the First Amendment may be an increasingly high hurdle to overcome with respect to such restrictions.[45] The FDA's proposed graphic warnings for cigarette packaging were recently struck down on First Amendment grounds, the trial court eschewing the *Central Hudson* commercial speech test in favor of strict scrutiny review.[46] In addition, the Supreme Court recently struck down two public health laws on First Amendment grounds, one involving age restrictions on violent video games and the other restricting the use of pharmacy data to prevent access to physician-specific prescribing information.[47] While a careful reading of these cases reduces the concern about their impact on marketing and advertising restrictions on tobacco or other products that cause harm to public health,[48] the flurry of cases concerning public health regulation and the First Amendment dictates that public health lawyers stay abreast of the issues and counsel their clients accordingly. Those seeking commercial speech regulation must clearly articulate the purpose for the regulation and demonstrate with sound evidence how the restriction will achieve that purpose. Public health lawyers should be mindful to track this First Amendment jurisprudence.

Conclusion

The tobacco regulation movement shows how law and policy change can enhance traditional public health strategies and provides insight into how public health officials might use the law to address other persistent or emerging public health problems. Looking to local regulators for novel and aggressive action may be the most expeditious and effective approach to improving public health through law change. Tax policy might also be used to improve public health by discouraging use of harmful products or encouraging use of particularly beneficial products. Attorneys assisting public health professionals and local legislators should be aware of potential preemptive legislation and be prepared to fight such provisions. Public health lawyers should also become familiar with recent decisions involving First Amendment challenges to public health laws, track the pending cases involving the FDA's graphic warnings, and prepare legislation and supportive materials that best position the legislation should a First Amendment challenge arise.

One of the most powerful tools in public health is collaboration. When lawyers gain an understanding of public health issues and educate themselves on the legal framework within which law might improve public health, they can work collaboratively with the public health community to bring about positive change.

Endnotes

1. U.S. Department of Health and Human Services, *The Health Consequences of Smoking: A Report of the Surgeon General*, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
2. "Owing to its unique place in American history and society, tobacco has its own unique political history." *Food and Drug Administration v. Brown and Williamson Tobacco Co.*, 529 S. Ct. 120, 160 (2000) (finding the FDA lacked power to regulate tobacco).
3. For an excellent review of the role of tobacco and the history of tobacco regulation, *see* A. Brandt, THE CIGARETTE CENTURY: THE RISE, FALL AND DEADLY PERSISTENCE OF THE PRODUCT THAT DEFINED AMERICA (2007).
4. Duffy, P., THE SANITARIANS: THE HISTORY OF AMERICAN PUBLIC HEALTH (1992).
5. *See* National Cancer Institute, *State and Local Legislative Action to Reduce Tobacco Use*, Smoking and Tobacco Control Monograph No.

11, U.S. Department of Health and Human Services, August 2000 (hereafter NCI Monograph 11).

6. "Congress, for better or for worse, has created a distinct regulatory scheme for tobacco products, squarely rejected proposals to give the FDA jurisdiction over tobacco, and repeatedly acted to preclude any agency from exercising significant policymaking authority in the area." *Brown and Williamson*, 529 U.S. at 160.

7. Givel, S. and Glantz, S., *Tobacco Lobby Political Influence on U.S. State Legislatures in the 1990s*, TOBACCO CONTROL, Vol. 10, pp. 124-134 at p. 131 (2001).

8. American Nonsmokers' Right Foundation, U.S. 100% Smokefree Laws in Non-Hospitality Workplaces and Restaurants and Bars (As of January 2, 2012), available at www.no-smoke.org/pdf/WRBLawsMap.pdf.

9. NCI Monograph 11, *supra* note 5, at p. 22; Patten, C., et al., Progress in Protecting Non-smokers from Environmental Tobacco Smoke in California Workplaces, TOBACCO CONTROL, Vol. 4: pp. 139-144 (1995); Koh, H., et al., The First Decade of the Massachusetts Tobacco Control Program, PUBLIC HEALTH REPORTS, Vol. 120, pp. 482-495 at p. 484 (2005).

10. Hyland, A., et al., Smoke-free Air Policies: Past, Present and Future, TOBACCO CONTROL, Vol. 21, pp. 154-161 at p. 156 (2012).

11. American Nonsmokers' Right Foundation, Municipalities with Local 100% Smokefree Laws (As of January 2, 2012), available at www.no-smoke.org/pdf/100ordlisttabs.pdf.

12. American Nonsmokers' Rights Foundation, States with Any Type of Preemption of Smokefree Air Laws (As of January 2, 2012), available at www.no-smoke.org/pdf/preemptionmap.pdf.

13. That provision remains law today. *See* Bylaws of the Town of Amherst, Massachusetts, May 2011 edition, ATM—April 27, 1987—Art. 53.

14. NCI Monograph 11, *supra* note 5, at p. 41.

15. That provision remains law today. *See* Baltimore City Zoning Code §11-207 (alcohol) and §11-208 (cigarettes).

16. *Anheuser Busch v . Schmoke*, 101 F.3d 325, 329 (4th Cir. 1996); *see also Penn Advertising v. Mayor and City Council of Baltimore*, 63 F.3d 1318 (1995) (This decision was vacated and remanded by the Supreme Court but ultimately upheld by the Fourth Circuit, relying on the *Anheuser Busch* opinion cited here.).

17. NCI Monograph 11, *supra* note 5, at pp. 41-42 and Figure 10 (Number of Ordinances Containing Advertising Restrictions by Year, 1985-1998); *see also* Garner, D., *Banning Tobacco Billboards: The Case for Municipal Action*, JAMA, Vol. 275, pp. 1263-1269 (1996).

18. 15 U.S.C. §1334(b) (Prior to 2009 amendments, this section preempted state or local restrictions on cigarette advertising or promotion that were "based on smoking and health.").

19. Public Law 111-31 (2009).

20. 15 U.S.C. § 1334(c) (allowing state and local jurisdictions to impose "specific bans or restrictions on the time, place, and manner, but not content, of the advertising or promotion of any cigarettes").

21. *U.S. Smokeless Tobacco Manufacturing Co. v. City of New York*, 2011WL5569431(D. N.Y. 2011); 17 New York City Administrative Code §17-715.

22. Code of Ordinances of the City of Providence, Rhode Island, Article XV, §§14-308 to 14-310; *see National Association of Tobacco Outlets, et al., v. City of Providence*, No. CA-12-96, U.S. District Court for the District of Rhode Island (February 13, 2012). Santa Clara County, California, has also imposed flavored tobacco restrictions. Santa Clara Ordinance §A18-369(h).

23. Baltimore City Health Commissioner, Regulation Banning the Sale of Single, Cheap Cigars (January 14, 2009); *see Altadis U.S.A., Inc. v. Mayor and City Council of Baltimore*, Baltimore City Circuit Court Case No. 24-C-09-007715 (City lost at trial court; case is stayed pending outcome of Prince George's County case).

24. Prince George's County Bill No. 6 (2009) (amending Subtitle 12 of the Prince George's County Code); *see Altadis U.S.A., Inc. v. Prince George's County*, Prince George's County Circuit Court Case No. CAL-08-38041 (County won at trial and certiorari was granted by the Court of Appeals (No. 85, September 2010); arguments were heard March 4, 2010, however, the Court has not yet issued a decision).

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26. Tobacco Control Legal Consortium, *Federal Regulation of Tobacco: Impact on State and Local Authority* (July 2009), available at www.publichealthlawcenter.org/sites/default/files/resources/tclc-fda-impact.pdf.

27. Tobacco Control Legal Consortium, *Local Board of Health Authority to Regulate Tobacco* (April 2011); *Restricting Tobacco Advertising* (May 2011); and *Placement of Tobacco Products* (May 2011). These documents are available at www.publichealthlawcenter.org/documents/publications/guides-toolkits.

28. Center for Public Health and Tobacco Policy, Factsheets and Other Publications—Retail Environment, available at www.tobaccopolicycenter.org/publications/fact-sheets-other-publications/.

29. San Francisco Health Code Article 19J, §§1009.91 to 1009.98.

30. *See, e.g.*, Boston Public Health Commission, Restricting the Sale of Tobacco Products in the City of Boston (December 1, 2011) (The Commission banned the sale of tobacco products in pharmacies in 2009 and recently expanded the ban to all health care institutions.).

31. San Francisco Administrative Code Article 105, §§105.1 to 105.9.

32. Alcohol and Tobacco Tax and Trade Bureau, *Tax and Fee Rates*, available at http://ttb.gov/tax_audit/atftaxes.shtml.

33. Campaign for Tobacco-Free Kids, *State Cigarette Excise Tax Rates and Rankings* (December 2011), available at www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf.

34. Campaign for Tobacco-Free Kids, *State Excise Tax Rates for Non-Cigarette Tobacco Products* (December 2011), available at www.tobaccofreekids.org/research/factsheets/pdf/0169.pdf.

35. CT. Gen. St. Ann. §12-330c.

36. Alcohol and Tobacco Tax and Trade Bureau, *Tax and Fee Rates*, available at http://ttb.gov/tax_audit/atftaxes.shtml.

37. Campaign for Tobacco-Free Kids, *Local Government Cigarette Tax Rates and Fees* (October 2011), available at www.tobaccofreekids.org/research/factsheets/pdf/0304.pdf.

38. Warner, K., TOBACCO CONTROL POLICY, *Tobacco Policy Research: Insights and Contributions to Public Health*, pp. 35-42 (2006).

39. Senate Bill 1302 (2012 Special Session #1) (State and Local Revenue and Financing Act).

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42. *See* Centers for Disease Control and Prevention, *State Preemption of Local Tobacco Control Policies Restricting Smoking, Advertising and Youth Access—United States, 2000-2010*, MMWR 2011; 60(33); 1124-27.

43. *Id*.

44. www.preemptionwatch.org/fact-essentials/.

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46. *R.J. Reynolds Tobacco Co. v. Food and Drug Administration*, 2012WL653828 (D.D.C. February 29, 2012).

47. *Sorrell v. IMS Health, Inc.*, 131 S. Ct. 2653 (2011) (pharmaceutical case); *Brown v. Entertainment Merchants Ass'n*, 131 S. Ct. 2729 (2011)(video games case).

48. Berman, M., *et al.*, *Sorrell and the Future of Commercial Speech Regulations*, JURIST—Forum, Oct. 4, 2011, available at http://jurist.org/forum/2011/10/berman-dachille-aoki-sorrell.php.

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