State Preemption: Impacts on Advances in Tobacco Control

Joann Yoon Kang, JD; Brandon Kenemer, MPH; Margaret Mahoney, JD; Michael A. Tynan

ABSTRACT

Context: Policy is an effective tool for reducing the health harms caused by tobacco use. State laws can establish baseline public health protections. Preemptive legislation at the state level, however, can prohibit localities from enacting laws that further protect their citizens from public health threats.

Approach: Preemptive state tobacco control laws were assessed using the Centers for Disease Control and Prevention's State Tobacco Activities Tracking and Evaluation System. Based on the assessments, the Centers for Disease Control and Prevention quantified the number of states with certain types of preemptive tobacco control laws in place. In addition, 4 different case examples were presented to highlight the experiences of 4 states with respect to preemption.

Discussion: Tracking and reporting on preemptive state tobacco control laws through the Centers for Disease Control and Prevention's State Tobacco Activities Tracking and Evaluation System provide an understanding of the number and scope of preemptive laws. Case examples from Hawaii, North Carolina, South Carolina, and Washington provide a detailed account of how preemption affects tobacco control governance at state and local levels within these 4 states.

KEY WORDS: preemption, tobacco control

Context

Tobacco use is the leading cause of preventable disease, disability, and death in the United States.[1] Smoking causes nearly 1 in 5 deaths in the United States, and smoking-related illness results in more than $300 billion in health care costs and lost productivity each year.[1] Although strategies implemented in the past few decades have contributed to recent declines in cigarette smoking rates, about 47 million US adults used a tobacco product in 2017, 34 million of whom smoked combustible cigarettes.[2] Among US middle and high school students, cigarette use is declining; however, tobacco product use is on the rise due to unprecedented increases in e-cigarette use over the last decade.[3]

Author Affiliation: *Office on Smoking and Health, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia.*

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Correspondence: *Joann Yoon Kang, JD, Office on Smoking and Health, Centers for Disease Control and Prevention, 4770 Buford Hwy, Mailstop S107-7, Atlanta, GA 30341 (vrz7@cdc.gov).*

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Tobacco control policies are among a suite of effective strategies that can reduce health harms caused by tobacco use. The US surgeon general found that passage and implementation of tobacco control policies at all jurisdictional levels—federal, state, and local—can play a critical role in eliminating tobacco use and improving population health.[1] Specifically, the surgeon general noted the importance of federal regulations that set manufacturing standards for tobacco products, such as future possible regulations that may reduce the amount of nicotine in combusted tobacco products.[1] Also recognized were evidence-based state and local laws that protect the public from secondhand smoke, reduce youth access to tobacco products, increase access to cessation resources, and increase the price of tobacco products.[1]

Many localities, including cities and counties, have implemented laws that play a key role in preventing and reducing tobacco product use.[4,5] The 2014 surgeon general's report, The Health Consequences of Smoking—50 Years of Progress, describes local smoke-free policies as the catalyst for transitioning social norms around smoking throughout the country.[1] Comprehensive smoke-free policies are those that prohibit smoking in private sector worksites, restaurants, and bars.[1] As for other types of tobacco control policies, as of July 31, 2019, more than 480 localities have raised the minimum legal sales age for tobacco

to age 21 years ("Tobacco-21").[6] In some cases, states with local Tobacco-21 laws later passed statewide Tobacco-21 laws.[6]* About 192 localities have prohibited the sale of tobacco products in pharmacies, while only 1 state, Massachusetts, has enacted a similar law.[7] Additional policy strategies currently gaining traction at the local level include elimination of price discounts and coupon redemptions for tobacco products in retail stores[8] and restrictions on the sale of flavored tobacco products, often including e-cigarettes and menthol cigarettes.[9]

Preemptive state laws

Preemption occurs when a higher level of government restricts or eliminates the authority of a lower level of government to regulate an issue.[10] Preemptive state laws preclude local governments from passing laws that differ from the state law and, in some cases, enacting any local laws on the same topic. Preemption can be the result of specific legislative language (expressed preemption) or from interpretations by courts (implicit or implied).[4] Although interpreting and determining the scope of any state law can be challenging in any context, state laws with preemptive language may require an additional level of analysis and are sometimes resolved only through litigation, which may introduce greater levels of confusion for public health leaders seeking to advance impactful public health protections.[4]

Implications of preemption on tobacco control policies

Local policies can play a critical role in public health, as evidenced by the fact that "[t]he strongest, most comprehensive smoke-free laws have typically originated at the local level."[11] As detailed in the 2006 surgeon general's report, one of the major political objectives of the tobacco industry during the mid-1990s was the passage of state preemption laws.[11] In response to the growing momentum of local smoke-free indoor air laws passed into law, the tobacco industry acknowledged that while reasonably successful in defeating smoking restrictions imposed at the state level, they had challenges in defeating local measures.[11] To counter what was seen as "widespread control of exposure to secondhand smoke," which the industry recognized as a threat to its own interests, the tobacco industry "support[s] state laws that preempt local smoking restrictions that are stronger than the state standard."[11]

Tracking state tobacco control preemption laws

Given the potential for preemption to hinder progress toward preventing and reducing tobacco-related health harms, it is important to surveil and report on preemptive state tobacco control laws. Since 1999, the Centers for Disease Control and Prevention (CDC) has tracked enactment of state tobacco control legislation for all 50 states and Washington, District of Columbia, through its State Tobacco Activities Tracking and Evaluation (STATE) System.[12] The STATE System contains tobacco-related epidemiologic and economic data, which stakeholders can access to track trends and inform a broader understanding of tobacco control efforts within and across states. In this report, the CDC quantified states with specific types of preemptive tobacco control laws in place and identified case examples to highlight the experiences of states with preemption.

Methods and Approach

The CDC examined the STATE System to assess the prevalence of state-level preemptive tobacco control laws. The CDC searches each state's laws using an online legal research database quarterly to identify newly enacted tobacco control legislation. It analyzes and codes the full text of new or amended laws, using CDC-developed criteria (eg, specific topics of interest, enforcement mechanisms, effective dates, express preemption, etc). Following analysis and coding of the provisions, the data are subject to a secondary review for quality control. After identified discrepancies are reconciled, the data are embedded within the STATE System and made available online.*

In determining whether state laws preempt local smoking restrictions, STATE System researchers take into account statutes and examine relevant case law, since court rulings at times determine whether local policies are preempted under existing state law. The STATE System does not include case law analyses for local youth access restrictions or local licensing requirements.

The CDC also assessed the experiences of 4 states with a known history of preemption—Hawaii, North Carolina, South Carolina, and Washington—to highlight varied experiences related to the adoption and, in some cases, repeal of state preemption laws.

*A federal law was enacted on December 20, 2019 that raises the minimum age of sales of tobacco products from 18 to 21 years nationwide. https://www.congress.gov/bill/116th-congress/house-bill/1865

*The full methodology for CDC's STATE System is available at https://www.cdc.gov/statesystem/index.html.

Findings

Quantitative findings

As of June 30, 2019, 32 states have enacted at least 1 type of preemptive tobacco law related to smoke-free indoor air, local tobacco retail licensing, and/or youth access,[12] as illustrated by Figure 1.

Twelve states have enacted legislation purporting to preempt local jurisdictions from passing smoke-free indoor air laws.[12] Of these 12, 4 states have a statewide comprehensive smoke-free indoor air law that prohibits smoking in all indoor areas of worksites, restaurants, and bars.[12] For those 4 states, although they have a statewide comprehensive smoke-free law, the preemptive language precludes localities from passing smoke-free indoor air laws that differ from the statewide law. These localities thereby are prevented from addressing secondhand smoke in additional locations not addressed by the statewide law and/or from enacting other provisions to align with potential scientific advances around secondhand smoke exposure that may develop. As for the 8 states with preemption that do not have a statewide comprehensive smoke-free indoor air law, this preemptive language purports to prohibit local governments from passing laws that establish protections against exposure to secondhand smoke in workplaces and public places.

Looking at the STATE data from a different perspective, as of June 30, 2019, 27 states and Washington, District of Columbia, have enacted a state-level comprehensive smoke-free indoor air law.[12] Among the 23 states that do not have a state-level comprehensive smoke-free indoor air law, 8 of the 23 states also have in place preemptive language that purportedly disallow local jurisdictions from passing their own smoke-free indoor air laws.[12] Although West Virginia is one of the 23 states that does not have a state-level comprehensive smoke-free indoor air law,[12] the state does not preempt local boards of health from promulgating smoke-free indoor air regulations. Therefore 65% of West Virginia residents live in a community with a local comprehensive smoke-free indoor air regulation.[13] Figure 2 illustrates the percentage of individuals by state protected from secondhand smoke exposure through a comprehensive smoke-free indoor air law, enacted either at the state or local level.

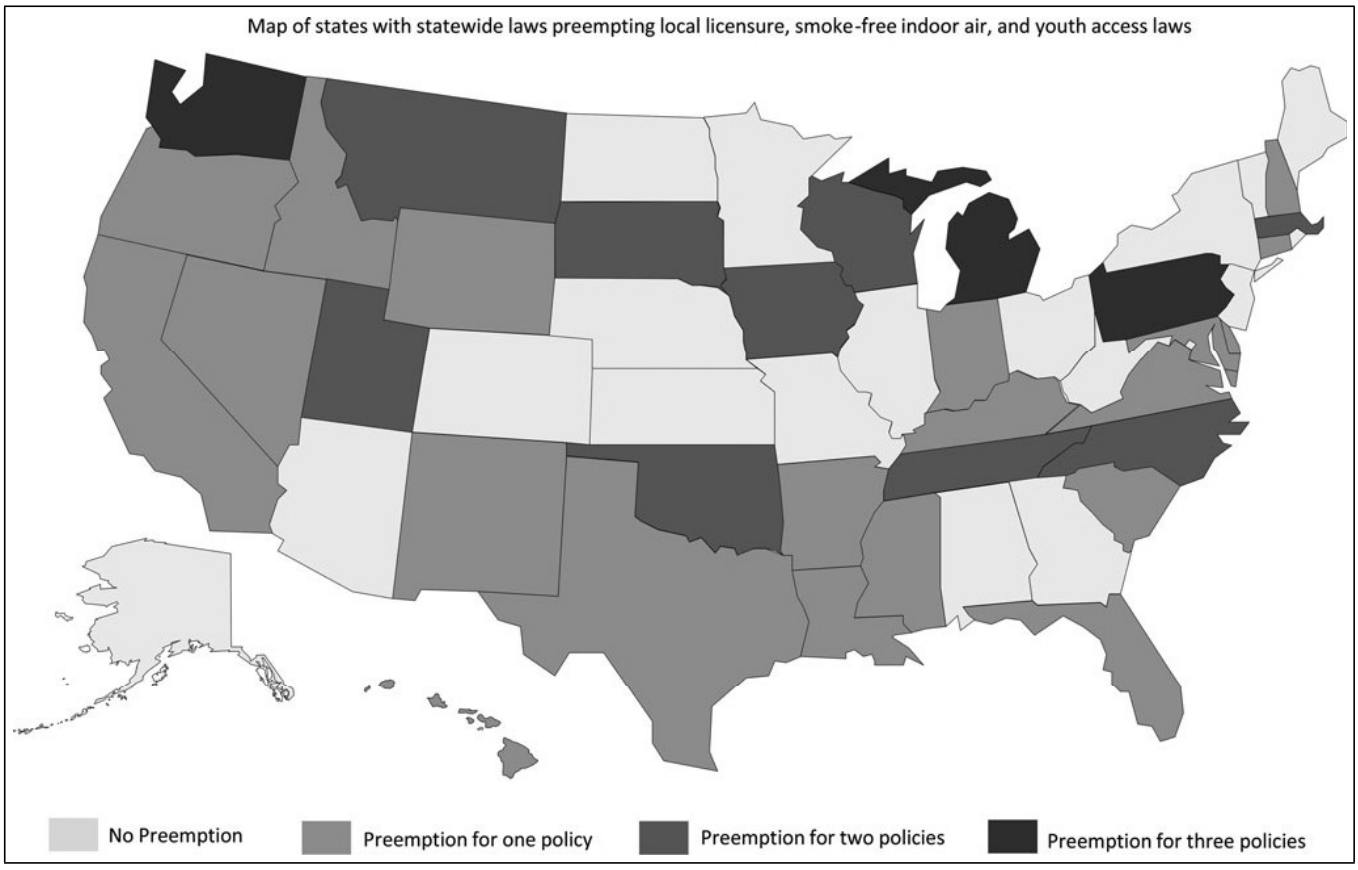

FIGURE 1 States With Policies Preempting Local Licensure, Smoke-Free Indoor Air, and Youth Access Laws, United States, June 30, 2019[a]
[a]The legend categorizes each state based on whether existing state law preempts a locality from passing more stringent local laws in 3 policy areas: local licensure, smoke-free indoor air, and/or youth access.

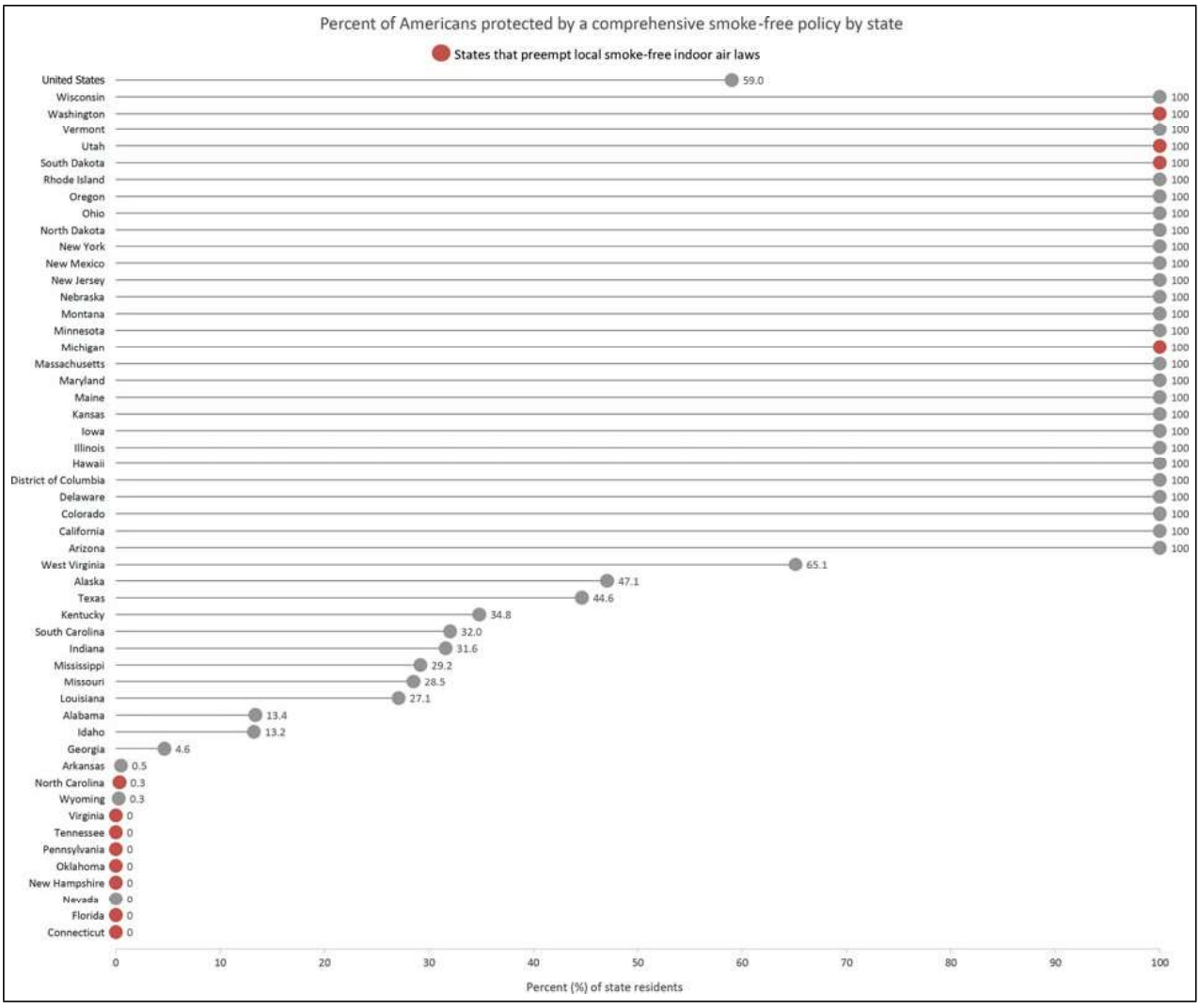

FIGURE 2 Percent of Population Protected by a Comprehensive Smoke-Free Policy, by State, United States, January 2019

Qualitative assessment using case examples

There are wide variations in what preemptive state laws cover and their implications on existing or future local policy activity within that state. State case examples exemplify the unique experiences presented by preemption.

Hawaii

Hawaii enacted a preemption law during its 2018 legislative session, which took effect on July 10, 2018.[14] Although the initial bill was primarily related to dialysis centers and unrelated to tobacco use or prevention, it ultimately included changes to the state's existing tobacco control laws. Section 6 of the relevant Act added a new section to Chapter 328J, which sets forth language stating:

> (B) All local ordinances or regulations that regulate the sale of cigarettes, tobacco products, and electronic smoking devices are preempted, and existing local laws and regulations conflicting with this chapter are null and void.

The stated intent behind the preemption provision was to regulate the sale of tobacco products in Hawaii in a "uniform and exclusive manner."[14] At the same time, the law also explicitly states that "[n]othing in this chapter shall be construed to limit a county's authority under Section 328J-15," which is the portion of Hawaii's statute that allows counties in Hawaii to maintain and/or enact smoke-free indoor air policies that are stronger than those at the state level.[14] In essence, the same law, which codifies that Hawaii counties are preempted from enacting their own tobacco product sales regulations based on the perceived need to "ensure uniformity and exclusivity" also explicitly maintains that Hawaii counties retain their existing authority to enact their own smoke-free indoor air laws as long as they are stronger than the

protections included in state law, which sets a minimum standard.

North Carolina

North Carolina's law explicitly preempting local smoke-free activity was enacted on July 15, 1993.[15] The preemption language was included as part of a stand-alone smoke-free law requiring that smoking be allowed in at least 20% of state-controlled buildings, stating the following:

> (a) This Article shall not supersede, nor prohibit the enactment or enforcement of any otherwise valid local law, rule, or ordinance enacted prior to October 15, 1993, regulating the use of tobacco products….
>
> (b) Any local ordinance, law, or rule that regulates smoking adopted on or after October 15, 1993, shall not contain restrictions regulating smoking which exceed those established in this Article. Any such local ordinance, law, or rule may restrict smoking in accordance with this subsection only in the following facilities….[15]

The facilities enumerated in the law were narrow in scope. Before July 15, 1993, a total of 16 ordinances or board of health regulations restricting smoking in public or private places were adopted. During the 3-month period between enactment and effective date of the 1993 law, ordinances or board of health regulations restricting smoking were proposed in more than half of the counties in North Carolina, and 89 were adopted, with several counties adopting multiple regulations.[16]

In 2006 and 2008, North Carolina incrementally began to grant local governments increased authority. Starting in 2006, local governments could require their buildings and vehicles to be smoke-free and, starting in 2008, universities and colleges could adopt smoke-free policies.[17] In 2009, North Carolina amended its statewide smoke-free law to prohibit smoking in all restaurants and bars, and partially repeal preemption, stating that "a local government may adopt and enforce ordinances … restricting or prohibiting smoking that are more restrictive than State law."[18] The law excluded private workplaces from the list of approved places where smoking can be regulated and added that local governments cannot regulate smoking in areas that are explicitly exempt from the statewide smoke-free law, including cigar bars, private clubs, and tobacco shops.[18]

Following North Carolina's partial repeal of preemption in 2009, 13 cities and 2 counties have used the authority returned to them, passing ordinances prohibiting smoking in enclosed public places.[19] All localities, however, continue to face the threat of having their authority limited through future state bills that may once again restrict local control.[17]

South Carolina

In 1996, South Carolina passed a tobacco control bill that amended 2 separate sections of the state code[20]: (1) the state smoke-free law, and (2) the state youth access law. A new provision in the youth access section limited local authority, stating the following:

> (A) [The amended youth access provisions] must be implemented in an equitable and uniform manner throughout the State …. Any laws, ordinances, or rules enacted pertaining to tobacco products may not supersede state law or regulation.
>
> (B) Smoking ordinances in effect before the effective date of this act are exempt from the requirements of subsection (A).

In 2006, 2 South Carolina cities adopted smoke-free ordinances. Each city's law was challenged in court on the grounds that the youth access law preempted localities from enacting smoke-free laws. The Sullivan's Island ordinance, enacted in June 2006, was upheld by the trial court in December 2006.[21] The Greenville ordinance, enacted in October 2006, was found by the trial court in March 2007 to be preempted by state law.[20]

The South Carolina Supreme Court heard an appeal in the Foothills Brewing Concern, Inc v City of Greenville case and in March 2008 unanimously ruled that local governments have the right to enact and enforce smoke-free laws.[20] The court found that a plain reading of the state statute showed that the preemption clause precluded only local regulations concerning the distribution of tobacco products to minors. It noted that although the youth access law's preemption language was added at the same time the smoke-free law was amended, it did not require that the preemption clause be read to limit local authority concerning smoke-free policies. This court decision clarified that localities in South Carolina retained their authority to adopt smoke-free ordinances, which cumulatively now protect an estimated 32% of the state population from exposure to secondhand smoke in public places and workplaces.[13]

Washington

In 1985, Washington enacted the Washington Clean Indoor Air Act, which restricted smoking to designated smoking areas in public places and allowed locations such as bars, taverns, bowling alleys, tobacco shops, and restaurants "to be designated as a smoking

area in its entirety."[22] Washington's law also included language that local fire departments, fire districts, and local health departments "may adopt regulations as required to implement this chapter."[22]

In 2003, Tacoma-Pierce County's Board of Health adopted a regulation that prohibited smoking in all indoor public places, including bars, taverns, bowling alleys, tobacco shops, and restaurants.[23] The Tacoma-Pierce County Board of Health regulation was challenged in court by the Entertainment Industry Coalition, funded in part by the tobacco industry,[24] that claimed that the regulation conflicted with specific provisions of the Washington Clean Indoor Air Act. The Washington State Supreme Court ruled on February 5, 2005, that while the statutory delegation under the Clean Indoor Air Act is broad, the delegation does not include any power to enact regulations that conflict with state legislation.[25] The court found that the local regulation conflicted with state law because it prohibited what state law permitted, and "when such a conflict is found to exist, under the principle of conflict preemption, the local regulation is invalid."[25]

On November 8, 2005, Washington voters approved Initiative Measure 901, which established a comprehensive statewide smoke-free law to prohibit smoking in workplaces, restaurants, bars, and other public places. The law took effect on December 8, 2005, and Washington became the fifth state to have a comprehensive smoke-free indoor air law.[26] However, this new law did not include language either expressly preempting or granting local communities or boards of health authority to enact local smoke-free laws or regulations. The 2005 law was silent on the issue of preemption; Washington continues to preempt localities from passing smoke-free laws.[27]

Discussion

The CDC's STATE System provides legislative data to inform a broader understanding of the number and scope of tobacco control preemption laws in place within states. Analyses of these data can help inform tobacco control efforts.

The qualitative assessments of the experiences of Hawaii, North Carolina, South Carolina, and Washington demonstrate the effect that preemption can have.

Hawaii often is recognized as a leading state in implementing tobacco control policies aligned with recognized best practices,[1,28] which includes being the first state to raise the minimum legal sales age for tobacco products to 21 years in 2015.[29] Tobacco control advocates in Hawaii therefore indicated their surprise when preemption passed in 2018 and noted "the importance of remaining vigilant to tobacco industry tactics" concerning tobacco control policy.[29] During Hawaii's 2019 state legislative session, legislation was proposed to repeal the preemptive language but did not pass.

Resolving questions about jurisdictional authority stemming from a preemption law through litigation can be costly in terms of time and taxpayer dollars.[30] In South Carolina, Sullivan's Island and Greenville were subjected to litigation challenging their authority to pass smoke-free ordinances under state law.[30] Although the South Carolina Supreme Court's decision in the Greenville case eventually led to both ordinances being upheld, it took 18 months after enactment of the Greenville ordinance for the issue to be resolved. Both cases were highly visible,[31] and the cities' engagement in litigation to defend their smoke-free ordinances may have had an adverse effect on other potential local smoke-free laws while their cases were pending.[30] Despite the holding from the State Supreme Court, the threat of litigation remains with respect to other tobacco control policies (eg, local retail-focused policies) in the state. Because the South Carolina Supreme Court found that only local laws specifically aimed at distribution to children are preempted, those opposed to future retail policies could still subject a city to lengthy and costly litigation to further clarify the scope of the state's preemption policy.

In North Carolina, the state's preemption law was enacted on July 15, 1993, but was not effective until October 15, 1993.[16] Faced with impending preemption, many localities were prompted to adopt tobacco control laws and regulations while they still had authority to do so.[16] Thus, the existence of the 3-month window created an "unnatural time frame for communities to organize, debate, and adopt restrictions for the indefinite future."[16] Because of this short time frame, the state law effectively limited the scope of the local ordinances that could be adopted in those 3 months.[16] In addition, local laws were drafted and adopted that may not have been as strong as they could have been from a public health standpoint and, once enacted, could not be strengthened through later legislative efforts because of the preemption language.[16] Although local preemption was partially repealed in 2009, local legislators remained restricted in their ability to fully regulate tobacco and the threat of preemption remains.[17] The experiences in North Carolina and other states may serve as examples for local leaders considering approaches to local tobacco control measures.

Washington's example highlights the ambiguity that results when a state law is silent on the issue of preemption. Such a law can be interpreted by the courts to imply that preemption applies, even if that

may not have been the legislative intent. A state law that does not expressly address preemption may also lead localities to presume that they are preempted from enacting their own policies, highlighting how inclusion of specific language enabling local laws can remove ambiguity and protect local control.

Although these case examples highlight challenges that can stem from preemption, other state and local experiences highlight public health progress possible when preemption is not a deterrent. On July 1, 2019, the Atlanta City Council passed a comprehensive smoke-free ordinance, effective beginning January 2, 2020, which prohibits smoking in all workplaces, restaurants, and bars.[32] In enacting its ordinance, the Atlanta City Council prohibits smoking in locations otherwise allowed under Georgia's Smokefree Air Act of 2005 and the Atlanta Indoor Air Ordinance from 2004. Prior to this local ordinance taking effect, only 4.7% of Georgians are covered by a comprehensive smoke-free indoor air law.[13] Following enactment, about 9% of Georgians will be covered by a comprehensive smoke-free indoor air law.[33]

Limitations

First, tobacco preemption legislation included in STATE System is limited to provisions related to advertising, licensure, smoke-free indoor air, and youth access. State laws preempting local regulation of tobacco sales, beyond what may be contained in the preemptive state youth access law, are not included or captured. Furthermore, the STATE System does not address case law related to preemption other than for laws related to smoke-free indoor air.

Second, also excluded from the STATE System are laws that are not tobacco-specific but have preemption language broadly prohibiting local jurisdictions from regulating the sale of commercial products, an umbrella category under which tobacco products would fall by definition.

Finally, the qualitative assessments of Hawaii, North Carolina, South Carolina, and Washington are not inclusive of all preemptive laws codified in each of the 4 states but provide a snapshot to highlight potential ways preemption may affect tobacco control governance at state and local levels.

Conclusion

Evidence-based policies play an integral role in advancing tobacco prevention and control. Tracking state legislation on preemption and conducting assessments of states' experiences can broaden understanding of the implications of preemption and inform public health strategies.

Implications for Policy & Practice

- CDC's STATE System provides critical data to improve understanding of the number and scope of preemptive tobacco control laws that may hinder tobacco control efforts.
- The evidence demonstrates that some state preemption laws impede local governments from adopting tobacco control laws and can thereby stymie innovative approaches in public health.
- Research shows that state tobacco preemption policies can prevent local governments from implementing local policy solutions to identified issues of concern.

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