State, Local and Federal Tobacco Control Legislation

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Executive Summary

The Environmental Protection Agency has designated second-hand smoke as a “Class A” carcinogen. Forty-eight states and the District of Columbia have enacted laws that restrict smoking in public places to some extent. Considering both state laws and state regulations combined, 42 states restrict smoking in public places such as restaurants, 44 restrict smoking in government workplaces, and 23 restrict smoking in private sector workplaces. Additionally, twenty-eight states and Washington, D.C., have laws that specifically restrict smoking in commercial day care centers. Texas has no state law regulating smoking in restaurants, government or private worksites, or day care centers. The limited Texas law prohibits smoking in a public primary or secondary school, elevator, enclosed theater or movie house, library, museum, hospital, transit system or interstate bus, plane, or train.

Texas charges 41 cents per pack excise taxes on cigarette sold within the state. As shown on the chart below, this is in the middle range. Kentucky only charges 3 cents, while Alaska and Hawaii each charge one dollar per pack, and in 1999, New York State raised it excise tax by 55 cents to $1.10. In 1998, Texas collected $548,936,000 in excise taxes on cigarettes. Research has shown that increasing excise taxes can reduce demand for cigarettes.

Texas provides Medicaid coverage for smoking cessation, but information about such coverage is difficult to find. Effective education of providers and recipients is needed to promote the coverage, and the benefits it can bring to recipients and to the state.

The federal government prohibits smoking on premises owned or leased by the federal government. Labeling and advertising of cigarettes is also regulated federally. The United States Supreme Court recently held that the Food and Drug Administration (FDA) lacks jurisdiction to regulate tobacco as a drug, which invalidated the FDA’s regulations governing tobacco products. The regulations principally restricted the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents.

In 1994, the federal Occupational Safety and Health Administration (OSHA) proposed to adopt standards addressing indoor air quality for indoor work environments. The provisions that addressed the control of environmental tobacco smoke were intended to apply to all work-sites, both industrial and non-industrial, approximately 6 million work environments. In buildings where smoking is allowed, the proposal required designated smoking areas that would be separate, enclosed rooms where the air would be exhausted directly to the outside. The standards proposed by OSHA have not been adopted. The provisions required congressional approval, but Congress has so far failed to provide it.

A recently conducted “Opinion Leaders Survey” found that 84% of respondents think the Texas Legislature should adopt a statewide smoke-free ban for workplaces and public buildings, and a majority think laws and controls of tobacco should be set at the state level. If Texas were to consider additional legislation to regulate smoking, the legislature would need to consider the
type of public locations to be regulated, the extent of regulation, e.g., whether to totally ban smoking, and whether a state statute should preempt municipal ordinances. The tobacco industry supports preemption, and tobacco control advocates oppose preemption.

Texas could devote a larger percentage of tobacco settlement funds towards tobacco prevention and control efforts. Texas created a tobacco settlement endowment from the tobacco settlement funds. About $10 million a year in interest from the endowment will be spent on tobacco prevention and control. Nineteen states have allocated a portion of their tobacco settlement dollars to tobacco prevention ranging from $100 million dollars in Washington State to $1 million in Rhode Island. According to the U.S. Centers for Disease Control and Prevention (CDC) the annual cost of an effective, comprehensive tobacco prevention program for Texas is between $103.2 million and $284.7 million, a per capita expenditure of $5.31 to $14.65. Texas currently spends 46 cents per capita for tobacco prevention—8.7% of the CDC’s minimum recommendation. Texas ranks 40th among the 45 states that have made decisions regarding their tobacco settlement funds or have committed other state funding for tobacco prevention.

Evidence from programs in Oregon, California and Massachusetts confirms that increased spending on comprehensive tobacco prevention and control programs significantly reduces tobacco consumption. While tobacco prevention and control efforts may focus on programmatic issues such as public education, community-based programs, cessation efforts, school based programs, and enforcement, a number of related policy efforts have proven effective in reducing tobacco when used as part of a comprehensive strategy. These policies include increases in cigarette excise taxes and new restrictions on environmental tobacco smoke in public places.
Preface: Effects of Environmental Tobacco Smoke—Factors Underlying Environmental Smoking Legislation

A significant development in tobacco control policy is the Environmental Protection Agency’s (EPA) designation of second-hand smoke as a “Class A” carcinogen. The EPA has made the following findings regarding second-hand smoke:

- It is a human lung carcinogen.
- It is responsible for approximately 3,000 lung cancer deaths annually in adult U.S. nonsmokers.
- It is causally associated with an increased risk of lower respiratory tract infections in children (estimating that 150,000 to 300,000 cases in infants and young children up to eighteen months of age are attributable to second-hand smoke annually).
- It is causally associated with increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation and a small but significant reduction in lung function in children.
- It is causally associated with additional episodes and increased severity of symptoms in children with asthma (estimating that 200,000 to 1,000,000 asthmatic children’s condition is worsened by second-hand smoke exposure).
- It is a risk factor for new cases of asthma in children who have not displayed symptoms previously. ¹

In addition to the EPA’s findings, a recent Harvard study shows that exposure to second-hand smoke can almost double a person’s risk of heart attack. The study estimates that the number of people dying from heart attacks brought on by second-hand smoke each year could exceed 50,000--more than ten times the number of people who die of lung cancers from second-hand smoke. ²

¹ Environmental Protection Agency, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders (December 1992), EPA/600/6-90/006F; see also Environmental Protection Agency, Fact Sheet on Respiratory Health Effects of Passive Smoking (January 1993), EPA-43-F-93-003, found at http://www.epa.gov/iedweb00/pubs/etsfs.html (for a summary of the EPA’s report).

² Action on Smoking and Health, Secondhand Smoke Almost Doubles Heart Attack Risk [05/20] (May 1997), found at http://www.ash.org/may97/5-20-97-1.html; see also Final Report of The Advisory Committee on Tobacco Policy and Public Health (July 1997) (hereinafter “Final Report”), found at http://www.ash.org/report2.html, (wherein the Task Force on Environmental Tobacco Smoke notes that second-hand smoke “is believed to cause tens of thousands of deaths each year and to cause or exacerbate cardiovascular and pulmonary illnesses in hundreds of thousands of additional individuals”).
I. How Texas Compares To Other States

A. At The State Level

1. Laws Restricting Smoking in Public Places

Forty-eight states and the District of Columbia have enacted laws that restrict smoking in public places to some extent. These laws range from comprehensive clean indoor air acts that restrict or prohibit smoking in virtually all public places, including workplaces, to more limited regulations (e.g. prohibiting smoking on school buses). As shown in the map below, 31 states have state laws regulating smoking in restaurants. Texas has no state law regulating smoking in restaurants.

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4 *Id.*
In 1975, Texas first enacted legislation restricting smoking in certain public places including primary and secondary schools, elevators, theaters, movie houses, libraries, museums, hospitals, and some buses.\(^5\)

2. **Laws Restricting Smoking in the Workplace**

Approximately 85% of U.S. employers restrict smoking on the job and an estimated 34% ban smoking in their workplaces entirely.\(^6\) The increasing adoption of smoking policies in the workplace is arguably a reflection of increasing regulation as well as increasing concern about potential liability and health effects of environmental tobacco smoke.\(^7\)

Additionally, twenty-one states and the District of Columbia restrict smoking in some way in private places of work by state statute. The following map illustrates state statutes regulating smoking at private worksites.\(^8\) Texas has no state law regulating smoking in private worksites.

![Map of Smokefree Indoor Air Restrictions in Private Worksites –2000, 1st Quarter](image)

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\(^5\) See *TEX. PENAL CODE ANN.* § 48.01 (Vernon 1994). SLATI 1999 characterizes 14 states, including Texas, as having “minimal” restrictions on smoking in public places. Only Mississippi and Alabama have no restrictions on smoking in public places. See SLATI 1999, Appendix C.


\(^8\) Available from CDC web site at [http://www2.cdc.gov/nccdphp/osh/state/report_index.htm#Legislative](http://www2.cdc.gov/nccdphp/osh/state/report_index.htm#Legislative) visited October 2, 2000.
In addition to state statutes, some states have restricted workplace smoking by regulations issued pursuant to state occupational safety and health acts (OSHA Acts). Arizona was the first state to restrict smoking in a number of public places\(^9\) and the first to do so explicitly because of the public hazard posed by environmental tobacco or second-hand smoke.\(^{10}\) It initiated these restrictions in 1973.\(^{11}\) Twenty years later, in 1993, Vermont became the first state to prohibit smoking in virtually all workplaces, which include almost all public places.\(^{12}\) Today, Vermont, California, Maryland, Utah and Washington have some of the most comprehensive smoking regulations at the state level\(^{13}\). Interestingly, Maryland and Washington’s restrictions were initiated by state agencies in regulations issued under their state OSHA Acts, while California, Utah and Vermont’s laws were initiated through their state legislatures.

Considering both state laws and state OSHA regulations combined, 42 states restrict smoking in public places, 44 restrict smoking in government workplaces, and 23 restrict smoking in private sector workplaces. California, Maryland and Washington require that private workplaces either ban smoking entirely, or alternatively provide separately ventilated smoking areas.\(^{14}\) Forty-two states regulate smoking at state government worksites. Texas has no state law regulating smoking in state government worksites.

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\(^{10}\) Centers for Disease Control and Prevention, Significant Developments Related to Smoking and Health 1964-1996 (1996) (hereinafter “Significant Developments”), found at [http://www.cdc.gov/tobacco/chron96.htm](http://www.cdc.gov/tobacco/chron96.htm). The terms environmental tobacco smoke and second-hand smoke will be used interchangeably throughout this memorandum.

\(^{11}\) This “milestone” along with other significant developments relating to environmental tobacco smoke are outlined in Appendix F of this memorandum.


\(^{13}\) Vermont, California, Maryland, and Utah are the only four states listed in SLATI 1999 as having “comprehensive” restrictions on smoking in public places. See SLATI 1999, Appendix C.

\(^{14}\) See SLATI 1999 at p. i.
3. Laws Restricting Smoking in Day Care Facilities

As of 1998, twenty-eight states and Washington, D.C., had laws that restrict smoking in commercial day care centers. Eleven states restrict smoking in home-based day care centers. States take various approaches to regulating smoking in day care facilities. For example, eleven states totally ban smoking in commercial day care centers at all times. California requires either no smoking or separate ventilation for smoking areas. Ten states ban smoking only when children are present. Five states and Washington, D.C., allow (or require) designated smoking areas at all times. One state requires or allows designated smoking areas only when children are present. For home-based day care, six states restrict smoking only when children are on the premises, California alone requires separate ventilation for smoking areas (or a ban on smoking) when children are on the premises. Two states require or allow designated smoking areas at all times; and two require or allow designated smoking areas only when children are on the premises.

For home-based day care, ten of the eleven states that have clean indoor air restrictions penalize either the smoker or the business for a violation. For commercial day care center, twenty-seven of the twenty-nine states that have clean indoor air restrictions penalize either the business or the smoker for a violation. Some state laws, including Michigan, New Jersey and Ohio, authorize license revocation for violations of the law. A majority (66%) of laws restricting

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15 See Julie A. Fishman, Harmony Allison, et al, State Laws on Tobacco Control -- United States, 1998 available at http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/ss4803a2.htm visited October 14, 2000. All the day care statistics in these paragraphs are from this report (hereinafter referred to as “State Laws 1998”).
smoking in day care centers designate an enforcement authority. See Table 5, containing a list of states with laws on smoking in commercial and home-based daycare centers as of December 31, 1998. Table 5 is attached as Appendix E.

4. Excise Taxes

Texas charges 41 cents per pack excise taxes on cigarettes sold within the state. As shown on the chart below, this is in the middle range. Kentucky only charges 3 cents, while Alaska and Hawaii each charge one dollar per pack. In 1999, New York State raised its excise tax by 55 cents to $1.10. See Appendix D for a list of state excise tax rates, together with the net cigarette excise tax revenue collected in fiscal year 1998. In 1998, Texas collected $548,936,000 in excise taxes on cigarettes. Research has shown that increasing excise taxes can reduce demand for cigarettes.
Attached to this memorandum are the following appendices compiled by the American Lung Association and others which illustrate in greater detail the existence and nature of smoking restrictions in the fifty states:

1. Appendix A- Lists of states with laws restricting smoking in public places, in government buildings and in private workplaces;

2. Appendix B- Chart of state laws restricting smoking in public places by type of place (e.g. sports arenas, restaurants, work places); and

3. Appendix C- Map of the United States identifying states with restrictions on smoking in public places by level of restriction (e.g. comprehensive, moderate, minimal)

4. Appendix D- List of state excise tax rates, together with the net cigarette excise tax revenue collected in fiscal year 1998. 

5. Appendix E- See Table 5, containing a list of states with laws on smoking in commercial and home-based daycare centers as of December 31, 1998.

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16 Appendixes A, B, C and D are contained in SLATI 1999.
17 Appendix E, Table 5, is contained in State Laws 1998.
B. At The Local Level

As of September 15, 2000, at least 1548 U.S. municipalities had adopted significant smoking restrictions in public places and workplaces. At least 160 cities provide for 100% smoke free workplaces, including restaurants; another thirty-seven cities provide for 100% smoke free workplaces, excluding restaurants.

II. Examples Of Legislation, Including Model Legislation

A. State Legislation

1. Overview

Texas’ law, which is not as comprehensive as the laws in some of the other states, is penal in nature and provides, “[a] person commits an offense if he is in possession of a burning tobacco product or smokes tobacco in a facility of a public primary or secondary school or an elevator, enclosed theater or movie house, library, museum, hospital, transit system bus, or intrastate bus, as defined by Section 541.201, Transportation Code, plane, or train which is a public place.”

California’s law on smoking in the workplace, one of the most comprehensive, provides in part:

The Legislature finds and declares that regulation of smoking in the workplace is a matter of statewide interest and concern. It is the intent of the Legislature in enacting this section to prohibit the smoking of tobacco products in all (100 percent of) enclosed places of employment in this state… thereby eliminating the need of local governments to enact workplace smoking restrictions within their respective jurisdictions. It is further the intent of the Legislature to create a uniform statewide standard to restrict and prohibit the smoking of tobacco products in enclosed places of employment…in order to reduce employee exposure to environmental tobacco smoke to a level that will prevent anything other than insignificantly harmful effects to exposed employees, and also to eliminate the

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18 See Significant Developments and NYT Article.
21 TEX. PENAL CODE ANN. § 48.01(a). The offense is a Class C misdemeanor. Id. § 48.01(f).
confusion and hardship that can result from enactment or enforcement of disparate local workplace smoking restrictions.22

The statute further provides that “[n]o employer shall knowingly or intentionally permit, and no person shall engage in, the smoking of tobacco products in an enclosed space at a place of employment.”23 The law provides for a number of exemptions including a percentage of guest rooms in a hotel or motel, cabs of motortrucks when only smokers are present, and private residences when not in use as family day care centers.24 The law allows employers to create breakrooms designated for smoking, provided that “[a]ir from the smoking room shall be exhausted directly to the outside by an exhaust fan. Air from the smoking room shall not be recirculated to other parts of the building.”25

Washington’s law is not workplace-specific, rather, it applies to public places in general. It provides, “[n]o person may smoke in a public place except in designated smoking areas.”26 It provides further that, “[w]here smoking areas are designated, existing physical barriers and ventilation systems shall be used to minimize the toxic effect of smoke in adjacent nonsmoking areas.”27 Like California, Washington enacted its law to reduce the dangers presented by environmental tobacco smoke.28

In contrast to its relatively weak regulation of environmental tobacco smoke (ETS), Texas has some of the toughest laws in the nation concerning minors’ access to tobacco. Recent changes made by S.B. 55 include penalties for minors caught with cigarettes or other tobacco products in their possession.29

2. Medicaid Coverage

a. Prescription and over-the-counter (OTC) drugs

The federal law governing Medicaid permits states to exclude or restrict coverage of drugs used to promote smoking cessation.30 The relevant provision was added by the Omnibus

22 CAL. LAB. CODE ANN. § 6404.5(a).
23 CAL. LAB. CODE ANN. § 6404.5(b).
24 Id. § 6404.5(d).
25 Id.
26 WASH. REV. CODE ANN. § 70.160.030. Maryland, Utah and Vermont’s restrictions or prohibitions on smoking in public places or workplaces may be found at MD. CODE ANN. LAB. & EMPLOYMENT §2-106(c) (Supp. 1997); UTAH CODE ANN. § 26-38-3 (1994); and VT. STAT. ANN. tit. 18, § 1742 (Supp. 1997).
27 WASH. REV. CODE ANN. § 70.160.040(2).
28 Id.§ 70.160.010 (wherein the legislative intent behind Washington’s Clean Indoor Act is described as follows: “[t]he legislature recognizes the increasing evidence that tobacco smoke in closely confined places may create a danger to the health of some citizens of this state. In order to protect the health and welfare of those citizens, it is necessary to prohibit smoking in public places except in areas designated as smoking areas”).
29 TEX. HEALTH & SAFETY CODE ANN. § 161.252 et seq.
Budget Reconciliation Act of 1990 (OBRA). At the time OBRA was passed, only one prescription drug for smoking cessation had been approved by the federal Food and Drug Administration, and smoking cessation products were generally viewed as ineffective. In the past decade, there have been dramatic changes in the availability of effective pharmacological treatments for nicotine addiction. Unfortunately, many states have been slow to respond. According to the National Conference of State Legislatures, in 1998 a total of 23 states chose to provide coverage for smoking cessation treatments under their Medicaid programs. On June 27, 2000, President Clinton issued a statement urging Congress to enact a budget proposal ensuring that every state Medicaid program covers both prescription and non-prescription smoking cessation drugs.

Texas is not among the states that specifically exclude coverage for smoking cessation products by statute or regulation. The Texas Medicaid Vendor Drug Program (VDP) formulary includes certain prescription and OTC drugs for treatment of tobacco or nicotine addiction, including nicotine replacement therapies. However, provider and patient awareness of this benefit may be limited. The VDP is administered by the Texas Department of Health. The VDP administers drug coverage for Medicaid beneficiaries in managed care arrangements as well as traditional Medicaid. Direct services to beneficiaries are provided through a network of approximately 3500 participating pharmacies, about 70 percent of all licensed pharmacies in Texas. Information on coverage of treatments for nicotine addiction is readily available from the Vendor Drug Help Desk, which has a toll-free number, but the number is primarily for use by pharmacists. While some Medicaid beneficiaries may seek out a pharmacist and request a smoking cessation product on their own, many will not take this step without the intervention of a physician or other primary care provider. Information on coverage is not readily available to primary care providers. For example, the index to the 2000 Texas Medicaid Provider Procedures Manual has no entries for “tobacco,” “smoking,” “prevention,” “preventive” or “preventative.” If information on smoking cessation is contained in the Manual, it is difficult to find.

b. Comprehensive prevention and treatment services

States may be required to cover prevention and treatment services related to tobacco use in the form of counseling to the same extent as other kinds of health-related counseling. The federal law that describes the benefit categories that make up “medical assistance” includes

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34 E.g., Alaska, Iowa, and Missouri. ALA. ADMIN. CODE tit. 7, § 43.590; IOWA ADMIN. CODE § 441-78.1 (249A); 13 MO. CODE REGS. tit. 13 § 70-20.032.
36 As of September 1, 1999, the DVP also assumed responsibility for prescription drugs provided under the Children with Special Health Care Needs and Kidney Health Care programs. See Texas Department of Health, Medicaid Vendor Drug Program, at www.tdh.state.tx.us/hcf/vdp/vdpstart.htm (visited Sept. 27, 2000).
preventive services, and treatment for smoking is, at the very least, an essential aspect of good prenatal care.\textsuperscript{37}

Some state Medicaid agencies have adopted regulations that use the comprehensive approach to smoking cessation described in the Clinical Practice Guidelines issued by the federal Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research). For example, the Smoking Cessation Treatment Policy in the Medicaid Services article of the Indiana Administrative Code, adopted in 1999, provides:

\textbf{405 IAC 5-37-1. LIMITATIONS}

Sec. 1. (a) Reimbursement is available for smoking cessation treatment subject to the requirements set forth in this rule...and when provided in accordance with provider bulletins, provider manuals, and the provider agreement.

(b) Reimbursement is available for one (1) twelve (12) week course of smoking cessation treatment per recipient per calendar year.

(c) The twelve (12) week course of treatment may include prescription of any combination of smoking cessation products and counseling. One (1) or more modalities of treatment may be prescribed. Counseling must be included in any combination of treatment.

(d) Prior authorization is not required for smoking cessation products or counseling.

\textbf{405 IAC 5-37-2. SMOKING CESSATION PRODUCTS}

Sec. 2. (a) Reimbursement is available to pharmacy providers for smoking cessation products when prescribed by a practitioner within the scope of his license under Indiana law.

(b) Products covered under this section include, but are not limited to, the following:

(1) Sustained release bupropion products.

(2) Nicotine replacement drug products (patch, gum, inhaler).

\textbf{405 IAC 5-37-3. SMOKING CESSATION COUNSELING}

Sec. 3. (a) Reimbursement is available for smoking cessation counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program and listed in subsection (b).

(b) The following may provide smoking cessation counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations of this rule...:


The Texas Administrative Code has no such provision. As noted above, the 2000 Texas Medicaid Provider Procedures Manual offers little guidance on provision and/or coverage of smoking prevention or treatment services to Medicaid beneficiaries in general.

\textsuperscript{37}“Medical assistance” is defined at 42 U.S.C. § 1396d.
The availability of comprehensive services for children and adolescents enrolled in Medicaid is assured under the Early and Periodic Screening, Diagnosis, and Treatment or EPSDT program. In Texas, EPSDT services are delivered through the Texas Health Steps program. Section 3.8.1 of the chapter of the 2000 Texas Medicaid Service Delivery Guide devoted to Texas Health Steps states that adolescent preventive service visits are covered for Medicaid beneficiaries at ages 11, 13, 15, 17, and 19. Section 3.8.7.5, “Healthy Lifestyles,” instructs providers to give eligible adolescents health guidance on avoidance of tobacco, among other things. Section 3.8.8.3, “Tobacco Use,” instructs providers to ask about use of cigarettes and smokeless tobacco. If an adolescent uses tobacco products, the provider is supposed to determine the patterns of use and develop a cessation plan.

In May 1999, the Texas Legislature enacted a law establishing a Children’s Health Insurance Program. This program provides health insurance for uninsured children who are not eligible for Medicaid up to 200 percent of the federal poverty level. Program materials indicate that smoking cessation services are covered; Phase II of the State Plan for Children's Health Insurance Program includes a one hundred dollar annual limit for smoking cessation.

3. Health Plan Coverage of Smoking Cessation Therapy

In May 1997, Congress asked former Surgeon General Koop to compile a report on tobacco policy, public health, and recommendations for improvements. The Koop-Kessler Advisory Committee Report outlined the extent of the tobacco problem in the United States among youths and adults. One of the recommendations provided for mandated insurance coverage of smoking cessation programs. The report describes coverage that should be provided as a “lifetime benefit rather than as a one-time opportunity to ‘kick the habit.’” Specifically, the report suggests that “coverage for tobacco use cessation programs and services should be required under all health insurance, managed care, and employee benefit plans, as well as all Federal health financing programs.” In addition to the Koop-Kessler Report, the Texas Cancer Council issued a Texas Cancer Plan that reiterated many of the Koop-Kessler’s findings concerning tobacco’s effects and further reiterated the need, at least in Texas, for expanded insurance coverage. Research by the Agency for Health Care Policy and Research [now AHRQ] indicates that smoking cessation intervention is as cost effective as other preventive

40 Id.
41 Id.
services, such as treatment of high cholesterol, yet few insurance providers include such coverage.\textsuperscript{43}

No states currently mandate that health insurance plans offer coverage of smoking cessation programs, though the issue has been debated in recent years. New York, Maryland and Wisconsin have considered legislation on the issue,\textsuperscript{44} but no state has yet passed such legislation. A Maryland health consulting firm, Pinney Associates, found that, as of 1994, insurance coverage for tobacco cessation was very poor. In a 1995 survey of 105 HMOs (health maintenance organizations), one-third did not offer smoking cessation services because of the belief that these services were ineffective.\textsuperscript{45} Among national HMOs’ plans of coverage, no single plan unconditionally covers smoking cessation treatments while most specifically exclude coverage.\textsuperscript{46} One regional HMO, Group Health Cooperative of Puget Sound, implemented full coverage of smoking cessation treatment in 1997, but few plans have since followed Puget Sound’s example.\textsuperscript{47}

Texas law requires coverage of chemical dependency programs in group health insurance policies, but nicotine dependence is not included in the definition of chemical dependency.\textsuperscript{48} Legislation to mandate coverage of smoking cessation programs has been introduced in three states. Supporters argue that coverage should be included in health insurance and HMO plans, but opposition still remains heavy due to concerns about mandates generally, i.e., an undesirable increase in costs that may come with expanded coverage.

B. Local Ordinances

1. Prior Surveys

A number of Texas cities have ordinances that restrict smoking in public places, including workplaces.\textsuperscript{49} One recent study reported on 59 such ordinances. The study found that 34 of the 59 ordinances regulated smoking in workplaces, 50 regulated smoking in restaurants, 4 regulated smoking in bars, and 55 regulated smoking in public places.\textsuperscript{50} A different study found that Austin and Wichita Falls have ordinances requiring 100% smokefree workplaces, including

\textsuperscript{44} S.B. 518, 414th Leg. (Md. 2000), S.B. 6461, 223rd Leg. (N.Y. 1999), S.B. 115, (Wis. 1999).
\textsuperscript{45} Texas Cancer Plan.
\textsuperscript{46} NC HMO Coverage- Smoking Cessation \url{http://www.nciom.org/hmoconguide/O-SMOKE.html}.
\textsuperscript{47} Group Health on Quest to Show Skeptics That Smoking Cessation Helps Bottom Line, NEWS AND STRATEGIES FOR MANAGED MEDICARE AND MEDICAID, (Dec. 6, 1999) \url{http://www.mcareol.com/mcolfree/mcolfre1/ARTCL401.htm}.
\textsuperscript{48} TEX. INS. CODE ANN. art. 3.51-9 (WEST 2000).
\textsuperscript{49} National Cancer Institute. \textit{State and Local Legislative Action to Reduce Tobacco Use. Smoking and Tobacco control Monograph No. 11}. Bethesda, MD; U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 00-4804 (August, 2000).(hereinafter Monograph 11).
\textsuperscript{50}Monograph 11 at p. 71.
Arlington has an ordinance requiring smokefree workplaces, excluding restaurants, and West Lake Hills has an ordinance requiring 100% smokefree restaurants only.\textsuperscript{52}

\section*{2. Health Law and Policy Institute’s Pilot Area Survey of Local Ordinances}

The goal of the study was to obtain and analyze city ordinances in the pilot area regulating the sale or use of tobacco. A total of 201 municipalities in the pilot area designated by the Texas Department of Health were surveyed. They were initially categorized according to population and inclusion in prior surveys by TDH and NCI. The results of these prior surveys for each municipality was noted and used to cross-reference and check outcomes. The cities were then called in the following order: largest population, included in a prior survey, to smallest population, not included in a prior survey. A record of all contacts made with each city was kept, including time and date of call, who was contacted, and the results of the call. Generally, the city secretary or their staff was contacted. If the city secretary determined that there was an ordinance for that city, they were requested to fax, e-mail, or mail a copy to the Institute. Sixty-four cities had ordinances, all of which were collected by the Institute. One hundred and twenty-one cities advised that they did not have ordinances. Sixteen cities in the pilot area were unreachable or did not respond to the survey, and for purposes of our analysis of survey results we have assumed they do not have an ordinance.\textsuperscript{53} The results of the survey will be published in a separate report on file with the Texas Department of Health.

\section*{3. Model Ordinance}

A proposed model ordinance developed by the Americans for Nonsmokers’ Rights (“ANR”) is attached to this memorandum as Appendix G.\textsuperscript{54} The model legislation was crafted to survive legal challenges commonly raised by smoking ordinance opponents.

\textsuperscript{51} ANR Smoke Free Ordinances.
\textsuperscript{52} Id.
\textsuperscript{53} Those cities were: Annona, Appleby, Bailey's Prairie, Bellmead, Bonney, Cove, Dayton Lakes, Fairchilds, Hallsburg, Leary, Leroy, Marietta, Piney Point Village, Red Lick, and Ross. All nonresponding cities had a population numbering less than 1,000, with the exceptions of Bellmead (pop. 15,018) and Piney Point Village (pop. 3,501). Populations are listed from 1990 census data.
\textsuperscript{54} Available at \url{http://www.no-smoke.org/100ord.html} visited October 2, 2000.
III. Federal Regulatory Efforts

A. Overview

It is the policy of the executive branch of the federal government to establish a smoke-free environment for federal employees and members of the public visiting or using federal facilities. Therefore, the smoking of tobacco is prohibited in all interior space owned, rented, or leased by the executive branch of the federal government, and in any outdoor areas under executive branch control in front of air intake ducts. Cigarette sales to minors in federal buildings are also prohibited. Several federal laws regulate tobacco and smoking. The Public Health Cigarette Smoking Act of 1969, Little Cigar Act of 1973 and Comprehensive Smoking Education Act of 1984 are all amendments of the Federal Cigarette Labeling & Advertising Act of 1965. These statutes regulate the labeling of cigarettes, limit states abilities to regulate labeling where manufacturers are in compliance with federal law, require ingredient reporting, limit advertising in electronic media, and grant authority to the Federal Trade Commission to regulate advertising.

The Comprehensive Smokeless Tobacco Health Education Act of 1986 creates a federal program designed to inform the public about the dangers of smokeless tobacco. It includes the smokeless tobacco warning requirements, ingredient reporting, and enforcement provisions. The Pro-Children Act of 1994 mandates a nonsmoking policy for children’s services in federal facilities, including leased or contracted facilities such as health care, day care, early childhood development, kindergarten through secondary schools and library services. The Cigarette Safety Act of 1984 and Fire Safe Cigarette Act of 1990 provide for federal efforts to determine the feasibility of developing cigarettes and little cigars less likely to ignite upholstered furniture or mattresses. A federal tax is imposed on cigars, cigarettes, cigarette papers and cigarette tubes manufactured in or imported into the US.

Section B below discusses the FDA’s efforts to regulate tobacco and the Supreme Court decision holding that the FDA does not have the authority to regulate tobacco. Section C outlines OSHA’s efforts to regulate smoking in the workplace. Section D. explains the Americans with Disabilities Act and how it may protect people with disabilities from exposure to second hand smoke. The EPA’s findings with respect to ETS were discussed in the preface.

B. FDA Attempts To Regulate Tobacco

56 Prohibition of Cigarette Sales to Minors in Federal Buildings and Lands Act, 40 U.S.C. Chapter 10, Section 486 (requirements for prohibiting tobacco vending machine sales in federal buildings and prohibition of free tobacco samples around federal buildings).
On August 14, 1998, the Fourth Circuit Court of Appeals held that the Food and Drug Administration (FDA) lacks jurisdiction to regulate tobacco products and invalidated the FDA’s August 28, 1996 regulations governing tobacco products. The regulations principally restricted the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents.  

The FDA’s mandate is to ensure that drugs are both safe and effective before being marketed to the public, yet in this instance the FDA not surprisingly found at the outset that tobacco products are “dangerous” and “unsafe.” The FDA would certainly not approve for sale and distribution any drug that is dangerous, unsafe, and that lacks any health benefit when used as intended. However, the FDA realized that it would be untenable politically at this time to totally ban the sale and use of tobacco products, so the agency proposed a creative regulation under a statutory provision that requires conditions on sale and distribution which provide a reasonable assurance of safety. The appellate court refused to accept the argument, noting that the FDA is unable to state any health benefit derived from leaving tobacco products on the market.

The appellate court found the FDA’s use of the definitions from the Food, Drug and Cosmetic Act (Act) overly technical and unconvincing. The FDA argued that nicotine is a “drug” which is defined in the Act as “[an] article[s]…intended to affect the structure or any function of the body.” The FDA also asserted that cigarettes are “combination devices.” A medical device is defined as “an article which is intended to affect the structure or any function of the body…and which does not achieve its primary intended purposes through chemical action within. . . the body.” Combination devices are products that contain a combination of a drug, device, or biological product. Neither party asserted that tobacco products contain any biological product.

The court below, which had upheld the FDA regulations in part, framed the issue as “whether Congress has evidenced its clear intent to withhold from FDA jurisdiction to regulate tobacco products as customarily marketed.” The appellate court found that the court below had fundamentally misconstrued the issue, and restated the question as “whether Congress intended to delegate such jurisdiction to the FDA.” Using traditional tools of statutory construction, the appellate court determined that Congress had not intended to delegate such jurisdiction to the FDA. The appellate court first considered the “plain meaning” of the statutory language defining “drugs” and “devices” and requiring that drugs be “safe and effective” before FDA approval could be granted. The appellate court also noted that from 1914 until the 1996 rulemaking attempt, the FDA had consistently stated that tobacco products were outside the scope of its jurisdiction. Also, neither the Act nor its legislative history mentions tobacco. Finally, in a footnote, the appellate court noted with irony that two of the main supporters of the Act were representatives from Kentucky and North Carolina, the two leading tobacco states, and that such representatives would have likely expressed opposition to the Act if there had been any indication that the Act might apply to tobacco products. In 1964, Congress specifically considered (and rejected) expansion of the Act to cover tobacco products by creating a new

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category of products subject to FDA jurisdiction. The court also noted that Congress has enacted legislation addressing many of the activities the FDA sought to regulate, including the Cigarette Labeling Act, the Smokeless Tobacco Act, and provisions in the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992 that provide financial incentives to states that enact and enforce access restrictions for individuals under age 18.

On March 21, 2000, the United States Supreme Court affirmed the decision of the Fourth Circuit Court of Appeals that the FDA cannot regulate tobacco as a drug. Justice O’Connor delivered the opinion, in which she was joined by Justices Rehnquist, Scalia, Kennedy, and Thomas. Justice Breyer, joined by Justices Stevens, Souter, and Ginsburg, filed a dissenting opinion. The question before the Court was whether the FDA had authority under the Act to regulate tobacco products as customarily marketed. In August 1996, the FDA put in place regulations aimed at curbing smoking by minors. The regulations prohibited tobacco sales to person under 18, required a photo identification of all tobacco purchasers under age 27, and restricted vending machine cigarette sales to adults-only locations.

According to the FDA, more than 400,000 people die annually from tobacco-related illnesses, 82% of adult smokers had their first cigarette as a minor, more than 50% of adult smokers became regular smokers before the age of 18, and smoking is a pediatric disease because 1 in 3 youths who become regular smokers will die prematurely as a result of it. The theory behind the FDA’s regulations was that by reducing the number of children who smoke, tobacco-related illnesses can be reduced because people who do not begin smoking as minors are unlikely to pick up the habit. The Court outlined the FDA’s arguments that nicotine is a drug and tobacco products are devices for purposes of the Act, and concluded that if they are, the FDA would have to ban them because it would be impossible to adequately protect consumers from their dangers and the products could not be made safe. The Court determined that tobacco products do not fit within the Act’s regulatory scheme because the Act did not permit a drug or device that cannot be used safely for any therapeutic purpose to remain on the market. Furthermore, Congress has enacted six pieces of legislation pertaining to human health and tobacco use since 1965, that addressed, for example, requiring health warnings on cigarette packages and prohibiting advertising of tobacco on television. In addition, the FDA had expressly disavowed having the authority to regulate tobacco numerous times before it changed course. The Court stated that Congress had created a distinct regulatory scheme for tobacco that focuses on labeling and advertising. Although it acknowledged the seriousness of the problem the FDA seeks to address, the Court concluded that Congress has plainly not given the FDA the authority to regulate tobacco.

The Clinton Administration has urged Congress to pass a law that would give effect to the FDA’s tobacco regulations. The tobacco industry says it wants to work with the government to keep tobacco products out of the reach of children, but it continues to fight every attempt by the government to put controls in place. The tobacco industry’s narrow victory in this lawsuit has the immediate effect of endangering children’s health. The day when the Supreme Court ruling came down, the Texas Department of Health (TDH) received instructions from the FDA

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to stop conducting FDA-sponsored retailer compliance checks immediately. The FDA had given TDH $277,000 to conduct inspections of retail outlets throughout Texas to determine whether stores were complying with federal regulations on tobacco sales to minors. As a result, it will be easier for children to buy cigarettes today than it was yesterday. It is now clear that Congress must act if Americans are to have any hope that tobacco will not continue to jeopardize children’s health.

Nonetheless, the FDA’s rulemaking attempt could still serve a useful purpose in advancing the debate about whether additional or different regulations are needed and perhaps even serve as a model for new limited tobacco legislation. As the appellate court noted, this case is not about such substantive issues, but is rather about “who has the power to make this type of major policy decision.” The proposed regulations were principally aimed at restricting the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents. Although Congress has recently rejected major tobacco legislation, the primary stated grounds for objection has been an unwillingness to raise taxes. Opponents of tobacco legislation might find it more politically difficult to oppose legislative enactment of more limited controls as contained in the FDA’s proposed regulations. Further, the proposed FDA regulations benefit from their exposure to the rule-making process, i.e., publication and public comment, which could further and narrow the public debate.

C. OSHA

The mission of the Occupational Safety and Health Administration (OSHA) is to protect the health and safety of American workers covered by the Occupational Safety and Health Act of 1970. OSHA’s jurisdiction extends to the majority of workers in the U.S. OSHA establishes and enforces protective standards, and provides technical assistance and consultation programs. Historically, one of OSHA’s primary concerns has been indoor air quality in the workplace. In 1994, OSHA determined that employees working in indoor environments face significant risk of material impairment to their health due to poor air quality. As a result of this finding, OSHA proposed to adopt standards addressing indoor air quality for indoor work environments. OSHA believed that compliance with the provisions would substantially reduce health risks. Much of the proposal addressed a variety of indoor contaminants and would apply only to indoor “non-industrial work environments.” However, the provisions that specifically addressed the control of ETS were intended to apply to all work-sites, both industrial and non-industrial, approximately 6 million work environments.

The proposed regulations called for businesses within OSHA’s jurisdiction to develop an indoor air quality (IAQ) written compliance program, and to designate a person to assure the implementation of the program. Employers were also asked to retain certain types of

64 See www.osha.gov/oshinfo/mission.html.
65 Excluding workers in industries regulated by similar legislation, including miners and transportation workers, as well as many public employees.
66 The proposed standards were published in 59 Fed. Reg. 15968 (April 5, 1994).
67 OSHA proposed that sections 1910.1033, 1915, and 1926.1133 of Title 29 of the C.F.R. be amended to include IAQ regulations.
information on record to assist in potential IAQ evaluations. Additionally, employers were required to keep written records of employee complaints of signs or symptoms related to “building related illness,” and any remedial action taken by the employer to correct the problem. The regulations also listed the actions that employers must implement to assure compliance with the written IAQ plan. The provisions pertaining to ETS were fairly stringent. In buildings where smoking is allowed, the proposal required designated smoking areas that would be separate, enclosed rooms where the air would be exhausted directly to the outside.

The standards proposed by OSHA have not been adopted. The provisions required congressional approval, but Congress has so far failed to provide it. However, since 1995, and as recently as April 2000, the Department of Labor (DOL) has published its “unified agenda” eight times in the Federal Register. Each time, the standards proposed by OSHA are listed as a “long term action” by the DOL. The following is a brief summary of the abstract, specific to the provisions on ETS:

OSHA was petitioned in May 1987 by Action on Smoking and Health, Public Citizen, and the American Public Health Association to issue an emergency temporary standard on environmental tobacco smoke (ETS) in the workplace. In March 1992, OSHA was petitioned by the AFL-CIO to establish workplace IAQ standards. In December 1992, ASH again petitioned for rulemaking on ETS.

The abstract went on to describe the number of Americans exposed to unnecessary health threats because of indoor air pollution, and the types of health impairments that could result:

After reviewing and analyzing available information, OSHA published a rule on April 5, 1995. The proposal would require employers to write and implement indoor air quality compliance plans . . . in buildings where smoking is allowed, the proposal would require designated smoking areas that would be separate, enclosed rooms where the air would be exhausted directly to the outside. . . . ETS provisions would apply to all 6 million industrial and non-industrial work environments under OSHA’s jurisdiction. OSHA preliminarily estimates that the proposed standard will prevent a substantial number of air quality related illnesses per year.

After the 1994 proposed regulations were published, OSHA received a substantial number of comments. Some comments argued that implementing IAQ compliance programs would be problematic for the hospitality industry because of the substantial contact between customers who smoke and the employees working in such locations. OSHA’s actions over the past six years confirm that indoor air quality and the effects of environmental tobacco smoke are

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70 Id.
still of great concern. However, there is no indication of specific future action that will move OSHA toward its goal of regulating IAQ more closely.

D. ADA

The Americans with Disabilities Act of 1990 (ADA)\textsuperscript{71} contains provisions relating to employment, public services, and public accommodations. Qualified individuals with disabilities affected by second-hand smoke may be able to use the ADA to force adoption of smoking restrictions.\textsuperscript{72} The ADA begins with a recital of findings and purposes and a number of general definitions applicable to the entire statute, including a definition of the key term “disability.” Title I governs employment and it applies to employers with 15 or more employees, excluding the United States government\textsuperscript{73} and certain private clubs. Title II governs public services and applies to state and local governments and specified transportation agencies. Title III governs public accommodations and services and applies to all private entities with operations affecting interstate commerce, including places of lodging, establishments serving food or drink, places of exhibition or entertainment, places of public gathering, sales or rental establishments, and service establishments.

Each of the titles contains a prohibition of discrimination—with some variation in phrasing—and an enforcement provision. A section labeled “miscellaneous provisions” offers guidance on interpretation of the statute generally. The Equal Employment Opportunity Commission (EEOC) is charged with issuing regulations under Title I of the ADA and enforcing its provisions, and the Department of Justice is responsible for Titles II and III of the ADA.

1. Are Individuals Affected by ETS Protected?

Under the ADA, disability can be established in one of three ways. First, an individual can show that he or she has “a physical or mental impairment that substantially limits one or more of the major life activities of such individual.” Second, an individual can show that he or she has “a record of such an impairment.” Third and finally, an individual can show that he or she is “being regarded as having such an impairment.”\textsuperscript{74} Although other provisions of the statute categorically exclude certain conditions from the definition of disability (e.g., transvestitism, pedophilia, compulsive gambling), the determination of whether a particular condition satisfies one of the three prongs of the definition of disability is made on a case-by-case basis.

According to the Title I regulations, a “physical or mental impairment” includes “any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss” affecting at


\textsuperscript{72} For a more extensive discussion, see Mary Kate Kearney, The ADA, Respiratory Disabilities and Smoking: Can Smokers at Burger King Really Have It Their Way? 50 SYRACUSE L. REV. 1 (2000).

\textsuperscript{73} The United States government is subject to the anti-discrimination mandates of Section 501 of the Rehabilitation Act. Pub. L. No. 92-112, as amended by Pub. L. No. 93-516 (codified at 29 U.S.C. §§ 701-796). The Rehabilitation Act also applies to federal government contractors and any entity receiving federal financial assistance.

\textsuperscript{74} 42 U.S.C. § 12102.
least one of the major body systems.\textsuperscript{75} Some examples of major life activities are given, e.g., walking, working and breathing. To “substantially limit” is to significantly restrict as to condition, manner or duration of performance, relative to the performance of the average person. Factors to be considered include the nature and severity of the impairment, its duration or expected duration, and “the permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment.”\textsuperscript{76} The implementing regulations for Titles II and III are similar on these points. Further, the interpretive analysis accompanying these regulations includes the following discussion of impairments affected by cigarette smoke and disability status:

Many commenters asked that environmental illness (also known as multiple chemical sensitivity) as well as allergy to cigarette smoke be recognized as disabilities. The Department, however, declines to state categorically that these types of allergies or sensitivities are disabilities, because the determination as to whether an impairment is a disability depends on whether, given the particular circumstances at issue, the impairment substantially limits one or more major life activities (or has a history of, or is regarded as having such an effect).

Sometimes respiratory or neurological functioning is so severely affected that an individual will satisfy the requirements to be considered disabled under the regulation.... In other cases, individuals may be sensitive to environmental elements or to smoke but their sensitivity will not rise to the level needed to constitute a disability. For example, their major life activity of breathing may be somewhat, but not substantially, impaired. In such circumstances, the individuals are not disabled and are not entitled to the protections of the statute despite their sensitivity to environmental agents.\textsuperscript{77}

In sum, the usual case-by-case analysis is required.

Individuals with impairments affected by smoking have had a difficult time establishing disability, especially in the employment context. Typically, these individuals argue that they are substantially impaired in the major life activities of breathing and working. As to breathing, it is difficult to establish that the impairment rises to the level of an ADA disability if there is evidence that an individual regularly engaged in recreational activities outside work. With the Supreme Court’s decision in \textit{Sutton v. United Airlines},\textsuperscript{78} any impairment that is effectively controlled by drugs or devices will fail to qualify as a disability, unless side-effects are significant or the “record of” or “regarded as” prongs of the disability definition apply. As to working, a number of courts have held that an individual must show that he or she was foreclosed from an entire class of jobs.\textsuperscript{79}

\begin{itemize}
  \item \textsuperscript{75} 28 C.F.R. § 36.104.
  \item \textsuperscript{76} 29 C.F.R. § 1630.2(h).
  \item \textsuperscript{77} U.S. Department of Justice, Appendix A to Part 35--Preamble to Regulation on Nondiscrimination on the Basis of Disability in State and Local Government Services (Published July 26, 1991), commentary on 28 C.F.R. Section 35.104; U.S. Department of Justice, Appendix B to Part 36--Preamble to Regulation on Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities (Published July 26, 1991), commentary on 28 C.F.R. Section 36.104.
  \item \textsuperscript{78} \textit{Sutton v. United Airlines}, 527 U.S. 471, 119 S.Ct. 2139, 144 L.Ed.2d 450 (1999).
\end{itemize}
In *Muller v. Costello*,\(^80\) a federal appellate court overturned a jury verdict in favor of a plaintiff, finding that as a matter of law the plaintiff was not substantially limited in the activity of breathing or working. While the plaintiff, a correctional officer, had asthma so severe that reactions to second-hand smoke sent him to the emergency room on several occasions, the court found that he was not substantially limited in the activity of breathing because he was active outside of work, participated in many sports, worked as a member of the military reserves, and felt “pretty good” outside of work when he used inhalers. He was not substantially limited in the activity of working because he found employment as a salesman, bank employee, and substitute teacher while his lawsuit was pending and would have been qualified to work as a security guard in an office building or a smoke-free county jail. Ironically, inmates may be in a stronger position than their guards in seeking restrictions on smoking under the ADA (Title II), since they have fewer outside opportunities.\(^81\)

### 2. Is a Failure to Adopt a Smoking Ban Discrimination?

If an individual has an impairment meeting one of the parts of the definition of disability, the ADA protects him or her from discrimination related to the impairment. Discrimination is defined as a failure to make reasonable accommodations in the workplace or a failure to make reasonable modifications in policies and procedures in public places and programs and (private) public accommodations.\(^82\) Beyond the flexibility introduced by the adjective “reasonable,” questions arise because defendants can resist a change that would constitute an “undue burden” or a “fundamental alteration” in the nature of the business or program or service. Title I permits an employer to refuse a request for accommodation if the employer can demonstrate that it would impose an “undue hardship” on its operations. “Undue hardship” characterizes an “action requiring significant difficulty or expense,” considering factors such as the nature and cost of the accommodation and the financial resources of the facilities affected and the operation as a whole.\(^83\) Title III, and the Title II regulations, create a defense where the covered entity can demonstrate that a modification “would fundamentally alter the nature of the service, program, or activity.”\(^84\)

Given that smoking bans in many states and municipalities have not affected the viability of businesses and services, or most workplaces, public services, and public accommodations, defendants would likely have difficulty demonstrating undue hardship or fundamental alteration from adoption of such a policy. On the other hand, plaintiffs first have to establish that the requested modification is reasonable, and that may be a challenge because of restrictive interpretations of the ADA by many courts.

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\(^{80}\) *Muller v. Costello*, 187 F.3d 298 (2nd Cir. 1999).

\(^{81}\) See *Candelaria v. Greifinger*, 1998 WL 187383 (N.D.N.Y. 1998), another case in which a court allowed the question of disability status to go to a jury.

\(^{82}\) 42 U.S.C. §§ 12111, 12182; 28 C.F.R. § 35.130(b)(7).

\(^{83}\) 42 U.S.C. § 12111(10).

\(^{84}\) 42 U.S.C. § 12182(b)(2)(A)(ii); 28 C.F.R. § 35.130(b)(7).
Staron v. McDonald’s Corp. is one of the few smoking restriction cases to progress to consideration of the reasonableness qualification. In Staron, the U.S. Court of Appeals for the Second Circuit stated: “Although neither the ADA nor the courts have defined the precise contours of reasonableness, it is clear that the determination of whether a particular modification is ‘reasonable’ involves a fact-specific, case-by-case inquiry that considers, among other factors, the effectiveness of the modification in light of the nature of the disability in question and the cost to the organization that would implement it.” The defendants argued that § 501(b) of the ADA—which states that the ADA has no preemptive effect on other laws that provide equal or greater protections and that nothing in the statute “shall be construed to preclude the prohibition of, or the imposition of restrictions on, smoking...in places of public accommodation”—expresses a congressional intent to leave the issue of smoking to state and local governments. The court found that to the contrary, “this language expressly permits a total ban on smoking if a court finds it appropriate under the ADA.” The court stressed the need for a careful, factual evaluation in each case. Other courts have stressed that the ADA does not require an irritant free work environment or “absolute accommodation.” In an early Title I case, a court found that an employer’s adoption of a partial smoking ban was a reasonable accommodation, and no further accommodation (e.g., the total smoking ban requested by the plaintiff) would be required, where the plaintiff was able to perform the essential functions of his job as evidenced by average job performance appraisals.

The case of Heather K. v. City of Mallard suggests a slightly different strategy for individuals with disabilities seeking to minimize or eliminate ETS. Plaintiff Heather K. suffered from respiratory and cardiac conditions that were aggravated by airborne particulates such as smoke. Using Title II of the ADA, she sought to force the city where she resided to adopt more stringent restrictions on open burning. (The city had a ban on open burning, but it included a number of exceptions.) The court found that Heather K. might win, in legal terms that there were “genuine issues of material fact,” and therefore the case would be allowed to proceed to trial. First, the court stated that Title II would reach the city’s regulation of open burning if the regulation had a discriminatory effect on the ability of persons with disabilities to take advantage of city services, programs, or facilities. The court stated that, in the alternative, regulation of open burning could itself be considered a program, service, or activity that must comply with Title II. Both of these arguments could be made regarding municipal regulation of smoking.

Plaintiffs who bring suits under the ADA often add claims under state anti-discrimination or civil rights laws. In Candaleria v. Greifinger, a case involving an inmate in a state correctional facility, the plaintiff sued under the ADA, the Rehabilitation Act, various civil rights laws.

85 Staron v. McDonald’s Corporation, 51 F.3d 353, 356 (2nd Cir. 1995)
86 Id. The court quotes the Department of Justice regulations, which state that the second sentence of § 501(b) “merely clarifies that the Act does not require public accommodations to accommodate smokers by permitting them to smoke.” 28 C.F.R. Pt. 36, App. B, 56 Fed.Reg. 35544, 35562. Id.
88 Id.
laws, and the Eighth Amendment to the U.S. Constitution prohibiting cruel and unusual punishment. The Texas Commission on Human Rights Act includes some language relating to employment discrimination that is very similar to that found in the ADA. Interpretation of key terms by the courts is likely to be similar as well. For example, in *Austin State Hosp. v. Kitchen*, a state appellate court held that the “reasonableness” of an accommodation is evaluated in terms of the plaintiff's ability to do the job. The evaluation of a defense of “undue hardship” will focus on the employer's financial and organizational ability to adopt the proposed modifications.

IV. Texas Regulatory Options

A. State Regulation of ETS

Texas could broaden the scope of its limited state regulation of environmental tobacco smoke (ETS) exposure to include regulation of smoking in a variety of public places, such as restaurants, government worksites, private worksites, and day care centers.

A 1997 Gallup poll shows that 95% of nonsmokers and 69% of smokers in California view California’s smoking prohibition in almost all workplaces positively. The poll also shows that 88% of nonsmokers and 83% of smokers believe that employees should be protected at work from second-hand smoke. Additionally, a survey conducted by the Centers for Disease Control and Prevention (“CDC”) in 1994 found 63% of those polled favored prohibiting smoking in fast food restaurants, 51% supported prohibiting smoking in sit-down restaurants, 67% favored prohibiting smoking at indoor sports events and 56% supported prohibiting smoking in shopping malls.

Preliminary results of a recently conducted “Opinion Leaders Survey” found that 84% of respondents think the Texas Legislature should adopt a statewide smoke-free ban for workplaces and public buildings, and a majority think laws and controls of tobacco should be set at the state level. If Texas were to consider additional state legislation to regulate smoking, three basic issues would need to be considered. First, the type of public locations to be regulated (day care centers, restaurants, workplaces, etc.) would need to be addressed. Next, the extent of regulation would need to be agreed upon, i.e., whether to totally ban smoking, require that no-smoking areas be established, or require separately ventilated areas for smoking. Finally, the issue of whether a state statute should preempt municipal ordinances would have to be decided.

The preemption issue is the most controversial. Preemptive legislation is defined as “legislation that includes a provision preventing local jurisdictions from enacting laws more

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91 Codified in the TEX. LAB. CODE § 21.001 et seq.
94 *Id*.
95 Policy Brief 1.
96 See *Opinion Leaders Survey. Preliminary Results*, Richard Murray, Center for Public Policy, University of Houston (August 31, 2000).
stringent than, or at a variance with, what the state (or federal) law mandates.” Weak preemptive laws have a wide range of negative effects on tobacco control efforts including: (1) elimination of local policy development where tobacco industry opposition is least effective; (2) establishment of weak statewide public health standards which cannot be strengthened at the local level; and (3) division of tobacco control coalitions. All the major public health organizations have adopted formal positions opposing preemption, including the American Cancer Society, the American Heart Association, the American Lung Association, the American Medical Association and others. One strategy of the tobacco industry is to support relatively weak state legislation that provides for preemption. The tobacco industry started avidly supporting preemption in 1985, and has been so successful that a number of tobacco control advocates hesitate to seek state legislation, fearing the power of the tobacco industry to include preemption provisions in such legislation. The chart below shows the 17 states that have statutes that preempt local smokefree indoor air ordinances.

### B. Excise Tax

Texas could increase the state excise tax on cigarettes.

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97 See Monograph 11 at p. 53.
98 Id. at p. 54.
99 Id.
The Texas tax rate of 41 cents per pack of 20 cigarettes was last changed July 1, 1990. The most recent Surgeon Generals report on reducing tobacco concluded that:

- The price of tobacco has an important influence on the demand for tobacco products, particularly among young people.

- Substantial increases in the excise taxes on cigarettes would have a considerable impact on the prevalence of smoking and, in the long term, reduce the adverse health effects caused by tobacco.

Additionally, Texas could substantially increase its tax collections, perhaps devoting the additional proceeds to tobacco prevention and control efforts. Prior attempts to raise cigarette excise taxes in Texas have been unsuccessful because of legislative opposition to increasing taxes.

C. Medicaid Coverage for Smoking Cessation

Texas could, by statute or administrative regulation, provide more comprehensive prevention and treatment services to Medicaid beneficiaries for smoking cessation therapy, and better publicize the availability of services presently offered so that both recipients and providers are aware of such services.

As discussed in Section II A. above, some state Medicaid agencies (e.g. Indiana) have adopted regulations that use the comprehensive approach to smoking cessation described in the Clinical Practice Guidelines issued by the federal Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research). Such regulations allow coverage for both smoking cessation products and counseling, and allow counseling to be provided by a range of health care providers including physicians, physician’s assistants, nurses, psychologists, and pharmacists. Also, even though Texas does offer some coverage for smoking cessation, information about such coverage is difficult to find. Effective education of providers and recipients is needed to promote the coverage, and the benefits it can bring to recipients and to the state.

D. Mandated Insurance Coverage for Smoking Cessation

Texas could require that health insurance companies subject to state regulation provide coverage for smoking cessation therapy.

As discussed in Section II A. above, one of the recommendations of the 1997 Koop-Kessler Advisory Committee Report is that "coverage for tobacco use cessation programs and services should be required under all health insurance, managed care, and employee benefit plans in Texas."
plans, as well as all Federal health financing programs.” In addition to the Koop-Kessler Report, the Texas Cancer Council issued a Texas Cancer Plan that reiterated many of the Koop-Kessler’s findings concerning tobacco’s effects and further reiterated the need, at least in Texas, for expanded insurance coverage. Research indicates that smoking cessation intervention is as cost effective as other preventive services, such as treatment of high cholesterol, yet few insurance providers include such coverage. New York, Maryland and Wisconsin have considered legislation on the issue, but no state has yet passed such legislation.

E. Allocation of Tobacco Settlement Funds

Texas could devote a larger percentage of tobacco settlement funds towards tobacco prevention and control efforts.

Texas created a tobacco settlement endowment from the tobacco settlement funds. About $10 million a year in interest from the endowment will be spent on tobacco prevention and control. Nineteen states have allocated a portion of their tobacco settlement dollars to tobacco prevention as of December 31, 1999. The amounts range from $100 million dollars in Washington State to $1 million in Rhode Island.

According to the U.S. Centers for Disease Control and Prevention (CDC) the annual cost of an effective, comprehensive tobacco prevention program for Texas is between $103.2 million and $284.7 million, a per capita expenditure of $5.31 to $14.65. Texas currently spends 46 cents per capita for tobacco prevention—8.7% of the CDC’s minimum recommendation. Texas ranks 40th among the 45 states that have made decisions regarding their tobacco settlement funds or have committed other state funding for tobacco prevention. Texas’s settlement agreement provided that the tobacco industry pay the state an initial $1.3 billion in 1999. The tobacco industry is scheduled to pay the state of Texas between $326.3 million and $580 million each year after 1999. During the 1999 legislative session, the Legislature appropriated a total of $1.8 billion, the first two tobacco settlement payments. Approximately $10 million annually

105 See SLATI at p. v. (SLATI only tracks settlement funds spent specifically on tobacco prevention, cessation, and education programs). Id.
107 The amount to be paid is subject to various factors that may increase or decrease the payment. Specifically, a reduced prevalence in smoking could reduce the amount payable. See id.
108 Permanent endowments were created for a variety of programs totaling $1.49 billion, and an additional $324 million was allocated to the Children’s Health Insurance Program. Interest from the endowments will be available for spending. The endowments were earmarked as follows: $350 million for the Higher Education Permanent
(7.5% of the interest generated from the endowment) will be available to fund a tobacco prevention and cessation program. The program is currently receiving approximately $9.5 million per year and is concentrated in a pilot area comprised of several East Texas communities.

Although it may be too early to show a causal relationship between spending of tobacco settlement funds and reduced prevalence, evidence does confirm that increased spending from other sources on comprehensive programs does work. In 1996, Oregon increased cigarette excise taxes by $.30 (to $.68 per pack) and implemented a new comprehensive tobacco prevention and education program. The program reduced cigarette consumption by 11.3 percent between 1996 and 1998, thus reversing a 4-year period (1993-1996) of increasing consumption prior to the measure. In addition to Oregon, similar comprehensive tobacco prevention and control efforts adopted in California and Massachusetts have resulted in significant reductions in tobacco use, thereby reversing the health and financial burden attributed to tobacco use. The CDC noted that:

Increasing excise taxes on cigarettes reduces tobacco consumption rates. But more importantly, when the excise taxes support effective community, media, and school programs to prevent tobacco use, decreases in per capita consumption will continue even if industry lowers tobacco prices to preexcise tax values. The tobacco industry itself has concluded that “the California campaign and those like it represent a very real threat to the industry in the intermediate term...” and “the environment for the sale and use of tobacco products in California continues to deteriorate. And because California serves as a bellwether State, tobacco-related steps taken there often find their way into other States.”

In 1988, California voters approved a ballot initiative (Proposition 99) that increased state cigarette taxes by 25 cents per pack, with 20 percent of the new revenues—over $100 million per year—devoted to health education against tobacco use. In 1990, California launched its tobacco control program. Since the passage of Proposition 99, cigarette consumption in California has declined by 38 percent, or twice as much as the decline of only 16 percent in the rest of the country. The program was successful despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco company interference with the program, and periodic cuts in program funding. The program has reduced tobacco use substantially.

110 Id.
111 See CDC’s Best Practices at p. 8.
According to the CDC, the goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by: (1) preventing the initiation of tobacco use among young people, (2) promoting cessation among young people and adults, (3) eliminating nonsmokers’ exposure to ETS, and (4) identifying and eliminating the disparities related to tobacco use and its effects among different population groups.113

While tobacco prevention and control efforts may focus on programmatic issues such as public education, community-based programs, cessation efforts, school based programs, and enforcement, a number of related policy efforts have proven effective in reducing tobacco when used as part of a comprehensive strategy. These policies include increases in cigarette excise taxes and new restrictions on environmental tobacco smoke in public places.114

113 See CDC’s Best Practices.
V. Appendices

(1) Appendix A-States laws restricting smoking in public places, government buildings and private workplaces

(2) Appendix B-Chart of state laws restricting smoking in public places by type of place (e.g. sports arenas, restaurants, workplaces)

(3) Appendix C-Map identifying states with restrictions on smoking in public places by level of restriction (e.g. comprehensive, moderate, minimal)

(4) Appendix D-List of state excise tax rates, together with the net cigarette excise tax revenue collected in fiscal year 1998\textsuperscript{115}

(5) Appendix E- See Table 5, list of states with laws on smoking in commercial and home-based daycare centers as of December 31, 1998\textsuperscript{116}

(6) Appendix F-Environmental Tobacco Smoke Milestones\textsuperscript{117}

(7) Appendix G-Proposed model ordinance developed by the Americans for Nonsmokers’ Rights\textsuperscript{118}

\textsuperscript{115} Appendixes A, B, C and D are contained in SLATI 1999.
\textsuperscript{116} Appendix E, Table 5, is contained in State Laws 1998.
\textsuperscript{117} See Significant Developments and NYT Article.
\textsuperscript{118} Available at \url{http://www.no-smoke.org/100ord.html} visited October 2, 2000.