

Developing Smokefree Implementation Regulations



Partner Organizations

Tobacco Technical Assistance Consortium.

The Tobacco Technical Assistance Consortium (TTAC) provides technical assistance, information resources and training for state and local tobacco control programs. TTAC is dedicated to assisting state and local partners in building and growing effective tobacco control programs. TTAC's mission is to build capacity within the tobacco control field to achieve highly effective tobacco prevention and control programs and policies.

Robert Wood Johnson Foundation.

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For more than 35 years the Foundation has brought experience, commitment and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime.

Americans for Nonsmokers' Rights.

Founded in 1976, Americans for Nonsmokers' Rights (ANR) pursues an action-oriented program of policy, legislation and advocacy to eliminate secondhand smoke from workplaces and public places, and to counter the tobacco industry's efforts to undermine such policies. The American Nonsmokers' Rights Foundation (ANRF) promotes smoking prevention and education on smoking, secondhand smoke and the tobacco industry. ANR/F's staff provides technical assistance and support on issues relating to secondhand smoke, clean indoor air policies, smokefree implementation and tobacco industry activities.

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Thank you, everyone,

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Foreword

Tobacco use is responsible for 443,000 deaths each year in the U.S. and an estimated 5.4 million worldwide. Secondhand smoke contains at least 250 chemicals known to be toxic or carcinogenic and is responsible for an estimated 50,000 deaths each year among U.S. nonsmokers. Secondhand smoke causes heart disease and lung cancer in nonsmoking adults, sudden infant death syndrome, acute respiratory infections, respiratory symptoms and slowed lung growth in children. The smokefree movement emerged as a response to the devastating toll of tobacco on the public's health. This movement has transformed the places where we live, work, learn and play into spaces where we can breathe clean, healthy air.

Strong, comprehensive smokefree laws protect the public from secondhand smoke in restaurants, theaters and all workplaces. Smokefree air laws help motivate smokers to quit—especially when paired with promotion of resources like toll-free quit lines. They serve as a deterrent to smoking among kids—a bulwark against the vicious cycle of tobacco addiction that almost always begins in the adolescent and teen years continuing through adulthood. Smokefree air laws and regulations give public health efforts the teeth they need to speed up wide-scale adoption and create societal norms. Now that you've been successful in passing a smokefree law, there are regulatory and enforcement issues to consider. Ensuring a smooth and successful implementation of the law may also be your responsibility. This may seem daunting, but you have help right here at your fingertips.

This companion guide to the Developing Smokefree Implementation Regulations (DSIR) website (www.dsir.org) includes information and resources to help draft and adopt effective smokefree implementation regulations. It also supplements the Smokefree Implementation Toolkit at www.goingsmokefree.org, a comprehensive, web-based resource for the public health community. Although these materials were developed with state and local health departments in mind, they are intended for anyone who is interested in supporting the successful implementation of smokefree laws.

The Robert Wood Johnson Foundation has had a longstanding commitment to tobacco control, including advocacy for public policies that prevent smoking, help smokers quit and save lives. In 2006, RWJF set a goal that 75% of the US population would be protected by comprehensive smokefree laws by 2015. To help achieve this goal, the Foundation has invested in advocacy, media campaigns and tools like Developing Smokefree Implementation Regulations to support public health departments, businesses and community health advocates in their efforts to ensure that state and local smokefree laws are successfully implemented with minimal disruption to businesses and their customers.

I hope you find this guide informative and useful. Congratulations on all you have done and will do to make our world smokefree.

Michelle Larkin, J.D., M.S., R.N.
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Smokefree Regulation and Rulemaking

Implementation

The implementation of smokefree laws is a public health success story. By 1993, there were already 543 local smoking ordinances in the United States, and remarkably, most have been “self-enforcing.”¹ Businesses and smokers willingly cooperated with increasingly strong limits on smoking in workplaces and public places. When Congress banned smoking completely on all domestic airline flights in 1990, for example, the change was met with open arms by everyone but the tobacco industry.

Since then, the enactment of smokefree policies has accelerated dramatically. Not only have cities and counties passed hundreds of strong, comprehensive smokefree ordinances, but they have been joined by entire states as varied as Delaware, New Mexico and Nebraska. With this new wave of smokefree laws, particularly at the state level, has come an increased awareness of the need for careful implementation planning. A comprehensive implementation plan can anticipate and prevent potential problems and implementation regulations are one important piece of the puzzle. The process of adopting such rules or regulations is called rulemaking.



Rulemaking Authority

A state agency can adopt regulations only if the legislature has given it the authority to do so, either in a smokefree law or in general. Local agencies may need to be granted authority by both state and local legislative bodies. However, “home rule” cities and counties are vested with broad legislative and regulatory authority and agencies in home rule cities and counties may not require a grant of rulemaking authority from the state. Even if a state or local agency lacks formal rulemaking authority, the agency normally has the authority to develop internal policies or procedures, including forms, implementation guidelines and procedures for sharing data among agencies.

A formal rule or regulation is usually defined as an agency statement that implements or interprets a law, adds details, or specifies a procedure. Each state has its own definition of what constitutes a rule and procedures required to propose, publicize and adopt them. Many state smokefree laws explicitly grant rulemaking authority in their statutory language. For example, the New Jersey Smoke-free Air Act, adopted in 2006, states:

The Commissioner of Health and Senior Services, pursuant to the ‘Administrative Procedure Act,’ shall adopt rules and regulations to effectuate the purposes of this act.



In other states, including New Mexico, the legislature has given the Secretary of Health the general authority to adopt needed regulations:

The secretary may make and adopt such reasonable and procedural rules as may be necessary to carry out the duties of the department and its divisions. No rule promulgated by the director of any division in carrying out the functions and duties of the division shall be effective until approved by the secretary unless otherwise provided by statute. (Annotated Statutes of New Mexico, §9-7-6. Secretary; duties and general powers.)

A smaller number of states expressly prohibit the health department from adopting implementation regulations, as in the case of New York. The New York Clean Indoor Air Act states:

The commissioner shall not promulgate any rules or regulations to effectuate the provisions of [the Clean Indoor Air Act]. The commissioner shall not promulgate any rules or regulations that create, limit or enlarge any smoking restrictions.

More than 700 cities and counties across the country have adopted local smokefree ordinances, and in the absence of state preemption, local legislators have broad authority to enact such laws. In a limited number of cases, state law may also authorize local health agencies to adopt smokefree regulations. For example, Massachusetts and West Virginia grant authority to local boards of health to adopt and enforce health regulations, and this authority has been used successfully to adopt strong local smoking regulations. However, courts in other states have not extended such broad local rulemaking authority.



Rulemaking Process

The rulemaking process often begins when the health department's tobacco control staff contacts its legal staff (or, in some cases, the state attorney general's office) to determine the extent of the agency's rulemaking authority. Our Background for Lawyers (page 12) can be a useful tool to help educate legal staff about tobacco control, secondhand smoke and the benefits of smokefree policy.

If your agency has rulemaking authority, identify the legal requirements and key steps for proposing and adopting regulations. Typical steps include:

- Publishing a Notice of Proposed Rulemaking and draft rules.
- Planning and convening a public hearing.
- Accepting and responding to written comments.
- Amending proposed rules.
- Publishing final regulations.

Under some circumstances, agencies may be authorized to adopt "emergency" rules on a faster timeline than regular rules. Even if an agency lacks formal rulemaking authority altogether, it usually has the authority to develop informal enforcement guidelines, procedures and forms.

Smokefree rulemaking is usually part of a broader implementation plan that includes public education and enforcement. As is the case with implementation in general, it is important to engage enforcement agencies and other stakeholders in the rulemaking process. Important stakeholders may include licensing and inspection agencies (e.g., fire departments, alcohol control agencies or assisted living inspection agencies), Quitline and cessation staff, voluntary health agencies and grassroots supporters.

It is especially important to build community support for implementation rulemaking by engaging nonsmokers' rights organizations and other grassroots supporters. These may include state and local tobacco control coalitions, local health departments, health department contractors, supportive business owners, medical professionals, labor organizations, faith communities, racial and ethnic coalitions and LGBT organizations.

The next step is to identify those issues or needs that can be addressed through regulations. Issues that often arise include defining terms like "enclosed" or adding details to enforcement provisions. If a provision in a state or local law already provides adequate detail to guide businesses and enforcement agencies, administrative rules may be unnecessary. But in some cases, as with the duties of business proprietors, a few additional details can prevent confusion and/or lawsuits before and after the effective date. Regulations may also include forms and procedures. For a list of common implementation issues, see our Rulemaking Checklist (page 22).

Once you have identified the issues you want to address, draft rules for review, publication and public comment. There are several sources for effective implementation language, and it is rarely necessary to “reinvent the wheel.” Start with our Model Language (page 16) and examples from our website:
www.ttac.org/products/DSIR/implementation/index.html.

Resources

You can find a case study of New Mexico's 2008 smokefree rulemaking process at http://www.ttac.org/products/DSIR/introduction/case_study.html.

Implementation and rulemaking Lessons from the Field can be found at <http://www.ttac.org/products/DSIR/introduction/lessons.html>.

¹ National Cancer Institute, US Department of Health and Human Services, Pertschuk, M. (Ed.). (1993). Major Local Tobacco Control Ordinances in the United States. Smoking and Tobacco Control Monograph (Monograph 3). Retrieved October 2, 2008



Background for Lawyers

The following is a summary of the health benefits, economic impact and law of smokefree policy for attorneys who are learning about tobacco control and the history of tobacco policy. For links to more detailed public health and legal resources, see Resources (page 23) and ttac.org/products/DSIR/links.html.

Strong, comprehensive smokefree laws not only protect nonsmokers from secondhand smoke, they also prevent youth tobacco addiction and help smokers who want to quit. There is also compelling evidence that smokefree laws have no negative economic impact on restaurants and bars. State and local smokefree laws have been tested extensively in the courts, with the conclusion that they are among the most successful and legally sound public health laws on the books.

During the past ten years, local smoking ordinances have become both stronger and more comprehensive, and many states have joined cities and counties in adopting comprehensive smokefree laws. However, the recent wave of smokefree laws has a successful history that extends more than 30 years. In the late 1970's, communities in California and other states adopted the first local smoking ordinances, and by the 1980's this trickle of relatively weak laws had grown into a flood of increasingly strong laws restricting smoking in workplaces and public places, including restaurants.

In the 1980's and 90's, public health efforts shifted from nonsmoking sections to 100% smokefree environments. In 1990, Congress eliminated smoking on commercial airline flights within the continental United States. At the same time, a handful of communities in California and Colorado adopted the first "smokefree" restaurant ordinances.

By January 2009, there were more than 300 local ordinances in the US eliminating smoking completely in workplaces, including restaurants and bars. Thirty states, as well as Puerto Rico and the District of Columbia, now have smokefree laws covering at least restaurants, workplaces or bars. Fifteen of these cover all three areas.¹

Health Benefits

Tobacco use is the leading preventable cause of death in the United States, responsible for 443,000 deaths each year in the US and an estimated 5.4 million worldwide.² More deaths are caused in the US each year by tobacco than by HIV, illegal drug use, alcohol, motor vehicle injuries, suicides and murders combined.³

Secondhand smoke contains at least 250 chemicals known to be toxic or carcinogenic, and is responsible for an estimated 50,000 deaths each year among US nonsmokers.⁴ Secondhand smoke causes heart disease and lung cancer in nonsmoking adults and sudden infant death syndrome, acute respiratory infections, respiratory symptoms and slowed lung growth in children.⁵

Recent research has found that even brief exposure to secondhand smoke, such as the duration of exposure a nonsmoker might receive in a bar that allows smoking, may cause blood vessel injury and interfere with the body's ability to repair itself, with some of these effects lasting for at least 24 hours following exposure.⁶

Not only is secondhand smoke associated with death and disease, studies now show that implementation of strong smokefree laws has an immediate effect on hospital admissions. Nine published studies report that after communities implemented smokefree laws, there was a rapid and sizeable reduction in hospital admissions related to heart attacks. The most recent study, in Pueblo, Colorado, showed a 41% reduction in heart attack hospitalizations during the three years immediately following enactment of the city's smokefree law.⁷

Millions of Americans are now protected from secondhand smoke in workplaces and public places. The benefits of smokefree policies extend beyond protecting nonsmokers from secondhand smoke: the passage of hundreds of state and local laws has spurred a fundamental change in the social acceptability of smoking, prompting smokers to quit and contributing to a sharp decrease in smoking rates.

Research has also confirmed that smokefree laws can prevent childhood tobacco addiction.⁸ By eliminating smoking in workplaces and public places, society has changed the perception of what is “normal” smoking behavior. Predictably, young people who live in communities with smokefree laws or work in smokefree environments are significantly less likely to become smokers.⁹



Economic Impact

While the purpose of smokefree laws is to protect health, some have expressed concern that such laws may have a negative economic impact on restaurants and bars. However, there is strong evidence from a large and growing body of domestic and international economic research that smokefree laws have no adverse economic impact on restaurants and bars.¹⁰

Despite the evidence to the contrary, the tobacco industry and some members of the hospitality industry may claim that smokefree laws harm business. These assertions are not backed by research, and are usually anecdotal. The science disproves these industry claims. In 2003, a comprehensive review of research on the economic impact of smokefree restaurant and bar laws found that all of the well-designed studies report no impact, or a positive impact, on sales or employment levels.¹¹ Research has also found that smokefree laws can have a positive impact on restaurant and bar business values.¹² The body of economic impact research has been conducted in widely diverse rural, suburban and urban communities across the US, including tourist destinations such as New York City, Los Angeles and Aspen, Colorado.

Smokefree workplace policies can also reduce business costs and absenteeism, improve productivity and reap other economic benefits. The only documented negative economic impact has been on the tobacco industry itself.

Legal Issues

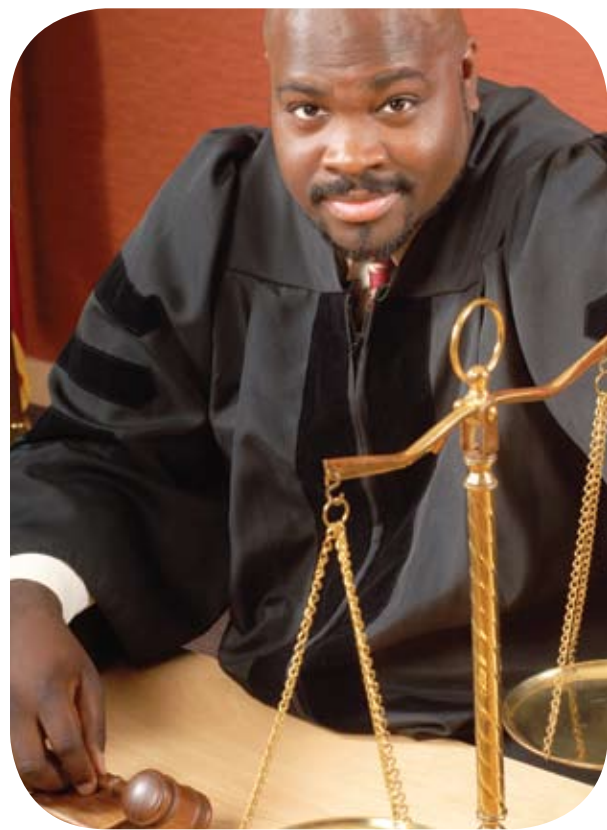
According to the Tobacco Control Legal Consortium,¹³ there is no “right” to smoke under the US Constitution. Smokers are not a specially protected class under the Equal Protection Clause, nor is smoking a specially protected right (like the use of contraceptives or other activities within the “fundamental right to privacy”) under the Due Process Clauses of the Fifth and Fourteenth Amendments. Policymakers must only demonstrate that smokefree laws are “rationally related” to a legitimate government interest, and the courts have consistently found that protecting the public health by eliminating secondhand smoke is a legitimate government goal.

Of more concern in smokefree drafting and rulemaking is the “vagueness doctrine,” which derives from the right to due process and requires that statutory and regulatory language is clear enough that a reasonable person could determine what actions are required or prohibited. Criminal laws are held to a higher standard of clarity than those with civil penalties. The risk that a smokefree law will be found void for vagueness increases as the law becomes more complex or includes more exemptions.

Exemptions and lack of clarity can also lead to unforeseen attempts to skirt the law. For example, a law which does not clearly define “enclosed” to include any physical barrier could encourage bars to erect a tent and claim an exemption permitting smoking. An exemption for theatrical productions in Minnesota’s Clean Indoor Air Act encouraged several bars to claim (unsuccessfully) that by simply declaring “theater nights” they could allow smoking.

The success of tobacco policy has been driven primarily by the introduction and passage of local smoking ordinances (and more recently, smokefree ordinances). Because the tobacco industry is more powerful at the national and state levels than at the local level, local smokefree ordinances have historically been easier to adopt and stronger than state or federal tobacco control legislation. Therefore, state preemption of local smoking ordinances has been among the highest priorities of the tobacco industry, and state laws should always contain an explicit non-preemption clause authorizing the passage and enforcement of stronger local laws. See Model Implementation Language, (page 16).

Eleven states currently preempt local smokefree ordinances. Other state laws contain language that is either partially preemptive or unclear. In some cases, such as California, the courts have resolved conflicting preemption language in favor of local control. In March 2008, the South Carolina Supreme Court found that a preemption clause in the statewide youth tobacco access law does not preempt local smokefree laws.



- ¹ ANR, Overview List - How Many Smokefree Laws? www.no-smoke.org/pdf/mediaordlist.pdf (2009).
- ² Centers for Disease Control and Prevention, Department of Health and Human Services, Morbidity and Mortality Weekly Report (45); 1226-1228, November 14, 2008. Retrieved Jan. 6, 2009; World Health Organization. (2008). <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm57>
- ³ Office on Smoking and Health, Centers for Disease Control and Prevention. (2008). Fact Sheet: Health Effects of Cigarette Smoking. Retrieved Oct. 2, 2008.
- ⁴ California Environmental Protection Agency. Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant. Sacramento, California: Environmental Protection Agency, Office of Environmental Health Hazard Assessment, final report released September 29, 2005, approved by Scientific Review Panel on June 24, 2005.
- ⁵ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2006). 2006 Surgeon General’s Report - The Health Consequences of Involuntary Exposure to Tobacco Smoke. Retrieved Oct. 2, 2008
- ⁶ Heiss, C, Amabile, N, et al. (2008) Brief Secondhand Smoke Exposure Depresses Endothelial Progenitor Cells Activity and Endothelial Function: Sustained Vascular Injury and Blunted Nitric Oxide Production. *J Am Coll Cardiol*, 51.
- ⁷ Centers for Disease Control and Prevention, Department of Health and Human Services, Morbidity and Mortality Weekly Report [http://www.cdc.gov/tobacco/data_statistics/mmwr/2009/mm5751a1_highlights.htm]. Reduced Hospital Admissions for Acute Myocardial Infarction After Implementation of a Comprehensive Indoor Smoke-Free Ordinance—City of Pueblo, Colorado, 2002-2006, January 2.
- ⁸ Siegel, M, Albers, A, et al. (2008) Results of a Multilevel Contextual Analysis Among Massachusetts Youth. *Arch Pediatr Adolesc Med*. 2008; 162(5):477-483; Americans for Nonsmokers’ Rights. (2004). Smokefree Air and Youth. Retrieved Oct. 2, 2008; Wasserman, J., et al., (1991). The effects of excise taxes and regulations on cigarette smoking, *Journal of Health Economics*, 10, 43-64.
- ⁹ Office on Smoking and Health, Centers for Disease Control and Prevention. (2006). Fact Sheet: Smoke-free Polices Reduce Smoking. Retrieved Oct. 2, 2008.
- ¹⁰ Americans for Nonsmokers’ Rights, Campaign for Tobacco-Free Kids & Robert Wood Johnson Foundation (2007). Smokefree Implementation Toolkit, The Economic Impact of Smokefree Laws. Retrieved Oct. 2, 2008.
- ¹¹ Scollo M, Lal A, Hyland A, Glantz S. (2003). Review of the quality of studies on the economic effects of smokefree policies on the hospitality industry. *Tobacco Control*. 12, 13-20.
- ¹² Alamar, A. C. and Glantz, S.A. (2004). Smoke-Free Ordinances Increase Restaurant Profit and Value. *Contemporary Economic Policy*, 22.
- ¹³ <http://tclconline.org/Tclc.asp>.

Model Language

The following is model language addressing some of the most common smokefree implementation issues. Most of these models are suitable as either statutory or regulatory language. Including strong and detailed language in a smokefree law from the beginning will minimize the need for more specific implementation regulations later.

For additional model language, see Americans for Nonsmokers' Rights' Model Ordinance, www.no-smoke.org/document.php?id=229, or for a copy of ANR's Model State Law contact ANR at 510-841-3032 or www.no-smoke.org/aboutus.php?id=437. Examples of implementation language can be found at www.ttac.org/products/DSIR/implementation/index.html.

Athletic Facilities

“Sports arena” means sports pavilions, stadiums, sports fields, gymnasiums, health spas, boxing arenas, swimming pools, roller and ice rinks, bowling alleys, amphitheaters, and other similar places where members of the general public assemble to engage in physical exercise, participate in athletic competition or witness sports or other events.



Prohibition in sports arenas. Smoking shall be prohibited in all enclosed and partially enclosed areas of sports arenas. Smoking shall also be prohibited in seating areas, bleachers, grandstands and concessions, and within twenty (20) feet of any of these areas.



Buffer Zone

Smoking is prohibited within twenty (20) feet of entrances, exits, operable windows and ventilation intakes that serve an enclosed or partially enclosed public place or workplace in which smoking is prohibited.

Comity

Governmental agency cooperation. The State and its designees shall annually request governmental and educational agencies within the State to establish local operating procedures in compliance with this chapter. The State and its designees shall urge all federal agencies owning facilities within the State to update their smoking policies and regulations to be consistent with this chapter.

*For model city or county comity language, see ANR's Model Ordinance:
www.no-smoke.org/document.php?id=229.*

Day Care Premises

Smoking is prohibited in a childcare, adult day care or home health care facility.

Note: Day care premises, which are often licensed at the state or local level, should be defined with reference to the law in your jurisdiction.



Duties of Proprietors

The person, firm, corporation or other entity that owns, leases, manages, operates, or otherwise controls the use of a public place, workplace or public transportation regulated by this law shall take necessary steps to prevent smoking by:

- Prominently posting “No Smoking” signs or the international “No Smoking” symbol,
- Removing all ashtrays intended for use on the premises,
- Asking any person who smokes in an area where smoking is prohibited to refrain from smoking,
- Refusing service to a person who is smoking,
- If the person does not refrain from smoking, asking the person to leave, and
- If the person refuses to leave, handling the situation in the same manner as for violations of other laws or house rules.

A person in control of a workplace shall handle smoking by an employee in the same manner as violations of other company policies.

Nothing in this section prohibits the proprietor or other person in charge from taking more stringent measures to protect individuals from secondhand smoke.

“Employee”

“**Employee**” means a person who works for an employer in consideration for direct or indirect monetary wages or profits, or a person who volunteers his or her services for an employer. “Employee” does not include a person who is a member of a private club and volunteers his or her time to the club without compensation.

“Employer”

“**Employer**” means a person, business, association, corporation (including a municipal corporation), sole proprietorship, partnership, joint venture, trust or nonprofit entity with one or more employees.

“Enclosed”

“**Enclosed**” means an area with a roof or other overhead covering and walls or side coverings of any kind covering more than 50 percent of the surface area of the vertical planes constituting the perimeter of the area. A wall includes any divider, garage door or other physical barrier, whether retractable, temporary or permanent, except that permanently uncovered window screens shall not be considered a wall or side covering for the purpose of this definition.



Gaming Facilities

Section X. Smoking restrictions.

1. Except as provided in Section Y, and in order to reduce the levels of exposure to environmental tobacco smoke, smoking shall be prohibited and no person shall smoke in an enclosed public place or workplace, including, but not limited to:

(z) Gaming facilities and any other facilities in which any gaming or gambling activity is conducted.

Health Care Facilities

“Health care facility” means an office or institution, including waiting rooms, hallways, private rooms, semiprivate rooms and wards, which provides care or treatment of diseases, whether physical, mental or emotional, or other medical, physiological or psychological conditions, including but not limited to hospitals, rehabilitation hospitals or other clinics, including weight control clinics, nursing homes, homes for the aging or chronically ill, laboratories and offices of surgeons, chiropractors, physical therapists, physicians, dentists and all specialists within these professions.

Smoking shall be prohibited in all enclosed or partially enclosed areas of health care facilities, except in designated outdoor smoking areas, which must be located at least twenty (20) feet from entrances, exits, operable windows and ventilation intakes, so as to insure that tobacco smoke does not enter those areas.



Native Ceremonial Tobacco Use

Traditional Native American ceremonies. Nothing in these rules shall prohibit smoking by a Native American as part of a traditional Native American spiritual or cultural ceremony held on an American Indian reservation. For the purposes of this section, a Native American is a person who is a member of an Indian tribe which is recognized as such by the state or federal government.

Non-Preemption

Legislative intent – local regulations. The Legislature declares its intent not to preempt the field of regulation of tobacco and smoking.

Local control. Nothing contained in this chapter shall be construed to restrict the power or authority of any city, county, board of health or other local governing entity to adopt and enforce local laws ordinances, or regulations that meet at least the minimum smokefree standards set forth in this chapter.

Outdoor Areas

Smoking shall be prohibited in the following outdoor places:

- Within twenty (20) feet of any outside entrance, exit, operable window, or ventilation intake of an enclosed or partially enclosed public place or workplace where smoking is prohibited.
- Outdoor seating or serving areas of restaurants, bars, nightclubs, taverns and retail food marketing establishments, and within twenty (20) feet thereof.
- Outdoor sports arenas, stadiums and amphitheaters, except in designated smoking areas, which may be established only in perimeter areas at least twenty (20) feet from any seating areas or concessions. Smoking shall also be prohibited in, and within twenty (20) feet of, bleachers and grandstands for use by spectators at sporting and other public events.
- Public transportation stations, platforms and shelters.
- Outdoor service lines.
- In outdoor common areas of nursing homes and acute care substance abuse treatment centers, except in designated smoking areas, which must be located at least twenty (20) feet from entrances, exits, operable windows and ventilation intakes of areas where smoking is prohibited.

“Partially enclosed”

“Partially enclosed” means closed in by a roof or overhang and at least two walls. Partially enclosed areas may include but are not limited to patios, food courts, lobbies, interior courtyards, covered walkways and concessions. A wall or overhang includes any divider, garage door or other physical barrier, whether retractable, temporary or permanent, except that permanently uncovered window screens shall not be considered a wall or side covering for the purpose of this definition.

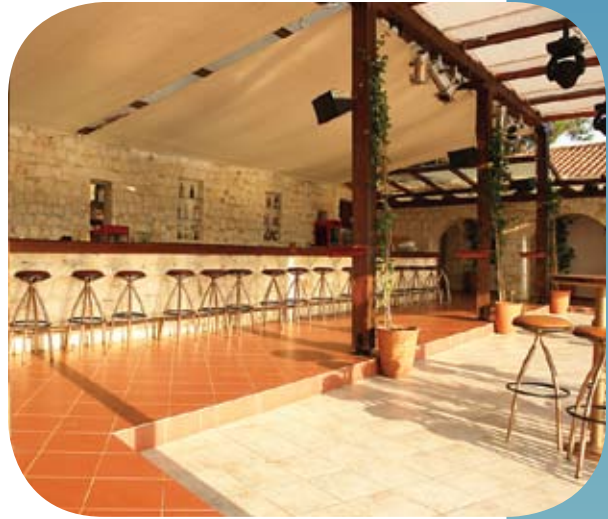
Patios and Other Outdoor Seating Areas

Smoking shall be prohibited in the enclosed and partially enclosed areas of public places and workplaces. Smoking shall be prohibited within 20 feet of the outside entrances, exits, operable windows and ventilation intakes of enclosed and partially enclosed areas in which smoking is prohibited.

Smoking shall be prohibited in any seating area of a business or nonprofit entity, that is not enclosed or partially enclosed, including but not limited to bars, restaurants, taverns, nightclubs, retail food establishments, museums, aquariums, galleries and libraries, and within 20 feet of such areas.

“Place of Employment”

“**Place of employment**” means an area under the control of a public or private employer, including, but not limited to, offices, work areas, lounges, restrooms, meeting rooms, classrooms, cafeterias, hallways, and within twenty (20) feet of any outside entrance, exit, operable window or ventilation intake. Vehicles owned by a public or private employer shall be considered a place of employment unless the vehicle is used exclusively by a single employee. A private residence is not a place of employment unless it is used as a child care, adult day care or health care facility.



Checklist for Smokefree Rulemaking

Adopting well-drafted rules prior to implementing a smokefree law can assure better compliance and enforcement. While remaining true to the original statutory language, regulations can clarify enforcement provisions or add useful details. Agencies can also develop forms or procedures through rulemaking or through more informal processes. The following is a checklist for planning the rulemaking process and drafting implementation regulations.

Who is responsible for rulemaking?

- Determine who in your agency will be responsible for developing and coordinating an action plan and timeline for the rulemaking process. (See implementation timeline, ttac.org/products/DSIR/timeline/timeline.html)
- What is the role of the tobacco control manager?
- Decide who the spokesperson(s) will be for the public health point of view.
- Does any money need to be budgeted for the rulemaking process?

What are the legal requirements for rulemaking?

- Consult with health department lawyers (or, in some cases, the state attorney general's office) to determine whether there is rulemaking authority. Rulemaking authority might be addressed in a smokefree law itself or granted to an agency generally.
- What are the steps required to propose and adopt regulations? If your agency lacks formal rulemaking authority, find out what authority the agency has to develop informal implementation guidelines, procedures or forms.
- Are fast-track "emergency" rules an option? If so, how do the procedural requirements differ from those for ordinary regulations?

What are the key steps required for rulemaking in your state? Typical steps include:

- Identifying effective implementation language. See Model Language, (page 16)
- Reviewing proposed rules internally with agency attorneys.
- Publishing a Notice of Proposed Rulemaking (What information must be contained in the Notice and how far in advance of the hearing must notice be given?).
- Planning and convening a public hearing.
- Accepting written comments.
- Responding to comments.
- Amending proposed rules, if necessary.
- Publishing final regulations.



What issues should be addressed?

Identify the implementation or enforcement issues that need to be addressed in proposed regulations. Regulations are most important when a statute does not provide adequate detail to guide businesses or enforcement agencies. On the other hand, regulations are unnecessary if the statute is detailed and specific. The scope of any new regulation is limited by the statutory language. **The following are some**

common issues:

- The duties of business proprietors
- Outdoor athletic facilities
- Defining “employees”
- Defining “enclosed”
- Smokefree health care facilities, including assisted living or inpatient drug treatment facilities
- Defining “patio” and other outdoor workplaces or public places
- Defining “retail tobacco store” (if exempted by the smokefree statute)
- Multi-unit housing such as apartments, condominiums or college dormitories
- Governmental cooperation (comity)
- Complaint procedures

Who is at the table?

In addition to the health department, many agencies and organizations can play important roles in the rulemaking process. Reach out to these stakeholders early in the process and communicate with them throughout the implementation and rulemaking process.

- Enforcement agencies
- Licensing and inspection agencies (e.g., fire departments, alcohol control agencies and assisted living inspection agencies)
- Quitline and cessation staff
- Local health departments
- State and local tobacco control coalitions
- Voluntary health agencies
- Health department contractors

Building grassroots support.

Move quickly to build grassroots support for implementation rulemaking (and to head off opposition) by engaging and educating:

- Nonsmokers’ rights groups
- Restaurant, bar and casino employees
- Restaurants, bars and other smokefree businesses
- Business associations and chambers of commerce
- Faith communities
- Racial and ethnic coalitions
- LGBT organizations
- Young adults and youth activists
- Musicians and other entertainers
- Civic organizations
- Local officials in jurisdictions with smokefree ordinances

Resources

For a complete list of smokefree implementation and rulemaking resources, including a state-by-state directory, go to ttac.org/products/DSIR/links.html. Definitions of key implementation and rulemaking terms can be found at ttac.org/products/DSIR/terms.html.

Americans for Nonsmokers' Rights

ANR provides technical assistance on all aspects of smokefree policy and implementation.

<http://www.no-smoke.org/>

2530 San Pablo Avenue, Suite J

Berkeley, CA 94702

510-841-3032

Campaign for Tobacco-Free Kids

CTFK offers technical assistance on implementation with special expertise in public relations and evaluation.

<http://tobaccofreekids.org/>

1400 I Street, NW Ste. 1200

Washington, DC 20005

202-296-5469

North American Quitline Consortium

The North American Quitline Consortium has produced an online Policy Playbook for integrating cessation into smokefree implementation.

<http://www.naquitline.org/playbook/>

3030 North Central Avenue, Suite 602

Phoenix, AZ 85012

602-279-2719

Office on Smoking and Health Centers for Disease Control and Prevention

CDC has developed and published a comprehensive toolkit for evaluating smokefree policies.

http://www.cdc.gov/tobacco/secondhand_smoke/evaluation_toolkit/index.htm

Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation has a longstanding commitment to tobacco control, including advocacy for public policies that prevent smoking, help smokers quit and save lives.

www.rwjf.org

P.O. Box 2316

College Road East and Route 1

Princeton, NJ 08543

Smokefree Implementation Toolkit

This comprehensive online toolkit includes an implementation timeline and other resources for implementing smokefree laws.

www.goingsmokefree.org

Tobacco Control Legal Consortium

William Mitchell College of Law

The TCLC is a national network providing advocates with better access to legal expertise. The Consortium works to assist communities with urgent legal needs and to increase the legal resources available to the tobacco control movement.

<http://tclconline.org/Tclc.asp>

tobaccolaw@wmitchell.edu

651-290-7506

Tobacco Control Network

TCN is comprised of the tobacco control program managers and additional staff from each state, territory, and the District of Columbia. This wide representation allows the network to access a wealth of expertise and experience from across the country.

<http://www.ttac.org/TCN/index.html>

Tobacco Technical Assistance Consortium

TTAC provides assistance to national, state or community-based organizations in building and developing highly effective tobacco control programs.

www.ttac.org

Rollins School of Public Health, Emory University

1520 Clifton Road, SON 225

Atlanta, GA 30322

(404) 712-8474

TobaccoScam

Provides research and analysis on the economic impact of smokefree laws and the tobacco industry's activities.

www.tobaccoscam.ucsf.edu/resource/

