

# Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers

Mark Pertschuk, JD; Jennifer L. Pomeranz, JD, MPH; Julie Ralston Aoki, JD; Michelle A. Larkin, JD, MS, RN; Marjorie Paloma, MPH

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In the United States, state and local public health policies play a fundamental role in innovation and progress. Preemption, by which Congress or the state legislatures limit the authority of lower jurisdictions, can eliminate the benefits of state and local policy initiatives. Preemption can also have a negative impact on enforcement, civic engagement, and grassroots movement building.

In June 2011, the Institute of Medicine published a groundbreaking report on policy and law that considered preemption as a crosscutting issue in public health. The Institute of Medicine recommended that federal and state policy makers “should set minimum standards . . . allowing states and localities to further protect the health and safety of their inhabitants,” and “should avoid language that hinders public health action.”

The Preemption Framework is a tool to support effective decision making by helping the public health field anticipate, assess, and, if necessary, counter preemptive policy proposals. We review the consequences of preemption, including its potential impact on grassroots public health movements, and propose practical questions and considerations to assist decision makers in responding to preemptive proposals.

**KEY WORDS:** framework, grassroots, local policy, preemption, state policy

Although the federal government plays a critical role in public health, state and local governments have often protected health and safety more aggressively than

Congress or federal regulators.<sup>1,2</sup> As Justice Brandeis observed, “[i]t is one of the happy incidents of the federal system that a single courageous State may . . . serve as a laboratory” for experimentation and innovation.<sup>3</sup> Cities and counties, in turn, serve both as policy laboratories and as the location for the implementation of most public health policies, services, and programs.<sup>2</sup> In the words of Assistant Secretary of Health Howard Koh, “all public health is local—it’s got to start and be sustained at the local level.”<sup>4</sup>

Preemption occurs when higher levels of government (federal or state) eliminate or limit the authority of lower levels.<sup>5</sup> Concerns about the negative impacts of preemption are nearly universal in public health, having been raised in alcohol policy,<sup>6</sup> nutrition,<sup>7</sup> tobacco control,<sup>8</sup> pesticide regulation,<sup>9</sup> gun violence prevention,<sup>10</sup> food safety,<sup>11</sup> illegal drug policy,<sup>12</sup> and fire prevention.<sup>13</sup>

In public health, the term “preemption” typically refers to “ceiling” preemption, by which a higher level of government takes away the power of lower jurisdictions to adopt *stronger* laws.<sup>14</sup> Congress and state legislators usually have the alternative of setting *minimum* health and safety standards, also known as “floor preemption,” without invalidating stronger state

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**Author Affiliations:** Preemption and Movement Building in Public Health, Public Health Law Center (Mr Pertschuk) and Public Health Law Center, William Mitchell College of Law (Ms Aoki), St Paul, Minnesota; Rudd Center for Food Policy and Obesity, Yale University, New Haven, Connecticut (Ms Pomeranz); and Robert Wood Johnson Foundation, Princeton, New Jersey (Mss Larkin and Paloma).

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**Correspondence:** Mark Pertschuk, JD, 2134 Carleton St, Berkeley, CA 94704 (pertschuk@gmail.com).

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or local laws.<sup>5</sup> The term “preemption” in this article refers to ceiling preemption unless otherwise noted.

In June 2011, at the request of the Robert Wood Johnson Foundation, the Institute of Medicine’s (IOM) Committee on Public Health Strategies to Improve Health released the report “For the Public’s Health: Revitalizing Law and Policy to Meet New Challenges.”<sup>5</sup> With the overarching goal of reviewing “how statutes and regulations prevent injury and disease, save lives, and optimize health outcomes,” the IOM’s report is the first major public health policy analysis to consider preemption as a crosscutting issue rather than a concern which is specific to a single endeavor such as tobacco control<sup>8</sup> or firearm violence prevention.<sup>10</sup> The IOM report addresses preemption in recommendation 5:

The committee recommends that when the federal government regulates state authority, and the states regulate local authority in the area of public health, their actions, wherever appropriate, should set minimum standards (floor preemption) allowing states and localities to further protect the health and safety of their inhabitants. Preemption should avoid language that hinders public health action.

In this article, we provide definitions relevant to preemption and explore the historic role preemption has played in public health policy. We developed the Preemption Framework (the Table) to help the public health field assess the likely impact of preemptive legislative proposals. The Framework covers practical issues, such as anticipating preemptive legislative amendments, and strategic concerns, such as the impact of preemption on grassroots movement building. The discussion section preceding the Framework provides greater detail about the evidence and rationale supporting our conclusions.

By addressing the concerns raised in the Table and including diverse voices in the decision-making process, representatives of the public health community in Washington and the state capitols can ensure that the potential negative consequences of preemption will be considered and mitigated.

## ● Preemption in Public Health

Federal preemption of state and local authority stems from the Supremacy Clause of the US Constitution,<sup>15</sup> and states have similar powers to grant or eliminate local authority.<sup>16</sup> In a few states, local jurisdictions have authority over matters of purely local concern, but as a practical matter, if there is a conflict between a higher level law and a lower level law, the higher level will prevail. Preemption may be adopted as part of a federal or state statute or regulation, but in each case, the outcome is largely the same.

*Express* preemption occurs when a law or regulation contains a preemption clause or other explicit preemptive language. Preemption clauses do not always use the word “preempt.” Words and phrases such as “consistent with,” “uniform,” “identical,” or “occupy the field” may also signify preemption. *Implied* preemption occurs when a court finds that legislators intended a law to be preemptive even in the absence of a preemption clause.<sup>17</sup> Statutes or regulations that include a “savings clause,” which *preserves* the authority of lower jurisdictions, can avoid implied preemption.<sup>18,19</sup>

Preemption has had a range of negative consequences in the public health field, some of which are evident immediately and others in the long term. Preemption can abrogate state or local authority to adopt innovative solutions to public health problems,<sup>12</sup> eliminate the flexibility to respond to the needs of diverse communities,<sup>5,10</sup> undermine grassroots public health movements,<sup>6</sup> and concentrate the power of industry lobbyists in Washington and the state capitols.<sup>20</sup>

The negative impact of preemption in tobacco control is well documented<sup>14,21</sup> and there is a strong consensus against it.<sup>22</sup> San Francisco adopted an historic workplace smoking ordinance in 1983<sup>23</sup>; however, many workers, such as those in bars, were not protected under the law.<sup>24</sup> In 1990, San Luis Obispo, California, adopted the first ordinance banning smoking in both bars and restaurants.<sup>23</sup> Had the public health community acquiesced to preemption in 1983, or even 1990, workers in bars, casinos, and other environments who have benefited from progressively stronger smoke-free protections would remain unprotected.

The negative consequences of preemption are also recognized in alcohol policy<sup>6</sup> and gun violence prevention,<sup>10</sup> and there is a general appreciation within the public health community of the value of protecting state and local authority.<sup>1,5</sup> However, among those addressing certain public health and safety issues, such as nutrition policy, there remains a lack of consensus regarding preemption.<sup>25</sup>

Under some circumstances, of course, preemption is appropriate. In the case of the airline smoking ban, for example, aircraft pass rapidly from one jurisdiction to another, and, therefore, differing state or local regulations could subject commercial aircraft to different rules within the course of an hour. Hence, an exclusive and comprehensive system of federal (or international) regulations makes sense from both public health and business perspectives. The IOM cites the additional example of federal oversight of food manufacturing, but concludes that in general, (ceiling) preemption is appropriate only in “situations where national uniformity is absolutely necessary and only after the impact on public health and enforceability has been thoroughly assessed and mitigated.”<sup>5</sup>

More typical examples include restaurant sanitation, alcoholic beverage sales, and fire prevention. In all of these cases, minimum federal or state standards augmented by stronger state or local regulations are both practical and beneficial. For example, the alcohol policies and interventions that best suit the needs of a college town may be different than those of a retirement community. Although the public costs of alcohol use may justify minimum state regulations, local jurisdictions should retain the authority to adopt additional or stronger measures to protect the public's health and safety based on diverse community needs.

Preemption is typically included in legislation as a political compromise rather than a decision based on public health considerations.<sup>16,26</sup> In the absence of a powerful and coordinated grassroots public health movement (eg, the nonsmokers' rights movement) preemption is often a "power play" in which an industry uses its superior influence to preempt state or local authority. This was the case with menu labeling (discussed later), in which the "price" for passage of a national calorie disclosure mandate was preemption of stronger state and local requirements.<sup>27-29</sup>

When passage of federal (or state) legislation without preemption is not feasible, the public health community should weigh the relative merits of federal, state, and local policy strategies and decide whether to accept preemption or, alternatively, preserve local (and state) authority and focus on more promising efforts at lower levels. As illustrated in the tobacco control case, local successes can initiate a "domino effect" by which growing numbers of communities pass progressively stronger policies. In turn, the success of (and lack of resistance to) local public health policies can ultimately vest the public health community with the political power to pass strong, preemption-free state and federal laws.

### ● The Case of Menu Labeling Preemption

In 2006, New York City enacted the country's first law requiring calorie disclosure on restaurant menus.<sup>30</sup> Momentum for similar requirements grew around the country leading at least 20 jurisdictions to pass similar laws.<sup>27,31</sup> At the same time, different menu labeling bills were introduced in Congress, with the restaurant industry insisting on a version including a preemption clause.<sup>27,32</sup> As a result, the federal menu labeling law included in 2010's comprehensive health care reform legislation preempts state and local laws that apply to retail food establishments with 20 or more locations and are "not identical to" the federal requirements.<sup>33</sup>

Unlike a number of the earlier state and local laws, the federal law requires only the disclosure of calories.<sup>34</sup> Public health representatives who supported preemp-

tion argued that a national requirement was preferable to no menu labeling requirement in states or communities they deemed unlikely to pass their own laws.<sup>29</sup> Although the courts must determine the precise extent of federal preemption, it is clear that jurisdictions that seek to require additional or different disclosures (eg, milligrams of sodium) to reflect the health concerns in their communities (eg, hypertension) may be hindered by preemption. As science evolves, there will be little opportunity for progress at the state or local levels. It also remains unclear whether the federal government can or will enforce its own law (in contrast to local public health agencies that already exercise jurisdiction over restaurant sanitation and conduct health and safety compliance inspections).

Finally, given the rapid growth of the local and state menu labeling movement prior to federal preemption, it is likely that the movement would have accelerated, as in the case of earlier public health movements. The greatest negative impact of preemption may result from the loss of this energetic and successful grassroots movement, an outcome which was not lost on the proponents of preemption.<sup>27,28</sup>

### ● Preemption Framework: A Tool for Decision Makers

The Preemption Framework identifies questions and concerns that should be considered while preparing for or negotiating preemption. Decision makers faced with preemptive policy proposals can be empowered by successful outcomes in the tobacco control arena. The analysis and inclusive process which we recommend here has been used effectively by those in the tobacco control field since at least 1996, when a consortium of national public health organizations formed a "Preemption Strike-force" to respond to the threat of preemption promoted by the tobacco industry.<sup>21,35</sup>

The following discussion expounds on the utility of the Framework (the Table) to support thoughtful consideration of the consequences of preemption among decision makers. Although we believe that advocates addressing all public health issues should be aware of the concerns raised here, it is ultimately the responsibility of those addressing different issues to determine if and when preemption is appropriate. It is beyond the scope of this article to balance the many nuances of strategy, policy, prevention, and politics that can influence the preemption decision in each instance.

#### Preparing to address preemption

Whenever public health legislation is under consideration at the federal or state level, a threshold question is

whether (ceiling) preemption is “absolutely necessary” (in the IOM’s words), as in the case of the airline smoking ban.<sup>5</sup> The questions and concerns identified in the Table should be considered as early as possible in the legislative process. Ideally, the public health community and legislative sponsors will agree on a position prior to the introduction of legislation. Absent a consensus, however, representatives of public health must be prepared to respond to preemption throughout the legislative process.

Past experience in alcohol policy, firearm violence prevention, nutrition, and other areas suggests that neither federal nor state preemption should come as a surprise to the public health community.<sup>6,7,10,14</sup> The supporters of public health legislation should understand the potential consequences of preemption and be savvy about the legislative process.<sup>36</sup> This can be achieved by learning from the experience of past public health initiatives and recognizing the role that industry often plays in promoting preemption.

Although a preemption clause may be included at the outset, legislation is often initially silent on preemption. It is prudent to include a *savings* clause in any proposed legislation to preserve local and/or state authority, anticipate preemptive amendments, and carefully monitor the legislative process.<sup>21</sup> Failure to address preemption with a savings clause increases the risk that the courts will later find implied preemption.<sup>17</sup>

Public health advocates have frequently supported federal or state policies that set *minimum* standards while allowing for stronger state or local health and safety protections (ie, floor preemption).<sup>20</sup> Because minimum standards answer the typical arguments in favor of preemption (eg, the “need for uniformity”) without limiting lower jurisdictions’ authority to adopt stronger public health protections, they should be considered the norm in public health policy.<sup>5</sup>

Industry lobbyists, the principle supporters of preemption, are generally more numerous and powerful in Washington and the state capitols than representatives of public health, thus creating an uneven playing field.<sup>20,37</sup> Therefore, once public health legislation has been introduced, its supporters may be unable to manage its progress, and supporters of public health legislation must be prepared to decide whether the inclusion of preemption nullifies the value of a proposed law.

### Who decides for the public health community?

Preemption is typically negotiated in Washington or the state capitols between legislative sponsors, impacted industries, and representatives of public health. Without the active participation of a broader spectrum of the public health community, public health lobbyists

may lack the experience or expertise to appreciate the consequences of preemption. Decision makers should ensure that major stakeholders *outside* of Washington and the state capitols are informed about preemption and agree to a common position.

State and local governments play an important role as leaders and innovators, and progress in public health policy often begins with state or local initiatives.<sup>1,2,5</sup> The participation of state and local actors in legislative negotiations can ensure that decisions about preemption take into account past progress and future opportunities. Although it is not necessary for every local official or grassroots advocate to agree to the same position on preemption, representatives of the broader public health community should be included in the process. Although the Preemption Framework identifies some likely stakeholders, professionals addressing specific public health matters are in the best position to know which practitioners and advocates in their own fields should be invited to the table.

As noted in the Table, important stakeholders may include state and local elected officials, health agencies, and representatives of impacted communities (including communities of color), public health coalitions, and community-based organizations.

### Who supports preemption (and why)?

Preemption is often supported by an industry that believes it will benefit from the abrogation of state or local authority.<sup>6,20,36</sup> From an industry’s perspective, preemption can eliminate regulatory uncertainty and prevent the adoption of stronger laws in lower jurisdictions.<sup>20</sup> Examples of recent industry-led preemption efforts include state preemption of smoke-free ordinances (tobacco industry),<sup>36</sup> alcohol regulations (alcohol industry),<sup>6</sup> residential fire sprinkler ordinances (homebuilders),<sup>38</sup> and menu labeling (restaurant industry).<sup>27</sup> As discussed in greater detail below, an industry may also view preemption as a tool to undermine a nascent grassroots movement.

Although an industry’s role may not be apparent,<sup>21</sup> identifying preemption’s supporters and their motivations can help the public health field understand and counter preemptive proposals. Industry lobbyists may have greater access to elected officials than public health advocates.<sup>37</sup> Careful attention to an industry’s legislative activities can help public health representatives track amendments, monitor the process, and assess the relative importance of amendments.

Industry representatives may view preemption as nonnegotiable. Because of the industry’s greater influence at higher levels,<sup>20,39</sup> this means that, as a practical matter, representatives of the public health community

**TABLE ● Preemption Framework****Be prepared**

- Expect preemption to become part of any proposed public health legislation at the federal or state levels even if it is not part of the original bill—it may be added later.
- Know your bottom line in advance. All major stakeholders should be informed about preemption and agree on a position before entering the legislative process.
- Make sure that proposed federal or state legislation includes a well-drafted “savings clause” that preserves the authority of lower jurisdictions to adopt stronger health protections. Then ensure that this antipreemption clause is not replaced or weakened.

**Who is at the table?**

- *Preemption can interfere with the work of organizations, agencies, grassroots advocates, and community members working at the state, regional, and local levels. Make sure that those who will be most impacted by preemption are represented in the decision-making process. These may include:*
- Parents, young people, seniors, diverse representatives of impacted communities, and grassroots advocates who support public health policies.
- Local and state officials.
- Community-based groups, including social justice and faith-based organizations.
- Foundations and other funders that support state or local prevention campaigns.

**Know (and learn from) your opposition**

- Make sure to identify the supporters of preemption to understand why they want to eliminate state or local authority. Because preemption can be unpopular, its proponents may work behind the scenes. Be prepared to “shine a light” on the industry lobbyists who are the most common supporters of preemption.
- Learn from observing lobbyists for industries that support preemption. They may have closer relationships with elected officials and legislative assistants than do public health advocates, and, therefore, may have more accurate and timely information about amendments and the legislative process.
- If vested interests oppose *any* legislation unless it includes preemption, ask: Why do they want preemption so badly? If they represent an industry that believes it benefits from weak health or safety regulations, then ask: what do they hope to gain by halting progress at the local and/or state level(s)?
- The supporters of preemption take the long view, so carefully consider the long-term opportunities for progress that may be lost due to preemption, including potential damage to a grassroots public health movement.

**Consider both the short- and long-term consequences of preemption**

- Is a single standard best for public health, or is flexibility needed to address diverse local or state needs?
- Will preemption interfere with local or state innovation in solving public health problems?

*(continues)***TABLE ● Preemption Framework (Continued)**

- Is it likely that science and social norms surrounding a particular public health issue will evolve in the future?
- Will preemption have a negative impact on the public education and social norms change that can accompany grassroots public health movements?
- Who will ensure compliance with the law? If a state or federal law is preemptive, does that level of government have the practical capacity and resources to enforce the law?

**Will preemption hinder a grassroots public health movement?**

- Have local, regional, or state organizations advocated for policy changes on the same topic at lower levels?
- Has legislation on the same topic been adopted or considered in lower jurisdictions?
- Have community members promoted policy changes on the same topic in schools, neighborhoods, or other community settings?

**Negotiating preemption**

- Have all major stakeholders, including those at the state or local levels, agreed on a position regarding preemption *before* legislative negotiations?
- Do those who are negotiating on behalf of the public health field have the relevant experience and expertise to appreciate the impact of preemption on public health initiatives at lower levels?
- Remember the bottom line: Will preemption improve the public's health, today and into the future?

must be prepared to decide between preemption and the passage of legislation.

**Consider preemption's short- and long-term consequences**

In the absence of preemption, cities, counties, and states can serve as laboratories to test innovative policies.<sup>5</sup> However, once Congress or the state legislatures preempt authority in lower jurisdictions, the opportunity to innovate and respond to diverse community needs is curtailed. Representatives of public health should also consider whether there are adequate resources available for public education, compliance, and enforcement.<sup>5</sup> For example, the 2010 passage of preemptive federal menu labeling legislation did not include funding for enforcement.<sup>40</sup> The public health community should also consider whether local (or state) agencies will retain the motivation to enforce policies after their legislative authority is stripped away.

Many of the potential consequences of preemption are not immediate. Although preemptive legislation may address a public health problem as it is currently understood, scientific knowledge and social norms evolve over time. Finally, beyond freezing progress in public health policy, the greatest long-term harm may result from the lost potential for grassroots movement building, discussed below.

## Will preemption hinder a grassroots public health movement?

In this article, *grassroots public health movement* is defined as an organized effort to address threats to the health and safety of the community, led by activated citizens and organizations that devote resources to building grassroots capacity.<sup>41-43</sup> Grassroots movements are usually built around a single issue, such as smoke-free policy<sup>44</sup> or environmental justice,<sup>45</sup> which energizes individuals who join in common cause. As illustrated by the case of the nonsmokers' rights movement, grassroots movements can vest public health with the political power to promote strong policies (without preemption) and create enduring positive changes in social norms and behavior.<sup>44,46</sup>

By taking away state or local authority, preemption eliminates the opportunity to promote state or local policy change—a key reason that grassroots advocates join together to take action. To what extent preemption will interfere with a public health movement depends, in part, on whether a movement is already underway. As noted in the Table, evidence of an ongoing grassroots movement can include policy advocacy by local (or state) activists and the introduction or adoption of legislation at lower levels of government.

## Negotiating preemption

Preemption may be the provision of public health legislation with the greatest potential impact on future progress and the greatest perceived benefits for the opponents of public health policies.<sup>20,28</sup> The negative consequences of federal preemption will be felt primarily at the state and local levels and those of state preemption at the local level. Public health advocates at the national or state level may lack the relevant experience to appreciate the full impact of preemption. Hence, preemption should be given special weight in the process of negotiation.

The most effective way to ensure that preemption will do no harm to future progress is to include grassroots representatives in decision making. Key stakeholders, such as those identified in the Table, should be informed about proposed preemption and agree to a position as early in the legislative process as possible. Including state and local stakeholders ensures that the impact of preemption on grassroots movement building will be considered and avoided or mitigated.

## ● Conclusion

Too often, preemption has been included in federal or state public health policies without an informed and

inclusive process. Following the recommendations of the IOM, the short- and long-term consequences of preemption must become part of the regular dialogue among public health advocates and policy makers. The potential impact of preemption on grassroots movements is an important part of that discussion. Although federal or state preemption is appropriate in some cases, the costs and benefits of preemption should be considered in a transparent process.

The Preemption Framework is a practical tool that can be consulted throughout legislative planning, drafting, advocacy, and negotiations. Considering the questions and concerns identified in the Framework can engage diverse stakeholders in the legislative process and empower the public health community to make informed decisions about federal and state preemption.

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