

Local Public Health Policymakers' Views on State Preemption: Results of a National Survey, 2018

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Objectives. To learn about local health policymakers' experiences and responses to preemption—the ability of a higher level of government to limit policy activity at a lower level.

Methods. Between March and June 2018, we conducted an anonymous Web-based survey of mayors and health officials in US cities with populations of 150 000 or more. We used descriptive statistics to analyze multiple-choice responses. We analyzed open text responses qualitatively.

Results. Survey response rates were 28% (mayors) and 32% (health officials). Nearly all respondents found preemption to be an obstacle to local policymaking. When faced with preemption, 72% of health officials and 60% of mayors abandoned or delayed local policymaking efforts.

Conclusions. Preemption is viewed as an impediment across a range of public health issues and may stifle local policy activity (i.e., have a chilling effect). Those working at the local level should consider the potential for preemption whenever seeking to address public health concerns in their communities.

Public Health Implications. Local governments should engage with advocates, practitioners, and public health lawyers to learn about successful and failed efforts to meet public health objectives when faced with preemption. (*Am J Public Health.* 2019;109:1107–1110. doi:10.2105/AJPH.2019.305140)

 See also Pomeranz, p. 1069.

Preemption refers to the ability of a higher level of government to legally limit or prevent a lower level of government from engaging in policy activity in a particular area.¹ In the United States, the federal and state governments use preemption for several reasons. The federal government may, for example, seek to establish a strong, consistent national standard to protect the public's health (e.g., safety devices in cars). A state government may use preemption to ensure that local governments in the state do not regulate in a certain area (e.g., residential sprinkler requirements).² This may happen when industry or other special interests lobby the state legislature to disallow local legislation. A state government may also preempt local policymaking because it has passed its own law and does not want a “patchwork” of additional—and possibly conflicting—local laws. Or, it may use preemption because it does not want any governmental regulation, at the state or local level, in a particular area.³

State preemption of local policy activity may arise in a variety of ways (“preemption” typically refers to ceiling preemption, which means that a higher level of government has legally prevented a lower level of government from acting in a particular area. Another concept, “floor preemption,” refers to instances in which a federal or state government sets minimum standards that local governments are allowed to exceed. Throughout this article, preemption refers to ceiling preemption, which curbs local activity).⁴ A state's intentions to preempt local action are most clear when the state explicitly, or expressly, includes language in a statute or constitutional

provision to prevent local governments from acting. A state may also impliedly preempt local policy activity by, for example, enacting such a comprehensive regulatory scheme that no opportunity remains for local policymaking. Although these are general principles, local governments are created by the state in which they sit, which allows some variation in states' abilities to preempt local policies. Some states may grant localities greater policymaking autonomy through home rule provisions or explicitly reserve areas in which local activity cannot be preempted.⁵

When states do preempt local action, public health policy innovation may be stifled. If local governments are not allowed to experiment by crafting, implementing, and evaluating policies tailored to the needs of their communities, then opportunities for testing novel policy solutions are missed.⁶ This occurs in jurisdictions throughout the United States. For example, Pomeranz et al. found that, from 2008 to 2018, 12 states enacted laws to preempt local efforts to enact nutrition policies concerning food labeling, portion size, or taxation of sugary beverages.⁷ For at least 3 decades, states have passed laws to prevent local governments from regulating in the area of tobacco control, with limitations placed on local clean indoor air laws, tobacco advertising restrictions, and efforts to curb youth access to tobacco products.⁸

Preemption has received relatively little attention in the empirical literature,⁹ and we are aware of no studies that systematically consider the perspectives of local leaders and health policymakers whose authority is affected by preemption. To address this gap, we surveyed mayors and health officials in communities throughout the United States

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to better understand their experiences with preemption and responses to it.

METHODS

Between March and June 2018, we conducted an anonymous Web-based survey of mayors and health officials of the 159 US cities with populations of 150 000 or more regarding their experiences with preemption. We selected cities of this size because they are typically large enough to have robust legislative and executive branches that engage in a wide range of local policymaking activities. We identified cities through the US Census Bureau. The Johns Hopkins 21st Century Cities Initiative provided mayoral contact information, and the National Association of County and City Health Officials (NACCHO) provided health official contact information.

To learn about local policymakers' experiences with preemption, the survey contained multiple-choice questions and opportunities for open text responses (Appendix, available as a supplement to the online version of this article at <http://www.ajph.org>). We developed and subsequently revised survey questions through an iterative process that included a literature review, the study team's a priori knowledge, and feedback provided by colleagues at NACCHO and the Johns Hopkins 21st Century Cities Initiative. We pilot tested the survey to ensure clarity and brevity.

Each mayor and health official received an initial recruitment e-mail with a survey link and, later, 2 reminder emails. In each e-mail, we indicated that participation by a mayor or health official was preferred, but designated deputies (i.e., senior staff) could complete the survey.

We used descriptive statistics to analyze multiple-choice question responses. We analyzed open text responses using a qualitative approach.

RESULTS

We successfully contacted mayors or their designated deputies for all 159 US cities. We received 45 responses to our mayoral survey (28% response rate). As we did not obtain viable e-mail addresses for 18 health officials,

TABLE 1—Preemption Experiences of Mayors and Health Officials by Topic, Legal Source, Reason for Concern, Local Response, Attempts to Counter, Beneficial Impact, and Perceived Effect on Policymaking: United States, March–June 2018

| Variable | Mayors (n = 45), No. Responded (%) | Health Officials (n = 45), No. Responded (%) |
|---|---------------------------------------|---|
| Preemption has been an obstacle to local policymaking in 1 or more areas ^a | 44 (97.8) | 42 (93.3) |
| Safe housing | 17 (38.6) | 6 (14.3) |
| Transportation | 16 (36.4) | 5 (11.9) |
| Firearms | 15 (34.1) | 14 (33.3) |
| Immigration | 14 (31.8) | 10 (23.8) |
| Minimum wage | 13 (29.5) | 15 (35.7) |
| Paid leave (sick leave) | 12 (27.3) | 9 (21.4) |
| Alcohol | 11 (25.0) | 7 (16.7) |
| Environmental hazards | 9 (20.5) | 17 (40.5) |
| Antidiscrimination | 9 (20.5) | 6 (14.3) |
| Obesity/food | 6 (13.6) | 13 (31.0) |
| Tobacco | 3 (6.8) | 19 (45.2) |
| Other ^b | 14 (31.8) | 10 (23.8) |
| None | 5 (11.4) | 2 (4.7) |
| Legal source of local preemption ^a | 36 (80.0) | 39 (86.7) |
| Statute/regulation | 24 (66.7) | 29 (74.4) |
| Litigation | 12 (33.3) | 13 (33.3) |
| No relevant law/litigation, but concerns remain ^c | 8 (22.2) | 15 (38.5) |
| Not sure | 8 (22.2) | 4 (10.3) |
| No response provided | 9 (20.0) | 6 (13.3) |
| Reasons local policymakers are concerned about preemption ^a | 28 (62.2) | 36 (80.0) |
| Possibility of local law being negated | 19 (67.9) | 31 (86.1) |
| Costs of potential litigation | 10 (35.7) | 16 (44.4) |
| Delays in implementation of local law | 10 (35.7) | 14 (38.9) |
| Lack of resources | 10 (35.7) | 6 (16.7) |
| Other | 3 (10.7) | 7 (19.4) |
| No response provided | 17 (37.8) | 9 (20.0) |
| Local responses when faced with preemption ^a | 30 (66.7) | 36 (80.0) |
| Abandon or delay local law/initiative | 18 (60.0) | 26 (72.2) |
| Seek legal advice | 12 (40.0) | 18 (50.0) |
| Redesign local law/initiative | 11 (36.7) | 14 (38.9) |
| Attempt to change relevant preemption law | 11 (36.7) | 13 (36.1) |
| Implement local law/initiative anyway ^d | 9 (30.0) | 8 (22.2) |
| Other | 4 (13.3) | 9 (25.0) |
| No response provided | 15 (33.3) | 9 (20.0) |
| Attempted to counter future preemption ^a | 27 (60.0) | 29 (64.4) |
| Working with advocacy organizations | 16 (59.3) | 18 (62.1) |
| Working with state legislature | 14 (51.9) | 15 (51.7) |
| Via legislation or regulation | 13 (48.1) | 13 (44.8) |
| With attorney advisors or colleagues | 10 (37.0) | 10 (34.5) |
| Involvement of city council | 10 (37.0) | 9 (31.0) |
| Through litigation | 5 (18.5) | 7 (24.1) |

Continued

TABLE 1—Continued

| Variable | Mayors (n = 45), No. Responded (%) | Health Officials (n = 45), No. Responded (%) |
|---|---------------------------------------|---|
| Other | 5 (11.5) | 4 (13.8) |
| No response provided | 18 (40.0) | 16 (35.6) |
| Has preemption been beneficial | 8 (17.8) | 7 (15.6) |
| Preemption's effect on local policymaking | 34 (75.6) | 37 (82.2) |
| A great deal | 7 (20.6) | 7 (18.9) |
| A lot | 12 (35.3) | 5 (13.5) |
| A moderate amount | 6 (17.6) | 13 (35.1) |
| A little | 7 (20.6) | 10 (27.0) |
| Not at all | 2 (5.9) | 2 (5.4) |
| No response provided | 11 (24.4) | 8 (17.8) |

Note. Percentages reported for each question refer to the proportion of individuals who provided responses to that question.

^aIndividuals could select more than 1 response.

^bRespondents wrote in the following issues for the “other” category: building codes, child care, drug enforcement, historic preservation, homelessness, immunization, marijuana, refugee health screenings, syringe exchange programs, taxation, waste management, and zoning.

^cRespondents' concerns may have been raised by the potential for future preemption through a legal source such as legislation, regulation, or litigation.

^dLocal policymakers who continue to implement a potentially preempted local law or initiative risk facing legal action. If local implementation is not challenged, it is possible that a state is not enforcing a preemptive law.

we successfully contacted 141 health officials. We received 45 responses to our health official survey (32% response rate). Considering other surveys of public policymakers, a difficult group to reach, these response rates are relatively strong.^{10,11}

Nearly all respondents to both surveys found preemption to be an obstacle to local policymaking (Table 1). For mayors, the issues most affected by preemption were safe housing (39%), transportation (36%), and firearms (34%). For health officials, the issues most affected were tobacco (45%), environmental hazards (41%), and minimum wage (36%). More than two thirds of mayors and nearly three quarters of health officials who identified a preemption source designated a state statute or regulation as the legal source of preemption of local policymaking. Another common source of preemption, selected by more than one third of respondents in both surveys, was litigation (e.g., a judicial opinion that had concluded that local policy action in a particular area was preempted).

The primary reason for mayors' (68%) and health officials' (86%) concern about preemption was the possibility that a local law would be invalidated. The next most common reasons for preemption concerns among

both groups were costs associated with potential litigation and delays in implementation of a local law. When faced with the possibility of preemption, 72% of health officials and 60% of mayors who reported any response to preemption had abandoned or delayed local policymaking efforts, and half of health officials and 40% of mayors had sought legal advice.

To counter future preemption of local policymaking, mayors and health officials have taken similar approaches. Among those who report taking any action, more than half have worked directly with advocacy organizations or with their state legislatures. More than one third of mayors and health officials have attempted to counter preemption through work with attorney advisors and others.

Although 18% of mayors and 16% of health officials found that preemption had been beneficial at some point, nearly 75% of mayors and 68% of health officials indicated that it affects local policymaking a moderate amount, a lot, or a great deal.

DISCUSSION

Findings from this study indicate that local leaders view preemption as an impediment to

policymaking across a wide range of public health issues. Historically, preemption has been viewed as affecting community responses to specific public health challenges, such as smoking, gun violence prevention, and obesity. Preemption is now used to prevent local governments from regulating to address a much broader array of issues, including paid sick leave, minimum wage, and environmental hazards.¹² Our survey responses suggest that local policymakers attempt to combat preemption in a variety of ways, such as redesigning local laws or attempting to change or repeal a state's preemptive law. It is important for advocates, public health coalitions, and other stakeholders who work at the local level to consider these and other strategies when preemption may negate efforts to mitigate public health concerns in their communities.¹³

Researchers suggest that preemption will restrict or negate local public health policymaking.¹⁴ Our findings confirm that the vast majority of health officials and mayors have abandoned or delayed policymaking initiatives because of preemption. Fewer than one third of mayors and health officials implemented a local law when faced with preemption. These data provide support for the concern that preemption—or even the threat of preemption—has a “chilling effect.” Preemption may stifle the development, passage, and implementation of local policies as well as the potential for local innovation.

Although our study has numerous strengths, including consideration of 2 types of local leaders, limitations should be noted. To protect respondents' anonymity, we did not collect geographic identifiers, so we cannot associate particular preemption challenges with specific jurisdictions. We focused on cities with populations of 150 000 or more, which may have caused us to miss different preemption experiences among leaders of smaller localities. However, limited available evidence suggests that preemption experiences do not necessarily vary by a locality's geographic location or size. Our response rates—although relatively strong for surveys of public policymakers—were 28% (mayoral survey) and 32% (health official survey). There may have been nonresponse bias in our survey in a number of areas, including positive or negative experiences with preemption. Our results should be interpreted with these

potential biases in mind. Finally, we cannot be sure that mayors and health officials interpreted the survey questions in precisely the same way, and this may have affected their responses. For example, preemption of tobacco control policies may have been viewed by mayors as an obstacle to the generation of local revenues, whereas health officials saw it as an obstacle to the reduction of tobacco use. These potential disparate interpretations suggest an important area for future analysis.

PUBLIC HEALTH IMPLICATIONS

Preemption may delay or prevent local leaders from enacting policies to address public health issues that arise in their communities. Local governments should therefore engage in a proactive information exchange to learn about successful and failed efforts to promote public health when faced with preemption. For example, several case studies provide detailed information about strategies that local governments have effectively used to advance tobacco control despite state-level preemption.¹⁵ Wide dissemination of these types of efforts becomes critical when preemption limits the tools available to localities seeking to protect the public's health. **AJPH**

CONTRIBUTORS

All authors made substantial contributions to conceptualization or design of the article, drafted the article, provided critical revision, approved the final version of the article, and are accountable for all aspects of the work.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

The Johns Hopkins Bloomberg School of Public Health institutional review board deemed this project to not be human participants research.

REFERENCES

1. Institute of Medicine. *For the Public's Health. Investing in a Healthier Future*. Washington, DC: National Academies Press; 2012.
2. Pertschuk M, Hobart R, Paloma M, Larkin MA, Balbach ED. Grassroots movement building and preemption in the campaign for residential fire sprinklers. *Am J Public Health*. 2013;103(10):1780–1787.
3. Hodge JG Jr, Corbett A. Legal preemption and the prevention of chronic conditions. *Prev Chronic Dis*. 2016; 13:E85.
4. Rutkow L, Vernick JS, Hodge JG, Teret SP. Preemption and the obesity epidemic: state and local menu labeling laws and the Nutrition Labeling and Education Act. *J Law Med Ethics*. 2008;36(4):772–789.
5. Briffault R. Our localism: part I—the structure of local government law. *Columbia Law Rev*. 1990;90(1):1–115.
6. Reeve B, Ashe M, Farias R, Gostin L. State and municipal innovations in obesity policy: why localities remain a necessary laboratory for innovation. *Am J Public Health*. 2015;105(3):442–450.
7. Pomeranz JL, Zellers L, Bare M, Pertschuk M. State preemption of food and nutrition policies and litigation: undermining government's role in public health. *Am J Prev Med*. 2019;56(1):47–57.
8. Centers for Disease Control and Prevention. State preemption of local tobacco control policies restricting smoking, advertising, and youth access—United States, 2000–2010. *MMWR Morb Mortal Wkly Rep*. 2011;60(33): 1124–1127.
9. Tung GJ, Vernick JS, Stuart EA, Webster DW. Political factors affecting the enactment of state-level clean indoor air laws. *Am J Public Health*. 2014;104(6):e92–e97.
10. Purtle J, Henson RM, Carroll-Scott A, Kolker J, Joshi R, Diez Roux AV. US mayors' and health commissioners' opinions about health disparities in their cities. *Am J Public Health*. 2018;108(5):634–641.
11. Fisher SH III, Herrick R. Old versus new: the comparative efficiency of mail and Internet surveys of state legislators. *State Polit Policy Q*. 2013;13(2):147–163.
12. Grassroots Change. Preemption Watch. Available at: <https://grassrootschange.net/preemption-watch>. Accessed January 23, 2019.
13. Bare M, Zellers L, Sullivan PA, Pomeranz JL, Pertschuk M. Combatting and preventing preemption: a strategic action model. *J Public Health Manag Pract*. 2019; 25(2):101–103.
14. Pomeranz JL, Pertschuk M. State preemption: a significant and quiet threat to public health in the United States. *Am J Public Health*. 2017;107(6):900–902.
15. Douglas MR, Manion CA, Hall-Harper VD, Teronez KM, Love CA, Chan A. Case studies from community coalitions: advancing local tobacco control policy in a preemptive state. *Am J Prev Med*. 2015;48(1 suppl 1): S29–S35.