

# Evidence-Based Point-of-Sale Policies to Reduce Youth Tobacco Use in North Carolina

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Many states and localities in the United States are implementing evidence-based tobacco control policies at the retail level, including Tobacco 21 laws, tobacco retailer licensing, restrictions on point-of-sale promotions, and bans on flavored tobacco products. With the passage of new point-of-sale tobacco control policies, North Carolina could reduce youth tobacco use rates.

## Introduction

While cigarette smoking among North Carolina youth has steadily decreased over time, e-cigarette use has increased dramatically [1]. According to the North Carolina Youth Tobacco Survey, self-reported e-cigarette use increased 510% for middle schoolers and 1129% for high schoolers from 2011 to 2019 [1]. Compared to 5.7% of high schoolers and 2.4% of middle schoolers reporting cigarette smoking, 20.9% of high schoolers and 6.1% of middle schoolers reported e-cigarette use in 2019 [1]. This rise in e-cigarette use offsets declines in smoking, stagnating progress in reducing youth tobacco use. As North Carolina continues to work to prevent youth tobacco use and eliminate tobacco-related health disparities, key state-level policy changes would bolster the effectiveness of tobacco control efforts. In this commentary we describe the evidence base for point-of-sale policies, including Tobacco 21 laws, restrictions on advertising and promotion, flavored tobacco product bans, tobacco retailer licensing, and repealing preemption.

## Tobacco 21

Both projections and real-world studies show that raising the minimum legal age for tobacco sales from 18 to 21 ("Tobacco 21" or "T21") reduces tobacco use among youth and young adults, with substantial long-term impacts expected for related health outcomes [2, 3]. Prior to the federal enactment of T21 in 2019, a 2015 Institute of Medicine (IOM) report estimated that a national T21 law would decrease cigarette smoking initiation by 25% for those aged 15-17 and by 15% for those younger than 15 or aged 18-20 [2]. Since adolescents frequently obtain tobacco products from social sources (e.g., classmates or older siblings), creating a larger distance between legal access and younger peer groups reduces opportunities for tobacco use initiation [2].

Because 95% of adults who use tobacco begin before age 21 [4], the IOM report predicted that T21 would reduce tobacco use not only in the short term but also over time [2]. Projections indicated that smoking prevalence would decrease by 12% by the time current teenagers became adults [2]. Decreased smoking prevalence would lead to "substantial reductions in smoking-related mortality" and long-term improvements in health outcomes related to other tobacco use, secondhand smoke, and pregnancy [2]. The IOM projected that enacting T21 nationwide in 2015 would have resulted in approximately 249,000 fewer premature deaths among people born between 2000 and 2019 [2].

A recent evaluation found that from 2009 to 2019, state-level T21 policies reduced cigarette smoking among young adults (aged 18-20 years) by 2.5%-3.9% [3]. Among 18-year-old high-school students, these policies reduced smoking by 3%-7% and e-cigarette use by 6%-12% [3]. The laws also had spillover effects, reducing cigarette use among youth (aged 16-17 years) and marijuana and alcohol use among young adults [3].

As of December 2019, it is illegal under federal law to sell nicotine or tobacco products to anyone under age 21 [5]. Although this law applies to all retailers in the United States, complementary state and local laws are important for policy implementation and enforcement [6]. Compliance with T21 is necessary for states to receive "Synar funding" from the Substance Abuse and Mental Health Services Administration [7]. North Carolina risks losing this federal funding for substance abuse prevention, treatment, and recovery efforts if 20% or more of randomly sampled tobacco retailers are found to be in violation of the T21 law [7]. Complementing the federal law, state-level T21 policies provide state agencies with greater control over enforcement activities to keep states in compliance with Synar provisions [7].

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In addition, state and local policies are useful for codifying best practices. For example, a state-level law should ban *retailers* from selling tobacco products instead of criminalizing *possession among underage youth*, a key recommendation included in a model policy produced by the Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society, Public Health Law Center, American Lung Association, and others [6]. Other best practices include imposing a structure of civil rather than criminal penalties for retailers, and defining products covered by the T21 law to include all current and future tobacco products, including e-cigarettes [6]. A broad definition of tobacco products is important given the high prevalence of e-cigarette use among middle and high schoolers and the potential for new product development by the tobacco industry [1].

T21 policies have been among the most rapidly adopted tobacco retail control policies and have widespread public support [8], including from tobacco companies and retailers [9, 10]. Nineteen US states had T21 policies in place before federal enactment and 21 more states passed state policies after the nationwide law [11]. Should North Carolina follow the other 40 states in adopting T21, it is important that the new law follow the best practices noted here. In addition, the law should include provisions related to enforcement. Specific provisions include requiring age verification and signage indicating age regulations, designating authority for—and requiring a minimum number of—compliance checks, and creating a licensing agency for tobacco retailers [6].

### Point-of-Sale Advertising and Promotion

Tobacco advertising is associated with increased tobacco initiation for youth and increased use for both adults and adolescents [12]. Existing policies prevent tobacco companies from advertising in outdoor settings, on billboards, on public transportation, and on television and radio. As a result, tobacco companies have funneled the majority of current advertising expenditures to the point of sale (POS) at retail outlets [13]. A recent analysis of tobacco advertising expenditures found that, in the United States, tobacco industry spending on POS advertising and promotions grew exponentially beginning in the 1990s and is now an astonishing 98% of the advertising budget [13]. Price promotions at the POS that lower the price of tobacco products, or give them away for free, supplement advertising as a marketing activity designed to stimulate purchasing behavior [14].

Exposure to tobacco advertising and promotions at the POS is associated with increased youth tobacco use [14]. Among adolescents who do not smoke, increased exposure to tobacco industry advertising and price promotions is associated with increased susceptibility to smoking during adolescence and increased smoking behavior later in life [14]. Furthermore, in a survey of young adult smokers, roughly one in three reported that frequent exposure to tobacco advertising made it difficult to quit [15]. Individuals who identified advertising as a barrier to quitting were also

more likely to report purchasing cigarettes once they were in a store without planning to do so beforehand [15].

The tobacco industry targets advertising and promotional efforts toward historically marginalized groups. For example, neighborhoods with a higher percentage of Black residents are more likely to have tobacco retailers with advertising, price promotions, and cheaper prices for menthol cigarettes [16]. This may be due, in part, to predatory contracts designed to promote menthol products in predominantly Black neighborhoods in urban areas [17].

Localities and states are working to address POS tobacco advertising and promotion. For example, Providence, Rhode Island, passed a regulation in 2012 that restricted discounting of tobacco products and banned multipack offers (e.g., “buy-one-get-one”) [18]. In 2020, New York State barred tobacco retailers from offering or redeeming price discounts for tobacco and vapor products and prohibited exterior tobacco advertisements within 1500 feet of schools (500 feet in New York City) [19]. In 2021, St. Paul, Minnesota, also passed a regulation that comprehensively prohibits price discounting on all tobacco products, including vape products [20].

### Menthol and Other Flavored Tobacco Bans

In 2021, 79.1% of youth tobacco users in the United States used a flavored product [21]. The United States Food and Drug Administration proposed rules in May 2022 to ban the sale of menthol cigarettes and flavored cigars in response to research demonstrating the public health benefits of banning flavored combustible tobacco products [22]. Among adults, approximately one-third of cigarette smokers use menthol cigarettes, the only remaining flavored cigarette on the market, and half of cigar users use flavored products [23, 24]. Flavors are added to tobacco products to improve their taste and reduce the harshness of smoke on the throat, which facilitates smoking initiation [25]. Studies indicate that flavored tobacco products also inhibit smoking cessation [25]. Banning flavored tobacco products would therefore not only reduce smoking initiation among youth but would also increase quit rates among smokers [25, 26]. A study simulating a ban on menthol cigarettes and flavored cigars in the United States projected a 15% decline in cigarette smoking in just five years [26].

As is typical in the field of public health, local communities have led the way in regulating flavored tobacco products [27]. To date, four states and more than 150 localities restrict the sale of menthol cigarettes or other flavored tobacco products [27]. Given that North Carolina’s rates of cigarette use among both youth and adults are higher than the national average, a ban on flavored tobacco products would have great public health benefits in the state [28].

Banning the sale of flavored tobacco products in North Carolina would also advance health equity. The tobacco industry’s targeted marketing of menthol cigarettes to Black communities increases appeal and accessibility of

**TABLE 1.**  
**Evidence for Tobacco Control Policies**

<b>Policy</b>	<b>Definition</b>	<b>Evidence</b>
<b>Tobacco 21 (T21)</b>	Raising the minimum legal age for tobacco sales from 18 to 21	<p>95% of individuals who smoke start before age 21 [4].</p> <p>Many youth obtain tobacco products from social sources. Increasing the minimum legal age widens the age difference between legal purchasers and younger teenagers, making tobacco use less likely [2].</p> <p>Projections and real-world studies show decreases in tobacco use initiation and prevalence among youth and long-term improvements in tobacco-related health outcomes [2, 3].</p> <p>State-level policies provide authority for enforcement of the federal T21 law, which is tied to federal funding [6, 7].</p> <p>40 states have state-level T21 policies [11].</p>
<b>Point-of-sale advertising and promotion regulations</b>	Restricting advertising and promotions in tobacco retail outlets	<p>Tobacco advertising and promotions are linked with youth tobacco use initiation, tobacco use later in life, and difficulty quitting [12, 14, 15].</p> <p>Tobacco companies spend 98% of their marketing budgets at the point of sale [13].</p> <p>Historically marginalized groups have higher exposure to tobacco advertising and promotions [16].</p> <p>Localities and states have implemented policies to restrict advertising and promotions in the retail environment [18–20].</p>
<b>Menthol and other flavor bans</b>	Restricting use of menthol and/or other flavors in tobacco products	<p>Menthol and other flavors facilitate youth tobacco use initiation and increase difficulty to quit for both youth and adults [26].</p> <p>According to projections, banning menthol cigarettes and flavored cigars in the United States would decrease cigarette smoking by 15% in five years [26].</p> <p>Targeted marketing of menthol has contributed to high rates of menthol cigarette smoking among Black individuals. Banning menthol would help reduce existing health disparities [16, 17, 29–32].</p> <p>Over 150 localities and four states have restricted the use of menthol or other flavors in tobacco products [27].</p>
<b>Tobacco retail licensing</b>	Establishing and maintaining a system of permits to lawfully sell tobacco products	<p>Retail licensing provides a system to enforce other regulations such as T21, flavor bans, and restrictions on proximity to schools [34].</p> <p>Retail licensing provides a regular source of funding for enforcement efforts [34].</p> <p>40 states have tobacco retail licensing.<sup>a</sup></p>
<b>Preemption repeal</b>	Revoking state-level laws that preempt local tobacco control regulations	Preemption prevents localities from enacting tobacco control regulations even when constituents desire them [35, 36].

Sources. See corresponding numbers in reference list.

<sup>a</sup>Centers for Disease Control and Prevention. STATE System Licensure Fact Sheet. Published February 7, 2022. Accessed May 24, 2022. <http://www.cdc.gov/statesystem/factsheets/licensure/Licensure.html>

the product and contributes to the disproportionate burden of tobacco-related disease and mortality within Black populations [29]. In 2018, 85% of Black individuals, 50% of Hispanic individuals, 47% of Asian individuals, and 35% of American Indian, Alaska Native, Native Hawaiian, or Other Pacific Islander individuals who smoked preferred menthol cigarettes, compared to 29% of white individuals who smoked [30]. A menthol cigarette ban would help reduce the existing Black-white disparity in lung cancer, cardiovascular disease, diabetes, and other tobacco-related health outcomes in North Carolina by reducing smoking prevalence

among Black individuals, who use menthol cigarettes at the highest rates [30–32].

### **Tobacco Retail Licensing**

A tobacco retail license—a permit to lawfully sell tobacco products—requires the retailer to comply with conditions of operation or risk license suspension [33]. Tobacco products are the most lethal products sold in the United States, which is why most states license their tobacco product retailers. However, North Carolina does not require a retail license to sell tobacco products and even preempts, or bans, local

communities from allowing local licensing regulations.

Retail licensing is sometimes called the “Swiss Army knife of tobacco control,” given its remarkable flexibility. Licensing typically includes the requirement to avoid selling tobacco products to those under the minimum legal age. If a store sells to a minor, the proprietor may be warned and reinspected [34]. If the store sells on a second or third inspection, their license may be revoked immediately or not renewed after the current license period. Bans on the sale of candy- and fruit-flavored tobacco products are often implemented through licensing restrictions, as are caps on the total number of retailers and bans on sales of tobacco products near schools [33].

Licensing provides a regular source of funding for enforcement efforts and a list of retailers to make it easier for enforcement officials to know where to visit for compliance inspections [33]. Currently, when local or state entities in North Carolina enforce youth access laws, they do so with their own resources. In other words, without funding provided by a licensing system, the government is subsidizing the costs associated with enforcing regulations governing the sale of tobacco products at private businesses.

## Preemption

Preemption laws in North Carolina make it difficult for local jurisdictions to make progress toward addressing youth tobacco use rates through the evidence-based policies described here. Preemption laws limit the power of local governments to pass local tobacco control policies sought by policy-makers and constituents. Preemption also releases potential pressure on the state government to adopt pervasive local policies [35]. Continuation of North Carolina’s 1993 preemption policy stifles tobacco control efforts by limiting localities’ ability to pass evidence-based tobacco regulations [36]. Without preemption, local governments can lead the way in future tobacco control and prevention efforts.

## Conclusion

Progress in reducing youth tobacco use has stagnated due to the meteoric rise in e-cigarette use over the past decade. Reducing youth tobacco use would lead to lower rates of tobacco-related chronic disease and improvements in health on a population level. State and local T21 laws, point-of-sale advertising and promotion regulation, and regulation of flavored tobacco products can reduce youth tobacco use and enhance health equity in North Carolina. A tobacco retail licensing system is needed to help implement and properly enforce these policies. Finally, repealing preemption is necessary to allow local jurisdictions to pass new tobacco control laws as innovative policy solutions are developed. NCMJ

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## References

1. North Carolina Department of Health and Human Services, Tobacco Prevention and Control Branch. North Carolina Youth Tobacco Survey. Updated April 20, 2021. Accessed March 27, 2022. <https://tobaccopreventionandcontrol.ncdhhs.gov/data/yts/index.htm>
2. Bonnie RJ, Stratton K, Kwan LY, eds. *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*. Institute of Medicine; 2015.
3. Bryan C, Hansen B, McNichols D, Sabia J. *Do State Tobacco 21 Laws Work?* Working Paper 28173. National Bureau of Economic Research; December 2020. Accessed March 29, 2022. [https://www.nber.org/system/files/working\\_papers/w28173/w28173.pdf](https://www.nber.org/system/files/working_papers/w28173/w28173.pdf)
4. Campaign for Tobacco-Free Kids. Raising the Tobacco Age to 21. Published June 7, 2017. Updated January 9, 2020. Accessed March 29, 2022. <https://www.tobaccofreekids.org/what-we-do/us/sale-age-21>
5. Tobacco 21. FDA. Published online February 10, 2022. Accessed March 27, 2022. <https://www.fda.gov/tobacco-products/retail-sales-tobacco-products/tobacco-21>
6. Campaign for Tobacco-Free Kids. *Tobacco 21: Model Policy*. Published online July 23, 2021. Accessed March 29, 2022. [https://www.tobaccofreekids.org/assets/content/what\\_we\\_do/state\\_local\\_issues/sales\\_21/2019\\_08\\_06\\_tobacco21\\_model\\_policy.pdf](https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/sales_21/2019_08_06_tobacco21_model_policy.pdf)
7. DiFranza JR. State and federal compliance with the Synar Amendment: federal fiscal year 1998. *Arch Pediatr Adolesc Med*. 2001;155(5):572-578. doi: 10.1001/archpedi.155.5.572
8. Ribisl KM, Mills SD. Explaining the rapid adoption of Tobacco 21 policies in the United States. *Am J Public Health*. 2019;109(11):1483-1485. doi: 10.2105/AJPH.2019.305269
9. Whyte LE, Nanez DM. Big Tobacco’s surprising new campaign to raise the smoking age. The Center for Public Integrity. Published May 23, 2019. Accessed March 29, 2022. <http://publicintegrity.org/politics/state-politics/copy-paste-legislate/big-tobaccos-surprising-new-campaign-to-raise-the-smoking-age/>
10. Zhang X, Vuong TD, Andersen-Rodgers E, Roeseler A. Evaluation of California’s ‘Tobacco 21’ law. *Tob Control*. 2018;27(6):656-662. doi: 10.1136/tobaccocontrol-2017-054088
11. Preventing Tobacco Addiction Foundation. Tobacco 21. Accessed April 4, 2022. <https://tobacco21.org/>
12. Robertson L, McGee R, Marsh L, Hoek J. A systematic review on the impact of point-of-sale tobacco promotion on smoking. *Nicotine Tob Res*. 2015;17(1):2-17. doi: 10.1093/ntr/ntu168
13. Ma H, Reimold AE, Ribisl KM. Trends in cigarette marketing expenditures, 1975-2019: an analysis of Federal Trade Commission cigarette reports. *Nicotine Tob Res*. Published online January 5, 2022:ntab272. doi: 10.1093/ntr/ntab272
14. Lovato C, Watts A, Stead LF. Impact of tobacco advertising and promotion on increasing adolescent smoking behaviours. *Cochrane Database Syst Rev*. 2011;(10). doi: 10.1002/14651858.CD003439.pub2
15. Clattenburg EJ, Elf JL, Apelberg BJ. Unplanned cigarette purchases and tobacco point of sale advertising: a potential barrier to smoking cessation. *Tob Control*. 2013;22(6):376-381. doi: 10.1136/tobaccocontrol-2012-050427
16. Mills SD, Henriksen L, Golden SD, et al. Disparities in retail marketing for menthol cigarettes in the United States, 2015. *Health Place*. 2018;53:62-70. doi: 10.1016/j.healthplace.2018.06.011

17. Yerger VB, Przewoznik J, Malone RE. Racialized geography, corporate activity, and health disparities: tobacco industry targeting of inner cities. *J Health Care Poor Underserved*. 2007;18(4 Suppl):10-38. doi: 10.1353/hpu.2007.0120
18. Pearlman DN, Arnold JA, Guardino GA, Welsh EB. Advancing tobacco control through point of sale policies, Providence, Rhode Island. *Prev Chronic Dis*. 2019;16:E129. doi: 10.5888/pcd16.180614
19. New York State Department of Health. NYS Tobacco Control Policies. Published March 2021. Accessed April 9, 2022. [https://www.health.ny.gov/prevention/tobacco\\_control/current\\_policies.htm](https://www.health.ny.gov/prevention/tobacco_control/current_policies.htm)
20. The Association for Nonsmokers-Minnesota. Saint Paul passes most comprehensive commercial tobacco ordinance in the United States. Published November 15, 2021. Accessed May 24, 2022. <https://www.ansrmn.org/saint-paul-passes-most-comprehensive-commercial-tobacco-ordinance-in-the-united-states/>
21. Gentzke AS, Wang TW, Cornelius M, et al. Tobacco product use and associated factors among middle and high school students — National Youth Tobacco Survey, United States, 2021. *MMWR Surveill Summ*. 2022;71(5):1-29. doi: 10.15585/mmwr.ss7105a1
22. FDA Commits to Evidence-Based Actions Aimed at Saving Lives and Preventing Future Generations of Smokers. News release. FDA; April 30, 2021. Accessed March 30, 2022. <https://www.fda.gov/news-events/press-announcements/fda-commits-evidence-based-actions-aimed-saving-lives-and-preventing-future-generations-smokers>
23. Rostron BL, Cheng YC, Gardner LD, Ambrose BK. Prevalence and reasons for use of flavored cigars and ENDS among US youth and adults: estimates from wave 4 of the PATH Study, 2016-2017. *Am J Health Behav*. 2020;44(1):76-81. doi: 10.5993/AJHB.44.1.8
24. Villanti AC, Mowery PD, Delnevo CD, Niaura RS, Abrams DB, Giovino GA. Changes in the prevalence and correlates of menthol cigarette use in the USA, 2004-2014. *Tob Control*. 2016;25(Suppl 2):ii14-ii20. doi: 10.1136/tobaccocontrol-2016-053329
25. Tobacco Products Scientific Advisory Committee. Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations. FDA. Updated November 12, 2019. Accessed April 26, 2022. <https://www.fda.gov/advisory-committees/committees-and-meeting-materials/tobacco-products-scientific-advisory-committee>
26. Levy DT, Meza R, Yuan Z, et al. Public health impact of a US ban on menthol in cigarettes and cigars: a simulation study. *Tob Control*. Published online September 2, 2021. doi: 10.1136/tobaccocontrol-2021-056604
27. Campaign for Tobacco-Free Kids. *States & Localities That Have Restricted The Sale of Flavored Tobacco Products*. Accessed May 24, 2022. <https://www.tobaccofreekids.org/assets/factsheets/0398.pdf>
28. Truth Initiative. Tobacco use in North Carolina 2021. Published January 31, 2022. Accessed March 30, 2022. <https://truthinitiative.org/research-resources/smoking-region/tobacco-use-north-carolina-2021>
29. Henley SJ, Thomas CC, Sharapova SR, et al. Vital Signs: disparities in tobacco-related cancer incidence and mortality — United States, 2004-2013. *MMWR Morb Mortal Wkly Rep*. 2016;65(44):1212-1218. doi: 10.15585/mmwr.mm6544a3
30. Delnevo CD, Ganz O, Goodwin RD. Banning menthol cigarettes: a social justice issue long overdue. *Nicotine Tob Res*. 2020;22(10):1673-1675. doi: 10.1093/ntr/ntaa152
31. Levy DT, Pearson JL, Villanti AC, et al. Modeling the future effects of a menthol ban on smoking prevalence and smoking-attributable deaths in the United States. *Am J Public Health*. 2011;101(7):1236-1240. doi: 10.2105/AJPH.2011.300179
32. American Lung Association. State of Lung Cancer: North Carolina. Accessed March 30, 2022. <https://www.lung.org/research/state-of-lung-cancer/states/north-carolina>
33. Ackerman A, Etow A, Bartel S, Ribisl KM. Reducing the density and number of tobacco retailers: policy solutions and legal issues. *Nicotine Tob Res*. 2017;19(2):133-140. doi: 10.1093/ntr/ntw124
34. ChangeLab Solutions. *Implementation Checklist for Tobacco Retailer Licensing*. Published 2012. Accessed April 26, 2022. [https://www.changelabsolutions.org/sites/default/files/TRL\\_Implementation-Checklist\\_FINAL\\_20120907.pdf](https://www.changelabsolutions.org/sites/default/files/TRL_Implementation-Checklist_FINAL_20120907.pdf)
35. ChangeLab Solutions. *Tobacco Point of Sale Preemption Playbook 2022*. Counter Tobacco; February 2022. Accessed April 4, 2022. [https://countertobacco.org/wp-content/uploads/2022/02/POSPreemptionPlaybook\\_2022.pdf](https://countertobacco.org/wp-content/uploads/2022/02/POSPreemptionPlaybook_2022.pdf)
36. Kang JY, Kenemer B, Mahoney M, Tynan MA. State preemption: impacts on advances in tobacco control. *J Public Health Manag Pract*. 2020;26 (Suppl 2). doi: 10.1097/PHH.0000000000001132