Territorial Jurisdiction of Local Board of Health Rules Regulating Smoking in North Carolina

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February 2013

Introduction

In 2007, the North Carolina General Assembly passed legislation that made local regulation of smoking part of the state's public health laws.[1] The 2007 law extended limited authority to regulate smoking to local governments via a new statute, G.S. 130A-498. Initially, the law limited the areas in which local governments could regulate smoking to local government buildings, local government vehicles, and the buildings and grounds of local health departments and departments of social services.[2]

In 2009, new legislation significantly expanded the authority of local government to regulate smoking.[3] Under the new law, local governments kept their authority to regulate smoking in local government buildings and vehicles, and acquired additional authority to regulate smoking on all local government grounds and in public places—with exceptions for private residences, private vehicles, and certain private businesses. G.S. 130A-498.

Local Entities Authorized to Regulate Smoking

The local entities that may regulate smoking under G.S. 130A-498 include cities, counties, airport authorities and other authorities, and local boards of health.

> [A] local government may adopt and enforce ordinances, board of health rules, and policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. G.S. 130A-498(a).[4]

Local Boards of Health

A local board of health is charged with protecting and promoting the public health, and serves as the policy-making, rule-making, and adjudicatory body for public health in a single- or multi-county jurisdiction.[5] There are four basic types of boards of health in North Carolina:

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[1] S.L. 2007-193 (H 24) (adding G.S. Ch. 130A, Art. 23).

[2] The provision for local vehicles first appeared in S.L. 2008-149 (S 1681). Other laws adopted in the mid-2000s regulated smoking in other places, including state government buildings, schools, and community colleges. For a history of smoking regulation in North Carolina, see Aimee Wall, Smoking in Public Places: Recent Changes in State Law, Health Law Bulletin No. 90 (May 2009), at http://www.sogpubs.unc.edu/electronicversions/pdfs/hlb90.pdf.

[3] S.L. 2009-27 (H2). The same legislation created a statewide ban on smoking in restaurants, bars, and certain lodging establishments—a ban that is enforced by local health departments but that is not a part of local regulation. G.S. 130A-496.

[4] Relevant terms, including *local government*, *local government building*, *grounds*, *local vehicles*, and *public places* are defined in G.S. 130A-492.

[5] G.S. 130A-39 (setting forth the powers and duties of a local board of health); see also G.S. 130A-2(4) (defining "local board of health" as a county board of health, a district board of health, or a public health authority board); G.S. 153A-77(d) (conferring the powers of duties of a local board of health on a consolidated human services board).

- A county board of health, serving a single county with a county health department
- A district board of health, serving a multi-county district with a district health department
- A consolidated human services board, serving a single county with a consolidated human services agency that includes public health functions[6]
- A public health authority board, which may serve a single-county or multi-county area that receives public health services through a public health authority created pursuant to G.S. Ch. 130A, Art. 2, Part 1B.[7]

In addition, legislation adopted in June 2012[8] authorized boards of county commissioners in all North Carolina counties to abolish their county board of health or consolidated human services board and directly assume the powers and duties of the abolished board. When this occurs, the board of commissioners acts as the board of health for the county.[9]

Board of Health Rule-Making Authority

Local boards of health serve as the rule-making bodies for public health in their jurisdiction. Before adopting, amending, or repealing any local rule, the board of health must give the public notice of its intent and offer the public an opportunity to inspect its proposed action. G.S. 130A-39(d). A board of health rule is valid throughout the county or counties in the board's jurisdiction, including within any municipalities served by the board. G.S. 130A-39(c) ("The rules of a local board of health shall apply to all municipalities within the local board's jurisdiction.")

In general, local board of health rules do not require the approval of any other entity. However, there are a couple of exceptions to this general rule. For example, local board of health rules pertaining to septic tanks must be approved by a state agency.[10] Another exception applies to local board of health rules regulating smoking:

> A rule or policy adopted on or after July 1, 2009 pursuant to this subsection by a local board of health or an entity exercising the powers of a local board of health[11] ***must be approved by an***

[6] G.S. 153A-77(b) authorizes the board of commissioners in a county that has a county manager appointed under G.S. 153A-81 to create a consolidated human services agency to carry out the functions of any combination of county human services agencies, potentially including public health.

[7] There is presently only one single-county public health authority in North Carolina that was established under this law (Hertford). One county (Cabarrus) provides public health services through a public hospital authority. This is authorized by an uncodified provision that appears to apply only to Cabarrus county. S.L. 1997-502, sec. 12

[8] S.L. 2012-126 (H 438).

[9] As of this writing, four North Carolina counties have boards of county commissioners acting as consolidated human services boards with responsibility for public health: Bladen, Brunswick, Mecklenburg, and Montgomery.

[10] G.S. 130A-39(b) specifies that local board of health rules regarding on-site wastewater management must be adopted in accordance with G.S. 130A-335(c), which generally requires the approval of the Environmental Health Section of the North Carolina Division of Public Health.

[11] "Local board of health" is defined as a county board of health, a district board of health, or a public health authority board. G.S. 130A-2(4). An "entity exercising the authority of a local board of health" is not defined but the entities authorized elsewhere in the law to exercise those authorities include consolidated human services boards (G.S. 153A-77(d)), and boards of county commissioners that have abolished the county board of health or consolidated human services board and assumed the abolished board's powers and duties (G.S. 153A-77(a)).

> ***ordinance adopted by the Board of County Commissioners of the county to which the rule applies***. G.S. 130A-498(a) (emphasis added).

This is the only circumstance in which a local board of health rule must be approved by a board of county commissioners.

Territorial Jurisdiction of Local Board of Health Smoking Rules

The Question

Does the requirement that a board of county commissioners approve a local board of health rule on smoking rules alter the territorial jurisdiction of the board of health's rule? Nothing in G.S. 130A-498(a) expressly alters G.S. 130A-39(c), which clearly states that a local board of health's rules apply to the municipalities in the board's jurisdiction. The question nevertheless arises because of another provision in G.S. 130A-498. Subsection (e) states: "A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122"—the law that establishes the territorial jurisdiction for county ordinances. Under that law, county ordinances are effective only in the unincorporated areas of the county and do not apply within a municipality unless the municipality consents to be governed by the ordinance:

> Except as otherwise provided in this Article, the board of commissioners may make any ordinance adopted pursuant to this Article applicable to any part of the county not within a city. In addition, the governing board of a city may by resolution permit a county ordinance adopted pursuant to this Article to be applicable within the city. The city may by resolution withdraw its permission to such an ordinance. If it does so, the city shall give written notice to the county of its withdrawal of permission; 30 days after the county receives this notice the county ordinance ceases to be applicable within the city. G.S. 153A-122.

Whether subsection (e) has the effect of altering the usual territorial scope of a board of health rule has been the subject of much debate in recent months. In August 2012, I published a blog post describing the issue and asking for further discussion.[12] While no one has taken advantage of the opportunity to discuss the issue in the comments section of the blog, I have nevertheless received a number of phone calls and emails on the subject, which have helped to refine my thoughts on the matter.

The presence of these two potentially contradictory provisions in G.S. 130A-498 creates an ambiguity. When a statute is ambiguous, there are principles of statutory construction that—while they can only be applied conclusively by a court—can assist us in reaching practical conclusions about the meaning of the statute. There are many specific rules of statutory construction and they do not always point to the same conclusions, but underlying all the rules is a core guiding principle: A statute should be interpreted in a fashion that is most consistent with legislative intent. Legislative intent is ordinarily

[12] Jill Moore, *What is the Territorial Jurisdiction of a Local Board of Health Rule Regulating Smoking?* (August 15, 2012), at (http://canons.sog.unc.edu/?p=6803).

inferred from the plain words of a statute, but when the plain words are ambiguous there are other principles that should be considered, including:[13]

- A single statute should be read together with other statutes on the same subject and harmonized into one law on the subject.
- The statute should be construed in a manner that gives meaning to all provisions, if possible.
- The individual parts of a statute should be construed in the context of the whole.
- The conclusion that a portion of a statute is redundant should be avoided, the assumption being that the legislature inserted every part for a purpose.

Taking these principles into account, my conclusion is that subsection (e) does not limit the territorial jurisdiction of a local board of health rule regulating smoking. Such a rule is effective throughout the board's jurisdiction—including within municipalities—upon the board of county commissioner's adoption of an ordinance approving the rule.

Considering the Requirement for Commissioner Approval in G.S. 130A-498(a)

G.S. 130A-39 confers rule-making authority upon local boards of health and extends the reach of those rules into municipalities. At the outset, I am reluctant to conclude that the board of health's jurisdiction has been altered absent a clear statement to that effect, and there is no such clear statement in G.S. 130A-498(a). Rather, there is simply a provision that boards of commissioners approve the board of health rules before they take effect. Viewed in this manner, the commissioner's approval of the rule is procedural in nature, not substantive. The ordinance approving the rule is a procedural step that does not alter the content of the board of health rule, nor does it alter the rule's territorial reach.

But then what is the point of the approval requirement? Nothing in the statutes answers this question, but I think it is significant that the legislature required that a board of health smoking rule be *approved by* an ordinance, rather than *adopted as* an ordinance. A requirement for approval strikes me as a provision the legislature might reasonably include to ensure that there is oversight of the board of health's decision-making authority in this area by the body that appoints the board,[14] without compromising the board of health's authority to regulate throughout the jurisdiction.

Considering the Effect of G.S. 130A-498(e)

Whatever the purpose of the approval requirement may be, what is its effect when read in conjunction with subsection (e)? One view is that subsection (e) limits the scope of the commissioners' approval to the unincorporated areas of the county and thus limits the applicability of the board of health rule to those areas as well. This view appears at first as if it may be supported by the plain language of the statute, but it seems to me to that it is not consonant with the legislative intent that

[13] This is far from an exhaustive list of the rules of statutory construction, but these are the main principles that I am relying on to reach the conclusions described in this document.

[14] Boards of county commissioners appoint boards of health directly or indirectly. The board appoints all members of a county board of health (G.S. 130A-35), a consolidated human services board (G.S. 153A-77), or a single-county public health authority (G.S. 130A-45.1). For multi-county boards of health, each participating county appoints one county commissioner to serve on the board, and those commissioners appoint the remaining members. G.S. 130A-37 (district boards of health); 130A-45.1(b) (multi-county public health authorities).

may be inferred when the statute is read in conjunction with the statute that gives boards of health their rule-making authority. Further, upon a closer look, I'm not sure the plain language supports that interpretation either.

Considering intent first: A conclusion that the effect of subsection (e) is to limit the commissioners' approval ordinance to the unincorporated areas of the county appears to be in tension with the laws that authorize local boards of health to regulate smoking in public places in the first place. Indeed, the interpretation appears to render the board of health's authority to regulate smoking meaningless. G.S. 130A-498 expressly authorizes cities and counties to adopt ordinances regulating smoking, but it also separately and specifically acknowledges board of health regulation.[15] There is no need for (or any reason for) a board of health to be authorized to adopt smoking rules if those rules must also be expressly adopted by both counties and municipalities to be effective within the board of health's jurisdiction. If each jurisdiction must act separately in any event—whether to adopt separate local ordinances or to accept local board of health rules—then the board of health's authority is illusory.

Further, if this is what is required, then a board of health's efforts to regulate smoking would be more advisory than regulatory in nature. If a board of health rule is ineffective absent the consent of all affected localities, then arguably it's not a rule at all—it's simply a recommendation or advice. Advising and informing local officials about public health matters is addressed in the public health statutes, but not in the context of board of health rule-making authority. A separate statute gives the duty to advise local officials on public health matters to the local health director. G.S. 130A-41. This is a separate activity from the board of health's rule-making authority, and as one would expect, there are no procedural trappings (such as giving notice) associated with the duty to advise. If local public health officials' action on smoking is intended to be advisory only, it makes little sense to invoke the board of health's formal rule-making process.

Returning to the question of the plain language of subsection (e): if the board of commissioners' approval is effective only in the unincorporated areas, does that mean that the commissioners' failure to approve the rules is similarly restricted to the unincorporated areas? In other words, does it mean that the commissioners' action (or inaction) has no effect on municipalities, and the board of health's rule therefore applies within municipalities immediately upon adoption by the board of health as provided by G.S. 130A-39(c)? I cannot imagine that was the legislature's intent—it seems so absurd that my initial reaction to this argument was not to take it seriously enough to include in my August blog post. But upon reflection, I think it is logically where one ends up if 130A-39(c) means what it says and 130A-498(e) limits the scope of the commissioners' approval ordinance. Reasonable people may differ on the subjective question of whether that's an absurd result, but we should bear in mind that avoiding an absurd result is another principle of statutory construction.

[15] It does not explain why boards of health have this authority independently of cities and counties. There may be no need for statutory explanation, given the authority boards of health have under G.S. 130A-39, but one possible policy explanation was proposed by one of my SOG colleagues shortly after the adoption of the new law: "[A board of health] rule allows for uniformity across an entire county or district, which may not be possible if multiple elected boards act (or choose not to act) independently." Aimee Wall, *Local Smoking Regulation: Should You Adopt a Rule or an Ordinance?* (Dec. 1, 2009), at http://canons.sog.unc.edu/?p=1426.

Considering the Purpose of G.S. 130A-498(e)

If my analysis is correct, then what is the point of subsection (e)? My take on that provision is that it applies to county ordinances directly regulating smoking in public places, not county ordinances approving a board of health rule. But isn't that the rule anyway, under G.S. 153A-122? And if so, why would the legislature repeat it unless it had a different intent? I believe this is the stickiest point in the interpretation of G.S. 130A-498, because we don't want to conclude that subsection (e) is meaningless or redundant. But I am not convinced it is redundant. Referring back to the full text of G.S. 153A-122, we can see that it refers repeatedly to ordinances adopted "pursuant to this Article"—i.e., G.S. Chapter 153A, Article 6. The law authorizing local governments to adopt smoking ordinances isn't part of that Article—it appears elsewhere in the statutes. It is difficult to divine the purpose of subsection (e), but perhaps it was to be clear about the territorial jurisdiction of a county ordinance directly regulating smoking, and also to provide the procedure for municipalities to consent to be governed by such ordinances.

Note also that subsection (e) has been part of G.S. 130A-498 since its initial adoption in 2007. At that time, there was nothing in the law that required a board of health rule to be approved by the county commissioners—the approval requirement was added in 2009. Clearly the intent at the time of the statute's initial enactment could not have been to restrict the scope of an approval ordinance, since no such approval was required. However, it is possible that was the intent in 2009 when the legislature amended G.S. 130A-498. The legislature is presumed to know current law and to act deliberately. It could have altered subsection (e) in 2009 to clarify the point and it did not do so, which may be significant. But I believe that leads directly back to the questions previously raised: why would the legislature give rule-making authority to boards of health if their action is ineffective (or merely advisory) absent the adoption of ordinances by both counties and cities, which already have separate authority to adopt ordinances regarding smoking?

<u>Conclusion</u>

The question of the territorial jurisdiction of a board of health rule regulating smoking arises because of two provisions in G.S. 130A-498. Subsection (a) authorizes board of health rules governing smoking but requires that they be approved by an ordinance of the county commissioners. Subsection (e) states that county ordinances adopted under G.S. 130A-498 are subject to the provisions of G.S. 153A-122, the law that establishes the territorial jurisdiction for county ordinances and makes them inapplicable within municipalities unless the municipality consents to be governed by them. I have read these provisions in conjunction with the law that gives boards of health their rule-making authority, and have formed these opinions:

- G.S. 130A-39 confers rule-making authority upon local boards of health and extends the reach of those rules into municipalities. Nothing in the plain language of G.S. 130A-498 alters a board of health's usual jurisdiction.
- The requirement in G.S. 130A-498(a) that commissioners approve a board of health rule on smoking was likely intended to be procedural in nature, not substantive, and as such does not alter either the content or the territorial reach of the board of health rule.

- Further, G.S. 130A-498(e) likely was not intended to limit the territorial jurisdiction of a local board of health rule regulating smoking by limiting the scope of the county commissioners' approval ordinance. The subsection predates the requirement for the approval ordinance, so that cannot have been its original intent, though it could have become part of the intent when the statute was amended. However, an interpretation that had the effect of limiting the reach of board of health rules would render the board of health's rule-making authority meaningless and more advisory than regulatory in nature. It could even produce the odd result that a board of health rule would be applicable only within municipalities and not within the unincorporated parts of the county, though that seems an absurd result. None of these outcomes aligns well with the overarching purposes of the statutes granting rule-making authority to boards of health and extending that authority to local smoking regulation.

My ultimate conclusion is that a board of health rule governing smoking is effective throughout the board's jurisdiction—including within municipalities—upon the board of county commissioners' adoption of an ordinance approving the rule.