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Tobacco: A Legal and Policy Issue of the Elderly

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I. Introduction

Food and Drug Administration Commissioner David Kessler calls tobacco a "pediatric disease" /1/ because almost 90 percent of current smokers started by the time they were 18 years old. /2/ However, about 14 million persons aged 50 and over are currently smokers, /3/ and over 434,000 current and former smokers, most of whom are middle-aged and older, die annually in the United States from tobacco-related diseases. /4/ Another 53,000 Americans (also mainly middle-aged and older) who never smoked die annually from the effects of secondhand smoke, /5/ largely of heart, lung, and cancer diseases. Tobacco clearly is also a "geriatric disease."

This article is intended to highlight how older Americans are particularly affected by the devastation that tobacco inflicts on the nation and to give an overview, concerning tobacco, of the legal and policy issues that affect elders and require further action by the legal community. Focusing on tobacco issues that affect our nation’s most vulnerable citizens -- our children and elders -- will enhance efforts to halt the scourge of tobacco.

The ravages of tobacco-related diseases on older Americans and the enormous financial costs of these diseases for the health care and social security systems make tobacco a significant legal and policy issue of the elderly. Direct medical costs related to smoking in 1993 in the United States were $50 billion. /6/ Former Health, Education, and Welfare Secretary Joseph Califano, now president of the Center on Addiction and Substance Abuse, estimates that in the next 20 years Medicare will pay $800 billion to treat tobacco-related diseases, /7/ and social security will pay $4.6 billion in disability benefits in 1995 alone to persons crippled by tobacco-related diseases. /8/ Califano reported that, in 1994, of $87 billion Medicare spent on inpatient hospital care, $16 billion went for conditions attributable to smoking. /9/ Underscoring the importance of tobacco as a public policy issue that concerns the elderly, Califano stated:

> The Annual Report of the Trustees of the Federal Hospital Insurance Trust Fund released in April, 1994 projected that the Medicare program will run out of money in seven years. . . . [T]he proposed solutions involve raising taxes or cutting benefits. . . . [H]owever, little time is spent in thinking about how we can keep elderly people healthy and avert hospitalizations. The worst example of this is our failure to move aggressively on the pervasive impact of substance abuse, including tobacco, alcohol and drugs, on both Medicare and overall health costs. . . . If the problems of

> substance abuse did not exist, we would not now be concerned about the solvency of the Hospital Trust Fund. /10/

Tobacco is a public policy and legal issue for older nonsmokers as well as smokers. In its 1992 report, the Environmental Protection Agency (EPA) concluded that environmental tobacco smoke (ETS): is a human carcinogen /11/ (i.e., there is a causal relationship between ETS and cancer), causes at least 3,000 lung cancer deaths annually, /12/ and "has subtle but statistically significant effects on the respiratory health of nonsmoking adults." /13/ Other studies have concluded that 53,000 Americans die annually from ETS-related heart disease and cancer. /14/ Due to the higher prevalence of respiratory and heart problems among older persons, ETS is of particular concern to the almost 70 million Americans aged 50 and over, who comprise 26 percent of the total U.S. population. Thus, local, state, and federal policies to mandate smoke-free public places are especially important to the health of older Americans.

The legal issues of tobacco and the elderly go far beyond public policy concerns. In spite of the tobacco industry's accurate boast that until 1996 /15/ it had never paid one cent in judgments, litigation against the tobacco industry is surging. Older Americans often are either the individual plaintiffs, as in the Cipollone and Carter cases, /16/ or a sizable part of potential classes, as in the Medicaid suits recently filed against the major tobacco companies by over ten states to recover the states' costs of providing medical care for Medicaid beneficiaries who had tobacco-related diseases. Since the physical horrors of smoking -- lung and other cancers, heart attacks, etc. -- attack primarily older persons, older Americans are most likely to be in the forefront of litigation seeking damages, appealing denials of health care coverage for treatment of tobacco-related diseases, or seeking injunctive relief to gain smoke-free workplaces or facilities.

While older Americans constitute about 30 percent of current adult smokers, /17/ and major public programs such as Medicare, Medicaid, and social security are profoundly affected by the health effects of tobacco, little research exists on matters concerning tobacco and the elderly. Even less attention has been focused specifically on legal and public policy issues related to tobacco and the elderly. This article, therefore, offers an overview, in regard to tobacco and elders, of current legal and policy issues that are ripe for further action by the legal and advocacy communities.

II. Policy Issues

A. Smoking Cessation and Health Care Coverage

The benefits of smoking cessation -- even for older persons -- have been well documented, /18/ and reports from the Surgeon General, the U.S. Preventive Services Task Force, and others have focused attention on the importance of coverage by health insurance of smoking-cessation services. /19/ Nevertheless, most private and public health insurance plans in the United States do not cover smoking-cessation services. /20/ Private health insurers are unlikely to add smoking-cessation services as a covered benefit until it has been shown that there is a good market for such services and that such services are cost-effective. /21/ When private insurers do cover smoking cessation, it is usually to treat smoking-related diseases, such as lung cancer or emphysema, rather than to

prevent them. /22/ State Medicaid programs have the option to cover smoking-cessation services as part of preventive services /23/ and/or as part of prenatal care. /24/ However, Medicare, in which almost all individuals 65 years of age and older currently participate, does not cover smoking-cessation services /25/ except under demonstration programs. /26/ This overall lack of coverage for smoking-cessation services may explain in part the low percentage of U.S. smokers who have received formal cessation treatment and why low-income Americans have received the least amount of smoking-cessation assistance. /27/

The increasing move to managed health care, however, may add to the number of older individuals who have access to smoking-cessation services. Approximately 4.2 million older individuals who receive Medicare are enrolled in managed care organizations (MCOs), /28/ and the numbers continue to rise. /29/ In addition, elderly Medicaid beneficiaries increasingly are becoming enrolled in managed care programs. /30/ Forty-two states had, by June 1994, a Medicaid managed care program, with 24 percent of Medicaid beneficiaries (7.8 million individuals) enrolled nationwide. /31/ While most Medicaid recipients currently enrolled in MCOs are not elderly, the number of older individuals enrolled in such programs is rising and is expected to continue to rise dramatically in the future. MCOs will play an increasingly significant role in the medical care that millions of elderly receive.

Because MCOs historically have emphasized the importance of prevention, one would expect these plans to offer preventive services such as smoking cessation. And, indeed, studies of insurance coverage for preventive services show that health maintenance organizations (HMOs) are the most likely to cover such services. /32/ However, many still do not provide this type of coverage. For instance, one recent study found that 33 percent of all people enrolled in HMOs in 1992 were not covered for smoking cessation. /33/ A 1993 survey of 147 HMOs revealed that 40 percent did not cover smoking-cessation services under their plans. /34/ Additionally, in 1993, approximately 25 percent of preferred provider organizations offered health promotion and disease prevention services. /35/

In deciding whether to provide preventive services such as smoking-cessation treatment, health care insurers are likely to continue to balance the need for preventive health services against the costs of providing health care, short-term competitive forces, and evidence of the efficacy of various types of prevention programs. /36/ Unfortunately, results of studies of intervention and smoking-cessation programs often conflict or demonstrate only a limited effect on smoking-cessation rates. /37/ Some studies, however, have found that tailoring programs to a specific audience (e.g., older individuals) achieves higher rates of smoking cessation than programs targeted to smokers generally. /38/

Smoking-cessation treatment may be even more out of the reach of low-income smokers who cannot afford the financial costs and do not participate in MCOs with smoking-cessation-treatment coverage. Because elderly people are more likely than other adults to be poor, /39/ cost of treatment is an important issue. While low-income elderly smokers may benefit greatly from treatment, /40/ smoking-cessation services, and particularly pharmacological treatments (nicotine gum, patches, and nasal spray), are rarely covered as preventive therapy and may simply be too expensive for the individual to purchase.

When covered by an insurer, prescription drugs are usually limited to those specifically prescribed for the treatment of a medical condition, that is, coverage for nicotine patches or gum is generally available only to those individuals with diagnosed smoking-related diseases. /41/ Medicare does not cover outpatient prescription drugs, Medicaid or state-financed drug plans are available only in some states, /42/ and not all employers offer prescription plans. Further, prescription drug plans may no longer provide coverage for nicotine patch or gum treatment since either has been approved for sale without a prescription by the Food and Drug Administration. /43/ Greater accessibility through over-the-counter sales may actually result in reduced accessibility for low-income elderly smokers.

B. Environmental Tobacco Smoke

1. Effect on the Elderly

Each year approximately 53,000 Americans die of diseases caused by exposure to ETS. /44/ which consists of both side-stream smoke (smoke emitted from burning tobacco between puffs by a smoker) and exhaled mainstream smoke (smoke inhaled by a smoker). /45/ Exposure to ETS is also commonly known as "passive smoking." Individuals are passive smokers when, because of close proximity to a smoker or because of an enclosed environment, they are forced to inhale ETS. Because of "serious health concerns" regarding ETS, and an awareness of a plethora of scientific studies finding that exposure to ETS causes a number of health problems, EPA recently analyzed and reviewed available data on the effects of passive smoking. EPA concluded that, while more dilute than mainstream smoke, ETS contains essentially the same cancer-causing and other toxic elements. /46/ In fact, EPA found ETS to be such a danger that it has classified ETS as a "Group A," known human carcinogen. /47/ The report released by EPA concluded that passive smoking causes lung cancer /48/ and other respiratory diseases. /49/ Studies conducted after the release of the EPA report have found that exposure to ETS also increases the risk of heart disease. /50/

Although over 80 percent of persons over 65 years old do not smoke, /51/ the nearly 50 million adult Americans who do smoke make it likely that virtually all Americans, including older persons, are at high risk of exposure to ETS. /52/ Exposure to ETS causes health problems in individuals of all ages. It is a particular concern for older persons, especially those with preexisting heart and respiratory diseases or disorders such as emphysema, asthma, allergies, or coronary artery disease. /53/ Exposure to ETS has been found to induce the onset of angina, arrhythmia, /54/ and the symptoms of bronchial asthma. /55/ In addition, passive smoking may cause nonsmoking adults to experience coughing, phlegm production, chest discomfort, and reduced lung function. /56/

2. Work Environment

While most older persons have retired, many remain active in the work force. In addition, older individuals as a group are more likely to suffer from disabilities, including respiratory and cardiovascular disease. For older working individuals, and those with disabilities in particular,

exposure to ETS in the workplace presents unnecessary health risks and may prevent them from adequately performing their jobs. Many employers and public facilities are sensitive to the health risks associated with passive smoking and have increased ventilation rates, installed air cleaning systems, and designated smoking sections to improve the air quality inside their buildings. While these changes have significantly improved the workplace environment, studies show that many of these limited smoking policies may not adequately reduce the risk from exposure to ETS. /57/ The least costly and most effective way to eliminate all risk to all individuals continues to be a no-smoking policy.

In recent years, a number of states have enacted smoke-free indoor air restrictions in state government work sites /58/ and in private work sites. /59/ While most of these laws allow substantial discretion for employers to provide smoking areas, employers are clearly moving to reduce smoking in the work setting. In addition, after discussions which began in the mid-1980s, the federal Occupational Safety and Health Administration (OSHA), in 1994, issued draft regulations which would require all workplaces to be smoke free, with smoking to be permitted only in separately ventilated areas. /60/ The OSHA proposal, if promulgated as issued, would have Herculean effects on protecting workers of all ages from ETS but would also have the side effect of protecting consumers who enter these workplaces, including possibly restaurants, bars, and other workplaces. /61/

3. Hospitals and Long-Term Care Facilities

As a result of state laws and accreditation requirements, smoking in hospitals has been virtually eliminated. Forty-two states, as of 1995, had passed laws restricting smoking in hospitals. /62/ In addition, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that smoking by employees, visitors, and patients be prohibited in all hospital buildings, with limited exceptions for patients with physician authorization; /63/ for instance, a hospital may choose to permit smoking in its psychiatric center if many of its psychiatric patients are addicted to tobacco. /64/ Smoking policies for Department of Veterans Affairs (VA) hospitals, unfortunately, are lagging behind. /65/ Previous policy for VA hospitals prohibited in-hospital smoking by patients, staff, or visitors. /66/ However, legislation passed in 1992 now requires VA facilities to establish and maintain either "a suitable indoor area in which patients or residents may smoke" or a smoking area in a separate building that is acc
essible to patients or residents of the facility. /67/

The imposition of smoking restrictions in long-term care facilities seems to be a somewhat more complex issue. Administrators and residents of long-term care facilities are concerned about the negative health effects of passive smoking on staff and residents /68/ and about the possibility of accidental fire resulting from resident smoking. /69/ However, the needs and concerns of nonsmoking residents must be balanced against the needs of smoking residents; this raises difficult issues when considering a smoking ban. For instance, is it ethical to impose a no-smoking policy on smokers who are likely to be permanent residents in an institution? Should cognitively impaired residents be required to stop smoking? /70/

While concerns remain about the appropriateness of imposing smoking restrictions in long-term care facilities, acceptance of greater regulation seems to be increasing. /71/ For example, Medicare and Medicaid both impose smoking restrictions and allow facilities to prohibit smoking by future residents. /72/In addition, the JCAHO standards for long-term care require that "the organization disseminate and enforce an organization-wide smoking policy that discourages the use of smoking materials by patients/residents." /73/If long-term care facilities do permit smoking, they must institute policies that "minimize to the greatest extent possible the use of smoking materials, and confine allowed smoking to a designated location(s) that is separated from nonsmoking patients/residents." /74/

4. Other Facilities Serving the Elderly

Millions of older persons live in or utilize facilities that provide specialized services for their care, such as continuing care retirement communities, assisted living facilities, public housing for the elderly, senior centers, congregate meal sites, and adult day care facilities. However, because these facilities are so diverse in their purposes and the nature of their regulation (if any), the approaches they take to protect users from ETS have little uniformity. Health-related facilities are most likely to ban or restrict smoking, while facilities such as senior centers appear more likely to allow smoking. Generally, any regulation is done through state or local health department regulations or through local ordinances which apply more broadly to "public places." However, the lack of any comprehensive study of these types of facilities makes unclear how and whether the health of elders using these facilities is being protected from the effects of ETS. Now that the clear dangers of ETS are known, particularly for the elderly, issues of smoke-free facilities are especially ripe for action.

5. Public Places

Public places commonly frequented by older persons include restaurants, bars, stores and shops, shopping malls, libraries, theaters, civic centers and arenas, bingo establishments, etc. Smoking restrictions affecting these locations vary by state and locality, with some statewide regulation and some handled locally by ordinances or health department regulations. /75/ In the past few years, the regulation of smoking in public places has become a major battleground between organizations concerned about the health effects of ETS and the tobacco industry. Thus far, only infrequently have organizations representing the elderly been very involved in the efforts to enact measures to protect the public from ETS in these locations.

The crux of the controversy over smoke-free public places has centered on whether there is any way to protect persons from the dangers of ETS without having either totally smoke-free facilities or those which allow a smoking area but only if it is separated from nonsmoking areas and separately ventilated. The tobacco industry has maintained that smokers should be "accommodated" with smoking and nonsmoking sections and that these sections need not be separately ventilated; health experts have maintained that such a proposal is akin to trying to have a nonchlorinated section of a swimming pool -- it simply is not possible. Areas of greatest

controversy have been restaurants, bars, bingo facilities, and bowling alleys, whereas theaters, civic centers and arenas, shopping centers, stores, and libraries have been much less controversial.

By 1995, a total of 32 states had implemented smoking restrictions in restaurants, 30 in grocery stores, 42 in certain forms of transportation and 23 in enclosed arenas. /76/ However, many of these statewide laws do not totally ban smoking in these facilities; for example, only Utah and Vermont completely ban smoking in restaurants, and California bans smoking in restaurants and/or requires separate smoking areas that are separately ventilated. /77/ Most statewide laws on smoke-free facilities state that a certain percentage of the seating in restaurants must be for smoking or that certain areas must be set aside for smoking in other public facilities. In recent years, increasing numbers of cities/towns have enacted ordinances that specifically require totally smoke-free facilities, including restaurants.

The major opposition to these laws has come from the tobacco industry, which is particularly strong on the federal and state levels where their lobbying dollars are most effective in influencing public policy. /78/ One of the major strategies of the tobacco lobby has been to gain passage of statewide laws requiring that public facilities have certain percentages of seating for smokers and for nonsmokers (thereby ensuring that facilities are not totally smoke free or separately ventilated), and having these laws preempt stronger local laws. /79/ As long as public facilities are not smoke free, older persons, especially those with respiratory problems, are at substantial risk of harm from ETS.

In addition to seeking statewide or local laws requiring smoke-free public places, the Americans with Disabilities Act also provides protection against ETS with respect to these public places (see section III.A infra).

6. Smoke-free Environments for Children and Grandchildren

Older persons' grandchildren are not immune to the harmful effects of ETS. EPA has concluded that in children, ETS exposure in the home and elsewhere causes noncancer respiratory diseases and disorders, including pneumonia, bronchitis, colds, flu, and ear infections, resulting in 7,500 -- 15,000 annual hospitalizations. /80/ In addition, passive smoking increases the severity of asthma in children who have the disease and may cause previously healthy children to develop the disease. /81/ Aware of the dangers of ETS exposure to children, particularly those children with respiratory problems, courts, in custody proceedings, are increasingly considering parents' smoking activities when determining which parent is granted custody of their children. /82/

III. Litigation on Environmental Tobacco Smoke and Smoking-Related Injury

A. Americans with Disabilities Act

The aging process is frequently associated with an increase in disabling conditions. Certain disabilities (e.g., lung and heart disease) are diagnosed more frequently in older adults than in other individuals. /83/ As discussed above, passive smoking by older persons -- especially those with preexisting disease -- can result in significant negative health consequences. The risk of danger can be so high for some individuals that they are unable to enter locations such as restaurants or their place of work. /84/ Today, the Americans with Disabilities Act (ADA) can be used as a tool to protect the rights of those individuals.

The general purpose of the ADA is to eliminate discrimination against persons with disabilities. Under the ADA, an "individual with a disability" includes someone with a "physical . . . impairment that substantially limits one or more of the major life activities of such individual." /85/ A "physical impairment" includes disorders or conditions that affect respiratory or cardiovascular systems, /86/ and "major life activities" /87/ includes breathing, speaking and working. /88/ Therefore, the ADA may cover individuals who suffer from asthma, emphysema, cystic fibrosis, chronic obstructive pulmonary diseases, lung cancer, or who, because of cardiovascular disease, must avoid exposure to ETS. /89/

Courts have held that the ADA covers claims by individuals sensitive to smoke who seek smoking bans /90/ and that whether an allergy to tobacco smoke is a disability must be determined on a case-by-case analysis applied to all other impairments. /91/ The ADA also provides that "nothing in this [Act] shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. Sec. 790 et seq.)." /92/ Courts have found that asthma, /93/ cystic fibrosis, /94/ and hypersensitivity to ETS /95/ can be disabilities under the Rehabilitation Act. /96/ Under the ADA specifically, courts have found that bronchial asthma /97/ and cystic fibrosis /98/ are disabilities.

Once an individual is found to have an impairment covered by the ADA, the question is, What is a reasonable accommodation? The ADA does not define "reasonable accommodation," and cases interpreting the statute have not articulated a precise test to determine if an accommodation is reasonable. However "it is clear that the determination of whether a particular modification is reasonable involves a fact-specific, case-by-case inquiry that considers, among other factors, the effectiveness of the modification in light of the nature of the disability in question and the cost to the organization that would implement it." /99/ With respect to smoking, the ADA specifically states that "[n]othing in this [Act] shall be construed to preclude the prohibition of, or the imposition of restrictions on, smoking . . . " /100/ So while there is no clear definition of "reasonable accommodation," it appears that a smoking ban, if reasonable under the circumstances, may be imposed.

1. Public Accommodations

Title III of the ADA prohibits discrimination based on disability with respect to the "full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." /101/ As defined in the ADA, the term "public accommodation" refers to most private businesses, including hotels, retail stores, movie theaters, bars, offices of health care

providers, libraries, senior citizen centers, spectator sports facilities, restaurants, and other establishments. /102/ These covered entities must

make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privilege, advantages, or accommodations . . . to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services . . . or accommodations. /103/

A public accommodation, however, "is not required to take any action that would result in a fundamental alteration of a service, program, or activity or would cause undue financial and administrative burdens." /104/

As discussed above, the ADA does not define the term "reasonable accommodation" as it applies to entities covered by Title III. A recent decision by the Second Circuit Court of Appeals, Staron v. McDonald's Corp., /105/ states that the decision as to what is a reasonable accommodation by a public accommodation is to be made on a case-by-case basis and does not rule out the possibility of a complete smoking ban as a reasonable accommodation. /106/

In Staron v. McDonald's Corp., the plaintiffs -- three children with asthma and a woman with lupus -- sued McDonald's and Burger King restaurants, alleging discrimination under the ADA and seeking a complete smoking ban at all of the defendants' restaurants. The plaintiffs' claim was based on several instances of being unable to enter the defendants' restaurants because each restaurant was full of tobacco smoke and caused them to experience breathing problems. They sought a declaratory judgment that the restaurants' smoking policies were discriminatory under the ADA; an injunction that would prohibit the restaurants from maintaining policies that would interfere with plaintiffs' rights under the ADA; and the imposition by the defendants of a complete smoking ban in all of their facilities. /107/ The trial court, in dismissing the case, found that a complete smoking ban was not a reasonable modification, as a matter of law.

The Circuit Court reversed the trial court's decision and remanded the case. The court specifically stated that whether an action was a reasonable modification was to be decided by the facts, on a case-by-case basis "that considers, among other factors, the effectiveness of the modification in light of the nature of the disability in question and the cost to the organization that would implement it." /108/ Therefore, although previous courts that had dealt with the issue of reasonable modification for a smoke-sensitive disability had not found a total ban to be necessary, the court saw "no reason why, under the appropriate circumstances, a ban on smoking could not be a reasonable modification," /109/ that is, whether a complete smoking ban is a reasonable accommodation is an issue of fact to decided by a trial. /110/

2. The Workplace

Title I of the ADA covers private employers, employment agencies, labor organizations, joint labor-management committees, and state and local governments that have 15 or more employees. /111/ It prohibits discrimination against a "qualified individual with a disability," with respect to various employment practices, including "hiring, advancement, or discharge of employees,

employee compensation, job training, and other terms, conditions, and privileges of employment." /112/ An individual with a disability /113/ is qualified if he or she is "an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position such individual holds or desires, and who, with or without reasonable accommodation, can perform the essential function of such position." /114/ If the claimant is indeed a qualified individual with a disability, the employer must provide a "reasonable accommodation." Again, what constitutes a reasonable accommodation varies according to the circumstances and is decided on a case-by-case basis. In an ETS case, it may range anywhere from a change of office location to a complete smoking ban. /115/ Courts have held that reasonable accommodations may include having separate smoking areas, no smoking restrooms, fans, and smokeless ashtrays. /116/

It is the disabled individual's responsibility to notify the employer of his or her disability (e.g., the individual must communicate that he or she suffers from a respiratory disorder and needs to be accommodated). The employer may choose the type of accommodation, as long as it is effective. /117/ If an employer fails to provide a reasonable accommodation to a qualified disabled individual, the employer commits prohibited discrimination under the ADA. /118/ Note, however, that the employer is not required to provide an accommodation that causes the employer to suffer "undue hardship." /119/

While courts have required employers to accommodate employees found to have a disability based on or aggravated by exposure to ETS, no court has yet required an employer to impose a complete smoking ban in its facilities. /120/ The first ETS case brought under the ADA to be decided is Harmer v. Virginia Electric and Power Co. /121/ In Harmer, an employee sued his employer, a large utilities company, alleging that employer's failure to create a completely smoke-free environment was a failure to accommodate his bronchial asthma under the ADA. While awaiting trial, the defendant provided smokeless ashtrays and filtration devices and banned smoking except in separately ventilated and designated smoking rooms. The Court held that although the ADA protected plaintiff from discrimination for his disability, /122/ defendant provided a reasonable accommodation under which the plaintiff was able to perform the essential functions of his position, and therefore a complete smoking ban was not required. /123/

Although the court in Harmer did not deem a complete smoking ban to be necessary, it recognized that the plaintiff's bronchial asthma, which is severely aggravated by tobacco smoke, is a disability covered by the ADA for which a reasonable accommodation must be made. In this particular instance, the court felt that a smoking ban was not required; however, the court did not state that a smoking ban would never be a reasonable accommodation. It is noteworthy that the defendant in this case was a company with sufficient funds to implement what can be costly accommodations. In the future, a court may rule that a less prosperous defendant must implement a no-smoking policy -- an effective and cost-free solution.

In another more recent case, Bell v. Elmhurst Chicago Stone Co., a claimant's suit against his former employer alleged a violation of the ADA. /124/ The court found that the claimant's bronchial asthma substantially limited his ability to breathe, qualifying him as disabled within the meaning of the ADA. Because his ability to breathe was so limited, the court also found that he need not show in order to be covered by the ADA that his ability to work was also "substantially limited." /125/

B. Other Approaches

Employees exposed to ETS in the workplace have sued their employers under a great variety of other legal theories, including wrongful discharge, common-law negligence, intentional or negligent infliction of emotional distress, assault and battery, the National Labor Relations Act, Title VII, the common-law duty to provide a safe workplace, /126/ workers' compensation acts, unemployment compensation acts, and constitutional law. /127/ While some claims have been successful, and others unsuccessful, overall the court decisions increasingly recognize the dangers of exposure to ETS. A brief review of the legal theories most frequently employed follows.

1. State Workers' Compensation Laws

Generally, state workers' compensation statutes allow individuals to seek monetary damages for employment-related accidents or diseases. In fact, most plaintiffs seeking monetary damages based on exposure to ETS in the workplace have sought relief through the states' workers' compensation statutes. Because laws are state specific, they vary.

In dealing with a workers' compensation claim, several courts have held that the severity of ETS exposure in an office can cause an "accidental injury" under workers' compensation laws. /128/ In a recent case, for instance, the New York Court of Appeals found that a claimant's bronchial asthma, aggravated by exposure to "excessive amounts of secondhand cigarette smoke in a confined work environment," constituted a compensable accidental injury under the state's workers' compensation law. /129/ Courts have found that accidental injuries may include contracting bronchial asthma, collapsing due to exacerbation of preexisting asthmatic conditions, and collapsing due to allergic reactions to tobacco smoke. /130/ Other courts, however, have rejected claims and stated that the injuries were only temporary since they healed after the individual was removed from the injuring situation. /131/ In addition, several courts have found that workers' compensation benefits may not be granted for a claim of "occupational disea se" based on exposure to ETS. /132/ Note that a court's analysis of and findings on the plaintiff's claim for benefits may depend greatly on whether the claim is for an accidental injury or an occupational disease. /133/

Of particular interest is a recent case in which the husband of a nurse, who worked in the smoke-filled psychiatric ward of a VA hospital, claimed workers' compensation benefits after his wife died from lung cancer. /134/ The husband was awarded these benefits. This may be the first time workers' compensation benefits have been granted for a death linked to ETS exposure. /135/

2. Common Law

If the state workers' compensation law does not cover accidental injuries and disease due to ETS as a matter of law, a plaintiff may also sue an employer under a common-law theory (common-law negligence or breach of duty to provide a safe working environment). In the landmark case Shimp

v. New Jersey Bell Telephone Co., the plaintiff, who was allergic to ETS, sought a smoking ban in her work area. /136/ The court reviewed evidence about the dangers of exposure to ETS, found that the employer was under a duty to provide safe working conditions for its employees, and therefore granted the plaintiff's request to enjoin the employer from allowing employees to smoke within the office area, except for the lunchroom and lounge, the designated smoking area. /137/ Other cases, however, have found that the "common law does not impose upon an employer the duty or burden to conform his workplace to the particular needs or sensitivities of an individual employee." /138/

3. Unemployment Compensation.

Still other claimants have sought unemployment compensation benefits based on ETS exposure. For instance, in Lapham v. Pennsylvania Unemployment Compensation Board, an employee suffered from allergic bronchitis due to exposure to cigarette smoke in her work area. /139/ Because of strong evidence of the negative health effects of tobacco and the employer's failure to offer the claimant a reasonable accommodation -- compelling her to resign -- the court held that the claimant had a right to receive unemployment compensation benefits. Other courts have also found that where an employee's medical condition is aggravated by exposure to ETS or an employee is forced to work in an enclosed area where other employees are smoking, the employee may be awarded unemployment compensation. /140/ However, other courts have not awarded unemployment compensation benefits when the employee fails to provide adequate evidence that exposure to ETS constitutes a health risk. /141/

C. Class Action Suits

In the past three years, a major new wave of litigation, seeking to equalize the balance of power between the plaintiffs and the tobacco companies, has confronted the tobacco industry. Previously, the tobacco industry's enormous financial resources produced an imbalance of power which enabled it to outspend and outlast the plaintiffs, such as in the Cipollone case discussed earlier. In this new wave of litigation, the plaintiffs are either the government, attorneys general or the U.S. Justice Department, or private attorneys who have substantial financial resources to invest in the litigation. /142/ Following the legal theories and strategies used in asbestos class action lawsuits, class action suits have been a primary strategy of private attorneys.

In Castano v. American Tobacco Co. a consortium of 60 law firms joined forces to bring the largest nationwide class action suit ever filed. /143/ The suit, against all the major tobacco companies, was filed on behalf of all the current approximately 50 million smokers in the United States and sought damages for the class on the basis of the tobacco industry having concealed knowledge that nicotine was addictive and having manipulated nicotine levels in cigarettes to keep smokers addicted. On May 23, 1996, the Fifth Circuit Court of Appeals in New Orleans, in unanimously dismissing the case, ruled that the nationwide class would be too unwieldy to handle. /144/ However, the plaintiffs' attorneys have already filed statewide class action suits against the tobacco firms in the District of Columbia and a number of states, including Louisiana, Maryland, and New Mexico, and expect to file in many more states, thereby hoping to avoid some of the problems inherent in a nationwide class. /145/

In Florida, a private attorney has filed two major class action suits against the tobacco industry. In Broin v. Philip Morris Cos. a nationwide class has been certified consisting of airline flight attendants who are seeking damages for injuries from secondhand smoke that filled airplanes prior to the advent of smoke-free flights. /146/ A second class action suit, Engle v. R.J. Reynolds Tobacco Co., by the same attorney seeks damages for smoke-related injuries suffered by all Florida's current and former smokers. /147/ The Broin case is expected to go to trial early in 1997.

While few attorneys have the resources to take on such class action suits against such a formidable adversary as the tobacco industry many individuals, wealthy and poor alike, may be eligible for damages if the class action route proves successful.

IV. Cost-Reimbursement Litigation

A. Medicaid Suits

"In FY'94, the combined Federal and state payments under the Medicaid program are estimated to reach $146 billion. Of this total, hospital costs (including psychiatric facilities) will represent 28 percent or $41 billion," according to the Center on Addiction and Substance Abuse (CASA) at Columbia University. /148/ CASA estimated that one out of five Medicaid hospital days (20 percent) is associated with substance abuse, /149/ which includes tobacco, alcohol, and illicit drugs, and that 41 percent of these days are related to tobacco. /150/ Thus, in fiscal year 1994 alone, tobacco-related diseases of Medicaid beneficiaries accounted for hospital costs totaling about $3.4 billion.

Under their Medicaid programs, states and the federal government have been paying billions of dollars every year for treatment of diseases caused by a product that while legal, if used as intended by the tobacco industry, ravages and kills its users. This prompted first Mississippi, then Florida, and now over ten states to sue the major tobacco companies to recover these costs. /151/ Mississippi Attorney General Mike Moore stated very concisely, "This lawsuit is premised on a simple notion -- you cause the health crisis, you pay for it." /152/ While each state is proceeding on similar, though slightly different, legal theories, these are all medical cost-reimbursement suits that seek to transfer the costs of Medicaid-financed medical care from the injured states to the responsible party, the tobacco industry. /153/

While the number of states filing Medicaid cost-reimbursement suits continues to grow, on June 19, 1996, Senator Frank Lautenberg (D-N.J.) introduced Senate bill number 1892, which is intended to encourage even more states to sue the tobacco industry. Since Medicaid is currently funded by both state and federal dollars, if states win their suits, each state would have to return a portion of any damage awards to the federal government. Senator Lautenberg's legislation would allow states to retain one-third of the federal share of the award for use as nonfederal share under the states' Medicaid programs, designate one-third of the federal share to the National Institutes of Health trust fund for the purpose of conducting disease research, and earmark the remaining one-third for deficit reduction.

B. Medicare Suits

At this time, no lawsuits seeking reimbursement for Medicare expenditures made for tobacco-related diseases have been filed against the tobacco industry. However, many of the legal theories being utilized in the Medicaid suits may also apply to Medicare suits. The Justice Department and Department of Health and Human Services are currently assessing whether to file suit against the tobacco industry to recover tobacco-related Medicare expenditures.

V. Conclusion

Since modern cigarettes were introduced in 1913, millions of lives have been lost and billions of health care dollars spent as a result of tobacco-related diseases. Tobacco industry advertising and promotions have hooked generation after generation of youth. Addiction to nicotine would hold these smokers, too often until tobacco-related diseases snuffed out their lives in their later years. Now the evidence mounts almost daily showing that the tobacco industry has knowingly marketed products that it knew to be addictive and lethal to smokers and nonsmokers alike. /154/

Because so many older Americans -- both smokers and nonsmokers -- are victims of tobacco and ETS-related diseases, tobacco is an older person's issue. For too long, the innocent victims have suffered, and the perpetrators of the harm have simply reaped the profits of their deadly products. The personal and health care cost issues related to tobacco and older Americans cannot be ignored any longer.

This article has been intended to provide background information on legal issues relating to tobacco and the elderly and to serve as a catalyst for action by the legal community. Public policy remedies are now available to protect nonsmokers from ETS and to assist smokers in quitting. Litigation strategies are evolving daily to protect potential victims and to provide restitution to past and current victims of tobacco-related diseases. It remains for the legal community in both the public and private bar to address these issues on behalf of older Americans.

Footnotes

/1/ Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco Products to Protect Children and Adolescents, 60 Fed. Reg. 41313 (1995) (to be codified at 21 C.F.R. pts. 801, 803 -- 4, 897) (proposed Aug. 11, 1995).

/2/ David E. Nelson et al., Trends in Cigarette Smoking Among U.S. Adolescents, 1974 Through 1991, 85 Am. J. Pub. Health 34 (1995).

/3/ Approximately 15 percent of men and 12 percent of women aged 65 and over are smokers, or about 4 million out of 31 million persons. About 28 percent of men and women between 50 and 64 are smokers, or over 10 million out of 36 million persons. See Centers for Disease Control and Prevention, Cigarette Smoking Among Adults -- United States, 43 Morbidity & Mortality Wkly. Rep. 926 (Dec. 23, 1994). See also Barbara K. Rimer & C. Tracy Orleans, Older Smokers, in Nicotine Addiction: Principles and Management 385 (C. Tracy Orleans & John Slade eds., 1993).

/4/ U.S. Dep't of Health & Human Servs., Preventing Tobacco Use Among Young People: A Report of the Surgeon General (1994) [introductory letter from Secretary of Health and Human Services Donna Shalala].

/5/ Stanton A. Glantz & William W. Parmley, Passive Smoking and Heart Disease: Epidemiology, Physiology, and Biochemistry, 83 Circulation 1 (1991). See also James L. Repace & Alfred H. Lowrey, An Enforceable Indoor Air Quality Standard for Environmental Tobacco Smoke in the Workplace, 13 Risk Analysis 463, 463 -- 64 (1993).

/6/ Office on Smoking and Health, Centers for Disease Control and Prevention, State Tobacco Control Highlights 1996 112 (1996).

/7/ Joseph Califano, The Impact of Substance Abuse, 4 Tobacco Control S20 (Autumn 1995 Supp. 2).

/8/ Id.

/9/ Adam Clymer, Addiction Center Says Tobacco's Hospital Costs Will Imperil Medicare, N.Y. Times, May 17, 1994, at A-14; Medicare's Big Cigarette Burn, N.Y. Times, May 18, 1994, at A-18.

/10/ Center on Addiction and Substance Abuse, Columbia University, The Cost of Substance Abuse to America's Health Care System -- Report 2: Medicare Hospital Costs 1 (1994).

/11/ Environmental Protection Agency, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders 5-68 (1992).

/12/ Id. at 6-31.

/13/ Id. at 7-70.

/14/ Glantz & Parmley, supra note 5. See also Repace & Lowrey, supra note 5, at 463 -- 64.

/15/ The first instance of the tobacco industry ever making payments in response to a lawsuit by aggrieved smokers came when Liggett & Myers agreed to settle both a major class action suit, Castano v. American Tobacco Co. , 84 F.3d 734 (5th Cir. 1996), and suits brought by five states to recover Medicaid costs incurred to cover treatment of tobacco-related diseases. In this settlement, entered into on March 12, 1996, Liggett & Myers broke ranks with the other major tobacco industry defendants, possibly as a business tactic to assist the major shareholder in Liggett in his

takeover attempt (later unsuccessful) of R. J. Reynolds Tobacco. The settlement is expected to cost Liggett over $50 million over 25 years. The second instance in which the tobacco industry may actually pay is the $750,000 judgment awarded by a Jacksonville, Florida, jury to Grady Carter, a 66-year-old lung cancer victim who had smoked for 44 years. Brown & Williamson Tobacco has appealed the Aug. 9, 1996, decision, so whether this will become the first such judgment the tobacco industry will pay remains uncertain. See Carter v. Brown & Williamson Tobacco Corp. [CITE]

/16/ Rose Cipollone filed suit against three tobacco companies in 1983 for damages for misrepresenting the risks of smoking; she died in 1984 at the age of 58, of lung cancer caused by smoking one to two packs a day for over 40 years. In 1988, a jury, for the first time ever, awarded damages to the plaintiff. The case was appealed and, ultimately, heard by the U.S. Supreme Court, Cipollone v. Liggett Group, 505 U.S. 504 (1992), which remanded it to the federal district court for retrial. In 1993, just months before the scheduled retrial, the case was dropped because the plaintiff's law firm simply ran out of funds to continue the action. See supra note 15 for a brief discussion of the Carter case [CITE]. See also Stricken Smoker Awarded $750,000, N.Y. Times, Aug. 19, 1996, at A1.

/17/ As stated above, about 14 million current smokers are aged 50 and over. The Centers for Disease Control estimate that in 1993 about 46 million adult Americans were smokers. See Centers for Disease Control and Prevention, supra note 3, at 925.

/18/ See, e.g., U.S. Dep't of Health & Human Servs., The Health Benefits of Smoking Cessation (1990) [hereinafter Smoking Cessation]; Cindy. L. Jajich et al., Smoking and Heart Disease Mortality in the Elderly, 252 JAMA 2831 (1984); R.L. Rogers et al., Abstention from Cigarette Smoking Improves Cerebral Perfusion Among Elderly Chronic Smokers, 253 JAMA 2970 (1985); Smoking Cessation Offers Significant Benefits for Older Adults, Geriatrics, May 1992, at 91; and C. Tracy Orleans et al., Long-Term Psychological and Behavioral Consequences and Correlates of Smoking Cessation, in The Consequences of Smoking: A Report of the Surgeon General (1990).

/19/ See, e.g., Smoking Cessation, supra note 18; U.S. Preventive Services Task Force, Guide to Clinical Preventive Services (1989).

/20/ Helen H. Schauffler & Michael D. Parkinson, Health Insurance Coverage for Smoking Cessation Services, 20 Health Educ. Q. 187 (Summer 1993); Robert M. Kaplan et al., Marshaling the Evidence for Greater Regulation and Control of Tobacco Products: A Call for Action, 17 Annals Beh. Med. 10 (1995).

/21/ Schauffler & Parkinson, supra note 20, at 189.

/22/ Id. at 187.

/23/ Social Security Act, Sec. 1905(a)(13), 42 U.S.C.A. Sec. 1396d(a)(13) (West Supp. 1996). See Schauffler & Parkinson, supra note 20, at 189.

/24/ Social Security Act, Sec. 9501, 42 U.S.C.A. Sec. 1396d (West 1996). See Schauffler & Parkinson, supra note 20, at 189.

/25/ 42 U.S.C.A. Sec. 1395y (West Supp. 1996).

/26/ See Schauffler & Parkinson, supra note 20, at 189; Pearl S. German et al., Extended Coverage for Preventive Services for the Elderly: Response and Results in a Demonstration Population, 85 Am. J. Pub. Health 379 (1995); Lynda C. Burton et al., Preventive Services for the Elderly: Would Coverage Affect Utilization and Costs Under Medicare? 85 Am. J. Pub. Health 387 (1995).

/27/ Kaplan et al., supra note 20, at 10.

/28/ As used here, "managed care organizations" refers to the full range of models available, including various types of health maintenance organizations, preferred provider organizations, physician-hospital organizations, etc.

/29/ Charles Marwick, Health Plan Accountability Still a Long-Term Goal, 276 JAMA 10 (1996).

/30/ Note that most elderly Medicaid beneficiaries are also eligible for Medicare. For a discussion of dual eligibility, see Robert Kane et al., Managed Care Handbook for the Aging Network 68 (1996).

/31/ Id. at 55. See also Jane E. Sisk et al., Evaluation of Medicaid Managed Care, 276 JAMA 50 (1996).

/32/ Schauffler & Parkinson, supra note 20, at 188.

/33/ John M. Pinney, Review of the Current Status of Smoking Cessation in the USA: Assumptions and Realities, Tobacco Control S12 (Autumn 1995, Supp. 2) (citing Group Health Association of America, HMO Industry Profile (1993)).

/34/ Id.

/35/ Id.

/36/ For an excellent discussion of the barriers to coverage of smoking-cessation services and policy and practice recommendations, see Schauffler & Parkinson, supra note 20, at 185 -- 206.

/37/ See COMMIT Research Group, Community Intervention Trial for Smoking Cessation (COMMIT): II. Changes in Adult Cigarette Smoking Prevalence, 85 Am. J. Pub. Health 193 (1995); Malcolm Law & Jin Ling Tang, An Analysis of the Effectiveness of interventions Intended to Help People Stop Smoking, 155 Archives of Internal Med. 1933 (1995).

/38/ See C. Tracy Orleans et al., Fox Chase Cancer Center, Smoking Patterns and Quitting Motives, Barriers and Strategies Among Older Smokers Aged 50 -- 74: A Report for the American

Association of Retired Persons (Dec. 1990); Barbara K. Rimer et al., The Older Smoker: Status, Challenges and Opportunities for Intervention, 97 Chest 547 (1990).

/39/ U.S. Senate Special Comm. on Aging, Aging America Trends and Projections 41 (1991 ed.).

/40/ See, e.g., C. Tracy Orleans et al., Use of Transdermal Nicotine in a State-Level Prescription Plan for the Elderly, 271 JAMA 601 (1994).

/41/ Schauffler & Parkinson, supra note 20, at 188.

/42/ 42 U.S.C.A. Sec. 1396d(a)(12) (West Supp. 1996).

/43/ Additional concerns about the approval of over-the-counter sales of the nicotine patch and/or gum include the possibility that these products will not be used as directed because of lack of involvement by a physician or other health care professional in individuals' cessation attempts. For instance, consumers who use these products without guidance may be unaware that smoking while using these products can lead to a nicotine overdose, causing serious symptoms such as palpitations, nausea, or vomiting.

/44/ Glantz & Parmley, supra note 5.

/45/ Environmental Protection Agency, supra note 11, at 1-6.

/46/ Id. at 1-2.

/47/ Environmental tobacco smoke (ETS) has been classified as a Group A carcinogen because epidemiological studies have demonstrated a causal connection between exposure to ETS and cancer. Id. at 1-4.

/48/ Approximately 3,000 deaths due to lung cancer each year in the United States are attributed to ETS. Id. at 1 -- 4.

/49/ Id. at 1 -- 5. See also James L. Repace, Risk Management of Passive Smoking at Work and at Home, 13 St. Louis U. Pub. L. Rev. 763, 784 (1994).

/50/ See Stanton A. Glantz & William W. Parmley, Passive Smoking and Heart Disease: Mechanisms and Risks, 273 JAMA 1047 (1995).

/51/ Centers for Disease Control and Prevention, 45 Morbidity & Mortality Wkly. Rep. 581, 589 (July 12, 1996).
52Id. at 588; Environmental Protection Agency, supra note 11, at 2-2.

/53/ Harald Kritz et al., Passive Smoking and Cardiovascular Risk, 155 Archives of Internal Med. 1942 (1995); Xiping Xu & Baoluo Li, Exposure-Response Relationship Between Passive Smoking and Adult Pulmonary Function, 151 Am. J. Respiratory & Critical Care Med. 41 -- 46 (1995); Glantz & Parmley, supra note 5, at 4.

/54/ Kritz et al., supra note 53, at 1942.

/55/ Barbara K. Rimer, Smoking Among Older Adults: The Problems, Consequences and Possible Solutions, in Background Papers: Surgeon General's Workshop on Health Promotion and Aging 3 (1988).

/56/ Environmental Protection Agency, supra note 11, at 1-6.

/57/ Repace, supra note 49, at 766 -- 84.

/58/ As of December 1, 1995, seven states prohibited smoking in state government work sites, two states required designated smoking areas with separate ventilation, thirty-two required or allowed designated smoking areas, and ten states had no restrictions. Office on Smoking and Health, supra note 6, at 122.

/59/ As of December 1, 1995, no states prohibited smoking in private work sites, but one state (California) required that private work sites which allowed smoking must have designated smoking areas with separate ventilation, while 20 other states either required or allowed private work sites to have designated smoking areas. Id. at 122.

/60/ 59 Fed Reg. 15968 -- 16039 (Apr. 5, 1994) (to be codified at 29 C.F.R. Secs. 1910, 1915, 1926, 1928).

/61/ The public comment period on the Occupational Safety and Health Administration (OSHA) rule closed on February 9, 1996, but when the final rule will be issued is uncertain. The tobacco industry mounted a massive campaign opposing the rule and is virtually certain to challenge any OSHA rule in court.

/62/ Centers for Disease Control and Prevention, 44 Morbidity & Mortality Wkly. Rep. 1, 3 (Nov. 3, 1995).

/63/ Thomas W. Jaeger, Smoke-Free Environments Protect Resident Rights, Promote Safety, Provider 45 (Nov. 1993).

/64/ See Hall v. Hackley Hosp., 532 N.W.2d 893 (Mich. Ct. App. 1995) (holding that, because of the special needs of psychiatric patients, hospital was not required to impose a smoking ban as requested by employee). See also Arbogast v. Peterson, 631 N.E.2d 673 (Ohio Ct. App. 1993) (holding that a state psychiatric hospital's no-smoking policy did not violate patients' equal protection rights).

/65/ See Anne M. Joseph, Is Congress Blowing Smoke at the VA? 272 JAMA 1215 (1994).

/66/ See Anne M. Joseph & Patricia J. O'Neil, The Department of Veterans Affairs Smoke-Free Policy, 267 JAMA 87 (1992); U.S. Dep't of Veterans Aff., Implementation of Smoke-Free Environments for Patients in VA Health Care Facilities (1990).

/67/ 38 U.S.C.A. Sec. 1715 (West 1995) [note].

/68/ In one study of nursing homes, nonsmoking residents of Department of Veterans Affairs nursing homes had filed complaints about ETS exposure in 23 percent of the nursing homes. Gary Kochersberger & Elizabeth C. Clipp, Resident Smoking in Long-Term Care Facilities -- Policies and Ethics, 111 Pub. Health Reps. 66 (Jan. -- Feb. 1996).

/69/ Smoking materials cause approximately 42 percent of fire-related injuries in long-term care facilities. Jaeger, supra note 63, at 45.

/70/ Paul Drinka, Nursing Home Residents Who Are Unsafe Smokers and Require Supervision While Smoking, [Letter] 42 J. Am. Geriatric Societies 689 (1994).

/71/ Kochersberger & Clipp, supra note 68, at 69.

/72/ See 42 C.F.R. Sec. 483.70 (incorporating by reference the 1985 edition of the National Fire Protection Association's Life Safety Code); National Fire Protection Association 101, Life Safety Code, Sec. 31-4.4 (1985 ed.) (smoking regulations for health care occupancies). See also Jaeger, supra note 63, at 45. E.g., Medicare and Medicaid regulations have incorporated by reference the National Fire Protection Association's Life Safety Code, which imposes smoking restrictions in nursing home facilities.

/73/ Kochersberger & Clipp, supra note 68, at 69 -- 70 (citing Joint Comm'n for the Accreditation of Healthcare Orgs., Accreditation Manual for Long Term Care (1994)).

/74/ Id. at 70.

/75/ See Office on Smoking and Health, supra note 6. See also Americans for Nonsmokers' Rights, Protecting Nonsmokers From Secondhand Smoke (July 8, 1993) (one-page fact sheet).

/76/ Centers for Disease Control and Prevention, supra note 62, at 14 -- 15.

/77/ Office on Smoking and Health, supra note 6, at 123.

/78/ See, e.g., Tobacco Strikes Back, Mother Jones 32 -- 58 (May -- June 1996).

/79/ Eighteen states as of December 1, 1995, had statewide laws which preempted localities from enacting stronger smoke-free indoor air laws. See Office on Smoking and Health, supra note 6, at 121.

/80/ Environmental Protection Agency, supra note 11, at 1-5. See also Fox Chase Cancer Ctr., Clear Horizons Guide 3 (1994).

/81/ Environmental Protection Agency, supra note 11, at 1-5.

/82/ See, e.g., Unger v. Unger, 644 A.2d 691 (N.J. Super. Ct. Ch. Div. 1994). See also Mireille O. Butler, Parental Autonomy Versus Children's Health Rights: Should Parents Be Prohibited from Smoking in the Presence of Their Children? 74 Wash. U. L. Q. 223 (1996).

/83/ J. Kenneth L. Morse & Sharon Rennert, Older Americans and the Americans with Disabilities Act of 1990: Title I, Best Practice Notes, Mar. 1994, at 2.

/84/ Mark A. Gottlieb et al., Second-Hand Smoke and the ADA: Ensuring Access for Persons with Breathing and Heart Disorders, 13 St. Louis U. Pub. L. Rev. 635, 636 (1994).

/85/ 42 U.S.C.A. Sec. 12102(2)(A) (West 1995); 29 C.F.R. Sec. 1630.2(g)(1) (1995). See also 29 C.F.R. Sec. 1630.2(j) (defining "substantially limits").

/86/ 29 C.F.R. Sec. 1630.2(h)(1) (1995).

/87/ Id. Sec. 1630.2(i) (1995).

/88/ See Homeyer v. Stanley Tulchin Assocs., Inc., 20 Mental & Physical Disability Law Reporter (American Bar Ass'n Comm'n on the Mentally Disabled) 65 (N.D. Ill. Nov. 17, 1995); Gupton v. Virginia, 14 F.3d 203 (4th Cir. 1994), cert. denied, 115 S. Ct. 59 (1994).

/89/ Gottlieb et al., supra note 84, at 640.

/90/ Emery v. Caravan of Dreams, 879 F. Supp. 640 (N.D. Texas 1995) (cystic fibrosis); Staron v. McDonald's Corp., 51 F.3d 353, 355 (2d Cir. 1995) (asthma and lupus). See also Bell v. Elmhurst Chicago Stone Co., 919 F. Supp. 308 (N.D. Ill. 1996).

/91/ Staron, 51 F.3d at 357.

/92/ 42 U.S.C.A. Sec. 12201(a) (West 1995).

/93/ Carter v. Tisch, 822 F.2d 465 (4th Cir. 1987); Pletten v. Merit Systems Protection Bd., 908 F.2d 973 (6th Cir. 1990), cert. denied, 498 U.S. 1053, reh'g denied, 499 U.S. 913 (1991).

/94/ Gerben v. Holsclaw, 692 F. Supp. 557, 563 (E.D. Pa. 1988).

/95/ Vickers v. Veterans Admin., 549 F. Supp. 85 (W.D. Wash. 1982); But see Gupton, 14 F.3d at 203 (to establish that allergy to tobacco smoke substantially limited the major life activity of working, claimant must show that allergy "foreclose[d] generally [her opportunity to obtain] the type of employment involved"); Peck v. Department of Human Rights, 600 N.E.2d 79, 82 (Ill. App. Ct. 1992), appeal denied, 610 N.E.2d 1267 (1993).

/96/ Gottlieb et al., supra note 84, at 642.

/97/ Bell, 919 F. Supp. at 308; Harmer v. Virginia Electric & Power Co., 831 F. Supp. 1300 (E.D. Va. 1993).

/98/ Emery, 879 F. Supp. at 640.

/99/ Staron, 51 F.3d at 356.

/100/ 42 U.S.C.A. Sec. 12201(b) (West 1995). Interpretive Guidance for 28 C.F.R. Sec. 36.210 states: "Section 36.210 restates the clarification in section 501(b) of the Act that the Act does not preclude the prohibition of, or imposition of restrictions on, smoking. Some commentaries argued that Sec. 36.210 does not go far enough, and that the regulation should prohibit smoking in all places of public accommodation. The reference to smoking in section 501 merely clarifies that the Act does not require public accommodations to accommodate smokers by permitting them to smoke in places of public accommodations." 28 C.F.R. pt. 36, app. B (1995).

/101/ 42 U.S.C.A. Sec. 12182(a) (West 1995).

/102/ Id. Sec. 12181(7) (West 1995); 28 C.F.R. Sec. 36.104 (1995).

/103/ 42 U.S.C.A. Sec. 12182(b)(2)(A)(ii) (West 1995); 28 C.F.R. Sec. 36.302(a) (1995).

/104/ 28 C.F.R. Sec. 36.302 (1995).

/105/ Staron, 51 F.3d at 353.

/106/ But see Emery, 879 F. Supp. at 643 -- 44.

/107/ Staron, 51 F.3d at 355.

/108/ Id. at 356. See 28 C.F.R. pt. 36, app. B (1995): "[T]he determination as to whether allergies to cigarette smoke . . . are disabilities covered by the regulation must be made using the same case-by-case analysis that is applied to all other physical or mental impairments."

/109/ Staron, 51 F.3d at 357.

/110/ On the same day the district court dismissed the case, McDonald’s announced a complete no-smoking policy in all of its corporate-owned-and-operated restaurants.

/111/ 42 U.S.C.A. Sec. 12111(2), 12111(5)(A) (West 1995).

/112/ Id. Sec. 12112(a) (1995); 29 C.F.R. Sec. 1630.4 (West 1995).

/113/ See supra notes 85 -- 98 and accompanying text. See also Homeyer, No. 95-3977, 1996 U.S. App. LEXIS 18867 (7th Cir. July 31, 1996) (holding that whether sensitivity to ETS substantially limits an individual’s ability to work is a question of fact); but see Gupton, 14 F.3d at 203.

/114/ 29 C.F.R. Sec. 1630.2(m) (1995); see 29 C.F.R. Sec. 1630.3 for exceptions to this definition. See Morse & Rennert, supra note 83, for an excellent discussion of title I of the ADA.

/115/ John C. Fox, An Assessment of the Current Legal Climate concerning Smoking in the Workplace, 13 St. Louis U. Pub. L. Rev. 591, 601 (1994).

/116/ Id. See e.g., Harmer, 831 F. Supp. at 1300.

/117/ See Interpretive Guidance for 29 C.F.R. Sec. 1630.9 (1995) (pt. 1630, app.) (guidance in determining an appropriate reasonable accommodation).

/118/ 29 C.F.R. Sec. 1630.9 (1995).

/119/ Id. Sec. 1630.15(d) (1995).

/120/ Fox, supra note 115, at 601. See Gupton, 14 F.3d at 203; Parodi v. Merit Systems Protection Bd., 690 F.2d at 731.

/121/ Harmer, 831 F. Supp. at 1300.

/122/ Id. at 1306.

/123/ Id. See 29 C.F.R. Sec. 1630.2(o) (1995), app. 1630.9.

/124/ Bell, 919 F.Supp. at 308.

/125/ Id. at 309.

/126/ See McCarthy v. Washington Dep't of Social & Health Servs., 730 P.2d 681, 685 (Wash. Ct. App. 1986); Shimp v. New Jersey Bell Tel. Co., 368 A.2d 408 (N.J. Super. Ct. Ch. Div. 1976).

/127/ Christine W. Lewis & Sara J. Bliss, Are You Treating Your Employees Like Prisoners? Employers' Liability for Environmental Tobacco Smoke, 73 Mich. Bar J. 416 (May 1994).

/128/ Christian G. Krupp, Warning! Working in a Smoke Filled Room is Dangerous to Your Health: Protecting Michigan Workers from Exposure to Environmental Tobacco Smoke, 7 Cooley L. Rev. 509, 517 -- 18 (1990). But see Hennly v. Richardson, 444 S.E.2d 317 (Ga. 1994), aff'g 448 S.E.2d 91 (Ga. Ct. App. 1994).

/129/ Johannesen v. New York City Dep't of Hous., 638 N.E.2d 981, 982 (N.Y. 1994).

/130/ See, e.g., Schober v. Mountain Bell Tel., 630 P.2d 1231 (N.M. Ct. App. 1980) (granting workers' compensation benefits to an employee who suffered an allergic reaction to tobacco smoke).

/131/ See, e.g., Ate Fixture Fab v. Wagner, 559 So. 2d 635 (Fla. Dist. Ct. App. 1990).

/132/ Fox, supra note 115, at 607. See, e.g., Mack v. County of Rockland, 525 N.E.2d 744 (N.Y. 1988).

/133/ See, e.g., Mack, 525 N.E.2d at 744 (holding that aggravation of a preexisting eye disorder as a result of exposure to ETS was not an occupational disease).

/134/ In re Wiley, No. A9-365951 (U.S. Dep't of Labor, Office of Workers' Compensation Programs, Dec. 9, 1995). See Julie Gannon Shoop, Widower Gets Death Benefits in Secondhand Smoke Case, Trial, Mar. 1996, at 14 -- 15.

/135/ Shoop, supra note 134, at 14 -- 15.

/136/ Shimp, 368 A.2d at 408.

/137/ Id. at 416. See also McCarthy v. Department of Social and Health Servs., 759 P.2d 351 (Wash. 1988) (en banc).

/138/ Gordon v. Raven Systems, 462 A.2d 10, 15 (D.C. Ct. App. 1983).

/139/ Lapham v. Pennsylvania Unemployment Comp. Bd., 519 A.2d 1101 (Pa. Commw. Ct. 1987).

/140/ Fox, supra note 115, at 621. See, e.g., McCrocklin v. Employment Dev. Dep't, 205 Cal. Rptr. 156 (Cal. Ct. App. 1984); Alexander v. California Unemployment Ins. Appeals Bd., 163 Cal. Rptr. 411 (Cal. Ct. App. 1980).

/141/ Fox, supra note 115, at 620. See e.g. Billman v. Sumrall, 464 So.2d 382 (La. Ct. App. 1985); Ruckstuhl v. Unemployment Comp. Bd. of Review, 426 A.2d 719 (Pa. Commw. Ct. 1981).

/142/ For more on this, see Richard Daynard & Graham Kelder, Jr., Medical Cost Reimbursement Suits as a Cancer Control and Public Health Strategy 1 -- 20 (1995) (unpublished paper); Richard Daynard, The Third Wave of Tobacco Products Liability Cases, Trial, Nov. 1994, at 34; Richard Daynard, Smoking out the Enemy: New Developments in Tobacco Litigation, Trial, Nov. 1993, at 16.

/143/ Castano, 84 F.3d at 734.

/144/ Id.; Glenn Collins, Huge Anti-Tobacco Lawsuit Is Rejected by Appeals Court, N.Y. Times, May 24, 1996, at A1.

/145/ Myron Levin & Henry Weinstein, Lawyers to Appeal Tobacco Ruling, L.A. Times, June 19, 1996, at D-2.

/146/ Broin v. Philip Morris Cos., 641 So. 2d 888 (Fla. Dist. Ct. App. 1994).

/147/ Engle v. R.J. Reynolds Tobacco Co., 672 So.2d 39 (Fla. Dist. Ct. App. 1996).

/148/ Center on Addiction and Substance Abuse, Columbia Univ., The Cost of Substance Abuse to America's Health Care System -- Report 1: Medicaid Hospital Costs 11 (1993).

/149/ Id. at 25.

/150/ Id. at 26.

/151/ The states which had filed or announced suits by July 1996 included Mississippi, Florida; Minnesota; Massachusetts; West Virginia; Louisiana; New Jersey; Arizona, Connecticut, Texas, and, Maryland. The City of San Francisco and the County of Los Angeles also have filed suits. See Agency for Health Care Admin. v. Associated Indus. of Florida, Inc., No. 86,213, 1996 Fla. LEXIS 1057 (Fla. June 27, 1996) (upholding most provisions of the Medicaid Third Party Liability Act and thereby allowing the state's Medicaid suit against the tobacco companies to proceed). See also State of Minnesota and Blue Cross and Blue Shield of Minnesota v. Philip Morris, Inc., No. C1-95-1324, 1996 Minn. LEXIS 497 (Minn. July 25, 1996) (affirming the standing of Blue Cross and Blue Shield of Minnesota to pursue claims against the tobacco companies for violations of statutes against deceptive trade practices, false advertising, and unlawful trade practices).

/152/ From page 2 of the press release of Attorney General Mike Moore on May 23, 1994, upon the filing of the Mississippi law suit.

/153/ See also Richard Daynard & Graham Kelder, Jr., Medical Cost Reimbursement Suits as a Cancer Control and Public Health Strategy 1 -- 20 (1995) (unpublished paper).

/154/ See, Stanton Glantz, et al, The Cigarette Papers (1996); Richard Kluger, Ashes to Ashes (1996); Philip Hilts, Smokescreen (1996).