Public Health Law and the Prevention and Control of Obesity

WILLIAM H. DIETZ, DONALD E. BENKEN, and ALICIA S. HUNTER

Centers for Disease Control and Prevention

Context: Obesity constitutes a major public health challenge in the United States. Obesogenic environments have increased owing to the consumption of calorie-dense foods of low nutritional value and the reduction of daily physical activity (e.g., increased portion sizes of meals eaten in and out of the home and fewer physical activity requirements in schools). Policymakers and public health practitioners need to know the best practices and have the competencies to use laws and legal authorities to reverse the obesity epidemic. For instance, statutes and regulations at the federal, state, and local levels of government have been implemented to improve nutritional choices and access to healthy foods, encourage physical activity, and educate consumers about adopting healthy lifestyles.

Methods: In an effort to understand the application of laws and legal authorities for obesity prevention and control, in June 2008 the Centers for Disease Control and Prevention convened the National Summit on Legal Preparedness for Obesity Prevention and Control. An outcome of this summit will be the publication of the proceeding's white papers written by eight law and subject-matter experts with substantive contributions from summit participants, which will identify actionable options that sectors and organizations at various jurisdictional levels can consider adopting.

Findings: Law has played a critical role in the control of chronic diseases and the behaviors that lead to them. The use of a systematic legal framework—the use of legislation, regulation, and policy to address the multiple factors

Address correspondence to: William H. Dietz, Division of Nutrition, Physical Activity, and Obesity, Centers for Disease Control and Prevention, 4770 Buford Highway NE, MS K-24, Atlanta, GA 30341 (email: wcd4@cdc.gov).

The Milbank Quarterly, Vol. 87, No. 1, 2009 (pp. 215–227)

that contribute to obesogenic environments—can assist in the development, implementation, and evaluation of a variety of legal approaches for obesity prevention and control.

Conclusions: Although public health–focused legal interventions are in an early stage and the direct and indirect impact they may have on the obesity epidemic is not yet understood, efforts such as the summit and white papers should help determine potentially viable legal interventions and assess their impact on population-level change.

Keywords: Obesity, legal, law, health promotion.

OBESITY IS BOTH AN URGENT REALITY AND AN URGENT THREAT to the nation's health and economic well-being. Currently, obesity affects more than 30 percent of adults (Ogden et al. 2007) and approximately 16 percent of children and adolescents aged two to nineteen years (Ogden, Carroll, and Flegal 2008). In fact, the Bogalusa Heart Study found that 61 percent of obese young people already had at least one additional risk factor for heart disease, and 39 percent had at least two additional risk factors (Freedman et al. 2007). Childhood obesity is a risk factor for severe obesity over the life span, and youth with a body mass index (BMI) of greater than the 95th percentile have an increased likelihood of developing an obesity-related chronic disease earlier in life that they will have to manage throughout their lifetime (Ferraro, Thorpe, and Wilkinson 2003).

The care and treatment of obesity and its comorbidities over the lifespan is a costly problem. Direct and indirect medical expenses in 1998 attributed to both overweight and obesity may have been as high as $78.5 billion (Finkelstein, Fiebelkorn, and Wang 2003), and more than 25 percent of the rise in medical costs between 1987 and 2001 has been attributed to obesity (Thorpe et al. 2004). Approximately half the cost of treating obesity was paid through Medicare or Medicaid, and between 1987 and 2002 the cost of obesity to private insurers increased tenfold, from $3.6 billion to $36.5 billion (Thorpe et al. 2005). One reason for the higher medical costs is the prevalence of obesity-associated diseases among U.S. adults (Thorpe 2006). This may also be true for children. For example, type 2 diabetes mellitus, which thirty years ago largely afflicted only adults, now in some cities accounts for almost half of all new cases of diabetes in children and adolescents (ADA 2000).

Although genes account for an increased susceptibility to obesity, changes in the population's genetic makeup cannot explain the rapid rise in obesity between 1980 and 1999. Over this period calorically dense foods became ubiquitous: the consumption of processed food and food outside the home, as well as soft drinks and portion sizes, all increased. Reduced physical activity may also be a contributing factor. Although the prevalence of adults who engaged in regular physical activity rose between 2001 and 2005, physical activity remains below the national health objective of 50 percent (MMWR 2007). Black women and Hispanic men have the lowest rates of regular physical activity compared with all U.S. adults (MMWR 2007). On most days of the week, 34.7 percent of young people in grades 9 through 12 regularly engaged in physical activity (MMWR 2008); the national health objective is 35 percent. The national health objective for fruit and vegetable consumption for all persons two years or older is 75 percent eating at least two servings of fruits each day and 50 percent eating at least three servings of vegetables each day (U.S. Dept. of Health and Human Services 2000). Only 32.6 percent of U.S. adults, however, ate the recommended two or more servings of fruits, and only 27.2 percent ate the recommended three or more servings of vegetables per day (MMWR 2007). Between 1999 and 2007, the percentage of U.S. youth in grades 9 through 12 who reported eating fruits and vegetables five or more times per day declined from 23.9 to 21.4 percent (MMWR 2008).

This article provides a synthesis of the use of public health law as a tool to prevent and control obesity through an overview of the obesity epidemic and the public health strategies to address it, the legal framework to address obesity, and an outline of specific laws and legal authorities that may be used to prevent and control obesity.

Public Health Strategies to Prevent and Control Obesity

To frame the discussion around the use of laws and legal authorities to prevent and control obesity, the National Summit on Legal Preparedness for Obesity Prevention and Control focused on six target areas, four key intervention settings (i.e., communities, medical care, schools, and workplaces), and three social issues around which policy and environmental change initiatives could be organized. The target areas are

increasing the consumption of fruits and vegetables, physical activity, and the duration and initiation of breast-feeding and decreasing the consumption of sugar-sweetened beverages and foods of high energy density and low nutritional value and the time spent watching television. The social issues are improving access to medical care and appropriate medical equipment, reducing health disparities for obese persons, and reducing disability related to obesity. Law-based efforts complementing and supporting traditional public health efforts can contribute to obesity prevention and control. The following is a discussion of the legal framework, with examples of efforts taken to address some of the target areas in different settings.

Laws and Legal Authorities Affecting Obesity

The development and implementation of legal frameworks could broaden the range of effective public health strategies and provide valuable tools for the public health workforce (Mensah et al. 2004). Indeed, law has played a critical role in the control of some chronic diseases and the behaviors leading to them (Wolfson 2001). For example, the Federal Communications Commission's decision to use the Fairness Doctrine to require cigarette counteradvertising on television that emphasized the adverse health effects of tobacco led the tobacco manufacturers to withdraw their advertising from television. Local regulation and state legislation resulted in smoke-free public buildings and helped change the social norms regarding cigarette smoking. Enforcement of the restrictions on tobacco sales to minors reduced youth access and increased communities' awareness of the importance of early prevention of tobacco use in youth. The CDC's Public Health Law Program has identified four core elements necessary to use the law effectively to address a broad range of public health issues: identifying and understanding essential laws and legal authorities pertaining to the issue; identifying and developing the competency of public health professionals to apply those laws and authorities; coordinating actions across jurisdictions, sectors, and settings; and identifying and disseminating information on public health laws' best practices. The systematic use of this framework can have a similar impact on the population's health by creating policy and environmental changes that reduce or eliminate obesogenic environments.

At the federal level, the legislation with the greatest impact on the U.S. food supply is the Food, Conservation, and Energy Act of 2008[1] (Farm Bill). More than 54 percent of the funds appropriated through this bill are allocated to nutrition programs (e.g., the national school meals programs, Community Food Security, Farmers' Markets Promotion, Fruit and Vegetable Promotion, and the more widely known Supplemental Nutrition Assistance Program, formerly known as the Food Stamp program). The 2008 reauthorization of the Farm Bill allocates approximately 15 percent of its funds to subsidize soybean and corn production (American Farmland Trust 2008). Because these crops are cheaper, they are widely used in food production, thereby lowering the cost of foods, which makes them more attractive to consumers. For example, these crops provide a cheap source of feed for cattle. In turn, the lower cost to fatten cattle contributes to the lower market price of beef and thus the greater availability to and consumption by consumers. Similarly, food and beverages containing corn or its by-products, such as high-fructose corn syrup, an inexpensive sweetener for sugar-sweetened beverages, are now more readily available in food supply stores and restaurants. The percentage of youth who consumed any carbonated soft drinks (regular and low calorie) climbed from 37 percent in 1977/1978 to 56 percent between 1994 and 1998, a 48 percent increase (French, Lin, and Guthrie 2003). Soft drinks account for approximately 14 percent of the daily caloric intake for adolescents aged twelve through nineteen years (Wang, Bleich, and Gortmaker 2008). Among adults, the consumption of carbonated soft drinks (regular and low calorie) and fruit drinks (not 100 percent juice) rose by at least 100 percent between 1977/1978 and 1994/1995 (Enns, Goldman, and Cook 1997; Enns, Mickle, and Goldman 2002). Increased consumption of sugar-sweetened beverages may have contributed to an excessive intake of calories (Vartanian, Schwartz, and Brownell 2007).

For the first time, the Farm Bill provides $1.3 billion in new funding over ten years for growing fruits, vegetables, and nuts (American Farmland Trust 2008); increases the funding of a number of programs that support farmers' markets; and provides vouchers for low-income seniors to purchase fruits and vegetables from local farmers (American Farmland Trust 2008). The Farm Bill also provides approximately $500 million for states to provide a fresh fruit or vegetable snack in schools and now permits schools greater flexibility in purchasing products from local farmers (American Farmland Trust 2008).

The Transportation Bill, known as the Safe, Accountable Flexible Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU)[2] is the physical activity counterpart of the Farm Bill because of its impact on transportation policy at the national, state, and local levels. For example, the bill contains a section on metropolitan transportation planning that addresses all modes of transportation, including public transportation. Thirty percent of people who use public transportation achieve the recommended daily thirty minutes of physical activity by walking to public transportation from their home, from public transportation to their place of employment, and the reverse, compared with persons who do not use public transportation (Besser and Dannenberg 2005). The bill also contains support for bicycle lanes and pedestrian walkways, recreational trails, and the National Safe Routes to School Program, a federal initiative to promote children walking and bicycling to school. This transportation infrastructure offers opportunities to improve physical activity levels by walking or biking to school or work.

The Federal Communications Commission may also help prevent and control obesity through its enforcement of the Fairness Doctrine, which ultimately affected tobacco advertising. In 2007, the Federal Trade Commission required forty-four food and beverage companies to disclose their child marketing practices (FTC 2007) and found that approximately $870 million was spent on child-directed marketing and a little more than $1 billion on marketing to adolescents, with approximately $300 million overlapping the two age groups (FTC 2008). In 2004, an estimated $10 billion was spent on the direct and indirect marketing of food and beverage products to children, including sugar-sweetened beverages, sugary cereals, candy, and highly processed foods with added sugar, fats, and sodium (McGinnis, Gootman, and Kraak 2006). Advertising is ubiquitous, spanning television, radio, and the print media to the Internet and "advergames," in which food is used as a lure in fun video games (Hawkes 2007). At state and local jurisdictional levels, legal approaches are also being applied to prevent or control obesity by educating consumers about their food choices. California passed legislation in 2008 that requires calorie content to be prominently labeled on the menu boards of chain restaurants in the state.[3] The New York City Department of Health and Mental Hygiene used its authority as the department responsible for controlling both communicable and chronic diseases to adopt a rule requiring chain restaurants that serve standardized meals to post calorie information on

their menus and menu boards.[4] Despite court challenges by the state restaurant association, the Department's rule ultimately resulted in the adoption and implementation of that regulation in January 2008. New York, San Francisco, and Seattle all serve as models for other jurisdictions. State and local education agencies are enforcing newly adopted statutes and federal regulations that allow local guidance to regulate the nutritional value of food available to students. For example, legislation enacted in Kentucky limits the beverages available in schools to water, 100-percent-juice drinks, low-fat milk, and beverages with no more than ten grams of sugar per serving.[5] By June 2008, a total of twenty-five states had established nutritional standards for "competitive foods," that is, foods and beverages available in schools but not approved for reimbursement under the National School Lunch Program (USDA 2004). Twenty-seven states had restricted the sale of competitive foods more tightly than did federal requirements, and eighteen had adopted nutritional standards for in-school meals that were stricter than those required by the U.S. Department of Agriculture (Trust for America's Health 2008).

At the state and local levels, legal approaches are also being applied to increase physical activity. For example, Texas and Florida have restored physical education programs to their elementary schools, and the Indiana legislature passed a statute requiring daily physical activity in all elementary schools.[6] The Mississippi state legislature enacted the Healthy Students Act in 2007 to set minimum standards for physical activity and health education for K through 12 students, among many other provisions.[7] However, surveys suggest that only 28 percent of high school students participate in daily physical education programs, and some schools have forgone physical education requirements altogether (Peterson and Fox 2007). In January 2007, New York City's Department of Health and Mental Hygiene implemented a Board of Health rule mandating that day care services offer at least sixty minutes of specified types of activity daily and limiting video viewing to "educational programs or programs that actively engage child movement."[8]

California passed legislation allocating funds to communities to build sidewalks that enable children to walk to school. Efforts by the city of Davis, California, to include bike lanes on all its major streets have been so successful that the city was able to discontinue using buses to take children to school. California state law mandates that every city and county adopt a "General Plan" to create healthy and sustainable

communities. The California-based Public Health Law and Policy created a tool kit to help jurisdictions adopt healthy General Plans (Public Health Law and Policy 2006). These policies have ameliorated obesogenic environments and supported individuals in making healthy choices. As a result of the "General Plan" mandate and using the Public Health Law and Policy tool kit, the city of Richmond, California, created a plan with eight consensus goals to ensure that the city has an extensive system of parks, playgrounds, and open space accessible to city households, as well as a joint-use project in collaboration with its local school district (City of Richmond 2007).

The National Committee for Quality Assurance (NCQA) recently approved Healthcare Effectiveness Data and Information Set (HEDIS) measures of health plan performance regarding the measurement of body mass index (BMI) for adults, children, and adolescents, and also for nutrition and physical activity counseling of children and adolescents. The majority of health plans use HEDIS measures to track provider performance regarding patient care and services and to report to providers, purchasers of health care plans, and consumers on the quality of the nation's health care (National Committee for Quality Assurance 2008). The new obesity-related measures are intended to improve providers' focus on obesity prevention, care, and treatment. The implementation of obesity-related HEDIS measures shows how a policy strategy can address behavioral change. In medicine, as in most settings, "what gets measured gets done."

Act 1220, a state law passed in 2003 in Arkansas, offers several strategies to address obesity in children and adolescents. The bill included the universal measurement of BMI in all schoolchildren, restricted access to vending machines in public elementary schools, mandated reporting by schools of vending machine revenues and expenditures from contracts with soft drink companies, and created district advisory committees of parents, teachers, and local community leaders. Arkansas has established a law-based screening policy that will provide surveillance information for the state. Other jurisdictions voluntarily participate in the Youth Risk Factor Behavior Surveillance System and the Behavioral Risk Factor Surveillance System, which track behavioral trends at the state and national levels. Additional measures are needed to identify and monitor indicators of obesogenic environments and evaluate interventions that address them across settings, jurisdictions, and sectors.

Similar to the statement "what gets measured gets done," in the medical care setting "what gets reimbursed gets treated." Our system of health care service and benefit design can have a major impact on overweight management and obesity prevention because the practice of health care is licensed and regulated, whereas the weight-loss industry is not. In July 2004, the Centers for Medicare and Medicaid (CMS) revised the statement that obesity was not a recognized disease in order to permit Medicare to consider covering payments for obesity-related treatments (CMS 2004). Even though Medicaid is managed at the state level, the Medicare ruling prompted some states to broaden their Medicaid programs' coverage of services for the prevention and treatment of obesity. For example, West Virginia (Unicare 2007) and Tennessee (Tenncare 2005) offer both full and partial reimbursement for Weight Watchers programs.

Obesity Prevention and Control: Actionable Opportunities

These observations, as well as other work emphasizing the importance of public health law as a relevant approach to the control of chronic diseases (Mensah et al. 2004), inspired the CDC, the Robert Wood Johnson Fund (RWJF), and other key partners to host a summit from June 18 through 20, 2008, on using laws and legal authorities to prevent and control obesity. At the 2008 National Summit on Legal Preparedness for Obesity Prevention and Control, participants[9] reviewed the current status of laws and legal strategies relating both directly and indirectly to obesity prevention and control. For example, the Farm Bill affects the United States' food supply directly, whereas zoning regulations for community design affect obesity indirectly through their impact on physical activity. The summit identified potential gaps in laws, competencies to apply them, and possible coordination of efforts across jurisdictions and sectors for obesity prevention and control. These deliberations contributed to the development of white papers for improving the contribution of laws and legal authorities to help reduce the health threats posed by obesity. Proceedings of the National Summit on Legal Preparedness for Obesity Prevention and Control, including the white papers, are expected to be published in June 2009 and will identify measures that sectors and organizations at various jurisdictional levels might

consider adopting to address the urgent threat of obesity in the United States.

Endnotes

1. Food, Conservation, and Energy Act of 2008, Pub.L. 110-234, May 22, 2008.
2. Safe, Accountable Flexible Efficient Transportation Equity Act: A Legacy for Users of 2005, Pub.L. 109-59, August 10, 2005.
3. Food Facilities: Nutritional Information, Cal. Retail Food Code § 114094 (2008).
4. N.Y.C. Health Code § 81.50 (2007).
5. KY Rev. Stat. § 158.854(1)(2)(c) (2007).
6. Ind. Code Ann. § 20-26-9-2 (2006).
7. MS Code Ann. § 37-13-134(1) (2008).
8. N.Y.C. Health Code § 47.36 (2008).
9. The summit convened more than 220 public health experts, lawmakers, academicians, lawyers, planners, regulators, and food industry representatives.

References

American Diabetes Association (ADA). 2000. Type 2 Diabetes in Children and Adolescents. *Pediatrics* 105:671–80.

American Farmland Trust. 2008. *Success in the 2008 Farm Bill, a New Direction for Farm and Food Policy: AFT Overview of the 2008 Farm Bill*. Available at http://www.farmland.org/programs/farm-bill/analysis/documents/AFT-2008-Farm-Bill-brochure-August2008.pdf (accessed November 4, 2008).

Besser, L.M., and A.L. Dannenberg. 2005. Walking to Public Transit: Steps to Help Meet Physical Activity Recommendations. *American Journal of Preventive Medicine* 29:273–80.

Centers for Medicaid and Medicare Services (CMS). 2004. *Treatment of Obesity*: MLN: MM3502. Washington, D.C.: USDA.

City of Richmond, California. 2007. Richmond General Plan Update: Community Health and Wellness, working draft version 1.0. Available at http://www.cityofrichmondgeneralplan.org/docs.php?oid=1000000663&oig=1000000507 (accessed August 25, 2008).

Enns, C., J. Goldman, and A. Cook. 1997. Trends in Food and Nutrient Intakes by Adults: NFCS 1977–78, CSFI 1989–91, and CSFII 1994–95. *Family Economics and Nutrition Review* 10(4):2–15.

Enns, C., S. Mickle, and J. Goldman. 2002. Trends in Food and Nutrient Intakes by Children in the United States. *Family Economics and Nutrition Review* 14(2):56–68.

Federal Trade Commission (FTC). 2007. *Food Industry Marketing to Children Report; Orders to File Special Report*: FTC Matter no. P064504, August. Available at http://www.ftc.gov/os/6b_orders/foodmktg6b/index.shtm (accessed September 11, 2008).

Federal Trade Commission (FTC). 2008. *Marketing Food to Children and Adolescents: A Review of Industry Expenditures, Activities, and Self-Regulation. A Report to Congress*. Available at http://www.ftc.gov/os/2008/07/P064504foodmktingreport.pdf (accessed September 11, 2008).

Ferraro, K.S., R.J. Thorpe Jr., and J.A. Wilkinson. 2003. The Life Course of Severe Obesity: Does Childhood Overweight Matter? *Journals of Gerontology, Series B, Psychological Sciences and Social Sciences* 58(2):S110–19.

Finkelstein, E.A., I.C. Fiebelkorn, and G. Wang. 2003. National Medical Spending Attributable to Overweight and Obesity: How Much, and Who's Paying? *Health Affairs* W3:219–26.

Freedman, D.S., H.S. Kahn, Z. Mei, L.M. Grummer-Strawn, W.H. Dietz, S.R. Srinivasan, and G.S. Berenson. 2007. Relation of Body Mass Index and Waist-to-Height Ratio to Cardiovascular Disease Risk Factors in Children and Adolescents: The Bogalusa Heart Study. *American Journal of Clinical Nutrition* 86(1):33–40.

French, S.A., B.H. Lin, and J.F. Guthrie. 2003. National Trends in Soft Drink Consumption among Children and Adolescents Age 6 to 17 Years: Prevalence, Amounts, and Sources, 1977/1978 to 1994/1998. *Journal of the American Dietetic Association* 103(10):1326–31.

Hawkes, C. 2007. Regulating Food Marketing to Young People Worldwide: Trends and Policy Drivers. *American Journal of Public Health* 97:1962–73.

McGinnis, J.M., J.A. Gootman, and V.I. Kraak, eds. 2006. *Food Marketing to Children and Youth: Threat or Opportunity?* Washington, D.C.: Institute of Medicine.

Mensah, G.A., R.A. Goodman, S. ZaZa, A.D. Moulton, P.L. Kocher, W.H. Dietz, T.F. Pechacek, and J.S. Marks. 2004. Law as a Tool for Preventing Chronic Diseases: Expanding the Range of Effective Public Health Strategies. *Preventing Chronic Diseases* 1(1): 1–8.

MMWR. 2007. Prevalence of Regular Physical Activity among Adults—United States, 2001 and 2005. *Morbidity and Mortality Weekly Report*, November 23, 56(46):1209–12.

MMWR. 2008. Youth Risk Behavior Surveillance—United States, 2007. *Morbidity and Mortality Weekly Report*, June 6, 57(SS04):1–131.

National Committee for Quality Assurance. 2008. *States Requiring HEDIS Reporting for Medicaid Plans*, September. Available at http://www.ncqa.org/LinkClick.aspx?fileticket=ClkKqM0a%2bfk%3d&tabid=135&mid=819&forcedownload=true (accessed November 6, 2008).

Ogden, C.L., M.D. Carroll, and K.M. Flegal. 2008. High Body Mass Index for Age among US Children and Adolescents, 2003–2006. *Journal of the American Medical Association* 299:2401–5.

Ogden, C.L., M.D. Carroll, M.A. McDowell, and K.M. Flegal. 2007. *Obesity among Adults in the United States—No Statistically Significant Change since 2003–2004*. NCHS Data Brief. Available at http://www.cdc.gov/nchs/data/databriefs/db01.pdf (accessed May 11, 2008).

Peterson, K.E., and M.K. Fox. 2007. Addressing the Epidemic of Childhood Obesity through School-Based Interventions: What Has Been Done and Where Do We Go from Here? *Journal of Law, Medicine & Ethics* 35(1):118.

Public Health Law and Policy. 2006. *General Plans and Zoning: A Toolkit on Land Use and Health*. Available at http://www.healthyplanning.org/toolkit_gpz.html (accessed August 22, 2008).

Tenncare. 2005. Tenncare Tackling Obesity through Weight Loss Program with Weight Watchers. Media Release. Available at http://tennessee.gov/tenncare/forms/151105.pdf (accessed December 16, 2008).

Thorpe, K.E. 2006. Factors Accounting for the Rise in Health-Care Spending in the United States: The Role of Rising Disease Prevalence and Treatment Intensity. *Journal of the Royal Institute of Public Health* 120:1002–7.

Thorpe, K.E., C.S. Florence, D.H. Howard, and P. Joski. 2004. Trends: The Impact of Obesity on Rising Medical Spending. *Health Affairs* Web Exclusive W4:480–86.

Thorpe, K.E., C.S. Florence, D.H. Howard, and P. Joski. 2005. The Rising Prevalence of Treated Disease: Effects on Private Health Insurance Spending. *Health Affairs* Web Exclusive W5:317–25.

Trust for America's Health. 2008. *F as in Fat: How Obesity Policies Are Failing in America, 2008*. Available at http://www.healthyamericans.org (accessed August 25, 2008).

Unicare. 2007. Innovative Collaboration to Help Curb West Virginia Obesity. News Release. Available at http://www.unicare.com (accessed December 16, 2008).

U.S. Department of Agriculture (USDA), Food and Nutrition Service. 2004. *Measuring Competitive Foods in Schools: Methods and Challenges*. Available at http://www.fns.usda.gov/oane/menu/published/CNP/FILES/CompFoodSum.pdf (accessed November 6, 2008).

U.S. Department of Health and Human Services. 2000. Understanding and Improving Health and Objectives for Improving Health. In *Healthy People 2010*, 2nd ed., 2 vols. Washington, D.C.: U.S. Government Printing Office.

Vartanian, L.R., M.B. Schwartz, and K.D. Brownell. 2007. Effects of Soft Drink Consumption on Nutrition and Health: A Systematic Review and Meta-Analysis. *American Journal of Public Health* 97:667–75.

Wang, Y.C., S.N. Bleich, and S.L. Gortmaker. 2008. Increasing Caloric Contribution from Sugar-Sweetened Beverages and 100% Fruit Juices among U.S. Children and Adolescents, 1988–2004. *Pediatrics* 121:e1604–14.

Wolfson, M. 2001. *The Fight against Big Tobacco*. Hawthorne, N.Y.: Aldine de Gruyter.

Acknowledgments: We would like to thank Anthony Moulton, co-director of the Centers for Disease Control and Prevention's Public Health Law Program, for his support of and invaluable contribution to the development of this article. The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.