2014

Cigarettes vs. Soda: The Argument for Similar Public Health Regulation of Smoking and Obesity Response

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CONNECTICUT
LAW REVIEW

VOLUME 46 JULY 2014 NUMBER 5

Article

The Limits of Anti-Obesity Public Health Paternalism: Another View

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This Article critiques Professor David Friedman's article, Public Health Regulation and the Limits of Paternalism, *and sets forth an alternative view of the limits of anti-obesity public health paternalism. Specifically, it critiques Friedman's classification of public health interventions based on how coercive the intervention is, and offers an alternative construct to analyze paternalistic public health interventions. The alternative approach, developed by Mark Hall, distinguishes between (1) "old" public health interventions that target specific pathogens or toxins, and (2) "new" public health interventions that target upstream behavioral risk factors and ecological factors.*

This Article then elaborates on the main example that Friedman uses to illustrate his claims about coercive public health paternalism, the New York City portion cap on sodas and other sugary drinks. By comparing Friedman's approach and the alternative approach, it shows that the latter better explains the case that invalidated the sugary drink portion cap rule. Moreover, this Article challenges Friedman's assertion that the case is a death knell for public health paternalism. Although the New York Board of Health now faces formidable challenges with respect to promulgation of new public health regulations, public health advocates in New York City can continue to advance the new public health goal of reducing obesity and diabetes in New York, by striving to foster greater political consensus regarding the legitimacy of that goal and the best means of achieving it. Beyond New York, in jurisdictions with less severe case law constraints on agency action, state and local public health agencies may have greater latitude to promulgate and enforce new public health regulations, including anti-obesity regulations.

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The Limits of Anti-Obesity Public Health Paternalism: Another View

KATHERINE PRATT*

I. INTRODUCTION

This Article comments on and critiques Professor David Friedman's article, *Public Health Regulation and the Limits of Paternalism*,[1] and sets forth an alternative view of the limits of anti-obesity public health paternalism. Part II of this Article discusses the approach that Friedman takes and the claims he makes, including the claim that coercive public health paternalism has peaked. Part III critiques Friedman's approach, which classifies public health interventions based on how coercive the intervention is, and offers an alternative construct to analyze paternalistic public health interventions. The alternative approach, developed by Mark Hall, distinguishes between (1) "old" public health interventions that target specific pathogens or toxins, and (2) "new" public health interventions that target upstream behavioral risk factors and ecological factors.

Part IV elaborates on the main example that Friedman uses to illustrate his claims about coercive public health paternalism, the New York City portion cap on sodas and other sugary drinks. Comparing Friedman's approach and the alternative approach, I show that the alternative approach better explains the case that invalidated the sugary drink portion cap rule. The defeat of the rule illustrates the perils of an executive agency acting unilaterally, without legislative approval, to adopt new public health interventions—especially in New York, where *Boreali v. Axelrod*[2] imposes severe constraints on agency promulgation of new public health regulations. I disagree with Friedman's assertion that the portion cap case is a death knell for public health paternalism, however. Although the New York Board of Health now faces formidable challenges with respect to promulgation of new public health regulations, public health advocates in New York City can continue to advance the new public health goal of

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[1] David Adam Friedman, *Public Health Regulation and the Limits of Paternalism*, 46 CONN. L. REV. 1687 (2014).

[2] 517 N.E.2d 1350 (N.Y. 1987).

reducing obesity and diabetes in New York, by striving to foster greater political consensus regarding the legitimacy of that goal and the best means of achieving it. In addition, the Board of Health retains the ability to promulgate and enforce old public health regulations—even highly coercive regulations—notwithstanding the portion cap case. Beyond New York, in jurisdictions with less severe case law constraints on agency action, state and local public health agencies may have greater latitude to promulgate and enforce new public health regulations, including anti-obesity regulations.

II. FRIEDMAN'S APPROACH AND CLAIMS

In his article, Friedman makes both descriptive and normative claims regarding the limits of public health paternalism. Although his primary focus is on anti-obesity public health paternalism, he argues that his conclusions are also broadly applicable to other types of public health paternalism.[3]

But before turning to Friedman's specific claims, note the rhetoric and approach that he uses to frame his argument. His article is structured to set up a dichotomy between "Free Market Approaches" and "Paternalistic Approaches" to the obesity problem.[4] Ultimately embracing a Libertarian perspective, he extolls the virtues of autonomy and the free market.[5] In addition to drawing a distinction between highly coercive "hard" paternalism and less coercive "soft" paternalism,[6] Friedman theorizes a paternalism spectrum with five categories, based on the degree to which the intervention is coercive.[7] This "coercion spectrum" ranges from apaternalism, which eschews government interventions entirely in favor of private market solutions, to highly coercive government bans and mandates.[8]

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[3] *See* Friedman, *supra* note 1, at 1753–65 (discussing trends related to marijuana, fluoride, and GMOs).

[4] *Id.* at 1721, 1726.

[5] *Id.* at 1767–68.

[6] *Id.* at 1696 & n.38.

[7] *Id.* at 1698–99.

[8] Friedman lists the categories and discusses them at length in Part II.B of his article. The five intervention categories along the spectrum are: (1) "Libertarian or apaternali[sm]" (no government coercion is required because free markets and rational consumers with full information will address any potential harm to consumers); (2) "Weak-form debiasing" (government provides "raw statistical and factual information" to inform consumers of relevant data, which is a mild form of coercion); (3) "Strong-form debiasing" (government provides a "concrete instance of the occurrence" or "truthful narratives of harm" to illustrate potential harms, which is a stronger form of coercion but not an absolute constraint on consumer choices); (4) "Insulating strategies" ("government protects consumers by creating barriers to entry or hard-to-satisfy standards," such as auto safety standards); and (5) "Outright bans and mandates" (government prohibits consumers from making harmful choices or requires harm-reducing action, in the strongest type of coercion). *Id.*

Friedman states that the overall purpose of his article "is to assess the role of paternalism in public health and whether paternalism, particularly paternalism in its harder forms, has reached natural limits in terms of popular viability and practical effectiveness."[9] His main descriptive claim is that "[p]aternalism has peaked, for now, in the realm of public health regulation,"[10] because the public rejects hard paternalism and soft paternalism is weak and ineffective.[11] In other words, Friedman seems to acknowledge that loss of autonomy, through government coercion, might be warranted in some settings, but he expresses skepticism about the political viability and effectiveness of various public health paternalist interventions.

Friedman recognizes that public health advocates may feel morally obligated to address the prevalence of obesity.[12] Although he seems sympathetic to their goals of reducing obesity-related morbidity and mortality,[13] he questions the need to intervene in free markets,[14] as well as the political viability and effectiveness of public health interventions.[15]

Friedman's analysis includes a discussion of the role of free markets in the current obesity problem. He notes that the increasing prevalence of obesity has been caused, at least in part, by consumers making their own "free choices" about which foods to consume.[16] In other words, he believes that obesity is not a problem to the extent that obesity results from

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[9] *Id.* at 1710.

[10] *Id.* at 1694.

[11] *Id.* at 1769.

[12] *Id.* at 1768.

[13] *See id.* at 1712 (describing obesity as a "grave public health issue"). Friedman is sympathetic to the "new" public health goal of reducing behavioral risk factors that significantly increase preventable disease and death—going as far as approving of less coercive and more coercive public health interventions to reduce preventable disease and death:

> Without a doubt, basic theories of both soft and hard paternalism would support [anti-obesity government interventions, such as] . . . regulatory, pricing, and health information mechanisms to substantially reduce salt and trans fats in prepared and packaged foods and to support research that can find effective strategies for modifying the other dietary, lifestyle, and metabolic risk factors that cause large numbers of premature deaths.

Id. at 1712–13 (quoting *Smoking, High Blood Pressure and Being Overweight Top Three Preventable Causes of Death in the U.S.*, HARV. SCH. PUB. HEALTH (Apr. 27, 2009), http://www.hsph.harvard.edu/news/press-releases/smoking-high-blood-pressure-overweight-preventable-causes-death-us/) (internal quotation marks omitted).

[14] *See id.* at 1721 (positing that free choice itself may lead to "healthier decisions" in the battle against obesity).

[15] *See id.* at 1692 (describing a "general rejection of paternalism" of all kinds). Since, in his view, hard paternalism is not politically viable and soft paternalism is weak and ineffective, Friedman argues that public health advocates might consider doing nothing to intervene in the obesity problem: "rejection of hard paternalism can lead regulators either to use strategies that preserve autonomy, or simply to do nothing to regulate personal choices." *Id.*

[16] *Id.* at 1721.

food consumers making the "choice" to be obese.[17] In addition, he implies that there may be no need for the government to intervene with respect to obesity because the growth rate of obesity has leveled off, which in his view indicates a "natural" upper limit to obesity rates.[18] He also observes that some free market responses, including food producer "voluntarism" (i.e., self-regulation) and the expanding diet and weight loss industry, have helped to reduce obesity rates.[19] In his view, free markets and free choice could, at least in theory, solve the obesity problem by allowing people to satisfy their own preferences:

> The most powerful solution available that eschews all paternalism in favor of autonomy would be a natural collective preference to engage in proper caloric intake and energy discharge. Though other factors like genetics might play into obesity, if these preferences, which would lead to better health and longer life expectancy, were dominant, free choice would lead to healthier decisions.[20]

Friedman acknowledges, however, that the free market approach has not completely solved the public health obesity problem[21] and concedes that government interventions may be warranted to respond to certain market failures, such as cognitive biases.[22] In the obesity context, he singles out the "present bias," which causes consumers to focus almost exclusively on the present consequences of actions and to ignore important future consequences.[23] In his view, a government intervention to "debias" the present bias might be warranted, but only if the effectiveness of the intervention is established.[24] Although the main "drivers" of obesity are known,[25] Friedman doubts whether public health interventions can significantly reduce the complex problem of obesity.[26]

In addition, the regulatory "full-court press" that Friedman believes is required to effectively respond to the obesity problem is, in his view, not

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[17] *See id.* at 1720 (arguing that reducing obesity requires "changing the way people of different ages, ethnic and racial backgrounds, and socioeconomic strata behave when they eat or drink").

[18] *Id.* at 1713.

[19] *Id.* at 1722–24.

[20] *Id.* at 1721.

[21] *See id.* at 1726 ("The evidence overwhelmingly indicates that the obesity problem has not been resolved by the combination of market forces and reactive intervention.").

[22] *See id.* at 1726–27 ("Regulatory strategies can be designed to address a bias or error that interferes with decisions, leading people to make suboptimal or harmful choices.").

[23] *Id.* at 1728.

[24] *Id.*

[25] *Id.* at 1714

[26] *See id.* at 1767 ("Undoubtedly, obesity presents a health crisis, but the complexity of the contributing dynamics renders the problem difficult to solve.").

possible in the current environment.[27] He discusses two specific obstacles to comprehensive anti-obesity public health interventions. First, he argues that public opinion is trending in favor of autonomy and against public health paternalism, especially highly coercive, hard public health paternalism.[28] He concludes that, where autonomy and public health paternalism are in conflict, Americans increasingly choose autonomy over improvements in public health.[29] Second, he argues that, although soft paternalism might be more acceptable to the public, it would be ineffective or inefficient.[30] In light of these two obstacles, Friedman concludes that anti-obesity public health paternalism cannot solve the obesity problem: "[R]ecent developments in public health regulation indicate that regulators may have a more limited range of tools going forward. In particular, when looking at obesity . . . finding viable opportunities to change consumption and physical activity patterns through hard paternalism proves difficult, and soft paternalism can prove ineffective."[31]

Friedman nonetheless expresses a normative claim that public health regulators may be morally obligated to continue their efforts to reduce obesity.[32] Notwithstanding his pessimistic evaluation of anti-obesity public health paternalism, Friedman says that paternalists should not wave the white flag, because some strategies may be used to reduce obesity.[33] First, he counsels that public health paternalists can sneak public health paternalistic interventions (including hard paternalism) past the pro-autonomy/anti-paternalistic public by crafting the paternalism so that the public does not notice that its autonomy has been constrained.[34] Second, he concludes that government can coerce more effectively in "Zones of Control," i.e., in food environments that are controlled by government, instead of private markets.[35] He provides two examples of such zones of control: (1) schools (a zone of physical control); and (2) the Supplemental Nutrition Assistance Program (a zone of legal control).[36] Finally, he closes

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[27] *Id.* at 1719.

[28] *Id.* at 1744, 1767–68.

[29] *Id.* at 1767; *see also id.* at 1756 (noting in the marijuana context that "the public increasingly desires to eschew paternalism in favor of more autonomy").

[30] *See id.* at 1768–69 (arguing that efforts to reduce obesity "would be blocked due to the weakness of most soft paternalism strategies" and that "softer paternalistic efforts help debias at the margin, but simply do not provide the power to put significant dents in this Gordian problem").

[31] *Id.* at 1693–94.

[32] *See id.* at 1769 ("Should regulators surrender? Morally, that might not be an option. Scientists and policymakers might have the obligation to play the paternal role, even if it proves unpopular.").

[33] *Id.* at 1769–70.

[34] *Id.* at 1747–51. Friedman argues that "regulators can intervene somewhat more easily" in "Zones of Intangibility," which he describes as situations in which paternalistic constraints on autonomy are "*not felt*." *Id.* at 1747.

[35] *Id.* at 1744.

[36] *Id.*

with a broader normative claim that public health regulators "*should* pursue all solutions open to them" and rationalize their public health regulations with cost-benefit analyses.[37]

III. CRITIQUE OF FRIEDMAN'S APPROACH AND CLAIMS

Friedman and I agree on some important issues. For example, we agree that obesity is a major risk factor for most of the chronic diseases that impair the health and quality of life of Americans and shorten their lives.[38] We also both agree that obesity is an important public health issue that policymakers in our country need to address.[39] In addition, I share Friedman's concerns about the increasing costs of obesity-related medical care[40] and agree that obesity is a complex problem with many inputs.[41]

He and I disagree about some of the facts of the obesity problem, however. Friedman's normative stance leads him to frame the facts in a way that, in my view, misrepresents the current reality of obesity in America. As a Libertarian, Friedman highly values autonomy and free markets.[42] He concedes, however, that his idealized free market would make Americans healthier only if we had a "collective preference" for healthy foods and exercise.[43] In fact, we do not have such a collective

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[37] *Id.* at 1769 (emphasis added). Friedman elaborates on this advice to regulators:

> Efforts should concentrate on the areas that science indicates would be the most impactful, and which would be the most practical to implement.
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> For example, initiatives that harness the market and promote voluntarism in areas that could matter (e.g., the voluntary changes made by food retailers), would meet those criteria. Debiasing initiatives that prove effective while preserving autonomy might prove weaker, but also could add up if enough of them were pressed. Opportunities to deploy hard paternalism should be sought with care, so as to minimize the perception that the regulators are usurping a tangible choice or are treading beyond the zone normally ceded to regulators. These opportunities may prove few, but if sought and pressed aggressively, they may have powerful effect.
>
> Though the opportunities for deploying paternalism effectively in the public health arena may prove limited, they do exist. If regulators minimize the perception that they are reducing autonomy, perhaps the public might give more slack to initiatives that tread on the border.

Id.

[38] *See id.* at 1712 (noting obesity is the "third leading stand-alone risk factor" for preventable deaths per year).

[39] *See id.* (noting that "[w]ithout a doubt, basic theories of both soft and hard paternalism would support interventions" to respond to obesity, which is "a grave public health issue.").

[40] *See id.* at 1714 ("[M]edical costs attributable to obesity rose from $78.5 billion in 1998 to $147 billion by 2008.").

[41] *See id.* at 1710 ("[O]besity presents perhaps the biggest and most complex public health challenge facing regulators.").

[42] *See supra* text accompanying notes 5, 16–20.

[43] *See* Friedman, *supra* note 1, at 1721.

preference; at least in the current food environment, we have quite the opposite collective preference. Our innate preferences for sugar, fat, and salt in our diet conferred a survival advantage in a prior time, in which food sometimes was scarce, and our tastes led us to consume a varied diet of whole foods that provided healthy micronutrients as well as macronutrients.[44] In the current food environment, however, sugars and fats occur not just in whole foods, but also in highly concentrated form in processed food, much of which tastes quite delicious, but is highly caloric and has little or no nutritional value; thus, our hard-wired tastes are maladaptive in today's food environment.[45]

Food markets suffer from various types of market failures, which may warrant government intervention.[46] For example, government can respond to the market failure of "incomplete information" by mandating disclosure or by compiling the missing information and disseminating it.[47] Friedman characterizes the provision of calorie counts for away-from-home foods (e.g., food served in fast food restaurants and sit-down restaurants) as "paternalism,"[48] but I do not see it as such. Weight conscious food consumers must be able to determine the calorie counts for the food they eat. They can discern taste, price, value, and other important aspects of foods; in the absence of calorie information, restaurants and food producers compete on the aspects that consumers can discern, resulting in increased calories in such foods.[49] This missing calorie information creates a market failure that justifies government intervention; regulations and laws that mandate the provision of calorie counts benefit consumers who want the information but otherwise cannot get it. Consumers who are not concerned about calorie counts ignore them. Mandating information that consumers want, to determine their own preferences, does not fit Friedman's definition of paternalism, which is implicitly "other-

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[44] Katherine Pratt, *A Constructive Critique of Public Health Arguments for Antiobesity Soda Taxes and Food Taxes*, 87 TUL. L. REV. 73, 99 (2012).

[45] *See id.* ("In an environment in which foods high in fat and sugar are plentiful, ubiquitous, and cheap, however, these fast and frugal heuristics lead to systematic decision-making errors, obesity, chronic disease, and reduced well-being.").

[46] *See, e.g.*, JOSEPH E. STIGLITZ, ECONOMICS OF THE PUBLIC SECTOR 83 (1986) (explaining that government can adopt market-corrective interventions to respond to market failures).

[47] *Id.* at 90–91.

[48] *See* Friedman, *supra* note 1, at 1733 (characterizing mandatory calorie disclosures as "soft paternalism").

[49] *See* JAYACHANDRAN N. VARIYAM, U.S. DEP'T OF AGRIC., NUTRITION LABELING IN THE FOOD-AWAY-FROM-HOME SECTOR: AN ECONOMIC ASSESSMENT 2 (2005), *available at* http://www.ers.usda.gov/publications/err-economic-research-report/err4.aspx#.UzG07q1dVOw ("Foods prepared away from home contain more calories per eating occasion . . . and are higher in total fat, saturated fat, and cholesterol and lower in dietary fiber, calcium, and iron on a per-calorie basis than food prepared at home."); *see also* Devin Alexander, *Restaurant Shockers: A Culinary Insider Reveals 7 Ways Chefs Sabotage Your Diet When You Go Out to Eat*, SHAPE, Oct. 2004, at 198 (discussing "common restaurant practices" that add hidden fat and calories to restaurant foods).

regarding."[50]

In the context of food markets, internalities are another prominent type of market failure. "Internalities" are costs, which are incurred by different "selves" at different points in time and result in inadvertent harm to self over time.[51] Internalities typically result from cognitive biases and heuristics.[52] Friedman singles out "present bias" as "the primary cognitive bias" that is implicated in the prevalence of obesity.[53] One problem with his discussion of present bias is that empirical evidence demonstrates that common sense measures to debias often fail.[54] In addition, present bias is but one of many biases and heuristics that affect food and beverage consumption and contribute to obesity. His single-minded focus on present bias oversimplifies the complex processes that are involved in eating "decisions." In a previous article, I discussed an entire catalogue of biases and heuristics, many of which are quite deliberately exploited by food producers.[55] The exploitation of consumer biases and heuristics by the food industry raises concerns about the role of the food industry in the obesity epidemic.

Friedman and I both regard food producers as important players in the resolution of the obesity problem in America, but we disagree about what it will take to encourage food producers to make their products healthier on a grand scale. In his discussion of the role of free markets in obesity, Friedman characterizes the food industry in an unrealistically beneficent fashion.[56] His application of the terms "paternalism" and "voluntarism" to food industry self-regulation[57] seems oxymoronic to me. Paternalism implies a benevolent concern and intention for the well-being of others.[58]

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[50] *See* Friedman, *supra* note 1, at 1769 ("[P]aternalism [is] the 'interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the [other] person being coerced.'" (quoting Gerald Dworkin, *Paternalism*, 56 THE MONIST 64, 65 (1972))).

[51] *See* Jonathan Gruber & Botond Köszegi, *Is Addiction "Rational"? Theory and Evidence*, 116 Q.J. ECON. 1263, 1292–93 (2001) (discussing time-inconsistent preferences of present and future selves and estimating the internal costs of smoking cigarettes).

[52] *See, e.g.*, Pratt, *supra* note 44, at 94–103 (discussing internalities in the context of making decisions about foods).

[53] Friedman, *supra* note 1, at 1720.

[54] *See, e.g.*, Lauren E. Willis, *Against Financial-Literacy Education*, 94 IOWA L. REV. 197, 272–75 (2008) (concluding that efforts to debias by improving consumers' financial literacy can backfire, leading to worse decision making).

[55] Pratt, *supra* note 44, at 100–06.

[56] *See* Friedman, *supra* note 1, at 1722 (arguing that food industry "voluntarism," to adopt anti-obesity measures, "might emerge out of sheer private paternal goodwill").

[57] *Id.*

[58] Friedman includes this aspect of paternalism when referring to an encyclopedia's example of paternalism: "a lifeguard presents a natural example of an omniscient, *benevolent* decision maker responsible for public and individual welfare." *Id.* at 1697 n.41 (emphasis added) (citing *Paternalism*, NEW WORLD ENCYCLOPEDIA, http://www.newworldencyclopedia.org/entry/Paternalism#Soft_vs._hard_paternalism (last updated Apr. 2, 2008)).

If the food industry adopts measures that might improve the well-being of others, but takes that action for a "selfish," defensive, profit-maximizing reason, that action may be a free market response, but does not seem to fit within the concept of paternalism. Corporations exist primarily to maximize corporate profits, not to paternalistically care for the corporation's customers in ways that reduce corporate profits.[59] Corporate advertising may create the illusion that corporations care for us (e.g., "We Do It All for You"), but those messages are merely marketing gimmicks that are designed to manipulate us into buying certain products;[60] that is what for-profit corporations do, for good or ill. On that basis, I disagree with Friedman's assertion that food industry voluntarism to reduce obesity can result from "sheer private paternal goodwill."[61] I agree with him, however, that industry self-regulation "may simply be good for business[] or . . . designed to pre-empt regulation."[62]

Unlike many public health advocates, who cast the food industry in the permanent role of arch villain in the obesity epidemic narrative,[63] I am of the view that the food industry could be part of the solution to the obesity problem—but only if legislation or regulations change the legal landscape so that meaningful self-regulation is in the economic best interests of the industry and its shareholders. I agree with Critical Realists that, in the current environment, food producers have every incentive to exploit consumers' cognitive biases and heuristics to encourage consumers to buy more of their products.[64] Consumer behavior does not always entail as much choice as Friedman would have us believe, or even as much choice as we all tend to believe we have. To date, left to their own devices, food producers have competed primarily based on taste, price, shelf life, and convenience, with no regard for the health consequences of their products.[65] The result is that Lunchables and Kraft Macaroni & Cheese

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[59] *See* Adam Benforado et al., *Broken Scales: Obesity and Justice in America*, 53 EMORY L.J. 1645, 1689 (2004) ("In the United States, norms and laws lead corporations to pursue a common single interest—profit maximization—and, in turn, the shared interests of encouraging markets, preventing profit-restricting regulation, and supporting a conception of human behavior that enhances revenues.").

[60] *See id.* at 1709 (reciting various food industry slogans that are designed to create the dispositionalist illusion, in the minds of exploited foods consumers, that they are in control of their own food purchasing decisions and the impression that the industry exists solely to serve consumers).

[61] Friedman, *supra* note 1, at 1722.

[62] *Id.*

[63] *See, e.g.*, Zita Lazzarini & David Gregorio, *Personal Health in the Public Domain: Reconciling Individual Rights with Collective Responsibilities*, 46 CONN. L. REV. 1839, 1847 (2014) ("[T]he contemporary discourse about food preferences and lifestyle is significantly skewed by an industry that benefits from the sale of items, regardless of the nutritional peril consumption poses to individuals . . . . The burdens of poor diets visited upon individuals, households, or communities are negligibly borne by the parties who encourage such consumption practices.").

[64] *See* Benforado et al., *supra* note 59, at 1694 (noting sales tactics that exploit biases for hot meals or that appeal to "patriotic impulses").

[65] MICHAEL MOSS, SALT, SUGAR, FAT: HOW THE FOOD GIANTS HOOKED US, at xiii–xiv (2013).

have become staples in the American diet.[66] Bob Drane, one of the original developers of Lunchables, who now lectures on the role of the food industry in the obesity problem, provided this recipe for success to business school students:

> Discover what consumers want to buy, and give it to them with both barrels. Sell more, keep your job! How do marketers often translate these "rules" into action on food? Our limbic brains love sugar, fat, salt (scarce and high energy). So, formulate products to deliver these. Perhaps add low cost ingredients to boost profit margins. Then "supersize" to sell more (# users x amount/user). And advertise/promote to lock in "heavy users." Plenty of guilt to go around here![67]

Notwithstanding the culpability of the food industry in the obesity problem to date, there is much we can do to encourage the food industry to develop healthier products. For example, First Lady Michelle Obama's "Let's Move!" campaign[68] sends a signal to food producers and retailers that they need to engage in self-regulation or face the threat of bad publicity or worse. In a previous article, I suggested that we develop a federal food classification and front-of-package labeling system that would classify foods as unhealthy, neutral, and healthy.[69] This framework would create an economic incentive for food producers to reformulate foods and make them healthier.

According to Friedman, the growth of the diet and weight loss industry is another laudable free market response to the obesity problem.[70] In spite of the growth of the weight loss industry, however, the overwhelming majority of diets fail over the long run.[71] It is easy to lose weight while staying at Miraval Resort, a controlled environment in which physical activity fills guests' days and healthy, delicious food is served in small attractive portions.[72] In the real world, however, our jobs are sedentary; our leisure time is short; and delicious, cheap, and convenient—albeit

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[66] *Id.* at 174–75, 184.

[67] *Id.* at 210 (internal quotation marks omitted). Years after helping to develop Lunchables, Drane developed a different perspective; he now "holds the entire [food] industry accountable for the [obesity] epidemic." *Id.* According to Drane, the epidemic is due to the "rise in corporate cooking, processed and preserved foods, often high in sugar/fat/salt/etc. More calories in, less calories burned, obesity up." *Id.*

[68] *About*, LET'S MOVE!, http://www.letsmove.gov/about (last visited July 15, 2014).

[69] Pratt, *supra* note 44, at 138–40.

[70] Friedman, *supra* note 1, at 1722.

[71] *See* Pratt, *supra* note 44, at 116 ("[I]n the long run 95% of diets fail because, in the real world, food cues in the obesogenic food environment are ubiquitous and compelling, although often hidden.").

[72] *Miraval: An Overview*, MIRAVAL, http://www.miravalresorts.com/overview/ (last visited July 15, 2014).

unhealthy—foods and drinks are everywhere.[73] In the obesogenic, real-world food environment, maintaining a normal weight is challenging.[74]

Although Friedman obviously is enamored with autonomy and free markets, he does not focus exclusively on autonomy, unlike some Libertarians. A welfarist normative orientation is implicit throughout his article, although Friedman does not self-identify as a welfarist.[75] Friedman seems willing to consider other normative goals and values, in addition to promoting autonomy, if doing so promotes social welfare. For example, he expresses sympathy for the efforts of public health paternalists to reduce obesity-related morbidity and mortality.[76] Also, Friedman concedes that it might be appropriate for the government to intervene to correct a market failure if the market correction will be effective.[77] This concession turns out to be a straw man, however, because he doubts the effectiveness of most market interventions.

Up to this point, Friedman's views follow a familiar script, which implies that it might be better to leave consumer preferences and markets alone because regulators will make a mess of things.[78] Critical Realists note that the "dispositional" orientation (i.e., the belief that consumers make their own "free," independent decisions and are not affected by the situations in which they find themselves)[79] is helpful to businesses, in part

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[73] *See* Pratt, *supra* note 44, at 94–95.

[74] *See, e.g.*, BRIAN WANSINK, MINDLESS EATING: WHY WE EAT MORE THAN WE THINK 27 (2006) ("[W]eight loss [through dieting] is not mindless. It's like pushing a boulder uphill every second of every day."). Nutritionist Marian Nestle shares a similar observation about the American food environment: "Even if you know what is good for you, you are likely to have a hard time putting principles into practice. . . . [I]n America today . . . it is very, very hard not to overeat." MARION NESTLE, WHAT TO EAT 11 (2006).

[75] Friedman describes his approach to developing advice for public health regulators:

> I note that moral justifications can be offered for different levels of paternalistic intervention, but I do not make normative prescriptions based on morality. I advise using restraint and expecting modest results from regulatory intervention in public health, based on the reality of public attitudes toward paternalism and the complexity of the problem being addressed.

Friedman, *supra* note 1, at 1697 n.40.

[76] *See id.* at 1711 ("[I]t can be difficult to discern where and how regulatory efforts can be deployed most efficiently and effectively to mitigate [obesity].").

[77] *See id.* at 1720 ("[T]he analysis must focus on the strategies that the public will support, or at least not aggressively oppose.").

[78] *See id.* at 1720–26 (discussing "apaternalistic" measures geared towards the obesity problem).

[79] Critical Realists Adam Benforado, David Yosifon, and Jon Hanson observe:

> [C]orporations, as entities, are largely justified as socially beneficial from the dispositionist perspective. If consumers are assumed to be dispositional—that is, if they act according to a stable set of preferences that only they can assess directly—then it follows naturally that the best way to maximize welfare is to allow consumers to satisfy their preferences through free markets. It is through mutually beneficial transactions that otherwise invisible preferences are satisfied and overall social

because that orientation discourages the regulation of businesses to prevent harms to consumers:

> Markets, which allow the free exercise of dispositions, are understood to be more responsive to consumer preferences than regulators who lack good information and the appropriate incentives. The dispositionist baseline translates to a presumption against regulatory intervention even against visible harms, for the actors involved are presumed to be choosing the inevitable risks that gave rise to those harms. Since the commercial interest merely responds to individual manifestations of choice, responsibility for bad outcomes—the giant gut and the cellulite thighs—can be squarely placed on the consumer. Regulatory intervention is warranted only in circumstances in which markets demonstrably fail to respond to consumer dispositions—for instance, when consumers clearly lack information or when a transaction creates significant negative externalities. But, even in the presence of such market imperfections, calls for regulation may be rebutted on the grounds that imperfect markets are preferable to imperfect regulations.[80]

Friedman goes on, however, to reach a conclusion that I found surprising at first. Although he privileges autonomy, choices, and free markets, he ultimately counsels public health regulators to try to overcome the formidable political obstacles to public health paternalism by *hiding* public health paternalism—even highly coercive hard paternalism—so that Americans do not notice or feel the loss of autonomy.[81] The only way that an autonomy-loving Libertarian could reach this conclusion is by adopting a welfarist normative stance, such as a utilitarian social welfare function, which trades off welfare gains from improved health against the minimal or nonexistent welfare loss caused by the hidden loss of autonomy.[82] Under this view, it is the feeling or mental state accompanying loss of

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> welfare is increased. Profit is the substantiation of these welfare-enhancing transactions and is therefore, by definition, good.

Benforado et al., *supra* note 59, at 1689.

[80] *Id.* at 1689–90.

[81] Friedman, *supra* note 1, at 1709, 1768. According to Friedman, "The forgone autonomy is invisible or simply has no value. If opportunities to deploy hidden paternalism emerge, they can be valuable for regulators to exploit." *Id.* at 1709.

[82] *See id.* at 1709 (suggesting that when a ban creates no visible reduction of individual choice, but results in enhanced individual welfare, it is a practical and beneficial solution); *see also id.* at 1691 (stating that a common critique of libertarian paternalism is that it cannot be reconciled with state efforts to promote social welfare).

autonomy that creates a welfare loss, not the actual loss of autonomy.[83] I found it difficult to reconcile this recommendation—that public health regulators should exploit hidden paternalism, even hard paternalism—with the dichotomy between autonomy and coercion that dominates the article as a whole. From the beginning of the article, Friedman stakes out a position in favor of free market autonomy and against government coercion. Throughout the article, he seems to disapprove of coercive public health paternalism that limits autonomy, and one of his main claims is that the public increasingly demands autonomy.[84]

The "coercion spectrum," which is the main theoretical construct that Friedman deploys in his article, classifies public health paternalistic measures based on the degree of government coercion involved.[85] One could see why a Libertarian might distinguish between public health interventions based on degree of coercion, as Libertarians highly value autonomy, and coercion and autonomy are thought to be mutually exclusive. Friedman's theoretical classification system, however, is not actually doing the work of distinguishing between well-advised and ill-advised forms of public health paternalism. In addition, this "coercion spectrum" would not help a policymaker decide whether to adopt a specific public health proposal, regardless of where the proposed intervention is on the spectrum of hard paternalism to soft paternalism.

Instead, I argue that a different sort of classification system is implicit in the public health examples Friedman uses. The alternative classification system, developed by Mark Hall, classifies public health interventions based on whether the intervention:

> (1) narrowly targets "a specific, identifiable pathogen or discrete causal agent" that causes disease or death;
>
> (2) more broadly targets behavioral risk factors, such as obesity, that significantly contribute to chronic diseases and death; or
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> (3) even more broadly targets ecological and societal factors, such as poverty and income inequality, that also significantly contribute to disease and death.[86]

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[83] *See id.* at 1747 ("[S]ome hard paternalistic initiatives can be implemented without triggering the perception of loss. If the regulators eliminate a truly poor choice, there should be an opportunity for a welfare gain."). A "mental-state" conceptualization of welfare focuses on subjective well-being. *See, e.g.*, MATTHEW D. ADLER & ERIC A. POSNER, NEW FOUNDATIONS OF COST-BENEFIT ANALYSIS 29 (2006) ("One type of mental-state view, pressed by Bentham, focuses on 'pains' and 'pleasures,' understood as positive and negative sensations or feelings.").

[84] *See* Friedman, *supra* note 1 at 1754 (finding that people are hesitant when "regulators restrict personal choice" but they "applaud the addition of choice").

[85] *Id.* at 1698–99.

[86] Mark A. Hall, *The Scope and Limits of Public Health Law*, 46 PERSP. BIOLOGY & MED. S199, S206 (2003).

Traditionally, public health law measures included only the first type of intervention. This "old" public health focused on the control of infectious diseases, pathogens, and toxins; provision of uncontaminated drinking water and food; and sanitation facilities.[87] To eliminate, reduce, or contain identifiable pathogens and toxins, public health authorities had police power to act, including the power to coerce; for example, public health authorities could order a quarantine to contain the spread of an infectious disease.[88] In the context of fighting pathogens and infectious diseases, the use of public health power to coerce is understood as necessary, notwithstanding the fact that assertion of such power limits individual freedom.[89]

"Old" public health interventions significantly reduced the incidence of many preventable causes of disease and death, resulting in an "epidemiological transition" in preventable causes of death.[90] In today's world, most preventable diseases and deaths are attributable to broader behavioral risk factors and ecological factors. The goal of reducing preventable disease and death leads proponents of the "new" public health to suggest that public health law be used to reduce behavioral risk factors, including tobacco, alcohol, and drug use; unhealthy diet and activity patterns; and risky sexual behaviors.[91] Recently, public health advocates have focused on anti-obesity public health measures as the "new frontier of public health law."[92]

The next Part of this Article considers the implications of applying (1) Friedman's "coercion spectrum," and (2) Hall's "old" public health and "new" public health distinction, to the rule that limited the portion size of sugary drinks served in New York City food service establishments to sixteen ounces. The portion cap rule, which was promulgated by the New York City Board of Health and subsequently invalidated by a New York court,[93] is the main piece of evidence offered by Friedman to support his

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[87] *See* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 9, 16–17 (2000) (describing the historical traditional approach to public health).

[88] Pratt, *supra* note 44, at 107.

[89] *See, e.g.*, Wendy E. Parmet, *Quarantine Redux: Bioterrorism, AIDS and the Curtailment of Individual Liberty in the Name of Public Health*, 13 HEALTH MATRIX 85, 85–87 (2003) (comparing the coercive public health measures adopted during the AIDS epidemic to proposed public health measures that might be adopted to respond to incidents of bioterrorism).

[90] Lawrence O. Gostin, *Fast and Supersized: Is the Answer to Diet by Fiat?*, 35 HASTINGS CENTER REP. 11, 11 (2005).

[91] *Id.*

[92] Michelle M. Mello et al., *Obesity—The New Frontier of Public Health Law*, 354 NEW ENG. J. MED. 2601, 2601 (2006) ("The public health law approach posits that the law can be used to create conditions that allow people to lead healthier lives . . . [because] the government has both the power and the duty to regulate private behavior in order to promote public health.").

[93] *See infra* Part IV.B.–C.

claim that anti-obesity public health paternalism "has peaked."[94] In my view, the judicial invalidation of the portion cap rule is much better explained by Hall's construct than by Friedman's coercion spectrum.

IV. THE SUGARY DRINK PORTION CAP EXAMPLE

A. *The Promulgation of the Sugary Drink Portion Cap Rule*

Reducing consumption of sugar-sweetened soda has been a focus of public health advocates for several decades.[95] During the last decade, senior public health officials in New York City, under the leadership of Mayor Michael Bloomberg, advocated for soda taxes to reduce soda consumption.[96] Although support for such taxes was strong in the public health community, both the New York State Assembly and the New York City Council repeatedly considered and rejected proposals to tax or regulate the consumption of sodas and other sugary drinks.[97] Although Mayor Bloomberg subsequently abandoned the proposed soda tax,[98] public health advocates in the City continued to search for alternative means of reducing soda consumption.

In a 2012 report, the New York City Obesity Task Force[99] noted the

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[94] Friedman, *supra* note 1, at 1694.

[95] *See, e.g.*, Jennifer L. Pomeranz, *Television Food Marketing to Children Revisited: The Federal Trade Commission Has the Constitutional and Statutory Authority to Regulate*, 38 J.L. MED. & ETHICS 98, 100 (2010) (discussing a failed attempt, during the late 1970s, to regulate soda and junk food television advertising directed towards children). Michael Jacobson of the Center for Science in the Public Interest has been a longstanding advocate for public health measures to reduce soda consumption. *See* MICHAEL F. JACOBSON, CTR. FOR SCI. IN THE PUB. INTEREST, LIQUID CANDY: HOW SOFT DRINKS ARE HARMING AMERICANS' HEALTH (2d ed. 2005), *available at* http://www.cspinet.org/new/pdf/liquid_candy_final_w_new_supplement.pdf. In 2000, Jacobson and Kelly Brownell proposed a tax on sodas to discourage soda consumption and raise revenue for anti-obesity programs. Michael F. Jacobson & Kelly D. Brownell, *Small Taxes on Soft Drinks and Snack Foods to Promote Health*, 90 AM. J. PUB. HEALTH 854, 854–57 (2000).

[96] *See, e.g.*, Kelly D. Brownell & Thomas R. Frieden, *Ounces of Prevention—The Public Policy Case for Taxes on Sugared Beverages*, 360 NEW ENG. J. MED. 1805, 1806 (2009).

[97] *See* N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *5, *17 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 970 N.Y.S.2d 200 (App. Div. 2013) (cataloguing various "sugary drink" proposals that the New York City Council and New York State Assembly considered and rejected).

[98] Anemona Hartocollis, *City's Health Commissioner, in a Medical Journal Article, Calls for a Tax on Soda*, N.Y. TIMES, Apr. 9, 2009, at A22.

[99] Mayor Bloomberg convened the New York City Obesity Task Force and charged it with developing and recommending "innovative, aggressive solutions to address the obesity challenge in New York City." N.Y.C., REVERSING THE EPIDEMIC: THE NEW YORK CITY OBESITY TASK FORCE PLAN TO PREVENT AND CONTROL OBESITY 2 (2012) [hereinafter N.Y.C. OBESITY TASK FORCE REPORT], *available at* http://www.nyc.gov/html/om/pdf/2012/otf_report.pdf. The Task Force articulated four key goals for its work: (1) "Reduce obesity"; (2) "Address disparities between communities"; (3) "Reduce preventable health conditions"; and (4) "Create strategies to lower health care spending and lost productivity." *Id.* at 3. The Task Force included commissioners from eleven

nutritional effects of increased consumption of sugar-sweetened soda:

> Americans consume about 200–300 more calories per day than 30 years ago, with the largest single increase due to sugar-sweetened drinks. Nearly half of added sugar we consume is from sugar-sweetened drinks. There also has been a significant increase in portion sizes over the past several decades. The promotion of healthy eating includes decreasing the consumption of foods and beverages that are high in calories and nutrient poor and increasing the consumption of foods and beverages that are low in calories and nutrient rich.[100]

Also expressing concern about higher rates of obesity and greater consumption of sugary drinks in poor neighborhoods and Black and Latino communities,[101] the Task Force set a goal of reducing New Yorkers' sugary drink consumption by thirty percent by 2016.[102] The Task Force recommended that the city "[e]stablish a maximum size for sugary drinks in food service establishments"[103] to reduce excessive consumption of sugary drinks. The idea was that changing the default portion size for sugary drinks served in restaurants would make New Yorkers think more consciously about how much soda they are drinking and "reacquaint New Yorkers with 'human size' portions."[104]

Based upon the Task Force's recommendation, Mayor Bloomberg proposed that the New York City Board of Health (the "Board of Heath" or "Board")[105] adopt the sugary drink portion cap proposal.[106] The Board of Health published the proposed portion cap rule in the City Record, for comment, and on July 24, 2012, it held a public hearing on the proposed

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diverse New York City agencies and representatives from the mayor's office, including the city's Food Policy Coordinator. *Id.* at 2–3.

[100] *Id.* at 12 (footnotes omitted). The Task Force noted that sugary drinks are "ubiquitous" and "are the leading items associated with excess intake of calories in adults." *Id.* at 5.

[101] *See id.* at 4 (noting that "the rate of overweight and obesity reaches 70 percent" in certain Black, Latino, and low-income communities in New York City).

[102] *Id.* at 7.

[103] *Id.* at 14.

[104] *Id.*

[105] The Board of Health is part of the New York City Department of Health and Mental Hygiene, which is an executive branch agency with a public health orientation. N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *2 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 970 N.Y.S.2d 200 (App. Div. 2013). The ten members of the Board of Health and the chairperson are appointed by the Mayor. *Id.* Under the New York City Charter, five of the ten Board members must be medical doctors and the other five, if not doctors, must be experts in related scientific fields. *Id.* Dr. Thomas Farley, the Commissioner of the New York City Department of Health and Mental Hygiene, served as the Chairperson of the Board at the time the Board adopted the portion cap rule. *Id.* at *3.

[106] *Id.*

rule.[107] Following the hearing, the New York City Department of Health and Mental Hygiene prepared a memorandum, dated September 6, 2012, for the Board of Health, summarizing and responding to comments and testimony that the Board received.[108] On September 13, 2012, the Board met and adopted the sugary drink portion cap rule.[109]

The sugary drink portion cap rule[110] applied to some, but not all, New York City business establishments that serve sugary drinks. It applied to "food service establishment[s],"[111] including "restaurants, delis, fast-food franchises, movie theaters, stadiums and street carts, but not to grocery stores, convenience stores, 7-Elevens, corner markets, gas stations and other similar businesses."[112] The "sugary drinks"[113] it regulated included sugar-sweetened sodas, energy drinks, and sweetened juices, but not potentially more caloric types of drinks, such as alcoholic beverages, fruit smoothies, milkshakes, and milky coffee drinks.[114] Although the portion cap rule limited the size of the container in which sugary drinks could be served, it did not prohibit consumers from buying more than one sugary drink, refilling a drink container, or adding any quantity of sugar after purchasing a drink.[115] Multiple plaintiffs challenged the soda portion cap and sought to enjoin its enforcement.[116]

B. *The Invalidation of the Sugary Drink Portion Cap Rule*

New York Supreme Court Judge Milton Tingling invalidated the sugary drink portion cap rule on the grounds that (1) it was "arbitrary and capricious,"[117] and (2) the members of the Board of Health "exceeded their authority and impermissibly trespassed on legislative jurisdiction" when they promulgated the rule.[118] Judge Tingling held that the portion cap rule

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[107] *Id.* at *4.

[108] *Id.*

[109] *Id.*

[110] 24 R.C.N.Y. § 81.53 (2013).

[111] *Id.* § 81.53(b).

[112] Verified Article 78 & Declaratory Judgment Petition at 3, *N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607 (No. 653584/12) [hereinafter Plaintiff's Petition].

[113] The rule defined "sugary drink" as a beverage that: "(A) [was] non-alcoholic; (B) [was] sweetened by the manufacturer or establishment with sugar or another caloric sweetener; (C) ha[d] greater than 25 calories per 8 fluid ounces of beverage; and (D) [did] not contain more than 50 percent of milk or milk substitute by volume as an ingredient." 24 R.C.N.Y. § 81.53(a).

[114] Plaintiff's Petition, *supra* note 112, at 3.

[115] *N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607, at *6.

[116] *Id.* at *1. The plaintiffs included the "New York Statewide Coalition of Hispanic Chambers of Commerce, The New York Korean-American Grocers Association, Soft Drink and Brewery Workers Union, Local 812, International Brotherhood of Teamsters, The National Restaurant Association, The National Association of Theatre Owners of New York State, and The American Beverage Association." *Id.*

[117] *Id.* at *20.

[118] *Id.* at *6.

was "arbitrary and capricious" because the rule did not apply to soda sold by businesses other than "food service establishments," did not apply to certain categories of highly caloric beverages and sugar-sweetened beverages, and permitted unlimited drink refills.[119] These exceptions to the rule "effectively defeat[ed] the stated purpose of the Rule," which was to reduce obesity.[120]

Judge Tingling analyzed the separation of powers issue by applying *Boreali v. Axelrod*.[121] In *Boreali v. Axelrod*, the New York Court of Appeals invalidated a rule, promulgated in 1987 by the New York State Public Health Council ("PHC"), which broadly prohibited indoor smoking in most public places, with specific enumerated exceptions.[122] (The PHC adopted the rule after the state assembly rejected a broad indoor smoking ban and instead enacted a narrowly drawn indoor smoking ban.[123]) Judge Titone, writing for a majority, articulated four "circumstances" that led the Court to conclude that the PHC had impermissibly usurped legislative power in promulgating the broad indoor smoking regulations: (1) the PHC balanced public health and "economic and social concerns,"[124] as demonstrated by various exceptions (based on economic and political concerns) to the general rule promulgated; (2) the PHC promulgated the rule "on a clean slate," with no "legislative guidance";[125] (3) the PHC acted "in an area in which the Legislature repeatedly had tried—and failed—to reach agreement in the face of substantial public debate and vigorous lobbying by a variety of interested factions";[126] and (4) the rule promulgated by the PHC did not require specialized public health "expertise or technical competence."[127]

In the case involving the sugary drink portion cap rule, Judge Tingling

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[119] *Id.* at *20.

[120] *Id.*

[121] *Id.* at *8. For an argument against the use of the *Boreali* framework to analyze the sugary drink portion cap rule, see Kara Marcello, Note, *The New York City Sugar-Sweetened Beverage Portion Cap Rule: Lawfully Regulating Public Enemy Number One in the Obesity Epidemic*, 46 CONN. L. REV. 807, 842–44 (2013).

[122] 517 N.E.2d 1350, 1352 (N.Y. 1987). The PHC promulgated the rules pursuant to the authority delegated to it by the New York State Legislature to regulate with respect to "matters affecting the security of life or health or the preservation and improvement of public health." *Id.* at 1358 (quoting N.Y. PUB. HEALTH LAW § 225 (McKinney 1986)) (internal quotation marks omitted). The PHC's proposed rules would have prohibited smoking in schools, hospitals, retail stores, taxis and limousines, indoor workplace common areas, and restaurants with more than fifty seats. *Id.* at 1352. An exception to the indoor smoking prohibition applied to bars, to hotels, and to restaurants with fewer than fifty seats. *Id.* In addition, the rules provided that businesses that did not qualify for an exception to the indoor public smoking prohibition could apply for a waiver of the prohibition. *Id.*

[123] *Id.* at 1357.

[124] *Id.* at 1355.

[125] *Id.* at 1356.

[126] *Id.*

[127] *Id.*

held that the rule violated the separation of powers doctrine based on the first three *Boreali* factors,[128] because: (1) the exceptions to the sugary drink portion cap rule indicated that the Board of Health impermissibly balanced public health concerns and economic and political concerns;[129] (2) the New York City Charter does not grant the Board "the authority to limit or ban a legal item under the guise of 'controlling chronic disease,'"[130] although it grants the Board the power to promulgate regulations "that prevent and protect against communicable, infectious, and pestilent diseases";[131] and (3) the New York City Council and New York State Assembly repeatedly had debated and rejected prior proposals to reduce consumption of sugary drinks.[132]

C. *Friedman's Interpretation of the Case*

The New York City sugary drink portion cap is Friedman's prime example of "flashpoint zones," which he defines as "high-profile clashes" that illustrate the recurring conflict between autonomy and coercive public health paternalism.[133] Based on the New York portion cap example, he draws various conclusions about the limits of anti-obesity public health paternalism. In addition, he argues that the limits of anti-obesity public health paternalism can be generalized and are applicable to *all* public health paternalism.[134]

After considering the degree of coercion that the New York City portion cap entailed, Friedman places the portion cap on his "coercion spectrum" by classifying it as an "insulation strategy," meaning that he views the portion cap as less coercive than a ban or mandate, but more coercive than strong-form debiasing (persuasive narratives about risks), weak-form debiasing (provision of neutral information about risks), and

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[128] N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *20 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 970 N.Y.S.2d 200 (App. Div. 2013). Judge Tingling noted that the four *Boreali* "factors" are considered together, with no single "factor" being dispositive. *Id.* at *7.

[129] *Id.* at *8–9. The economic considerations that the Board of Health relied upon included the public costs of treating obesity. *Id.* at *9. The Board of Health also based the rule on political considerations by making no attempt to coordinate the portion cap rule with the New York State Department of Agriculture and Markets, despite a prior Memorandum of Understanding that required coordination between the two bodies. *Id.* at *8–9.

[130] *Id.* at *16.

[131] *Id.* at *15.

[132] *Id.* at *18. The portion cap rule did not violate the fourth *Boreali* factor, however, because the Board of Health held a hearing on the draft rule and used its "expertise or technical competence" to prepare a detailed memorandum, in which it discussed various medical and scientific studies. *Id.*

[133] Friedman, *supra* note 1, at 1691–92.

[134] *See id.* at 1753–54 (generalizing his conclusions about the limits of anti-obesity paternalistic regulation to paternalistic regulation of marijuana and genetically-modified organisms).

free market apaternalism.[135] Although he assumes that Mayor Bloomberg's goal was "to insulate consumers from the effects of over-imbibing" in sugary drinks,[136] Friedman counters that "[t]he facts . . . did not support the notion that [the portion cap rule] would have any concrete effect."[137] In support of his argument, he refers to Judge Tingling's conclusion that the portion cap rule "was arbitrary and capricious, exacting a burden without a reasonable basis."[138]

In his analysis of the implications of the case, Friedman observes that New Yorkers "overwhelmingly opposed this autonomy deprivation, even though the excessive consumption habit in question was only engaged in by a small part of the public."[139] Essentially, Friedman argues that the majority was not defending its own autonomy, but instead was defending the autonomy of the minority—and autonomy itself. Based on the failure of the portion cap, he concludes that "the public increasingly" rejects paternalism as an unwarranted infringement of autonomy.[140] His claim is that the "trend" toward public rejection of anti-obesity public health paternalism,[141] especially "visible, hard paternalism," significantly narrows the options that will be available to public health advocates to reduce the prevalence of obesity.[142] He then generalizes his conclusion about anti-obesity public health paternalism to other public health contexts, arguing:

> [Other] flashpoint zones show a general rejection of paternalism—especially visible, hard paternalism. This leaves regulators with the more limited toolkit of soft paternalism to attack some of the more difficult public problems. In fact, a rejection of hard paternalism can lead regulators either to use strategies that preserve autonomy, or simply to do nothing to regulate personal choices.[143]

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[135] *See id.* at 1738 (determining the category in which the portion cap rule should be placed).

[136] *Id.* at 1739.

[137] *Id. But see* N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *19–20 (N.Y. Sup. Ct. Mar. 11, 2013) (finding that the Board had a "reasonable basis" for adopting the rule, but that the rule as promulgated was "arbitrary and capricious").

[138] Friedman, *supra* note 1, at 1739.

[139] *Id.* at 1740. Friedman stresses that the public rejected the portion cap notwithstanding the fact that it "was mostly directed at others and targeted at a narrow category and manner of consumption." *Id.* at 1741. He reiterates that "a broad segment of [New Yorkers] objected to this kind of paternalism, even though the regular consumption of large sweetened drinks was limited to a small subset of consumers." *Id*. at 1690.

[140] *Id.* at 1757; *see also id.* at 1744 ("The reaction to the [portion cap] indicates that the public attitude toward paternalism in contexts involving private consumption decisions may be trending negative.").

[141] *Id.* at 1719.

[142] *Id.* at 1692.

[143] *Id.*

Friedman thus makes the broad claim that "[p]aternalism has peaked, for now, in the realm of public health regulation."[144]

D. *An Alternative Interpretation of the Case*

What does the failure of the sugary drink portion cap teach us about anti-obesity public health paternalism or about public health paternalism in general? In my view, not exactly what Friedman claims it does. An alternative interpretation of the New York City portion cap rule case is that it illustrates the difference between (1) old public health interventions that target specific pathogens or toxins, and (2) new public health interventions that target upstream behavioral risk factors. In the context of old public health interventions, public health regulators can easily justify their interventions—even highly coercive, paternalistic interventions. In the context of new public health interventions, however, public health regulators face an uphill battle to justify their public health interventions—even much less coercive interventions, such as "nudges." This is especially true where the public health regulators take unilateral regulatory action without the guidance from the relevant legislative bodies or—worse yet—in spite of the prior rejection of arguably similar interventions by those legislative bodies.

Despite the invalidation of the sugary drink portion cap rule, public health regulators in New York continue to have extensive power with respect to old public health interventions, including interventions to contain the spread of infectious disease or to promote food and water purity and sanitation. With respect to old public health interventions, public health regulators can promulgate rules that are located at any point on Friedman's coercion spectrum. For example, even highly coercive, hard paternalistic interventions to eliminate deadly E. coli bacteria from the food supply are widely considered to be appropriate and uncontroversial.[145] No one seriously argues that autonomy requires that consumers be free to ingest E. coli; it is a pathogen and the first mission for public health regulators of food is to ensure food safety.[146] The traditional powers of the Board, however, do not include the power to create new

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[144] *Id.* at 1694.

[145] *See* N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *16 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 970 N.Y.S.2d 200 (App. Div. 2013) (noting that the New York City Board of Health has the power to "call for any [disease-causing] food to be destroyed"). For a list of recent outbreaks of foodborne illness in the United States, see CAROLINE SMITH DEWAAL & MARCUS GLASSMAN, CTR. FOR SCI. IN THE PUB. INTEREST, OUTBREAK ALERT! 2001–2010: A REVIEW OF FOODBORNE ILLNESS IN AMERICA 6 (2013), *available at* http://cspinet.org/new/pdf/outbreak_alert_2013_final.pdf.

[146] *See N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607, at *16 (stating that the Board of Health may "supervise and regulate the food supply of the City when it affects public health").

public health interventions to reduce unhealthy behavioral "risk factors."[147]

What anti-obesity public health regulators fail to recognize is that new public health interventions are much more controversial and difficult to justify.[148] To explore the difference between old and new public health interventions, compare: (1) recent public health interventions to ban or regulate substances that have been shown to be pathogenic or toxic, including lead, trans fats, and tobacco; and (2) the New York City sugary drink portion cap. The development of public health regulation of lead, trans fats, and tobacco follows a similar chronology: the substance initially was assumed to be safe; medical researchers hypothesized that the substance, in fact, might be toxic; studies analyzed that hypothesis; results of early studies were inconclusive; later studies proved an association between the substance and certain specific negative health effects; and, eventually, medical researchers established that the substance was toxic or pathogenic.[149] As evidence accumulated, public health interventions to regulate the substance became increasingly proactive, interventionist, and coercive. Now that researchers have proven the health risks of ingesting small quantities of lead or trans fats and of smoking or chewing tobacco, the public is insulated from those risks by way of bans, labeling

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[147] Hall, *supra* note 86, at S206; *see N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607, at *14 (rejecting the plaintiff's argument that amendments to the New York City Charter significantly expanded the power of the Board of Health to address broader public health issues). Judge Tingling stated: "[I]n looking at the history of the Charter, the intention of the legislature with respect to the Board of Health is clear. It is to protect the citizens of the city by providing regulations that prevent and protect against communicable, infectious, and pestilent diseases." *Id.* at *15.

[148] Pratt, *supra* note 44, at 108–09. In a previous article, I offered public health advocates some suggestions for developing and refining anti-obesity public health proposals: (1) distinguish between the public health goal of obesity reduction, the public health goal of improved nutrition, and other specific public health goals; (2) understand the implications of using an "externalities" justification to support anti-obesity measures; (3) understand the implications of using an "internalities" justification to support anti-obesity measures; (4) distinguish between "old" public health interventions that target specific pathogens or toxins and "new" public health interventions that target upstream behavioral risk factors; (5) offer empirical support for assumptions upon which public health proposals are based; (6) explore the possible and likely intended and unintended consequences of the measure, considering the benefits, costs, inefficiencies, and potential unfairness caused by the intervention; (7) consider competing goals and values in addition to the anti-obesity public health goal; and (8) develop a reasonable form of performance review for the intervention. *See generally id.* Perhaps some of these suggestions could have helped the Task Force develop an alternate proposal for reducing the consumption of sugary drinks, or at least articulate a more specific policy rationale for the portion cap rule that better fit the predictable consequences of the rule.

[149] *See, e.g.*, Friedman, *supra* note 1, at 1707–08 (summarizing the chronology of the ban on lead in paint); *Artificial Trans Fat: A Timeline*, CENTER FOR SCI. PUB. INT., http://cspinet.org/transfat/timeline.html (last visited July 15, 2014) (summarizing the chronology of trans fat labeling and bans).

requirements, or restrictions on use.[150]

Compare the sugary drink portion cap rule. Soda is not a toxin and is not per se "inherently dangerous." The sugary drink portion cap rule thus is a new public health intervention, not an old public health intervention to eliminate or reduce exposure to a pathogen or toxin. Research cited by the Board indicates that "excessive" consumption of sugary drinks is a behavioral risk factor that contributes to obesity, diabetes, and various other serious medical conditions.[151] Although use of the word "excessive" might at first seem subjective and judgmental, there is empirical support for the Task Force characterizing consumption of super-sized sodas as "excessive." According to the U.S. Department of Agriculture, "refined sugars should provide no more than 6 to 10 percent of . . . total daily calories," to reserve enough calories for consuming the recommended servings of various types of foods.[152] For example, a teenager whose recommended daily caloric intake is 2200 calories should not consume more than twelve teaspoons of sugar per day.[153] The average teenage boy who drinks soda (or similar sugary drinks) consumes twenty-five ounces per day, which includes over twenty teaspoons of sugar.[154]

Consuming such "excessive" refined sugar leads to one of two outcomes, both of which are detrimental to health: (1) if a soda drinker consumes soda in addition to consuming other foods and beverages that meet recommended dietary guidelines, the individual will gain weight; or (2) if a soda drinker avoids weight gain by reducing consumption of foods that meet recommended dietary guidelines, the individual will lack essential nutrients. Empirical evidence establishes: (1) "foods and beverages high in added sugars are displacing more nutrient-rich foods in the American diet;"[155] (2) "[a] remarkably lower percentage of [heavy consumers of added sugars] met their RDA for many micronutrients;"[156] and (3) "disproportionately high percentages of lower-income Americans (40 percent) and African Americans (44 percent) were heavy consumers of

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[150] *See, e.g.*, TOBACCO CONTROL LEGAL CONSORTIUM, FEDERAL REGULATION OF TOBACCO: A SUMMARY (2009), *available at* http://publichealthlawcenter.org/sites/default/files/resources/tclc-fda-summary.pdf (discussing federal bans on tobacco products).

[151] *See supra* text accompanying notes 100–06; *see also* Marcello, *supra* note 121, at 819–22 (discussing the New York City Board of Health's reasoning in enacting the portion cap rule).

[152] JACOBSON, *supra* note 95, at 4.

[153] *Id.*

[154] *Id.* at ii; *see* The Nutrition Source, *How Sweet Is It? Calories and Teaspoons of Sugar in 12 Ounces of Each Beverage* (2009), http://cdn1.sph.harvard.edu/wp-content/uploads/sites/30/2012/10/how-sweet-is-it-color.pdf (stating that there are ten teaspoons of sugar in twelve ounces of non-diet carbonated colas).

[155] JACOBSON, *supra* note 95, at 6. "As teens have doubled or tripled their consumption of soft drinks, they have cut their consumption of milk by more than 40%." *Id.* at 5.

[156] *Id.* at 7.

added sugars."[157] Put differently, "soft drinks pose health risks both because of what they *contain* (extra calories, sugar, and various additives) and what they *replace in the diet* (beverages and foods that provide vitamins, minerals, and other nutrients)."[158] Although the Task Force focused on obesity reduction, its goal of reducing the empty calories from soda also incorporates the important but distinct public health goal of improving nutrition.[159] Thus, the Obesity Task Force had a dual goal of reducing both the obesity and the malnutrition that are attributable to the consumption of large quantities of sugary drinks.

The stated goal of the rule, as articulated by the Obesity Task Force and the Board of Health, was to reduce obesity.[160] Judge Tingling concluded that the rule was "arbitrary and capricious," in part because the portion cap rule did not apply to alcoholic beverages or to some sugary drinks, such as milky coffee drinks, milkshakes, and fruit smoothies, which are even more caloric than the drinks the portion cap rule regulated.[161] Also, the portion cap rule allowed unlimited sugary drink refills and did not prevent consumers from adding any quantity of sugar to their drinks.[162] With so many seemingly inexplicable exceptions and loopholes, all of which were inconsistent with the anti-obesity goal that the Board of Health offered to justify the rule, Judge Tingling expressed concern that the benefits of the portion cap rule would not materialize, much less justify the costs of the rule.[163]

The Board could have done a better job of informing Judge Tingling of the reasonable basis for the seemingly arbitrary and capricious application of the portion cap rule to some sugary drinks, but not others.[164] The Board could have argued effectively that sodas and similar sugary drinks "are a special problem."[165] If Judge Tingling had a better understanding of why some drinks were covered by the rule but other drinks were not, he may not have concluded that the rule was arbitrary and capricious. "Sugary drinks," as defined by the portion cap rule, were the target of the intervention for a variety of specific reasons, including the following: (1) reducing the consumption of sugary drinks, especially those that are aggressively marketed to children, has been a continuing focus of public

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[157] *Id.*

[158] *Id.* at 9.

[159] N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 12.

[160] *See supra* notes 99, 106 and accompanying text.

[161] N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *6, *20 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 970 N.Y.S.2d 200 (App. Div. 2013).

[162] *Id.* at *8.

[163] *Id.* at *6.

[164] *See* Plaintiff's Petition, *supra* note 112, at 3 (discussing the portion cap rule's inclusion of certain sugary drinks and detailing excluded beverages).

[165] JACOBSON, *supra* note 95, at 12.

health proposals since the late 1970s;[166] (2) sugar-sweetened soda is disproportionately consumed in poor neighborhoods in which the prevalence of obesity and Type II diabetes rates is disproportionately high;[167] (3) sugary drinks contain only "empty calories,"[168] whereas drinks that contain mostly milk or fruit, along with added sugar, at least have some nutritional value;[169] (4) sugary drinks are aggressively marketed by beverage companies;[170] (5) children, especially teens, are deficient in calcium and other important nutrients, in part because they typically drink soda instead of milk and juice, which increases the risk of osteoporosis and broken bones;[171] (6) high fructose corn syrup, a sugar syrup that is commonly used in drinks that are subject to the portion cap, may have more negative health effects than other types of sugars, such as the sugars in milk, fruits, and vegetables;[172] (7) sugary drinks, as opposed to drinks containing milk or whole fruit, do not make us feel "full" and do not reduce our overall intake of calories;[173] and (8) sugary drink consumption also may increase the risk of dental caries, kidney stones, and heart disease.[174]

Also, sugary drinks are one of few specific, easily identifiable categories of nutrient-poor, caloric foods or drinks that make up a double-

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[166] *See* Thomas R. Frieden et al., *Reducing Childhood Obesity Through Policy Change: Acting Now to Prevent Obesity*, 29 HEALTH AFF. 357, 359 (2010) (discussing children's exposure to "extensive marketing and promotion of food items"); *see also* Gretchen Goetz, *Three Studies Link Sugary Drinks to Weight Gain*, FOOD SAFETY NEWS (Sept. 24, 2012), http://www.foodsafetynews.com/2012/09/sugary-drinks-get-the-one-two-three-punch-from-obesity-research/#.U01v6PldUVw (describing research that has been conducted regarding sugary drink consumption since the late 1970s).

[167] N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 8, 13.

[168] JACOBSON, *supra* note 95, at 8.

[169] *See id.* at 19, 26 (comparing soft drinks to healthful foods).

[170] *See id.* at 19–23 (describing aggressive marketing strategies used by beverage companies to market their products and providing estimates of amounts beverage companies spend on advertising); *see also* HARVARD SCH. OF PUB. HEALTH, FACT SHEET: SUGARY DRINK SUPERSIZING AND THE OBESITY EPIDEMIC 1 (2012), *available at* http://cdn1.sph.harvard.edu/wp-content/uploads/sites/30/2012/10/sugary-drinks-and-obesity-fact-sheet-june-2012-the-nutrition-source.pdf ("Beverage companies in the US spent roughly $3.2 billion marketing carbonated beverages in 2006, with nearly a half billion dollars of that marketing aimed directly at youth ages 2–17. And each year, youth see hundreds of television ads for sugar-containing drinks. In 2010, for example, preschoolers viewed an average of 213 ads for sugary drinks and energy drinks, while children and teens watched an average of 277 and 406 ads, respectively. Yet the beverage industry aggressively rebuffs suggestions that its products and marketing tactics play any role in the obesity epidemic." (footnotes omitted)).

[171] JACOBSON, *supra* note 95, at 13.

[172] *See id.* at 11–12 (discussing the contribution of high fructose corn syrup to weight gain and obesity).

[173] *See* N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 14 (discussing the increased intake of calories in relation to feeling full after consuming sugary drinks). High-protein foods and drinks and high-fiber foods and drinks create a full feeling, but sugary sodas do not.

[174] JACOBSON, *supra* note 95, at 14–16.

digit percentage of American caloric intake.[175] The extraordinarily large aggregate volume of "sugary drinks" consumed by Americans, especially children and teenage boys and girls, makes sugary drinks a prominent target for obesity reduction.[176] The idea is that sugary drinks provide a simple, identifiable point of leverage against obesity; put simply, public health regulators think that eliminating or significantly reducing soda consumption could reverse recent increases in obesity.[177]

In addition to better articulating the reasoning for specifically targeting sugary soda and similar nutrient-poor, caloric sugary beverages, the Board could have better explained the reasoning for using a portion cap to try to reduce soda consumption.[178] Imposing a portion cap on soda was motivated by two separate public health goals: (1) countering the fast food industry super-sizing trend; and (2) reducing excessive consumption of nutrient-poor, caloric sugary drinks. Portion sizes of "sugary drinks" have increased dramatically in the last thirty years.[179] Super-sized sugary drinks increase beverage industry profits because consumers focus myopically on the salient aspect of added value, without understanding the subtle way in which their caloric intake and, in the long run, their weight increases.[180] In other words, larger portion sizes increase caloric consumption without consumers realizing that that their caloric intake has significantly increased.[181] Among high calorie drinks, sodas are sold in super-sized

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[175] *Id.* at 1, 10 ("Carbonated soft drinks are the single most-consumed food in the American diet . . . .").

[176] *See* N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 12 (articulating an initiative to "[e]ncourage [h]ealthy [e]ating" by focusing on the reduction of New Yorkers' consumption of sugary drinks); *see also* JACOBSON, *supra* note 95, at 1–3 (documenting large quantities of sugary drinks that are consumed in the United States and particularly noting the soda consumption by children, teenagers, and young adults).

[177] *See* N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 7 (discussing the implementation of initiatives that would reduce the prevalence of obesity, including reducing sugary beverage consumption).

[178] Having ruled out soda taxes, the Obesity Task Force and Board of Health focused on establishing a maximum portion size for sugary drinks that would counter the super-sizing trend for sugary drinks. *Id.* at 14. Brian Galle argues that "nudges" can be more efficient than traditional interventions, such as Pigouvian taxes. *See* Brian D. Galle, *Tax, Command . . . or Nudge?: Evaluating the New Regulation*, 92 TEX. L. REV. 837, 857–59 (2014) (explaining why nudges can work and what they depend on). One of the advantages of the New York City sugary drink portion cap was the way in which the rule specifically targeted the problematic overconsumption of soda, instead of indiscriminately subjecting all consumption to regulation or taxation. *See id.* at 885 (explaining that the New York City Health Department targeted soda for the portion cap because "soda contributes significantly to obesity" and that "[s]ize limits are better targeted at soda-drinkers' potential internalities than a tax would be").

[179] *See* N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 13 (illustrating "Exploding Beverage Sizes" with a graph demonstrating 457% growth in drink size).

[180] *See* JACOBSON, *supra* note 95, at 3 (providing sample pricing for smaller portions of drinks and larger, value-added portions of drinks).

[181] *See* WANSINK, *supra* note 74, at 69–70 (noting that the serving size bias affects caloric consumption even if the consumers have been educated about serving size bias and concluding that

containers more often than other high calorie drinks that Judge Tingling mentioned in the opinion (e.g., milkshakes).[182] According to the Obesity Task Force, the portion cap rule would "reacquaint New Yorkers with 'human size' portions to reduce excessive consumption of sugary drinks."[183]

The sugary drink portion cap was supposed to gently tip the scales back toward less gargantuan portion sizes for nutrient-poor, caloric sugary beverages. Although Judge Tingling seemed to think that allowing refills would prevent the portion cap from being effective,[184] he did not understand that the portion cap was not designed to be a "ban" that prevented consumers from drinking more than sixteen ounces of soda; it was supposed to reduce consumption more subtly by framing sixteen ounces as a normal portion size and making consumers stop and think about whether they actually want to drink more than sixteen ounces of soda.[185] If Judge Tingling had better understood the reasoning behind the sugary drink portion cap rule, he may not have concluded that the rule was arbitrary and capricious.

The portion cap rule nonetheless would have been invalidated because

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"[n]o one is immune to serving-size norms—not even 'intelligent, informed' people who have been lectured on the subject *ad nauseum*"). "In the end, setting the table with the wrong dinner plates or serving bowls—the big ones—sets the stage for overeating. And there are heavyweight consequences . . . ." *Id.*

[182] *See* N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 653584/12, 2013 WL 1343607, at *6 (N.Y. Sup. Ct. Mar. 11, 2013), *aff'd*, 970 N.Y.S.2d 200 (App. Div. 2013) (listing caloric drinks that are not subject to the sugary drink portion cap rule).

[183] N.Y.C. OBESITY TASK FORCE REPORT, *supra* note 99, at 14.

[184] *See N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607, at *6 (observing that "no restrictions exist on refills further defeating the Rule's state purpose").

[185] *See id.* at *6, *8 (explaining that the portion cap does not "preclude unlimited free refills or multiple purchases of 16-oz. beverages or providing unlimited sugars after purchase . . . but does limit the containers at self service fountains to be limited to 16 oz irrespective of whether a consumer is purchasing water or one of the non-regulated drinks"). The Obesity Task Force or Board of Health could have reduced the costs of the sugary drink portion cap rule by limiting drink containers to a size just smaller than the truly super-sized thirty-two and sixty-four ounce drinks. The standard size container for a bottled soda is twenty ounces, although a 16.9 ounce container also is widely used. *See* Mike Esterl, *Coke Tailors Its Soda Sizes—Backing Off of "Supersizing," Company Aims for Wider Range of Ounces, Prices*, WALL ST. J., Sept. 19, 2011, at B4 (describing Coke's launch of new bottle sizes "represent[ing] a departure from years of relying heavily on three basic packages—20-ounce bottles in convenience stores and two-liter bottles and cases of 12-ounce cans in supermarkets"). Imposing a sixteen ounce container limit would require bottlers of sugary drinks to reconfigure their molds and production processes, at great expense to them. Perhaps the implicit goal of the portion cap rule was to require exactly this type of container reformulation in order to shift standard soda portion sizes back toward the smaller portion sizes of years past. The costs of forcing bottlers and distributors to reconfigure their production processes might be quite disproportionate when compared to the benefits of reducing the standard drink portion size by either .9 ounces (from 16.9 ounces to sixteen ounces), or by four ounces (from twenty ounces to sixteen ounces).

of the extent to which the Board attempted to usurp legislative power.[186] Going forward, this aspect of the portion cap case presents a formidable barrier to promulgation of new public health regulations by the Board of Health. *Boreali v. Axelrod* seemingly does not permit a New York administrative agency to take into consideration any "ends" that might conflict with the ends that the agency is charged to pursue. The Board of Health, which is charged with maximizing the health of New Yorkers, violates *Boreali* if the Board takes into account any political or economic considerations in fashioning a public health rule.

There is an irony implicit in the *Boreali* test. The first *Boreali* factor considers "whether the challenged regulation is based upon concerns not related to the stated purpose of the regulation, i.e., is the regulation based on other factors such as economic, political or social concerns?"[187] The only way that an executive agency can avoid running afoul of this factor is to myopically disregard information other than information that pertains directly to the agency's charge, for example the Board of Health's charge to promote health. An administrative agency's weighing of competing interests, such as "economic, political or social" considerations,[188] is a factor that counts against the agency in the *Boreali* analysis.[189] The idea is that the legislature has the power to balance such competing interests, but an administrative agency does not have that power.[190]

In a previous article, I advised public health advocates to examine critically the empirical assumptions upon which their new public health proposals rest, and consider carefully both the intended and unintended consequences of their proposals.[191] In effect, my suggestion is that public health advocates perform, at a minimum, a rough, qualitative form of cost-benefit analysis.[192] Performing such an analysis, which requires a

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[186] *See N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607, at *20 (expressing grave concerns about the portion cap rule eviscerating the separation of powers doctrine).

[187] *Id.* at *8.

[188] *Id.*

[189] *See id.* at *8–9 (noting that "the statement of financial costs related to the chronic epidemic further evidences a balancing being struck between safeguarding the public's health and economic considerations," and holding that such balancing "violates the first prong of *Boreali*").

[190] *See id.* at *16 ("It is the province of the people's elected representatives, rather than appointed administrators, to resolve difficult social problems by making choices among competing interests." (quoting Boreali v. Axelrod, 517 N.E.2d 1350, 1356 (N.Y. 1987)) (internal quotation marks omitted)).

[191] Pratt, *supra* note 44, at 75 (arguing that public health advocates should consider both intended and unintended consequences of public health interventions, including soda taxes).

[192] According to Adler and Posner:

> [Cost-Benefit Analysis] is a procedure that measures the impact of agency choice on a plurality of aspects of human welfare using a money scale. Frequently, however, agencies compare the welfare "costs" and "benefits" of their choices in a more qualitative way. Policy effects will be described, and indeed might be quantified on various scales (for example, numbers of deaths, . . . jobs lost or gained), but no

balancing of competing costs and benefits, appears to be prohibited under *Boreali*. The *Boreali* separation of powers objection would seem to apply to any new public health interventions that balance competing goals, because *Boreali* stands for the proposition that such balancing more properly is the subject of legislative decision-making.

If a statute enacted by the legislature specified that the Board of Health (in New York City, or the Public Health Council in New York State) could balance competing interests to reduce the prevalence of obesity and diabetes and provided some guidelines for performing such balancing, *Boreali* may not bar the Board from promulgating new public health regulations. In the portion cap case, however, the Board promulgated the rule without any legislative guidance. Not only was the Board operating on a "clean slate," with no legislative guidance,[193] it acted in contravention—one might even say defiance—of the City Council's rejection of soda taxes and soda regulation proposals, as well as the overt, public disapproval of certain members of the City Council.[194] Judge Tingling endorsed the view expressed in the petitioners' brief that the Board's promulgation of the sugary drink portion cap rule was designed as an "end-run" around the legislature.[195] That aspect of the rule promulgation was fatal.[196] Judge Tingling concluded that the Board's actions exceeded their power to act: "To accept [the Board's] interpretation of the authority granted to the Board by the New York City Charter would leave its authority to define, create, mandate and enforce limited only by its imagination."[197]

Under a literal interpretation of *Boreali* and the sugary drink portion cap case, a public health regulation promulgated by the New York Board of Health without prior legislative guidance or subsequent ratification by the City Council cannot survive a separation of powers challenge unless

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> monetary scale for commensurating all these impacts will be deployed. Instead, the trade-off will be done more intuitively.

ADLER & POSNER, *supra* note 83, at 73.

[193] *See N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343607, at *17, *28–29 (noting that an agency writes on a clean slate when it "creates its own set of comprehensive rules without the benefit of legislative guidance" and concluding that amendments to the New York City Charter did not provide legislative guidance regarding agency regulation of legal unadulterated foods to control chronic diseases).

[194] *See* Plaintiff's Petition, *supra* note 112, at 1, 30 (noting the "public objection of 17 members of the City Council" to the sugary drink portion cap rule).

[195] *See id.* at 1 (arguing that the portion cap rule was "imposed by executive fiat [and] usurps the role of the City Council" and that "[t]he proposal was immediately recognized for what it was —an end-run around the City Council").

[196] *See N.Y. Statewide Coal. of Hispanic Chambers of Commerce*, 2013 WL 1343507, at *20 (indicating that the Board's promulgation of the portion cap rule violated separation of powers doctrine).

[197] *Id.*

the regulation pertains to an imminent, discrete, per se public health hazard or threat. Also, in developing and promulgating rules, the New York Board of Health must focus exclusively on maximizing health (i.e., it is prohibited from balancing public health and economic or political ends), unless the legislature has delegated to the Board the authority to engage in such balancing and has specified the manner in which the Board is to perform such balancing of competing ends. *Boreali*, in effect, conceptualizes an administrative agency as performing only the ministerial work of filling in the blanks of a statute, in a manner specified by the legislature, instead of forming and implementing specific policies to further the broad policy goals delegated to the agency by the legislature.

Beyond New York, state and local public health agencies that are not hamstrung by *Boreali* probably have much greater latitude to continue to develop and promulgate new anti-obesity regulations. For example, the public health agencies in Boston and in Washington State, which like the New York City Board of Health have promulgated public health interventions that target chronic diseases including obesity, may continue to proactively innovate in the interest of public health.[198]

Public health regulators in New York City and elsewhere remain free to independently promulgate old public health regulations (including highly coercive regulations) that reduce or eliminate a specific pathogen or toxin. Eventually, research may establish that sugary drinks (or potentially certain "doses" of sugary drinks) are pathogenic or toxic, similar to lead, trans fats, and tobacco.[199] If proof develops, as it did for lead, trans fats, and tobacco, public health regulators will have greater power to regulate soda. Until they have that proof, however, they will face an uphill battle if they continue to adopt unilateral new public health regulations—even interventions that are not very coercive—to reduce soda consumption. For now, public health advocates appear to overreach when they say that soda

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[198] *See, e.g.*, Paul A. Diller, *Local Health Agencies, The Bloomberg Soda Rule, and the Ghost of Woodrow Wilson*, 40 FORDHAM URB. L.J. 1859, 1879, 1882 (2013) (describing regulatory actions of the Boston Public Health Commission, an independent state agency, and the King County-Seattle Board of Public Health, an agency that enacts some of the most aggressive public health regulations).

[199] *See* Lori Dorfman et al., *Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?*, 9 PLOS MED., June 2012, at 5 (concluding that "[e]merging science on the addictiveness and toxicity of sugar, especially when combined with the addictive properties of caffeine found in many sugary beverages, should further heighten awareness of the product's public health threat similar to the understanding about the addictiveness of tobacco products"). *See generally* Robert H. Lustig et al., *The Toxic Truth About Sugar*, 482 NATURE 27, 28, 29 (2012) (advocating that sugar—specifically soda and other sugary beverages—should be regulated, proposing that the justifications for alcohol regulation—"unavoidability (or pervasiveness throughout society), toxicity, potential for abuse and negative impact on society"—apply to sugar, and pointing to "successful . . . control strategies" for tobacco and alcohol that can serve as "[a] reasonable parallel for sugar").

must be regulated like lead in paint.[200]

Make no mistake: the invalidation of the sugary drink portion cap case was a significant defeat for the New York City Board of Health and will make it much more difficult, going forward, for the Board to promulgate new public health regulation. The defeat of the portion cap rule does not signal the end of public health paternalism, however. In the future, the Board simply will have to do a better job of advocating for its new public health proposals to garner the support of the City Council and the public.

Local public health agencies that are not subject to the severe rule promulgation restrictions imposed by *Boreali v. Axelrod* will have greater freedom to promulgate new public health regulations without advance legislative approval. They nonetheless should clearly articulate the values that motivate their proposals, to enlist the support of legislators and the public.

V. CONCLUSION

Making the food environment less obesogenic will require government intervention, or at least a plausible threat that government will intervene if the food and beverage industry does not rein in obesity. As I have indicated in a previous article, I support anti-obesity interventions that meet performance standards. Public health advocates should recognize, however, that new public health interventions to reduce obesity raise heightened objections about the executive branch usurping legislative power to the exclusion of competing goals. Mayor Bloomberg's administration and public health regulators in New York are to be commended for their good intentions, their passion for improving the health of New Yorkers, and their development of innovative interventions—some of which have turned out to be effective.

The invalidation of the sugary drink portion cap rule is a serious setback for the New York Board of Health. The portion cap case and the reassertion of the strict administrative constraints imposed by *Boreali v. Axelrod* will hamper the ability of the New York Board of Health to promulgate innovative anti-obesity regulations without the approval of the legislature. The case demonstrates the significant risk of unilateral adoption by public health regulators of new public health interventions. Going forward, public health advocates—especially public health advocates in New York—will need to do a better job of advocating for their goals and involving the legislature and the public. I recommend that

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[200] *See, e.g.*, David Rosner & Gerald Markowitz, *Why It Took Decades of Blaming Parents Before We Banned Lead Paint*, THE ATLANTIC (Apr. 22, 2013), http://www.theatlantic.com/health/archive/2013/04/why-it-took-decades-of-blaming-parents-before-we-banned-lead-paint/275169/ (advocating that public health agencies not delay soda regulation, based on lessons learned from delaying lead paint regulation).

smaller scale pilot projects be used to test anti-obesity interventions that show promise and to establish the costs and benefits of proposed interventions. The interventions that are most successful can generate legislative proposals that are supported by empirical research. Anti-obesity public health advocates should: (1) clarify their multiple public health goals and articulate them clearly; (2) develop proposals that are a good fit for the goals articulated; (3) consider both intended and unintended consequences of the proposals; and (4) try to build consensus for the most promising proposals.

Although the portion cap case prohibits New York public health agencies from balancing public health goals and competing economic and political ends, the legislature is free to balance competing concerns. In New York, and even in jurisdictions in which public health agencies have greater latitude to innovate without legislative authorization, I urge anti-obesity public health regulators to build the empirical case for specific anti-obesity interventions and take their argument to the public and the legislature. The sugary drink portion cap case shows that, at least in New York, courts will invalidate rules that implement unilateral new public health interventions—highly coercive or otherwise—and are promulgated by an executive agency as an end-run around uncooperative legislators. Instead of defying the legislature, public health paternalists everywhere should make such a compelling case for public health interventions that even uncooperative legislators cannot in good conscience refuse.

Ultimately, Friedman and I reach slightly different conclusions about the future of anti-obesity public health paternalism: he is pessimistic and sees the glass—sixteen-ounce or otherwise—as half empty, while I am optimistic and see it as half full.

POSTSCRIPT

The New York Supreme Court Appellate Division decision cited in this Article was affirmed by the New York Court of Appeals in *N.Y. Statewide Coalition of Hispanic Chambers of Commerce v. N.Y.C. Department of Health & Mental Hygiene*, 23 N.Y.3d 681 (2014), after this Article was selected for publication.