SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Civil Division

THE PRAXIS PROJECT, et al.,	Case No. 2017 CA 004801 B
Plaintiffs,	
v.	Honorable Judge Elizabeth C. Wingo
THE COCA-COLA COMPANY, et al.,	Next Event: Motion Hearing March 15, 2018 at 11:00 a.m.
Defendants.	

COCA-COLA'S SPECIAL MOTION TO DISMISS PURSUANT TO DISTRICT OF COLUMBIA ANTI-SLAPP ACT, D.C. CODE § 16-5501 *ET SEQ.*

Defendant The Coca-Cola Company ("Coca-Cola"), by and through the undersigned, hereby moves this Court, pursuant to the District of Columbia Anti-SLAPP Act, D.C. Code § 16-5501 *et seq.*, to dismiss Plaintiffs' Complaint with prejudice, to award Coca-Cola reasonable attorneys' fees and costs, and to stay discovery in this case until ruling on this motion is made.

In support of the instant Motion, Coca-Cola respectfully refers this Court to the Memorandum of Law and Points of Authorities filed herewith.

ORAL HEARING REQUESTED

Pursuant to Rule 12-I(h) of the Superior Court Rules of Civil Procedure, Coca-Cola respectfully requests an oral hearing on this motion.

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Dated: October 23, 2017

Respectfully submitted,

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MEMORANDUM OF LAW IN SUPPORT OF COCA-COLA'S SPECIAL MOTION TO DISMISS PURSUANT TO DISTRICT OF COLUMBIA ANTI-SLAPP ACT, D.C. CODE § 16-5501 *ET SEQ.*

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PRELIMINARY STATEMENT

This suit is an attempt to bar The Coca-Cola Company ("Coca-Cola") from participating in public discussion about obesity, diabetes and heart disease. As these conditions have increased in prevalence, a national debate—among scientists, policymakers and citizens—has ensued about the causes of that trend and strategies for reversing it. Some, including Plaintiffs, argue that sugar-sweetened beverages ("SSBs") are "uniquely" to blame for obesity. This viewpoint has led lawmakers at various levels to consider, and in some cases adopt, restrictions on the marketing and sale of SSBs, such as SSB-specific taxes and health warnings.

Others, such as Coca-Cola and the U.S. Food and Drug Administration ("FDA"), question the science underlying these initiatives. They maintain that numerous lifestyle factors contribute to obesity and that prevention depends on balancing overall calories consumed with those expended through physical activity. They credit the considerable scientific literature that shows that, to quote FDA, "sugar-sweetened beverages[] are no more likely to cause weight gain in adults than any other source of energy." 79 Fed. Reg. 11880, 11903-04 (Mar. 3, 2014). Coca-Cola therefore opposes, and FDA has thus far rejected, measures that would require SSBs to bear health warnings.

Plaintiffs argue that Coca-Cola's participation in this health policy debate—even in such non-commercial contexts as media interviews and scientific symposia—is unlawful under the District of Columbia Consumer Protection Procedures Act, D.C. Code § 28-3901 *et seq.* ("CPPA"). They assert that their ideology regarding SSBs and obesity reflects a "scientific consensus," and that statements contradicting this perspective should be outlawed. They thus ask this Court to enjoin Coca-Cola from making any statements, including ***truthful statements of fact***, that either contradict or "switch the focus" from their preferred theory.

As detailed in Coca-Cola's accompanying motion to dismiss under Super. Ct. Civ. R. 12(b)(6) and 12(b)(1), Plaintiffs' audacious request must be denied for multiple reasons, including that the First Amendment precludes their complaint in its entirety. But a subset of Plaintiffs' claims—those arising from Coca-Cola's statements to the media and at scientific conferences—is barred for an additional reason. The District of Columbia Anti-SLAPP[1] Act, D.C. Code § 16-5501 *et seq.*, was enacted to prevent lawsuits such as this, which seek "to muzzle speech or efforts to petition the government on issues of public interest." *See* Council of the District of Columbia, Report of Committee on Public Safety and the Judiciary on Bill 18-893 (Nov. 18, 2010) ("Committee Report") at 1. The statute embodies the bedrock principle that efforts to petition the government are entitled to absolute First Amendment protection.

The Anti-SLAPP Act thus permits the filing of a "special motion to dismiss" in any lawsuit that "aris[es] from an act in furtherance of the right of advocacy on issues of public interest." D.C. Code § 16-5502(a)-(b). Here, aside from the few that have appeared in Coca-Cola's advertising, all of the disputed statements fall within the class of "speech or efforts to petition the government" that the statute protects. *See* Committee Report at 1. Accordingly, to the extent the complaint arises from Coca-Cola's non-advertising statements, it should be dismissed pursuant to the Anti-SLAPP Act.

BACKGROUND

A. The Public Debate On SSBs

As set forth in Coca-Cola's companion motion, there is no "scientific consensus" supporting Plaintiffs' belief in a "unique" link between SSBs and obesity. (Compl. ¶¶ 36, 58) Even the studies Plaintiffs rely upon acknowledge that obesity is "a complex, systemic, multi-

[1] SLAPP stands for "Strategic Lawsuit Against Public Participation."

causal problem" and that "[t]he role of [SSBs] in promoting obesity is controversial." *See* Mot. to Dismiss at 5-6 (citing Compl. ¶¶ 50 n.19, 59 n.27).[2] Accordingly, while some scientists and policymakers share Plaintiffs' view, many do not.

This diversity of perspectives has led to a vibrant public debate about how communities can reduce the occurrence of obesity and related conditions. FDA, for example, has recognized that "[m]any factors contribute to weight gain and obesity," 79 Fed. Reg. 11880, 11903-04 (Mar. 3, 2014), and declined to adopt a rule that would single out products with added sugars for inclusion of "warning statements" concerning their purported "link[] to obesity, type [2] diabetes, [and] cardiovascular disease," 81 Fed. Reg. 33742, 33829 (May 27, 2016). Such a warning, in FDA's view, is "not consistent with [its] review of the evidence." *See id.* at 33830.

Some lawmakers, however, have been more receptive to Plaintiffs' view that SSB restrictions are an effective means of combating obesity. In recent years the U.S. Congress and state legislatures of California, Connecticut, New York, and Washington have all considered measures to deter SSB consumption, either by imposing a tax on SSBs or by requiring them to

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[2] *See also* Declaration of Jane Metcalf, Ex. 1, Ravi Dhingra et al., *Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community*, 116 CIRCULATION 480, 485 (2007) (cited in Compl. ¶ 49 n.18) (describing disagreement among researchers on whether "intake of sugar-sweetened beverages induces less compensation than intake of artificially sweetened soft drinks"); Ex. 2, Vasanti S. Malik et al., *Sugar Sweetened Beverages and Weight Gain in Children and Adults: A Systematic Review and Meta-Analysis*, 98 AM. J. CLINICAL NUTRITION 1084, 1084 (2013) (cited in Compl. ¶ 49 n.18) (observing that "the relation between consumption of sugar-sweetened beverages (SSBs) and body weight has become a matter of much public and scientific interest" and "controversy remains" over whether there is a causal link between SSBs and obesity because recent studies displayed "mixed" results); Ex. 3, Cara B. Ebbeling et al., *A Randomized Trial of Sugar-Sweetened Beverages and Adolescent Body Weight*, 367 NEW ENG. J. MED. 1407, 1408 (2012) (cited in Compl. ¶ 49 n.18) (explaining that results from randomized controlled trials on the effects of SSBs have "not been conclusive" and observing that "the use of public health measures to reduce the consumption of sugar-sweetened beverages remains controversial"); Ex. 4, Sonia Caprio, *Calories from Soft Drinks—Do They Matter?*, 367 NEW ENG. J. MED. 1462, 1462-63 (2012) (cited in Compl. ¶ 57 n.25) (describing evidence on the "hypothesis" that SSBs elicit a different response than other forms of sugar as "inconclusive").

bear health warnings.[3] And multiple municipalities, including Philadelphia, Pennsylvania and Berkeley, California, have actually imposed "soda taxes" on SSBs sold within their borders.[4]

The controversial nature of SSB restrictions has also led some lawmakers to pass these measures and then promptly withdraw them—in response to backlash from local businesses, challenges to the restrictions' legality, or both. For example, Cook County, Illinois imposed a tax on soft drinks in 2016, but recently yielded to pressure from retailers to repeal it.[5] In 2012, the New York City Board of Health promulgated a citywide ban on certain SSB serving sizes, only to have a group of labor unions and nonprofit organizations persuade New York's highest court that the measure exceeded the Board's authority. *See In re N.Y. Statewide Coalition of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, 16 N.E.3d 538, 541 (N.Y. 2014). The New York City restriction generated intense public interest. The Board of

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[3] *See* Metcalf Decl., Ex. 5, Sugar-Sweetened Beverages Tax Act of 2015, H.R. 1687, 114th Cong. 1st Sess. (Mar. 26, 2015) (bill to impose a $0.01 tax per 4.2 grams of caloric sweetener on certain distributors of SSBs); *id.*, Ex. 6, Healthy California Fund, Assembl. 2782, 2015-2016 Sess. (Cal. Feb. 19, 2016) (bill to impose a $0.02 tax per fluid ounce on certain distributors of SSBs); *id.*, Ex. 7, An Act Imposing a Tax on Sugary Soft Drinks, Gen. Assembl. 5461, 2015 Sess. (Conn. Mar. 19, 2015) (bill to impose a $0.01 tax per ounce on carbonated beverages with any added caloric sweetener); *id.*, Ex. 8, An Act to Amend the Agriculture and Markets Law, In Relation to the Labeling of Sugar-Sweetened Beverages with Warnings, Assembl. AO2320B, 2015 Leg. Sess. (N.Y. Jan. 15, 2015); *id.*, Ex. 9, Concerning Mitigation of the Adverse Impacts of Sugar-Sweetened Beverages, H.R. HB 2798, 2016 Reg. Sess. (Wash. 2016).

[4] Metcalf Decl., Ex. 10, Julia Terruso, *Philly: Soda tax revenue to fall short*, THE INQUIRER (June 13, 2017), *available at* http://www.philly.com/philly/news/city-soda-tax-revenue-to-fall-short-20170613.html; *id.*, Ex. 11, Allison Aubrey, *How Did Berkeley Pass A Soda Tax? Bloomberg's Cash Didn't Hurt*, NATIONAL PUBLIC RADIO (Nov. 5, 2014), *available at* http://www.npr.org/sections/thesalt/2014/11/05/361793296/how-did-berkeley-pass-a-soda-tax-bloombergs-cash-didnt-hurt.

[5] Metcalf Decl., Ex. 12, Greg Trotter & Becky Yerak, *Cook County retailers cheer soda tax repeal: 'This was a nightmare'*, CHICAGO TRIB. (Oct. 11, 2017) *available at* http://www.chicagotribune.com/business/ct-biz-soda-tax-repeal-reaction-20171011-story.html; *id.*, Ex. 13, Hal Dardick & John Byrne, *Vote to repeal Cook County soda tax delayed a month, as ad campaigns continue*, CHICAGO TRIBUNE (Sept. 14, 2017), *available at* http://www.chicagotribune.com/news/local/politics/ct-cook-county-board-soda-pop-tax-met-0914-20170913-story.html.

Health received a "substantial number of comments," reflecting "a groundswell of public interest and concern." The Court of Appeals similarly received a wide array of amicus briefs, another "indication of the interest of the subject to diverse persons." *Id.* at 541, 543.

More recently, San Francisco passed an ordinance that would have required SSB advertisements in that city to feature "warnings" that SSBs "contribute[] to" obesity and diabetes. *American Bev. Ass'n v. City and County of San Francisco*, 2017 U.S. App. LEXIS 18150, at *4 (9th Cir. Sept. 19, 2017). But last month, the Ninth Circuit enjoined the ordinance from taking effect, holding that the American Beverage Association ("ABA"), Coca-Cola's co-defendant in this case, was likely to succeed on its First Amendment challenge to the law. The Ninth Circuit concluded that the ordinance unconstitutionally required SSB advertisers to disseminate a "controversial" scientific viewpoint despite ongoing "debate over whether [SSBs] pose unique health risks." *Id.* at *21-22.

As this narrative reflects, policy proposals to restrict SSBs have attracted considerable attention and generated vigorous debate over the past several years. This debate has occurred not only among legislators and administrative bodies, but also labor unions, retailers, trade associations, and private citizens. Accordingly, the question whether SSB consumption is a unique risk factor for obesity is not just an academic or medical issue, but a political one as well.

B. Plaintiffs' Allegations About Coca-Cola's Participation in the Debate

Although Plaintiffs present their complaint as one of "misleading advertising" (Compl. ¶ 1), in fact their claims arise primarily from Coca-Cola's contributions to this public discussion. Plaintiffs challenge the following statements that Coca-Cola has made in public fora about the causes of obesity and limited science supporting SSB restrictions.

- Plaintiffs cite various statements that Coca-Cola executive Katie Bayne made to *USA Today* in 2012, including that "our drinks offer . . . hydration" and "[t]here is

no scientific evidence that connects sugary beverages to obesity." (Compl. ¶¶ 75, 130; *see also* Metcalf Decl., Exs. 14-15) Ms. Bayne gave the interview to provide Coca-Cola's perspective on the proposed SSB restriction in New York City. During the interview she was asked, *inter alia*, what she "would say to [New York City] Mayor Bloomberg if he were sitting across from [her]." (*Id.*, Ex. 15) The article containing Ms. Bayne's remarks began "Sorry Mayor Bloomberg, but the folks at Coca-Cola say you've got your facts fizzy." (*Id.*, Ex. 14)

- Plaintiffs claim that Coca-Cola CEO James Quincey has "joined the campaign of deception" by asserting, in a 2013 interview with CNN, that "[a] calorie is a calorie." (Compl. ¶ 77) Mr. Quincey made this remark in response to a reporter's questioning about Coca-Cola's efforts to "take the front foot in the world's fight against obesity." (Metcalf Decl., Ex. 20, 21 at 2:1-7, 5:5-13) In the same interview, Mr. Quincey referenced Coca-Cola's "belie[f] that businesses need to exert leadership and always engage with government and society [o]n the big issues of the day." (*Id.*, Ex. 20, Ex. 21 at 6:2-6)

- Plaintiffs object to a 2013 statement of Dr. Rhona Applebaum, then-Chief Science and Health Officer at Coca-Cola, that Coke is "safe, it hydrates, it's enjoyable." (Compl. ¶ 131) Dr. Applebaum made this comment during a one-hour speech at a symposium sponsored by the Canadian Obesity Network that explored the causes and prevention of obesity. (Metcalf Decl., Ex. 16, Ex. 17 at 4:17-25)

- Plaintiffs take issue with a 1998 statement to a Brazilian newspaper, attributed to then-CEO Douglas Ivester, that "Coca-Cola is an excellent complement to the habits of a healthy life." (Compl. ¶ 76, Metcalf Decl., Ex. 22)

Each of these statements reflects Coca-Cola's contributions to a public policy debate.[6] By expressing its views in the media and other public platforms, Coca-Cola encourages informed nutritional choices and critical evaluation of the science purportedly supporting SSB restrictions.

Plaintiffs' attempts to classify these statements as "false advertising" are misguided—

[6] The complaint also alleges that Coca-Cola violated the CPPA by expressing its views about nutrition and obesity in television ads. (Compl. ¶¶ 109-117) Those commercials are not the subject of this Special Motion to Dismiss. Notably, however, Plaintiffs' counsel, the Center for Science in the Public Interest ("CSPI"), has stated that these ads are also part of Coca-Cola's contributions to public policy debate. In 2013, CSPI asserted in its newsletter that Coca-Cola's "Coming Together" commercial, which Plaintiffs challenge here, represented an effort to "forestall sensible policy approaches to reducing sugary drink consumption, including taxes, further exclusion from public facilities, and caps on serving sizes such as the measure proposed by [New York City] Mayor Bloomberg." Metcalf Decl., Ex. 23, CSPI on New Coca-Cola Advertising Campaign & Obesity (Jan. 14, 2013), *available at* https://cspinet.org/new/201301142.html.

particularly since, in an earlier complaint, they described the same statements as part and parcel of Coca-Cola's political opposition to SSB restrictions. Prior to filing their complaint in this Court, Plaintiff The Praxis Project ("Praxis"), a nonprofit organization allegedly devoted to "build[ing] healthier communities" (Compl. ¶ 23), filed a similar action in the United States District Court for the Northern District of California. *See* Metcalf Decl., Ex. 24 ("Praxis I Complaint"). There, Praxis took issue with many of the statements listed above, including Ms. Bayne's statement to *USA Today* and Dr. Applebaum's remarks at the Canadian obesity symposium. (Praxis I Compl. ¶¶ 51-53, 101) In that pleading, Praxis explicitly recognized that these comments were intended to influence legislative outcomes, alleging that "[a] ***primary purpose*** of these [statements] is . . . to thwart and delay efforts of government entities to regulate [SSBs] through warning labels, taxes, and other measures." (Praxis I Compl. ¶ 8 (emphasis added)); *see also id.* ¶ 42 (alleging that Coca-Cola directed its statements at "city, county, and state regulators . . . [who] were openly discussing a variety of measures intended to address the epidemics of obesity, diabetes, and cardiovascular disease").)

Shortly after filing the California case, Praxis abruptly withdrew it, only to resurface several months later with this one. Along with its co-plaintiffs Pastors William H. Lamar IV and Delman L. Coates—who allege that they have been forced to spend too much time counseling congregants affected by obesity—Praxis claims that Coca-Cola violated the CPPA by expressing its views on these issues. This time, Praxis has scrubbed its complaint of explicit acknowledgments that the statements constituted petitioning activity, apparently having realized that such conduct is protected by the First Amendment. But Praxis still alleges that Coca-Cola's public statements have "forced" it to "expend resources attempting to educate . . . policy-makers about the inaccuracy of Defendants' messages," and to engage in SSB "advocacy" including

"meetings with policy makers in various local and state regulatory bodies." (Compl. ¶¶ 160, 164) As these allegations reflect, Coca-Cola's statements are part of the ongoing legislative and policy debate over the science of SSBs and the wisdom of SSB restrictions. They are accordingly protected by the First Amendment, and Plaintiffs' attack on them is subject to dismissal under the Anti-SLAPP Act.

ARGUMENT

Public speech in furtherance of a legislative outcome is absolutely privileged under the First Amendment. The Anti-SLAPP Act prohibits use of the courts as retribution for statements made in connection with an "issue under consideration or review by a legislative, executive, or judicial body," or any "issue of public interest." D.C. Code 16-5501(1)(A)-(B). The Act provides defendants with a means to "expeditiously and economically dispose of" lawsuits arising from such statements by, among other things: (1) imposing an automatic stay of discovery upon the filing of a special motion; (2) requiring plaintiffs to make a prompt evidentiary showing of "likely . . . succe[ss] on the merits"; and (3) awarding attorneys' fees to successful Anti-SLAPP movants. Committee Report at 4; D.C. Code §§ 15-5504; 16-5502(b)-(c). Although the Court may consider materials outside the pleadings on an Anti-SLAPP special motion, and the plaintiff is *required* to make an evidentiary showing in order to withstand dismissal, there is no "corresponding evidentiary demand on the defendant who invokes the Act's protection." *Competitive Enter. Inst. v. Mann*, 150 A.3d 1213, 1237 (D.C. 2016).

The statements Plaintiffs challenge here fall squarely within the class of "speech or efforts to petition the government" the statute protects. Moreover, because their claims are constitutionally and statutorily barred, Plaintiffs necessarily cannot make the showing of likely success on the merits required to defeat an Anti-SLAPP motion. Accordingly, to the extent their

complaint arises from Coca-Cola's non-advertising statements, it should be dismissed pursuant to the Anti-SLAPP Act.[7]

I. PLAINTIFF'S CLAIMS ARE BARRED BY THE ANTI-SLAPP ACT

A. The Challenged Statements Are Protected By the First Amendment

A statement made in connection with an effort to "persuade the legislature or the executive to take particular action" is absolutely privileged under the First Amendment. *E.R.R. Pres. Conference v. Noerr Motor Freight*, 365 U.S. 127, 136 (1961). This principle, known as the *Noerr-Pennington* doctrine, encompasses not only statements made directly to government authorities, but also those made in connection with a "publicity campaign to influence governmental action." *Id.* at 140. In *Noerr*, for instance, the Supreme Court held that the First Amendment protected the defendant railroads' efforts to encourage stricter government oversight of the trucking industry by "conduct[ing] a publicity campaign against the truckers. . . [and] creat[ing] an atmosphere of distaste for the truckers among the general public." *Id.* at 129; *see also Feld Entm't, Inc. v. ASPCA*, 873 F. Supp. 2d 288, 307-08 (D.D.C. 2012) (*Noerr-Pennington* applicable to "participat[ion] in press conferences[,] . . . statements to news outlets, and . . . letters [to] organizational websites," where those activities "were part of a publicity campaign to influence government action.") (internal quotation marks and alteration omitted).

Although the doctrine originated as a limitation on Sherman Act liability, it operates as a bar to any private claim that would curtail a defendant's right to petition the government. *See, e.g., Sliding Door Co. v. KLS Doors*, 2013 U.S. Dist. LEXIS 71304, at *23-24 (C.D. Cal. May 1,

[7] Although no District court has considered a SLAPP motion directed at some, but not all, allegations of a complaint, the California Supreme Court has permitted such motions when applying that state's similar statute. *See Baral v. Schnitt*, 376 P.3d 604, 614-15 (Cal. 2016) (holding that application of California's analogous statute does not "turn on how the challenged pleading is organized" and rejecting argument that plaintiffs may "escape[]"an Anti-SLAPP motion simply by including allegations arising from conduct outside the scope of the statute).

2013) (false advertising and unfair-competition claims "barred by the *Noerr-Pennington* doctrine"); *Brownsville Golden Age Nursing Home, Inc. v. Wells*, 839 F.2d 155, 160 (3d Cir. 1988) (same for tortious-interference claims).

The absolute protection afforded by *Noerr-Pennington* extends even to statements that are intentionally false when made. Indeed, the Supreme Court in *Noerr* applied the protection to the defendants' efforts to "deliberately deceive[] the public and public officials," through "manufacture of bogus sources of reference [and] distortion of public sources of information." *Noerr*, 365 U.S. at 140, 145. The Court has since reiterated that "[a] publicity campaign directed at the general public" enjoys *Noerr-Pennington* protection "even when the campaign employs unethical and deceptive methods." *Allied Tube & Conduit Corp. v. Indian Head*, 486 U.S. 492, 499-500 (1988).[8]

Coca-Cola's public contributions to a scientific and policy debate cannot be proven "false," let alone deliberately so. But they enjoy absolute First Amendment protection in any event, because they were part of a "publicity campaign to influence governmental action" by opposing SSB restrictions. *Noerr*, 365 U.S. at 140. Indeed, Ms. Bayne's 2012 remarks to *USA Today*, in which she discussed the SSB restriction then under consideration in New York City, were explicitly associated with that campaign. *See* Metcalf Decl., Exs. 14-15. Mr. Quincey, when making the challenged remarks to CNN, likewise emphasized Coca-Cola's global efforts

[8] In *Philip Morris v. United States*, 566 F.3d 1095, 1123 (D.C. Cir. 2009), the D.C. Circuit concluded that "the [*Noerr-Pennington*] doctrine does not protect deliberately false or misleading statements." Although, as noted above, Plaintiffs do not plausibly allege that the challenged statements were false or misleading—let alone deliberately so—the statements would be protected even if Plaintiffs had so alleged. The D.C. Circuit's contrary conclusion in *Philip Morris* is irreconcilable with Supreme Court precedent expressly extending the protection to "deceptive" and "bogus" statements. *Noerr*, 365 U.S. at 140; *Allied Tube*, 486 U.S. at 499; *see also Feld Entm't*, 873 F. Supp. 2d at 307-08 (applying doctrine to "false or misleading statements" made "as part of publicity campaign[] to influence governmental action") (internal quotation marks and alteration omitted).

to "engage with government and society" in fighting obesity. (*Id.*, Ex. 20, Ex. 21 at 6:2-6) And all of Coca-Cola's critiques of the core theory underlying SSB restrictions—that SSBs are "uniquely" to blame for obesity—were essential to its efforts to influence legislative action, as Praxis acknowledged in its earlier complaint. Its public statements on this issue are thus entitled to *Noerr-Pennington* protection.

B. The Challenged Statements Fall Within the Scope of the Statute

Because lawsuits directed at petitioning activity are inimical to First Amendment values, the Anti-SLAPP Act provides for prompt dismissal of any suit "arising from an act in furtherance of the right of advocacy on issues of public interest." D.C. Code § 16-5502(a). Such an act includes any statement made "[i]n connection with an issue under consideration or review by a legislative, executive, or judicial body, or any other official proceeding authorized by law." *Id.* § 16-5501(1)(A)(i). It further encompasses ***all*** public statements made "[i]n a place open to the public or a public forum . . . in connection with an issue of public interest." *Id.* § 16-5501(1)(A)(ii). Issues of public interest include, *inter alia*, those related to "health or safety," "community well-being," or "a good . . . in the market place." *Id.* § 16-5501(3).

Coca-Cola's statements easily fall within these parameters. As set forth above, over the past decade lawmakers across the nation have considered, debated, and sometimes adopted SSB restrictions. These deliberations have generated intense public scrutiny. Private citizens and interest groups have grappled with the economic effects of SSB restrictions, their encroachment on individual freedoms, and the limited scientific evidence that they will appreciably reduce obesity. Coca-Cola's public remarks on that question thus pertain to "an issue . . . under consideration" by legislative bodies throughout the United States. *Id.* § 16-5501(1)(A)(i).

Coca-Cola's statements also trigger the Anti-SLAPP Act for the independent reason that they relate to "an issue of public interest," which expressly includes issues related to "health or safety." *Id.*. §§ 16-5501(1)(B), 16-5501(3). The question of how individuals can best maintain a healthy weight is among the most widely discussed topics of our time. *Id.* Coca-Cola's public discussion of that question would thus fall within the reach of the Anti-SLAPP Act even absent its clear connection to Coca-Cola's legislative goals.

That Coca-Cola's speech on this topic may have indirectly served its commercial interests does not preclude invocation of the Anti-SLAPP Act. The statute embraces ***all*** statements about "issue[s] . . . under consideration" by legislative bodies—even commercially motivated ones—unless those statements are "made for the purpose of promoting . . . commercial transactions" to an "intended audience" of "actual or potential buyer[s]." *Id.* § 16-5505. The challenged statements here, which do not even mention the purchase of any Coca-Cola products and were made in the non-commercial settings of media interviews and scientific conferences, satisfy neither criterion.

Although the statute's protection of statements on "issue[s] of public interest" excludes those "directed ***primarily*** toward protecting the speaker's commercial interests," *id.* § 16-5501(3) (emphasis added), this Court need not reach the question whether that exclusion applies, because the statements' relevance to issues "under consideration" by legislative bodies independently qualifies them for Anti-SLAPP protection. But the exclusion does not apply in any event. D.C. courts have held that an interested party's statements regarding "the safety of [a product category] in general," as opposed to representations regarding a particular product, are not "directed primarily" toward the speaker's commercial interests. Metcalf Decl., Ex. 25, *Simpson v. Johnson & Johnson*, No. 2016 CA 1931 B, Tr. of Oral Ruling at 39:18-21 (Jan. 13, 2017); *see*

also Farah v. Esquire Magazine, Inc., 863 F. Supp. 2d 29, 38-39 (D.D.C. 2012), aff'd, 736 F.3d 528 (D.C. Cir. 2013) (statements disparaging thesis of a competitor's book constituted statements on "issue of public interest" despite potential for commercial benefit to speaker). The challenged statements are thus protected under the Anti-SLAPP Act both because of their pertinence to legislative debate and because of their connection to issues of public interest.

C. Plaintiffs Cannot Demonstrate That Their Claim Is Likely to Succeed

Upon a prima facie showing that the Anti-SLAPP Act applies, the defendant is entitled to dismissal with prejudice "unless the [plaintiff] demonstrates that the claim is likely to succeed on the merits." D.C. Code § 16-5502(b). Unlike a Rule 12(b)(6) motion to dismiss, this showing "requires more than mere reliance on allegations in the complaint, and mandates the production or proffer of evidence that supports the claim." *Mann*, 150 A.3d at 1233. In other words, the Anti-SLAPP Act "up[s] the ante" by requiring the Plaintiffs to put forward *evidence*, not just allegations, at an early stage of the litigation. *Id.* at 1238.

As set forth in Coca-Cola's accompanying motion, Plaintiffs cannot even satisfy the more lenient standards of Rule 12(b), for three primary reasons. *First*, all of the statements that Plaintiffs challenge are protected by the First Amendment. *See* Mot. to Dismiss at 11-17.

Second, Plaintiffs lack standing to sue in this Court because they have not alleged that they suffered "injury-in-fact" as a result of Coca-Cola's alleged misconduct. *Grayson v. AT&T Corp.*, 15 A.3d 219, 225 (D.C. 2011). They do not allege that they were deceived by Coca-Cola's purported misstatements or even that they consumed Coca-Cola products. Rather, they premise standing on their "exposure" to Coca-Cola's conduct and their belief that Coca-Cola's statements hindered their efforts to disseminate their own views about obesity among their constituencies. Neither of these constitutes an "injury-in fact" sufficient to confer standing. *See*

Mot. to Dismiss at 17-26.

Third, Plaintiffs' allegations are insufficient to state a claim under the CPPA for several reasons, including that they are time-barred and involve conduct beyond the geographical reach of the statute. *See* Mot. to Dismiss at 26-30.

These deficiencies defeat Plaintiffs' claims even when all of their allegations are presumed to be true, as Rule 12(b) requires. It follows *a fortiori* that they cannot meet the more demanding standard of the Anti-SLAPP Act, which requires an evidentiary showing of likelihood of success on the merits. Accordingly, Plaintiffs' claims based on Coca-Cola's non-advertising statements should be dismissed under the Anti-SLAPP Act as well as Rule 12(b).

II. COCA-COLA IS ENTITLED TO OTHER RELIEF

In addition to providing for dismissal of SLAPP suits, the Anti-SLAPP Act confers certain procedural benefits on SLAPP defendants. Upon the filing of an Anti-SLAPP special motion such as this, "discovery proceedings on the claim shall be stayed until the motion has been disposed of." D.C. Code § 16-5502(c)(1). Although a limited exception exists "[w]hen it appears likely that targeted discovery will enable the plaintiff to defeat the motion and . . . discovery will not be unduly burdensome," *see id.* § 16-5502(c)(2), that is not the case here. It is apparent from Plaintiffs' allegations that they fall within the purview of the Anti-SLAPP Act and that, even if true, they are insufficient to state a claim. Coca-Cola should not be subject to the burdens of discovery (much less costly electronic discovery, as Plaintiffs' counsel suggested at the October 20, 2017 status conference) under these circumstances.

The Anti-SLAPP Act also entitles Coca-Cola to "an expedited hearing on the special motion to dismiss," a ruling "as soon as practicable after the hearing," dismissal with prejudice, and "the costs of litigation, including reasonable attorney fees." *Id.* §§ 16-5502(d), 16-5504(a).

The Court has set a hearing date of March 15, 2018 on defendants' various motions to dismiss. Coca-Cola reserves the right to seek attorneys' fees should it prevail on this motion.

CONCLUSION

Over the past decade, lawmakers, public health officials and citizens have vigorously debated the effectiveness of SSB restrictions in reducing the occurrence of obesity and related conditions. Coca-Cola has participated in this debate, arguing in media outlets and at scientific symposia that such measures have negligible scientific support.

Plaintiffs are free to disagree with these arguments, but they may not use the courts to silence Coca-Cola's views altogether. The First Amendment guarantees Coca-Cola the right to express its opinions in public debate, and the D.C. Anti-SLAPP Act protects its right to do so without the interference and expense of meritless lawsuits such as this one. The Court should grant this motion and dismiss Plaintiffs' claims under the Anti-SLAPP Act to the extent they arise from Coca-Cola's non-advertising statements.

Dated: October 23, 2017

Respectfully submitted,

/s/ Steven A. Zalesin

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Civil Division

THE PRAXIS PROJECT, et al.,	Case No. 2017 CA 004801 B
Plaintiffs,	
v.	Honorable Judge Elizabeth C. Wingo
THE COCA-COLA COMPANY, et al.,	Next Event: Motion Hearing March 15, 2018 at 11:00 a.m.
Defendants.	

DEFENDANT COCA-COLA'S RULE 12-I(a) CERTIFICATION

Pursuant to Rule 12-I(a) of the Superior Court Rules of Procedure, the undersigned certifies that the parties conferred on the relief requested in the underlying motion and Plaintiffs do not consent to such relief.

[SIGNATURE BLOCK ON NEXT PAGE]

Respectfully submitted,

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
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Plaintiffs,	
v.	Honorable Judge Elizabeth C. Wingo
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Defendants.	

[PROPOSED] ORDER

Upon review of Defendant Coca-Cola's Special Motion to Dismiss pursuant to the District of Columbia Anti-SLAPP Act, D.C. Code § 16-5501 et seq., and good cause being shown, it is hereby:

ORDERED that discovery is stayed in this matter until such time as Defendant Coca-Cola's Special Motion to Dismiss is ruled upon.

SO ORDERED.

Honorable Judge Elizabeth C. Wingo
(signed in chambers)

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
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THE COCA-COLA COMPANY, et al.,	Next Event: Motion Hearing March 15, 2018 at 11:00 a.m.
Defendants.	

[PROPOSED] ORDER

Upon review of Defendant Coca-Cola's Special Motion to Dismiss pursuant to the District of Columbia Anti-SLAPP Act, D.C. Code § 16-5501 *et seq.*, and good cause being shown, it is hereby:

ORDERED that the MOTION is **GRANTED**; and it is further:

ORDERED that Plaintiffs' Complaint is dismissed with prejudice; and it is further:

ORDERED that Defendant Coca-Cola is awarded reasonable attorneys' fees and costs associated with this matter.

SO ORDERED.

Honorable Judge Elizabeth C. Wingo
(signed in chambers)

[CONTINUED ON NEXT PAGE]

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Civil Division

THE PRAXIS PROJECT, et al.,	Case No. 2017 CA 004801 B
Plaintiffs,	
v.	Honorable Judge Elizabeth C. Wingo
THE COCA-COLA COMPANY, et al.,	Next Event: Motion Hearing March 15, 2018 at 11:00 a.m.
Defendants.	

CERTIFICATE OF SERVICE

On October 23, 2017, the undersigned hereby certifies that a true and correct copy of the foregoing Memorandum of Law in Support Of Coca-Cola's Special Motion to Dismiss Pursuant to District of Columbia Anti-SLAPP Act, D.C. Code § 16-5501 Et Seq. was electronically served via the CaseFileXpress system on:

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Civil Division

THE PRAXIS PROJECT, et al.,	Case No. 2017 CA 004801 B
Plaintiffs,	
v.	Honorable Judge Elizabeth C. Wingo
THE COCA-COLA COMPANY, et al.,	
Defendants.	

DECLARATION OF JANE METCALF IN SUPPORT OF COCA-COLA'S SPECIAL MOTION TO DISMISS PURSUANT TO THE DISTRICT OF COLUMBIA ANTI-SLAPP ACT, D.C. CODE § 16-5501 *ET SEQ.*

I, Jane Metcalf, hereby declare as follows:

1. I am over 21 years of age and competent to make the following statements.

2. I am a member of the New York bar and an attorney at the law firm of Patterson Belknap Webb & Tyler LLP, counsel for Defendant The Coca-Cola Company ("Coca-Cola") in this matter.

3. I have personal knowledge of the facts set forth in this Declaration in Support of Coca-Cola's Special Motion to Dismiss.

4. Attached hereto are true and accurate copies of the following documents:

Exhibit 1. Ravi Dhingra et al., *Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community*, 116 CIRCULATION 480 (2007) (cited at Compl. ¶ 49 n.18).

Exhibit 2. Vasanti S. Malik et al., *Sugar-sweetened beverages and weight gain in children and adults: a systematic review and meta-analysis*, 98 AM. J. CLINICAL NUTRITION 1084 (2013) (cited at Compl. ¶ 49 n.18).

Exhibit 3. Cara B. Ebbeling et al., *A Randomized Trial of Sugar-Sweetened Beverages and Adolescent Body Weight*, 367 NEW ENG. J. MED. 1407 (2012) (cited at Compl. ¶ 49 n.18).

Exhibit 4. Sonia Caprio, *Calories from Soft Drinks – Do They Matter?*, 367 NEW ENG. J. MED. 1462 (2012) (cited at Compl. ¶ 57 n.25).

Exhibit 5. Sugar-Sweetened Beverages Tax Act of 2015, H.R. 1687, 114th Cong. 1st Sess. (Mar. 26, 2015).

Exhibit 6. Healthy California Fund, Assembly Bill 2782, 2015-2016 Sess. (Cal. Feb. 19, 2016).

Exhibit 7. An Act Imposing a Tax on Sugary Soft Drinks, Gen. Assembly Bill 5461, 2015 Sess. (Conn. Mar, 19, 2015).

Exhibit 8. An Act to Amend the Agriculture and Markets Law, In Relation to the Labeling of Sugar-Sweetened Beverages with Warnings, Assembly Bill AO2320B, 2015 Leg. Sess. (N.Y. Jan. 15, 2015).

Exhibit 9. An Act Relating to Mitigating the Adverse Impacts of Sugar-Sweetened Beverages, H.B. 2798, 2016 Reg. Sess. (Wash. 2016).

Exhibit 10. Julia Terruso, *Philly: Soda tax revenue to fall short*, THE INQUIRER (June 13, 2017), *available at* http://www.philly.com/philly/news/city-soda-tax-revenue-to-fall-shotr-20170613.html.

Exhibit 11. Allison Aubrey, *How Did Berkeley Pass a Soda Tax? Bloomberg's Cash Didn't Hurt*, NATIONAL PUBLIC RADIO (Nov. 5, 2014), http://www.npr.org/sections/thesalt/2014/11/05/361793296/how-did-berkeley-pass-a-soda-tax-bloombergs-cash-didnt-hurt.

Exhibit 12. Greg Trotter & Becky Yerak, *Cook County retailers cheer soda tax repeal: "This was a nightmare"*, CHICAGO TRIBUNE (Oct. 11, 2017), *available at* http://www.chicagotribune.com/business/ct-biz-soda-tax-repeal-reaction-20171011-story.html.

Exhibit 13. Hal Dardick & John Byrne, *Vote to repeal Cook County soda tax delayed a month, as ad campaigns continue*, CHICAGO TRIBUNE (Sept. 14, 2017), *available at* http://www.chicagotribune.com/news/local/politics/ct-cook-county-board-soda-pop-tax-met-0914-20170913-story.html.

Exhibit 14. Bruce Horovitz, *Coke Says Obesity Grew as Sugar Drink Consumption Fell*, USA TODAY (June 7, 2012), *available at* http://usatoday30.usatoday.com/money/industries/food/story/2012-06-07/mayor-bloomberg-coca-cola/55452558/1 (cited at Compl. ¶ 75 n.38).

Exhibit 15. *Coke executive answers questions about sugary drinks*, USA TODAY (June 7, 2012), *available at* https://usatoday30.usatoday.com/money/industries/food/story/2012-06-07/coke-q-and-a-coca-cola-mayor-bloomberg/55453016/1 (cited at Compl. ¶¶ 114 n.79, 130 n.93).

Exhibit 16. Canadian Obesity-Network, *COS2013 Symposia – Coca Cola – Dr. Rhona Applebaum*, YOUTUBE (May 29, 2013), retrieved from https://www.youtube.com/watch?v=5Kfzu0ndhqY (cited at Compl. ¶ 131 n.94) (hard copy filed pursuant to Super. Ct. R. 5(d)(6)(B)).

Exhibit 17. Transcription of excerpts of Exhibit 16 by Veritext Legal Solutions (Oct. 13, 2017) (minutes 15:00 to 20:00).

Exhibit 18. Ignoredvoices, *BBC Interview by Jeremy Paxman with James Quincey, in London, England*, YOUTUBE (Nov. 27, 2013), https://www.youtube.com/watch?v=DWLQaz8nhQw (cited at Compl. ¶¶ 77 n.40, 91 n.53) (hard copy filed pursuant to Super. Ct. R. 5(d)(6)(B)).

Exhibit 19. Transcription of excerpts of Exhibit 18 by Veritext Legal Solutions (Oct. 13, 2017).

Exhibit 20. CNN, *Interview by Richard Quest with James Quincey, in London, England*, YOUTUBE (May 9, 2013), https://www.youtube.com/watch?v=126nvtHoBgk (cited at Compl. ¶ 91 n.53) (hard copy filed pursuant to Super. Ct. R. 5(d)(6)(B)).

Exhibit 21. Transcription of excerpts of Exhibit 20 by Veritext Legal Solutions (Oct. 13, 2017).

Exhibit 22. *The Unhappy Truth about Soda*, CTR. FOR SCI. IN THE PUB. INTEREST, http://www.therealbears.org (cited in Compl. ¶ 76 n.39), *and* CONSTANCE L. HAYS, THE REAL THING: TRUTH AND POWER AT THE COCA-COLA COMPANY (2005) (excerpt).

Exhibit 23. Center for Science in the Public Interest, "CSPI on New Coca-Cola Advertising Campaign & Obesity" (Jan. 14, 2013), https://cspinet.org/new/201301142.html.

Exhibit 24. Complaint, *The Praxis Project v. The Coca-Cola Co. et al.*, No. 4:17-cv-00016, ECF No. 1 (N.D. Cal. Jan. 4, 2017).

Exhibit 25. *Simpson et al v. Johnson & Johnson et al.*, No. 2016 CA 1931 B, Transcript of Oral Ruling (D.C. Super. Ct. Jan. 13, 2017).

I declare under penalty of perjury under the law of the District of Columbia that the foregoing is true and correct.

Dated: October 23, 2017

Jane Metcalf

Exhibit 1

Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community

Ravi Dhingra, MD; Lisa Sullivan, PhD; Paul F. Jacques, PhD; Thomas J. Wang, MD; Caroline S. Fox, MD; James B. Meigs, MD, MPH; Ralph B. D'Agostino, PhD; J. Michael Gaziano, MD, MPH; Ramachandran S. Vasan, MD

Background—Consumption of soft drinks has been linked to obesity in children and adolescents, but it is unclear whether it increases metabolic risk in middle-aged individuals.

Methods and Results—We related the incidence of metabolic syndrome and its components to soft drink consumption in participants in the Framingham Heart Study (6039 person-observations, 3470 in women; mean age 52.9 years) who were free of baseline metabolic syndrome. Metabolic syndrome was defined as the presence of ≥3 of the following: waist circumference ≥35 inches (women) or ≥40 inches (men); fasting blood glucose ≥100 mg/dL; serum triglycerides ≥150 mg/dL; blood pressure ≥135/85 mm Hg; and high-density lipoprotein cholesterol <40 mg/dL (men) or <50 mg/dL (women). Multivariable models included adjustments for age, sex, physical activity, smoking, dietary intake of saturated fat, trans fat, fiber, magnesium, total calories, and glycemic index. Cross-sectionally, individuals consuming ≥1 soft drink per day had a higher prevalence of metabolic syndrome (odds ratio [OR], 1.48; 95% CI, 1.30 to 1.69) than those consuming <1 drink per day. On follow-up (mean of 4 years), new-onset metabolic syndrome developed in 765 (18.7%) of 4095 participants consuming <1 drink per day and in 474 (22.6%) of 2059 persons consuming ≥1 soft drink per day. Consumption of ≥1 soft drink per day was associated with increased odds of developing metabolic syndrome (OR, 1.44; 95% CI, 1.20 to 1.74), obesity (OR, 1.31; 95% CI, 1.02 to 1.68), increased waist circumference (OR, 1.30; 95% CI, 1.09 to 1.56), impaired fasting glucose (OR, 1.25; 95% CI, 1.05 to 1.48), higher blood pressure (OR, 1.18; 95% CI, 0.96 to 1.44), hypertriglyceridemia (OR, 1.25; 95% CI, 1.04 to 1.51), and low high-density lipoprotein cholesterol (OR, 1.32; 95% CI 1.06 to 1.64).

Conclusions—In middle-aged adults, soft drink consumption is associated with a higher prevalence and incidence of multiple metabolic risk factors. (***Circulation.* 2007;116:480-488.**)

Key Words: diabetes mellitus ■ metabolic syndrome ■ epidemiology ■ obesity ■ risk factors ■ carbonated beverages

Several reports from the United States and Europe indicate increasing consumption of soft drinks among children, adolescents, and adults over the past 3 decades.[1,2] Many clinical studies have linked the rising consumption of soft drinks to the present epidemic of obesity and diabetes mellitus among children and adolescents[3–6] and to the development of hypertension in adults.[7] Furthermore, added sweeteners in soft drinks have been linked to an increase in serum triglycerides levels in some reports[8,9] but not in others.[10,11] The association of soft drink consumption with obesity and higher insulin resistance has been attributed to multiple factors, including greater caloric intake, the high

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The online-only Data Supplement, consisting of tables, is available with this article at http://circ.ahajournals.org/cgi/content/full/CIRCULATIONAHA.107.689935/DC1.

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fructose corn syrup content,[12] less satiety and compensation, and a general effect of consuming refined carbohydrates (see review by Drewnowski and Bellisle[13]).

The aforementioned data raise the possibility that the consumption of soft drinks can fuel metabolic derangements, including insulin resistance, that can translate into a greater risk of developing abdominal obesity, high triglyceride levels, low levels of high-density lipoprotein cholesterol (HDL-C), elevated blood pressure, and impaired glucose tolerance; this constellation of metabolic traits has been collectively referred to as the metabolic syndrome.[14] Higher prevalence of the metabolic syndrome poses greater risk for cardiovascular disease in the community,[15] although the independent contribution of this entity to vascular risk beyond its components has been questioned.[16]

In the present prospective investigation, we tested the hypothesis that greater soft drink consumption increases the risk of developing metabolic risk factors (alone and in combination [metabolic syndrome]) in middle-aged adults in the community. Additionally, we evaluated whether metabolic risk varied on the basis of consumption of sugar-sweetened ("regular") versus artificially sweetened ("diet") soft drinks.

Methods

Study Sample

The Framingham Heart Study began in 1948 with the enrollment of 5209 participants into the original study cohort.[17] In 1971, children of the original cohort participants and the spouses of the children were enrolled into the Framingham Offspring Study (n=5124).[18] Offspring study participants are evaluated approximately every 4 years. Information on daily consumption of soft drinks was collected via a physician-administered questionnaire at each study visit from the fourth (1987–1991) through the sixth (1995–1998) examination cycles. That examination questionnaire did not elicit information regarding consumption of regular versus diet soft drinks; however, such information was available from the self-administered food frequency questionnaires (FFQ; Willett questionnaire)[19] completed by participants at the fifth (1992–1995) and sixth examination cycles (see below).

For the present investigation, we selected offspring cohort participants who attended any 2 consecutive examinations from the fourth through the seventh (1998–2001) examination cycles. We excluded participants with missing data on covariates (n=207) and those with prevalent cardiovascular disease (n=926). After exclusions, a total of 8997 person-observations (4871 in women) were eligible for the cross-sectional analyses. For prospective analyses, we excluded individuals with baseline metabolic syndrome (n=2897 person-observations; metabolic syndrome as defined below) and those with any missing metabolic syndrome components on follow-up (n=61 person-observations). The schema for selection of individuals eligible for cross-sectional and longitudinal analyses is displayed in the Figure. All participants provided written informed consent, and the protocol for the study was approved by institutional review board of Boston Medical Center.

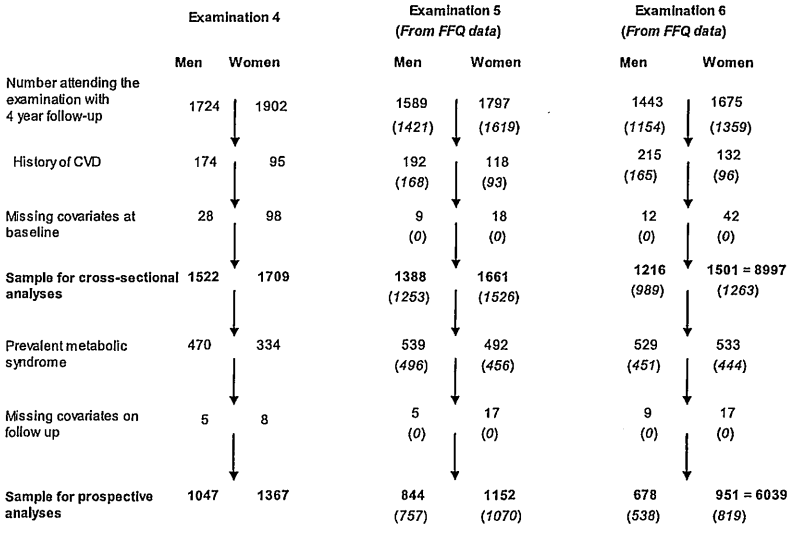
Measurement of Covariates

At each Framingham Heart Study examination, participants provided a medical history and underwent a complete standardized physical examination that included anthropometry, blood pressure measurements, and laboratory assessment of vascular risk factors. Fasting levels of blood glucose, triglycerides, and HDL-C were measured with standard assays. Blood pressure was measured by a physician using a mercury sphygmomanometer and with the participant resting in a seated position for 5 minutes; the average of 2 readings obtained on the participant's left arm constituted the examination blood pressure. Physical activity was assessed by calculating a "physical activity index"; participants were asked specific questions regarding how many hours in a typical day they spent sitting, sleeping, or performing light-moderate or heavy physical activities.[20] Alcohol intake was assessed by averaging the number of alcoholic beverages consumed per week. Participants who reported smoking 1 or more cigarettes per day in the year before the Framingham Heart Study examination were considered current smokers.

Assessment of Soft Drink Consumption and Dietary Intake of Other Foods

At the index examinations, participants reported the average number of 12-oz servings of soft drinks (Coke, Pepsi, Sprite, or other carbonated soft drinks, separately categorized into caffeinated or decaffeinated drinks) consumed per day in the year preceding the examination. The responses to the questions were entered as integers (0 or more) separately for caffeinated and decaffeinated soft drinks. This questionnaire (referred to as the "examination cola questionnaire") did not separate nondrinkers from infrequent drinkers (<1 drink per day). Accordingly, we compared individuals who reported consuming 1, ≥1, or ≥2 soft drinks per day with attendees who reported consuming <1 soft drink per day (infrequent drinkers and nondrinkers, who served as the referent).

Intake of regular and diet soft drinks was assessed from FFQs[19] that were administered at the fifth and sixth examinations. We also



Selection of study sample from baseline examinations using the examination cola questionnaire and from the sample with available FFQ data (within parentheses, for examinations 5 and 6). Eligible participants and exclusions are indicated in the Figure. CVD indicates cardiovascular disease.

assessed the dietary information on consumption of total calories, saturated fat, trans fat, fiber, magnesium, and glycemic index from the FFQ.[19] Because a FFQ was not administered at the fourth examination cycle, dietary covariate data from the fifth examination cycle were used for analyses using information from the examination cola questionnaire at all 3 examinations.

Data from the FFQ were considered valid only if total energy intakes reported were ≥2.51 MJ/d (600 kcal/d) for men and women but <17.54 MJ/d (4200 kcal/d) for men or <16.74 MJ/d (4000 kcal/d) for women and if fewer than 13 food items were left blank. Each food item was categorized in 9 categories that ranged from never or <1 serving per month to >6 servings per day. For assessment of saturated fat, trans fat, or dietary fiber, the nutrient intakes from all specific food items were multiplied by the frequency of consumption. The validity of the FFQ has been demonstrated previously.[21]

Definition and Components of the Metabolic Syndrome

The metabolic syndrome was considered present if 3 or more of the following individual components were present[14,22]: waist circumference ≥35 inches (88 cm) for women or ≥40 inches (102 cm) for men; fasting blood sugar ≥100 mg/dL (5.5 mmol/L) or treatment with oral hypoglycemic agents or insulin; blood pressure ≥135/85 mm Hg or treatment for hypertension; serum triglycerides ≥150 mg/dL (1.7 mmol/L) or treatment for hypertriglyceridemia (with niacin or fibrates); and HDL-C <40 mg/dL (1.03 mmol/L) in men or <50 mg/dL (1.3 mmol/L) in women.

Statistical Analyses

Age- and sex-adjusted baseline characteristics of the participant groups defined according to the number of soft drinks consumed in 1 day (<1, 1, or ≥2 per day) were compared by multiple linear and multiple logistic regression analysis for continuous and categorical characteristics, respectively. Data on consumption of soft drinks at each of the 3 eligible baseline examinations (examination cola questionnaire) were used for this purpose. Tests for trend in baseline characteristics across soft drink consumption categories were performed with multiple regression. We also assessed the baseline characteristics after excluding participants with prevalent metabolic syndrome at baseline examinations (sample used for incidence analyses; see below).

Soft Drink Consumption and Prevalence of the Metabolic Syndrome

We used data from examinations 4, 5, and 6 (examination cola questionnaire) and generalized estimating equations to compare the prevalence of metabolic syndrome in participants who consumed ≥1 soft drink per day with those who consumed <1 soft drink per day (referent). Each participant could contribute up to 3 person-examinations of data for analysis. We also evaluated a dose response by comparing individuals who consumed 1 soft drink per day and those who consumed ≥2 soft drinks per day with the referent group. We constructed multivariable models in hierarchical fashion with adjustment for age and sex (model I) and for age, sex, physical activity index, smoking, dietary consumption of saturated fat, trans fat, fiber, magnesium, total calories, and glycemic index (model II).

We used soft drink consumption data from FFQs at examinations 5 and 6, which yielded a smaller sample (Figure), to relate the prevalence of metabolic syndrome across the following categories of intake of regular versus diet soft drinks using generalized estimating equations: (1) <1 diet or regular soft drink per week (referent), (2) 1 to 6 diet soft drinks per week, (3) ≥1 diet soft drink per day, (4) 1 to 6 regular soft drinks per week, (5) 1 to 6 regular or diet soft drinks per week, and (6) ≥1 regular soft drink per day. Individuals reporting consumption of both diet and regular soft drinks ≥1/d (n=16) were grouped into the last category empirically. We evaluated the 2 sets of models (I and II) noted above.

Soft Drink Consumption and Incidence of the Metabolic Syndrome

To assess the relations of soft drink consumption to the incidence of metabolic syndrome, we excluded participants with prevalent metabolic syndrome at each of examination cycles 4, 5, and 6 (n=2897 person-observations). Then, we used pooled logistic regression analyses by combining each 4-year follow-up period of observations to relate the number of soft drinks consumed per day (examination cola questionnaire) to the incidence of metabolic syndrome (from examination cycles 4 to 5, 5 to 6, and 6 to 7).[23] The eligible participants were free of metabolic syndrome at each baseline examination, and in this setting, pooled logistic regression has been shown to provide risk estimates similar to time-dependent Cox models.[24] We compared the consumption of soft drinks ≥1 per day with infrequent drinkers (<1 per day; referent) and also tested for a dose response by comparing groups consuming 1 and ≥2 soft drinks per day with the referent group. We evaluated 2 sets of models (covariates as in models I and II above), which paralleled the analyses of prevalence of metabolic syndrome.

Consumption of soft drinks varies with age and by sex.[25] It has also been suggested that the effects of soft drinks and carbohydrates on metabolic traits may vary according to age, sex,[26] and baseline body weight.[27] Therefore, we assessed for effect modification by age (modeled as a continuous variable), sex, and body mass index (<30 versus ≥30 kg/m^2) by incorporating appropriate interaction terms in the multivariable models. We repeated analyses with additionally adjustment for alcohol consumption and baseline levels of systolic and diastolic blood pressure, blood glucose, serum triglycerides, and HDL-C. These models were constructed to account for baseline levels of metabolic traits. Additionally, we repeated analyses to examine the association between consumption of caffeinated and decaffeinated soft drinks, considered separately, and incidence of the metabolic syndrome. Because individuals with diabetes mellitus are a particularly high-risk group for developing metabolic abnormalities, we also repeated our analyses after excluding those with prevalent diabetes mellitus at baseline.

To compare the risk of new-onset metabolic syndrome according to the type of soft drink consumed (regular versus diet), we used data from the FFQs at examinations 5 and 6 and evaluated the incidence of the metabolic syndrome across categories of soft drinks consumed. The 6 categories of regular and diet soft drinks were those noted above (for the analyses of the prevalence of metabolic syndrome), and 2 sets of models were evaluated (models I and II, as described above).

Incidence of Individual Components of Metabolic Syndrome

We used multivariable logistic regression to evaluate the relations of soft drink consumption to the incidence of each individual component of metabolic syndrome using data from the examination cola questionnaire. We excluded participants who had the specific metabolic trait prevalent at baseline; for example, we excluded individuals with blood glucose ≥100 mg/dL (5.5 mmol/L) from the "at-risk" group for analysis that examined the incidence of impaired fasting glucose. Thus, we examined the incidence of increased waist circumference, impaired fasting glucose, high blood pressure, hypertriglyceridemia, and low HDL-C (all defined as above) according to the number of soft drinks consumed per day.

We evaluated 2 sets of models (I and II, as noted above) and compared the risk of developing metabolic traits associated with consumption of ≥1 soft drinks per day with that in infrequent drinkers (<1 soft drinks per day). We also evaluated for a dose response as detailed above. We did not perform analyses of development of individual metabolic syndrome components in relation to regular versus diet soft drink intake using the FFQ data at examinations 5 and 6 because the grouping of incident events into 6 categories resulted in modest numbers of events in each category.

All analyses were performed with SAS software version 9.0 (SAS Institute, Cary, NC). A 2-sided probability value of <0.05 was considered statistically significant.

The authors had full access to and take full responsibility for the integrity of the data. All authors have read and agree to the manuscript as written.

Results

The baseline characteristics of participants according to the categories of soft drinks consumed per day are presented in Table 1. Approximately 35% of the participants reported consuming ≥1 soft drink per day in response to the examination cola questionnaire (data based on all 3 examinations). In comparison, only 22% of participants reported intake of at least 1 soft drink (diet or regular) per day in response to the FFQ (data available for examinations 5 and 6 only). The lower proportion reporting daily intake on the FFQ may be related to the greater number of options available to indicate soft drink intake; participants drinking 1 to 6 soft drinks per week (also 22% on the FFQ) may have rounded their responses on the examination cola questionnaire to the nearest integer.

In age- and sex-adjusted models, the prevalence of obesity (assessed both by body mass index and by waist circumference), high blood pressure, glucose intolerance, low HDL-C, and hypertriglyceridemia was significantly higher in those who consumed a greater number of soft drinks per day. Serum total cholesterol, low-density lipoprotein cholesterol, physical activity index, and alcohol consumption did not vary across categories of soft drinks consumed. Similar trends were obtained when we excluded individuals with prevalent metabolic syndrome (Data Supplement, Table I).

Prevalence of the Metabolic Syndrome

There was a 48% higher adjusted prevalence of metabolic syndrome among those who consumed 1 or more soft drinks per day relative to individuals with infrequent soft drink consumption (Table 2). We observed a rising prevalence of metabolic syndrome across categories of 1 and ≥2 soft drinks per day. In parallel analyses with the data from the FFQ (Table 2), participants who consumed ≥1 diet or regular soft drink per day had nearly a 1.8-fold adjusted prevalence of metabolic syndrome compared with infrequent drinkers (<1 per week).

Incidence of the Metabolic Syndrome

Individuals who consumed at least 1 soft drink per day had a 44% higher adjusted risk (95% CI, 20% to 74%) of developing metabolic syndrome compared with infrequent drinkers in multivariable-adjusted analyses (Table 3). There was no effect modification by age, body mass index, or sex (interaction terms were not statistically significant). After additional adjustment for baseline levels of covariates (blood sugar, systolic and diastolic blood pressure, triglycerides, and HDL-C) and alcohol consumption in our models, the association of consumption of ≥1 soft drink per day with incidence of metabolic syndrome remained robust (odds ratio [OR], 1.44; 95% CI, 1.19 to 1.74). Further exclusion of individuals with diabetes mellitus at baseline (n=138) attenuated the association (OR for ≥1 soft drink per day, 1.16; 95% CI 1.00 to 1.34). After stratification of analyses by caffeinated versus decaffeinated drinks, results were consistent with the primary analyses; consumption of ≥1 soft drink per day was associated with incident metabolic syndrome for both types of beverages (Data Supplement, Table II).

In analyses with FFQ data (Table 3), intake of at least 1 regular or diet soft drink per day was associated with a >50% higher incidence of metabolic syndrome than among those who drank <1 soft drink per week, although the association was borderline significant for intake of ≥1 regular soft drink per day ($P=0.07$). We also observed a graded increase in the risk of metabolic syndrome from those who were consuming 1 to 6 diet or regular soft drinks per week to those who drank ≥1 soft drinks per day (diet or regular).

Incidence of Individual Components of the Metabolic Syndrome

Compared with infrequent drinkers, individuals who consumed ≥1 soft drink per day had a 25% to 32% higher adjusted risk of incidence of each individual metabolic trait (Table 4), with the exception of development of high blood pressure, for which there was a borderline significant 18% higher adjusted odds ($P=0.10$).

Discussion

In the present study, we observed a significantly higher prevalence of metabolic syndrome among middle-aged adults who consumed ≥1 soft drink per day. This association was consistent for intake of both regular and diet soft drinks. Our prospective analyses corroborated the cross-sectional findings; we observed an increase in the incidence of metabolic syndrome among adults consuming at least 1 soft drink per day, regardless of whether it was of the regular or diet type. Additionally, consumption of soft drinks daily was associated with a higher incidence of each metabolic syndrome component. The present study extends results from prior studies that reported that a greater intake of soft drinks is associated with increased prevalence of metabolic syndrome,[28] higher risk of obesity,[4–6] high blood pressure,[7] and diabetes mellitus.[5] The similar metabolic hazard posed by both regular and diet soft drinks is noteworthy given the lack of calories in the latter; however, other studies have also reported associations of diet soft drinks with weight gain in boys[29] and with hypertension in adult women.[7]

Mechanisms

There are several mechanisms that can explain the higher risk of metabolic abnormalities associated with greater consumption of soft drinks. These can be broadly grouped under physiological effects, dietary behavior, and the economics of food choice.[13]

There are several physiological effects of soft drinks that may pose an adverse metabolic risk. Larger consumption of added nutritive sweeteners such as high fructose corn syrup (the primary sweetener in soft drinks) can lead to weight gain, increased insulin resistance,[30,31] a lowering of HDL-C,[32] and an increase in triglyceride levels.[27] Typically, in the United States, the high fructose corn syrup added to the beverages contains ≈55% fructose.[30,31] Al-

TABLE 1. Baseline Characteristics of Participants According to Soft Drink Consumption (n=8997)

	No. of Soft Drinks Consumed Per Day			
Characteristic	<1 (n=5840)	1 (n=1918)	≥2 (n=1239)	P*
Age, y	56±10	53±10	51±9	...
Men, %	42.8	50.2	53.4	...
Systolic BP, mm Hg	127±19	125±17	126±18	<0.0001
Diastolic BP, mm Hg	76±10	77±10	78±11	<0.0001
BP ≥130/85 mm Hg or on treatment, %	48.9	46.7	48.4	<0.0001
Hypertension, %	22.5	18.7	21.6	0.0014
Treatment for hypertension, %	18.9	16.1	17.6	0.0011
BMI, kg/m^2	26.8±4.8	27.8±5.1	28.5±5.4	<0.0001
BMI ≥30 kg/m^2, %	20.9	27.1	32.1	<0.0001
Weight, kg	75.5±16.1	79.4±16.9	82.1±18.1	<0.0001
Waist circumference, in	36.0±5.6	36.9±5.7	37.8±6.1	<0.0001
Increased waist circumference, %†	33.9	37.2	41.1	<0.0001
Men	36.3	40.9	48.1	<0.0001¶
Women	32.0	33.4	33.2	<0.0001¶
Total cholesterol, mg/dL	206±37	204±37	202±38	0.72
Low-density liporotein cholesterol, mg/dL	129±34	128±33	127±34	0.30
Triglycerides, mg/dL	127±83	141±119	148±118	<0.0001
High triglycerides, %‡	28.3	32.7	35.9	<0.0001
HDL-C, mg/dL	52±16	50±15	47±14	<0.0001
Low HDL-C, %§	34.8	38.7	46.1	<0.0001
Men	37.5	42.0	45.1	<0.0001¶
Women	32.8	35.5	47.2	<0.0001¶
Blood sugar, mg/dL	97±21	99±26	105±39	<0.0001
Impaired fasting glucose, %‖	28.2	30.4	33.7	<0.0001
Diabetes mellitus, %	6.1	7.5	12.4	<0.0001
Metabolic syndrome, %	29.1	32.2	37.3	<0.0001
Physical activity index, %	36±6	36±7	36±7	0.74
Alcohol, drinks/wk	2.6±3.9	2.7±3.8	2.7±4.1	0.14
Smoking, %	17.5	17.5	25.7	0.0009
Dietary variables, g/d				
Saturated fat	20.9±9.8	22.3±9.6	24.6±11.5	<0.0001
Trans fat	2.9±1.9	3.1±1.9	3.5±2.3	<0.0001
Dietary fiber	18.4±7.9	17.9±7.1	17.0±7.6	<0.0001
Magnesium, mg/d	308±111	304±105	296±111	0.0002
Glycemic index	54±3	55±3	55±4	0.0001
Total energy, cal/d#	1855±611	1959±654	2009±745	0.0837

All values are mean±SD unless otherwise noted. BP indicates blood pressure; BMI, body mass index; and LDL-C, LDL cholesterol.

*P comparing all 3 categories of soft drink consumption, adjusted for age and sex.

†Increased waist circumference ≥40 in (102 cm) for men and ≥35 in (88 cm) for women.

‡≥150 mg/dL (1.7 mmol/L) or undergoing treatment with fibrates or nicotinic acid.

§Low HDL-C (men <40 mg/dL [1.03 mmol/L], women <50 mg/dL [1.3 mmol/L]).

‖≥100 mg/dL or undergoing treatment.

¶Age-adjusted.

#Sample sizes are n=2742, 820, and 466, respectively.

though the association of high fructose corn syrup intake and insulin resistance may be a contributory mechanism,[31] in the present study, both regular and diet soft drinks appeared to pose similar metabolic hazards, which suggests that other factors may be operational. Consumption of liquids is associated with a lesser degree of dietary compensation (the adjustment in energy intake made in subsequent meals in response to food intake). Some

TABLE 2. Cross-Sectional Relationships of Soft Drink Consumption With Prevalence of Metabolic Syndrome

Soft Drink Consumption, Servings/d	Metabolic Syndrome, n	No. at Risk*	Age- and Sex-Adjusted OR (95% CI)	Multivariable Adjusted OR (95% CI)†
Model I: any soft drink (regular or diet); data from all 3 examinations (4, 5, and 6; n=8997)				
None	1697	5840	Referent	Referent
1	618	1918	1.18 (1.06 to 1.33)	1.38 (1.19 to 1.61)
≥2	462	1239	1.43 (1.24 to 1.66)	1.67 (1.38 to 2.01)
≥1	1080	3157	1.26 (1.14 to 1.40)	1.48 (1.30 to 1.69)
Model II: regular vs diet soft drink; data from FFQ at examinations 5 and 6 (n=5031)‡				
Diet or regular, <1/wk	650	2129	Referent	Referent
Diet, 1 to 6/wk	359	882	1.72 (1.45 to 2.03)	1.81 (1.48 to 2.22)
Diet, ≥1/d	328	819	1.87 (1.57 to 2.23)	1.80 (1.45 to 2.25)
Regular, 1 to 6/wk	235	671	1.33 (1.09 to 1.61)	1.20 (0.94 to 1.53)
Diet and regular 1 to 6/wk	106	239	1.79 (1.35 to 2.38)	1.99 (1.40 to 2.83)
Regular, ≥1/d	130	291	2.31 (1.77 to 3.01)	1.81 (1.28 to 2.56)

*No. of people represents person-observations. FFQ indicates food frequency questionnaire; OR, odds ratio; and CI, confidence interval.

†Multivariable model adjusts for age, sex, physical activity index, smoking, dietary consumption of saturated fat, trans fat, fiber, magnesium, total calories, and glycemic index (No. eligible for multivariable models: model I, any soft drink, n=5350; model II, for regular vs diet soft drink, n=3493).

‡Individuals who reported drinking both diet and regular soft drinks ≥1/d (n=16) were included in the regular ≥1/d category.

investigators believe that intake of sugar-sweetened beverages induces less compensation than intake of artificially sweetened soft drinks,[33] but others disagree.[34] The high sweetness of diet or regular soft drinks may lead to conditioning for a greater preference for intake of sweetened items,[35] although this explanation also has been questioned by some experts.[13] The caramel content of both regular and diet drinks may be a potential source of advanced glycation end products,[5] which may promote insulin resistance[36] and can be proinflammatory.[37]

Dietary behavior among individuals consuming soft drinks may account in part for the clustering of metabolic risk factors in these people.[13] Individuals with greater intake of soft drinks also have a dietary pattern characterized by greater intake of calories and saturated and trans fats, lower consumption of fiber[38] and dairy products,[39] and a sedentary life.[40] These observations were corroborated by the our findings of increased consumption of saturated and trans fat, lower consumption of dietary fiber, and higher rates of smoking in those with greater intake of soft drinks. Nonetheless, in the present investigation, we adjusted for saturated fat and trans fat intake, dietary fiber consumption, smoking, and physical activity in multivariable analyses and still observed a significant association of

TABLE 3. Multiple Logistic Regression Examining Soft Drink Consumption and Incidence of Metabolic Syndrome (n=6154)

Soft Drink Consumption, Servings/d	Metabolic Syndrome, n	No. at Risk*	Age- and Sex-Adjusted OR (95% CI)	Multivariable-Adjusted OR (95% CI)†
Model I: any soft drink (regular or diet): data from all 3 examinations (4, 5, and 6; n=6154)				
None	717	4033	Referent	Referent
1	267	1259	1.34 (1.14 to 1.58)	1.53 (1.24 to 1.89)
≥2	166	747	1.46 (1.20 to 1.78)	1.29 (0.98 to 1.70)
≥1	433	2006	1.39 (1.21 to 1.59)	1.44 (1.20 to 1.74)
Model II: regular vs diet soft drink: data from FFQ at examinations 5 and 6 (n=3184)‡				
Diet or regular, <1/wk	253	1456	Referent	Referent
Diet, 1 to 6/wk	98	518	1.17 (0.90 to 1.52)	1.32 (0.96 to 1.81)
Diet, ≥1/d	106	486	1.42 (1.10 to 1.84)	1.53 (1.10 to 2.15)
Regular, 1 to 6/wk	79	434	1.01 (0.76 to 1.35)	1.13 (0.79 to 1.62)
Diet and regular 1 to 6/wk	29	130	1.21 (0.78 to 1.89)	1.41 (0.80 to 2.50)
Regular, ≥1/d	34	160	1.33 (0.88 to 2.02)	1.62 (0.96 to 2.75)

*No. of people represents person-observations. FFQ indicates food frequency questionnaire; OR, odds ratio; and CI, confidence interval.

†Multivariable models adjust for age, sex, physical activity index, smoking, dietary consumption of saturated fat, trans fat, fiber, magnesium, total calories, and glycemic index (No. eligible for multivariable models: any soft drink, n=3655; for regular vs diet soft drink, n=1864).

‡Individuals who reported drinking both diet and regular soft drinks ≥1/d (n=7) were included in the regular ≥1/d category.

TABLE 4. Multiple Logistic Regression Analysis Examining the Relations of Incidence of Individual Components of Metabolic Syndrome According to Soft Drink Consumption (Data From All 3 Examinations [4, 5, and 6])

Soft Drink Consumption, Servings/d	Incident, n	No. at Risk*	Age- and Sex-Adjusted OR (95% CI)	Multivariable-Adjusted OR (95% CI)
Incidence of obesity (BMI ≥30 kg/m^2)				
None	327	4665	Referent	Referent
1	130	1420	1.29 (1.04 to 1.60)	1.21 (0.90 to 1.62)
≥2	91	853	1.51 (1.18 to 1.94)	1.50 (1.06 to 2.11)
≥1	221	2273	1.37 (1.14 to 1.65)	1.31 (1.02 to 1.68)
Incidence of increased waist circumference (≥102 cm for men and ≥88 cm for women)				
None	840	3665	Referent	Referent
1	281	1113	1.29 (1.10 to 1.51)	1.25 (1.02 to 1.54)
≥2	181	645	1.55 (1.28 to 1.88)	1.40 (1.08 to 1.83)
≥1	462	1758	1.38 (1.20 to 1.58)	1.30 (1.09 to 1.56)
Incidence of impaired fasting glucose (≥5.5 mmol/L or diabetes)				
None	898	4264	Referent	Referent
1	322	1359	1.20 (1.03 to 1.39)	1.21 (0.99 to 1.47)
≥2	206	836	1.28 (1.07 to 1.53)	1.32 (1.03 to 1.69)
≥1	528	2195	1.23 (1.08 to 1.39)	1.25 (1.05 to 1.48)
Incidence of high blood pressure (≥135/85 mm Hg or on treatment)				
None	631	3055	Referent	Referent
1	232	1043	1.23 (1.03 to 1.46)	1.16 (0.92 to 1.47)
≥2	141	654	1.20 (0.97 to 1.49)	1.20 (0.90 to 1.60)
≥1	373	1697	1.22 (1.05 to 1.41)	1.18 (0.96 to 1.44)
Incidence of hypertriglyceridemia (≥1.7 mmol/L or on treatment)				
None	695	4258	Referent	Referent
1	250	1317	1.24 (1.05 to 1.46)	1.35 (1.09 to 1.67)
≥2	148	807	1.20 (0.98 to 1.46)	1.09 (0.82 to 1.44)
≥1	398	2124	1.22 (1.07 to 1.41)	1.25 (1.04 to 1.51)
Incidence of low HDL-C (<1.03 mmol/L for men or <1.3 mmol/L for women or on treatment)				
None	460	3878	Referent	Referent
1	183	1201	1.28 (1.06 to 1.54)	1.38 (1.08 to 1.77)
≥2	96	684	1.13 (0.89 to 1.43)	1.21 (0.87 to 1.68)
≥1	279	1885	1.22 (1.04 to 1.44)	1.32 (1.06 to 1.64)

Sample sizes for multivariable models in each category differed from age-adjusted models for obesity (n=4277), waist circumference (n=3321), impaired fasting glucose (n=3858), high blood pressure (n=2803), high triglycerides (n=3792), and low HDL-C (n=3501). OR indicates odds ratio; CI, confidence interval.

*Participants without the individual component at baseline were eligible. No. of people represents person-observations.

†Multivariable models adjust for baseline level of the metabolic syndrome component and age, sex, physical activity index, smoking, dietary consumption of saturated fat, trans fat, fiber, magnesium, total calories, and glycemic index.

soft drink consumption with the risk of developing metabolic syndrome and its component traits. It is conceivable, though, that there may be residual confounding caused by lifestyle factors not adjusted for in the present analyses.

Last, it has been suggested that the obesity-promoting effects of soft drinks may be related in part to their costs, with less expensive drinks being associated with greater hazard by virtue of their preferential selection for economic reasons.[13] The present investigation could not explore this explanation.

Strengths and Limitations

The strengths of the present study include the large community-based sample of men and women and the adjustments for potential confounders; however, several limitations merit comment. We chose to use the modified definition of metabolic syndrome recommended by the National Cholesterol Education Program[14] and did not use other criteria for the syndrome (such as those suggested by the World Health Organization[41] or the European panel). Researchers have found high correlation between these guidelines.[42] Given the

observational nature of the present study, we cannot infer that the observed associations are causal. As noted above, it is conceivable that residual confounding by lifestyle/dietary factors not adjusted for may have contributed to the metabolic risks associated with soft drink intake. Finally, participants in the present study were all white Americans, which may limit the generalizability of our results to nonwhites.

Conclusions

In our large community-based sample of middle-aged adults, soft drink consumption was associated with higher risk of developing adverse metabolic traits and the metabolic syndrome. The present observational data raise the possibility that public health policy measures to limit the rising consumption of soft drinks in the community may be associated with a lowering of the burden of metabolic risk factors in adults.

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Disclosures

None.

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CLINICAL PERSPECTIVE

Consumption of soft drinks among children, adolescents, and middle-aged adults has risen in the United States and Europe during the past 3 decades. Prior studies have shown a higher prevalence of obesity and diabetes mellitus in children who consume more soft drinks, although these associations are less clear for adults. We evaluated the relations of metabolic syndrome and its components to soft drink consumption in Framingham participants. Cross-sectionally, individuals consuming at least 1 soft drink per day had ≈50% higher prevalence of the metabolic syndrome than those consuming <1 drink per day. During a follow-up period of ≈4 years, consumption of ≥1 soft drink per day was associated with a higher incidence of metabolic syndrome and a higher incidence of each of its components, ie, obesity, increased waist circumference, impaired fasting glucose, higher blood pressure, hypertriglyceridemia, and low high-density lipoprotein cholesterol. Analyses that used food frequency questionnaire data suggested that intake of ≥1 drink per day of either regular or diet soft drinks was associated with a >50% higher incidence of metabolic syndrome compared with intake of <1 soft drink per week. We conclude that consumption of more than 1 soft drink per day is associated with a higher prevalence and incidence of multiple metabolic risk factors in middle-aged adults. Our observational data raise the possibility that public health measures to limit consumption of soft drinks may be associated with a lowering of the burden of cardiometabolic risk factors in adults.

Circulation

Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community

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Correction

In the article, "Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community" by Dhingra et al, which appeared in the July 31, 2007, issue (*Circulation.* 2007;116:480–488), the following corrections are needed:

1. In the Results section of the Abstract, the sentence "On follow-up (mean 4 years), new-onset MetSyn developed in 765 of 4095 participants (18.7%) consuming <1 drink/day, and in 474 of 2059 persons (22.6%) consuming ≥1 soft drink/day" should read, "On follow-up (mean 4 years), new-onset MetSyn developed in 717 of 4033 participants (17.8%) consuming <1 drink/day, and in 433 of 2006 persons (21.6%) consuming ≥1 soft drink/day."

2. In the title and first entry in the stub column of Table 3, the total value of "n=6154" should read "n=6039."

The current online version of the article has been corrected.

DOI: 10.1161/CIRCULATIONAHA.107.187928

(*Circulation.* **2007;116:e557.**)

***Circulation* is available at http://circahajournals.org**

Exhibit 2

Sugar-sweetened beverages and weight gain in children and adults: a systematic review and meta-analysis[1–3]

Vasanti S Malik, An Pan, Walter C Willett, and Frank B Hu

ABSTRACT

Background: The relation between sugar-sweetened beverages (SSBs) and body weight remains controversial.

Objective: We conducted a systematic review and meta-analysis to summarize the evidence in children and adults.

Design: We searched PubMed, EMBASE, and Cochrane databases through March 2013 for prospective cohort studies and randomized controlled trials (RCTs) that evaluated the SSB-weight relation. Separate meta-analyses were conducted in children and adults and for cohorts and RCTs by using random- and fixed-effects models.

Results: Thirty-two original articles were included in our meta-analyses: 20 in children (15 cohort studies, $n = 25{,}745$; 5 trials, $n = 2772$) and 12 in adults (7 cohort studies, $n = 174{,}252$; 5 trials, $n = 292$). In cohort studies, one daily serving increment of SSBs was associated with a 0.06 (95% CI: 0.02, 0.10) and 0.05 (95% CI: 0.03, 0.07)-unit increase in BMI in children and 0.22 kg (95% CI: 0.09, 0.34 kg) and 0.12 kg (95% CI: 0.10, 0.14 kg) weight gain in adults over 1 y in random- and fixed-effects models, respectively. RCTs in children showed reductions in BMI gain when SSBs were reduced [random and fixed effects: −0.17 (95% CI: −0.39, 0.05) and −0.12 (95% CI: −0.22, −0.2)], whereas RCTs in adults showed increases in body weight when SSBs were added (random and fixed effects: 0.85 kg; 95% CI: 0.50, 1.20 kg). Sensitivity analyses of RCTs in children showed more pronounced benefits in preventing weight gain in SSB substitution trials (compared with school-based educational programs) and among overweight children (compared with normal-weight children).

Conclusion: Our systematic review and meta-analysis of prospective cohort studies and RCTs provides evidence that SSB consumption promotes weight gain in children and adults. *Am J Clin Nutr* 2013;98:1084–102.

INTRODUCTION

As the search for solutions to the worldwide epidemic of obesity continues, the relation between consumption of sugar-sweetened beverages (SSBs)[4] and body weight has become a matter of much public and scientific interest. SSBs are composed of energy-containing sweeteners such as sucrose (50% glucose, 50% fructose), high-fructose corn syrup (HFCS; most often 45% glucose and 55% fructose), or fruit juice concentrates that are added to the beverage by manufacturers, establishments, or individuals and usually contain >25 kcal per 8 fluid ounces. Although temporal patterns from the United States have shown a decrease in added sugar consumption between 2000 and 2008, primarily from reductions in SSBs, average intakes still exceed recommended limits and SSBs continue to be the largest contributor to added sugar and top sources of calories in the US diet (1). Globally, intake of SSBs has been increasing steadily, because of rapid urbanization and heavy marketing in low- and middle-income countries (2).

Within the past 2 decades, a number of epidemiologic studies both in children and adults have evaluated the association between SSB intake and weight gain and obesity. In general, findings from large observational studies support a link between SSB consumption and development of obesity (3, 4). However, controversy remains whether the association is causal and whether public action should be taken on the basis of the observational evidence. Recently, several randomized controlled trials (RCTs) have been performed to evaluate whether adding SSBs into the habitual diet can increase body weight or if substituting SSBs by other low- or noncaloric beverages can reduce weight gain or facilitate weight loss. The results have been mixed as a result of heterogeneity in study design, sample size, and study duration.

For clinicians and policymakers to make informed evidence-based recommendations about SSBs, the totality of the available evidence needs to be examined in a thorough and systematic manner. Thus, we conducted a systematic review and meta-analyses of prospective cohort studies and RCTs in children and adults to provide a comprehensive summary of the literature evaluating SSBs and body weight gain.

METHODS

Literature search

Standard methods were used for conducting and reporting meta-analyses (5). Relevant articles were identified by searching

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[2] Supported by the NIH (grants DK58845, P30 DK46200, U54CA155626, and HL60712).

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[4] Abbreviations used: FFQ, food-frequency questionnaire; HFCS, high-fructose corn syrup; RCT, randomized controlled trial; SSB, sugar-sweetened beverage; WMD, weighted mean difference.

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PubMed (http://www.ncbi.nlm.nih.gov/pubmed; since 1966), EMBASE (http://www.embase.com; since 1947), and the Cochrane library (http://www.thecochranelibrary.com/; since 1951) databases from the index date through March 2013 for studies evaluating the association between SSBs and body weight in children and adults. Our search strategy combined various terms for SSBs (eg, carbonated beverages, sweetened beverages, soda, sports drink, fruit drink) and body weight (ie, body weight, BMI, overweight, obesity), related cardiometabolic outcomes (ie, diabetes mellitus, insulin resistance, cardiovascular diseases, hypertension), and study design/epidemiologic methods (ie, epidemiologic studies, cohort, case-control, clinical trials) by using exploded versions of nedical subject headings terms and corresponding key words in titles and abstracts. Additional articles were identified from reference lists of included studies and relevant reviews. Full details on our search terms and strategy are shown in Supplemental Table 1 under "Supplemental data" in the online issue. The current meta-analysis focused on outcomes related to body weight. Our search strategy included terms for cardiometabolic outcomes because some of these studies also report outcomes for body weight.

Study selection

Studies were considered for inclusion in our meta-analysis if they met the following criteria: *1*) were original research, ie, not a review, abstract, editorial, letter, or commentary; *2*) were prospective cohort studies or clinical trials conducted in children or adults; *3*) reported multivariable-adjusted coefficients for the association between SSBs and body weight (any available metric) from prospective cohort studies or the difference in changes in body weight (any available metric) between intervention and control groups from clinical trials; *4*) did not combine SSBs with other beverages, foods, or lifestyle factors as a composite exposure; and *5*) had a control group and intervened for at least 2 wk in clinical trials. We restricted publications to the English language, and we did not consider cross-sectional or ecologic studies because they are highly prone to confounding and reverse causation. Titles and abstracts of identified studies were screened, and potentially relevant articles were selected for full-text review, which was performed independently by 2 investigators (VSM and AP). Discrepancies were resolved by consensus or consultation with a third author (FBH).

Data extraction

For each article identified, we extracted information on study characteristics (authors, publication year, geographic location, sample size, and duration), participant characteristics (sex, age, and baseline body weight), SSB assessment method [food-frequency questionnaire (FFQ), 24-h recall, or diet record], type of SSB and serving size, body weight assessment method (measured, self-report), intervention design (crossover trial, parallel trial, or cluster RCT), intervention and control modality, and analysis strategy (statistical models, adjustment for total energy and covariates). For prospective cohort studies, we extracted multivariable-adjusted β coefficients and corresponding SEs for the association between SSBs and any available measure of body weight. Because total energy intake partly mediates the association between SSBs and weight, where possible we extracted estimates that were not adjusted for total energy. For RCTs, we extracted means and SDs of changes in body weight (any available metric) from baseline to the end of follow-up for intervention and control regimens. If a trial did not report the SD for the measurement of change, we imputed this value by using the correlation coefficient method referenced in the Cochrane Handbook for Systematic Reviews of Interventions (6). We used a correlation coefficient of 0.95 because the correlation between body weights at the 2 time points was assumed to be very high.

Data synthesis and analysis

For a number of studies it was necessary to obtain data from authors or apply scaling factors and transformations with various assumptions to generate consistent units for the meta-analyses (*see* Supplemental Table 2 under "Supplemental data" in the online issue). For prospective cohort studies in children, our primary estimate of interest was the predicted change in BMI per one 12-oz–serving/d increment of SSBs during the time period specified in each study. Studies that reported serving sizes in units other than 12 oz were scaled accordingly. Studies by Blum et al (7), Newby et al (8), and Mundt et al (9) were scaled from 1-oz servings to 12-oz servings. Studies by Striegel-Moore et al (10), Johnson et al (11), Libuda et al (12), and Olsen et al (13) were scaled from 100 g/d, 180 g/d, 1 MJ/d, and 10 g/d to one 12-oz serving/d, respectively. For studies that did not specify a serving size (14–19), we assumed the standard serving size of 12 oz. Two studies were converted from servings per week to servings per day (15, 19). Studies reporting estimates using BMI *z* score (7, 12, 13, 18, 20, 21) were converted to BMI by using the LMS method developed by Cole (22), and studies reporting estimates of fat mass (kg) were converted to BMI by dividing the coefficients by average height in meters squared (9, 11). Finally, studies reporting estimates categorically (18, 19) were converted into continuous variables by assigning medians to each intake category, which were plotted against weight change by using least squares linear regression to obtain the slope (β) and SE. This transformation makes the assumption of linearity. Because studies evaluating change in SSB intake in relation to change in weight have some features of a quasi-experimental design, we conducted a separate meta-analysis for the 1-y change in BMI per 1-serving/d increment of SSBs by using studies that reported change versus change estimates (12, 14–17, 19, 21). Units were converted to 1-y change by dividing β coefficients by the time period specified in each study (*see* Supplemental Table 2 under "Supplemental data" in the online issue).

For trials in children, our primary estimate of interest was the mean difference in BMI between intervention and control regimens (*see* Supplemental Table 2 under "Supplemental data" in the online issue).

For prospective cohort studies in adults, our primary estimate of interest was the 1-y change in weight (kg) per 1-serving/d increment of SSBs by using studies that reported change in weight in relation to change in SSBs (23–29). Units were converted to 1-y change by dividing coefficients by the time period specified in each study, and the serving size was assumed to be 12 oz, consistent with most cans and glasses. Two studies (23, 27) were converted from servings per week to servings per day, and one study (28) was converted from change in 1 percentage

unit of SSBs to servings per day. The study by Palmer et al (25) was converted into continuous data by assigning medians to each intake category, which were plotted against weight change by using least squares linear regression to obtain the slope (β) and SE. Data were converted from pounds to kilograms by multiplying coefficients by 0.45. For trials in adults, the unit of interest was the mean difference in weight in kilograms from baseline to end of follow-up between intervention and controls (*see* Supplemental Table 2 under "Supplemental data" in the online issue).

Summary estimates were calculated by combining inverse-variance–weighted study-specific estimates using random-effects models, which accounts for between-study heterogeneity and is generally considered the more conservative method (6). Fixed-effects models were also evaluated for comparison. Forest plots were used to visualize individual and summary estimates, and the Cochrane Q test and I^2 statistic were used to evaluate between-study heterogeneity (30, 31). An I^2 value >50% was generally considered to be high (32). Potential sources of heterogeneity, including adjustment for total energy, duration, age, dietary assessment method, sample size, and baseline weight status, were explored by using univariate meta-regressions and stratified analyses (36). We also tested the influence of individual studies on the results in sensitivity analysis (36). The potential for publication bias was evaluated by using Begg's test and visual inspection of funnel plots (33, 34). All analyses were performed by using Stata 10.0 (StataCorp).

Risk of bias assessment

Study-level risk of bias was assessed by 2 authors (VSM and AP), and disagreements in ratings were discussed until consensus. For cohort studies, the Newcastle Ottawa scale was used (35), which assesses 3 broad areas: the selection of exposed and unexposed participants, the comparability of the groups, and the assessment of the outcome. A star was awarded for high quality in each area, with a maximum of 4 stars for the "Selection" category, 2 stars for "Comparability," and 3 stars for "Outcome." For comparability, we awarded a star for studies that provided coefficients that did not adjust for total energy intake (36) and for those that adjusted for age and other important factors. Studies with a score ≥7 were considered as good quality and those with a score <5 were considered as poor quality. RCTs were reviewed by using the Cochrane Collaboration's risk of bias tool (6), which rates 7 domains (sequence generation, allocation concealment, blinding of participants and study personnel, blinding of outcome assessment, completeness of outcome data, selective reporting of outcomes, and other threats to validity, eg, contamination of intervention, baseline imbalance, and carry-over effect in crossover trials) as having a low risk of bias, a high risk of bias, or an unclear risk of bias.

RESULTS

Literature search

Our search strategy identified 9833 unique citations, of which 60 were selected for full-text review after screening titles and abstracts, plus an additional 5 articles identified from reference lists (**Figure 1**). After reviewing full texts, 33 articles were additionally excluded. Among cohort studies in children, 11 studies were excluded because we were not able to obtain data in the necessary units from transformations or author correspondence: 4 presented ORs (37–40), 2 did not report longitudinal data for SSBs (41, 42), one presented data as frequencies by weight change group (43), one presented SSBs in grams of carbohydrate per day by BMI gainers/losers (44), one did not present weight change data for all categories of beverage intake (45), one modeled SSBs dichotomously (46), and one presented standardized β coefficients (47). Among RCTs in children, 2 studies were excluded because one was a follow-up of an included trial (48) and the other was conducted in a duplicate study population (49). Another study was excluded because it substituted SSBs with flavored milk (50).

Among cohort studies in adults, 6 studies were excluded because of unavailability of data or heterogeneity of outcome measures: 2 reported ORs (51, 52), one reported results stratified by weight gain before baseline (53), 2 reported BMI rather than body weight (54, 55), and one presented data in a figure that could not be extracted (56). Two studies were additionally excluded because they were conducted in duplicate study populations (57, 58). Among intervention studies in adults, the study by Raben et al (59) was excluded because the intervention combined beverages and foods. We did not include the trial by Tate et al (60) because unlike other trials, which evaluated the effects of adding SSBs on body weight, this study substituted SSBs with water or artificially sweetened beverages in a context of active weight-loss intervention (60). Therefore, the data could not be combined because of the different study questions. After final exclusions, 32 original articles were included in our meta-analyses: 20 in children (15 prospective cohort studies and 5 trials) and 12 in adults (7 prospective cohort studies and 5 trials). The excluded studies were evaluated qualitatively.

Study characteristics

Characteristics of the prospective cohort studies included in our meta-analyses are shown in **Tables 1** and **2**. Among the 15 cohort studies in children, the majority were from the United States (n = 10), Europe (n = 4), and Canada (n = 1), with ages at baseline ranging from 2 to 16 y (Table 1). The number of participants in each study ranged from 141 to 11,703, with durations of follow-up ranging from 6 mo to 14 y. Studies used a variety of methods to assess diet, including FFQs (n = 5), 24-h recalls (n = 4), diet and lifestyle questionnaires (n = 3), and diet records (n = 3); and all studies adjusted for additional diet or lifestyle risk factors, although 2 studies did not adjust for age (13, 20) and one study adjusted only for age and time (12). Only 3 studies adjusted for total energy intake (7, 8, 10). Among the 7 cohort studies in adults, the majority were conducted in black or white populations from the United States (n = 6) and one study was from the Netherlands (Table 2). Cohorts ranged in size from 173 to 120,877 participants, with durations of follow-up ranging from 1 to 20 y. Two studies were conducted exclusively in overweight or obese women (27, 28), and one study was conducted in participants with prehypertension or stage 1 hypertension (26). All but one study (28) used an FFQ to assess diet, and all studies adjusted for additional diet and lifestyle factors, although one study did not adjust for age (27). None of the studies adjusted for total energy intake.

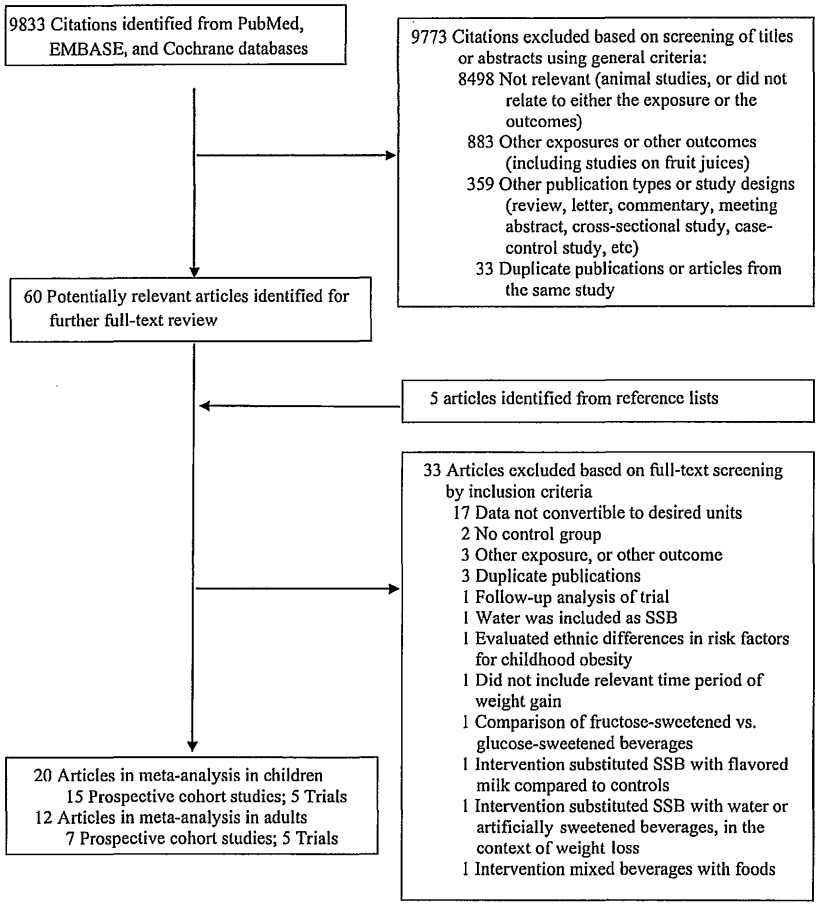

FIGURE 1. Flowchart of study search and selection. PubMed, http://www.ncbi.nlm.nih.gov/pubmed; EMBASE, http://www.embase.com; Cochrane, http://www.thecochranelibrary.com/. SSB, sugar-sweetened beverage.

Characteristics of the RCTs included in our meta-analyses are shown in **Tables 3** and **4**. Among the 5 trials conducted in children and adolescents, 2 were from the United States, 2 were from Europe, and one was from Brazil (Table 3). All of these studies evaluated the effect of reducing intake of SSBs on body weight. Two studies were school-based interventions using focused nutrition education (61, 62) for 1 school year among 644–1140 children aged 8–10 y, and 3 studies were randomized trials replacing SSBs with noncaloric beverages (63–65) for 25 wk to 18 mo among 103–641 children ranging in age from 8 to 16 y. One trial used a double-blind design (65), and one was conducted exclusively in overweight adolescents (64).

The majority of trials conducted in adults were from Europe (2 United Kingdom, 2 Denmark, 1 Switzerland) and one was from the United States, with sample sizes ranging from 29 to 133 (Table 4). All studies evaluated the effect of adding SSBs to the diet on body weight. Most studies compared SSBs (sucrose- or HFCS-sweetened beverages) with artificially sweetened beverages in either a parallel (66–68) or crossover (69, 70) design, for 3 wk to 6 mo, with intervention doses ranging from 600 mL to >1 L SSBs/d. One study included semiskim milk and mineral water in addition to artificially sweetened beverages as control regimens (68), and one study compared SSBs with dietary advice (70). Three (59, 67, 68) of the 5 studies were conducted exclusively in overweight individuals.

Risk of bias

Risk of bias is summarized for cohort studies in Supplemental Table 3 under "Supplemental data" in the online issue. Among studies in children, scores ranged from 4 (8) to 8 (14, 16, 21) out of a possible score of 9. Sixty percent of studies received a score ≥7, denoting good quality (9, 11, 12, 14, 16, 17, 19–21), whereas 40% were considered to be of poorer quality (7, 8, 10, 13, 15, 18). Among the 7 studies in adults, 3 studies received a score of 6, and 4 studies received a score ≥7 (25, 26, 28, 29).

Risk of bias summaries for RCTs are shown in Supplemental Table 4 under "Supplemental data" in the online issue. For studies in children and adults, risk of bias tended to be low or unclear for most domains assessed. A quantitative summary for each domain can be found in the footnote to the table.

SSBs and body weight in children

Prospective cohort studies

On the basis of data from 20 comparisons of the 15 studies (25,745 children and adolescents), we found a positive association between SSB consumption and BMI. The pooled estimate for the change in BMI (in kg/m^2) during the time period specified in each study associated with each one 12-oz serving/d increase in SSBs was 0.07 (95% CI: 0.01, 0.12; random-effects model;

TABLE 1
Characteristics of studies included in meta-analysis of prospective cohort studies in children[1]

Reference	Study population and location	Sample size	Mean ± SD baseline age or age range	Duration	Dietary assessment method	Outcome assessment method	Study question	Covariates	Adjusted for energy
Ludwig, 2001 (16)	Intervention and Evaluation Project, Planet Health, Massachusetts	548	11.7 ± 0.8 y	19 mo	FFQ	BMI based on measured height and weight	Change in SSBs from baseline to end of follow-up and BMI at end of follow-up	Baseline BMI, age, sex, ethnicity, school, percentage of energy from fat and energy-adjusted fruit juice intake at baseline and change from baseline to follow-up, physical activity, television, and change in television from baseline to follow-up	No
Berkey, 2004 (17)	Growing Up Today Study (GUTs), 50 states, USA	11,703	9–14 y	2 y	132-item FFQ	Self-reported BMI	1-y change in SSB intake and change in BMI	Age, Tanner stage, race, menarche (girls), prior BMI *z* score, height growth, milk type, physical activity, inactivity, diet soda juice, milk	No
Newby, 2004 (8)	North Dakota, Women, Infants, and Children (WIC), USA	1345	2–5 y	6–12 mo	84-item FFQ	BMI based on measured height and weight	SSB intake at baseline and change in BMI between baseline and end of follow-up	Age, sex, total energy, ethnicity, residence, level of poverty, maternal education, and birth weight	Yes
Blum, 2005 (7)	Nebraska schoolchildren, USA	166	9.3 ± 1.0 y	2 y	24-h diet recall	BMI *z* score based on measured height and weight	SSB intake and year 2 BMI *z* score	Baseline BMI *z* score, age, sex, age × sex, baseline and year 2 milk, juice, diet soda, SSBs, total calories	Yes
Mundt, 2006 (9)	University of Saskatchewan's Pediatric Bone Mineral Accrual Study, Canada	208	8–15 y	7 y	24-h diet recall	Fat mass (kg) using dual-energy X-ray absorptiometry	SSB intake at each measurement occasion and change in fat mass (kg) over time	Age, fat-free mass, physical activity, adjusted total energy adjusted for SSBs	Yes, but SSBs removed from total energy
Striegal-Moore,2006 (10)	National Heart, Lung, and Blood Institute Growth and Health Study, California, Ohio, Maryland, USA	2379 girls	9–10 y	10 y	3-d diet records	BMI based on measured height and weight	SSB intake at each measurement occasion and change in BMI over time	Milk, diet soda, fruit juice, fruit drinks, coffee/tea, site, visit (proxy for age), race, and total energy	Yes

(Continued)

TABLE 1 (*Continued*)

Reference	Study population and location	Sample size	Mean ± SD baseline age or age range	Duration	Dietary assessment method	Outcome assessment method	Study question	Covariates	Adjusted for energy
Viner, 2006 (18)	1970 British cohort, UK	4461	16 y	14 y	Questionnaire, intake the day before	BMI *z* score based on measured height and weight at baseline and self-reported at end of follow-up	SSB at baseline and BMI *z* score at the end of follow-up	Baseline BMI *z* score, sex, SES, and height at baseline and end of follow-up	No
Johnson, 2007 (11)	Avon Longitudinal Study of Parents and Children, UK	682	5 y	4 y	Parent-administered 3-d unweighed diet records	Fat mass (kg) using dual-energy X-ray absorptiometry	SSB intake at age 5 y and fat mass (kg) at age 9 y	Sex, height at 9 y, BMI at baseline, television, maternal education, paternal class, maternal BMI, paternal BMI, misreporting of energy intake, dietary energy density, percentage of energy from fat, and fiber density	No
Laurson, 2008 (15)	Idaho, Montana, Wyoming, rural USA	268	10 y	18 mo	Diet and lifestyle questionnaire	BMI based on measured height and weight	Change in SSB intake and change in BMI from baseline to end of follow-up	Age, baseline BMI, change in height, ethnicity, and state of residence	No
Libuda, 2008 (12)	DONALD study, Germany	244	Girls: 11.8 ± 1.5 y; boys: 11.9 ± 1.6 y	5 y	Self- and parent-administered 3-d weighed diet records	BMI-SDS based on measured height and weight	1-y change in SSB intake and change in BMI-SDS	Time and age	No
Vanselow, 2009 (19)	Project EAT (Eating Among Teens) II Minnesota, USA	2294	14.9 y	5 y	149-item FFQ	Self-reported BMI	SSBs at end of follow-up and change in BMI from baseline to end of follow-up	Age, sex, race, SES, baseline BMI, baseline SSBs	No
Carlson, 2012 (21)	Control group of a community-based obesity-prevention program California, USA	254	6.7 ± 0.7 y	2 y	Parent-administered diet and lifestyle questionnaire	BMI *z* score based on measured height and weight	Change in SSB intake and change in BMI *z* score from baseline to end of follow-up	Age, sex, ethnicity, parent education, height	No
Laska, 2012 (14)	Identifying Determinants of Eating and Activity (IDEA) and the Etiology of Childhood Obesity (ECHO) studies, Minnesota, USA	693	14.6 y	2 y	24-h diet recall	BMI based on measured height and weight	Change in SSB intake and change in BMI from baseline to end of follow-up	Physical activity, puberty, race, parental education, eligibility for free/reduced-price lunch, age, and study	No

(Continued)

TABLE 1 (*Continued*)

Reference	Study population and location	Sample size	Mean ± SD baseline age or age range	Duration	Dietary assessment method	Outcome assessment method	Study question	Covariates	Adjusted for energy
Olsen, 2012 (13)	European Youth Heart Study, Denmark	359	9.6 y	6 y	24-h diet recall, supplemented with FFQ, diet record	BMI *z* score based on measured height and weight	SSB intake at baseline and change in BMI *z* score between baseline and follow-up	Baseline anthropometric measures, total intake of complex carbohydrates, total intake of fat, maternal SES, maternal SES × sex, started puberty, physical activity, sex, intake of solid sucrose	No

[1] DONALD, DOrtmund Nutritional and Anthropometric Longitudinally Designed; FFQ, food-frequency questionnaire; SDS, SD score; SES, socioeconomic status; SSB, sugar-sweetened beverage.

Figure 2). Results from the fixed-effects model (0.16; 95% CI: 0.15, 0.16) differed from the random-effects model and was most likely a result of the high degree of between-study heterogeneity (I^2 = 91.6%, *P*-heterogeneity < 0.001). Meta-regressions for duration (P = 0.51), age (P = 0.70), adjustment for total energy (P = 0.37), use of an FFQ (P = 0.43), and sample size (P = 0.95) were not significant, suggesting that these factors may not be substantial sources of heterogeneity. However, when we stratified the analysis by whether a study had adjusted for total energy, the estimate was greater in studies that did not adjust for total energy (0.08; 95% CI: 0.02, 0.14; I^2 = 91.1%; n = 17) compared with those that did (0.04; 95% CI: 0.00, 0.07; I^2 = 0%; n = 3). In general, studies with greater statistical weight (>5%) tended to have positive associations, except for the study by Mundt et al (9). This study (9) along with the study by Johnson et al (11), evaluated fat mass (kg) as the outcome, which may not be comparable to BMI despite our scaling. We made the assumption that differences in fat mass are equal to differences in body weight, which may not be the case. Excluding these studies that estimated BMI from fat mass (9, 11) slightly increased the strength of the estimate (0.09; 95% CI: 0.04, 0.15) but had no impact on heterogeneity (I^2 = 90.3%). However, excluding the study by Viner and Cole (18), which had the greatest statistical weight, reduced heterogeneity by ~23% (I^2 = 68.3%), yielding more comparable estimates between the random-effects (0.05; 95% CI: 0.01, 0.10) and fixed-effects (0.04; 95% CI: 0.02, 0.06) models.

Our analysis of 1-y change in BMI included 7 studies with 11 comparisons in 15,736 children and adolescents. The summary estimate indicated that BMI increased by 0.06 (95% CI: 0.02, 0.10; random-effects model) for each additional daily 12-oz serving of SSBs over a 1-y period (**Figure 3**). Results from the fixed-effects model were similar (0.05; 95% CI: 0.03, 0.07), and significant heterogeneity was observed (I^2 = 63.8%; *P*-heterogeneity = 0.002). Removing the study by Laurson et al (15) as an outlier reduced heterogeneity (I^2= 44.4%; *P*-heterogeneity = 0.07) but did not change the summary estimate (0.06; 95% CI: 0.03, 0.09).

Trials

A total of 5 studies including 2772 children and adolescents were included in our analysis of SSB trials and body weight. On the basis of these data, we found a nonsignificant difference in change in BMI from reducing SSB consumption [weighted mean difference (WMD): −0.17; 95% CI: −0.39, 0.05; I^2 = 74.6%; *P*-heterogeneity = 0.003] in the random-effects model (**Figure 4**). Results from the fixed-effects model were significant (−0.12; 95% CI: −0.22, −0.02). This difference is likely a result of the random-effects model giving greater statistical weight to smaller studies and having wider CIs in the presence of heterogeneity compared with the fixed-effects model. Meta-regressions for intervention modality (education or beverage substitution; P = 0.08), duration (P = 0.18), and age (P = 0.84) were not significant, although power to detect a difference was low with only 5 studies. When we stratified our analysis by intervention modality, we observed a significant weight reduction among the 3 studies that provided noncaloric beverages as substitutes for SSBs (63–65): the summary estimate was −0.34 (95% CI: −0.50, −0.18; I^2 = 0%). In contrast, we did not find a significant

TABLE 2
Characteristics of studies included in meta-analysis of prospective cohort studies in adults[1]

Reference	Study population and location	Sample size	Mean ± SD baseline age and/or age range	Duration	Dietary assessment method	Outcome assessment method	Study question	Covariates	Adjusted for energy
French, 1994 (23)	Healthy Worker Project, USA	3552	Women: 37.3 ± 10.7 y; men: 39.1 ± 9.8 y	2 y	18-item FFQ	Measured by investigators	Change in SSB consumption and body weight changes (lb) from baseline to end of follow-up	Age, education, marital status, job, treatment group, dieting history, baseline weight, physical activity, smoking change, certain food items (dairy, grains, sweets, alcohol, meat, eggs, fats, French fries)	No
Nooyens, 2005 (24)	The Doetinchem Cohort Study, Netherlands	288 men	50–65 y	5 y	178-item FFQ	Measured by investigators	Change in SSB consumption and body weight changes (kg) from baseline to end of follow-up	Retirement, type of job, interaction between retirement and type of job, age, smoking, base level of the behavior, physical activity, potatoes, fruit, breakfast, fiber density	No
Palmer, 2008 (25)	Black Women's Health Study (BWHS), USA	43,960 women	21–69; 38.4 ± ~10.0 y	6 y	68-item FFQ at baseline and 6 y later	Self-reported	Change in SSB consumption and body weight changes (kg) from baseline to end of follow-up	Age; smoking; years of education; physical activity; family history of diabetes; baseline BMI; intake of red meat, processed meat, cereal fiber, and coffee; glycemic index; changes in physical activity; cigarette smoking; dietary factors from 1995 to 2001; and the other types of beverages	No
Stookey, 2008 (28)	The Stanford A TO Z weight-loss intervention, USA	173 premenopausal overweight women	25–50 y	1 y	Three unannounced 24-h diet recalls at baseline and follow-up	Measured by investigators	Change in SSB consumption and body weight changes (kg) from baseline to end of follow-up	Age, race-ethnicity, baseline status, diet treatment group, energy expenditure, energy intake from food, and food macronutrient and water composition	No

(Continued)

TABLE 2 (*Continued*)

Reference	Study population and location	Sample size	Mean ± SD baseline age and/or age range	Duration	Dietary assessment method	Outcome assessment method	Study question	Covariates	Adjusted for energy
Chen, 2009 (26)	PREMIER: Lifestyle Interventions for Blood Pressure Control trial, USA	810 adults with prehypertension or stage 1 hypertension	50 ± 8.9 y; 25–79	1.5 y	Two 24-h recalls at baseline, 6 mo, and 18 mo	Measured by investigators	Change in SSB consumption and body weight changes (kg) from baseline to end of follow-up	Baseline sex, race, age, income, education, marital and employment status, BMI status, intervention group, concurrent change in fitness, physical activity, and changes in other beverage intakes (diet drinks, milk, coffee and tea, alcoholic beverages)	No
Mozaffarian, 2011 (29)	NHS, NHS II, and HPFS, USA	NHS: 50,422; NHS II: 47,898; HPFS: 22,557	NHS: 52.2 ± 7.2 y; NHS II: 37.5 ± 4.1 y; HPFS: 50.8 ± 7.5 y	NHS: 20 y; NHS II: 12 y; HPFS: 20 y	133–165-item FFQ	Self-reported	Change in SSB consumption and body weight changes (lb) from baseline to the end of follow-up over 4-y periods	Age, baseline BMI at the beginning of each 4-y period, sleep duration, changes in physical activity, alcohol use, television use, smoking, and all of the dietary factors	No
Barone Gibbs, 2012 (27)	Women on the Move through Activity and Nutrition, (WOMAN) Study, USA	481 overweight and obese postmenopausal women	57 ± 2.9	4 y	32-item FFQ	Measured by investigators	Change in SSB consumption and body weight changes (kg) from baseline to end of follow-up	Group, baseline weight, baseline eating behavior values, baseline physical activity (author correspondence)	No

[1] FFQ, food-frequency questionnaire; HPFS, Health Professionals Follow-Up Study; NHS, Nurses' Health Study; SSB, sugar-sweetened beverage.

TABLE 3
Characteristics of studies included in meta-analysis of randomized controlled trials in children

Reference	Study population and location	Sample size	Mean age	Baseline BMI	Duration	Design	Study question	Intervention	Control
James, 2004 (61)	The Christchurch Obesity Prevention Project in Schools (CHOPPS), UK	644; 29 clusters	Intervention: 8.7 y. Control: 8.7 y girls, 8.6 y boys	Intervention: BMI (in kg/m^2) of 17.4 Control: BMI of 17.6	One school year	Parallel-cluster randomized intervention	School-based education program aimed at reducing SSBs[1] and weight	Focused educational program on nutrition to discourage consumption of SSBs	Not specified
Ebbeling 2006 (63)	Beverages and Student Health, Massachusetts, USA	103	Intervention: 16.0 y Control: 15.8 y	Intervention: BMI of 25.7 Control: BMI of 24.9	25 wk	Parallel, randomized intervention	Replacement of SSBs with noncaloric beverage on weight	Four 12-oz servings of noncaloric beverages/d, provided by weekly home deliveries, motivational phone calls, mailed fridge magnets with intervention messages	Asked to continue their usual beverage consumption habits
Sichieri, 2008 (62)	Schoolchildren, Brazil	1140; 47 clusters	Intervention: 10.9 y Control: 10.9 y	Intervention: BMI of 18.3 Control: BMI of 18.2	One school year	Parallel-cluster randomized controlled intervention	School-based education program aimed at reducing SSBs and weight	Focused nutrition education with emphasis on decreasing SSBs and increasing water intake	Control clusters received 2 general information sessions about health and given material about healthy diets
de Ruyter, 2012 (65)	Double-blind, Randomized Intervention Study in Kids (DRINK), Netherlands	641	Intervention: 8.2 y Control: 8.2 y	Intervention: BMI of 16.9 Control: BMI of 16.8	18 mo	Parallel, double-blind, randomized intervention	Replacement of SSBs with noncaloric beverage on weight	One 8-oz can of artificially sweetened beverage/d (0 calories, 35 mg sucralose, 12 mg acesulfame potassium) provided at school	One 8-oz can of SSB/d (104 kcal, 26 g sucrose) provided at school
Ebbeling, 2012 (64)	Overweight adolescents, Massachusetts, USA	244	Intervention: 15.3 y Control: 15.2 y	Intervention: BMI of 30.4 Control: BMI of 30.1	1 y	Parallel, randomized intervention	Replacement of SSBs with noncaloric beverage on weight	Home deliveries of noncaloric beverages, motivational phone calls, check-in visits, mailed written intervention messages	Supermarket gift cards as a retention strategy

[1] SSB, sugar-sweetened beverage.

TABLE 4
Characteristics of studies included in meta-analysis of randomized controlled trials in adults

Reference	Study population	Sample size	Mean ± SD baseline age and/or age range	Mean ± SD baseline BMI and/or BMI range	Duration	Design	Study question	Intervention	Control
Tordoff, 1990 (69)	USA	9 women and 21 men	Women: 28.2 ± 2.7 y; men: 22.9 ± 0.8 y	Women: 25.4 ± 1.4; men: 25.1 ± 0.5	3 wk	Crossover	Adding HFCS[1] soda to the normal diet and changes in body weight compared with diet soda with aspartame	1135 mL soda including 133 g HFCS/d (530 kcal)	1135 mL diet soda including 590 mg aspartame/d, no calories
Reid, 2007 (66)	UK	133 women	31.8 ± 9.1 y; 20–55 y	22.5 ± 2.8; range: <25	4 wk	Parallel	Adding sucrose beverages to the normal diet and changes in body weight compared with artificially sweetened beverages	1 L sucrose-sweetened drinks (1800 kJ/d)	1 L artificially sweetened drinks (67 kJ/d)
Reid, 2010 (67)	UK	53 overweight women	34.5 ± 11.0 y in the intervention group and 32.9 ± 8.8 y in the control group; 20–55 y	27.2 ± 2.06 in the intervention group and 27.8 ± 1.8 in the control group; 25–30	4 wk	Parallel	Adding sucrose beverages to the normal diet and changes in body weight compared with artificially sweetened beverages	1 L sucrose-sweetened drinks (1800 kJ/d)	1 L artificially sweetened drinks (67 kJ/d)
Aeberli, 2011 (70)	Switzerland	29 healthy-weight men	26.3 ± 6.6 y	22.4 ± 1.9	3 wk	Crossover	Adding sucrose beverages to the normal diet and changes in body weight compared with dietary advice	600 mL drinks including 80 g sucrose/d	Dietary advice aimed at reducing free fructose intake
Maersk, 2012 (68)	Denmark	30 women and 17 men who were overweight	Mean: ~39 y; 20–50 y	Mean: ~32; 26–40	6 mo	Parallel	Adding sucrose beverages to the normal diet and changes in body weight compared with 3 other beverages (milk, diet soda, and water)	1 L sucrose-sweetened regular cola/d (1800 kJ)	1 L semiskim milk/d (1900 kJ) or still mineral water (0 kJ) or aspartame-sweetened diet cola (15 kJ)

[1] HFCS, high-fructose corn syrup.

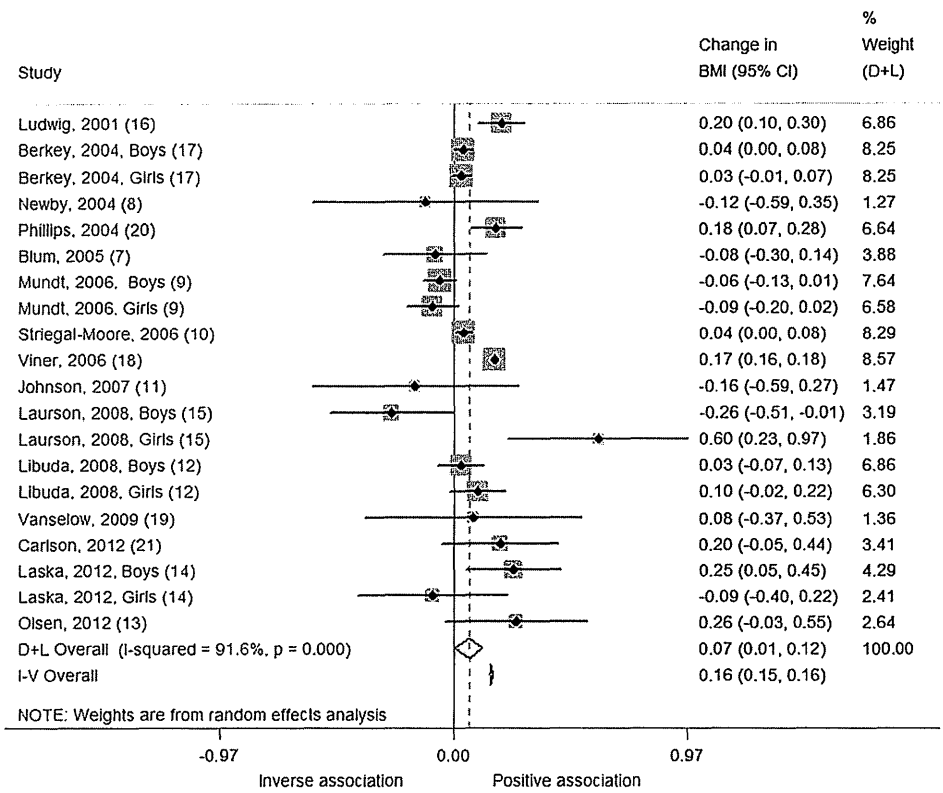

FIGURE 2. Changes in BMI (95% CI) per 1-serving/d increase in sugar-sweetened beverages during the time period specified in each study from prospective cohort studies in children. Horizontal lines denote 95% CIs; solid diamonds represent the point estimate of each study. Open diamonds represent pooled estimates, and the dashed line denotes the point estimate of the pooled results from the random-effects model (D+L). Study weights are from the random-effects analysis (D+L). Pooled estimates from the random-effects analysis (D + L) and the fixed-effects analysis (I-V) are shown based on 15 cohort studies (n = 25,745). The I^2 and P values for heterogeneity are shown. D+L, DerSimonian and Laird; I-V, inverse variance.

intervention effect in the 2 studies that used focused school-based education (61, 62) to discourage SSB consumption (0.01; 95% CI: −0.19, 0.20; I^2 = 59.6%). For the study by James et al (61), although the difference in BMI change did not reach significance, there was a significant difference in the prevalence of childhood overweight and obesity between intervention (0.2% reduction) and control clusters (7.5% increase). This suggests that the intervention may be more effective in preventing weight gain in higher risk children. Heterogeneity was reduced when we removed the study by Sichieri et al (62), which had the largest sample size in the meta-analysis, from the analysis (−0.25; 95% CI: −0.43, −0.06; I^2 = 43.8%; P-heterogeneity = 0.15).

All of the studies except for the one by Sichieri et al (62) showed a beneficial effect or trend of interventions to reduce SSB intake on weight. The study by Sichieri et al (62) was a school-based intervention that used focused education to discourage consumption of carbonated SSBs, but according to the authors, students compensated by increasing their consumption of sugar-added juices and fruit drinks, which may explain the lack of findings. However, in subgroup analysis, children who were overweight at baseline showed greater BMI reduction in the intervention group, which was significant among girls (62). Similarly, Ebbeling et al (63) found more pronounced benefits of the intervention among adolescents who were overweight at baseline, and another study by Ebbeling et al (64), which was conducted exclusively in overweight adolescents, showed the strongest intervention effect among studies included in our analysis. Combining Ebbeling et al (64) with the subgroup findings from Ebbeling et al (63), we observed an increased benefit of substituting noncaloric beverages for SSBs on weight gain (−0.64; 95% CI: −1.07, −0.21), suggesting that this type of intervention may have greater impact on those who are overweight. We were not able to include the subgroup findings from Sichieri et al (62) in this secondary analysis because the data were not available in the necessary units.

SSBs and body weight in adults

Prospective cohort studies

Our analysis of 1-y change in weight (kg) in adults was based on 7 studies, including 8 comparisons and 170,141 men and women. We found that each serving per day increase in SSBs was associated with an additional weight gain of 0.22 kg over 1 y (0.22 kg; 95% CI: 0.09, 0.34 kg; I^2 = 70.2%; P-heterogeneity < 0.001) from the random-effects model (**Figure 5**). The estimate from the fixed-effects model was significant but not as strong (0.12 kg; 95% CI: 0.10, 0.14 kg). This is probably because the random-effects model gives greater weight to smaller studies compared with the fixed-effects model and there are a couple of small studies that are outliers (estimates that fall outside of the 95% CI of other estimates included in the analysis), such as Barone Gibbs et al (27) and Chen et al (26). Meta-regressions for age at baseline (P = 0.32), duration (P = 0.37), use of an FFQ to assess diet (P = 0.26), sample size (P = 0.48), and baseline weight status (P = 0.10) were

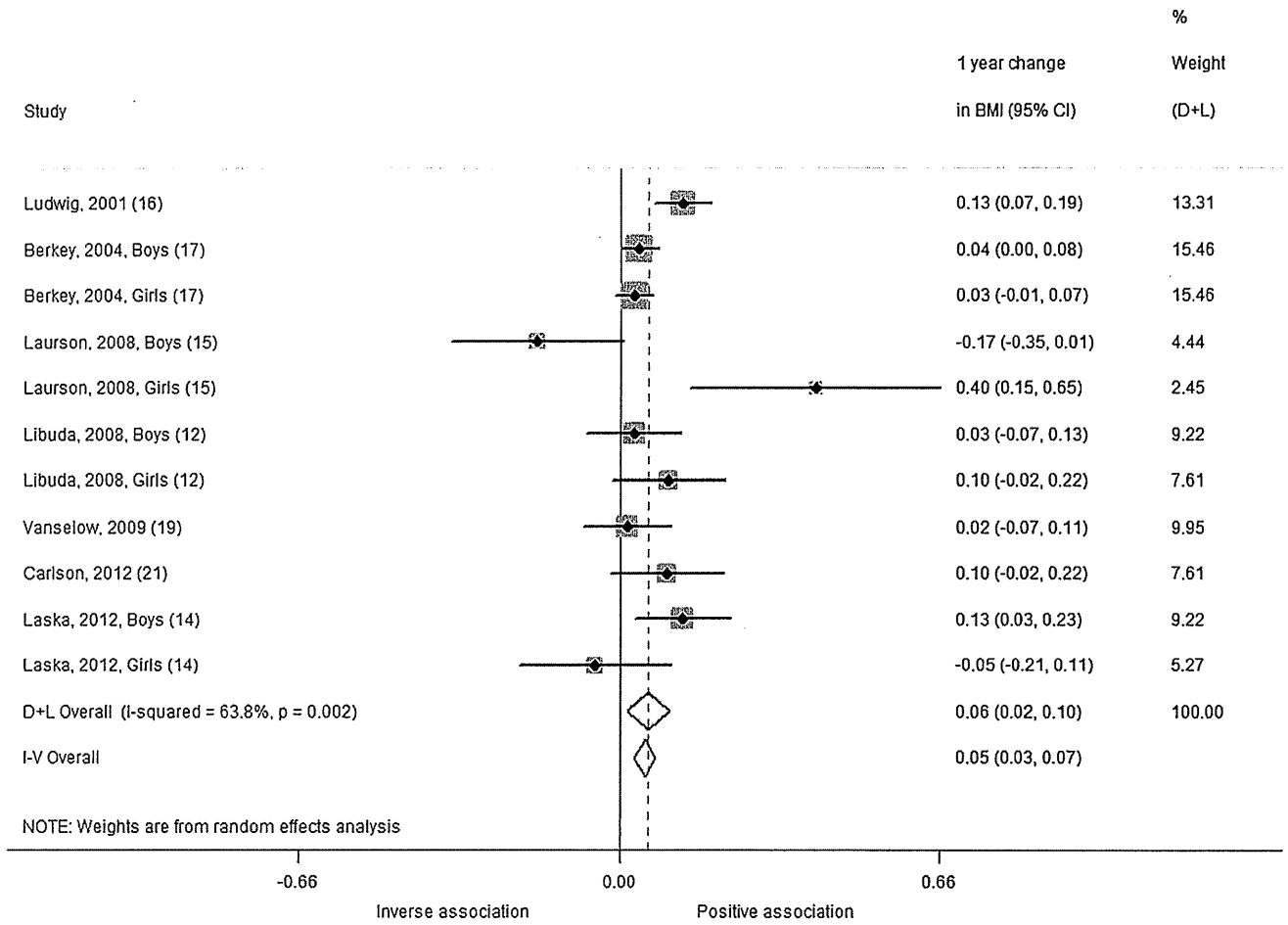

FIGURE 3. One-year changes in BMI (95% CI) per 1-serving/d increase in sugar-sweetened beverages from prospective cohort studies in children using a change versus change analysis strategy. Horizontal lines denote 95% CIs; solid diamonds represent the point estimate of each study. Open diamonds represent pooled estimates, and the dashed line denotes the point estimate of the pooled result from the random-effects model (D+L). Weights are from the random-effects analysis (D+L). Pooled estimates from the random-effects analysis (D+L) and the fixed-effects analysis (I-V) are shown based on 7 cohort studies (n = 16,004). The I^2 and P values for heterogeneity are shown. D+L, DerSimonian and Laird; I-V, inverse variance.

not significant. However, when we stratified the analysis by baseline weight status, we observed greater although nonsignificant weight gain in the 2 studies (27, 28) conducted in overweight populations (1.22 kg; 95% CI: −0.23, 2.68 kg; I^2 = 77.5%) compared with nonoverweight populations (0.15 kg; 95% CI: 0.06, 0.24 kg; I^2 = 50.3%). Excluding the study by Barone Gibbs et al (27) from the overall analysis as an outlier reduced heterogeneity somewhat (I^2 = 59.8%). Excluding the study by Mozaffarian et al (29) from the overall analysis, which had the largest sample size in the meta-analysis, increased summary estimates for both the random-effects model (0.31 kg; 95% CI: 0.11, 0.50 kg) and the fixed-effects model (0.18 kg; 95% CI: 0.10, 0.26 kg) but did not reduce heterogeneity (I^2 = 71.3%).

Trials

A total of 5 studies including 6 comparisons with 292 men and women were included in our analysis of trials in adults. We found a significant difference in change in body weight (kg) between intervention and control regimens (WMD: 0.85; 95% CI: 0.50, 1.20; I^2 = 0.0%; P-heterogeneity = 0.78) from the random-effects model (**Figure 6**). The estimate from the fixed-effects model was identical. All studies observed significantly greater weight gain or trends toward greater weight gain in intervention compared with control regimens, and there was no evidence of heterogeneity. When we stratified our analysis by baseline weight status, we observed greater weight gain in intervention compared with control regimens among the 3 studies conducted in nonoverweight populations (WMD: 0.89; 95% CI: 0.52, 1.26; I^2 = 0.0%;) compared with the 2 studies conducted in overweight populations (WMD: 0.47; 95% CI: −0.70, 1.63; I^2 = 0.0%;). Adding the study by Raben et al (59) to the analysis, which was excluded because the intervention contained some foods in addition to beverages (~70% beverages and 30% food), increased the overall estimate but introduced some heterogeneity (WMD: 1.06; 95% CI: 0.54, 1.58; I^2 = 46.3%; P-heterogeneity = 0.08).

Publication bias

Visual inspection of funnel plots (*see* Supplemental Figures 1–5 under "Supplemental data" in the online issue) along with

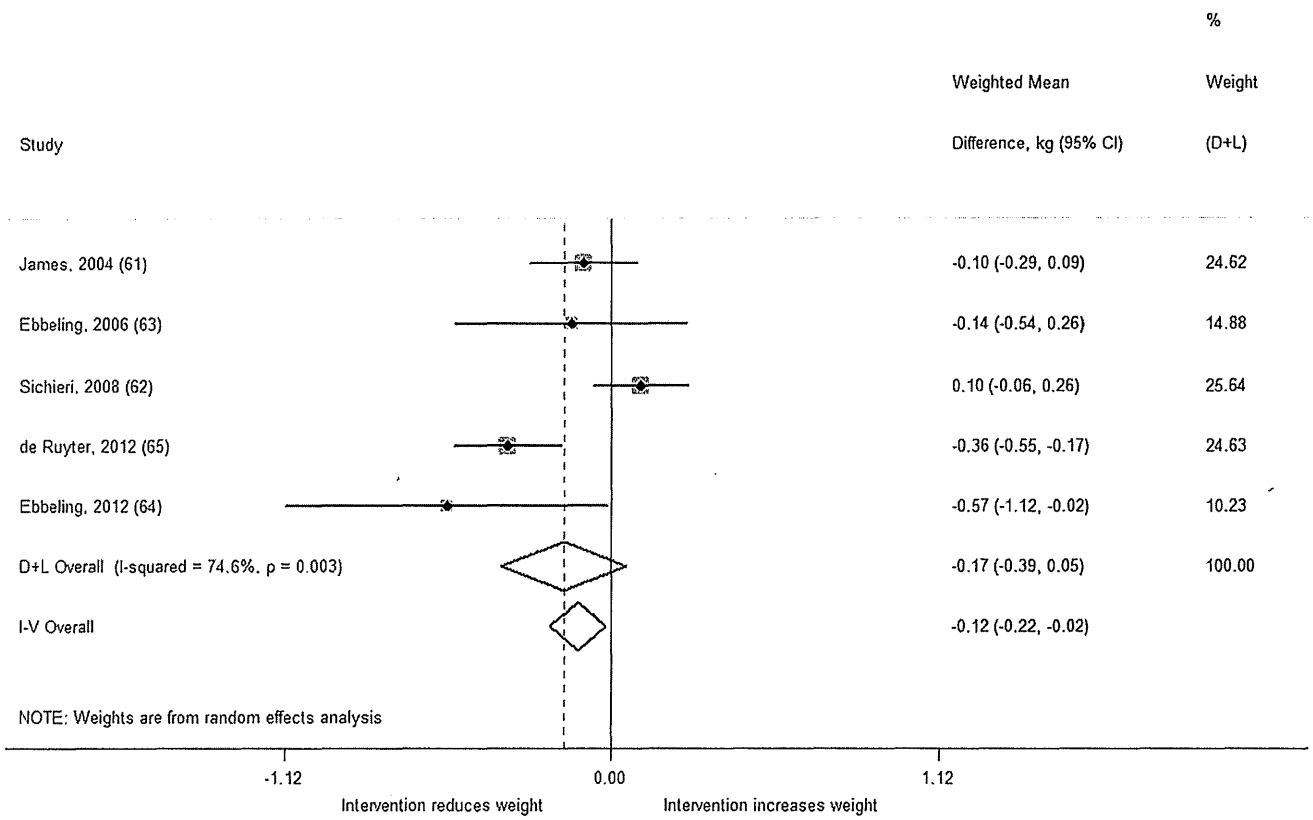

FIGURE 4. Weighted mean differences in BMI change (95% CI) between the intervention and control regimens from randomized controlled trials in children. Interventions evaluated the effect of reducing sugar-sweetened beverages. Horizontal lines denote 95% CIs; solid diamonds represent the point estimate of each study. Open diamonds represent pooled estimates of the intervention effect, and the dashed line denotes the point estimate of the pooled result from the random-effects model (D+L). Weights are from the random-effects analysis (D+L). Pooled estimates from the random-effects analysis (D+L) and the fixed-effects analysis (I-V) are shown based on 5 randomized controlled trials ($n = 2772$). The I^2 and P values for heterogeneity are shown. D+L, DerSimonian and Laird; I-V, inverse variance.

Begg's test suggested that publication bias was unlikely in our analyses in children (all prospective cohort studies, $P = 0.12$; prospective cohort studies evaluating change versus change, $P = 0.88$; trials, $P = 0.47$) and in trials in adults ($P = 0.59$). However, for cohorts in adults there was suggestion of publication bias ($P = 0.02$). This may be due to the lack of estimates in the bottom right quadrant of the funnel plot, indicating a lack of publication of small, null studies. However, this is complicated by the narrow spread of studies about the plot, which is likely a result of the preponderance of large studies.

Qualitative review of studies not included in meta-analyses

A number of prospective cohort studies evaluating SSB consumption and body weight in both children and adults were excluded from our meta-analyses because we were not able to obtain data in the necessary units from either transformations or author correspondence. Among these studies in children, 9 of 11 supported the findings from our meta-analysis of a positive association between SSBs and body weight (37–39, 41, 42, 44–47), whereas 2 did not find an association (40, 43). Four studies found significant positive associations between SSB consumption and weight gain (44–47), with one study reporting associations for only boys (46). Four studies found positive associations between SSB consumption and risk of developing overweight or obesity (37–39, 42), with one study reporting significant associations only among children who were at risk of becoming overweight at baseline (37). One small study ($n = 49$) found a positive association between SSB consumption and change in waist circumference but not BMI z score among children followed from age 3 to 6 y (41). Among studies that did not find an association between SSBs and childhood body weight, Wijga et al (40) suggested that their lack of findings among 1871 Dutch children followed from age 5 to 8 y might have been a result of reverse causation and selective underreporting by parents of children who became overweight. In the study by Sugimori et al (43), which was conducted in a cohort of 8170 Japanese children followed from age 3 to 6 y, consumption amounts may have been too low to observe significant between-group differences.

Similar to studies in children, the majority (4 of 6) of cohort studies in adults that were excluded as a result of difficulty in obtaining optimal units found positive associations between SSBs and body weight in either primary analysis or subgroup findings (52, 53, 55, 56), whereas 2 studies did not find significant associations (51, 54). Among studies that evaluated baseline SSB consumption and weight change, Bes-Rastrollo et al (53) found that higher SSB consumption was associated with significant weight gain among subjects with previous weight gain (≥3 kg in 5 y before baseline) in a cohort of 7194 adults from Spain followed for over 2 y. Odegaard et al (56) found that individuals

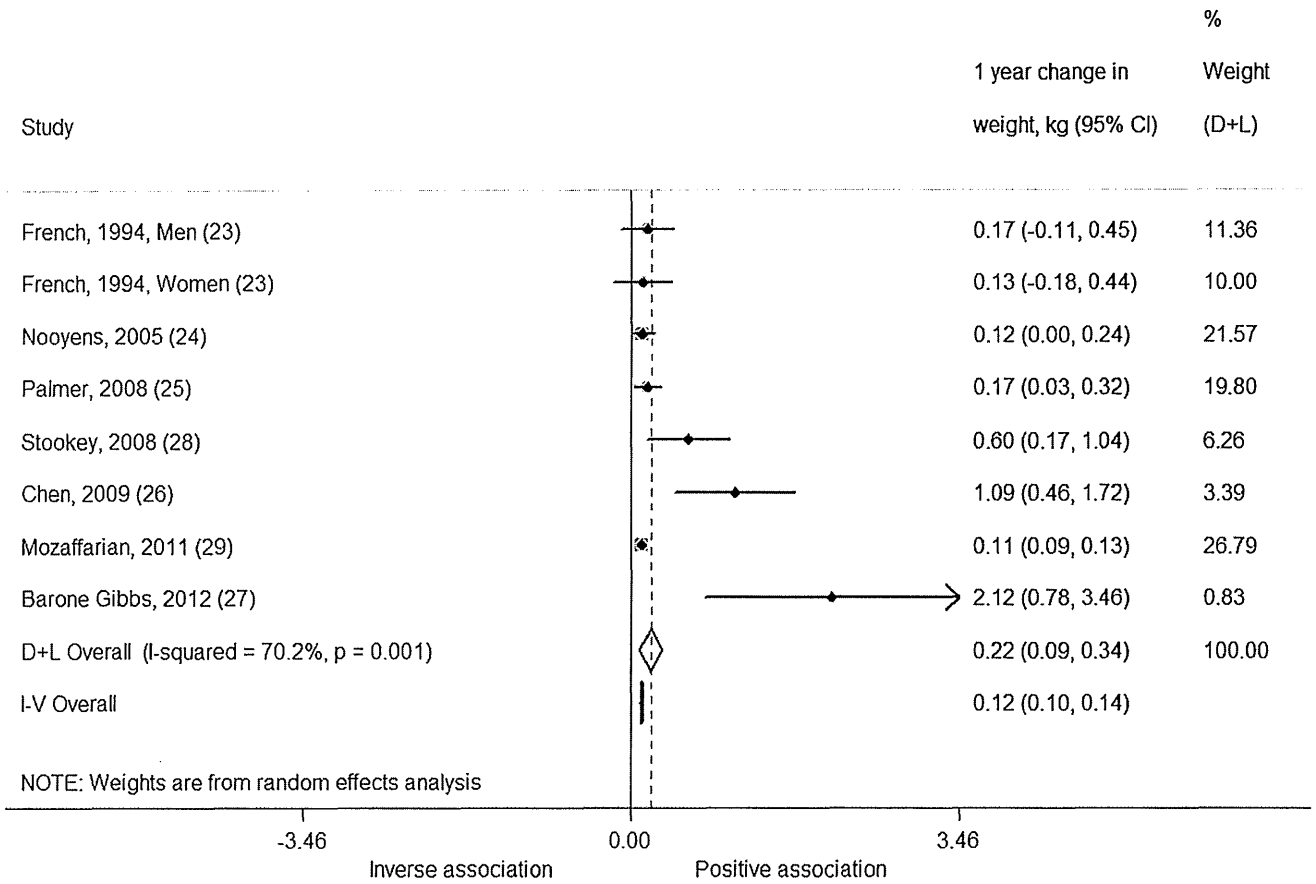

FIGURE 5. One-year changes (95% CI) in weight (kg) per 1-serving/d increase in sugar-sweetened beverages from prospective cohort studies in adults using a change versus change analysis strategy. Horizontal lines denote 95% CIs; solid diamonds represent the point estimate of each study. Open diamonds represent pooled estimates, and the dashed line denotes the point estimate of the pooled result from the random-effects model (D+L). Weights are from the random-effects analysis (D+L). Pooled estimates from the random-effects analysis (D+L) and the fixed-effects analysis (I-V) are shown based on 7 cohort studies (n = 174,252). The I^2 and P values for heterogeneity are shown. D+L, DerSimonian and Laird; I-V, inverse variance.

with higher SSB consumption had a subtle but significant increase in weight (0.53 kg) compared with those who did not consume soft drinks ($P < 0.001$) in a large cohort (n = 43,580) of Chinese Singaporeans with a mean weight change of 0.10 kg over 5.7 y. In contrast, Fowler et al (54) did not find an association between SSBs and change in BMI in a small (n = 3371) US cohort. The authors did, however, find a positive association between artificially sweetened beverages and BMI change, which they largely ascribed to reverse causation. Two studies (52, 55) evaluating baseline SSB intake and risk of obesity found significant positive associations, although the association was significant only in women in the study by Inoue et al (55): a Japanese cohort that included >75% women. The study by Kvavvik et al (51), which evaluated change in SSBs and risk of obesity in a small cohort from Norway (n = 422), found that risk was increased for long-term high-SSB consumers (≥3 servings/wk) compared with long-term low consumers, although this finding was not significant. Two large cohort studies (57, 58), which were excluded because they were conducted in duplicate populations of Mozaffarian et al (29), found significant positive associations between SSB consumption and weight change.

Among trials in children not included in our meta-analysis, one found an adverse effect of SSBs and body weight (49), whereas 2 did not find significant effects (48, 50), although the study by James et al (48) was a follow-up analysis of a previous school-based intervention (61). This study (48), along with the recent RCT by Ebbeling et al (64), examined the sustained effects of their interventions on body weight at 2 and 1 y postintervention, respectively. Both of these studies found that the beneficial effects of the interventions dissipated after the interventions had ended. We combined these studies and observed a summary WMD in BMI between the intervention and control of −0.26 (95% CI: −0.53, 0.03), suggesting that, despite a beneficial trend, the interventions did not have a sustained effect on weight gain, highlighting the importance of active intervention. The study by Albala et al (50), which evaluated replacing SSBs with flavored milk beverages providing 80 kcal and 11 g carbohydrate/serving, did not find a beneficial intervention effect on body weight. In contrast, the study by Sichieri et al (49), which was excluded from our meta-analysis because it was a duplicate study population, confirmed that consumption of SSBs is a significant risk factor for BMI gain.

Among 2 studies that were excluded from our analysis of trials in adults, one found an adverse effect of SSBs on body weight (59), whereas the other evaluated a different study question related to weight loss (60). The study by Raben et al (59) was excluded because the intervention combined beverages and foods but found that body weight and fat mass increased in overweight

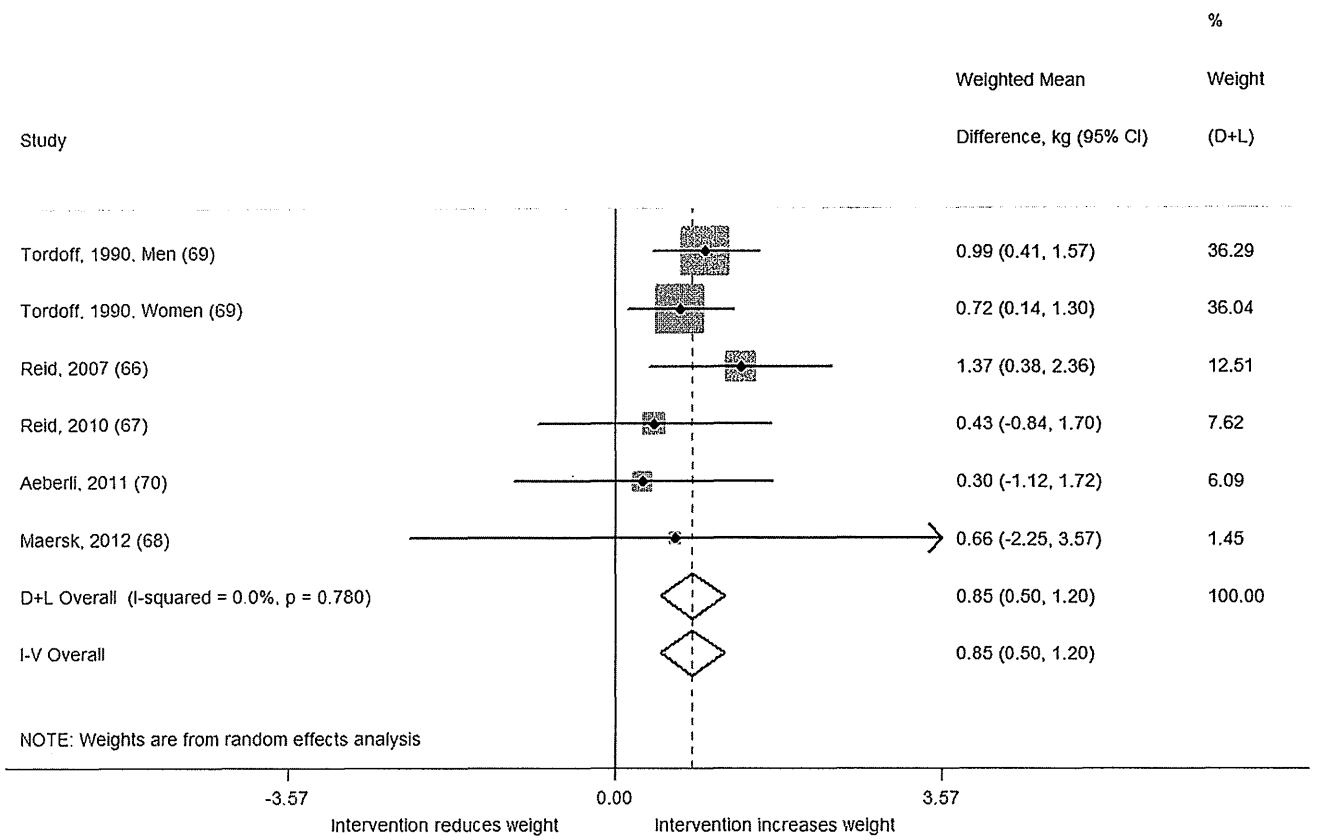

FIGURE 6. Weighted mean differences (95% CI) in weight change (kg) between the intervention and control regimens from randomized controlled trials in adults. Interventions evaluated the effect of adding sugar-sweetened beverages. Horizontal lines denote 95% CIs; solid diamonds represent the point estimate of each study. Open diamonds represent pooled estimates of the intervention effect, and the dashed line denotes the point estimate of the pooled result from the random-effects model (D+L). Weights are from the random-effects analysis (D+L). Pooled estimates from the random-effects analysis (D+L) and the fixed-effects analysis (I-V) are shown based on 5 randomized controlled trials (n = 292). The I^2 and P values for heterogeneity are shown. D+L, DerSimonian and Laird; I-V, inverse variance.

participants who consumed sucrose (mostly from beverages) and decreased in those who consumed artificial sweeteners after 10 wk. The study by Tate et al (60) found that participants who were assigned to caloric beverage replacement with water and diet beverages compared with controls were twice as likely to have achieved a 5% weight loss during 6 mo, although no significant between-group differences in weight reduction were found.

DISCUSSION

Findings from our systematic review and meta-analyses of prospective cohort studies and trials showed an overall positive association between consumption of SSBs and body weight gain in both children and adults with the exception of trials in children from the random-effects model. On the basis of the totality of the available evidence from prospective cohort studies, a 1-serving/d increase in SSBs was associated with a 0.06-unit increase in BMI over a 1-y period among children and adolescents and an additional weight gain of 0.12 to 0.22 kg (~0.25–0.50 lb) over 1 y among adults. In children, it is difficult to gauge the impact of our findings, because weight gain in childhood varies as a function of age, maturation, and growth velocity. Adult weight gain in the general population is a gradual process, occurring over decades and averaging ~1 lb/y (29). Thus, eliminating SSBs from the diet could be an effective way to prevent age-related weight gain.

Our findings from trials generally support those from prospective cohort studies. Trials in children were of 2 modalities, either reducing SSBs by substitution with noncaloric beverages or school-based education programs aimed at discouraging intake of SSBs. In sensitivity analysis, we showed that the substitution trials, which included 2 recent trials that were the most rigorous to date (64, 65), resulted in significantly less BMI gain compared with the education interventions. Some of the trials in our analysis were "effectiveness trials" of behavioral modification (eg, school-based education programs), which are useful in evaluating real-world scenarios for policy decisions. However, these studies evaluate intervention modalities more so than causal relations because their findings are greatly affected by intervention intensity and adherence. Thus, a lack of benefit does not mean that the relation between SSBs and weight gain is not causal but rather that the given modality might not be effective at changing behaviors.

The current set of analyses support findings from our previous systematic review in children and adults (3) and meta-analysis in children (4), both of which reported a significant link between SSB consumption and weight gain. Our previous meta-analysis (4) was a reanalysis of an article that did not find an association between SSBs and BMI in children resulting from methodologic errors and inclusion of coefficients that adjusted for total energy intake (71). In contrast to these previous meta-analyses (4, 71), here we conducted separate analyses for prospective cohort

studies and trials, qualitatively reviewed studies that were not included in our analyses, and independently evaluated prospective cohort studies that used a change versus change analysis. This type of analysis has some of the features of a quasi-experimental design, although it lacks the element of randomization in a clinical trial. An advantage of this design is the generalizability to a noncontrolled setting, relative to a controlled setting, because participants are able to change their diet and lifestyle without investigator-driven intervention. We also included a number of more recent cohort studies (11–15, 18, 19, 21) and trials (62, 64, 65) in children that were not included in these previous analyses. To our knowledge, this is the first meta-analysis to evaluate prospective cohort studies of SSBs and body weight in adults. A previous meta-analysis of 6 trials found a significant dose-dependent increase in weight among studies that added SSBs to the diet but found no effect on BMI among another 6 trials that attempted to reduce SSBs (72). However, a significant benefit on body weight was observed among individuals who were overweight at baseline (72), a finding that we also observed in children. These analyses combined studies in children and adults and included various trials excluded from our analyses, such as a study that substituted flavored milk for SSBs (50), a doctoral dissertation, and a study of postintervention follow-up after completion of the trial (48). Our analyses also included more recent trials in children (64, 65) and adults (67, 68, 70).

The studies included in our meta-analyses varied substantially with respect to study design, exposure assessment, adjustment for covariates, and specific outcomes evaluated. Although we did not identify these factors as significant sources of heterogeneity, we cannot rule them out. Estimates from cohort studies are also likely to be underestimated because of random measurement error in SSB assessment. The relatively high degree of unexplained heterogeneity observed in our analyses may limit the validity of our summary estimates. In addition, the data transformations that we performed to obtain consistent units across studies may further limit the validity of our estimates by imposing various assumptions. Our assumption of a 12-oz serving size for some studies, which is consistent with most cans and glasses, may have introduced some random misclassification and further attenuated our estimates. Publication bias is always a potential concern in meta-analysis, but standard tests and visual inspection of funnel plots suggested that there was limited evidence for publication bias in most of our analyses. In addition, we were not able to include a number of studies in our analysis because of difficulty in obtaining consistent units; however, these studies were reviewed qualitatively. Ascertainment of unpublished results via author correspondence may have reduced the likelihood of publication bias, but it should be noted that our search was limited to English-language publications and non-English reports may exist.

Because observed associations between SSBs and weight may be confounded by other diet and lifestyle factors, some scholars have put into question the validity of findings from observational studies. However, all of the cohort studies in our meta-analyses adjusted for potential confounding by various diet and lifestyle factors, and for most, a positive association persisted, suggesting an independent effect of SSBs, although residual confounding by unmeasured or poorly measured factors cannot be dismissed. Results from rigorously conducted RCTs also support conclusions from our observational analyses, further lending to their validity. Risk of bias assessment suggested that most cohort studies were of good quality and the majority of trials had a low or unclear risk of bias for the domains that were evaluated. Longitudinal studies evaluating diet and weight may also be prone to reverse causation. Although it is not possible to completely eliminate this issue, studies with longer durations and repeated measures as in our change versus change analyses are less prone to this process (73).

SSBs can lead to weight gain through their high added-sugar content, low satiety, and an incomplete compensatory reduction in energy intake at subsequent meals after intake of liquid calories (3). On average, SSBs contain 140–150 calories and 35.0–37.5 g sugar per 12-oz serving. In addition, fructose from any sugar or HFCS has been shown to promote development of visceral adiposity and ectopic fat deposition (74–77). Odegaard et al (78) recently found in a cross-sectional analysis that increased SSB consumption was associated with an adverse abdominal adipose tissue deposition pattern. Numerous societies and organizations including the American Heart Association, the American Academy of Pediatrics, and the US 2010 Dietary Guidelines technical review committee have called for reductions in intake of SSBs to help prevent obesity and improve overall health. Our meta-analyses offer additional support for these recommendations. Our results also suggest the need for targeted strategies to reduce SSB consumption among high-risk populations, particularly children who are already overweight to prevent further weight gain, and highlight the importance of sustained strategies. The studies included in our analyses evaluated risk or prevention of weight gain rather than weight loss. From a public health point of view, identifying dietary determinants of weight gain is critical for reducing obesity prevalence because once an individual becomes obese, it is increasingly difficult to achieve and maintain weight loss (79).

In conclusion, our systematic review and meta-analyses provide additional evidence that SSB consumption is associated with weight gain in both children and adults. Our findings have broad implications for developing public health strategies and policies targeting SSBs for weight control and obesity prevention.

The authors' responsibilities were as follows—VSM, AP, WCW, and FBH: designed the research; VSM and AP: conducted the analyses; VSM: wrote the manuscript; AP, WCW, and FBH: critically reviewed the manuscript; VSM and FBH: had primary responsibility for final content; and all authors: read and approved the final manuscript. The authors reported no conflicts of interest.

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Exhibit 3

ORIGINAL ARTICLE

A Randomized Trial of Sugar-Sweetened Beverages and Adolescent Body Weight

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ABSTRACT

BACKGROUND

Consumption of sugar-sweetened beverages may cause excessive weight gain. We aimed to assess the effect on weight gain of an intervention that included the provision of noncaloric beverages at home for overweight and obese adolescents.

METHODS

We randomly assigned 224 overweight and obese adolescents who regularly consumed sugar-sweetened beverages to experimental and control groups. The experimental group received a 1-year intervention designed to decrease consumption of sugar-sweetened beverages, with follow-up for an additional year without intervention. We hypothesized that the experimental group would gain weight at a slower rate than the control group.

RESULTS

Retention rates were 97% at 1 year and 93% at 2 years. Reported consumption of sugar-sweetened beverages was similar at baseline in the experimental and control groups (1.7 servings per day), declined to nearly 0 in the experimental group at 1 year, and remained lower in the experimental group than in the control group at 2 years. The primary outcome, the change in mean body-mass index (BMI, the weight in kilograms divided by the square of the height in meters) at 2 years, did not differ significantly between the two groups (change in experimental group minus change in control group, −0.3; P=0.46). At 1 year, however, there were significant between-group differences for changes in BMI (−0.57, P=0.045) and weight (−1.9 kg, P=0.04). We found evidence of effect modification according to ethnic group at 1 year (P=0.04) and 2 years (P=0.01). In a prespecified analysis according to ethnic group, among Hispanic participants (27 in the experimental group and 19 in the control group), there was a significant between-group difference in the change in BMI at 1 year (−1.79, P=0.007) and 2 years (−2.35, P=0.01), but not among non-Hispanic participants (P>0.35 at years 1 and 2). The change in body fat as a percentage of total weight did not differ significantly between groups at 2 years (−0.5%, P=0.40). There were no adverse events related to study participation.

CONCLUSIONS

Among overweight and obese adolescents, the increase in BMI was smaller in the experimental group than in the control group after a 1-year intervention designed to reduce consumption of sugar-sweetened beverages, but not at the 2-year follow-up (the prespecified primary outcome). (Funded by the National Institute of Diabetes and Digestive and Kidney Diseases and others; ClinicalTrials.gov number, NCT00381160.)

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THE CONSUMPTION OF SUGAR-SWEETened beverages among adolescents[1] has increased in tandem with the prevalence of pediatric obesity in the United States,[2] suggesting a causal relationship. At present, a substantial proportion of high-school students habitually consume sugar-sweetened beverages, including carbonated soda, sports drinks, energy drinks, and highly sweetened coffees and teas.[3] Sugar-sweetened beverages are the leading source of added sugar in the diet of a wide range of racial and ethnic groups.[4] According to nationally representative data, overweight and obese adolescents obtain more than 300 kcal per day from these products, amounting to an average of 15% of their total daily energy intake.[5]

Short-term feeding studies show greater energy intake and weight gain with the consumption of sugar-sweetened beverages than with beverages containing artificial sweeteners,[6] and prospective observational studies show positive associations with the risk of obesity and related complications.[7] However, the findings from the relatively few randomized, controlled trials designed to examine the effects of sugar-sweetened beverages on body weight have not been conclusive,[8-10] and the use of public health measures to reduce the consumption of sugar-sweetened beverages remains controversial.[11,12]

We previously conducted a 6-month pilot study[10] involving normal-weight, overweight, and obese adolescents who consumed sugar-sweetened beverages habitually. The experimental group received home delivery of noncaloric beverages, and the control group did not. The mean body-mass index (BMI, the weight in kilograms divided by the square of the height in meters) decreased significantly in the experimental group, as compared with the control group, only among the overweight and obese adolescents. The current study, which is a follow-up to the pilot study,[10] was designed to test the hypothesis that overweight and obese adolescents who received an intervention to reduce the consumption of sugar-sweetened beverages would gain weight at a slower rate than those who did not receive the intervention. We examined prespecified covariates as potential effect modifiers and mediators. In addition, we reanalyzed data from an observational study[13] involving 548 middle-school students to corroborate the findings of the current study.

METHODS

STUDY DESIGN

We randomly assigned participants to an experimental group or a control group for 2 years. The study included a 1-year intervention and a 1-year follow-up, with assessment of study outcomes at the end of each period. The institutional review board at Boston Children's Hospital approved the study protocol (available with the full text of this article at NEJM.org). Parents provided written informed consent, and participants provided written assent. Beverages for the intervention group were purchased from an online delivery service (Peapod) affiliated with a supermarket chain. The study was conducted between October 2007 and December 2011. The first two authors and the last author vouch for the accuracy and completeness of the data and analysis and the fidelity of the study to the protocol.

PARTICIPANTS

We enrolled 224 adolescents (124 boys and 100 girls) who reported consuming at least one serving (12 oz) per day of sugar-sweetened beverages or 100% fruit juice. Additional inclusion criteria were enrollment in grade 9 or 10 and a BMI at or above the 85th percentile for sex and age.[14] During telephone conversations with parents, we collected demographic information, including sex, date of birth, race (white, black, Asian, multiple, or other), ethnic group (Hispanic or non-Hispanic), parents' level of education, and total annual household income.

INTERVENTION

We used a multicomponent intervention designed to reduce the consumption of sugar-sweetened beverages in the experimental group. The emphasis was on displacing sugar-sweetened beverages with noncaloric beverages in the home as a strategy to decrease consumption.[5] The 1-year intervention consisted of home delivery of noncaloric beverages (e.g., bottled water and "diet" beverages) every 2 weeks, monthly motivational telephone calls with parents (30 minutes per call), and three check-in visits with participants (20 minutes per visit). Written intervention messages with instructions to drink the delivered beverages and not to buy or drink sugar-sweetened beverages were mailed to participants. Unsweetened water was recommended over artifi-

cially sweetened beverages. Discussions during telephone calls and check-in visits focused exclusively on beverage consumption, with no attention to other dietary behaviors or to physical activity. We mailed $50 supermarket gift cards to participants in the control group at 4 and 8 months as a retention strategy but did not provide instructions on what to purchase with the cards.

OUTCOMES

All personnel who assessed study outcomes were unaware of the group assignments. The primary outcome was the change in BMI at 2 years. To calculate BMI, trained personnel measured weight and height using calibrated scales and stadiometers, respectively. We used data from bioelectrical impedance analysis (BIA) and the equation of Sun et al.[15] to calculate body fat as a percentage of total body weight. In three telephone interviews conducted at each assessment (baseline, 1 year, and 2 years), participants were asked to recall their dietary intake and physical activity during the preceding 24 hours. Dietary intake data were collected with Nutrition Data System for Research (NDSR) software, versions 2006 through 2011, developed by the Nutrition Coordinating Center, University of Minnesota, Minneapolis. Final calculations were completed with NDSR, version 2011. Variables used to assess dietary quality included reported daily servings of sugar-sweetened, artificially sweetened, and unsweetened beverages; servings of 100% fruit juices; total energy and sugar intakes; and energy intake from sugar-sweetened beverages and 100% fruit juices. The interviewer also asked each participant to recall the activity performed most often during each 15-minute block throughout the previous day.[16,17] We calculated a daily physical-activity factor, using metabolic equivalent (MET) levels for each reported activity,[18] and hours of television viewing.

ADVERSE EVENTS

An adverse event was defined as any symptom or safety concern requiring medical attention that was reported by an adolescent or a parent during participation in the study.

STATISTICAL ANALYSIS

The trial was designed to have 80% power at a type I error rate of 5% to detect a net intervention effect with respect to the primary outcome BMI of 0.49, as attained with a shorter intervention in our pilot study.[10] All analyses followed the intention-to-treat principle. Baseline demographic characteristics, dietary intake, and obesity-related behavioral variables were compared between the experimental and control groups with the use of Student's t-test and Fisher's exact test for continuous and categorical variables, respectively. Changes in BMI and other anthropometric outcomes were compared between groups with a general linear model, adjusted for baseline covariates that could affect body weight. We performed identical but separate analyses for the change from baseline after 1 year (intervention period) and the change from baseline after 2 years (follow-up period without further intervention). Dietary intakes and obesity-related behavioral outcomes were analyzed similarly, without adjustment for covariates. Residual analysis confirmed that the assumption of normal error was satisfied. The net intervention effect (the mean change in the experimental group minus the mean change in the control group) was calculated from the parameters of the fitted model.

We tested each covariate for interaction and, finding Hispanic ethnic group to be the sole significant effect modifier for between-group differences in the change in BMI, we constructed additional ethnicity-specific summary statistics for the anthropometric and behavioral outcomes from a model that included an interaction term for study group and ethnic group. Testing 14 covariates for effect modification with a critical value of $P<0.05$ gave us an expected number of 0.7, or less than 1, type I error for each time point. Missing values for BMI were conservatively imputed by assuming that the participant's BMI z score was unchanged from baseline and calculating BMI at the appropriate later age from national norms.[14] Other methods for treating missing data, including use of the immediately preceding BMI z score, produced similar results.

We also reanalyzed data from a 19-month prospective observational study of 548 ethnically diverse middle-school students[13] to test for effect modification by ethnic group in the association of a change in the consumption of sugar-sweetened beverages with a change in BMI. We added an interaction term for ethnic group and change in consumption of sugar-sweetened beverages to the fully adjusted model. This regression included covariates related to diet (change in consumption of sugar-sweetened beverages,

adjusted for total energy intake and controlled for baseline consumption; baseline fat and change in fat, expressed as a percentage of total energy intake; and baseline energy-adjusted intake of fruit juice and change in fruit-juice intake), demographic characteristics (age, sex, ethnic group, and race, with indicator variables for schools), anthropometric variables (BMI and triceps skinfold thickness), physical activity (exercising to lose weight at baseline [yes or no], number of physical-education classes per week at baseline, and baseline physical activity [<3 METs vs. ≥3.5 METs] and change in physical activity), and hours of daily television viewing (baseline and change).

SAS software (version 9.2) was used for all computations. A two-sided P value of 0.05 or less was interpreted as a statistically significant result.

RESULTS

STUDY POPULATION

At baseline, there were no significant differences between the experimental and control groups with regard to demographic characteristics (Table 1) or other variables (Tables 2 and 3). The retention rate for study participants was 97% at 1 year and 93% at 2 years (Fig. 1), with no significant difference between groups in the percentage

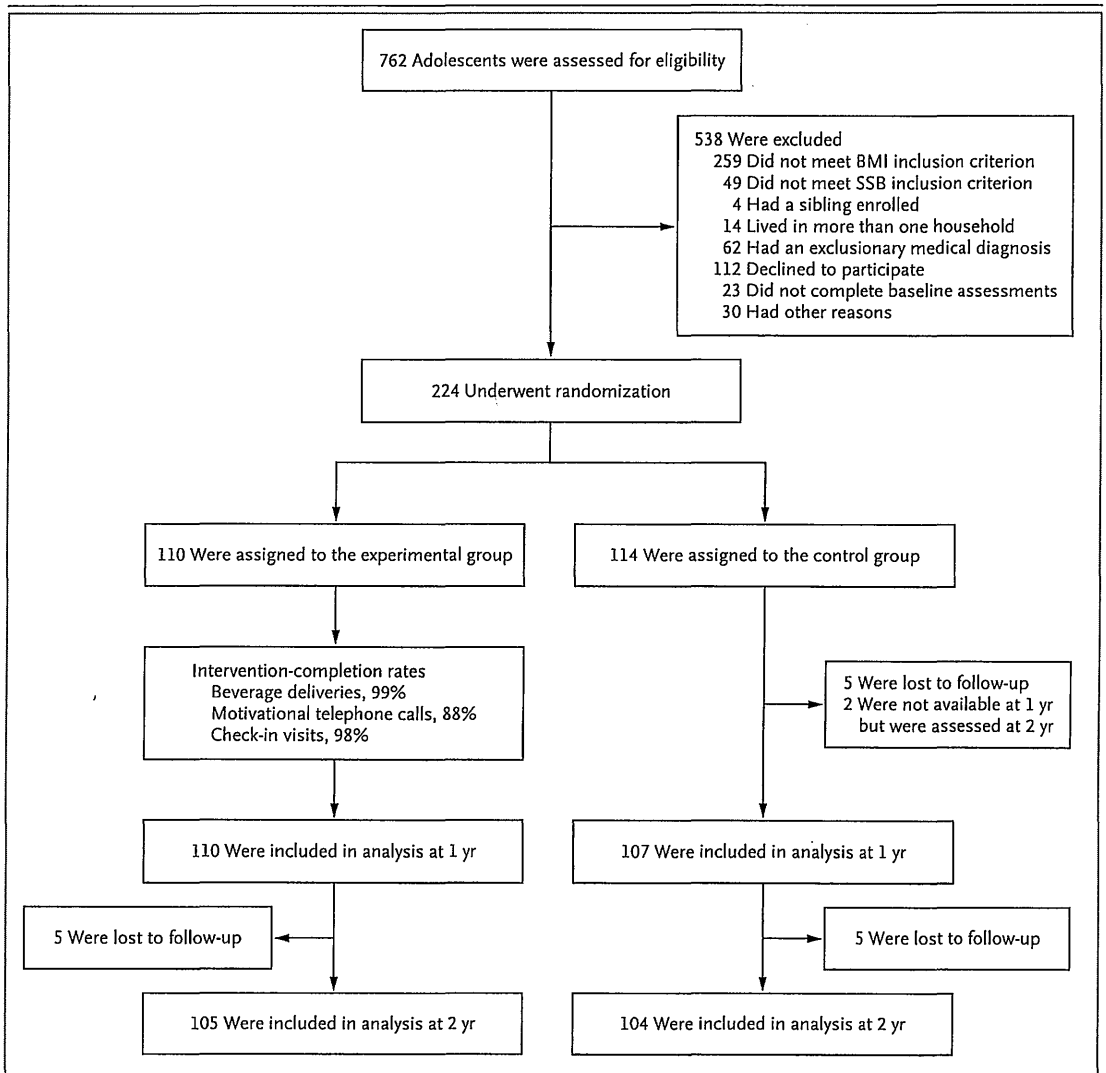

Figure 1. **Screening, Randomization, and Follow-up of the Study Participants.**
Among the 538 adolescents who were excluded, 15 of the 49 who did not meet the sugar-sweetened–beverage (SSB) criterion also had other reasons and are included in the counts for those reasons. The weight and height of all available participants were measured at each time point in order to calculate BMI.

Table 1. **Baseline Characteristics of the Study Participants.***

Characteristic	Experimental Group (N=110)	Control Group (N=114)	P Value
Sex — no. (%)			
Male	58 (53)	66 (58)	0.50
Female	52 (47)	48 (42)	
Race or ethnic group — no. (%)†			
Race			
White	60 (55)	64 (56)	0.99
Black	26 (24)	27 (24)	
Asian	4 (4)	4 (4)	
Multiple or other	20 (18)	19 (17)	
Ethnic group			
Hispanic	27 (25)	19 (17)	0.19
Non-Hispanic	83 (75)	95 (83)	
Age — yr	15.3±0.7	15.2±0.7	0.50
Weight — kg	85.2±16.8	86.1±17.0	0.70
Height — cm	167.4±8.8	168.9±9.1	0.21
BMI	30.4±5.2	30.1±4.7	0.64
Weight status‡			
Overweight	40 (36)	44 (39)	0.78
Obese	70 (64)	70 (61)	
Body fat — % of total weight	31.9±8.3	31.2±8.2	0.55
Annual household income — no. (%)			
<$30,000	30 (27)	31 (27)	0.71
$30,000–$59,999	38 (35)	34 (30)	
≥$60,000	42 (38)	49 (43)	
Parental educational level — no. (%)§			
Some high school	2 (2)	5 (4)	0.56
High-school diploma or GED certificate	23 (21)	20 (18)	
Some college or vocational school	28 (25)	24 (21)	
Associate's degree	7 (6)	14 (12)	
Bachelor's degree	33 (30)	33 (29)	
Some graduate school or graduate degree	17 (15)	18 (16)	
Daily physical activity level — MET	1.53±0.18	1.54±0.18	0.85
Television viewing — hr/day	3.0±1.8	2.8±1.4	0.46

* Plus–minus values are means ±SD. Means were compared with the use of the Student's t-test and proportions compared with the use of Fisher's exact test. Percentages may not sum to 100 owing to rounding. GED denotes General Educational Development, and MET metabolic equivalent.

† Race and ethnic group were reported by the parents of the participants. "Multiple" included white–black (8 participants), white–Asian (3), white–black–Asian (1), and white–Arabic (1). "Other" included Latino or Latina (8 participants), Hispanic (7), Brazilian (2), Cape Verdean (2), Puerto Rican (4), Latino or Latina–Brazilian (1), Spanish (1), and American (1). Comparisons of baseline characteristics according to ethnic group are provided in Table S1 in the Supplementary Appendix.

‡ Participants at or above the 85th percentile for BMI but below the 95th percentile were classified as overweight, and participants at or above the 95th percentile were classified as obese. The BMI range was 23.2 to 28.8 for overweight participants and 26.7 to 50.7 for obese participants.

§ The educational level listed is for the father or mother, depending on which parent had the higher level of education.

Table 2. **Dietary Intake.***

Intake	Unadjusted Data			Change from Baseline			
	Baseline	1 Yr	2 Yr	1 Yr	P Value†	2 Yr	P Value‡
Beverages (servings/day)							
Sugar-sweetened							
Experimental group	1.7±0.9	0.2±0.4	0.4±0.5	−1.5±0.1	<0.001	−1.3±0.1	<0.001
Control group	1.7±1.1	0.9±1.1	0.8±0.8	−0.8±0.1	<0.001	−0.9±0.1	<0.001
Difference				−0.7±0.1	<0.001	−0.4±0.1	0.005
Fruit juices							
Experimental group	0.4±0.5	0.1±0.2	0.2±0.3	−0.3±0.0	<0.001	−0.2±0.1	0.002
Control group	0.3±0.4	0.2±0.3	0.2±0.3	−0.1±0.0	0.02	−0.1±0.1	0.03
Difference				−0.2±0.1	0.01	−0.1±0.1	0.48
Artificially sweetened							
Experimental group	0.1±0.3	0.9±1.0	0.4±0.8	0.8±0.1	<0.001	0.3±0.1	<0.001
Control group	0.1±0.2	0.3±0.5	0.3±0.6	0.2±0.1	0.01	0.2±0.1	<0.001
Difference				0.6±0.1	<0.001	0.1±0.1	0.32
Unsweetened							
Experimental group	0.9±1.0	1.9±1.5	1.8±1.4	1.0±0.1	<0.001	0.9±0.1	<0.001
Control group	1.1±1.0	1.2±1.1	1.4±1.2	0.2±0.1	0.18	0.2±0.1	0.04
Difference				0.8±0.2	<0.001	0.6±0.2	<0.001
Energy intake (kcal/day)							
Total							
Experimental group	1967±553	1513±509	1619±444	−454±48	<0.001	−361±54	<0.001
Control group	1901±510	1720±420	1726±467	−176±48	<0.001	−178±54	0.001
Difference				−278±69	<0.001	−183±76	0.02
Sugar-sweetened beverages							
Experimental group	242±140	29±58	52±70	−213±14	<0.001	−188±15	<0.001
Control group	242±155	134±159	109±112	−108±14	<0.001	−130±15	<0.001
Difference				−105±20	<0.001	−58±21	0.007
Fruit juices							
Experimental group	94±112	30±44	59±84	−63±11	<0.001	−37±12	0.003
Control group	82±92	65±86	58±76	−18±11	0.12	−23±12	0.05
Difference				−45±16	0.005	−13±17	0.44
Sugar (g/day)							
Experimental group	133±42	57±34	71±32	−76±4	<0.001	−63±5	<0.001
Control group	132±48	96±49	89±36	−37±4	<0.001	−44±5	<0.001
Difference				−39±6	<0.001	−19±7	0.005

* Plus–minus values for unadjusted data are means ±SD, and plus–minus values for changes from baseline are means ±SE. Changes were calculated at 1 year and 2 years from the general linear model, without adjustment for covariates.

† The P values for changes from baseline in each study group are based on tests of the hypothesis that the mean change was zero.

‡ The P values for the between-group differences in changes from baseline are based on tests of the hypothesis that the mean change was the same in the two groups. There were no significant ethnic group–study group interactions for any of the dietary variables.

Table 3. **Study Outcomes.***

Variable	Unadjusted Data			Change from Baseline			
	Baseline	1 Yr	2 Yr	1 Yr	P Value†	2 Yr	P Value‡
BMI							
All participants							
Experimental group	30.36±5.24	30.50±5.55	31.10±5.94	0.06±0.20	0.75	0.71±0.28	0.01
Control group	30.05±4.66	30.61±5.37	31.03±5.51	0.63±0.20	0.001	1.00±0.28	<0.001
Difference				−0.57±0.28	0.045	−0.30±0.40	0.46
Non-Hispanic participants							
Experimental group	30.14±5.20	30.41±5.49	31.16±5.81	0.19±0.23	0.41	0.95±0.33	0.005
Control group	29.96±4.63	30.41±5.25	30.78±5.38	0.48±0.22	0.03	0.77±0.30	0.01
Difference				−0.29±0.31	0.36	0.18±0.44	0.68
Hispanic participants							
Experimental group	31.06±5.39	30.79±5.82	30.90±6.41	−0.36±0.45	0.42	−0.08±0.64	0.89
Control group	30.52±4.90	31.60±6.01	32.29±6.14	1.43±0.52	0.006	2.27±0.73	0.002
Difference				−1.79±0.65	0.007	−2.35±0.92	0.01
Weight (kg)							
All participants							
Experimental group	85.2±16.8	87.0±18.0	90.1±19.4	1.6±0.6	0.01	4.3±1.0	<0.001
Control group	86.1±17.0	90.2±19.8	92.3±20.7	3.5±0.6	<0.001	5.1±1.0	<0.001
Difference				−1.9±0.9	0.04	−0.8±1.4	0.55
Non-Hispanic participants							
Experimental group	86.1±17.4	88.5±18.6	92.5±20.0	2.2±0.7	0.003	5.5±1.1	<0.001
Control group	85.8±16.9	89.3±19.1	91.3±19.9	3.0±0.7	<0.001	4.4±1.0	<0.001
Difference				−0.8±1.0	0.42	1.1±1.5	0.48
Hispanic participants							
Experimental group	82.7±15.1	82.6±15.6	83.2±16.2	−0.5±1.4	0.74	0.3±2.1	0.88
Control group	87.8±18.2	95.4±23.4	98.2±24.6	6.0±1.7	<0.001	9.2±2.5	<0.001
Difference				−6.4±2.1	0.003	−8.8±3.1	0.005
Height (cm)							
All participants							
Experimental group	167.4±8.8	168.8±9.2	169.7±9.4	1.4±0.2	<0.001	2.3±0.2	<0.001
Control group	168.9±9.1	170.7±9.8	171.5±10.0	1.6±0.2	<0.001	2.1±0.3	<0.001
Difference				−0.2±0.2	0.49	0.2±0.4	0.67
Non-Hispanic participants							
Experimental group	168.8±8.4	170.3±8.6	171.5±8.7	1.6±0.2	<0.001	2.6±0.3	<0.001
Control group	168.8±9.0	170.5±9.6	171.3±9.8	1.7±0.2	<0.001	2.2±0.3	<0.001
Difference				−0.1±0.3	0.80	0.4±0.4	0.29
Hispanic participants							
Experimental group	163.2±8.6	164.0±9.3	164.4±9.8	0.8±0.4	0.05	1.1±0.6	0.05
Control group	169.4±10.0	171.7±11.1	172.4±11.6	1.4±0.5	0.004	2.1±0.7	0.002
Difference				−0.6±0.6	0.30	−1.0±0.8	0.24

* Plus–minus values for unadjusted data are means ±SD, and plus–minus values for changes from baseline are means ±SE. Changes were calculated at 1 year and 2 years from the general linear model, and were adjusted for sex, race, ethnic group, household income, parental education, baseline BMI, baseline beverage consumption (energy from sugar-sweetened beverages and fruit juices and servings of artificially sweetened beverages and unsweetened beverages), baseline total energy intake, baseline sugar intake, and baseline obesity-related behavioral measures (physical activity and hours of television viewing). Results specific to ethnic group are from a model that included an interaction term for study group and ethnic group. For the change during the 2 years, before imputation, BMI data were available for 166 non-Hispanic participants (78 in the experimental group and 88 in the control group) and 43 Hispanic participants (27 in the experimental group and 16 in the control group).

† The P values for changes from baseline in each study group are based on tests of the hypothesis that the mean change was zero.

‡ The P values for the between-group differences in changes from baseline are based on tests of the hypothesis that the mean change was the same in the two groups.

of participants available at 2 years for assessment of the primary outcome (P=0.29).

CHANGES IN DIETARY INTAKE

Changes in reported dietary intake are shown in Table 2. At 1 year, the change in consumption of sugar-sweetened beverages was significantly different between the groups (P<0.001), declining almost to 0 in the experimental group. Concomitantly, consumption of artificially sweetened and unsweetened beverages increased significantly in the experimental group as compared with the control group (P<0.001). At 2 years, the consumption of sugar-sweetened beverages remained lower and the consumption of unsweetened beverages remained higher in the experimental group (P=0.005 and P<0.001, respectively), whereas the consumption of artificially sweetened beverages did not differ significantly between the groups (P=0.32). Total energy intake and sugar intake decreased in the experimental group as compared with the control group at 1 year (P<0.001 for both comparisons), with group differences persisting at 2 years (P=0.02 for total energy intake and P=0.005 for sugar intake).

OUTCOMES

Study outcomes are presented in Table 3 and in the Supplementary Appendix (available at NEJM .org). The prespecified primary outcome, the net intervention effect on BMI at 2 years (the change in the experimental group minus the change in the control group), was not significant (−0.30, P=0.46). However, the effect on BMI at the end of the 1-year intervention was significant (−0.57, P=0.045). When sugar intake was added to the model, the intervention effect on BMI was strongly attenuated and no longer significant (−0.39, P=0.24). The change in the mean (±SE) percentage of body fat in the experimental group as compared with the change in the control group was not significant (−0.5%±0.6, P=0.40). Although there was no significant intervention effect for the change in overall reported physical activity (0.01±0.04 METs, P=0.86), the experimental group had significant decreases in reported time spent watching television at 1 year (−0.6±0.2 hours per day, P=0.002) and at 2 years (−0.7±0.2 hours per day, P=0.001), whereas the control group had no significant change. The difference between the two groups (change in experimental group minus change in control group) was significant at 1 year (−0.7±0.3 hours per day, P=0.01) and at 2 years (−0.6±0.3 hours per day, P=0.04). Neither the change in television viewing (P=0.03 for intervention effect on change in BMI at 1 year with change in television viewing added to the model) nor the change in any covariate other than sugar intake mediated the intervention effect on the change in BMI at 1 year.

EFFECTS OF ETHNIC GROUP

In prespecified tests of covariates for interaction with group assignment, we found significant effect modification according to ethnic group for changes in BMI (P=0.04 at 1 year and P=0.01 at 2 years) and body weight (P=0.02 at 1 year and P=0.005 at 2 years). Among Hispanics, there were significant intervention effects on the change in BMI at 1 year (−1.79, P=0.007) and at 2 years (−2.35, P=0.01) and on the change in body weight at 1 year (−6.4 kg, P=0.003) and at 2 years (−8.8 kg, P=0.005) (Table 3). Other covariates were not significant effect modifiers.

Given these results, we reanalyzed data from a 19-month prospective observational study that showed an overall positive association between change in consumption of sugar-sweetened beverages and change in BMI (β=0.24, P=0.03).[13] Here, too, we found effect modification according to ethnic group (P=0.007). The association for the 84 Hispanic youths in the study was strong (β=0.63, P=0.007), whereas that for the 464 non-Hispanics (predominantly non-Hispanic whites but also non-Hispanic blacks, Asian Americans, American Indians, and others) was not significant (β=0.164, P=0.11).

ADVERSE EVENTS

A total of seven events were reported by the parents of participants in the experimental group during motivational telephone calls (diagnosis of Graves' disease, diagnosis of polycystic ovary syndrome, an infected finger, an asthma attack, a mild head injury due to a car accident, the development of a blood clot after knee surgery, and temporary hearing loss due to the buildup of fluid and wax in the ears).

DISCUSSION

The provision of noncaloric beverages virtually eliminated reported consumption of sugar-sweetened beverages and reduced total reported

energy intake among overweight and obese adolescents after a 1-year intervention, and there were persistent effects on diet through follow-up at 2 years. The change in BMI differed significantly between the experimental and control groups at 1 year but not at 2 years. We also found evidence of effect modification according to ethnic group, with the change in BMI differing between groups in a small sample of Hispanics but not among non-Hispanic participants.

Multicomponent interventions, targeting several aspects of diet and physical activity to promote negative energy balance, constitute a common strategy for treating adolescent obesity.[19,20] However, most intensive interventions have yielded disappointing results. In the present study, education and behavioral counseling focused specifically on decreasing consumption of sugar-sweetened beverages, a single dietary behavior that may be particularly important for controlling body weight. The significant intervention effect for the change in BMI observed at 1 year, together with the findings of de Ruyter et al. involving children 5 to 12 years of age (reported elsewhere in the *Journal*),[21] provides support for public health guidelines that recommend limiting consumption of sugar-sweetened beverages.[22] The lack of effect at 2 years could reflect increasing energy intake from sugar-sweetened beverages or fruit juices in the experimental group on discontinuation of the intervention; decreasing intake of sugar-sweetened beverages or fruit juices in the control group, possibly due to a secular trend resulting from efforts to eliminate these beverages from schools[23]; or both.

We examined several variables that could confound or mediate the effect of the intervention on BMI. We observed a difference in television viewing between the groups, but in our statistical models, this difference did not account for the difference in the change in BMI at 1 year. Similarly, no covariate other than sugar intake attenuated the intervention effect, suggesting that sugar intake had a mediating influence. However, we recognize that the intensity of the intervention, rather than provision of noncaloric beverages per se, may have led to salutary changes in other behaviors, such as decreased television viewing, and that these changes may affect body weight.

We conducted a subgroup analysis after a prespecified test revealed significant effect modification according to ethnic group, and reanalysis of data from a prospective observational study[13] provided corroborative evidence. However, these data must be interpreted cautiously in view of the small size of the Hispanic subgroup. The reason for effect modification according to ethnic group remains speculative but may involve differences in physiology (e.g., involving insulin secretion in response to the ingestion of sugar[24-26]) or in genetic susceptibility (as reported elsewhere in the *Journal*[27]). Still, even though our statistical models controlled for baseline covariates and no effect modification was detected in our measures of household income and education, we cannot exclude the possibility that effect modification according to ethnic group arose from socioeconomic or behavioral differences between ethnic groups rather than from inherent physiological differences. Additional study is needed to determine whether ethnic group influences the effect of consuming sugar-sweetened beverages on body weight.

The strengths of our trial include a focus on a single dietary behavior in the home environment, a diverse sample, excellent participant-retention rates, collection of data on dietary process measures, and assessment of physical activity and television viewing. The limitations include a small sample as compared with samples in multisite studies, reliance on self-reporting of dietary intake (with the likelihood of underreporting)[28] and physical activity, use of the BIA (a relatively inaccurate method)[29] to estimate body fat, and lack of data on obesity-related risk factors, such as biomarkers of lipid and glucose metabolism.

In conclusion, replacement of sugar-sweetened beverages with noncaloric beverages did not improve body weight over a 2-year period, but group differences in dietary quality and body weight were observed at the end of the 1-year intervention period.

The views expressed in this article are those of the authors and do not necessarily represent the official views of the National Institute of Diabetes and Digestive and Kidney Diseases, the National Center for Research Resources, the National Institute of Child Health and Human Development, the National Institutes of Health, or the Centers for Disease Control and Prevention.

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Exhibit 4

EDITORIAL

Calories from Soft Drinks — Do They Matter?

Sonia Caprio, M.D.

Obesity has emerged as one of the greatest global health challenges of the 21st century.[1] Its increase among children and adolescents is particularly frightening, given the associated metabolic and cardiovascular complications.[2,3] Studies from developing countries with populations that are undergoing rapid changes in nutrition are showing increases in the prevalence of childhood obesity.[4]

The increase in consumption of sugar-sweetened beverages among both adults and children in the United States and other countries is considered a potential contributor to the obesity pandemic.[5,6] Sugar intake from sugar-sweetened beverages alone, which are the largest single caloric food source in the United States, approaches 15% of the daily caloric intake in several population groups.[7,8] Adolescent boys in the United States consume an average of 357 kcal of the beverages per day.[8] Sugar-sweetened beverages are marketed extensively to children and adolescents, and large increases in consumption of sugar-sweetened beverages have occurred among black and Mexican-American youth,[8,9] who are known to be at higher risk for obesity and the development of type 2 diabetes than their white counterparts.[10]

Unlike carbohydrates with high fiber content, sugar-sweetened beverages are nutrient-poor and are often associated with consumption of salty foods and fast foods. An emerging association between the increased consumption of sugar-sweetened beverages and chronic diseases such as type 2 diabetes, hypertension, and coronary heart disease is a major concern.[6] A widely proposed explanation for this association is that caloric beverages elicit weak satiety and compensatory dietary responses.[6] However, the evidence supporting this hypothesis remains inconclusive. Another potential explanation is the use of high-fructose corn syrup, a key ingredient in most sugar-sweetened beverages. Many studies have shown that dietary fructose promotes hepatic lipogenesis and the development of insulin resistance,[11] thereby fueling the development of fatty liver disease and type 2 diabetes.

Three studies now published in the *Journal*, by de Ruyter et al.,[12] Ebbeling et al.,[13] and Qi et al.,[14] provide new data showing that consumption of sugar-sweetened beverages may influence the development of obesity among children, adolescents, and adults. The study by Qi and colleagues examined the interaction between the intake of sugar-sweetened beverages and a genetic-predisposition score that was calculated on the basis of 32 body-mass index (BMI) loci associated with obesity in women and men from two large prospective cohorts and in an independent replication cohort. This study provides strong evidence that there is a significant interaction between an important dietary factor — intake of sugar-sweetened beverages — and a genetic-predisposition score, obesity, and the risk of obesity. Hence, participants with a greater genetic predisposition may be more susceptible to the adverse effects of sugar-sweetened beverages on obesity; this is a clear example of gene–environment interaction. It is important to note, however, that this interaction is apparent only when a score is calculated from multiple genetic variants. The mechanisms accounting for the observed interaction are, unfortunately, not provided by the study. Nevertheless, the study by Qi et al. provides support for the need to test whether interventions aimed at reducing the intake of sugary drinks to reduce the risk of obesity might be more effective in persons with a high genetic-predisposition score.

In their articles on their rigorously designed randomized, controlled trials, de Ruyter et al. and

Ebbeling et al. describe the effects of interventions to reduce consumption of sugar-sweetened beverages on weight gain in normal-weight children and overweight and obese adolescents, respectively. The study by de Ruyter and colleagues is laudable for its double-blind design, large sample of normal-weight schoolchildren from 4 years 10 months to 11 years 11 months of age, and measurement of sucralose in urine as an additional compliance marker. An important limitation is that 26% of the participants did not complete the study, for unspecified reasons. Nevertheless, the results clearly suggest that masked replacement of a sugar-containing beverage (104 kcal) with a sugar-free beverage significantly reduced weight gain and fat accumulation in normal-weight children.

Ebbeling and colleagues randomly assigned 224 overweight and obese adolescents who regularly consumed sugar-sweetened beverages to experimental and control groups. The experimental group received a 1-year intervention consisting of home delivery of noncaloric beverages. This intervention was designed to decrease consumption of sugar-sweetened beverages, with a follow-up for an additional year. A particular merit of the study is its choice of the home as the place for the intervention, since the greatest consumption of sugar-sweetened beverages in both children and adolescents occurs at home.[5] Another strength of the study is its excellent participant-retention rates. The difference in the primary outcome, the change in BMI at 2 years between the experimental and control groups, was not significant. However, at 1 year, significant changes in BMI were observed, particularly among Hispanic participants. These changes were modest, occurring mainly in a very small number of obese Hispanic adolescents, and they were not sustained at 2 years.

These randomized, controlled studies — in particular, the study by de Ruyter et al. — provide a strong impetus to develop recommendations and policy decisions to limit consumption of sugar-sweetened beverages, especially those served at low cost and in excessive portions, to attempt to reverse the increase in childhood obesity. Such interventions, if successful, may also help prevent the development of type 2 diabetes and its complications in youth.

Taken together, these three studies suggest that calories from sugar-sweetened beverages do matter. Furthermore, policy decisions about sugar-sweetened beverages should not be considered in isolation. Other strategies to achieve and maintain normal weight, including increasing physical activity, will be important to stem the obesity epidemic and its effects. The time has come to take action and strongly support and implement the recommendations from the Institute of Medicine, the American Heart Association, the Obesity Society, and many other organizations to reduce consumption of sugar-sweetened beverages in both children and adults.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Exhibit 5

I

114TH CONGRESS
1ST SESSION

H. R. 1687

To amend the Internal Revenue Code of 1986 to impose an excise tax on sugar-sweetened beverages, to dedicate the revenues from such tax to the prevention, treatment, and research of diet-related health conditions in priority populations, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 26, 2015

Ms. DELAURO (for herself, Ms. NORTON, and Mr. RUSH) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986 to impose an excise tax on sugar-sweetened beverages, to dedicate the revenues from such tax to the prevention, treatment, and research of diet-related health conditions in priority populations, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Sugar-Sweetened Beverages Tax Act of 2015" or as the "SWEET Act".

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—The Congress finds that:

(1) The prevalence of obesity in the United States has increased dramatically over the past 30 years. From the 1960s to the late 1970s, the prevalence was relatively constant, with about 15 percent of the population classified as obese. After the 1970s, these rates began to climb. According to the Centers for Disease Control and Prevention, by 2012 more than one-third (34.9 percent) of adults and 17 percent of youth in the United States were obese. Although no group has escaped the epidemic, low income people and communities of color are disproportionately affected. In 2012, nearly half (47.8 percent) of African-American adults were obese and 42.5 percent of Hispanic adults were obese.

(2) The percentage of children who are overweight has also increased dramatically in recent decades. After being relatively constant from the 1960s to the 1970s, the prevalence of overweight children has more than tripled among children between 6 and 11 years of age and nearly quadrupled among those between 12 and 19 years of age. Despite significant public and private investment, childhood obesity rates remain high. Overall, obesity among our Nation's young people, aged 2–19 years, has not

changed significantly since 2004 and remains at about 17 percent—equaling 12.5 million children and adolescents.

(3) There are significant racial and age disparities in obesity prevalence among children and adolescents. In 2011–2012, obesity prevalence was higher among Hispanics (22.4 percent) and non-Hispanic Black youth (20.2 percent) than non-Hispanic White youth (14.1 percent). The prevalence of obesity was lower in non-Hispanic Asian youth (8.6 percent) than in youth who were non-Hispanic White, non-Hispanic Black, or Hispanic.

(4) Overweight and obesity are responsible for an estimated $190 billion in health care costs nationally, or approximately 5 to 10 percent of all medical spending—with over 20 percent of these costs paid publicly through the Medicare and Medicaid programs. The medical costs for people who are obese are dramatically higher ($2,741 per year) than those of normal weight.

(5) The obesity epidemic is of particular concern because obesity increases the risk of diabetes, heart disease, certain types of cancer, arthritis, asthma, and breathing problems. Depending on their level of obesity, from 60 percent to over 80 percent

of obese adults have type 2 diabetes, high blood cholesterol, high blood pressure, or other related conditions. According to the CDC, nearly 60 percent of overweight children have at least one risk factor for heart disease.

(6) Overweight and obesity increase the risk for several types of common cancers, including postmenopausal breast, colorectal, endometrial, kidney, pancreatic, esophageal, and gall bladder cancer. Up to one in four of all cancer cases and one in three cancer deaths are due to poor nutrition, physical inactivity, and overweight and obesity.

(7) There is overwhelming evidence of the link between the consumption of sugar-sweetened beverages, such as non-diet soft drinks, energy drinks, sweet teas, and sports drinks, and obesity and diabetes. Adults who drink one sugar-sweetened beverage or more per day are 27-percent more likely to be overweight or obese, regardless of income or ethnicity. After six months, daily consumption of one liter of sugar-sweetened beverages increases fat deposits in the liver by 150 percent, which directly contributes to both diabetes and heart disease.

(8) According to nutrition experts, sugar-sweetened beverages, such as soft drinks, energy drinks,

sweet teas, and sport drinks, offer little or no nutritional value, but massive quantities of added sugars. A 20-ounce bottle of soda contains about 16 teaspoons of sugars. Yet, the American Heart Association recommends that Americans consume no more than six to nine teaspoons of sugar per day.

(9) The 2010 Dietary Guidelines stated that almost one-half of the added sugars Americans consume come from sugar-sweetened beverages, with the average American drinking nearly 45 gallons of sugar-sweetened beverages a year, the equivalent of 39 pounds of extra sugar every year.

(10) Though sugar-sweetened beverage consumption is declining modestly as people learn about their harmful health effects, Americans are still consuming twice as much of these products as they did in the 1970s. Five percent of Americans consume at least 567 kcal from sugar drinks on any given day—equal to more than four 12-ounce cans of soft drink. According to the National Center for Health Statistics, one-third of calories from added sugars (33 percent) consumed in the United States were from beverages. In children and adolescents, 40 percent of the calories from added sugars came from beverages. Children and adolescents consume 10 to 15 percent

of their total daily caloric intake from sugar-sweetened beverages.

(11) In a study of more than 50,000 female nurses, women who increased their sugar-sweetened beverage consumption from no more than one per week to at least one per day gained an average of 10 pounds over four years. Research also shows a significant link between sugar-sweetened beverage consumption and weight gain in children. In a randomized double-blind controlled trial of roughly 640 children, those who were given one 8-ounce serving of a sugar-sweetened beverage a day gained more weight and body fat over 1½ years than those who got one 8-ounce serving of a sugar-free beverage.

(12) Sugar-sweetened beverages are a unique contributor to excess caloric consumption. A large body of research shows that calories from sugar-sweetened beverages do not satisfy hunger the way calories from solid food or fat or protein-containing beverages such as those containing milk and plant-based proteins. As a result, sugar-sweetened beverages tend to add to the calories people consume rather than replace calories from other foods and beverages.

(13) Overweight children have a much greater chance of being obese as adults, with all the health risks that entails.

(14) Type 2 diabetes, previously only seen among adults, is now increasing among children. Data show that almost a quarter of teens now have either diabetes or prediabetes. If the current trends are not reversed, it is predicted that one in three children and nearly one-half of Latino and African-American children born in the year 2000 will develop type 2 diabetes in their lifetime.

(15) People who consume an average amount of added sugar equivalent to one 20-ounce soda per day are 30-percent more likely to die from a heart attack over 15 years. People who consume the added sugar equivalent of at least 2–3 20-ounce sodas per day are 2.75 times more likely to die from a heart attack.

(16) Tooth decay (dental caries) is the single most common chronic childhood disease, experienced by more than one-fourth of United States children aged 2–5 years and half of those aged 12–15 years. About half of all children and two-thirds of adolescents aged 12–19 years from lower-income families have had decay. According to the American Academy

of Pediatric Dentistry, children who frequently or excessively consume beverages high in sugar are at increased risk for dental caries. Untreated dental caries can lead to pain, infection, tooth loss, and in severe cases, even death. It can slow normal growth and development by restricting nutritional intake. Children who are missing teeth may have chewing problems that limit their food choices and result in nutritionally inadequate diets.

(b) PURPOSES.—It is the intent of the Congress, by adopting the Sugar-Sweetened Beverages Tax Act (also known as the SWEET Act), to diminish the human and economic costs of diabetes, obesity, dental caries, and other diet-related health conditions. This Act is intended to discourage excessive consumption of sugar-sweetened beverages by increasing the price of these products and by creating a dedicated revenue source for programs and research designed to reduce the human and economic costs of diabetes, obesity, dental caries, and other diet-related health conditions in priority populations.

SEC. 3. EXCISE TAX ON CERTAIN SUGAR-SWEETENED BEVERAGES.

(a) IN GENERAL.—Subchapter D of chapter 32 of the Internal Revenue Code of 1986 is amended by inserting after part I the following new part:

"PART II—SUGAR-SWEETENED BEVERAGES

"SEC. 4171. IMPOSITION OF TAX.

"(a) IN GENERAL.—There is hereby imposed a tax on the sale or transfer of any specified sugar-sweetened beverage product by the manufacturer, producer, or importer thereof.

"(b) RATE OF TAX.—The rate of tax imposed under subsection (a) shall be equal to one cent per 4.2 grams of caloric sweetener contained in such specified sugar-sweetened beverage product.

"(c) PERSONS LIABLE FOR TAX.—The manufacturer, producer, or importer referred to in subsection (a) shall be liable for the tax imposed by such subsection.

"SEC. 4172. DEFINITIONS.

"(a) SPECIFIED SUGAR-SWEETENED BEVERAGE PRODUCT.—For purposes of this part—

"(1) IN GENERAL.—For purposes of this part, the term 'specified sugar-sweetened beverage product' means—

"(A) any liquid intended for human consumption which contains a caloric sweetener, and

"(B) any liquid, or solid mixture of ingredients, which—

"(i) contains a caloric sweetener, and

"(ii) is intended for use as an ingredient in a liquid described in subparagraph (A).

"(2) EXCEPTIONS.—The following shall not be treated as liquids described in paragraph (1)(A):

"(A) Any liquid the primary ingredients of which are milk or soy, rice, or similar plant-based milk substitute.

"(B) Any liquid composed entirely of one or more of the following:

"(i) The original liquid resulting from the pressing of fruit or vegetables.

"(ii) The liquid resulting from the reconstitution of fruit or vegetable juice concentrate.

"(iii) The liquid resulting from the restoration of water to dehydrated fruit or vegetable juice.

"(C) Infant formula.

"(D) Any liquid products manufactured for use as—

"(i) an oral nutritional therapy for persons who cannot absorb or metabolize dietary nutrients from food or beverages,

"(ii) a source of necessary nutrition used due to a medical condition, or

"(iii) an oral electrolyte solution for infants and children formulated to prevent dehydration due to illness.

"(E) Any liquid with respect to which tax is imposed under chapter 51 (relating to distilled spirits, wines, and beer) or under section 7652 by reason of the tax imposed under chapter 51 being imposed on like articles of domestic manufacture.

"(b) CALORIC SWEETENER.—For purposes of this part, the term 'caloric sweetener' means monosaccharides, disaccharides, and high-fructose corn syrup.

"SEC. 4173. SPECIAL RULES.

"(a) SWEETENER TAXED ONLY ONCE.—In the case of any specified sugar-sweetened beverage product which is manufactured or produced by including one or more other specified sugar-sweetened beverage products, no tax shall be imposed under this section on any caloric sweetener contained in the resulting specified sugar-sweetened beverage product if tax was previously imposed under this section on such caloric sweetener when contained in the specified sugar-sweetened beverage product so included.

"(b) INFLATION ADJUSTMENT.—In the case of any sale after December 31, 2015, the one cent amount in section 4171(b) shall be increased by an amount equal to—

"(1) such amount, multiplied by

"(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such sale occurs, determined by substituting 'calendar year 2014' for 'calendar year 1992' in subparagraph (B) thereof.

Any increase determined under this subsection shall be rounded to the nearest multiple of one-tenth of a cent.".

(b) CONFORMING AMENDMENTS.—

(1) Section 4221(a) is amended by adding at the end the following: "Paragraphs (1), (4), (5), and (6) shall not apply to the tax imposed under section 4171.".

(2) The table of parts for subchapter D of chapter 32 of such Code is amended by inserting after the item relating to part I the following new item:

"PART II. SUGAR-SWEETENED BEVERAGES".

(c) REVENUES USED FOR PREVENTION, TREATMENT, AND RESEARCH OF DIET-RELATED HEALTH CONDITIONS IN PRIORITY POPULATIONS.—

(1) TRANSFER TO PREVENTION AND PUBLIC HEALTH FUND.—There are hereby appropriated to

the Prevention and Public Health Fund created under section 4002 of the Patient Protection and Affordable Care Act (in addition to any other amounts appropriated to such Fund) amounts equivalent to taxes received in the Treasury under part II of subchapter D of chapter 32. Rules similar to the rules of section 9601 of the Internal Revenue Code of 1986 shall apply with respect to amounts appropriated under this paragraph.

(2) RESTRICTION ON USE OF FUNDS.—Notwithstanding subsections (c) and (d) of section 4002 of the Patient Protection and Affordable Care Act, amounts appropriated to the Prevention and Public Health Fund under paragraph (1) may be transferred to accounts in the Department of Health and Human Services only for the purpose of making expenditures for programs and research designed to reduce the human and economic costs of diabetes, obesity, dental caries, and other diet-related health conditions in priority populations (within the meaning of section 901(c) of the Public Health Service Act).

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section

shall take effect on the date of the enactment of this Act.

(2) EXCISE TAX.—The amendments made by subsections (a) and (b) shall apply to sales after the date of the enactment of this Act.

○

Exhibit 6

AMENDED IN ASSEMBLY MARCH 30, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2782

Introduced by Assembly Member Bloom
(Coauthors: Assembly Members Chiu and Wood)

February 19, 2016

~~An act to amend Section 104655 of the Health and Safety Code, relating to nutrition.~~ *An act to add Chapter 5 (commencing with Section 104895.50) to Part 3 of Division 103 of the Health and Safety Code, relating to public health.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2782, as amended, Bloom. ~~Healthy food.~~ *Healthy California Fund.*

Existing law provides for various programs that prevent disease and promote health.

This bill, subject to specified exemptions, would impose a fee on every distributor, as defined, for the privilege of distributing in this state bottled sweetened beverages, at a rate of $0.02 per fluid ounce and for the privilege of distributing concentrate in this state, either as concentrate or as sweetened beverages derived from that concentrate, at the rate of $0.02 per fluid ounce of sweetened beverage to be produced from concentrate. The Board of Equalization would be responsible for administering and collecting the fee and registering the distributors upon whom the fee is imposed. These amounts would be deposited into the Healthy California Fund, created by the bill. The bill would require moneys in the fund, upon appropriation by the Legislature, to be allocated to the State Department of Public Health, the State Department of Health Care Services, the Department of

Education, and the Department of Food and Agriculture, as specified, for various purposes related to statewide diabetes and childhood obesity treatment and prevention activities and programs, including awarding competitive grants to local governments, nonprofit organizations, school districts, and other entities for activities in support of the bill's objectives. This bill would also authorize the State Public Health Officer, the Director of Health Care Services, the Superintendent of Public Instruction, and the Secretary of Food and Agriculture to establish regulations and provide procedural measures to bring into effect those purposes.

The bill would create the Healthy California Fund Oversight Committee, to advise the affected state departments in implementing the bill's requirements. Among other requirements, the committee would evaluate programs and interventions funded under the bill and report to the Legislature annually regarding programs funded by the Healthy California Fund. The committee would produce a comprehensive master plan for implementing diabetes and obesity prevention programs throughout the state, increase healthy eating and active living, reduce food insecurity, and promote sustainable, healthy, resilient communities.

This bill would require the State Department of Public Health, in consultation with the other participating departments, to prepare and adopt an annual program budget, as specified. The bill would establish the Children and Family Health Promotion Administration Account within the fund, to be used, upon appropriation by the Legislature, to reimburse expenditures by the State Department of Public Health in administering and implementing the activities required by the bill, and to repay specified loans from other funds.

This bill would make legislative findings and declarations relating to the consumption of sweetened beverages, diabetes, childhood obesity, and dental disease.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

~~Existing law requires the State Department of Public Health to establish and implement the 5 A Day—For Better Health program to promote public awareness of the need to eat more fruits and vegetables in order to improve health and prevent major chronic diseases. Existing law provides that nothing shall operate to prohibit contributions to the~~

~~program by certain marketing organizations and commissions subject to specified provisions.~~

~~This bill would make technical, nonsubstantive changes to this provision.~~

Vote: ~~majority~~ *2/3*. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares as follows:

(a) Over 2.3 million California adults report have been diagnosed with diabetes, representing one out of every 12 adult Californians. The vast majority of diabetes cases in California are type II, affecting 1.9 million adults.

(b) According to the State Department of Public Health, diabetes is the seventh leading cause of death in California and has been determined to be the underlying cause of death for almost 8,000 people each year.

(c) Adults with type II diabetes more often have other health problems. Half of adults with type II diabetes also have hypertension. This rate of occurrence is twice as high as for those without diabetes. Adults with diabetes are also twice as likely to have cardiovascular disease than adults without diabetes.

(d) Adults with diabetes are 50 percent more likely to have arthritis than adults without diabetes. Over 40 percent of new cases of kidney failure are attributed to diabetes. New cases of kidney failure declined slightly from 2001 to 2007, but began to increase again after 2007.

(e) Hispanics, African Americans, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders have a higher prevalence of type II diabetes than non-Hispanic whites. Hispanics and African Americans have two times higher prevalence: 7 percent of non-Hispanic Whites have type II diabetes, compared with 12 percent of Latinos, 9 percent of Asian Americans, 14 percent of Pacific Islander Americans, 13 percent of African Americans, and 17.5 percent of American Indian and Alaska Native populations. In some populations, type II diabetes remains undiagnosed. For example, more than half of Asian Americans with type II diabetes, and even more Asian Americans with prediabetes, are undiagnosed. Nationally, the lifetime risk of

developing diabetes is now 40 percent, or 2 of every 5 adults, and exceeds 50 percent for Hispanic men and women and non-Hispanic black women. If trends are not reversed, it is predicted that 40 percent of Americans and nearly half of Latino and African American children born in the year 2000 will develop type II diabetes in their lifetime.

(f) The prevalence of obesity in the United States has increased dramatically over the past 30 years. In California, obesity rates have increased even more, rising from 8.9 percent in 1984 to 23.8 percent in 2011. Although no group has escaped the epidemic, low-income populations and communities of color are disproportionately affected.

(g) The rate of children who are overweight has also increased dramatically in recent decades. In 2010, 38 percent of California children in grades 5, 7, and 9 were overweight or obese. Thirty-one of California's 58 counties experienced an increase in childhood obesity from 2005 to 2010.

(h) In 2006, overweight and obesity-related health costs in California were estimated at almost $21 billion. The cost of health care alone for diabetes in California in 2010 is estimated to have been $13 billion.

(i) There is overwhelming evidence of the link between obesity, diabetes, and heart disease and with the consumption of sweetened beverages, including soft drinks, energy drinks, sweet teas, and sports drinks. California adults who drink one or more per day are 27 percent more likely to be overweight or obese, regardless of income or ethnicity.

(j) According to nutritional experts, sweetened beverages, such as soft drinks, energy drinks, sweet teas, and sports drinks, offer little or no nutritional value, but massive quantities of added sugars. A 20-ounce bottle of soda contains the equivalent of approximately 16 teaspoons of sugar, yet the American Heart Association recommends that Americans consume no more than five to nine teaspoons of sugar per day.

(k) Research shows that almost half of the extra calories Americans consume in their diet comes from sugar-sweetened beverages, with the average American drinking nearly 50 gallons of sugar-sweetened beverages a year, the equivalent of 39 pounds of extra sugar every year.

(l) Research shows that 41 percent of California children from 2 to 11 years of age, inclusive, and 62 percent of California teens from 12 to 17 years of age, inclusive, drink soda daily, and for every additional serving of sweetened beverage that a child consumes per day, the likelihood of the child becoming obese increases by 60 percent.

(m) Sugary drinks are a unique contributor to excess caloric consumption. A large body of research shows that calories from sugary drinks do not satisfy hunger the way calories from solid food or beverages containing fat or protein do, such as those containing milk and plant-based proteins. As a result, sugary beverages tend to add to the calories people consume rather than replace them.

(n) Dental caries, commonly referred to as tooth decay, is the most common chronic childhood disease, and by third grade tooth decay affects almost two-thirds of the children in California. Twenty-eight percent of elementary school children– some 750,000– have untreated tooth decay. Dental disease caused by tooth decay is linked to broader health problems, including cardiovascular disease, strokes and diabetes. It can lead to serious health, developmental, and social concerns, as well as significantly increased cost of restorative care and reliance on high-cost health care settings like hospital emergency departments.

(o) Research shows that low income and minority populations disproportionately feel the burden of tooth decay, as low-income children suffer twice as much from dental disease as those from higher income families, and their disease is more likely to be untreated. Nationally, 32 percent of Latino children and 28 percent of African American children have untreated tooth decay, compared to only 18 percent of white children. Pain and infection from untreated tooth decay impairs concentration and learning in students and leads to missed schooldays.

(p) Sugar is the primary and necessary factor in the development of tooth decay. In addition to sugar, the acids found in beverages like soda, energy drinks, and juice erode tooth enamel, making sweetened beverage consumption one of the most significant contributors to dental caries in children. Children from families of low socioeconomic status have a significantly higher consumption of soda and other types of sugary beverages.

(q) It is the intent of the Legislature in creating the Healthy California Fund to diminish the human and economic costs of diabetes, obesity, heart disease, and dental disease in California. The fund is intended to create a dedicated revenue source for health, education, and wellness programs designed to prevent and treat obesity, diabetes, and heart and dental disease and to reduce the burden of attendant health conditions that result from the overconsumption of sugar-sweetened beverages.

SEC. 2. Chapter 5 (commencing with Section 104895.50) is added to Part 3 of Division 103 of the Health and Safety Code, to read:

CHAPTER 5. HEALTHY CALIFORNIA FUND

104895.50. The following definitions shall apply for purposes of this chapter:

(a) (1) "Beverage for medical use" means a beverage suitable for human consumption and manufactured for use as an oral nutritional therapy for persons who cannot absorb or metabolize dietary nutrients from food or beverages, or for use as an oral rehydration electrolyte solution for infants and children formulated to prevent or treat dehydration due to illness.

(2) "Beverage for medical use" includes a "medical food." Consistent with Section 5(b)(3) of the Orphan Drug Act (Public Law 97-414; at 21 U.S.C. 360ee(b)(3)), "medical food" means a food that is formulated to be consumed or administered enterally under the supervision of a physician and that is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

(3) "Beverage for medical use" does not include drinks commonly referred to as "sports drinks," or any other derivative or similar terms.

(b) "Board" means the State Board of Equalization.

(c) "Bottle" means any closed or sealed container, regardless of size or shape, including, without limitation, those made of glass, metal, paper, plastic, or any other material or combination of materials.

(d) "Bottled sugar-sweetened beverage" means any sugar-sweetened beverage contained in a bottle that is ready for

consumption without further processing, such as dilution or carbonation.

(e) "Caloric sweetener" means any caloric substance suitable for human consumption that humans perceive as sweet, including, but not limited to, sucrose, fructose, glucose, fruit juice concentrate, or other sugars. "Caloric sweetener" excludes noncaloric sweeteners. For purposes of this definition, "caloric" means a substance that adds calories to the diet of a person who consumes that substance.

(f) "Consumer" means a person who purchases a sugar-sweetened beverage for consumption and not for sale to another.

(g) "Distributor" means any person, including a manufacturer or wholesale dealer, who receives, stores, manufactures, bottles, or distributes bottled sugar-sweetened beverages, syrups, or powders for sale to retailers doing business in the state, or any combination of these activities, whether or not that person also sells those products to consumers.

(h) "Fund" means the Healthy California Fund.

(i) "Milk" means natural liquid milk, regardless of animal or plant source or butterfat content, natural milk concentrate, whether or not reconstituted, or dehydrated natural milk, whether or not reconstituted.

(j) "Natural fruit juice" means the original liquid resulting from the pressing of fruits, or the liquid resulting from the dilution with water of dehydrated natural fruit juice.

(k) "Natural vegetable juice" means the original liquid resulting from the pressing of vegetables, or the liquid resulting from the dilution with water of dehydrated natural vegetable juice.

(l) "Noncaloric sweetener" means any noncaloric substance suitable for human consumption that humans perceive as sweet, including, but not limited to, aspartame, acesulfame-K, neotame, saccharin, sucralose, and stevia. "Noncaloric sweetener" excludes caloric sweeteners. For purposes of this definition, "noncaloric" means a substance that contains fewer than five calories per serving.

(m) "Person" means a natural person, partnership, cooperative association, limited liability company, corporation, personal representative, receiver, trustee, assignee, or other legal entity.

(n) "Place of business" means any place where sugar-sweetened beverages, syrups, or powders are manufactured or received for sale in the state.

(o) "Powder" means any solid mixture of ingredients used in making, mixing, or compounding sugar-sweetened beverages by mixing the powder with one or more other ingredients, including, but not limited to, water, ice, syrup, simple syrup, fruits, vegetables, fruit juice, vegetable juice, or carbonation or other gas.

(p) "Retailer" means any person who sells or otherwise dispenses in the state a sugar-sweetened beverage to a consumer whether or not that person is also a distributor.

(q) "Sale" means the transfer of title or possession for valuable consideration, regardless of the manner by which the transfer is completed.

(r) "State" means the State of California.

(s) (1) "Sugar-sweetened beverage" means any nonalcoholic beverage, carbonated or noncarbonated, that is sold for human consumption and contains added caloric sweetener. As used in this subdivision, "nonalcoholic beverage" means any beverage that contains less than one-half of 1 percent alcohol per volume.

(2) "Sugar-sweetened beverage" does not include any of the following:

(A) Bottled sugar-sweetened beverages, syrups, and powders sold to the United States government and American Indian tribal governments.

(B) Bottled sugar-sweetened beverages, syrups, and powders sold by a distributor to another distributor that is registered pursuant to Section 104895.58 if the sales invoice clearly indicates that the sale is exempt. If the sale is to a person who is both a distributor and a retailer, the sale shall also be fee-exempt and the fee shall be paid when the purchasing distributor or retailer resells the product to a retailer or a consumer. This exemption does not apply to any other sale to a retailer.

(C) Beverages sweetened solely with noncaloric sweeteners.

(D) Beverages consisting of 100 percent natural fruit or vegetable juice, with no added caloric sweetener.

(E) Beverages in which milk, or soy, rice, or similar milk substitute, is the primary ingredient or the first listed ingredient on the label of the beverage.

(F) Beverages with fewer than five grams of added sugar or other caloric sweeteners per 12 ounces.

(G) Coffee or tea without added caloric sweetener.

(H) Infant formula.

(I) Beverages for medical use.

(J) Water without any caloric sweetener.

(t) "Syrup" means a liquid mixture of ingredients used in making, mixing, or compounding sugar-sweetened beverages using one or more other ingredients, including, but not limited to, water, ice, powder, simple syrup, fruits, vegetables, fruit juice, vegetable juice, carbonation, or other gas.

(u) "Water" includes nonflavored water, or water flavored with noncaloric "natural fruit essence" or "natural flavor." The source of the water may be artesian, mineral, spring, or well. The type of water may also include carbonated, such as sparkling, club, or seltzer, and still, distilled, or purified, such as demineralized, deionized, or reverse osmosis.

(v) "Culturally and linguistically appropriate" means meeting the requirements of paragraphs (1) and (2) of subdivision (c) of Section 2190.1 of the Business and Professions Code.

104895.51. (a) (1) The Healthy California Fund is hereby established in the State Treasury with the purpose of diminishing the human and economic costs of diabetes, obesity, heart disease, and dental disease in California. The fund shall support culturally and linguistically appropriate programs and interventions that use educational, environmental, policy, and systems change, and other public health approaches to improve access to, and consumption of, healthy and affordable foods and beverages, reduce access to, and consumption of, calorie-dense and nutrient-poor foods, encourage physical activity and decrease sedentary behavior, improve oral health literacy, raise awareness about the importance of nutrition and physical activity in the prevention of obesity and diabetes, and raise awareness of the impact of nutrition and oral health habits on dental disease.

(2) The majority of expenditures shall be directed to support comprehensive policy, systems, and environmental change approaches that promote healthy eating, active living, and improved oral health, including, but not limited to, those recommended by the Institute of Medicine and the federal Centers of Disease Control and Prevention. The fund shall consist of all

fees, interest, penalties, and other amounts collected pursuant to this chapter, less refunds and reimbursement for expenses incurred in the administration and collection of the fees.

(b) Fifty-one percent of the moneys in the fund shall be allocated to the State Department of Public Health and distributed for the following purposes:

(1) Twenty-seven percent to develop and administer a regular grant program to all county and city health departments, or their nonprofit designee, seeking to invest in obesity, diabetes, and dental disease prevention activities. Funds shall be distributed in a reasonable proportion for prevention activities across the three chronic diseases and pursuant to the Target Population Funding Criteria under Section 104895.52.

(2) Twenty-eight percent to develop and administer a competitive grant program for nonprofit and community based organizations seeking to invest in obesity, diabetes, and dental disease prevention activities. At least 15 percent and up to 20 percent of these funds shall be used to support nonprofit organizations working statewide, including those that provide capacity building and technical assistance services. At least 8 percent of these funds shall be used for statewide priority population leadership networks, including African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian and Pacific Islander and low socioeconomic status populations. Grants to community-based organizations shall be distributed in a reasonable proportion for prevention activities across the three chronic diseases and shall meet the Target Population Funding Criteria pursuant to Section 104895.52.

(3) Twenty-eight percent to develop and administer a competitive grant program for clinics licensed under subdivision (a) of Section 1204 to invest in a comprehensive approach to obesity, diabetes, and dental disease prevention and treatment activities. In addition to direct services, funding shall support programs that use culturally and linguistically appropriate educational and other public health approaches that raise awareness about the importance of nutrition and physical activity in the prevention of childhood obesity, diabetes, and dental disease. Funds shall be distributed in a reasonable proportion for prevention activities across the three chronic diseases and pursuant to the target population funding criteria specified in Section 10895.52.

(4) Seven percent to the department or its nonprofit partners for statewide advertising and media campaigns, including social media initiatives, to change social and cultural norms around risk factors for chronic diseases, including diet and physical activity, and dental disease prevention. The statewide advertising and media campaigns shall be guided by a subcommittee of the Oversight Committee pursuant to Section 104895.53 and ensure that advertising and media campaigns are tailored for the populations most affected, as listed in subdivision (a) of Section 104895.52.

(5) Ten percent to the department, of which no more than 3 percent may be used for administration of the Fund to include technical assistance to potential grantees and its prevention activities; a minimum of 3 percent for independent evaluation; 1 percent subgranted to California-based public universities or nonprofits to strengthen chronic disease surveillance, including measures to track economic, racial, and ethnic disparities and health inequities; and 3 percent to the department's Oral Health Program to support statewide coordination and delivery of preventive dental health programs and to ensure that funding is directed to programs in accordance with the implementation of the Oral Health Program.

(c) Four percent to the Expanded Access to Primary Care, Rural Health Services Development, Health of Seasonal Agricultural Migratory Workers, and Indian Health programs in the State Department of Health Care Services. Funds shall be used to support culturally and linguistically appropriate clinic-based obesity and diabetes prevention and related disease management pursuant to subdivision (v) of Section 104895.50 with no more than 3 percent going towards department administrative costs.

(d) Twenty-five percent to the Department of Education and distributed for the following purposes and pursuant to the Target Population Funding Criteria, under Section 104895.52, with no more than three percent to be used for department administrative costs:

(1) Twenty-eight percent to administer a competitive grant program for school districts for educational, environmental, policy, and other public health approaches that promote physical activity. The approaches funded pursuant to this paragraph may include improving or constructing school recreational facilities that are used for recess and physical education, joint-use activities during

after hours, providing continuing education training for physical education teachers, hiring qualified physical education teachers, and implementing Safe Routes to School programs.

(2) Thirty-one percent to administer a competitive grant program for school districts for educational, environmental, policy, and other public health approaches that promote improved nutrition and access to healthy foods and beverages. The approaches funded pursuant to this paragraph may include improving the quality and nutrition of school breakfasts, lunches, and snacks, increasing access to federal meal programs for underserved populations, and incorporating practical nutrition education into the curriculum.

(3) Fourteen percent to the California Farm to School Program administered by the department.

(4) Twenty-four percent to administer a competitive grant program for school districts for ensuring access to clean drinking water throughout the schoolday, including, but not limited to, drinking fountains and water bottle refilling stations.

(e) Twenty percent to the Department of Food and Agriculture, to be distributed equally for the following purposes, with no more than 3 percent going towards department administrative costs:

(1) To the Office of Farm to Fork, including, but not limited to, consumer incentive programs, pursuant to Section 49001 of the Food and Agricultural Code.

(2) To the Office of Farm to Fork, Chapter 12 (commencing with Section 49001) of Division 17 of the Food and Agricultural Code, to administer a competitive grant program to aide community food producers, as defined under Section 113752, or socially disadvantaged, beginning, military veteran, or limited resource specialty crop producers that improve the health and resilience of their communities by increasing access to any variety of fresh, canned, dried, or frozen whole or cut fruits and vegetables without added sugars, fats or oils, and salt.

104895.52. (a) The target populations described in paragraphs (1) to (5), inclusive, at a minimum, shall be the focus of the campaign implemented pursuant to this chapter, and all moneys in the fund, including those designated for statewide activities, shall be allocated with no less than 60 percent priority given to communities located in zip codes with the highest 30 percentile of type II diabetes, as reported by the California Health Interview

Survey (CHIS) conducted by the University of California, Los Angeles Center for Health Policy Research. Departments shall use the most current survey data available in identifying the following populations:

(1) African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian, and Pacific Islander.

(2) Low socioeconomic status populations.

(3) Zip codes with the top 30th percentile of rates of type II diabetes.

(4) Communities identified as dentally underserved or with high rates of dental disease.

(5) At-risk populations, as determined by the California Health Interview Survey (CHIS) and other data sources.

(b) Pursuant to this chapter, the State Department of Public Health and the State Department of Education shall use the most current survey data available to target all moneys in the fund to address the needs of the identified target populations using the following criteria and methodologies:

(1) For funding to the California Department of Public Health:

(A) (i) Pursuant to the county and local government funding criteria, funding shall be focused and primarily expended on programs and activities with a priority and focus on directly serving communities identified in paragraph (1) of subdivision (a), and where consumption of bottled sugar-sweetened beverages is the highest, in neighborhoods with schools with a high concentration of students who qualify for supplemental and concentration grants, pursuant to Section 2574 of the Education Code, and in neighborhoods with a demonstrated need for services, including a high concentration of Medi-Cal eligible residents.

(ii) The department shall develop a funding formula to provide a minimum base level to all county and city health departments with the additional amount weighted to reflect the number of residents in each jurisdiction living below 150 percent of the federal poverty level. Funding shall be dependent on each local health department submitting an approved implementation plan and maintaining a community coalition to support the objectives of the funding. At least one third of each jurisdiction's funds shall be subgranted to community partners selected through a competitive process with a priority and focus on directly serving

communities and populations described in paragraph (1) of subdivision (a).

(B) Grants for nonprofit and community-based organizations, pursuant to paragraph (2) of subdivision (b) of Section 104895.51, shall be reserved for providing activities in communities described in paragraph (1) of subdivision (a) and assisting populations that are no more than 150 percent above the poverty level. Priority shall be given to culturally and linguistically appropriate activities, pursuant to subdivision (v) of Section 104895.50. Those activities shall directly serve communities with a demonstrated need for health care services, including those with high levels of limited–English-Proficient residents.

(2) Funding to the State Department of Education shall be focused and primarily expended on campuses located in neighborhoods and serving children, pursuant to paragraph (1) of subdivision (a), with a high density of students who qualify for the National School Lunch Program or the federal School Breakfast Program, more than 50 percent of students who would qualify for supplemental or concentration grants, pursuant to Section 2574 of the Education Code, and a demonstrated need that may include showing that access to fresh fruits and vegetables is limited in the neighborhood surrounding the school.

104895.53. (a) Upon appropriation by the Legislature, all moneys in the fund shall be expended only for the purposes expressed in this chapter and shall be used only to supplement existing levels of service. Moneys in the fund shall not supplant any federal, state, or local funding for existing levels of service.

(b) The State Public Health Officer, the Secretary of the Department of Food and Agriculture, the Director of Health Care Services, and the Superintendent of Public Instruction may coordinate to establish regulations and procedural measures necessary to effectuate the purposes of this chapter. The regulations may provide for specific programs to be funded consistent with the allocation of funds as set forth in this chapter. In establishing these regulations, the departments shall give particular consideration to reducing the prevalence of diabetes, as identified by data from the CHIS and other data sources.

(c) The California State Auditor's office shall conduct periodic audits to ensure that the annual allocation to individual programs is awarded by the fund in a timely fashion consistent with the

requirements of this chapter. The first audit shall be conducted no later than 24 months after the effective date of this section.

104895.54. (a) The Healthy California Fund Oversight Committee is hereby created in state government. The committee shall advise the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education with respect to policy development, integration, and evaluation of the state and local programs funded under this chapter, and shall develop a master plan for the future implementation of diabetes, obesity, and dental disease prevention programs.

(b) The committee shall be composed of 13 members to be appointed as follows, with specific consideration to address the needs of the target populations described in Section 104895.52:

(1) Two members representing nonprofit public health organizations dedicated to healthy eating, active living, and diabetes and obesity prevention, appointed by the Speaker of the Assembly.

(2) One member representing an organization that represents the health center community, appointed by the Senate Rules Committee.

(3) One member of a professional education association, such as an association of teachers, appointed by the Senate Rules Committee.

(4) One representative of a professional dental organization, a nonprofit dental health organization, or representing an organization dedicated to dental disease prevention, appointed by Governor.

(5) One member of a university facility with expertise in programs intended to promote healthy eating, active living, and diabetes and obesity prevention, appointed by the Governor.

(6) Two representatives of a target population group, appointed by the Governor.

(7) One representative of the State Department of Public Health, appointed by the Governor.

(8) One representative of the State Department of Health Care Services, appointed by the Governor.

(9) One representative of the Department of Food and Agriculture, appointed by the Governor.

(10) One representative of the State Department of Education, appointed by the Superintendent of Public Instruction.

(11) One representative of local health departments, appointed by the Governor.

(c) Members shall serve for a term of three years, renewable at the option of the appointing authority, with up to two consecutive terms. The initial appointments of members shall be for two or three years, to be drawn by random lot at the first meeting. The committee shall be staffed by the coordinator of the State Department of Public Health programs created pursuant to subdivision (b) of Section 104895.51.

(d) The committee shall meet as often as it deems necessary, but not fewer than four times per year.

(e) The members of the committee shall serve without compensation, but shall be reimbursed for necessary travel expenses incurred in the performance of the duties of the committee.

(f) An equity subcommittee shall be established as part of the Oversight Committee to ensure progress on advancing health equity.

104895.55. The committee shall be advisory to the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education, for the following purposes:

(a) Evaluating programs and interventions funded under this chapter as necessary in order to assess the overall effectiveness of efforts made by the program to promote healthy eating and active living and to prevent diabetes and obesity. In order to evaluate programs, the committee shall seek the cooperation and assistance of the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, the State Department of Education, the University of California, local health departments, local education agencies, administrative representatives, target populations, school officials, nongovernmental organizations, and researchers. A principal measurement of effectiveness shall be the reduction of diabetes and obesity and the increased consumption of healthy foods and levels of physical activity among a given target population.

(b) Facilitating programs directed at promoting healthy eating and active living and preventing diabetes and obesity that are

operated jointly by more than one agency or entity. The committee shall propose strategies for the coordination of proposed programs administered by the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education, and local lead agencies, in order to avoid the duplication of services and to maximize the public benefit of the programs.

(c) Making recommendations to the Department of Public Health, the Department of Health Care Services, the Department of Food and Agriculture, and State Department of Education regarding the most appropriate selection criteria for, and standards of, the operation and the types of programs to be funded under this chapter.

(d) (1) Notwithstanding Section 10231.5 of the Government Code, reporting to the Legislature on or before January 1 of each year on the number and scope of programs funded by the Healthy California Fund created by Section 104895.51, the amount of money in the fund, any moneys previously appropriated to the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education, but unspent by the departments, a description and assessment of all programs funded under this chapter, and recommendations for any necessary policy changes or improvements for program interventions and strategies.

(2) A report submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(e) Ensuring that the most current research findings regarding diabetes and obesity prevention are applied in designing the programs administered by the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education. The departments shall apply the most current findings and recommendations of research and best practice.

(f) Based on the results of programs supported by this chapter and any other proven methodologies available to the committee, producing a comprehensive master plan for implementing diabetes and obesity prevention programs throughout the state to increase healthy eating and active living, reduce food insecurity, and promote sustainable, healthy, resilient communities. The master

plan shall include longitudinal data on obesity prevalence and incidence rates, data on diabetes prevalence and incidence rates, and longitudinal information on sweetened beverage consumption rates across the state population. The master plan shall also include implementation strategies for programs to address the needs of underserved and at-risk target populations throughout this state. The Healthy California Fund Oversight Committee shall submit the master plan to the Legislature biennially, in compliance with Section 9795 of the Government Code. The master plan and its revisions shall include recommendations for administrative arrangements, funding priorities and integration and coordination of approaches by the Department of Public Health, the Department of Health Care Services, the Department of Food and Agriculture, and State Department of Education and their support systems, local lead agencies, and nongovernmental organizations, as well as progress reports relating to the needs of specific target populations.

104895.56. (a) A health impact fee is hereby imposed on every distributor for the privilege of distributing bottled sweetened beverages and concentrate in the state, for deposit into the fund. The fees shall be calculated as follows:

(1) The fee on bottled sweetened beverages distributed in this state shall be two cents ($0.02) per fluid ounce.

(2) The fee on concentrates distributed in the state either as concentrate or as a sweetened beverage derived from that concentrate shall be equal to two cents ($0.02) per fluid ounce of sweetened beverage produced from that concentrate. For purposes of calculating the fee for concentrate, the volume of sweetened beverage to be produced from concentrate shall be the largest volume resulting from use of the concentrate according to any manufacturer's instructions.

(b) In each transaction described in subdivision (a), the distributor shall include the following information on each receipt, invoice, or other form of accounting for the distribution of bottled sweetened beverages or concentrate:

(1) The name and address of the distributor.

(2) The name and address of the purchaser.

(3) The date of sale and invoice number.

(4) The kind, quantity, size, and capacity of packages of bottled sweetened beverages, sweetened beverages, or concentrate sold.

(5) The amount of fees due from the distributor on the sale of the bottled sweetened beverages, sweetened beverages, or concentrate.

(6) Any other information, as required by the board.

(c) The program shall develop reimbursement criteria to enable participating departments to recover administrative costs associated with collecting the charge.

(d) This section shall not preempt a city or county from enacting or enforcing an ordinance related to taxation of sugar-sweetened beverages if the ordinance is more stringent than this section.

104895.57. (a) (1) No later than July 1, 2017, and annually thereafter, the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education shall commence preparation of a program budget for the following calendar year. The budgets shall include all of the following information:

(A) Anticipated revenues and costs of implementing the program, including related programs, projects, contracts, and administrative expenses.

(B) A recommended funding level sufficient to cover the program's budgeted costs and to operate the program over a multiyear period in a prudent and responsible manner.

(C) The amount of the health impact fees, as described in Section 104895.56, and itemization of costs that the fees cover.

(2) The State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education shall solicit feedback on their proposed budgets from the Healthy California Fund Oversight Committee before adopting a final budget.

(3) The departments shall adopt final program budgets for purposes of this chapter by October 1 of each year.

(b) The fund shall reimburse the State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education for administration and implementation costs the departments incur pursuant to this chapter, as provided in subdivision (c). The reimbursement shall not exceed the departments' direct costs to implement and enforce this chapter.

(c) The State Department of Public Health, the State Department of Health Care Services, the Department of Food and Agriculture, and the State Department of Education shall deposit all moneys submitted for reimbursement costs by the program into the Healthy California Fund Administration Account, which is hereby established within the fund. Upon appropriation by the Legislature, moneys in the account shall be expended by the departments to administer and enforce this chapter and to repay any outstanding loans made from other funds used to finance startup costs of the department's activities pursuant to this chapter.

104895.58. (a) The board shall administer and collect the charges imposed by this chapter pursuant to the Fee Collection Procedures Law (Part 30 (commencing with Section 55001) of Division 2 of the Revenue and Taxation Code). The board may use no more than 3 percent of the revenues generated to cover its administrative costs in collecting the fees imposed under this chapter.

(b) The board may prescribe, adopt, and enforce regulations relating to the administration and enforcement of this chapter, including, but not limited to, collections, reporting, refunds, and appeals.

(c) The board may adopt regulations to implement this chapter. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

104895.59. The fees imposed by this chapter are due and payable to the board on or before the last day of the first month following each calendar quarter.

104895.60. (a) On or before the last day of the first month following each calendar quarter, a return for the preceding calendar quarter shall be filed with the board using electronic media.

(b) The board may prescribe those forms and reporting requirements as are necessary to implement the fees, including, but not limited to, information regarding the total amount of bottled sweetened beverages and concentrate sold and the amount due.

(c) Returns shall be authenticated in a form or pursuant to methods prescribed by the board.

104895.61. A distributor required to pay the fees imposed under this chapter shall register with the board. An application for registration shall be made upon a form prescribed by the board and shall set forth the name under which the applicant transacts or intends to transact business, the location or locations of each place of business, and any other information required by the board. An application for an account under this section shall be authenticated in a form, or pursuant to methods, prescribed by the board.

104895.62. The distribution of bottled sweetened beverages or concentrate by a distributor to either of the following persons shall be exempt from the fees imposed by this chapter:

(a) A person when, pursuant to the contract of sale, the bottled sweetened beverages or concentrate shall be shipped, and are shipped, to a point outside of this state by the distributor by means of either of the following:

(1) Facilities operated by the distributor.

(2) Delivery by the distributor to a carrier, customs broker, or forwarding agent, whether hired by the purchaser or not, for shipment to the out-of-state point.

(b) A person who is otherwise exempt from the taxation of that sale, use, or consumption under the Constitution of the United States, federal law or regulation, or the California Constitution.

104895.63. A distributor who has paid a fee, either directly to the state or to another distributor registered under this chapter and makes a subsequent distribution of bottled sweetened beverages or concentrate may claim a credit on the distributor's return for the period in which the subsequent sale or distribution occurs.

~~SECTION 1. Section 104655 of the Health and Safety Code is amended to read:~~

~~104655. Notwithstanding any other law, nothing shall operate to prohibit contributions to the program created pursuant to this article by organizations and commissions subject to Division 22 (commencing with Section 63901) of the Food and Agricultural Code.~~

O

Exhibit 7

General Assembly **File No. 104**

January Session, 2015 Substitute House Bill No. 5461

House of Representatives, March 19, 2015

The Committee on Children reported through REP. URBAN of the 43rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT IMPOSING A TAX ON SUGARY SOFT DRINKS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2015, and applicable to sales occurring on and after said date*) (a) For purposes of this section:

(1) "Consumer" means any person who purchases a soft drink for personal consumption;

(2) "Person" means "person" as defined in subdivision (1) of section 12-407 of the general statutes;

(3) "Retailer" means "retailer" as described in subdivision (12) of section 12-407 of the general statutes; and

(4) "Soft drink" means any carbonated nonalcoholic beverage that is intended for human consumption and contains any added caloric sweetener.

(b) A tax is hereby imposed on the purchase of any soft drink, at a rate of one cent per ounce of such soft drink. Said tax shall be in addition to any tax otherwise applicable to any such transaction. Said tax shall be paid by the consumer to the retailer and each retailer shall collect from the consumer the full amount of the tax imposed by this section.

(c) (1) The tax collected by a retailer pursuant to this section is due and payable to the Commissioner of Revenue Services monthly on or before the last day of the month next succeeding each monthly period.

(2) On or before the last day of the month following each monthly period a return for the preceding period shall be filed with the commissioner in such form as the commissioner may prescribe. Returns shall be signed by the person required to file the return or by such person's authorized agent but need not be verified by oath, provided a return required to be filed by a corporation shall be signed by an officer of such corporation.

(3) Any retailer who fails to pay the tax collected pursuant to this section within the time required shall pay a penalty of fifteen per cent of the tax or fifty dollars, whichever amount is greater, in addition to the tax, plus interest at the rate of one per cent per month or fraction thereof from the due date of such tax to the date of payment. Subject to the provisions of section 12-3a of the general statutes, the commissioner may waive all or any part of the penalties provided under this section when it is proven to the satisfaction of the commissioner that failure to pay any tax was due to reasonable cause and was not intentional or due to neglect.

(4) The commissioner, if he or she deems it necessary in order to ensure payment to or facilitate the collection by the state of the amount of taxes, may permit or require returns and payment of the amount of taxes for other than monthly periods.

(5) The commissioner for good cause may extend the time for making any return and paying any amount required to be paid under this section if a written request therefor is filed with the commissioner together with a tentative return that shall be accompanied by a payment of the tax, which shall be estimated in such tentative return, on or before the last day for filing the return. Any retailer to whom an extension is granted shall pay, in addition to the tax, interest at the rate of one per cent per month or fraction thereof from the date on which the tax would have been due without the extension until the date of payment.

(d) For calendar quarters ending on or after December 31, 2015, the Commissioner of Revenue Services shall deposit the amounts received by the state from the tax imposed under subsection (b) of this section into the soft drink tax account, established pursuant to section 2 of this act, except, after notification to and approval by the Secretary of the Office of Policy and Management, the commissioner may deduct and retain from such amounts received an amount equal to the costs of administering the provisions of this section.

(e) The administration of this section is vested in the Commissioner of Revenue Services. All forms necessary and proper for the enforcement of this section shall be prescribed and furnished by the commissioner. The commissioner may prescribe regulations, in accordance with chapter 54 of the general statutes, to carry into effect the provisions of this section, which regulations and subsequent rulings, when reasonably designed to carry out the intent and purpose of this section, shall be prima

facie evidence of its proper interpretation. The commissioner shall, at least annually, and more often in his or her discretion, publish for distribution all regulations adopted pursuant to this subsection and such rulings as appear to the commissioner to be of general interest.

(f) The provisions of sections 12-548 to 12-554, inclusive, of the general statutes and section 12-555a of the general statutes shall apply to the provisions of this section in the same manner and with the same force and effect as if the language of said sections 12-548 to 12-554, inclusive, and said section 12-555a had been incorporated in full into this section and had expressly referred to the tax under this section, except to the extent that any provision is inconsistent with a provision in this section.

Sec. 2. (NEW) (*Effective October 1, 2015*) There is established an account to be known as the "soft drink tax account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Department of Public Health for purposes of public education and outreach regarding obesity, including childhood obesity, heart disease and diabetes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2015, and applicable to sales occurring on and after said date*	New section
Sec. 2	*October 1, 2015*	New section

KID *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
Public Health, Dept.	GF - Revenue Gain	62.1 million	86.2 million
Department of Revenue Services	GF - Cost	507,000	247,000
Public Health, Dept.	GF - Cost	Up to 237,100	Up to 432,500
State Comptroller - Fringe Benefits[1]	GF - Cost	148,457	220,482

Municipal Impact: None

Explanation

The bill results in revenue gain of $62.1 million in FY 16 and $86.2 million in FY 17 by imposing a tax of one cent per fluid ounce on soft drinks, as defined by the bill. The bill creates a "soft drink tax account" and requires the Commissioner of Revenue Services to deposit the revenue generated by this tax into the account.

The bill results in a total cost of up to $892,557 in FY 16 and $899,982 in FY 17 to administer the tax and the funds generated by the tax.

Tax Administration

To administer the newly established tax, DRS would require one Tax Corrections Examiner ($55,000 for salary and $21,258 for fringe costs) to verify the accuracy of tax returns and three Revenue Examiners ($64,000 for salary and $24,736 for fringe costs per position) for audit and enforcement, resulting in a total annualized cost of $342,466 beginning in FY 16. This estimate is based on the administrative requirements for other state trust taxes.[2]

The DRS would also incur a one-time cost of approximately $260,000 in FY 16 for form development and printing, changes to the online Taxpayer Service Center (TSC) associated with electronic filing, and programming changes to the Department's Integrated Tax Administration System (ITAS). It is anticipated that DRS administrative costs will be funded through the revenue generated by the tax.

Department of Public Health Administration (DPH)

The bill requires DPH to use funds in the soda tax account for education and outreach regarding obesity, heart disease and diabetes. The implementation of the education and outreach is not defined by the bill.

It is expected that DPH will undertake the education and outreach required under the bill by establishing a community grant process. The agency may require additional staff to oversee the development of the Request for Proposal (RFP) process through which grants would be distributed. It is anticipated that funding for positions will be provided through the soda tax account. Additional staff may include one Nurse Consultant and three Health Program Associates (one for each program area: obesity, heart disease and diabetes) with a half year cost of approximately $137,100 in FY 16 and a full year cost of $323,500 in FY 17 would be required. In addition, the bill will require an additional cost of $52,991 in FY 16 and $125,016 in FY 17 for fringe benefits.

The agency may also require an Advisory Board to oversee the disbursement of grant funding which may result in an annual cost of $50,000 to $100,000.

It is anticipated that the majority of the remaining funding will be distributed as grants through an RFP process. This process will be used to identify community-based partnerships which will likely include municipalities, healthcare systems, non-profits, businesses, regional planning organizations and schools to provide research-based interventions to address obesity, diabetes and heart disease.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: UConn Rudd Center

Beverage Marketing Corporation

Massachusetts Community and Prevention Wellness Trust Fund

OLR Bill Analysis

sHB 5461

AN ACT IMPOSING A TAX ON SUGARY SOFT DRINKS.

SUMMARY:

This bill imposes a one cent per ounce tax on retail purchases of soft drinks (i.e., carbonated nonalcoholic beverages intended for human consumption that contain added caloric sweetener) and directs the revenue from the tax to DPH to fund obesity education and outreach programs. The bill requires the Department of Revenue

Services (DRS) commissioner to administer the tax, which applies in addition to other taxes on retail sales of soft drinks (i.e., sales and use taxes).

Under the bill, retailers must collect the tax from customers at the point of sale and remit it to DRS. The bill requires the DRS commissioner to deposit the revenue into the soft drink tax account, which the bill creates. With the Office of Policy and Management (OPM) secretary's approval, the DRS commissioner may deduct and retain administrative costs from the revenue.

Retailers who fail to remit the tax to DRS with a tax return on a monthly basis are subject to a penalty for each full or partial month that the tax remains unpaid.

EFFECTIVE DATE: October 1, 2015

TAX COLLECTION AND ADMINISTRATION

The bill requires (1) consumers to pay the tax to retailers and (2) retailers to collect it from consumers. Retailers must remit tax payments and file signed tax returns monthly, on a DRS-prescribed form. The returns must include the amount of tax due for the preceding month.

The commissioner may allow or require returns and tax payments more or less frequently if necessary to ensure payment or facilitate tax collection.

The commissioner may also extend the time for filing a return and paying the tax for good cause if the retailer applies for an extension, files a tentative return, and pays an estimated amount by the original due date. In addition to the tax, a retailer who receives an extension must pay 1% interest for each month or partial month on any amount that would have been due without the extension.

The commissioner must administer the tax and prescribe and furnish any forms necessary and proper for its enforcement. The bill allows the commissioner to prescribe regulations in accordance with the Uniform Administrative Procedures Act to administer the tax. The regulations and subsequent administrative rulings, when reasonably designed to carry out the bill's intent and purpose, are prima facie evidence of the bill's proper interpretation. The commissioner must publish annually, or more often at his discretion, all such regulations and any related ruling that appear to him to be of general interest.

TAX ENFORCEMENT

Under the bill, unpaid taxes are subject to a penalty of 15% of the unpaid amount or $50, whichever is greater, plus 1% interest for each full or partial month that the tax remains unpaid. The commissioner may waive all or part of the penalty if he is satisfied that the failure to pay was due to reasonable cause and was not intentional or due to neglect. The Penalty Review Commission must review and approve all penalty waivers over $1,000 in the same way it already approves waivers by the commissioner.

In addition, the bill applies the same enforcement, liability, and appeal process requirements established in statute for the admissions and dues taxes to the soft drink tax and requires them to be adapted accordingly. Under these provisions, the DRS commissioner can (1) assess tax deficiencies where necessary; (2) require the retailers to keep certain records and examine all of their records; and (3) administer oaths, subpoena witnesses, and receive testimony. The retailers can file for a refund for tax overpayments, request a hearing on the amount of taxes they are required to pay, and appeal the hearing decision if aggrieved. Lastly, an additional penalty may be imposed on retailers for willful violations or filing fraudulent returns.

SOFT DRINK TAX ACCOUNT

Under the bill, the soft drink tax account is a separate, nonlapsing account within the General Fund. The bill requires DPH to use the funds for obesity education and outreach, including child obesity, heart disease, and diabetes.

Quarterly, beginning by December 31, 2015, the DRS commissioner must deposit the tax proceeds into the soft drink tax account. The commissioner may deduct or retain administrative costs from the revenue before depositing it in the account, if he first notifies, and receives approval from, OPM.

COMMITTEE ACTION

Committee on Children

Joint Favorable Substitute

Yea 7 Nay 6 (03/05/2015)

TOP

[1] The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 38.65% of payroll in FY 16 and FY 17.

[2] Trust taxes in this context are those which are not paid directly by taxpayers but rather are collected and aggregated by an intermediary and remitted by that third party to the Department of Revenue Services. Other examples include the Sales and Use Tax and the Withholding portion of the Personal Income Tax.

Exhibit 8

S T A T E O F N E W Y O R K

2320--B

2015-2016 Regular Sessions

I N A S S E M B L Y

January 15, 2015

Introduced by M. of A. DINOWITZ, GOTTFRIED, MOSLEY, HIKIND, JAFFEE, SIMON, JOYNER, COLTON, GALEF, STECK, ARROYO, LINARES, SIMOTAS -- Multi-Sponsored by -- M. of A. BROOK-KRASNY, COOK, GLICK, PERRY -- read once and referred to the Committee on Consumer Affairs and Protection -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the agriculture and markets law, in relation to the labeling of sugar-sweetened beverages with warnings

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Short title. This act shall be known and may be cited as the "sugar-sweetened beverages safety warning act".

S 2. The agriculture and markets law is amended by adding a new section 204-e to read as follows:

S 204-E. LABELING OF SUGAR-SWEETENED BEVERAGES. 1. FOR THE PURPOSES OF THIS SECTION:

(A) "BEVERAGE CONTAINER" MEANS ANY SEALED OR UNSEALED CONTAINER REGARDLESS OF SIZE OR SHAPE INCLUDING, BUT NOT LIMITED TO, THOSE MADE OF GLASS, METAL, PAPER, PLASTIC, OR ANY OTHER MATERIAL OR COMBINATION OF MATERIALS THAT IS USED OR INTENDED TO BE USED TO HOLD A SUGAR-SWEETENED BEVERAGE FOR INDIVIDUAL SALE TO A CONSUMER.

(B) "BEVERAGE DISPENSING MACHINE" MEANS ANY DEVICE THAT MIXES CONCENTRATE WITH ANY ONE OR MORE OTHER INGREDIENTS, AND DISPENSES THE RESULTING MIXTURE INTO AN UNSEALED CONTAINER AS A READY-TO-DRINK BEVERAGE.

(C) "CALORIC SWEETENER" MEANS ANY SUBSTANCE CONTAINING CALORIES, SUITABLE FOR HUMAN CONSUMPTION, THAT HUMANS PERCEIVE AS SWEET AND SHALL INCLUDE, BUT NOT BE LIMITED TO, SUCROSE, FRUCTOSE, GLUCOSE, AND OTHER SUGARS AND FRUIT JUICE CONCENTRATES. "CALORIC" MEANS A SUBSTANCE THAT ADDS CALORIES TO THE DIET OF THE INDIVIDUAL WHO CONSUMES SUCH SUBSTANCE.

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD03793-04-5

(D) "CONCENTRATE" MEANS A SYRUP OR POWDER THAT IS USED OR INTENDED TO BE USED FOR MIXING, COMPOUNDING OR MAKING A SUGAR-SWEETENED BEVERAGE.

(E) "CONSUMER" MEANS AN INDIVIDUAL WHO PURCHASES A SUGAR-SWEETENED BEVERAGE FOR A PURPOSE OTHER THAN RESALE.

(F) "DISTRIBUTE" MEANS TO SELL OR OTHERWISE PROVIDE A PRODUCT TO ANY PERSON FOR RESALE.

(G) "MENU OR MENU BOARD" MEANS THE PRIMARY WRITING OF A PUBLIC FOOD SERVICE ESTABLISHMENT, AS DEFINED IN SUBDIVISION THREE OF SECTION THIRTEEN HUNDRED NINETY-NINE-N OF THE PUBLIC HEALTH LAW, FROM WHICH A CONSUMER MAKES AN ORDER SELECTION, WHICH CAN BE IN DIFFERENT FORMS SUCH AS BOOKLETS, PAMPHLETS, OR SINGLE SHEETS OF PAPER, AND CAN BE LOCATED INSIDE OR OUTSIDE OF SUCH PUBLIC FOOD SERVICE ESTABLISHMENT.

(H) "NATURAL FRUIT JUICE" MEANS THE ORIGINAL LIQUID RESULTING FROM THE PRESSING OF FRUIT, THE LIQUID RESULTING FROM THE RECONSTITUTION OF NATURAL FRUIT JUICE CONCENTRATE OR THE LIQUID RESULTING FROM THE RESTORATION OF WATER TO DEHYDRATED NATURAL FRUIT JUICE.

(I) "NATURAL VEGETABLE JUICE" MEANS THE ORIGINAL LIQUID RESULTING FROM THE PRESSING OF VEGETABLES, THE LIQUID RESULTING FROM THE RECONSTITUTION OF NATURAL VEGETABLE JUICE CONCENTRATE OR THE LIQUID RESULTING FROM THE RESTORATION OF WATER TO DEHYDRATED NATURAL VEGETABLE JUICE.

(J) "POWDER" MEANS A SOLID MIXTURE WITH ADDED CALORIC SWEETENER USED IN MAKING, MIXING OR COMPOUNDING A SUGAR-SWEETENED BEVERAGE BY MIXING SUCH SOLID MIXTURE WITH ANY ONE OR MORE OTHER INGREDIENTS INCLUDING, BUT NOT LIMITED TO, WATER, ICE, SYRUP, SIMPLE SYRUP, FRUITS, VEGETABLES, FRUIT JUICE, OR CARBONATION OR OTHER GAS.

(K) "PRINCIPAL DISPLAY PANEL" MEANS THE PART OF A LABEL THAT IS MOST LIKELY TO BE DISPLAYED, PRESENTED, SHOWN OR EXAMINED UNDER CUSTOMARY CONDITIONS OF DISPLAY FOR RETAIL SALE.

(L) "SEALED BEVERAGE CONTAINER" MEANS A BEVERAGE CONTAINER HOLDING A BEVERAGE THAT IS CLOSED OR SEALED BEFORE BEING OFFERED FOR SALE TO A CONSUMER.

(M) (1) "SUGAR-SWEETENED BEVERAGE" MEANS ANY SWEETENED NONALCOHOLIC BEVERAGE, CARBONATED OR NONCARBONATED, SOLD FOR HUMAN CONSUMPTION THAT HAS ADDED CALORIC SWEETENERS AND WHICH CONTAINS SEVENTY-FIVE CALORIES OR MORE PER TWELVE FLUID OUNCES.

(2) SUCH TERM SHALL NOT INCLUDE:

(A) ANY BEVERAGE CONTAINING ONE HUNDRED PERCENT NATURAL FRUIT JUICE OR NATURAL VEGETABLE JUICE WITH NO ADDED CALORIC SWEETENERS;

(B) ANY LIQUID PRODUCT MANUFACTURED FOR ANY OF THE FOLLOWING USES AND COMMONLY REFERRED TO AS A "DIETARY AID":

(I) AN ORAL NUTRITIONAL THERAPY FOR PERSONS WHO CANNOT ABSORB OR METABOLIZE DIETARY NUTRIENTS FROM FOOD OR BEVERAGES,

(II) A SOURCE OF NECESSARY NUTRITION USED AS A RESULT OF A MEDICAL CONDITION, OR

(III) AN ORAL ELECTROLYTE SOLUTION FOR INFANTS AND CHILDREN FORMULATED TO PREVENT DEHYDRATION DUE TO ILLNESS;

(C) ANY PRODUCT FOR CONSUMPTION BY INFANTS AND THAT IS COMMONLY REFERRED TO AS "INFANT FORMULA";

(D) ANY BEVERAGE WHOSE PRINCIPAL INGREDIENT BY WEIGHT IS MILK; OR

(E) ANY ALCOHOLIC BEVERAGE THAT IS SUBJECT TO REGULATION BY THE ALCOHOLIC BEVERAGE CONTROL LAW.

(N) "SYRUP" MEANS A LIQUID MIXTURE WITH ADDED CALORIC SWEETENER USED IN MAKING, MIXING OR COMPOUNDING A SUGAR-SWEETENED BEVERAGE BY MIXING SUCH LIQUID MIXTURE WITH ANY ONE OR MORE OTHER INGREDIENTS, INCLUDING, BUT NOT LIMITED TO, WATER, ICE, A POWDER, SIMPLE SYRUP, FRUITS, VEGETABLES, FRUIT JUICE, VEGETABLE JUICE, OR CARBONATION OR OTHER GAS.

(O) "UNSEALED BEVERAGE CONTAINER" MEANS A BEVERAGE CONTAINER INTO WHICH A BEVERAGE IS DISPENSED OR POURED AT THE PREMISES WHERE THE BEVERAGE IS PURCHASED INCLUDING, BUT NOT LIMITED TO, A CONTAINER FOR FOUNTAIN DRINKS.

2. (A) NO PERSON SHALL DISTRIBUTE, SELL OR OFFER FOR SALE A SUGAR-SWEETENED BEVERAGE IN A SEALED BEVERAGE CONTAINER UNLESS SUCH CONTAINER BEARS THE FOLLOWING SAFETY WARNING AND OTHERWISE MEETS ALL OF THE REQUIREMENTS OF THIS SUBDIVISION:

"SAFETY WARNING: DRINKING BEVERAGES WITH ADDED SUGAR CONTRIBUTES TO OBESITY, DIABETES AND TOOTH DECAY."

(B) THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE DISPLAYED IN A CLEAR AND CONSPICUOUS MANNER AND READILY LEGIBLE UNDER ORDINARY CONDITIONS ON THE PRINCIPAL DISPLAY PANEL OF THE SEALED BEVERAGE CONTAINER, SEPARATE AND APART FROM ALL OTHER INFORMATION, AND SHALL BE ON A CONTRASTING BACKGROUND. THE ENTIRE SAFETY WARNING SHALL APPEAR IN BOLD TYPE.

(C) IF THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION IS NOT PRINTED DIRECTLY ON THE BEVERAGE CONTAINER, THE SAFETY WARNING SHALL BE AFFIXED TO THE BEVERAGE CONTAINER IN SUCH A MANNER THAT IT CANNOT BE REMOVED WITHOUT THOROUGH APPLICATION OF WATER OR OTHER SOLVENTS.

(D) NO PERSON SHALL DISTRIBUTE, SELL OR OFFER FOR SALE A MULTIPACK OF SUGAR-SWEETENED BEVERAGES IN SEALED BEVERAGE CONTAINERS UNLESS THE MULTIPACK OF BEVERAGES BEARS THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION. THE SAFETY WARNING SHALL BE POSTED IN A CLEAR AND CONSPICUOUS MANNER ON THE PRINCIPAL DISPLAY PANEL AND ON AT LEAST ONE OTHER SIDE OF THE MULTIPACK, IN ADDITION TO BEING POSTED ON EACH INDIVIDUAL SEALED BEVERAGE CONTAINER.

(E) NO PERSON SHALL DISTRIBUTE, SELL OR OFFER FOR SALE A CONCENTRATE UNLESS THE PACKAGING OF THE CONCENTRATE, WHICH IS INTENDED FOR RETAIL SALE, BEARS THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION. THE SAFETY WARNING SHALL BE POSTED IN A CLEAR AND CONSPICUOUS MANNER ON THE PRINCIPAL DISPLAY PANEL OF THE PACKAGING OF THE CONCENTRATE.

(F) THIS SUBDIVISION SHALL NOT BE CONSTRUED TO REQUIRE THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION TO BE PLACED IMMEDIATELY PRECEDING ANY COMMON NAME OR PRIMARY PRODUCT DESCRIPTOR.

3. (A) EVERY PERSON WHO OWNS, LEASES OR OTHERWISE CONTROLS THE PREMISES WHERE A VENDING MACHINE OR BEVERAGE DISPENSING MACHINE IS LOCATED, OR WHERE A SUGAR-SWEETENED BEVERAGE IS SOLD IN AN UNSEALED BEVERAGE CONTAINER, SHALL PLACE OR CAUSE TO BE PLACED, A SAFETY WARNING IN EACH OF THE FOLLOWING LOCATIONS:

(1) ON THE EXTERIOR OF ANY VENDING MACHINE THAT INCLUDES A SUGAR-SWEETENED BEVERAGE FOR SALE;

(2) ON THE EXTERIOR OF ANY BEVERAGE DISPENSING MACHINE USED BY A CONSUMER TO DISPENSE A SUGAR-SWEETENED BEVERAGE THROUGH SELF-SERVICE; AND

(3) AT THE POINT-OF-PURCHASE, WHICH MAY INCLUDE THE MENU OR MENU BOARD, WHERE ANY CONSUMER PURCHASES A SUGAR-SWEETENED BEVERAGE IN AN UNSEALED BEVERAGE CONTAINER, WHEN THE UNSEALED BEVERAGE CONTAINER IS FILLED BY AN EMPLOYEE OF A FOOD ESTABLISHMENT RATHER THAN THE CONSUMER; PROVIDED, HOWEVER, THIS SUBPARAGRAPH SHALL NOT APPLY UNLESS THE PREMISES WHERE A BEVERAGE DISPENSING MACHINE IS LOCATED, OR WHERE THE SUGAR-SWEETENED BEVERAGE IS SOLD IN AN UNSEALED BEVERAGE CONTAINER IS PART OF A NETWORK OF SUBSIDIARIES, AFFILIATES OR OTHER MEMBER STORES,

UNDER DIRECT OR INDIRECT COMMON CONTROL, WITH THREE OR MORE STORES LOCATED IN NEW YORK.

(B) THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION SHALL CONTAIN THE FOLLOWING LANGUAGE:

"SAFETY WARNING: DRINKING BEVERAGES WITH ADDED SUGAR CONTRIBUTES TO OBESITY, DIABETES AND TOOTH DECAY."

(C) THE SAFETY WARNING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE DISPLAYED IN A CLEAR AND CONSPICUOUS MANNER AND READILY LEGIBLE UNDER ORDINARY CONDITIONS, SEPARATE AND APART FROM ALL OTHER INFORMATION, AND SHALL BE ON A CONTRASTING BACKGROUND. THE ENTIRE SAFETY WARNING SHALL APPEAR IN BOLD TYPE.

4. (A) WHENEVER IT SHALL APPEAR THAT THERE HAS BEEN A VIOLATION OF THIS SECTION, AN APPLICATION MAY BE MADE BY THE ATTORNEY GENERAL IN THE NAME OF THE PEOPLE OF THE STATE OF NEW YORK TO A COURT OR JUSTICE HAVING JURISDICTION BY A SPECIAL PROCEEDING TO ISSUE AN INJUNCTION, AND UPON NOTICE TO THE DEFENDANT OF NOT LESS THAN FIVE DAYS, TO ENJOIN AND RESTRAIN THE CONTINUANCE OF SUCH VIOLATION; AND IF IT SHALL APPEAR TO THE SATISFACTION OF THE COURT OR JUSTICE THAT THE DEFENDANT HAS, IN FACT, VIOLATED THIS ARTICLE, AN INJUNCTION MAY BE ISSUED BY SUCH COURT OR JUSTICE, ENJOINING AND RESTRAINING ANY FURTHER VIOLATION, WITHOUT REQUIRING PROOF THAT ANY PERSON HAS, IN FACT, BEEN INJURED OR DAMAGED THEREBY. IN ANY SUCH PROCEEDING, THE COURT MAY MAKE ALLOWANCES TO THE ATTORNEY GENERAL AS PROVIDED IN PARAGRAPH SIX OF SUBDIVISION (A) OF SECTION EIGHTY-THREE HUNDRED THREE OF THE CIVIL PRACTICE LAW AND RULES, AND DIRECT RESTITUTION. WHENEVER THE COURT SHALL DETERMINE THAT A VIOLATION OF THIS ARTICLE HAS OCCURRED, THE COURT MAY IMPOSE A CIVIL PENALTY OF NOT LESS THAN FIFTY DOLLARS NOR MORE THAN FIVE HUNDRED DOLLARS FOR EACH SUCH VIOLATION. IN CONNECTION WITH ANY SUCH PROPOSED APPLICATION, THE ATTORNEY GENERAL IS AUTHORIZED TO TAKE PROOF AND MAKE A DETERMINATION OF THE RELEVANT FACTS AND TO ISSUE SUBPOENAS IN ACCORDANCE WITH THE CIVIL PRACTICE LAW AND RULES.

(B) THE PROVISIONS OF THIS SECTION MAY BE ENFORCED CONCURRENTLY BY THE DIRECTOR OF A MUNICIPAL CONSUMER AFFAIRS OFFICE, OR BY THE TOWN ATTORNEY, CITY CORPORATION COUNSEL, OR OTHER LAWFUL DESIGNEE OF A MUNICIPALITY OR LOCAL GOVERNMENT, AND ALL MONEYS COLLECTED UNDER THIS SECTION SHALL BE RETAINED BY SUCH MUNICIPALITY OR LOCAL GOVERNMENT.

5. A RETAILER SHALL NOT BE SUBJECT TO THE PENALTIES UNDER THIS SECTION UNLESS: (A) THE RETAILER IS THE MANUFACTURER OF THE SUGAR-SWEETENED BEVERAGE, THE PACKAGER OF A MULTIPACK OF SUGAR-SWEETENED BEVERAGES IN SEALED BEVERAGE CONTAINERS, OR THE MANUFACTURER OF A CONCENTRATE AND SELLS THE SUGAR-SWEETENED BEVERAGE, MULTIPACK OF SUGAR-SWEETENED BEVERAGES, OR CONCENTRATE UNDER A BRAND IT OWNS; OR (B) THE RETAILER'S FAILURE TO LABEL WAS KNOWING AND WILLFUL.

S 3. Severability clause. If any provision of this act or its application to any person, legal entity, or circumstance is held invalid, the remainder of the act or the application of the provision to other persons, legal entities or circumstances shall not be affected.

S 4. This act shall take effect one year after it shall have become a law.

Exhibit 9

H-3683.1

HOUSE BILL 2798

State of Washington 64th Legislature 2016 Regular Session

By Representatives Robinson, Walkinshaw, Jinkins, Riccelli, Goodman, Ormsby, and Tarleton

Read first time 01/20/16. Referred to Committee on Health Care & Wellness.

AN ACT Relating to mitigating the adverse impacts of sugar-sweetened beverages; adding a new chapter to Title 70 RCW; prescribing penalties; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** SHORT TITLE. This chapter may be known and cited as the sugar-sweetened beverages safety warning act.

NEW SECTION. **Sec. 2.** FINDINGS—INTENT. (1) The legislature finds that:

(a) In the United States, obesity and overweight rates have increased dramatically over the past thirty years. In Washington, over sixty-one percent of all adults are overweight, with one-quarter of all adults being obese. One-third of the nation's children are either obese or overweight. Calorie intake by American adults has increased by thirty percent in the past thirty years, with children's calorie intake also increasing. This epidemic of obese and overweight individuals has resulted in approximately one hundred ninety billion dollars in health care costs nationally. Overweight children and adults face an increased risk of diabetes, heart disease, stroke, high blood pressure, certain types of cancer, arthritis, asthma, and tooth decay. Research shows that sugar-sweetened beverage consumption

is associated with long-term weight gain and increased obesity rates among children, adolescents, and adults.

(b) Evidence shows that consumption of sugar-sweetened beverages is consistently associated with an increased risk of diabetes and tooth decay. Type 2 diabetes is increasing among children; almost one-quarter of teens have either diabetes or prediabetes. Tooth decay is the most common chronic childhood disease. One-fourth of children in the United States aged two to five years and half of children aged twelve to nineteen years have experienced tooth decay. Children who excessively consume sugar-sweetened beverages are at an increased risk of dental caries, which can lead to pain, infection, tooth loss, and, in rare cases, death.

(c) Sugar-sweetened beverages, such as sweetened fruit juices, fruit drinks, carbonated soft drinks, sports drinks, energy drinks, and flavored milks, offer little or no nutritional value. A twenty ounce soft drink contains almost sixteen teaspoons of sugar, yet the American heart association recommends that Americans consume no more than six to nine teaspoons of sugar per day. Evidence demonstrates that sugar-sweetened beverages have become a more significant part of Americans' diets. Each day, nearly half of the people in the United States over the age of two consume at least one sugar-sweetened beverage, and one-quarter drink at least two hundred calories from sugar-sweetened beverages. Almost half of sugar-sweetened beverage calories consumed by Americans are consumed outside the home.

(2) It is the intent of the legislature to protect consumers and promote informed purchasing decisions by requiring a warning about the dangerous health effects of excessive consumption of sugar-sweetened beverages.

NEW SECTION. **Sec. 3.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Beverage dispensing machine" means any device that dispenses a sugar-sweetened beverage into an unsealed container as a ready-to-drink beverage.

(2) "Caloric sweetener" means any substance containing calories, suitable for human consumption, that humans perceive as sweet, and includes, but is not limited to, sucrose, fructose, glucose, other sugars, and fruit juice concentrate. "Caloric sweetener" does not include noncaloric sweeteners.

(3) "Container" means any receptacle that is intended or used to hold a sugar-sweetened beverage for individual sale to a consumer, such as a bottle, box, can, cup, glass, or pouch.

(4) "Department" means the department of health, and any agency or person lawfully designated by the department to enforce or implement the provisions of this chapter.

(5) "Distribute" means to sell or otherwise provide a product to any person for resale to a consumer in the ordinary course of business within this state.

(6) "Nonalcoholic beverage" means any beverage that contains less than one-half of one percent alcohol per volume.

(7) "Noncaloric sweetener" means any substance that contains fewer than five calories per serving, suitable for human consumption, that humans perceive as sweet, and includes, but is not limited to, aspartame, saccharin, stevia, and sucralose.

(8) "Person" means any natural person, partnership, cooperative association, limited liability company, corporation, personal representative, receiver, trustee, assignee, or other legal entity.

(9) "Powder" means any solid mixture of ingredients that contains caloric sweetener, which is intended to be used in making, mixing, or compounding a sugar-sweetened beverage by combining the powder with any one or more other ingredients.

(10) "Sale" or "sell" means any distribution or transfer for a business purpose, whether or not consideration is received.

(11) "Sealed container" means a container holding a beverage, which is closed or sealed before a retailer obtains the container for resale.

(12) "Sugar-sweetened beverage" means any nonalcoholic beverage, carbonated or noncarbonated, intended for human consumption that has added caloric sweeteners and contains seventy-five calories or more per twelve fluid ounces. "Sugar-sweetened beverage" does not include:

(a) A beverage consisting of one hundred percent natural fruit or vegetable juice with no added caloric sweetener. For purposes of this subsection (12)(a), "natural fruit juice" and "natural vegetable juice" mean the original liquid resulting from the pressing of fruits or vegetables, or the liquid resulting from the dilution of dehydrated or concentrated natural fruit juice or natural vegetable juice;

(b) A dietary aid, which means a liquid product manufactured for use as:

(i) An oral nutritional therapy for persons who cannot absorb or metabolize dietary nutrients from food or beverages;

(ii) A source of necessary nutrition used as a result of a medical condition; or

(iii) An oral electrolyte solution for infants and children formulated to prevent dehydration due to illness;

(c) Infant formula; and

(d) Sweetened medication.

(13) "Syrup" means any liquid mixture of ingredients that contains caloric sweetener, which is intended to be used in making, mixing, or compounding a sugar-sweetened beverage by combining the syrup with any one or more other ingredients.

(14) "Unsealed container" means a container into which a beverage is dispensed or poured at the business premises where the beverage is purchased, and includes, but is not limited to, glasses, cups, and all containers for fountain drinks.

NEW SECTION. **Sec. 4.** SAFETY WARNING REQUIRED FOR SEALED CONTAINERS. (1) A person may not distribute, sell, or offer for sale a sugar-sweetened beverage in a sealed container unless the container bears the following safety warning and otherwise meets the requirements of this section: "STATE OF WASHINGTON SAFETY WARNING: Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth decay."

(2) The safety warning required by this section must be prominently displayed and readily legible under normal conditions, separate and apart from all other information, and must be on a contrasting background.

(3) A person may not distribute, sell, or offer for sale a multipack of sugar-sweetened beverages in sealed containers unless the multipack of beverages bears the safety warning required by subsection (1) of this section. The safety warning must be posted conspicuously on at least two sides of the multipack, in addition to being posted on each individual sealed container.

(4) A person may not distribute, sell, or offer for sale a syrup or powder in packaging that is intended for retail sale in this state unless the packaging of the syrup or powder bears the safety warning required by subsection (1) of this section. The safety warning must be posted conspicuously on the front of the packaging of the syrup or powder.

(5) The department shall adopt rules necessary to administer and implement the requirements of this section, including rules to establish the size, font, colors, placement, and durability of the safety warning. Notwithstanding subsection (1) of this section, the department shall periodically adopt rules to create alternative language for the safety warning required by this section and may require that the alternative language be posted in lieu of the safety warning set forth in subsection (1) of this section.

NEW SECTION. **Sec. 5.** VENDING MACHINES—BEVERAGE DISPENSING MACHINES—POINT OF SALE—SAFETY WARNING REQUIRED. (1) Every person who owns, leases, or otherwise legally controls the premises where a vending machine or beverage dispensing machine is located, or where a sugar-sweetened beverage is sold in an unsealed container, must place, or cause to be placed, a safety warning in each of the following locations:

(a) On the exterior of any vending machine that includes a sugar-sweetened beverage for sale;

(b) On the exterior of any beverage dispensing machine used by a consumer to dispense a sugar-sweetened beverage through self-service; and

(c) At the point on the premises where any consumer would normally order or request a sugar-sweetened beverage in an unsealed container, when the unsealed container is filled by the person's employee or agent rather than the consumer.

(2) The safety warning required by this section must use the warning language prescribed by section 4(1) of this act.

(3) The safety warning required by this section must be prominently displayed and readily legible under normal conditions, separate and apart from all other information, and must be on a contrasting background.

(4) The department shall adopt rules to establish the specific guidelines for the safety warning required by this section, including regulations to establish the size, font, colors, and placement of the safety warning. Notwithstanding subsection (2) of this section, the department shall periodically adopt rules to create alternative language for the safety warning required by this section and may require that the alternative language be posted in lieu of the safety warning set forth in subsection (2) of this section.

NEW SECTION. **Sec. 6.** OUTREACH AND EDUCATION. The department shall develop and conduct a retailer outreach and education program designed to inform businesses about the requirements of this chapter and provide retailers with examples of compliant safety warnings. Nothing in this section creates a right of action in any person against the state or its agents.

NEW SECTION. **Sec. 7.** EVALUATION. The department shall develop criteria and components for an independent evaluation to assess the impact of the safety warnings required by this chapter on consumer purchasing and consumption patterns, and rates of diabetes and obesity.

NEW SECTION. **Sec. 8.** ENFORCEMENT AND PENALTIES. (1) Each container, multipack, and package of syrup or powder distributed, sold, or offered for sale in violation of this chapter constitutes a separate violation. Each day of a continuing violation of this chapter constitutes a separate violation.

(2) The department shall enforce the provisions of this chapter and adopt any rules necessary to implement this chapter.

(3) The department has the primary responsibility for inspections for violations of this chapter.

(4) Actions pursuant to this section may be brought by the attorney general in the name of the people of the state of Washington.

(5) Any person who violates any of the requirements of this chapter may be enjoined in any court of competent jurisdiction.

(6) Any person who has violated any of the requirements of this chapter is liable for a civil penalty not to exceed two thousand five hundred dollars per day for each violation, in addition to any other penalty established by law. That civil penalty may be assessed and recovered in a civil action brought in any court of competent jurisdiction.

(7) This chapter may also be enforced through an administrative proceeding that complies with chapter 34.05 RCW, the administrative procedure act.

NEW SECTION. **Sec. 9.** PRESERVATION OF LOCAL AUTHORITY. Nothing in this chapter preempts or prohibits adoption and implementation of any policy related to sugar-sweetened beverages by a municipal

government or political subdivision of the state, except for any policy requiring a safety warning on sugar-sweetened beverage containers that is inconsistent with this act. A policy may not be deemed inconsistent with this act if it affords greater consumer protection than this act.

NEW SECTION. **Sec. 10.** Sections 1 through 9 and 12 of this act constitute a new chapter in Title 70 RCW.

NEW SECTION. **Sec. 11.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 12.** This act takes effect July 1, 2017.

--- END ---

Exhibit 10

News (Http://Www.Philly.Com/News)

Philly: Soda tax revenue to fall short

Updated: JUNE 13, 2017 — 7:34 PM EDT

(http://philly.reprintmint.com/006-default.html?src=http%3A%2F%2Fmedia.philly.com%2Fimages%2F250*250%2Fdixon-30656-f-wp-content-uploads-2017-06-556777_89e9e00ecb361d0-1200x800.jpg&verification=http%3A%2F%2Fmedia.philly.com%2Fimages%2Fdixon-30656-f-wp-content-uploads-2017-06-556777_89e9e00ecb361d0-1200x800.jpg&source=006&title=PSODATAX24-a&caption=Philadelphia Mayor Jim Kenney speaks to the media earlier this year.) Buy Photo

MICHAEL BRYANT / STAFF PHOTOGRAPHER

Philadelphia Mayor Jim Kenney speaks to the media earlier this year. 02/23/2017 MICHAEL BRYANT / Staff Photographer

by **Julia Terruso**, Staff Writer @JuliaTerruso (http://twitter.com/JuliaTerruso) | jterruso@phillynews.com (mailto:jterruso@phillynews.com)

The city will lower its projections for beverage tax revenue this fiscal year, saying the tax will bring in less than had been anticipated.

RELATED COVERAGE

- **What soda-tax showdown in Chicago area might mean for Philly** (http://www.philly.com/philly/news/soda-tax-repeal-chicago-philadelphia-20171009.html)
- **Philly NAACP leader goes from soda-tax supporter to paid consultant for Mayor Kenney** (http://www.philly.com/philly/news/politics/kenney-rodney-muhammad-philly-naacp-leader-soda-tax-consultant-kale-ciancaglini-20171006.html)
- **Soda, pre-K, beer, and the latest in the fight over Philly beverage tax** (http://www.philly.com/philly/news/soda-pre-k-beer-and-the-latest-in-the-fight-over-philly-beverage-tax-20170901.html)

The 1.5-cent-per-ounce tax on sweetened beverages, in effect since January, has brought in $25.6 million, but will fall short of a projected $46.2 million for fiscal year 2017, which ends June 30. While the size of the shortage is unclear, to hit its projected target, the city would need to collect $20 million from May through June, a near-impossibility, the Kenney administration recognized, given that the highest monthly revenue so far has been $7 million in March.

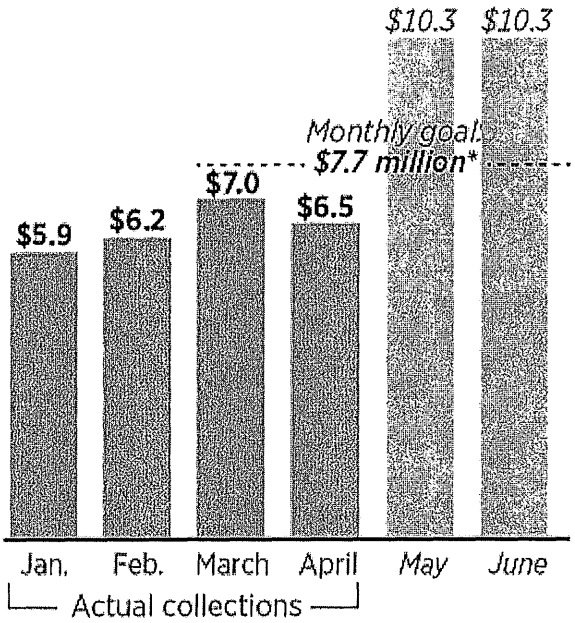
As first reported by Billy Penn on Tuesday (https://billypenn.com/2017/06/13/philly-admits-it-will-earn-less-money-from-the-soda-tax-than-it-planned/), the mayor's office said it would lower its revenue projections when it presents a revised five-year plan later this month, but it will keep in place its prediction for fiscal year 2018.

Soda Tax Collections Are Coming Up Flat

City officials expect collections for its tax on sugar-sweetened beverages will fall short of the goal for fiscal 2017,

City spokeswoman Lauren Hitt said the budget office still believes it will hit its fiscal year 2018 projection of $92 million for the tax because the levy is only four months old and the city is still "working out the kinks."

which ends in June. To reach its target, the city would need to collect an average of **$10.3 million** for May and June (including accruals), a figure well above its average monthly goal of $7.7 million, which has not yet been met.



*The monthly goal was set at $7.7 million, beginning in March. Goals for the first two months of the year were lower: $2.3 million in January and $5.4 million in February. The city's fiscal 2017 goal of **$46.2 million** includes a $7.7 million accrual.

SOURCE: Philadelphia Department of Revenue

Staff Graphic

"We're not concerned. Out of the four months of collection, three were solid and very much where we expected to be, so we still expect to hit our long-term projections," she said.

Members of the Ax the Tax beverage coalition, backed by the American Beverage Association, called the news early evidence that the tax won't bring in enough to support the programs it funds. "Reality is finally catching up with the mayor's inflated projections," Dave McCorkle, president and chief executive officer of the Pennsylvania Food Merchants Association, said in a statement. "The city has yet to achieve its full collections target and is once again moving the goalposts."

City Controller Alan Butkovitz was skeptical, too, saying the deficit could create a "multimillion-dollar burden" for taxpayers, a concern Mayor Kenney's office was quick to dismiss as overblown and politically motivated.

Butkovitz, who has publicly criticized the tax, sent a letter to the mayor's office raising concerns over the shortfall (http://www.philadelphiacontroller.org/media/press-releases/controller-butkovitz-raises-concerns-over-beverage-tax-shortfalls) and asking the city why, given the gap, it assumes revenue will bounce back in the next fiscal year. The city projected that it would need to bring in an average of $7.7 million per month, but has yet to hit that target in its first four months.

"The city appears to be creating a short-term and a long-term deficit through the beverage tax by not budgeting with true and accurate figures," Butkovitz said.

Hitt accused Butkovitz of weighing in for political reasons. Butkovitz opposed the tax during his recent reelection campaign in which he was defeated by Rebecca Rhynhart, a former city budget director. Butkovitz has also met with members of the American Beverage Association (http://www.philly.com/philly/news/politics/city/Could-a-2019-bid-for-mayor-and-a-Super-PAC-be-in-Butkovitzs-future.html) this spring.

"The controller has been very open about the fact that he intends to use his remaining months in public service to partner with the beverage industry to paint the tax in a negative light and to advance his own political career," Hitt said.

Butkovitz said the city was using politics to deflect attention from the numbers. "They admit they're not reaching their number, and their response is to say, 'Look over there,' " he said. "There's a shortfall. but we're going to stick to our initial faulty assumptions? That's not the way things are done."

In a letter responding to Butkovitz sent on Tuesday, city finance director Rob Dubow said the city was sticking with its long-term projections because early months were always expected to come in on the lower side of the $7.7 million – on average – the tax needs to bring in per month. He said inventory purchased just before the tax went into effect might have driven down revenue. Dubow also said the city expects seasonality – months when drinks tend to sell better – to make up for some of the slower months.

The city brought in $5.9 million in January, $6.2 million in February, $7 million in March and early returns show $6.5 million in April.

The city recently added 10 additional enforcement staff at an annual cost of $310,090 to continue spreading information on how businesses can register and remit payment.

The tax primarily funds a pre-K program and a city-wide rebuilding of parks and recreation centers, though spending on both programs will be halted while a panel of judges considers the legality of the tax in court (http://www.philly.com/philly/news/politics/State-appellate-panel-grills-both-sides-on-soda-tax.html).

MORE COVERAGE

Even with sweetened-drinks tax, Philly's food and beverage wages rose in 1st-quarter 2017

Jun 12 - 12:12 PM
(http://www.philly.com/philly/blogs/inq-phillydeals/even-with-soda-tax-phillys-food-and-beverage-wages-rose-in-1st-quarter-2017-20170612.html)

Could a 2019 bid for mayor (and a Super PAC) be in Butkovitz's future?

May 26 - 4:47 PM
(http://www.philly.com/philly/news/politics/city/Could-a-2019-bid-for-mayor-and-a-Super-PAC-be-in-Butkovitzs-future.html)

Seattle passes tax on sugary drinks

Jun 6 - 11:24 AM
(http://www.philly.com/philly/business/seattle-passes-tax-on-sugary-drinks-20170606.html)

Published: June 13, 2017 — 7:38 PM EDT

Exhibit 11

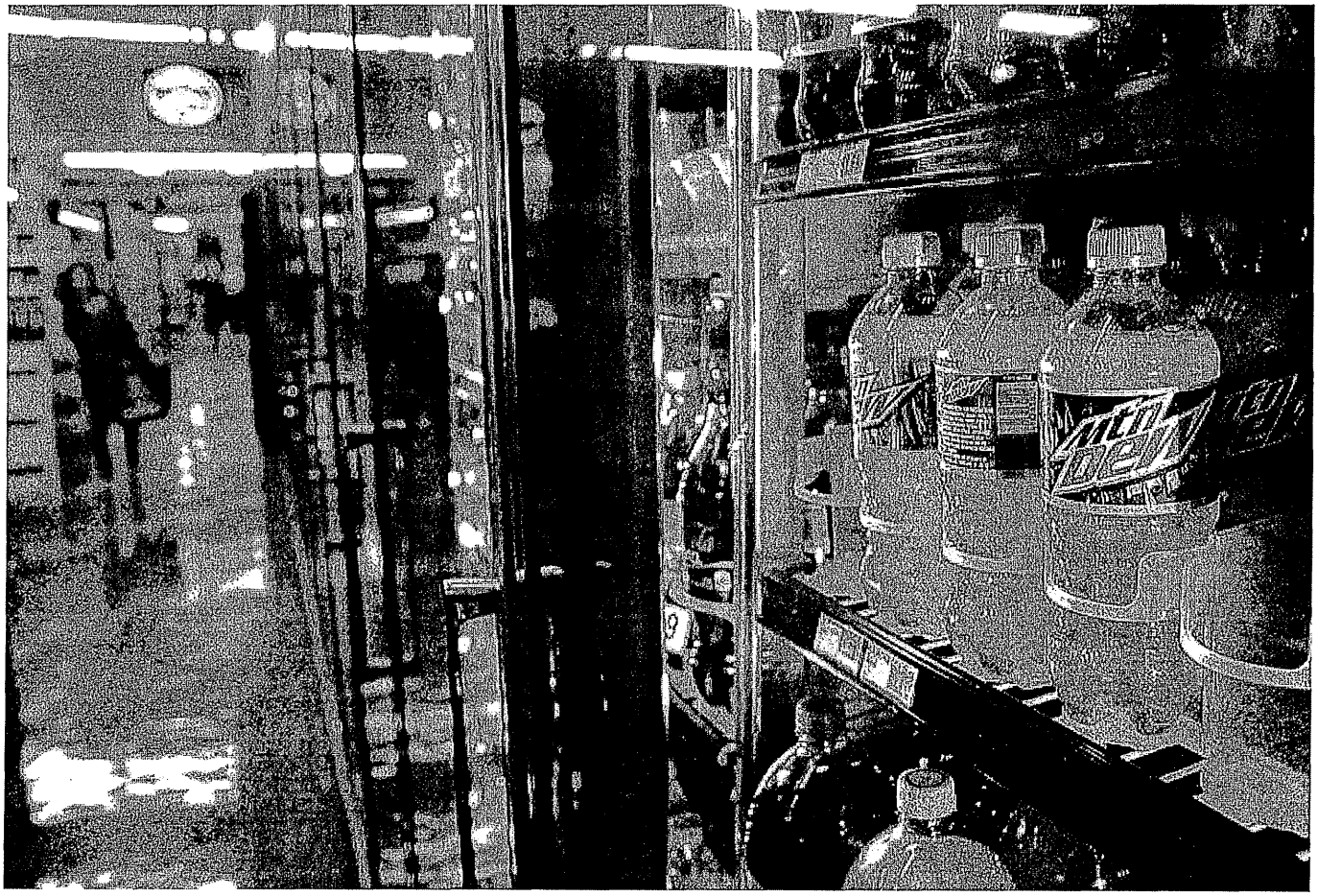
the **salt**

FOOD FOR THOUGHT

How Did Berkeley Pass A Soda Tax? Bloomberg's Cash Didn't Hurt

November 5, 2014 · 5:50 PM ET

ALLISON AUBREY



Berkeley's efforts to pass a penny-per-ounce tax on sugary drinks faced opposition with deep pockets — but it also got sizable cash infusions from some big-name donors.

Justin Sullivan/Getty Images

It's no secret that the American Beverage Association spent a lot of money to defeat soda tax initiatives in California this election season.

As local media reported, ABA ads blanketed a Berkeley train station in the weeks leading up to Election Day. They were "plastered on the walls across from the trains, pinned to spaces near the ticket machine, and laid out on the floor of the station," according to Berkeleyside.com.

So the grass-roots coalition in Berkeley, Calif., that succeeded in getting 75 percent of voters to support the first-of-its-kind soda tax in the nation is celebrating.

"It was a thrilling campaign, and I think it will be the first of many," Larry Tramutola, a consultant to the coalition, said during a post-election debrief Wednesday.

The measure imposes a penny-per-ounce tax on most sugar-sweetened beverages. The coalition says it studied how the American Beverage Association worked to defeat a similar sugar-sweetened-beverage tax initiative in Richmond, Calif., in 2012.

"Knowing the opposition, and knowing what they were likely to do, was important," Tramutola says.

One thing that most likely helped the Berkeley coalition succeed: sizable infusions of cash.

The American Heart Association and the Center for Science in the Public Interest put their support behind the effort. And perhaps the most notable donor: Michael Bloomberg — who, during his tenure as the mayor of New York City, pushed for limits

on big, sugary drinks — stepped in during the final weeks of this election season with donations. **UPDATE: The latest reports suggest Bloomberg gave more than $650,000 during the course of the campaign.**

The Bloomberg cash infusions helped pay for television ads that ran on local, San Francisco-area broadcasts during the World Series.

During a conference call Wednesday, Howard Wolfson, senior adviser to Michael Bloomberg, said, "Last night was a huge defeat for Big Soda and a big victory for public health. The results will surely encourage other municipalities across the nation to pursue similar initiatives to fight obesity and diabetes."

Wolfson also indicated that Bloomberg may be willing to support organizers in other towns or municipalities that want to rally behind a soda tax in their communities. "We look for a strong, locally led effort," Wolfson explains.

He says the movement can't be led from the top down; it's got to be bottom up. So, he says, "we stand ready to assess and assist other local efforts in the coming election cycle."

Following its defeat in the Berkeley soda tax battle, the American Beverage Association released a statement on its website saying, "People don't support taxes and bans on common grocery items, like soft drinks."

And the ABA says the debate should move on from taxes and bans "onto real solutions." Leading beverage companies, the ABA says, have "set a goal to reduce beverage calories consumed per person by 20 percent by 2025."

soda tax soda

More Stories From NPR

Exhibit 12

Cook County retailers cheer soda tax repeal: 'This was a nightmare'

Shopper Charles Joaquin selects some drinks Oct. 11, 2017, at Fairplay Foods in Chicago's Back of the Yards neighborhood, moments after the Cook County sweetened beverage tax was repealed. (Phil Velasquez / Chicago Tribune)

By **Greg Trotter and Becky Yerak**
Chicago Tribune

OCTOBER 11, 2017, 4:00 PM

Daniel Stein estimates Cook County's sweetened beverage tax has cost his vending machine company about $75,000 so far, a figure that doesn't even include lost sales.

The Dec. 1 repeal of the penny-per-ounce tax on sugar and artificially sweetened beverages likely will cost him more before it's all over. He'll again have to send technicians to his 850 or so vending machines in Cook County to adjust the price of products. But Stein feels only happiness and relief that the tax that's consumed his life for months will soon go away.

"I don't want to sound judgy but this whole thing has been kind of unfortunate. I'm just glad it's almost over. ... Closure is good," said Stein, owner of Northbrook-based Mark Vend.

Wednesday's repeal vote was a resounding victory for the beverage industry, powered by giant corporations like the Coca-Cola Co. and PepsiCo, that spent millions fighting the unpopular tax. But Cook County retailers and restaurants, many of whom joined forces with Big Soda in opposition, also celebrated the win after seeing sales dwindle and customers stray across county lines since the tax was implemented Aug. 2.

"Obviously, our members are very pleased," said Rob Karr, president and CEO of the Illinois Retail Merchants Association. "Now the hard work for retailers begins — to win back shoppers who took their business elsewhere across county lines."

The short-term impact of the tax was felt by stores both big and small.

Costco's nine Cook County locations saw a 34 percent decline in sales of beverages affected by the tax, said John McKay, chief operating officer of Costco's northern division.

The chain saw a corresponding increase of 38 percent in sales of sweetened beverages in its nine stores just outside Cook County, McKay said.

"You're displacing shopping from one area, you're creating congestion in another and it's just counterproductive," McKay said.

At Fairplay Foods in suburban Worth, sweetened beverage sales were down about 47 percent, said Rosie Regas, co-owner of the independent chain. Fairplay's three Chicago stores saw a smaller but still significant drop in sweetened drink sales of around 27 percent.

Regas said she didn't blame customers for shopping elsewhere; she did the same, driving from her home in Orland Park into Will County to avoid the tax.

"This was a nightmare. I get it — the county needs money. But find another way," Regas said.

And the hospitality industry already has been feeling the cumulative burden of various taxes, said Sam Toia, CEO of the Illinois Restaurant Association. The sweetened beverage tax did nothing but further diminish already thin profit margins, he said.

There are similar sweetened beverage taxes in other jurisdictions in the U.S. — such as Philadelphia and Berkeley, Calif. — but Cook County's tax was unique in how mired in controversy it was leading up to and during its implementation, said John Cawley, professor of policy analysis and management at Cornell University.

At one point, the county said the the tax would apply to purchases made with federal food stamp benefits, then reversed course after receiving further guidance from the state, Cawley noted. Such administrative gaffes created genuine confusion and the well-funded opposition benefited, he said.

"There were constant challenges that may have contributed to this fatigue. It's not just on the county government. Millions were spent by the beverage industry and the Can the Tax Coalition to engineer this result," Cawley said.

The sweetened beverage tax also triggered numerous lawsuits, some of which are still playing out in court. The Illinois Retail Merchants Association sued the county to get the tax thrown out days before it was to take effect. The court granted a restraining order to keep the tax from being imposed. Later, however, the court allowed the tax to move forward. The merchants appealed that decision.

"The appeal of the circuit court judge's dismissal is still pending," said lawyer David Ruskin, who is representing the merchants.

Several retailers have been sued for allegedly misapplying the tax. A Schaumburg man is suing Walgreens for allegedly wrongly charging the tax on unsweetened sparkling water. The case, which seeks class-action status, is still pending, said Elizabeth Fegan, the lawyer for Vincent De Leon.

"Walgreens has filed a motion to dismiss, which we plan to oppose," Fegan said.

Cawley, the Cornell professor, said there is a legitimate policy argument for taxing sugary food and beverages linked to obesity and diabetes because those conditions drive up health care costs for all.

Groups like the American Heart Association, the Illinois Public Health Institute, the World Health Organization and the Center for Science in the Public Interest have touted the public health benefit of taxing sugar-sweetened beverages.

But that argument was watered down in Cook County, where the tax also included artificially sweetened beverages and also didn't apply to food stamp purchases.

"(Taxpayers) will continue to cover the rising costs of treating the chronic diseases caused by drinking too many sugary beverages while also seeing cuts to health care services for our most vulnerable communities," Elissa Bassler, CEO of the Illinois Public Health Institute, said in a statement.

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Exhibit 13

Vote to repeal Cook County soda tax delayed a month, as ad campaigns continue

A boisterous rally outside the Thompson Center took aim at Cook County Board President Toni Preckwinkle and her push for a Cook County soda pop tax. Preckwinkle countered at a more sedate news conference at Provident Hospital. (Lou Foglia / Chicago Tribune)

By **Hal Dardick and John Byrne**
Chicago Tribune

SEPTEMBER 14, 2017, 6:45 AM

The Cook County Board on Wednesday delayed a vote on repealing the controversial soda pop tax, ensuring at least 27 more days of mailers, radio ads and TV commercials that aim to sway public opinion on the issue.

Sending the proposal to the county's Finance Committee for an Oct. 10 hearing allows time for Cook County Board President Toni Preckwinkle's administration to conduct a financial analysis. Without one, a vote to repeal the penny-an-ounce tax on sugar- and artificially sweetened beverages could have faced a legal challenge.

"Ultimately, nobody wanted an up-or-down vote today more than myself, with the exception of nearly 90 percent of the constituents who oppose this regressive tax," said Commissioner Sean Morrison, a Palos Park

Republican and lead sponsor on the repeal ordinance. But "there is no political will here today to take up a repeal vote," he added.

Wednesday's anticlimactic committee referral came after more than two hours of testimony from members of the public that flooded the meeting. Scores of people who wanted to attend were turned away and left to listen to a loudspeaker broadcast in a hallway on the fifth floor of the County Building.

Beverage industry workers, retailers and suburban mayors were among the nearly 100 people who signed up to voice their opinions. Worth Village President Mary Werner said residents of her small town were driving 10 miles or more to buy their pop in Will County or Indiana.

"It would be bad enough if they were only buying their beverages, but they are so mad and they are so angry and they are so fed up with the taxes in Cook County, they are doing all their shopping, and while they're there, they're buying their gas as well," Werner said.

County government union representatives, doctors and health care advocates, meanwhile, called on commissioners to keep the tax. Among them was Dr. Clare Crosh, a third-year pediatric resident at Advocate Hope Children's Hospital in Oak Lawn. She talked about an 11-year-old patient battling obesity who consumes too many sugary drinks and appears to be on the path to developing Type 2 diabetes.

"This tax will work," she said, noting declines in sugary-drink consumption in other locales where similar taxes have been in place longer. "I'm asking for your help. I cannot do this alone. Pediatricians and clinicians cannot do this alone."

Afterward, Commissioner and Illinois Republican Party Chairman Tim Schneider of Bartlett expressed confidence that tax opponents would have enough votes to pass repeal next month.

But Preckwinkle had a different take. "We anticipate that we will continue to have the votes for a sweetened beverage tax," she said.

Last November, she broke a rare 8-8 tie vote to approve the tax. It takes nine votes to repeal it, but at least 11 to override a Preckwinkle veto. She did not directly respond to questions about whether she would veto a repeal.

Two commissioners — Finance Committee Chairman John Daley, D-Chicago, and Edward Moody, D-Chicago Ridge — told the Tribune they were undecided on the issue. On Wednesday, newly appointed Commissioner Dennis Deer, D-Chicago, said he was "looking at all options."

Whatever commissioners thought on Wednesday, their opinions could be swayed over the next month. Former New York Mayor Michael Bloomberg, who supports the tax, and opponents from the beverage industry coalition Can the Tax have committed $6.4 million toward dueling radio and TV ads on the issue. Representatives for both sides said after the meeting that their ad campaigns would continue.

In addition, Bloomberg has sponsored mailers backing the tax and pledged to spend "whatever it takes" to help those who voted for the tax survive any reelection challenges next year.

And on Wednesday, the Illinois Manufacturers' Association announced the formation of the Government Accountability PAC, an independent expenditure committee that plans to spend money to unseat backers of the tax. The association also released examples of digital ads and mailers it was sending out.

That comes on top of the Citizens for a More Affordable Cook County Political Action Committee, which has pledged to back commissioners who support repealing the tax. Its treasurer is well-known Democratic attorney Michael Kasper, who counts the American Beverage Association among his clients.

And Preckwinkle has been out advocating for the tax, both to maintain county services and to help reduce sugar consumption-related ailments like obesity, diabetes and heart disease. She acknowledged Tuesday she has "work to do" to make her case before an October vote.

After a Wednesday breakfast speech at the City Club of Chicago, she told reporters she was still working to shore up the backing of the commissioners who voted in favor of the tax last time, saying she "let them know that I would be supportive and helpful of them in any way I could." She also said she spoke with Deer. He replaced the late Robert Steele, who was absent from the original vote tax vote.

And she made it clear she will try to put the onus on tax opponents to prove their own financial plans.

"Those who support repeal will have to propose ways in which we will cut our programs and services to make up for the $200 million in lost revenue," she said. "We'll see what they come up with."

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This article is related to: Toni Preckwinkle, Michael Bloomberg, Diabetes, Robert Steele, City Club of Chicago, John P. Daley

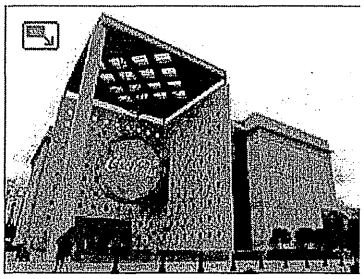
Exhibit 14

Coke says obesity grew as sugary drink consumption fell

By Bruce Horovitz, USA TODAY

Updated 6/7/2012 8:47 PM

Sorry Mayor Bloomberg, but the folks at Coca-Cola say you've got your facts fizzy.



Doug Collier, AFP/Getty Images file

The World of Coca-Cola attraction in Atlanta, site of the soft drink giant's corporate headquarters.

Coca-Cola, the world's largest soft-drink maker, is pushing back against New York Mayor Michael Bloomberg's provocative proposal a week ago to limit to 16 ounces the size of sugary drinks that could be sold at city restaurants, theaters and street carts.

"There is no scientific evidence that connects sugary beverages to obesity," says Katie Bayne, Coca-Cola's president of sparkling beverages in North America, in an exclusive interview.

STORY: Coke executive answers questions about sugary drinks

In fact, Bayne says, during the period from 1999 through 2010, when obesity was rising, sugar intake from beverages was decreasing. During that period, she says, sugars from soda consumption fell 39% even as the percentage of obese kids jumped 13% and obese adults climbed 7%.

Mayor Bloomberg was unavailable, but his deputy press secretary, Samantha Levine, says Coke's numbers have more fizz than fact. "The fact remains," she says, "sugary beverages are a key driver of the obesity crisis that is killing 5,800 New Yorkers and costing the city $4 billion annually."

Bayne, who is emerging as a key face at Coke on the sugary drink issue, says she "agrees" with Bloomberg that obesity is a critical issue. "But singling out single brands or foods is not going to help the situation. Working together in partnership will."

Coca-Cola introduced 20 new low-calorie and no-calorie beverages in 2011, bringing the total of its diet and light drinks in the U.S. to 150. That's roughly one-third of its U.S. beverage portfolio, Bayne says.

Marion Nestle, nutrition professor at New York University, doesn't buy Coke's argument. "They're in an awful bind," she says. "They sell expensive sugar water."

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Pat Hatch
Yep.. when people are down.. they eat and then look at more entertainment to get them back UP... I love my Coke Zero.
Like · Reply · Jun 7, 2012 5:48pm

Pat Hatch
Then PC, cell phone and internet are a direct cause of obesity.. think about it.. We don't even get out of car to open the garage door today.. if we did that.. or manually roll down window.. We would be fit. but noooo. we love the fat.
Like · Reply · 11 · Jun 7, 2012 5:51pm

David Nelson
add to that game consoles and that no two kids can play a game without adults organizing them into teams and leagues and high pressure coaches. We're just more sedintary that in the past. We have too much stuff. When I was growing up families only had one car and so kids biked everywhere, we all snorted when Edina, MN passed a city ordinance that all homes had to have a 2 car garage. When we bought our last place I was look for 4 stalls.
Like · Reply · 4 · Jun 7, 2012 7:17pm

Georgiana Hall · Georgetown University
David Nelson WHatever happened to "Tag?" or "Hide and go seek?"
Like · Reply · 1 · Jun 8, 2012 4:59am

Glen DeGelnor
Hell David, in some areas of AZ you must have a garage for your golf cart!
Like · Reply · Jun 8, 2012 8:23am

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Charles E Bosworth III · Charles H. McCann Technical High School

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MONEY

Glen DeGelnor

Hell David, in some areas of AZ you must have a garage for your golf cart!

Like · Reply · Jun 8, 2012 8:23am

Show 2 more replies in this thread

Charles E Bosworth III · Charles H. McCann Technical High School

They're just jealous that Pepsi stole most of their business.... I agree that sugarly beverages could very well play the perhaps, largest role in obesity...

Like · Reply Jun 7, 2012 5:58pm

Joe Buchanan

I disagree. There is no one main cause of obesity other than the lack of moderation factor. As somebody here has already said we don't move around much anymore. Does that not strike you as a major contribution to obesity rather than just soda?

So, why should we teach moderation (and perhaps a bit of exercise too) instead of trying to completely take away soda and chips and who knows what all else from people?

Well, for example, studies have been done (one by the University of IL) showing that pulling soda out of schools hasn't reduced the obesity rate one bit at those schools (compared to sc... See More

Like Reply · 1 · Jun 7, 2012 6:37pm

Zac Smith · Bartender at Yellowfin Steak & Fish House

You discount the further advent of video games, social networking/internet useage, and other technologies that keep our kids increaingly glued to the screen instead of running rampant outside....

Like · Reply · 1 · Jun 7, 2012 8:10pm

Charles E Bosworth III · Charles H. McCann Technical High School

I was hoping no one would say anything about sitting on the couch all day playing video games and eating fists full of candy, cookies and other junk food... Now what am I to do..?

Like · Reply · Jun 8, 2012 1:21am

Joe Buchanan

There is nothing wrong with having a soda every now and again. The problem here is that people have confused 'every now and again' with 'multiple times/daily'. Everything in moderation. I'm getting so sick of seeing every day things (like this) continuing to be demonized by the government or the health freaks or whoever else. Listen, we're all going to die someday anyway - no matter what. So, have a Coke every now and again. If you're having one every day or multiple times/day then maybe re-evaluate that. I disagree with the deputy press secretary - you can't just blame soda on the whole obesity epidemic. There are a wide range of factors that contribute to that. Furthermore, I think it's silly that Coke has to feel the need to defend itself against this crap - listen nobody is forcing anybody to drink Coke. It's still a free society and people still are free/responsible to make their own decisions as far as what they eat/drink. It's not Coke's fault that obesity is a problem!

Like · Reply · 3 · Jun 7, 2012 6:25pm

Lionel J Morata · Branch Manager at PNC

so 16oz of soda is not enough "moderation"? What could be a proper limit other than 1 pound (or 16 oz)? 32 oz (2 lbs) of soda?

Like · Reply · 1 · Jun 7, 2012 6:32pm

Joe Buchanan

I think you're missing the point? Why try to legislate the same amount for everyone? That never works. It's no different than some people trying to say that nobody should drink alcohol because there are alcoholics. I'm perfectly capable of just having one beer or a glass of wine and that's it. Alcohol doesn't

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Like · Reply · 4 · Jun 7, 2012 6:42pm

Neil Moss · Lagrange High School

Lionel. Ever left any food on your plate? Ever left part of a drink at the bar? Nuff said

Like · Reply · 1 · Jun 7, 2012 6:50pm

Show 3 more replies in this thread

Darrah Smith

Limiting the cup size is a ridculous solution. Just means more refill trips..the Mayor should focus on something a bit more mayorial!

Like · Reply · 9 · Jun 7, 2012 6:25pm

David Nelson

That's the exercise program, getting up and walking from you chair to the soda refill station.

Like · Reply · 8 · Jun 7, 2012 7:18pm

Penelope Butera · Goodyear, Arizona

No - "help" is not the intention - "control" is - and if they can control something this menial then they will move on to bigger and better things until one day we wake up and realize that ALL our freedoms have been taken away.

Like · Reply · 10 · Jun 7, 2012 9:36pm

Chris Lynch

I only get my nutrition history from American food corporations. Because I trust them to give me the facts. Now, where's my double cheeseburger and large coke?

Like · Reply · 6 · Jun 7, 2012 6:30pm

Chris Lynch

Hey, nice name bud!

Like · Reply · 1 · Jun 8, 2012 5:18am

Chris Lynch

heh, I saw that "Chris Lynch" replied, and had a heart attack thinking that my PC was hacked and someone was posting remarks with my facebook account.

Like · Reply · 1 · Jun 8, 2012 8:14am

Vanessa Raney · Our Lady of the Lake University

Chris Lynch Actually, you CAN eat a "double cheeseburger and large coke" if, for the rest of the day, you ate veggies and drank tea or water - and that's without exercising. On the other hand, if you exercised for about an hour before that meal, you'll actually be burning it faster and could probably get away with a light dinner later. lol

Like · Reply · Jun 8, 2012 10:51am

Like · Reply · 1 · Jun 8, 2012 8:14am

Vanessa Raney · Our Lady of the Lake University

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Like · Reply · Jun 8, 2012 10:51am

Al Cordova

What else would you expect Coke and Pepsi to say?

Like · Reply · Jun 7, 2012 6:48pm

Kerry Lothbrok · Portland, Oregon

I normally don't support big corporations but I agree with Coke on this issue. Banning the big drinks won't change a thing, except limiting our freedom of choice.

Like · Reply · 3 · Jun 7, 2012 7:19pm

Al Cordova

I agree that minimizing the size of the drink will only mean buying multiple drinks.

Like · Reply · 1 · Jun 7, 2012 7:30pm

Modesto Rodriguez Montes · Los Angeles, California

Mr. Bayne is just the voice of his masters. He will say whatever he needs to say to make the point for the cola manufacturers. It is like any other public face. The problem is not that he is wrong, is that he is trying to perpetuate a problem that is killing people. I do not know how he can live with himself.

There are very serious scientific documents that explain why fructose is such a serious poison. This video was an eye opener for me and for another 2 M people that have seen it: http://www.youtube.com/watch?v=dBnniua6-oM

The video is sometimes very scientific and difficult to follow, but it is damn good to show how fructose is converted into fat in your liver, and the toxins that your body generates in the process.

On the other hand, the "zero-calories" beverages are even worst, because they are loaded with artificial sweeteners that are even worst than sugar. Drink water, it is far better.

Like · Reply · 2 · Jun 7, 2012 6:49pm

Matt Gunmetal

New Yorkers thank God every night that they have Bloomberg to make the decisions for them that they're incapable of making themselves.

Like · Reply · 8 · Jun 7, 2012 7:11pm

Joe Cressaty

She's a woman, not a dude

Like · Reply · Jun 7, 2012 7:32pm

John Matesowicz · Works at Apple Hill Farm and Country Club

It should be a persons choice what they would like to drink and how much they would like to drink. Soda isn't the problem. Coke has been around much longer than the country's weight problem. Limiting certain drinks sold in certain places will do nothing. Alcohal isn't limited to 16oz with this law and it's much more unhealthy and fattening than soda.

Like · Reply · 2 · Jun 7, 2012 8:18pm

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Colleen Murray-Ellis

I would focus energy on educating children on healthy eating than taxing or banning

will do nothing. Alcohal isn't limited to 16oz with this law and it's much more unhealthy and fattening than soda.

Like · Reply · 2 · Jun 7, 2012 8:18pm

Show 5 more replies in this thread

Colleen Murray-Ellis

I would focus energy on educating children on healthy eating than taxing or banning consumables with sugar. Did taxing cigarettes stop smoking? No. Sugar doesnt cause obesity. People over eating high carb foods and not exercising does. Ban video games first!

Like · Reply · 1 · Jun 7, 2012 6:54pm

Neil Moss · Lagrange High School

Obesity is not caused by sugary drinks...it's caused by laziness. We can't do physical stuff in school becaues someone may not be able to do is well as others (like in real life) and we certainly cannot hurt someone's self esteem. Parents are perfectly happy having their children sit on the computer all day or watch TV. When I was a kid if you stayed in the house you were given projects to do...result...outside with your buds. You had 1 hour EVERYDAY in school that you were doing something physical ...basketball, track..you name it...and it was your choice. Some things one was good at...some not...but it was required and we all seemed to get beyond "self esteem" problems. Then when we got inot the "real" world we really did not get po'd because the boss dissed us or had no concern about our self esteem.

Like · Reply · 17 · Jun 7, 2012 7:03pm

Sam Taylor · Mississippi State University

Obesity is caused far more by overeating than drinking sugary drinks. There's not enough calories in softdrinks to really make a difference. The problem is with the food that people eat and their lack of exercise.

Like · Reply · 2 · Jun 8, 2012 7:19am

Jeff Berlat · University of Houston

600 calories in a 32oz Big Gulp is a ton of calories for a drink.

Like · Reply · 2 · Jun 8, 2012 8:01am

Vanessa Raney · Our Lady of the Lake University

Neil Moss Not necessarily. If you get into a car accident and have to go through physical therapy, you might get fatter simply by your muscles atrophying. Age, gender, etc. also influence your ability to gain or lose weight. So does pregnancy, illness, etc.

What matters is what you eat and if you're exercising. More important than that is your family history. Health, however, is a much more complicated topic.

The truth is you can eat anything you want, as long as it's in balance. Also, you only need at least 15 minutes a day of exercise to open more blood pathways around your heart.

Like · Reply · Jun 8, 2012 10:30am

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Like · Reply · Jun 8, 2012 10:30am

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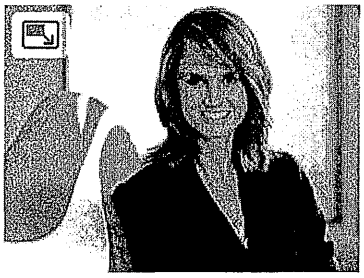
Exhibit 15

Coke executive answers questions about sugary drinks

Updated 6/7/2012 9:18 PM

Until now, beverage giant Coca-Cola hasn't put a face to its staunch opposition to last week's proposal by New York Mayor Michael Bloomberg to limit to 16 ounces the size of sugary drinks sold at New York restaurants, movie theaters and street carts. But in an exclusive interview, **Katie Bayne**, Coca-Cola's 45-year-old president of sparkling beverages in North America, explains to USA TODAY marketing reporter **Bruce Horovitz** where she differs with Bloomberg and discusses which beverages she permits her young sons to drink. She will speak on Monday in New York City at a *Beverage Digest* conference. This interview is edited for clarity and space.



Coca-Cola

Katie Bayne is president and general manager of sparkling beverages for Coca-Cola North America.

Q: If Mayor Bloomberg were sitting across from you, what would you say to him?

A: I'd say, Mayor, we believe you're absolutely right. Obesity is a critical health challenge facing our nation. But singling out single brands or foods is not going to help the situation. Working together in a partnership will.

STORY: Coke says obesity grew as sugary drink consumption fell

Q: Is there any merit to limits being placed on the size of sugary drinks folks can buy?

A: Sugary drinks can be a part of any diet as long as your calories in balance with the calories out. Our responsibility is to provide drink in all the sizes that consumers might need.

Q: Is anyone at Coca-Cola trying to figure out a way to get sugar out of all drinks?

A: There is a large portion of the population that relies on the carbohydrates and energy in our regular beverages. When my son gets home from school, he needs a pick-up with calories and great taste.

Q: But critics call soft drinks "empty" calories.

A: A calorie is a calorie. What our drinks offer is hydration. That's essential to the human body. We offer great taste and benefits whether it's an uplift or carbohydrates or energy. We don't believe in empty calories. We believe in hydration.

Q: Because sugary drinks have been linked with obesity, some suggest soft-drink makers place "warning" labels on cans and bottles.

A: There is no scientific evidence that connects sugary beverages to obesity. If you look

Q: But critics call soft drinks "empty" calories.

A: A calorie is a calorie. What our drinks offer is hydration. That's essential to the human body. We offer great taste and benefits whether it's an uplift or carbohydrates or energy. We don't believe in empty calories. We believe in hydration.

Q: Because sugary drinks have been linked with obesity, some suggest soft-drink makers place "warning" labels on cans and bottles.

A: There is no scientific evidence that connects sugary beverages to obesity. If you look at the data, you can see that during the same period obesity was rising, sugar intake from beverages was decreasing. Between 1999 and 2010, sugars from soda consumption decreased by 39%, but the percentage of obese children increased by 7%, and 13% for adults.

Q: Shouldn't teens drink less cola and more milk and water?

A: Teens should get a healthy diet through food and beverage choices throughout the day.

Q: How much Coke should a kid drink a day?

A: We don't make recommendations on what kids should drink. But a 12-ounce can of Coke has 140 calories, the same as a lunch-box-size bag of pretzels.

Q: What sugary drink limits do you place on your kids?

A: My job as a parent is to guide them through the day to make the best choices. If my son has lacrosse practice for three hours, we go straight to McDonald's and buy a 32-ounce Powerade.

Q: What do you drink daily?

A: I might have a mini Diet Coke while cooking breakfast for my family. After the kids leave for school, I go for a run and then have a Powerade Zero. At work I may have a Diet Coke in the morning and in the afternoon, Gold Peak Tea. In the middle of the afternoon, I may have an 8-ounce Coke. I'd rather have that than a candy bar or cookie for a pick-me-up.

Q: What do you say to those who believe that sugar — particularly in soft drinks — works on the brain like an addictive substance?

A: There is no scientific evidence.

Q: Critics say Coke is pushing sugary drinks in China and India and will cause obesity there just like here.

A: Every person in those countries is different and should be able to choose what's right for them.

Posted 6/7/2012 8:39 PM | Updated 6/7/2012 9:18 PM

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Ray Gibson
Dr. Pepper and Mr. Pibb could get married in NYC but heaven forbid they serve 20 oz bottles at the reception....

Like · Reply · 19 · Jun 7, 2012 5:53pm

Nathan Mathias · Anchorage, Alaska
Who said Dr. Pepper isn't a woman? (assuming your comment is a gay marriage reference)

Like · Reply · 7 · May 8, 2013 11:37am

Jim Charbonneau
We don't have many "sugar" drinks. Get rid of the high fructose corn syrup, and go back to sugar.

Like · Reply · 35 · Jun 7, 2012 7:40pm

David Pipe
Have you ever had a Coke manufactured in Mexico? They still use real cane sugar ... the taste is amazing - so much better! Now, if they'd just go back to putting real cocaine in the recipe...

Like · Reply · 15 · Jul 6, 2012 5:24am

Bruce Teare · Parsippany High School
GMO is high fructose corn syrup double dose of poison ! Boycott all coke products .

Like · Reply · 8 · May 8, 2013 7:02am

Evan Follmer · Site Leader / Manager at Staples Premedia
Switch to Jones Soda - pure cane sugar - no corn syrup

Like · Reply · 3 · May 8, 2013 11:14am

Show 1 more reply in this thread

Infinity Oh · Director at The Jupiter Project
anything that you mix (in your stomach) with Coke becomes indigestible .
We need nutrients not 'calories' .

Like · Reply · 21 · Jun 7, 2012 8:26pm

Jacqueline Stickel · Registered Dietitian at Prince Albert Parkland Health Region
I agree that we need nutrients, not calories...but Coke itself doesn't prevent

Infinity Oh · Director at The Jupiter Project

anything that you mix (in your stomach) with Coke becomes indigestible .
We need nutrients not 'calories' .

Like · Reply · 21 · Jun 7, 2012 8:26pm

Jacqueline Stickel · Registered Dietitian at Prince Albert Parkland Health Region

I agree that we need nutrients, not calories...but Coke itself doesn't prevent food components from being digested or nutrients from being absorbed. Yes, it's acidic, but your stomach acid is even more acidic.

Like · Reply · 2 · May 8, 2013 9:56pm

Modesto Rodriguez Montes · Los Angeles, California

There is more than enough scientific evidence that fructose (around 50% of the sugar we eat) is basically a poison that has to be metabolized in our livers and creates a whole bunch of toxins in our bodies.

This video gives a lot of data on this matter. It opened my eyes and the eyes of the 2.4 M people that has seen it. It is sometimes too scientific, but it is very clear on how sugar is pounding our bodies as a poison: http://www.youtube.com/watch?v=dBnniua6-oM

Mrs. Baynes will never accept any argument like this, it does not matter who says it or how much science is behind it. She is doing what many others do, close your eyes and continue counting your money. I would not mind if the lives of so many people would not be at stake.

The best way to get more people to realize about this situation and stop drinking colas and sugary drinks is to provide information about the problem. It is better than regulate, as there is an understanding of what is going on.

Like · Reply · 39 · Jun 7, 2012 9:03pm

Danielle Curry

Rocky Sly, as Modesto said--education NOT regulation, however, there are a lot of people with vested interests funding junk science. That said, let the people decide, then let natural selection take over!

Like · Reply · 9 · Jun 9, 2012 11:32am

George Butiri · CTO at ActingShowcase.com

Rocky, I agree. Everything is harmful when not in moderation. We have to learn to control our own selves before we blame others for our actions.

Like · Reply · 6 · Jun 9, 2012 4:50pm

Jake Freppel · Napoleon, Ohio

Too bad restaurants have taken away our right to choose more sensible portion sizes of drinks.

Like · Reply · Jun 9, 2012 6:38pm

Show 6 more replies in this thread ▼

Robert Willison · Chief Engineer, US Post Office Next Generation Vehicle at Workhorse Group

"I might have a mini Diet Coke while cooking breakfast for my family." - This is the dream. To have sugar drinks morning, noon, and night. So funny.... "Please keep drinking our stuff so we make money....." Junk Marketing at its finest..

Like · Reply · 3 · Jun 8, 2012 2:57am

Mark Arena · London, United Kingdom

The PR Verdict: F (Full Fiasco) for Coke. Claiming you are as concerned about diabetes and obesity as the next person while advocating the sale of jumbo sodas is a hard sell. Why resist the flow toward health for consumers?

Like · Reply · 1 · Jun 8, 2012 7:16am

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Like · Reply · 1 · Jun 8, 2012 7:16am

Larry Gregerson · Eastern Illinois University

The Coke PR team really got her prepared. Sugar is like a drug...unhealthy and very difficult to kick the habit.

Like · Reply · 1 · Jun 8, 2012 7:22am

Kevin Butler

She's totally right. Companies print the calories right on the product. If you're too stupid to moderate your intake, the fault is yours. This whole tactic of blaming companies for producing items is ridiculous.

Now, if Coke was putting acid in their drinks and not putting it on the labels, then by all means, sue them. But everything is right there on the label.

The lazy and stupid don't deserve to profit from their laziness and stupidity.

Like · Reply · 3 · Jun 8, 2012 8:00am

Christina Sabo

I had a passenger on my aircraft that works in a Coca Cola factory and will never drink it again. He claimed that the syrup dropped on his shoe and the acidity ate right through the fabric! And, you're right...the acid is on the label. It's just that most are too ignorant to know what those big words mean or care enough to look it up. They would rather just be dumb and happy and fat.

Like · Reply · 5 · Jun 9, 2012 4:22pm

Kevin Butler

Actually, any acid, in a high enough concentration, can eat through things. Even citric acid.

Like · Reply · Jun 14, 2012 4:04am

Sarah Craighead Dedmon · Machiasport, Maine

You're right! That's why I'm coming out with my new line of radioactive gumballs, with machines to sell it on playgrounds. If your kids are too stupid not to buy them, well, don't blame me.

Like · Reply · 1 · Jun 15, 2012 12:35pm

Show 2 more replies in this thread ▾

Raymond Daniel · Works at Defense Finance and Accounting Service

She is right. People are responsible for their daily health needs and choices. This is after all America. to single out a product is not right. I would rather see high fructose corn syrup taken out of all the canned and boxed products. This is what is making Americans fat and not Coke.

Like · Reply · Jun 8, 2012 8:17am

Jeff Chausse · Principal UX Designer at Forrester

A calorie is not a calorie... Intense sweetness (even artificial) has been proven to override self-control mechanisms. The calories in a Coke may have the same effect on your body as those in a salad, but the Super Size Fries you then eat due to sugar-driven cravings are another thing.

'In 2007, researchers at the University of Bordeaux, France, reported that when rats were allowed to choose between a calorie-free sweetener and intravenous cocaine, 94 percent preferred the sugar substitute. The researchers concluded that "intense sweetness can surpass cocaine reward. . . . The supranormal stimulation of these receptors by sugar-rich diets, such as those now widely available in modern societies,

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Like · Reply · Jun 8, 2012 8:17am

Jeff Chausse · Principal UX Designer at Forrester

A calorie is not a calorie... Intense sweetness (even artificial) has been proven to override self-control mechanisms. The calories in a Coke may have the same effect on your body as those in a salad, but the Super Size Fries you then eat due to sugar-driven cravings are another thing.

'In 2007, researchers at the University of Bordeaux, France, reported that when rats were allowed to choose between a calorie-free sweetener and intravenous cocaine, 94 percent preferred the sugar substitute. The researchers concluded that "intense sweetness can surpass cocaine reward. . . . The supranormal stimulation of these receptors by sugar-rich diets, such as those now widely available in modern societies, would generate a supranormal reward signal in the brain, with the potential to override self-control mechanisms and thus to lead to addiction."'

http://www.details.com/.../carbs-caffeine-food-cocaine...

Like · Reply · 8 · Jun 8, 2012 9:34am

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Exhibit 16

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Exhibit 17

SUPERIOR COURT

DISTRICT OF COLUMBIA

2017-CALIFORNIA-004801 B[13998]

PASTOR WILLIAM H. LAMAR IV, et. al.

v. THE COCA-COLA COMPANY, et. al.

Client #: C5530 - THE COCA-COLA COMPANY

Matter #: 112A00

COS2013 Symposia - Coca Cola -

Dr. Rhona Applebaum

RHONA APPLEBAUM: People are surprised. I know I was surprised when I came to the company in 2004 when they told me--it was then 50 years--50 years Coca-Cola, our sparkling had not advertised to children. I had to go back. I had to go look. Absolutely.

I was in kidvid. I was doing kidvid and FTC, for those here at the Federal Trade Commission, where the industry was attacked for Saturday morning shows featuring chocolate and a host of other products. Reason Coke wasn't there is because Coke wasn't doing it. Oh, my gosh. That was a surprise. And it was a surprise because you just didn't know.

And one of the reason people are saying, oh, look, they're getting more active in terms of telling their story--yeah, we are. We are. Because if we don't tell our story, just like with you, other people will tell it for us. And whether intentionally or just by natural error, they're going to get it wrong.

So, we're stepping up and we're standing up, as some people have identified, and we're telling our story. So, this is just one of the stories that—and based on fact that I wasn't

aware of that needs to be shared. And we're doing more in terms of that particular area of marketing.

Innovation, executing and educating around choice? We do believe in choice. Absolutely, we believe in choice. I believe in choice in everything I do. It's a right that I have as an American, but I also have as a citizen of the world, and all of you do also.

So, again, what can we do more to provide you with choice and informed choice? Because shame on us if we are not giving you the necessary information. And I'll go into that in terms of what we're trying to do. But if you think we need to do more, that's part of the partnership. That's part of the collaboration. That's part of just engaging, and again, promoting active healthy living.

So, let's talk about active healthy living, our vision. Our vision is we want to aspire to help people around the world lead active healthy lives, through our products, our commitments, our actions, and of course, our resources. And our resources is not just about dollars. It's also about our time and it's about

what we do as a company.

Okay, so active healthy living. When we first did it--and this is the difference between scientists and marketers. As a scientist, we looked at this and it's about, okay, we got it, this is what we have to do. Education isn't easy, but if you teach the people to fish versus giving them a fish, it's gonna make all the difference in their lives.

So, it's about education, it's about variety. It's about variety. And I'd be lying to you up here if I didn't say it was about growing our business. Of course, it is. We're a for profit company. But we wanna do right by the consumer and our stakeholders. So, it is about variety.

And again, 127 years ago we started off with one beverage that I personally am very proud of. It's safe. It hydrates. It's enjoyable. You can laugh. Thank you. You can laugh.

It's about the how, how much, and how often. We're not expecting all your hydration needs to come from Coca-Cola. Lord knows that's not balance, variety and moderation. So, over 127 years we have 3500 products. And again,

recognizing the issues associated with weight and obesity, 25 percent of those are low and no calorie, and it's continuing to grow.

And then, of course, fiscal activity. So, where as a scientist we would say education, variety and physical activity, our marketers looked at it and just said, okay, it's about think, drink and move. Because we're not afraid of consumers who think, who are mindful and make the necessary choices with the information that they're provided with.

And if that includes not drinking Coca-Cola, that's why we have 3500--oh, it should say 3499 other products. So, let's continue.

Okay. What is active healthy living? It's about these three work streams, think, drink and move. We have what we call strategic priorities as it relates to what we wanna do. We wanna identify and understand the issue. If you think we have all the answers, we don't. I'm not trying to be humble. I'm just being truthful. We don't have all the answers.

There's a lot of questions we have. We wish there were government agencies and others who would take our questions and do the research.

They don't. So, we also support research, hands-off, conflict of interest, independent advisory panels, completely 6 degrees of separation, if not 6000 degrees of separation.

But we do, we want to identify and we want to understand the issues. We want to advance and utilize the science. That is truth. As a scientist, research is done to identify what is and what isn't, but it's not a one—you know, it's not a one-trick pony. We have to, when we're working in this area, continue to do research. That's why you just don't do one experiment. That's why you just don't have one sample. I don't have to tell you this. You guys are the experts in this room.

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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Date: October 13, 2017

Exhibit 18

Hard Copy Filed Pursuant to Super. Ct. R. 5(d)(6)(B)

Exhibit 19

SUPERIOR COURT

DISTRICT OF COLUMBIA

2017-CALIFORNIA-004801 B[13998]

PASTOR WILLIAM H. LAMAR IV, et. al.

v. THE COCA-COLA COMPANY, et. al.

Client #: C5530 - THE COCA-COLA COMPANY

Matter #: 112A00

Jeremy Paxmn vs Head of Coke Europe over dozens of teaspoons of sugar in a cup of Coke

MAN 1: And believe me, Type II Diabetes is a condition do you not want to get if you can avoid it, and is entirely preventable. This is a condition that is associated with heart attacks, strokes, kidney disease, blindness, amputation, increased risk of depression, increased risk of Alzheimer's Disease, and even increasing the risk of many cancers.

NARRATOR: Coca-Cola is introducing a new smaller can for the UK. Does it demonstrate a new commitment to tackling obesity, or just a cleverer way to sell sugar?

JAMES PAXMAN: Well, James Quincey is the President of Coca-Cola Europe. What good does Coca-Cola do you physically?

JAMES QUINCEY: I think Coca-Cola, as the introduction said, does have some sugar in it. It is energy. Is it an absolute necessity? No, it's not. Millions of people enjoy it as part of their diet across the UK.

JAMES PAXMAN: Does have some sugar in it, you say?

JAMES QUINCEY: It does.

JAMES PAXMAN: Why don't you say specifically how much sugar there is in this can,

for example?

JAMES QUINCEY: I think if you find--if you turn--

JAMES PAXMAN: On the side, you say 13. Do you have a percentage on there, don't you?

JAMES QUINCEY: Yes, right here on the front, it quite clearly calls out the amount of sugar in this can of Coke, 35--

JAMES PAXMAN: And what's it say?

JAMES QUINCEY: Thirty-five grams, which is--

JAMES PAXMAN: Right.

JAMES QUINCEY: Which is six teaspoons of sugar, which is, you know, about the same amount of calories as a cappuccino or half a croissant. So, there is calories. And actually, what we're doing is to say, look, the information is here. We want to actually promote—

JAMES PAXMAN: All right.

JAMES QUINCEY: --and make sure people do know—

JAMES PAXMAN: Do you imagine people know if they go to the cinema and they get—this is a small one, and there are big ones here too. You go to the cinema and you get a jug of coke

like this, do you think people have any idea how much sugar's in it?

JAMES QUINCEY: And maybe they don't. And I think one of the things we need to do—

JAMES PAXMAN: Well, do you know what it is? Look, look, look at this? Twenty-three sachets of sugar in that single container, the equivalent thereof. That is a staggering amount of sugar, isn't it?

JAMES QUINCEY: That is why we're very focused, it's one of the things we're doing on getting the information out there. We're not trying to hide the information behind what's in a Coca-Cola Classic--

JAMES PAXMAN: But you are trying to hide it.

JAMES QUINCEY: But there's zero sugar in a Coke Zero.

JAMES PAXMAN: Clearly, it's called a Coke Zero. But a Coke Classic--look at this one here. There's 44 packets of sugar in this one. Forty-four.

JAMES QUINCEY: Indeed there are. And I think what we're saying is, look, we wanna make sure that people have the information available

to them so that they can make the choices. And if they don't want the big one, then fine, that clearly is not one that's going to be for everyone.

JAMES PAXMAN: Well--

JAMES QUINCEY: We wanna make sure the information is available and we wanna make sure there's more availability of more choices, whether it's smaller packages, as you had in your intro—

JAMES PAXMAN: Yeah, but whether it's 23 in something this size--

JAMES QUINCEY: Mm hmm.

JAMES PAXMAN: --or 44 in something this size, each of which is to be consumed in one single sitting at a cinema, this is staggering, isn't it?

JAMES QUINCEY: Look, I think we do need to recognize that things need to change. The bigger cups need to come down. I don't think that we are talking that the world can't change and the world doesn't need to move on.

I think what it comes back to is we recognize that we need to play our part in helping to fix this very important issue of

obesity. It's something that's come about from, you know, us taking in too many calories and not burning them off with activity, many things over many decades. And we're gonna--we're taking actions.

We are promoting the information. As you point out, it is on the can. We're putting it in the advertising. We're increasing choices of the small cans, helping people manage their calories, promoting the zero calorie options if people are having trouble.

JAMES PAXMAN: So, you accept your role in the obesity epidemic, do you?

JAMES QUINCEY: I think as a contributor of calories into the British diet, of course we must. I think as a contributor of calories into the British diet, of course we must. I mean, soft drinks, all soft drinks together contribute two percent of the calories. It's a part of it, and therefore, we need to accept that role. And we do. And that's why we wanna focus on actions that we believe will help bring this crisis under control.

JAMES PAXMAN: Isn't what you're doing very similar to what the tobacco companies did

when after the link with cancer being established, started then trying to get us all to smoke light cigarettes as opposed to saying, don't have any of them?

JAMES QUINCEY: I think there's a very clear distinction between tobacco and anything to do with food and drink, because in the end, there is no amount of tobacco that's good for you. It directly causes some of the diseases--or no, it might not. Whereas with food and drink anything in moderation can work within your lifestyle.

JAMES PAXMAN: Maybe one of these packets in a cup of tea during the course of the day, or maybe even two. Twenty-three in the smallest container at the cinema.

JAMES QUINCEY: The reality, people aren't drinking those, and I think what we need to focus on is, you know, if we're trying to solve obesity, it's about information. And if you had the information, and you decide or whoever decides not to have it, absolutely, fine.

What we're here to do is to get the information into people's hands, help them make the choices that fit their lifestyle, their choices during the week, and also get out there

and try and promote activity with some NGO partners to try and help the other side of the equation and burn off some of those calories.

Because when you actually look out there and say—has anyone actually solved the crisis? Because sometimes we look at things and say, well, you know, what will work? But what's important is to look at some of those examples where things have actually happened.

There's an approach called ECOG out there. Started in France, moved across Europe, is now spreading across the world, where they brought down childhood obesity by 20 percent. And it's not by taking some--

JAMES PAXMAN: You could take--

JAMES QUINCEY: --eye-catching or simple measures. They did a number of things, bringing in--

JAMES PAXMAN: Okay.

JAMES QUINCEY: --private companies, health companies, local government, and communities, and brought down childhood obesity by 20 percent.

JAMES PAXMAN: Thank you very much.

JAMES QUINCEY: You're welcome.

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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Exhibit 20

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Exhibit 21

SUPERIOR COURT

DISTRICT OF COLUMBIA

2017-CALIFORNIA-004801 B[13998]

PASTOR WILLIAM H. LAMAR IV, et. al.

v. THE COCA-COLA COMPANY, et. al.

Client #: C5530 - THE COCA-COLA COMPANY

Matter #: 112A00

Coca-Cola pledges to tackle obesity

RICHARD QUEST: Coca-Cola, easily the most recognized brand in the world and the third most powerful brand, according to Forbes, is now trying to take the front foot in the world's fight against obesity. There are 139 calories in each can of Coke. In comparison, Pepsi tips the scale at 142.

Now, there's little doubt Coke's challenge is to get consumers to burn these 139 calories off. And the company has now determined on a global scale, global scale, mind, that it is going to put the detailed nutritional details and fight obesity.

Joining me to talk about it is James Quincey, the President of Coco-Cola in Europe.

You have put numbers on cans in mature markets like the EU for a long time, correct?

JAMES QUINCEY: Correct. Since 2008, 2009.

RICHARD QUEST: So, why didn't you do it everywhere else, and why are you doing it everywhere else now?

JAMES QUINCEY: Look, I think that it is true that a number of the things in these four commitments we've done in some of the countries

before. And that's what important about today is that we're taking those things that we think are starting to contribute to the problem, to solving the problem, and taking them global.

So, what today is about is global scaling reach, getting everywhere in the more than 200 countries that we operate in around the world and being public about it, joining very publicly in the conversation and inviting—

RICHARD QUEST: Well, what is that conversation? I mean, I'm just going to go and grab one of your cans, if I may.

JAMES QUINCEY: Sure.

RICHARD QUEST: I mean, what is your conversation actually really all about? Is it saying, well, there's 139 calories, but there's 35 grams of sugar in it as well. Is it telling people this is good, this is bad, this is what you need to do?

JAMES QUINCEY: What it's about is giving people the information. So, as you can see, we've got already here in the UK all five different ingredients on there, both the calories and the sugars. What we believe in is providing people the information and providing them choice

of drinks so that whether they've got calories in the drinks or not got calories in the drinks, they can help manage their balance of intake, which is what they're burning off, which is getting off the sofa is the other half of the problem.

RICHARD QUEST: And how are you—and I know Muhtar Kent, of course, your CEO is passionate about—

JAMES QUINCEY: Yes.

RICHARD QUEST: --this issue. But you need to do more, don't you? And you said you're going to do more.

JAMES QUINCEY: Yeah, we believe these four commitments, you know, offering more low and no calorie beverages across the 200 countries we work in gives the choice. Putting the calories on—

RICHARD QUEST: I'm gonna come back—

JAMES QUINCEY: --gives the information.

RICHARD QUEST: I'm gonna come back—

JAMES QUINCEY: Yes, of course, Richard.

RICHARD QUEST: --to this. I'm coming back to this thing of the cal--you know and I know it's not the caloric content per se. And it

says it here, 139 calorie is seven percent of the recommended da--but it's the 35 grams, which is nearly 40 percent, that's the bit that has to be reduced.

JAMES QUINCEY: Absolutely not. When we talk about obesity, that's not the case. When we talk about obesity, a calorie is a calorie. The experts are clear, the academics, the government advisors, diabetes associations. We need to have balance of the calories in it. If you're taking in too many or not burning them off, that's a problem wherever they come from. A calorie is a calorie.

Now, Coca-Cola can have a role within a balanced diet. If you're taking too many calories, try a Coke Zero, nice black can here with no calories in it.

RICHARD QUEST: Right. It's important to point out here that whatever anybody might think of what you're doing, the reality is you are the largest, or one of the largest, in the business. So, where you go, others will follow. And it is up to your company to be that model, that role model, to some extent, isn't it? In the same way that one can arguably say about McDonalds and

fast food.

JAMES QUINCEY: Yeah, we're a big company. We're a leader in our industry and we believe that businesses need to exert leadership and always engage with government and society in the big issues of the day.

We may only count for two to three percent of the calories in the countries in Europe, but we believe we need to engage and take a leadership position. And that's what these four commitments are about, being a leader and being public about it.

RICHARD QUEST: Fascinating. Thank you very much indeed for joining us.

JAMES QUINCEY: Thank you very much indeed.

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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Date: October 13, 2017

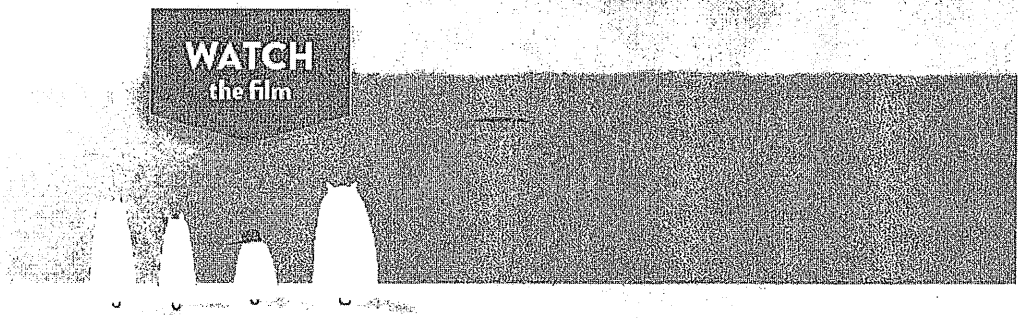
Exhibit 22

WATCH SHARE THE TRUTH

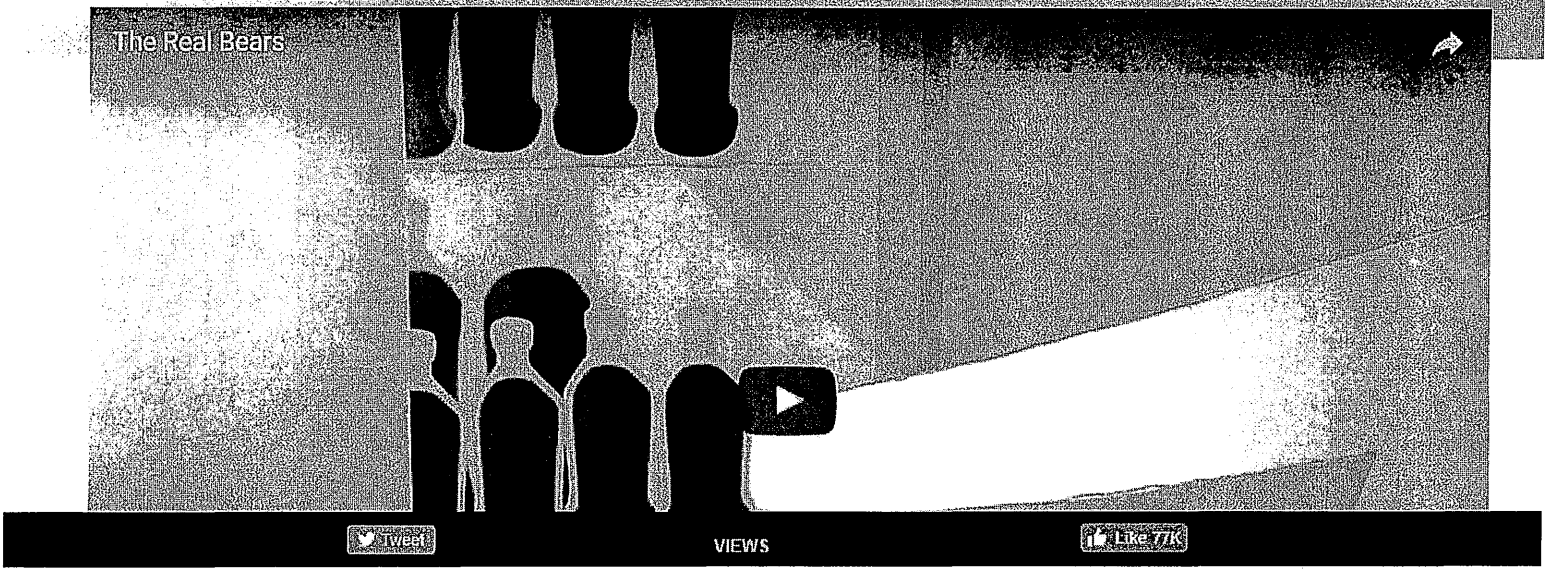
THE UNHAPPY TRUTH ABOUT SODA

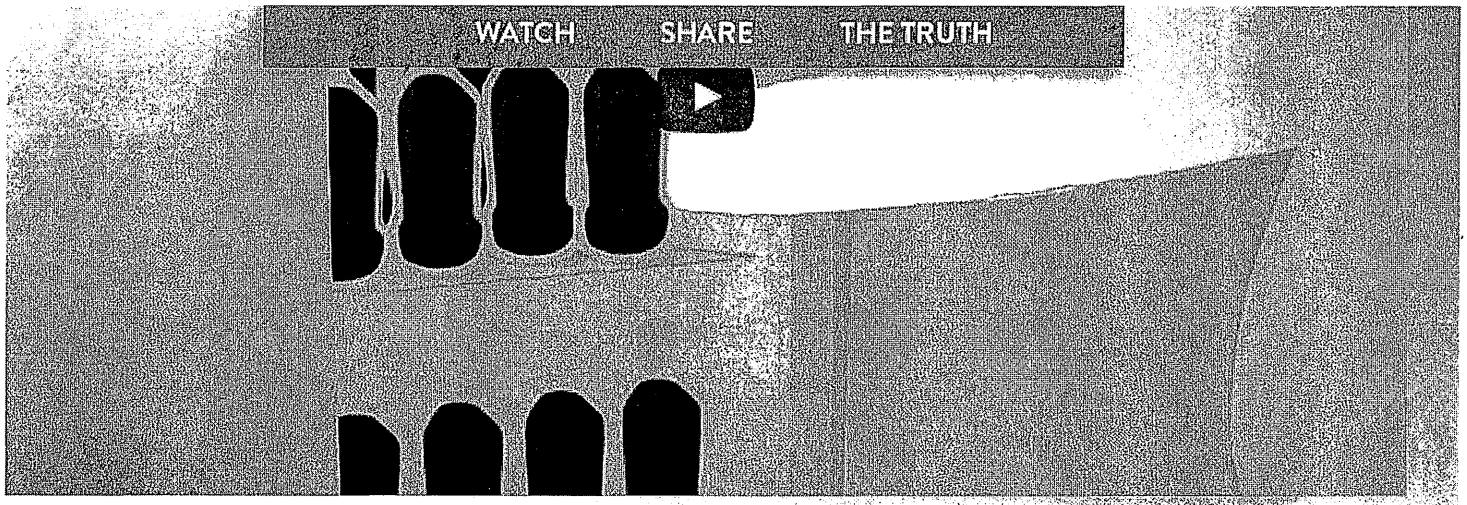
It wasn't so bad when soft drinks were the occasional treat.
But now sugary drinks are the number one source of calories in the American diet.

With one third of America overweight and another third obese, it's a wonder anyone is still swallowing what the soda companies are selling.



SHARE [About half of men with diabetes will experience erectile dysfunction.] THE TRUTH





SHARE

HELP THE REAL BEARS TELL THEIR STORY

Big soda companies have billions of dollars to tell their story, but we have each other. Oh—and we have the truth. Help The Real Bears spread the truth about soda by sharing the film.

Facebook it. Tweet it. Pin it. Google+ it. Email the link to your friends and relatives. Show it at school. Sit down and watch it with your whole family. Host a movie night and watch it before the main feature. Talk about The Real Bears on your YouTube show. Embed it on your website or blog. Have at it. You are the messenger.

Sharing is the only means we have to make sure the unhappy truth about soda gets out to the world.

Pin it

If you're interested in receiving information from the Center for Science in the Public Interest about its work to decrease soda consumption and to promote healthier, safer diets, fill in your details below and we'll add you to our email list. LEARN MORE AT CSPINET.ORG

First Name | Last Name

Email | Zip / Postal

By signing up you are agreeing to receive email updates from CSPI

Tweet | VIEWS | Like 7K

WATCH SHARE THE TRUTH

Email Zip / Postal

By signing up you are agreeing to receive email updates from CSPI

SIGN ME UP!

THE TRUTH

SODA FACTS 101

Research has proven a direct relationship between consumption of sugary drinks and an increase in obesity, which promotes diabetes, heart disease, stroke, and many other health problems.

Now you know the plight of The Real Bears. Real human families should also know about the risks of drinking too much soda. Here are the unhappy facts.

LIE "There is no scientific evidence that connects sugary beverages to obesity."

Katie Bayne,
Coca-Cola President of Sparkling Beverages North America

Truth: Each additional sugary drink consumed per day increases the likelihood of a child becoming obese by about 60%. Sugary drinks are connected to other health problems as well.

Truth: Each soda consumed per day increases the risk of heart disease by 19% in men.

Truth: Drinking one or two sugary drinks per day increases your risk for type 2 diabetes by 25%.

Truth: Diabetes can lead to erectile dysfunction.

LIE "If you're consuming the calories from the banana and there is the same number of calories as in a beverage that you consume, the

Truth: Liquid calories are more conducive to weight gain than solid calories, because the human body doesn't compensate by reducing calorie intake later in the day.

Truth: Sugary drinks are the single-largest source of calories in the American diet, providing an average of about 7 percent of total calories per person, and that average includes all the people who rarely drink them. The percentage of calories from sugary drinks is much higher for people who consume them often—such as several times a day.

LIE "If you're consuming the calories from the banana and there is the same number of calories as in a beverage that you consume, the impact on your body is calories are calories."

Maureen Storey
Former Senior Vice President for Science Policy
American Beverage Association

...rgest source of calories in the American diet, providing an average of about 7 percent of total calories per person, and that average includes all the people who rarely drink them. The percentage of calories from sugary drinks is much higher for people who consume them often—such as several times a day.

Truth: Most sugary drinks are devoid of nutrition—vitamins, minerals, protein, or fiber—and contain only empty calories.

Truth: It would take the average adult over one hour of walking to burn off the 240 calories in a 20-ounce Coke.

Truth: Americans consume about 38 pounds of sugar from sugary drinks each year.

LIE "At The Coca-Cola Company, we know our business can only be as strong and sustainable and healthy as the communities we serve."

Muhtar Kent
Coca-Cola Chairman and CEO

Truth: If communities were healthier, Coca-Cola Co. would be selling a lot fewer Cokes. The tripling of sugary carbonated drink consumption since the mid-1950s is one of the major causes of obesity.

Truth: Between 20% and 50% of the approximately 300 calories Americans have added to their diets in the past 30 years is attributable to increasing sugary drink consumption, now at an average of 178 calories for men and 103 calories for women per day.

Truth: Coca-Cola plans to spend more than $21 billion over the next five years to expand its business in just four countries: China, India, Brazil, and Mexico—which will undermine the health of "the communities we serve."

Truth: When Congress was considering a soda tax to help pay for health-care reform and improve the health of communities, Big Soda increased its lobbying expenses by 3,000% over the 2005 levels.

Truth: Big Soda gives generously to community groups, organizations of public officials, minority groups, and medical and health groups to influence policy positions and discourage criticism of the companies for undermining the health of communities. It often "changes the conversation" by focusing on building playgrounds and encouraging physical activity.

Truth: Not only do children under 12 see Coke and Pepsi logos everywhere, but Coca-Cola Co. promotes its products heavily at Disneyland, on American Idol, and on telecasts of the Olympics, all of which are seen by huge numbers of young children. Also, they sell kids' tee-shirts, toys, games, and stuffed animals with Coca-Cola logos at its web store, and the company licenses similar kid-friendly products at Toys "R" Us, and elsewhere.

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Truth: Coke has long reached millions of young children by marketing its drinks at child-friendly fast food restaurants, including McDonald's, the home of Happy Meals.

Truth: While soda companies, thankfully, have not advertised on TV shows intended for little kids, they have spent heavily to get their brand names onto school scoreboards and their products into elementary, middle, and high schools. An internal 1995 Coke newsletter exclaimed, "The Coca-Cola Company is focusing upon the education market with revitalized efforts around the world." Only recently did public pressure force them to stop.

Truth: Soft drink companies do market aggressively to teens. According to the Federal Trade Commission, in 2006, companies spent $474 million marketing carbonated beverages directly to adolescents-more than twice the marketing budget for any other consumable product.

LIE

"[O]ur member companies do not advertise beverages other than juice, water or milk based drinks to any audience that is comprised predominantly of children under 12."

– American Beverage Association

LIE

"Coca-Cola is an excellent complement to the habits of a healthy life."

– Douglas Ivester
Former Coca-Cola Chairman and CEO

Truth: Coca-Cola and other colas undermine that healthy life with loads of obesity-promoting high-fructose corn syrup, mildly addictive caffeine, caramel coloring with its carcinogenic 4-methylimidazole contaminant, and tooth-rotting phosphoric acid.

UNFORTUNATELY, THIS IS NO LIE:

"There is a large portion of the population that relies on the carbohydrates and energy in our regular beverages."

– Katie Bayne, Coca-Cola President of Sparkling Beverages, North America

Truth: Far too many people do rely too much on soft drinks for their calories. Sugary drinks' empty calories displace healthier foods, and Americans already consume hundreds more calories per day on average than they did 30 years ago.

Truth: Two-thirds of American adults and one-third of children are overweight or obese.

Truth: The American Heart Association urges Americans to consume 60% less sugary drinks by 2020.

Truth: Overall, males 12 to 19 years old consume 273 calories per day from sugary drinks; female teens down 171 per day.

* Want to dive deeper into the facts? Download Soda Facts 101 with citations here >>

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THE REAL THING

TRUTH AND POWER AT THE COCA-COLA COMPANY

"Tells the 130-year history of Coca-Cola with flair and gusto."
—*The Washington Post Book World*

CONSTANCE L. HAYS

With a new Afterword by the author

Contents

Coca-Cola Beverages. When it went public on the London Stock Exchange in July 1998, when the Coca-Cola Company's financial success seemed unstoppable, Isdell expected to be sitting on top of the world. Less than a year later, the stock was in tatters, with a war in Kosovo, a depressed Russian ruble, and a general slowdown in soft-drink consumption ruining the grand vision for the bottler that Ivester and Isdell had shared.

It would not have taken much to persuade Isdell to come to Atlanta and become the president of Coca-Cola. And there were quite a few people who thought he would be an excellent choice. "He was a warm, gracious, inviting personality," one former executive said. "Where Doug was uncomfortable speaking publicly, Neville was a natural. If you had never met Keough, you would say that Neville was the greatest speaker in the world."

But no, Neville Isdell was not going to be Ivester's choice. The chairman and chief executive of Coke preferred to keep his options open a little while longer. With the problems at Coca-Cola Beverages, he couldn't move Isdell now. Besides, he believed he had plenty of time to figure out this issue.

Ivester, impatient himself with failure, must have known the long knives had been unsheathed. First there was the stalled Orangina transaction, then the scaled-back Cadbury deal. And the Belgian episode—the biggest recall of Coca-Cola anywhere, ever—had been another strike against him. But in every case, he could argue, or have others argue on his behalf, this wasn't his fault.

But he didn't. He did not appeal to his friends among the Coke directors or suggest that someone speak on his behalf. He maintained his own sturdy faith in Coca-Cola—that it was the greatest, best-loved brand in all the world. This was a rough patch, but Coke would be fine. He was telling the truth.

IN SEPTEMBER, IVESTER agreed to an interview with a Brazilian newsweekly whose reporter flew to Atlanta for the session. The publication, *Veja*, was widely read in Brazil, and Brazil had been a tantalizing but problem-plagued market for Coke for some time. Ivester believed that the Coca-Cola Company was at a disadvantage there when it came to competing with cheaper sodas, known as *tubainas,* that were locally produced and distributed. The owners of the *tubainas* filled up any old bottle with their flavored drinks. Their reputation for being less than pure and clean was not even debatable. And they did not pay the kinds of taxes that an American company had to pay, Ivester often said, and he pressed the Brazilian government officials he met with to repeal that

tax. Without an even playing field, he believed, Coke would always have to struggle in a market like that. As it was, the company was paying $1.5 billion in marketing support to its bottlers in Brazil, spread over several years, to help offset the most recent downturn in sales. Brazilian workers would buy a Coke at the beginning of the month, when their paychecks came in, but midway through the month they were drinking *tubainas* exclusively. Were it not for those competitors, Ivester must have fumed privately, Brazil, the country with the fourth-largest population on the planet, would belong to Coke, too.

When the request for an interview came along, he was ready to consider it. Clearly, it would help to have the chairman and chief executive of the Coca-Cola Company talking in print about his company. He could discuss Coke's plans for the future, and detail some of the reasons that Coke was so strong in so many markets, and deliver—courtesy of someone else's publication—the kind of message to the Brazilian consumer that Coke would otherwise have to pay mightily to send out. So Ivester consented to the *Veja* request. He would sit down in Atlanta with one of its reporters, whose name was Euripedes Alcantara.

The day arrived, and Ivester seemed to have made the right decision in allowing the interview. It was boring, mostly, filled with predictable questions and even more predictable corporate answers. The reporter asked one question about Coke's place in a world where people were increasingly concerned about health. Ivester was primed to answer that one. He loved taking on questions about whether Coca-Cola was good for people. For the record, he would always say that it was. In an interview with *The New York Times* in 1998, he had asserted that by selling Coca-Cola across Africa, the company was actually performing an important public health service. "Fluid replenishment is a key to health, and when you have a population that has appropriate fluid intake, what you find is they have a lot less kidney problems and kidney disease," he said. And he did indeed seem to believe it, although the World Health Organization did not even list kidney disease on its long list of Africa's problems. He had spent time with scientists, he said, who understood kidney problems, and "some of them will tell you Coca-Cola does a great service because it encourages people to take in more and more liquids."

Now he addressed the question for Euripides Alcantara. "First of all, we have a very healthy product," he declared. "Of course, our beverage contains sugar, but sugar is a good source of energy, of vitality, not to mention that it is a source of foreign exchange for exporter countries." Brazil was one of these sugar-producing engines of the world, as Cuba had been when Goizueta lived there. But in many

places Coca-Cola was no longer made with cane sugar. That ingredient had been replaced under Goizueta, who saw high-fructose corn syrup as an acceptable substitute, not to mention one that saved the company millions of dollars a year.

"Coca-Cola is an excellent complement to the habits of a healthy life," Ivester went on. "Naturally, people need to exercise and follow a balanced diet." But concerns about health didn't seem to have stopped anyone from imbibing the world's most popular soft drink, he added. These days, he told Euripedes Alcantara, "people drink more Coca-Cola than in any other period in the past." That, indeed, was true.

The reporter asked Ivester about the company's adventures in Belgium, and about prospects for growth. Ivester responded to both predictably. And then, tape recorder whirring, Alcantara asked another question: about an obscure new technology he had heard Coke may have been testing, a technology focused around the vending machine.

The vending machine was a subject close to Ivester's heart. The company sold about 11 percent of its products through vending machines, known in Coke parlance as "cold-drink equipment." The potential in being able to sell ice-cold Cokes to a thirsty public had first dawned on a Coca-Cola bottler named George Cobb, who turned his idea into a contraption that he field-tested in 1910. Cobb was an Opelika, Alabama, native, the son of a country dentist whose patients brought him kindling and sweet potatoes as payment for his services. He named his machine the Vend-All Nickel in Slot Vending Machine and received a patent on it two years later. Depositing a nickel would release a catch that held down the machine's lid, and once open, a person could help himself to a bottle of Coke. The container held a dozen Coca-Colas, along with a chunk of ice, and Cobb sold several of them to his fellow Coke entrepreneurs. Cobb, whose bottling franchise was based in West Point, Georgia, in the southwestern part of the state, went on to become one of the most successful bottlers in the entire Coke system. "A Coca-Cola bottler with all of his family and loyal employees is one of the strongest business influences in any community," he once wrote, "and what a tremendous asset to the Parent Company!"

It was not until 1932 that the Coca-Cola Company officially approved coin-operated vending machines. Two years earlier it had endorsed mechanically refrigerated coolers as a way to "improved serving of the bottled product," and in 1929, the year of the market crash, Coke had approved a refrigerated tub from which stores and other places could sell bottles of Coke. These tubs, known as open-top coolers, made it possible for Coke to be sold front and center. Bot-

Exhibit 23

ARTICLE

CSPI on New Coca-Cola Advertising Campaign & Obesity

Statement of CSPI Executive Director Michael F. Jacobson

January 14, 2013

The soda industry is under siege, and for good reason. This new advertising campaign (http://lifeinc.today.com/_news/2013/01/14/16506023-cokes-new-anti-obesity-ad-is-a-soda-maker-first) is just a damage control exercise, and not a meaningful contribution toward addressing obesity. What the industry is trying to do is forestall sensible policy approaches to reducing sugary drink consumption, including taxes, further exclusion from public facilities, and caps on serving sizes such as the measure proposed by Mayor Bloomberg.

# # #

Note: CSPI's animated short film, The Real Bears (http://www.therealbears.org/), shows the impact of obesity, diabetes, and other soda-related diseases, on a family of Polar Bears.

TOPIC: Soda (/topics/soda) Obesity (/topics/obesity) Public Places (/topics/public-places)

BRAND: Coca-Cola (/brand/coca-cola)

Michael Jacobson

Michael F. Jacobson, Ph.D., is a **Co-founder and long-time Executive Director** of CSPI. He is now serving as **Senior Scientist** at CSPI. Jacobson has written numerous books and reports, including *Eater's Digest: the Consumer's Fact Book of Food Additives*, *Nutrition Scoreboard*, Salt: the Forgotten Killer, and Liquid Candy: How Soft Drinks are Harming Americans' Health. He has also been honored with such awards as the Centers for Disease Control and Prevention's Hero Award (2010), the American Public Health Association's David P. Rall award for advocacy in public health (2011), and the Food Marketing Institute's Esther Peterson Consumer Service Award (1992). His Ph.D. in microbiology is from the Massachusetts Institute of Technology.

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TIP

No Time for Breakfast? We Have a Solution (/tip/no-time-breakfast-we-have-solution)

TIP

5 Things You Should Know About High Blood Pressure (/tip/5-things-you-should-know-about-high-blood-pressure)

TIP

Exercise and Beyond for Blood Pressure (/tip/exercise-and-beyond-blood-pressure)

Can Yoga, Meditation, or Acupuncture Also Work?

(/)

- Eating Healthy (/eating-healthy)
- Protecting Our Health (/protecting-our-health)
- What You Can Do (/what-you-can-do)
- About (/about)
- News (/news)

Resource Library (/library)

Contact (/contact)

Exhibit 24

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

THE PRAXIS PROJECT, a non-profit corporation, Plaintiff, v. THE COCA-COLA COMPANY and AMERICAN BEVERAGE ASSOCIATION, Defendants.	Case No. _____ **COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF** **DEMAND FOR JURY TRIAL**

Plaintiff The Praxis Project ("Praxis" or "Plaintiff") brings this action against The Coca-Cola Company ("Coca-Cola") and the American Beverage Association ("ABA") (collectively,"Defendants"). Plaintiff's allegations against Defendants are based on information and belief and on investigation of Plaintiff's counsel, except for allegations specifically pertaining to Plaintiff, which are based on Plaintiff's personal knowledge.

NATURE OF THE ACTION

1. This is an action under the California Unfair Competition Law and False Advertising Law to enjoin Coca-Cola and the ABA from engaging in false and misleading marketing of sugar-sweetened beverages.[1] Plaintiff also asserts claims for the intentional and negligent breach of a special duty.

2. Coca-Cola, the leading manufacturer and supplier in the world of sugar-sweetened beverages, deceives consumers about their health impact. It does so independently, and also with the assistance of and through statements made by the American Beverage Association, a trade organization which Coca-Cola funds and materially directs.

3. For years, Defendants have engaged in a pattern of deception to mislead and confuse the public (and governmental entities that bear responsibility for the public health) about the scientific consensus that consumption of sugar-sweetened beverages is linked to obesity, type 2 diabetes, and cardiovascular disease.

4. Defendant Coca-Cola has also engaged in a pattern of deception to mislead the public (and governmental entities that bear responsibility for the public health) regarding its advertising to children.

5. Although Defendants have publicly pledged allegiance to objective scientific criteria, they have instead represented falsely that sugar-sweetened beverages are not scientifically linked to obesity, diabetes, and cardiovascular disease, and have waged an

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[1] "Sugar-sweetened beverage" refers to any carbonated or non-carbonated drink that is sweetened with sugar or high fructose corn syrup, or other caloric sweeteners, including soda, fruit drinks, teas, coffees, sports drinks, and energy drinks. CTRS. FOR DISEASE CONTROL & PREVENTION, THE CDC GUIDE TO STRATEGIES FOR REDUCING THE CONSUMPTION OF SUGAR-SWEETENED BEVERAGES 4 (2010), http://goo.gl/OWgFs.

aggressive campaign of disinformation about the health consequences of consuming sugar-sweetened beverages.

6. Defendants have undertaken these actions even though they know and have known that sugar-sweetened beverages are linked to serious medical conditions, including obesity, diabetes, and cardiovascular disease, when consumed regularly.

7. Although Defendant Coca-Cola promised that it would not advertise sugar-sweetened beverages to children, it has advertised to children on a massive scale.

8. A primary purpose of these ongoing campaigns of disinformation and misrepresentation is to maintain and increase the sales of sugar-sweetened beverages, and to thwart and delay efforts of government entities to regulate sugar-sweetened beverages through warning labels, taxes, and other measures designed to make consumers aware of the potential for harm.

9. Defendants have engaged in this conduct despite knowing that sugar-sweetened beverages are scientifically linked to obesity, diabetes, and cardiovascular disease, and these diseases are at epidemic levels in California and the United States.

10. Each year, millions of Californians, and others across the United States, will either develop, or develop the markers for, obesity, type 2 diabetes, and/or cardiovascular disease, owing at least in part to consumption of sugar-sweetened beverages.

11. Each year, Coca-Cola reaps huge profits from the sale of its sugar-sweetened beverages.

12. Each year, Coca-Cola spends billions of dollars on misleading and deceptive promotions and advertising that have enormous appeal to consumers, including children, which advertising effects persist over years.

13. Plaintiff seeks injunctive relief for the conduct alleged in the complaint. Among other things, Plaintiff seeks a permanent injunction to require the Defendants to: publicly disclose their files on the potential health implications of consuming sugar-sweetened beverages; fund a public education campaign to educate consumers about the association between sugar-sweetened beverage consumption and obesity, diabetes, and cardiovascular disease; cease

prospectively all deceptive advertising and promotions that imply in any manner that sugar-sweetened beverage consumption is not linked to obesity, diabetes, and cardiovascular disease, and conversely is healthy; and, in the case of Coca-Cola, cease all advertising that reaches children under the age of 12 in significant numbers.

PARTIES

14. Plaintiff Praxis is a nonprofit corporation pursuant to section 501(c)(3) of the Internal Revenue Code, with offices in Oakland, California, and Washington, DC. Plaintiff's mission is to build healthier communities, and through the efforts of its staff, Plaintiff engages in significant advocacy relating to sugar-sweetened beverages and the health consequences of their frequent consumption. Plaintiff's work is well recognized, including but not limited to the efforts of its Executive Director, Xavier Morales. As alleged in more detail below, Plaintiff has diverted significant resources to its advocacy concerning sugar-sweetened beverages. This diversion has prevented Plaintiff from allocating resources to other projects that advance healthier communities. Plaintiff could have avoided many of these expenditures if Defendants had not engaged in deception about the consequences of consuming sugar-sweetened beverages, consistent with its legal duty.

15. Defendant Coca-Cola is a public corporation, organized and existing under the laws of the State of Delaware, and headquartered in Atlanta, Georgia. Coca-Cola describes itself as the largest manufacturer, distributor, and marketer of nonalcoholic beverage concentrates and syrups in the world, many of which are sugar-sweetened beverages, including its flagship Coca-Cola, or Coke. In 2012, Coca-Cola's gross profits were $28.96 billion.[2] In 2012, its advertising budget was $3.34 billion.[3]

16. Defendant American Beverage Association is a trade association headquartered in Washington, DC that represents the manufacturers, bottlers and distributors of various drinks,

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[2] The Coca-Cola Co., Annual Report (Form 10-K), at 50 (Feb. 27, 2013), http://goo.gl/RzMbtF (FY 2012).

[3] *Id.* at 54.

including sugar-sweetened beverages. Coca-Cola executives help manage and direct the ABA, and materially fund its operations.

JURISDICTION AND VENUE

17. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332 because Plaintiff and Defendants are citizens of different states and the amount in controversy exceeds $75,000.

18. The Court has personal jurisdiction over Defendant Coca-Cola because it conducts substantial business in this district and throughout the State of California, and over Defendant American Beverage Association because it has made statements in this district and has specifically sought to influence consumer perceptions on sugar-sweetened beverages in this district.

19. Venue is proper in this Court under 28 U.S.C. § 1391(b) because a substantial number of the acts and omissions alleged herein occurred within this district.

ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

I. HEALTH CONSEQUENCES OF SUGAR-SWEETENED BEVERAGE CONSUMPTION

20. The American Heart Association recommends a daily maximum of six (6) teaspoons of added sugar for adult women and children, and nine (9) teaspoons for men.[4]

21. A 16-ounce bottle of Coke, by comparison, has 12 teaspoons of sugar, a 15-ounce bottle of Coca-Cola's Minute Maid Cranberry Grape Juice Beverage has approximately 13 teaspoons of added sugar, and a 20-ounce bottle of the company's vitaminwater has 8 teaspoons.[5] Twelve teaspoons of sugar is 200% of the AHA recommended daily maximum for women, and more than twice the sugar content of a Twix candy bar.[6]

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[4] *Added Sugars*, AM. HEART ASS'N, http://goo.gl/PoigAa (last visited Jan. 4, 2017).

[5] Of the parents who purchased vitaminwater for their children, 78% thought it was healthy. Tina Rosenberg, *Labeling the Danger in Soda,* N.Y. TIMES (March 30, 2016), http://goo.gl/TnryHW.

[6] *Id.*

22. Sugar-sweetened beverages are the leading source of added sugars in the American diet.[7]

23. Sugar-sweetened beverage consumption is scientifically linked to obesity, type 2 diabetes, and cardiovascular disease.

24. Stronger evidence links these diseases with the consumption of sugar-sweetened beverages than with the consumption of added sugar in non-liquid forms.[8]

25. Numerous governmental and medical bodies have recognized this link, including the Centers for Disease Control and Prevention ("CDC"), the 2015 Dietary Guidelines Advisory Committee, the Institute of Medicine, the American Heart Association, the Obesity Society, and the World Health Organization, and have urged reduction of sugar-sweetened beverage consumption, mainly as a means to address the epidemics of obesity, type 2 diabetes, and/or cardiovascular disease.

26. Consistent with these conclusions and recommendations, and after entertaining key expert testimony, this Court found that the warning required on certain sugar-sweetened beverage advertisements in San Francisco—which reads, "WARNING: Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth decay"—is "factual and accurate."[9]

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[7] U.S. DEP'T OF AGRIC. & U.S. DEP'T OF HEALTH & HUMAN SERVS., SCIENTIFIC REPORT OF THE 2015 DIETARY GUIDELINES ADVISORY COMMITTEE 148 fig. D1.36 (2015) (DIETARY GUIDELINES ADVISORY COMMITTEE), http://goo.gl/2rc9v3.

[8] CREDIT SUISSE, SUGAR CONSUMPTION AT A CROSSROADS 8–9 (2013), https://goo.gl/7rMhXY; Expert Report of Walter Willett at ¶ 10, *Am. Beverage Ass'n v. City & Cty. of San Francisco*, No. 3:15-cv-03415-EMC (N.D. Cal. filed Feb. 23, 2016) ("Willett Report").

[9] *Am. Beverage Ass'n v. City & Cty. of San Francisco*, No. 3:15-cv-03415-EMC, 2016 WL 2865893, at *18 (N.D. Cal. May 17, 2016).

27. Studies tracking thousands of adults for years show that those who consume sugar-sweetened beverages have higher rates of obesity and obesity-related chronic diseases.[10]

28. One highly regarded study (double-blind, randomized controlled intervention trial ("RCT")) involving 641 Dutch children reported that those who were given just one 8-ounce sugar-sweetened drink a day gained more weight and body fat over 1½ years than those who were given sugar-free drinks. Similar findings have been reported in a number of other clinical trials on adults and children.[11]

29. Scientific research has also established a link between the consumption of sugar-sweetened beverages and type 2 diabetes, which is only partly due to the impact of sugar-sweetened beverages on weight gain.

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[10] *See, e.g.*, Ravi Dhingra et al., *Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community*, 116 CIRCULATION 480 (2007); Frank B. Hu & Vasanti S. Malik, *Sugar-Sweetened Beverages and Risk of Obesity and Type 2 Diabetes: Epidemiologic Evidence*, 100 PHYSIOLOGY & BEHAV. 47 (2010); Vasanti S. Malik et al., *Sugar Sweetened Beverages and Weight Gain in Children and Adults: A Systematic Review and Meta-Analysis*, 98 AM. J. CLINICAL NUTRITION 1084 (2013); Julie R. Palmer et al., *Sugar-Sweetened Beverages and Incidence of Type 2 Diabetes Mellitus in African American Women*, 168 ARCHIVES INTERNAL MED. 1487 (2008); Qibin Qi et al., *Sugar-Sweetened Beverages and Genetic Risk of Obesity*, 367 NEW ENG. J. MED. 1387 (2012); Matthias B. Schulze et al., *Sugar-Sweetened Beverages, Weight Gain, and Incidence of Type 2 Diabetes in Young and Middle-Aged Women*, 292 JAMA 927 (2004); Jiantao Ma, *Sugar-Sweetened Beverage but Not Diet Soda Consumption Is Positively Associated with Progression of Insulin* Resistance, J. OF NUTRITION 234047 (Nov. 9, 2016), http://jn.nutrition.org/content/early/2016/11/09/jn.116.234047.full.pdf+html.

[11] Janne C. de Ruyter et al., *A Trial of Sugar-Free or Sugar-Sweetened Beverages and Body Weight in Children*, 367 NEW ENG. J. MED. 1397 (2012); *see also* Cara B. Ebbeling et al., *A Randomized Trial of Sugar-Sweetened Beverages and Adolescent Body Weight*, 367 NEW ENG. J. MED. 1407 (2012); Cara B. Ebbeling et al., *Effects of Decreasing Sugar-Sweetened Beverage Consumption on Body Weight in Adolescents: A Randomized Controlled Pilot Study*, 117 PEDIATRICS 673 (2006); Janet James et al., *Preventing Childhood Obesity by Reducing Consumption of Carbonated Drinks: Cluster Randomised Controlled Trial*, 328 BMJ 1237 (2004); Anne Raben et al., *Increased Postprandial Glycaemia, Insulinemia, and Lipidemia After 10 Weeks' Sucrose-Rich Diet Compared to an Artificially Sweetened Diet: A Randomized Controlled Trial*, 55 FOOD NUTRITION RES. 5961 (2011); Anne Raben et al., *Sucrose Compared with Artificial Sweeteners: Different Effects on Ad Libitum Food Intake and Body Weight After 10 Wk of Supplementation in Overweight Subjects*, 76 AM. J. CLINICAL NUTRITION 721 (2002); Michael G. Tordoff & Anne M. Alleva, *Effect of Drinking Soda Sweetened with Aspartame or High-Fructose Corn Syrup on Food Intake and Body Weight*, 51 AM. J. CLINICAL NUTRITION 963 (1990).

30. Put another way, the consumption of sugar-sweetened beverages is linked to an increase in type 2 diabetes even after researchers account for the impact of sugar-sweetened beverages on weight.[12]

31. The 2015 Dietary Guidelines Advisory Committee concluded that "[s]trong evidence shows that higher consumption of added sugars, especially sugar sweetened beverages, increases the risk of type 2 diabetes among adults and this relationship is not fully explained by body weight."[13]

32. Scientific studies also link sugar-sweetened beverage consumption to a higher risk of other obesity-related conditions, including coronary heart disease and stroke (collectively, cardiovascular disease).[14]

33. A systematic review and meta-analysis of 39 randomized clinical trials concluded that higher intakes of sugars are associated with risk factors for cardiovascular disease including

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[12] Ravi Dhingra et al., *Soft Drink Consumption and Risk of Developing Cardiometabolic Risk Factors and the Metabolic Syndrome in Middle-Aged Adults in the Community*, 116 CIRCULATION 480 (2007); Darren C. Greenwood et al., *Association Between Sugar-Sweetened and Artificially Sweetened Soft Drinks and Type 2 Diabetes: Systematic Review and Dose-Response Meta-Analysis of Prospective Studies*, 112 BRIT. J. NUTRITION 725 (2014); Fumiaki Imamura et al., *Consumption of Sugar Sweetened Beverages, Artificially Sweetened Beverages, and Fruit Juice and Incidence of Type 2 Diabetes: Systematic Review, Meta-Analysis, and Estimation of Population Attributable Fraction*, 351 BMJ h3576 (2015); Lawrence de Koning et al., *Sugar-Sweetened and Artificially Sweetened Beverage Consumption and Risk of Type 2 Diabetes in Men*, 93 AM. J. CLINICAL NUTRITION 1321 (2011); Vasanti S. Malik et al., *Sugar-Sweetened Beverages and Risk of Metabolic Syndrome and Type 2 Diabetes: A Meta-Analysis*, 33 DIABETES CARE 2477 (2010); Andrew O. Odegaard et al., *Soft Drink and Juice Consumption and Risk of Physician-Diagnosed Incident Type 2 Diabetes*, 171 AM. J. EPIDEMIOLOGY 701 (2010); Julie R. Palmer et al., *Sugar-Sweetened Beverages and Incidence of Type 2 Diabetes Mellitus in African American Women*, 168 ARCHIVES INTERNAL MED. 1487 (2008); Matthias B. Schulze et al., *Sugar-Sweetened Beverages, Weight Gain, and Incidence of Type 2 Diabetes in Young and Middle-Aged Women*, 292 JAMA 927 (2004); The InterAct Consortium, *Consumption of Sweet Beverages and Type 2 Diabetes Incidence in European Adults: Results from EPIC-InterAct*, 56 DIABETOLOGIA 1520 (2013).

[13] DIETARY GUIDELINES ADVISORY COMMITTEE, *supra* note 7, at Part D, Chapter 6, p. 20; *accord* Willett Report, *supra* note 8, at ¶ 51 ("Findings from well-designed prospective cohort studies have shown a strong and consistent association between SSB consumption and diabetes.").

[14] Adam M. Bernstein et al., *Soda Consumption and the Risk of Stroke in Men and Women*, 95 AM. J. CLINICAL NUTRITION 1190 (2012); Lawrence de Koning et al., *Sweetened Beverage Consumption, Incident Coronary Heart Disease, and Biomarkers of Risk in Men*, 125 CIRCULATION 1735 (2012); Teresa T. Fung et al., *Sweetened Beverage Consumption and Risk of Coronary Heart Disease in Women*, 89 AM. J. CLINICAL NUTRITION 1037 (2009).

higher levels of triglycerides, LDL ("bad") cholesterol, and blood pressure, and that "the relation is independent of effects of sugars on body weight.[15]

34. Thus, the Dietary Guidelines Advisory Committee said, "higher intake of added sugars, especially in the form of sugar-sweetened beverages, is consistently associated with increased risk of hypertension, stroke, and [cardiovascular disease] in adults."[16]

35. Likewise, "[T]he recommendations from the Institute of Medicine, the American Heart Association, the Obesity Society, and many other organizations [are] to reduce the consumption of sugar-sweetened beverages in both children and adults."[17]

36. This is because the "consumption of sugar-sweetened beverages causes excess weight gain and is associated with increased risk of type 2 diabetes and cardiovascular disease; thus, these beverages are unique dietary contributors to obesity and related chronic diseases."[18]

37. Today, roughly one-third of children and two-thirds of adults in the United States are overweight or obese.[19] Since 1980, obesity rates in the United States have tripled in children,[20] and doubled in adults.[21]

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[15] Te Morenga LA, et al. *Dietary Sugars and Cardiometabolic Risk: Systematic Review and Meta-analyses of Randomized Controlled Trials of the Effects on Blood Pressure and Lipids*, AM. J. CLINICAL NUTRITION 65-79 (2014).

[16] DIETARY GUIDELINES ADVISORY COMMITTEE, *supra* note 7, at Part D, Chapter 6, p. 20.

[17] Sonia Caprio, *Calories from Soft Drinks—Do They Matter?*, 367 NEW ENG. J. MED. 1462, 1463 (2012).

[18] Vasanti S. Malik & Frank B. Hu, *Fructose and Cardiometabolic Health: What the Evidence from Sugar-Sweetened Beverages Tells Us*, 66 J. AM. C. CARDIOLOGY 1615 (2015).

[19] Cynthia L. Ogden et al., *Prevalence of Childhood and Adult Obesity in the United States, 2011–2012*, 311 JAMA 806 (2014). Worldwide, according to McKinsey & Company, "almost half of the world's adult population could be overweight or obese by 2030." MCKINSEY GLOB. INST., OVERCOMING OBESITY: AN INITIAL ECONOMIC ANALYSIS 11 (2014) (internal citation omitted). The McKinsey Report added a critical public health perspective: the 2.1 billion obese or overweight people in the world is two and a half times the number of undernourished people. *Id.* at 14.

[20] CYNTHIA OGDEN & MARGARET CARROLL, CTRS. FOR DISEASE CONTROL & PREVENTION, PREVALENCE OF OBESITY AMONG CHILDREN AND ADOLESCENTS: UNITED STATES, TRENDS 1963–1965 THROUGH 2007–2008, at 5 (2010), https://goo.gl/6afktw.

[21] CHERYL D. FRYAR, MARGARET D. CARROLL & CYNTHIA L. OGDEN, CTRS. FOR DISEASE CONTROL & PREVENTION, PREVALENCE OF OVERWEIGHT, OBESITY, AND EXTREME OBESITY AMONG ADULTS: UNITED STATES, 1960–1962 THROUGH 2011–2012, at tbl. 2 (2014), http://goo.gl/dc2UHy.

38. Fifty-five percent (55%) of adult Californians are estimated to have diagnosed diabetes, undiagnosed diabetes, or pre-diabetes.[22]

39. Forty-six percent (46%) of adults in the United States have pre-diabetes or diabetes.[23]

40. Estimates on the annual cost of medical care and premature mortality attributable to the consumption of sugar-sweetened beverages are astronomical. For example, in New York City alone, the figure is estimated at between $16.4 billion and $17.96 billion.[24]

II. DEFENDANTS' FALSE PROMISES AND MISREPRESENTATIONS

41. In 2012, faced with an established and growing body of scientific research linking its products to obesity, type 2 diabetes, and cardiovascular disease, Coca-Cola and the ABA ramped up their campaign of misrepresentation and deception.

42. Around the same time, various other city, county, and state regulators, as well as foreign governments, were openly discussing a variety of measures intended to address the epidemics of obesity, diabetes, and cardiovascular disease, and consumer misperceptions of sugar-sweetened beverages and their potential for harm.

43. To combat this perceived threat to the security of the company's products and corporate profitability, Coca-Cola executives embarked on an intensive public speaking and marketing campaign in which they knowingly made material misrepresentations and omissions to the public and, upon information and belief, to various governmental entities tasked with protecting the public health, about the health consequences of consuming their sugar-sweetened beverage products.

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[22] SUSAN H. BABEY ET AL., UCLA CTR. FOR HEALTH POLICY RESEARCH, PREDIABETES IN CALIFORNIA: NEARLY HALF OF CALIFORNIA ADULTS ON PATH TO DIABETES 1 (2016), https://goo.gl/f3NKqI.

[23] NATIONAL DIABETES STATICS REPORT OF THE CDC (2014), https://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf.

[24] Shi-Ling Hsu, *A Cost-Benefit Analysis of Sugary Drink Regulation in New York City*, 10 J. FOOD L. & POL'Y 73, 103 tbl. 12 (2014).

44. In particular, Coca-Cola falsely propounded that sugar-sweetened beverages are not linked to obesity, type 2 diabetes, or cardiovascular disease.

45. As part of this misrepresentation, Coca-Cola executives and agents misleadingly sought to divert focus from sugar-sweetened beverage consumption to a purported lack of exercise as the explanation for the rise in obesity-related chronic conditions, despite the fact that they knew this explanation was not scientifically sound. To do this, Coca-Cola employed, and together with the American Beverage Association continues to employ, various euphemisms like "balance," "calories in, calories out," and "mixify."

46. Defendants have made these representations in the face of an overwhelming body of evidence establishing that sugar-sweetened beverages are linked to obesity, diabetes, and cardiovascular disease, and that exercise alone—particularly of the type promoted by Defendants—does not protect consumers from these harms.

47. Defendants continue to deny that sugar-sweetened beverages are linked to obesity, diabetes type-2, and cardiovascular disease, and continue to misrepresent the science on sugar-sweetened beverages despite widespread agreement in the scientific and medical communities that sugar-sweetened beverages are a primary cause of obesity, type 2 diabetes, and cardiovascular disease.

48. In addition to engaging in this deceptive campaign to promote false facts to consumers, Coca-Cola also took the following actions to respond to the growing scientific evidence linking consumption of its products to obesity, type 2 diabetes, and cardiovascular disease: (A) it secretly funded and publicly promoted biased scientific research, and intentionally mischaracterized objective scientific research on sugar-sweetened-beverage-consumption; (B) it funded and worked with the American Beverage Association to organize expensive initiatives that promoted exercise, or "balance," in California, across the United States, and globally, as an alternative to reducing consumption of sugar-sweetened beverages; and (C) it ran false and misleading advertising campaigns.

A. False Representations to Consumers by Coca-Cola and Its Front Groups

49. Faced with a growing scientific consensus linking its products to obesity, type 2 diabetes, and cardiovascular disease, Coca-Cola's top scientists and executives have unambiguously pledged and represented to the public that sugar-sweetened beverage consumption is not linked to obesity, type 2 diabetes, or cardiovascular disease. Coca-Cola's representatives have done so despite actual knowledge of facts to the contrary.

50. Coca-Cola knew or should have known that consumers (and regulatory agencies responsible for protecting their health) would consider the Coca-Cola's representations material to their decisions whether to purchase Coca-Cola's sugar-sweetened beverages, decisions that consumers otherwise would have modified had Coca-Cola been truthful in its representations and its public pledges about promoting unbiased science.

51. Coca-Cola's Senior Vice President, Katie Bayne, has repeatedly been quoted stating that "[t]here is no scientific evidence that connects sugary beverages to obesity."[25]

52. Coca-Cola's former Chairman and Chief Executive Officer, Douglas Ivester, has made similar high publicity misrepresentations, such as that "Coca-Cola is an excellent complement to the habits of a healthy life."[26]

53. Coca-Cola also funded "front" groups, such as the Global Energy Balance Network ("GEBN") and the European Hydration Institute ("EHI"), that are presented to the public as disinterested research entities but are or were actually Coca-Cola-funded and used by Coca-Cola to more effectively misrepresent, suppress, and confuse the facts about sugar-sweetened beverages and their health dangers.

54. Dr. Steven Blair, the vice president of GEBN, which claimed to fund unbiased research into causes of obesity, put it this way: "Most of the focus in the popular media and the scientific press . . . blames . . . sugary drinks [for the obesity epidemic], and there is really

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[25] Bruce Horovitz, *Coke Says Obesity Grew as Sugar Drink Consumption Fell*, USA TODAY (June 7, 2012), http://goo.gl/w0jFU2 (statement by Coke executive Katie Bayne).

[26] *The Unhappy Truth About Soda*, CTR. FOR SCI. IN THE PUB. INTEREST, http://www.therealbears.org/ (last visited Sept. 16, 2016).

virtually no compelling evidence that that, in fact, is the cause. Those of us interested in science, public health, medicine, we have to learn how to get the right information out there."[27]

55. In 2015, claiming to be "the voice of science," GEBN touted "strong evidence" that the key to preventing weight gain is not reducing sugar-sweetened beverage intake, "but maintaining an active lifestyle and eating more calories."[28]

56. EHI touts the same message in Europe.[29] Notably, like GEBN, EHI professes independence.[30] However, Coca-Cola co-founded EHI, and its Director, Dr. Jane Holdsworth, is a paid Coca-Cola consultant.[31]

57. Whether through GEBN, or various universities, Coca-Cola spent approximately $120 million, between 2010–2015 alone, surreptitiously funding various research and programs intending to confuse and misrepresent the science on the link between sugar-sweetened beverages and obesity, type 2 diabetes, and cardiovascular disease.[32]

58. An analysis of beverage studies published in PLOS Medicine found that those funded by Coca-Cola, PepsiCo, and the American Beverage Association were five times more likely to find no link between sugar-sweetened beverages and obesity than studies whose authors reported no financial conflicts.[33] A recent study found by Dr. Schillinger of the University of

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[27] CrossFit, *Dr. Steven Blair of Coca-Cola and ACSM's Global Energy Balance Network*, YOUTUBE (Sept. 10, 2015), https://goo.gl/h14Yq8.

[28] Anahad O'Connor, *Coca-Cola Funds Scientists Who Shift Blame for Obesity Away from Bad Diets*, N.Y. TIMES (Aug. 9 2015), http://goo.gl/tpfrg7 (quoting GEBN's now-discontinued website). *See also* Anahad O'Connor, *Coke's Chief Scientist, Who Orchestrated Obesity Research, Is Leaving*, N.Y. TIMES (Nov. 24, 2015), http://goo.gl/u33ZNF (while Coca-Cola said it had no influence on GEBN, "reports show that Dr. Applebaum and other executives at Coke helped pick the group's leaders, create its mission statement and design its website").

[29] EUROPEAN HYDRATION INST., http://goo.gl/JEKIb (last visited Sept. 15, 2016).

[30] "The members of the Science Advisory Board of the EHI do not have any conflicts of interest with any commercial organization." *Id.* (quote de-italicized).

[31] *What Is the European Hydration Institute?*, EUROPEAN HYDRATION INST., http://goo.gl/TGOr6W (last modified June 14, 2016; last visited Sept. 16, 2016).

[32] Anahad O'Connor, *Coke Discloses Millions in Grants for Health Research and Community Programs*, N.Y. TIMES (Sept. 22, 2015), http://goo.gl/hK48HC.

[33] Anahad O'Connor, *Coca-Cola Funds Scientists Who Shift Blame for Obesity Away from Bad Diets*, N.Y. TIMES (Aug. 9 2015), http://goo.gl/tpfrg7 (referencing Maira Bes-Rastrollo et al., *Financial Conflicts of Interest and Reporting Bias Regarding the Association Between Sugar-*

California San Francisco's Division of General Internal Medicine and Center for Vulnerable Populations, found an even greater impact. He found that 26 of 26 "negative" studies (finding no link between SSBs and obesity), or 100%, received funding from the soda industry, and only one of 34 "positive" studies received industry funding. His research led him to conclude that "[t]he SSB industry appears to be manipulating contemporary scientific processes to create controversy and advance their business interests at the expense of the public's health."[34]

59. Just as the tobacco industry formed the Tobacco Industry Research Committee in 1953 to respond to scientific evidence linking smoking to lung cancer, Coca-Cola's strategy was one of "cultivating relationships" with scientists as a way to "balance the debate" on sugar-sweetened beverages.[35] Dr. Rhona Applebaum, Coca-Cola's "Chief Science and Health Officer" was put in charge of locating such scientists.

60. Applebaum funded Dr. James Hill, of the University of Colorado, for example, after he explicitly proposed publishing research that would help Coca-Cola fend off criticism about its products by shifting the blame for obesity to lack of physical activity. "I . . . could provide a strong rationale for why a company selling sugar water should focus on promoting physical activity. This would be a very large and expensive study, but could be a game changer. We need this study to be done."[36]

Sweetened Beverages and Weight Gain, 10 PLOS MEDICINE e1001578 (2013)). Another analysis found that beverage industry-funding studies are as much as eight times more likely to be favorable to industry's marketing interests. Willett Report, *supra* note 8, at ¶ 27 (citing Leonard I. Lesser et al., *Relationship Between Funding Source and Conclusion Among Nutrition-Related Scientific Articles*, 4 PLOS MEDICINE e5 (2007)).

[34] Dr. Dean Schillinger, *Do Sugar-Sweetened Beverages Cause Obesity and Diabetes? Industry and the Manufacture of Scientific Controversy,* ANN AM. MEDICINE (NOV. 2016), https://WWW.NCBI.NLM.NIH.GOV/PUBMED/27802504.

[35] Anahad O'Connor, *Coke's Chief Scientist, Who Orchestrated Obesity Research, Is Leaving*, N.Y. TIMES (Nov. 24, 2015), http://goo.gl/u33ZNF.

[36] *Id.*

61. Dr. Hill further added, "I want to help your company avoid the image of being a problem in people's lives and back to being a company that brings important and fun things to them."[37]

62. Coca-Cola's Chief Executive Officer, Muhtar Kent, directed Dr. Applebaum to seek to persuade CBS to invite Dr. Hill on "CBS This Morning," so as to have him help shape media coverage about sugar-sweetened beverages.[38]

63. Meanwhile, Dr. Applebaum and various scientists misrepresented to the public and consumers that the science Coca-Cola was funding constituted totally independent research efforts with completely unrestricted funding.

64. Similarly, James Quincey, who is slated to become Defendant's CEO as of May 2017, has repeatedly publicized that Coca-Cola's role is to "get information [about obesity and SSBs] into people's hands" to empower their "choices." Put another way, that Defendant is "not trying to hide the information," instead pledging that "we are focused on getting the information out there." Contemporaneously, he shifted responsibility for the obesity and diabetes epidemics away from sugar-sweetened beverages and, explicitly, to a lack of activity, claiming that sugar-sweetened beverages constitute less than 2% of all calories, and by implication, bear only a tiny fraction of responsibility for the obesity epidemic.[39]

65. Coca-Cola's representations as to the state of the science, and about sponsoring independent and objective research and "bringing the facts to light," were false and deceptive. They were made to gain the trust of the consuming public and to cast doubt on the substantial, credible science linking Coca-Cola's products to obesity, diabetes, and cardiovascular disease.

66. Likewise, Coca-Cola funded and guided industry groups in promoting its deceptive campaign. Defendant ABA, a trade association of soda manufacturers, financed extensively by Coca-Cola, reduced the entire body of scientific research linking sugar-sweetened

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[37] *Id.*

[38] *Id.*

[39] BBC Interview by Jeremy Paxman with James Quincey, in London, England (Nov. 27, 2013), https://www.youtube.com/watch?v=DWLQaz8nhQw (last visited Jan. 4, 2017).

beverages and obesity and related diseases to a mere 'emotional' impulse. Its statement in June 2016, argued that "[a]pplying a tax to certain items because those items have an emotional association to obesity in the minds of some groups is not only flawed, it's shortsighted and lazy."[40]

67. Sandy Douglas, President of Coca-Cola North America, sits on the board of directors of the ABA, along with *six other* Coca-Cola executives and affiliate executives, including Claude Nielsen of Coca-Cola Bottling Company United, who is also an ex-officio officer.[41]

68. Beyond its management function, Coca-Cola principally funds the ABA, treating it as an arm of Coke's public relations enterprise. Coca-Cola executives commonly refer to "working an issue through" the ABA.

69. As of September 2016, the ABA's website was replete with misleading and materially incomplete representations about the link between sugar-sweetened beverages and obesity-related chronic diseases. For example, the following omits entirely the prominent role played by routine sugar-sweetened beverage consumption in the rise of obesity and related chronic diseases:

> Soda is a hot topic. And the conversation is full of opinions and myths, but not enough facts. America's beverage companies created this site to clear a few things up about the products we make. So read on. Learn. And share the clarity.
>
> * * *
>
> Fact: Obesity. Obesity is a complex condition, that can't be boiled down to one specific product or ingredient. Many health organizations, including the Mayo Clinic, have found multiple risk factors including genetics, ages, and even lack of sleep.
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[40] *Taxing Beverages Is "Flawed" and "Lazy,"* AM. BEVERAGE ASS'N (June 24, 2016), http://goo.gl/rcn2qb (quoting Jeff Rogut, CEO of the Australasian Association of Convenience Stores) (last visited Sept. 16, 2016).

[41] *Board of Directors*, AM. BEVERAGE ASS'N, https://goo.gl/8lo6w (last visited Sept. 16, 2016).

> Focusing on [soda]—ignores the bigger problem and doesn't offer real solutions.[42]

70. Other red herrings advanced by the ABA include discussions of high fructose corn syrup ("HFCS")—which is irrelevant because whether sugar-sweetened beverages are sweetened with HFCS or traditional sugar, their link with disease is established:

> Myth: High Fructose Corn Syrup (HFCS) causes obesity and diabetes.
> Fact: Actually, the American Medical Association has concluded that HFCS . . . is not a unique contributor to either obesity or type 2 diabetes. In fact, HFCS is so similar to sucrose (table sugar) that your body can't tell the difference between the two and processes both in the same way.[43]

71. Coca-Cola and the ABA have marshalled an army of spokespersons who systematically deny through various public relations means the science linking sugar-sweetened beverages to obesity and related diseases and promote falsehoods and misimpressions in its place.

72. By way of further example, in an op-ed entitled "Soda Tax is wrong formula, regardless of ideology," for example, Professor Baylen Linnekin—without disclosing that he is a paid "expert" of Americans for Food & Beverage Choice, a self-identified "affiliate" of the ABA—wrote that "key data shows the lack of a causal link between soda consumption and obesity."[44]

73. Other paid experts asserted that "the claim linking diabetes to soda is remarkably fragile," "according to the American Diabetes Association, Type 2 diabetes is caused by genetics

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[42] Am. Beverage Ass'n, *Home*, LET'S CLEAR IT UP, http://goo.gl/Ft8VNp (last visited Sept. 16, 2016); Am. Beverage Ass'n, *Health*, LET'S CLEAR IT UP, http://goo.gl/NZCwGy (last visited Sept. 16, 2016); Am. Beverage Ass'n, *Beverages*, LET'S CLEAR IT UP, http://goo.gl/D1o8EI (last visited Sept. 16, 2016).

[43] Am. Beverage Ass'n, *Obesity*, LET'S CLEAR IT UP, http://goo.gl/AAUPzD (last visited Sept. 16, 2016).

[44] Baylen J. Linnekin, Op-Ed., *Soda Tax Is Wrong Formula, Regardless of Ideology*, BERKELEYSIDE (Oct. 14, 2014), http://goo.gl/ydWgGK (last visited Sept. 16, 2016).

and lifestyle factors, not soda," and "eliminating soda and sugary beverages from your diet will not save your health any more than over-emphasizing fruits and vegetables."[45]

74. ABA press releases follow the same approach, including:

- "You may have read articles recently suggesting that there is something unique about soda when it comes to diabetes. Yes, diabetes. It's always something if you're reading the headlines. But if you dig deep enough, there's no 'there' there";[46]
- "There is no unique link between soda consumption and obesity";[47]
- "[T]here's nothing unique about beverage calories when it comes to obesity or any other health condition. Sadly, however, the days of simply enjoying a refreshing beverage are under assault – that is, if you choose to listen to our critics";[48]
- "Sugar isn't the enemy, the problem is calories. . . . demonizing [] sugar isn't going to improve public health";[49]
- "[T]he attack on added sugars is not founded on the totality of scientific evidence. . . . Like past false food scares, the anti-soda campaign misleads people with unsound science";[50]
- "You may have seen some attention to research presented at an American Heart Association meeting that suggests that drinking two or more sugar-

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[45] Ams. for Beverage Choice, *Warning Labels on Soda? California's Newest Crazy Idea*, CALIFORNIANS FOR FOOD & BEVERAGE CHOICE (Feb. 14, 2014), http://goo.gl/dd88US (last visited Sept. 16, 2016).

[46] *Cut Through the Headlines and Get the Facts*, AM. BEVERAGE ASS'N (Nov. 8, 2013), http://goo.gl/s1w3eK (last visited Sept. 16, 2016).

[47] *Last Ditch Effort in New York Budget Debates*, AM. BEVERAGE ASS'N (May 24, 2010), http://goo.gl/kN3FZ6 (last visited Sept. 16, 2016).

[48] *Simply Soda. . . .*, AM. BEVERAGE ASS'N (June 11, 2012), http://goo.gl/JstcDx (last visited Sept. 16, 2016).

[49] *Experts: Blaming Sugar Won't Yield Results*, AM. BEVERAGE ASS'N (Oct. 1, 2015), http://goo.gl/19E0Gm (quoting, in part, Dr. John L. Sievenpiper) (last visited Sept. 16, 2016).

[50] *The Added Sugar Fantasy*, AM. BEVERAGE ASS'N (June 17, 2015), http://goo.gl/JngEQA (last visited Sept. 16, 2016).

sweetened beverages per day increases the risk of cardiovascular disease among women. It's always worth questioning a news report on a study if it only presents one side";[51]

- "In 1984, President Ronald Reagan designated July as National Ice Cream Month, recognizing ice cream as a fun and nutritious food that 90% of our population enjoys. . . . [W]e want to remind you to grab a beverage to go with your ice cream. It's important to stay hydrated, especially in these warm summer months";[52]
- "Despite what you may read in frequent stories that come out in the media, sugar-sweetened beverages are not a unique driver of public health concerns such as obesity and diabetes. Simply put, it is wrong to say beverages cause disease";[53]
- "[A]ll calories are the same regardless of food source. . . . 100 calories from a donut or a yogurt is still 100 calories";[54]
- "Recently we've seen some food activists allege that sugar-sweetened beverages 'cause' obesity, diabetes and a host of other adverse health conditions. Obviously they are hoping you never look at the science behind their claims. Because it doesn't exist";[55]

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[51] *Here We Go Again . . . .*, AM. BEVERAGE ASS'N (Nov. 14, 2011), http://goo.gl/0Ywg96 (last visited Sept. 16, 2016).

[52] *Did You Get Your Ice Cream*, AM. BEVERAGE ASS'N (July 26, 2013), http://goo.gl/Y1emwi (last visited Sept. 16, 2016).

[53] *Taking a Closer Look at Recent Studies on Diabetes*, AM. BEVERAGE ASS'N (July 23, 2015), http://goo.gl/JQtXgK (last visited Sept. 16, 2016).

[54] *Setting the Record Straight on Calories*, AM. BEVERAGE ASS'N (Sept. 16, 2015), http://goo.gl/0HVYB3 (quoting Megan Meyer, PhD, program manager of health and wellness communications at the Int'l Food Info. Council—a Coca-Cola-funded group) (last visited Sept. 16, 2016).

[55] *Clearing up the Conversation on Beverages*, AM. BEVERAGE ASS'N (June 24, 2015), http://goo.gl/tkL2Se (last visited Sept. 16, 2016).

- "Consuming . . . sugar is not uniquely related to insulin resistance or diabetes. . . It is over-consumption of calories that increases the risk of health issues like Type 2 diabetes and obesity";[56] or
- "Overconsumption of anything (even water) can be risky."[57]

75. The ABA's Americans for Food and Beverage Choice regularly pushes misrepresentations through multiple media outlets as well. Such as statements that:

- "Managing diabetes is all about balancing what you eat with your activity level. . . . A daily soda is fine";[58]
- "At the end of the day, all calories count—from any source. The body of science is clear and supports that a calorie is still a calorie regardless of the source";[59] and
- "The same holds true for headlines that say drinking soda can cause obesity, type 2 diabetes, or heart disease. What's missing from those unfounded statements is any evidence from randomized clinical trials."[60]

76. Coca-Cola also pays individual health professionals to promote sugar-sweetened beverages. According to Coca-Cola spokesperson Ben Sheidler, Coca-Cola "ha[s] a network of dietitians we work with." In February of 2015, these dietitians wrote numerous online pieces for American Heart Month, each including the suggestion that a soda could be a healthy snack, "like . . . packs of almonds."[61]

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[56] *Warning Labels Won't Work*, AM. BEVERAGE ASS'N (Mar. 16, 2015), http://goo.gl/aSmnBa (quoting Lisa Katic, a registered dietitian and ABA consultant) (last visited Sept. 16, 2016).

[57] *Overconsumption of Anything (Even Water) Can Be Risky*, AM. BEVERAGE ASS'N (Aug. 3, 2015), http://goo.gl/SvKeb2 (last visited Sept. 16, 2016).

[58] Amy Myrdal Miller, *You Can't Eat That! And Other Bad Advice*, AMS. FOR FOOD & BEVERAGE CHOICE (Apr. 25, 2016), http://goo.gl/htslCQ (last visited Sept. 16, 2016).

[59] Amber Pankonin, *Myth or Fact: Is a Calorie Just a Calorie?*, STOP THE ALA. BEVERAGE TAX (Sept. 21, 2015), https://goo.gl/qS8cQn (site spearheaded by a chapter of the Americans for Food and Beverage Choice) (last visited Sept. 16, 2016).

[60] Robyn Flipse, *Bacon, Soda, and Longevity – What's the Connection*, AMS. FOR FOOD & BEVERAGE CHOICE (Aug. 24, 2015), http://goo.gl/bH58TU (last visited Sept. 16, 2016).

[61] Candice Choi, *Coca-Cola Teams up with Nutritionists to Push Coke as Healthy Treat*, FOOD MANUFACTURING (Mar. 16, 2015), http://goo.gl/CnWLgA.

77. While designed to look like regular stories, the pieces were sponsored by Coca-Cola, and ran in 1,000 or more news outlets. Sometimes the authors indicated that they were "consultants," other times not—but rarely if ever did any disclaimer make clear that Coca-Cola paid for the columns even though such nutritionists presented themselves as trustworthy authorities.[62]

B. Balance & Hydration: Coca-Cola's Deceptive Advertising Campaign

78. As part of its concerted campaign to shift attention away from the substantial, credible science linking sugar-sweetened beverages to obesity, diabetes, and cardiovascular disease, Coca-Cola also developed a direct advertising campaign that falsely and misleadingly promoted to consumers that they could "balance" their consumption of sugar-sweetened beverages with exercise and through careful monitoring of "calories-in, calories-out."

79. Directly through its own advertising and through the ABA, Coca-Cola falsely and misleadingly advertised that balance—of calories in and calories out—enables healthful consumption of sugar-sweetened beverages and prevents obesity.

80. However, the scientific consensus is that exercise, especially light exercise like the "75 seconds of laughing out loud" featured in one ad by Coca-Cola,[63] cannot offset the negative health effects, including obesity and related chronic diseases, of drinking sugar-sweetened beverages.

81. While health authorities such as the federal government's 2008 Physical Activity Guidelines encourage people to exercise, these same Guidelines acknowledge that "the contribution that physical activity makes to weight loss and weight stability is relatively small."[64]

82. The tiny expenditures of exercise suggested in Coca-Cola ads pale in comparison to the quantity of exercise needed to redress excess calories from sugar-sweetened beverages.

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[62] *Id.*

[63] *See* The Coca-Cola Co., *Be OK*, YOUTUBE (Jan. 16, 2013), https://goo.gl/l2e520 (video advertisement by Coke) (last visited Sept. 16, 2016).

[64] *See, e.g.,* Guidelines, https://health.gov/paguidelines/report/G4_energy.aspx#q1c.

Furthermore studies find that even intensive exercise programs often fail to lead to expected weight loss.[65]

83. As Dr. Margaret Chan, Director-General of the World Health Organization, told the annual meeting of the National Academy of Medicine in October 2016:

> When crafting preventive strategies, government officials must recognize that the widespread occurrence of obesity and diabetes throughout a population is not a failure of individual willpower to resist fats and sweets or exercise more. It is a failure of political will to take on powerful economic operators, like the food and soda industries.[66]

84. Coca-Cola's advertising campaigns, however, represent otherwise.[67]

85. For example, the "Be Ok" advertising campaign, which ran extensively in the United States, including during the popular television show American Idol and the Super Bowl, implied that light activities—always undertaken by trim and fit models, instead of overweight, obese or diabetic consumers—like laughing for 75 seconds, or doing a victory jig in the bowling

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[65] *See, e.g.,* Timothy S. Church et al., *Changes in Weight, Waist Circumference and Compensatory Responses with Different Doses of Exercise Among Sedentary, Overweight Postmenopausal Women*, 4 PLOS ONE e4515 (2009) (increased food intake because of heightened hunger); Emily J. Dhurandhar et al., *Predicting Adult Weight Change in the Real World*, 39 INT'L J. OBESITY (LONDON) 1181 (2015) (metabolic compensation via slowing of basal rate); Edward L. Melanson et al., *Resistance to Exercise-Induced Weight Loss: Compensatory Behavioral Adaptations*, 45 MED. & SCI. SPORTS & EXERCISE 1600 (2013) (compensatory behaviors like resting post exercise); Herman Pontzer et al., *Constrained Total Energy Expenditure and Metabolic Adaptation to Physical Activity in Adult Humans*, 26 CURRENT BIOLOGY 410 (2016) (energy expenditure ceiling); K. A. Shaw et al., *Exercise for Overweight or Obesity*, Cochrane Libr., Oct. 18, 2006 (meta-analysis of studies showing exercise does not equate with weight loss); D. M. Thomas et al., *Why Do Individuals Not Lose More Weight from an Exercise Intervention at a Defined Dose? An Energy Balance Analysis*, 13 OBESITY REV. 835 (2012) (overestimation of how much energy exercise burned versus calories taken in); Klaas R. Westerterp, *Physical Activity and Physical Activity Induced Energy Expenditure in Humans: Measurement, Determinants, and Effects*, 4 FRONTIERS PHYSIOLOGY 90 (2013) (exercise accounts for small portion of daily calorie burn (10-30%) whereas calories in accounts for 100% of energy intake of the body).

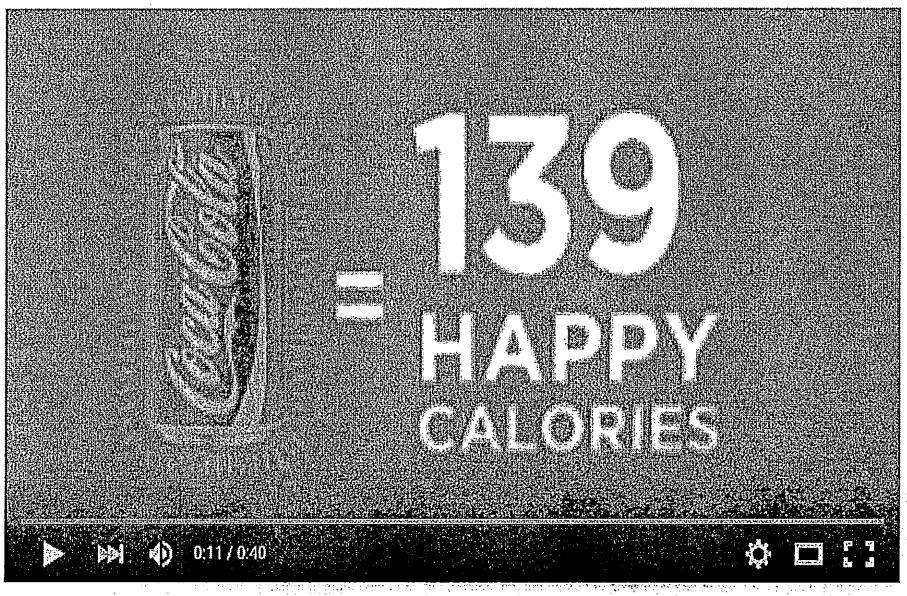
[66] Dr. Margaret Chan, *Obesity and diabetes: the slow-motion disaster,* KEYNOTE ADDRESS 47TH MTG OF THE NATIONAL ACADEMY OF MEDICINE, HTTP://WWW.WHO.INT/DG/SPEECHES/2016/OBESITY-DIABETES-DISASTER/EN/.

[67] Tiffany Hsu, *Coca-Cola Takes on Obesity Issue in Prime-Time Ad Campaign*, L.A. TIMES (Jan. 14, 2013), http://goo.gl/HMDF7F; *Coca-Cola Ad Pushes Exercise, Soft Drink Moderation*, AJC.COM (Jan. 14, 2013); http://goo.gl/OOOP4m.

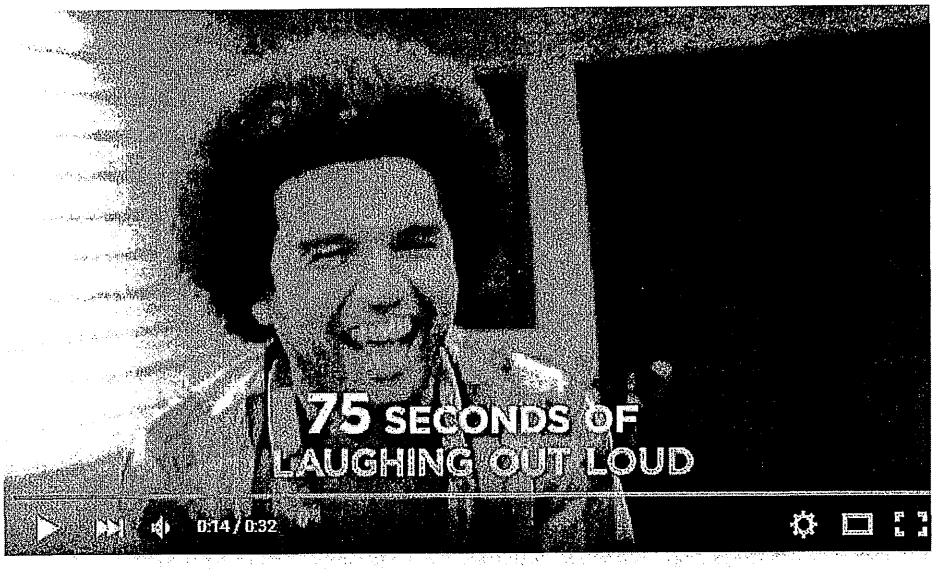
alley, or 15 minutes of happy dancing—would offset the harmful health consequences of consuming sugar-sweetened beverages. *See* Illustrations 1–3.

Illustrations 1–3

"A 12oz can of Coke = 140 calories. There are many ways to burn those calories through EXTRA physical activity and have fun while doing so. Balance your lifestyle. **Be OK. Open happiness.** Visit http://comingtogether.com."



Coca-Cola: 'Be OK' 139 calories advert



Be OK

Coca-Cola: 'Be OK' 139 calories advert

86. Coca-Cola's claims are prolific that avoiding obesity and other bad health outcomes is substantially about "balance," or "energy in and energy out."

87. Coca-Cola has extensively promoted the claim that "[s]ugary drinks can be a part of any diet as long as your calories in balance with the calories out.[68]

88. Likewise, the "Mixify" multi-platform advertising campaign, sponsored by Coca-Cola, the American Beverage Association, and other sugar-sweetened beverage producers, pitches kids on the notion that they should not be concerned about added sugar or calories. It encourages them to consume sugar-sweetened beverages and then exercise more.[69] Advertisements sponsored by Coca-Cola through the Mixify campaign advise kids, "Just finished an afternoon of Frisbee? Maybe you've earned a little more [soda]."[70]

89. Cola-Cola's "Coming Together" advertising campaign promotes a related deception. It proclaims, "All calories count. No matter where they come from including Coca-Cola and everything else with calories."[71] This statement is misleading given the health consequences associated with drinking sugar-sweetened beverages, and their lack of nutritional value.

90. As Professor Ruth Fagan, Wagley Professor of Biomedical Ethics and Director of the Johns Hopkins Berman Institute of Bioethics, said of the Coming Together campaign,

> For Coca-Cola to suggest that all calories are equal flies in the face of reality. . . . Coca-Cola wants us to ignore the considerable research confirming that sugary soda is a major contributor to obesity, and that it has no nutritional value.[72]

91. The Coming Together campaign also flies in the face of the CDC's conclusion that all calories are not equal because, among other things, "individuals may fail to compensate

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[68] *Coke Executive Answers Questions About Sugary Drinks*, USA TODAY (June 7, 2012), http://goo.gl/z1SPqh (statement made by Coke executive Katie Bayne during interview).

[69] *Find Your Mixify*, MIXIFY, http://goo.gl/6U05e7 (last visited Sept. 15, 2016).

[70] MyMixify, *MyMixify*, YOUTUBE (Sept. 23, 2014), https://goo.gl/8azpWA (last visited Sept. 16, 2016).

[71] Isabela Carvalho Santos, *Coming Together The Real Ad from Coca Cola*, YOUTUBE (Oct. 25, 2013), https://goo.gl/fZkvRO (video advertisement by Coke) (last visited Sept. 16, 2016).

[72] Ruth Faden, *Coke's Unconscionable New Ad*, THE ATLANTIC (Jan. 25, 2013), http://goo.gl/eGYEgI.

for . . . calories consumed as liquid."[73] More, some calories have nutritional value, and others are neutral or adverse nutritionally; this distinction is the rationale for Dietary Guidelines.

92. As part of Coca-Cola's insistence on refocusing the sugar-sweetened beverage conversation around exercise and balance, in 2014, it spent $22 million on "physical activity" programs internationally,[74] in which it also advertised its products.[75] *See* Illustrations 4 & 5.[76]

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[73] CTRS. FOR DISEASE CONTROL & PREVENTION, THE CDC GUIDE TO STRATEGIES FOR REDUCING THE CONSUMPTION OF SUGAR-SWEETENED BEVERAGES 4 (2010), http://goo.gl/OWgFs; *accord* Robin P. Bolton et al., *The Role of Dietary Fiber in Satiety, Glucose, and Insulin: Studies with Fruit and Fruit Juice*, 34 AM. J. CLINICAL NUTRITION 211 (1981); Diane M. DellaValle et al., *Does the Consumption of Caloric and Non-Caloric Beverages with a Meal Affect Energy Intake?*, 44 APPETITE 187 (2005); D. P. DiMeglio & R. D. Mattes, *Liquid Versus Solid Carbohydrate: Effects on Food Intake and Body Weight*, 24 INT'L J. OBESITY 794 (2000); G. B. Haber et al., *Depletion and Disruption of Dietary Fibre: Effects on Satiety, Plasma-Glucose, and Serum-Insulin*, 310 LANCET 679 (1977); Jessica N. Kuzma et al., *No Difference in Ad Libitum Energy Intake in Healthy Men and Women Consuming Beverages Sweetened with Fructose, Glucose, or High-Fructose Corn Syrup: A Randomized Trial*, 102 AM. J. CLINICAL NUTRITION 1373 (2015); R. D. Mattes, *Beverages and Positive Energy Balance: The Menace Is the Medium*, 30 INT'L J. OBESITY S60 (2006); D. M. Mourao et al., *Effects of Food Form on Appetite and Energy Intake in Lean and Obese Young Adults*, 31 INT'L J. OBESITY 1688 (2007); An Pan & Frank B. Hu, *Effects of Carbohydrates on Satiety: Differences Between Liquid and Solid Food*, 14 CURRENT OPINION CLINICAL NUTRITION & METABOLIC CARE 385 (2011).

[74] THE COCA-COLA CO., 2014/2015 SUSTAINABILITY REPORT 10 (2015), http://goo.gl/E4N5gM (last visited Sept. 16, 2016).

[75] Notably too, Coke's extravagant spending belies Coke's Forward Looking Statements, which clearly minimize the impact of "obesity concerns." *E.g.*, The Coca-Cola Co., Current Report (Form 10-K), at 38 (Feb. 9, 2016).

[76] THE COCA-COLA CO., 2014/2015 SUSTAINABILITY REPORT 8, 11 (2015), http://goo.gl/E4N5gM (last visited Sept. 16, 2016).

Illustrations 4 & 5

93. Beginning in May 2013, Coca-Cola introduced its "Get the Ball Rolling" program which hosted events it claimed were aimed at "bringing together happiness and movement in a way that only The Coca-Cola company can."[77] According to a story posted on the company's website, the program's activities "build on our Company's global commitments to help fight obesity and be part of the solution," and involved seeking partners "to help address obesity in every community we serve."[78] In its first year of operation, the company co-hosted "Get the Ball Rolling" events (targeted at children) with organizations such as the Boys & Girls Clubs of America, National Foundation for Governors' Fitness Councils, NASCAR, and many others.[79] Coca-Cola continues to fund and promote the program.

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[77] Stuart Cronauge, Coca-Cola USA Sets Goal To Inspire Americans To Rediscover The Joy Of Activity, COCA-COLA (May 13, 2013), http://www.coca-colacompany.com/press-center/press-releases/coca-cola-gets-the-ball-rolling-for-a-fun-active-summer.

[78] *Id.*

[79] Caren Pasquale Seckler, How Has Coca-Cola Inspired More Than 3 Million People To "Get The Ball Rolling"? COCA-COLA (Sept. 23, 2013), http://www.coca-colacompany.com/coca-cola-unbottled/how-has-coca-cola-inspired-more-than-3-million-people-to-get-the-ball-rolling.

94. Through the ABA, Coca-Cola also subsidized the 2016 Childhood Obesity Prevention Awards. These high-fanfare grants are given by the U.S. Conference of Mayors to six cities for their activity-focused nutrition programs.[80]

95. In widely promoting these exercise programs, Coca-Cola proclaimed that "[w]ell-being is integral part of our business—from the communities we serve to the people we refresh. Our well-being commitments serve as a guide for our global efforts . . . with an end goal to inspire happier, healthier lives." [81]

96. Coca-Cola and the ABA also promoted a program called the "Balance Calories Initiatives," which, according to a Coca-Cola press release, "encourages people to balance all of their calories – including beverages – with daily physical activity."[82] Susan K. Neely, President and CEO of the ABA emphasized the collaborative nature of the project, noting that the common goal of "health and wellbeing of communities across the country" overrides the normally competitive nature of commercial interests, joining all the members of the Association.[83]

97. Coca-Cola paid nutritionists, too, to blog about balance and sugar-sweetened beverages as healthy snacks.[84]

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[80] U.S. Conference of Mayors, *Six Cities Share $445,000 in Grants to Support Childhood Obesity Prevention Programs*, PR NEWSWIRE (Jan. 21, 2016), https://goo.gl/X4IpQ7; Press Release, Am. Beverage Ass'n, Six Cities Share $445,000 in Grants to Support Childhood Obesity Prevention Programs (Jan. 21, 2016), https://goo.gl/nS7Tkb (last visited Sept. 15, 2016); *see also* Press Release, Coca-Cola Co., The Coca-Cola Foundation Awards $8.1 in Third Quarter Benefitting 3.8 Million People Worldwide (Oct. 18, 2013), https://goo.gl/SZRYkE (promoting Coca-Cola Foundation's funding of foreign childhood obesity programs) (last visited Sept. 15, 2016).

[81] THE COCA-COLA CO., 2014/2015 SUSTAINABILITY REPORT 8 (2015), http://goo.gl/E4N5gM (last visited Sept. 16, 2016).

[82] Journey Staff, Coca-Cola Joins America's Beverage Companies and the Alliance for a Healthier Generation in Landmark Partnership to Promote Healthy Lifestyles, Coca-Cola (Sept. 26, 2014), http://www.coca-colacompany.com/coca-cola-unbottled-old/coca-cola-joins-americas-beverage-companies-and-the-alliance-for-a-healthier-generation-in-landmark-partnership-to-promote-healthy-lifestyles.

[83] *Id.*

[84] Candice Choi, *Coke as a Sensible Snack? Coca-Cola Works with Dieticians Who Suggest Cola As A Snack*, STAR TRIBUNE (Mar. 16, 2015), https://goo.gl/2t44MM.

98. For example, in her list of "sensible snacks for any time of day," Robyn Flipse equated Coca-Cola mini-cans with packs of almonds.[85] And in interviews, Dr. Rani Whitfield similarly promoted drinking Coca-Cola mini-cans as part of a healthy, balanced diet, commenting, "70 calories and my taste buds love it!"[86] In addition to deceiving on nutrition, Ms. Flipse also missed on figures: Mini-cans of Coca-Cola have 90 calories.

99. To respond to the scientific consensus that sugar-sweetened beverages have no nutritional value, Coca-Cola made claims that its sugar-sweetened beverages aren't "empty calories" but are sources of "essential hydration."

100. According to its Senior Vice President Katie Bayne, "What our drinks offer is hydration. That's essential to the human body. We offer great taste and benefits whether it's an uplift or carbohydrates or energy. We don't believe in empty calories. We believe in hydration."[87]

101. Coca-Cola's [now-departed] Chief Science and Health Officer, Rhona Applebaum, routinely made similar claims like, "We started with one beverage that I personally am very proud of. It's safe, it hydrates, it's enjoyable."[88]

102. Even Coca-Cola's website promotes the "science" of hydration with links to "Food Insight" publications—"Your Nutrition and Food Safety Resource"—produced by the International Food Information Council Foundation ("IFIC"). These publications stress the importance of hydration "whether you're an elite athlete . . . or more the spectator type," though

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[85] Robyn Flipse, *Every Day Heart Health in February and Beyond*, NUTRITION COMMC'N SERVS. (Feb. 19, 2015), https://goo.gl/Pu5q5W (last visited Sept. 15, 2016).

[86] *Get Well Wednesday: Dr. Rani Whitfield Answers Your Questions About Prioritizing Health*, BlackAmericaWeb.com, https://goo.gl/oAouCD (last visited Sept. 15, 2016) (transcript of radio interview). Coca-Cola reported paying health professionals and scientific experts a total of $2.3 million for "travel grants, related expenses and professional fees" between 2010 and 2015. *List of Health Professionals and Scientific Experts*, THE COCA-COLA CO. (Mar. 24, 2016), https://goo.gl/VRU3BW (last visited Sept. 15, 2016).

[87] *Coke Executive Answers Questions About Sugary Drinks*, USA TODAY (June 7, 2012), http://goo.gl/OWgFs (statement made by Coke executive Katie Bayne during interview).

[88] Canadian Obesity-Network, *COS2013 Symposia - Coca Cola - Dr. Rhona Applebaum*, YOUTUBE (May 29, 2013), https://goo.gl/I1SK6M (comments made by Dr. Rhona Applebaum, during presentation at Canadian Obesity Network's 2013 symposia) (17:55) (last visited Sept. 15, 2016).

almost no Americans are under-hydrated. More, IFIC emphasizes that with respect to hydration, "the term 'water' can mean more than just plain drinking water. . . . It includes . . . beverages such as soft drinks . . . ."[89]

103. Coca-Cola financially supports the IFIC, but this is not indicated in IFIC publications.[90]

104. The reasonable implication of this Coca-Cola and Coca-Cola-sponsored message is that the "essential hydration," as offered by sugar-sweetened beverages, is good for the body.

105. More than half of the US population drinks soda on a daily basis.[91] More than half of the world's population has had a Coke.[92] But untold millions are unaware of the health consequences of frequent consumption of a product billed as "essential hydration."

106. In fact, scientific consensus is that frequent hydration by way of sugar-sweetened beverages is linked to obesity, diabetes, cardiovascular disease, and other chronic diseases. These beverages are not "*essential*," or even advisable, for the human body; they are antithetical to well-being of the body if consumed routinely.

C. Advertising to Minors

107. Despite a pledge not to do so,[93] Coca-Cola continues to target children with its advertising for sugar-sweetened beverages.

108. Advertising messages for sugar-sweetened beverages are all-pervasive, appearing on billboards, buses, trains, magazines, newspapers, twitter, BUZZFEED, etc.

109. The goal of Coca Cola's advertising is to convey to young people that sugar-sweetened beverages are desirable, safe, healthy and prevalent in society.

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[89] INT'L FOOD INFO. COUNCIL FOUND., HYDRATION: DOES IT ALWAYS HAVE TO BE WATER?, at 1 (2011), https://goo.gl/95XDlB (last visited Sept. 15, 2016).

[90] *See, e.g., id.*

[91] Willett Report, *supra* note 8, at ¶ 8.

[92] Muhtar Kent, *A Letter from Our Chairman and Chief Executive Officer*, THE COCA-COLA CO. (May 4, 2015), http://goo.gl/yzdOHj.

[93] *Responsible Marketing*, THE COCA-COLA CO. (Sept. 25, 2015), https://goo.gl/pPZfr (last visited Sept. 15, 2016).

110. Despite its pledge not to do so, Coca-Cola continues to target children with a material segment of its advertising. Like the tobacco industry, Coca Cola needs to replenish the ranks of its customers, and it tries to recruit them young.

111. To attract young consumers to their sugar-sweetened beverages, for example, Coca Cola has used cartoons, celebrities, over 300 apps, billboards at sponsored events, and otherwise has massively disseminated other consumer products branded with Coca-Cola. The advertising has been effective in attracting children and adolescents.

III. PLAINTIFF HAS EXPENDED CONSIDERABLE RESOURCES COMBATTING DEFENDANTS' MISINFORMATION CAMPAIGN ABOUT SUGAR-SWEETENED BEVERAGES THAT IT COULD AND WOULD HAVE ALLOCATED ELSEWHERE.

112. Aware of the momentous health consequences of sugar-sweetened beverage consumption—that is, their link to the rising epidemics of obesity, type 2 diabetes, and cardiovascular disease—Plaintiff has been forced to expend substantial resources attempting to educate the public and policy-makers about sugar-sweetened beverages, including the inaccuracy of Defendants' messages on the science of sugar-sweetened beverages, the need for enhanced regulation and transparency, and reduction in consumption.

113. Aware that consumers purchase Coca-Cola sugar-sweetened beverages believing them to be part of a healthy diet, not linked to obesity, and/or good sources of hydration, and the like, relying on Defendants' deceptive representations, and that consumers would not have purchased them had they known the truth, Plaintiff has been forced to expend substantial resources attempting to educate the public and policy-makers about sugar-sweetened beverages, including the inaccuracy of Defendants' messages on the science of sugar-sweetened beverages, and the need for reduction in consumption and marketing transparency.

114. Plaintiff has allocated significant resources to support advocacy about sugar-sweetened beverages, including through its major initiative on obesity prevention for children aged 0-5. In addition to providing educational materials, this initiative includes frequent keynotes and speeches by Plaintiff's staff, including its Executive Director, and participation in

material conferences addressing the determinants of obesity, including SSBs, and rebutting information disseminated by Coca-Cola and the ABA.

115. Plaintiff also serves on the national advisory committee for Voices for Healthy Kids, and on the Advisory Board for Open Truth, which seeks to increase awareness of the negative impacts of sugar-sweetened beverages on health and seeks to expose non-transparent and manipulative marketing techniques by Defendants. Its Executive Director, Xavier Morales, serves on the Berkeley Sugar-Sweetened Beverage Commission, which makes investment recommendations for the Berkeley City Council relating to programs that aim, in key part, to educate the public about the risks of routine consumption of sugar-sweetened beverages.

116. Plaintiff has allocated substantial resources to cover the cost of its advocacy, including for meetings with policy makers in various local and state regulatory bodies.

117. The funding that Plaintiff expends on its sugar-sweetened-beverage advocacy efforts requires it to divert resources away from other important public health and nutrition initiatives.

118. Each of these resource-intensive activities was untaken prior to and independent of this litigation, and not in furtherance of it.

119. If Plaintiff prevails in this litigation, it will no longer need to divert its resources to combat the false and misleading representations and tactics employed by Defendants about sugar-sweetened beverages, and can allocate such resources to other health-based projects.

CLAIMS FOR RELIEF

FIRST CLAIM

Violation of the California Unfair Competition Law, CAL. BUS. & PROF. CODE § 17200 *et seq.*

120. Plaintiff realleges and incorporates by reference the allegations in each of the preceding paragraphs of this Complaint.

121. Cal. Bus. & Prof. Code § 17200 (the "UCL") prohibits any "unlawful, unfair, or fraudulent business act or practice." Defendants have engaged in unlawful, unfair, and fraudulent business acts and practices in violation of the UCL.

122. Defendant Coca-Cola has violated the unlawful prong of the UCL by virtue of its violations of the False Advertising Law ("FAL"), as described below.

123. Defendants have violated the unfair prong of the UCL because the acts and practices set forth herein offend established public policy supporting truth in advertising to consumers. Defendants' conduct is immoral, unethical, oppressive, unscrupulous, and injurious to consumers. The harm that these acts and practices cause to consumers greatly outweighs any benefits associated with them. Defendants' conduct also impairs competition within the beverage industry.

124. Defendants have violated the fraudulent prong of the UCL because their material misrepresentations and omissions were likely to deceive a reasonable consumer and the true facts would be material to a reasonable consumer.

125. As alleged herein, Defendants' advertising and public relations campaigns create the false impression that there is no link between consumption of sugar-sweetened beverages and obesity, diabetes, cardiovascular disease, or other related conditions, that sugar-sweetened beverages are a healthy component of any diet when "balanced" with some activity, and that drinking beverages to hydrate is "essential" to human health and that sugar-sweetened beverages are a good source of hydration.

126. Defendants have represented to the consumer public, and to those who advance and protect their health, that they were disclosing objective, unbiased scientific facts about the health consequences of consuming sugar-sweetened beverages when they were not.

127. Defendants have made and continue to make representations and statements about the safety of sugar-sweetened beverages and their effect on human health. These representations and statements have been materially false, incomplete, and fraudulent at the time Defendants made them, and Defendants knew or had reason to know of their falsity.

128. At all relevant times, Defendants intentionally, willfully, or recklessly misrepresented or failed to disclose material facts about the health consequences of regularly consuming sugar-sweetened beverages, including their link to obesity, type 2 diabetes, and cardiovascular disease.

129. Defendants' knowledge of the material facts about sugar-sweetened beverages was and is superior to that of the consumer public.

130. By expressly raising the issue of sugar-sweetened beverage safety and denying any link between sugar-sweetened beverages and obesity, type 2 diabetes, and cardiovascular disease, and in addition making false statements about this issue, Defendants had a duty to reveal all the material facts of which they had notice, in order not to deceive and mislead the consumer public.

131. Defendants' disclosure of fragmentary information and half-truths and suppression of relevant facts constitutes actionable misrepresentation under the UCL.

132. Defendants undertook such misrepresentations in order to induce the consumer public to purchase and continue to purchase sugar-sweetened beverage products and raise profits.

133. By virtue of their affirmative misconduct, Defendants had a duty to disclose that the scientific consensus is that: a) sugar-sweetened beverages are linked to obesity, type 2 diabetes, and cardiovascular disease; b) activity does not "balance" away, or negate, the link between sugar-sweetened beverages and obesity-related chronic diseases; and c) hydration with sugar-sweetened beverages is not healthful or "essential" to the human body. They also had a duty to disclose all other material facts about the potential health hazards of sugar-sweetened beverage consumption of which they had notice.

134. Defendants' omissions are material because reasonable consumers would consider the omitted science linking sugar-sweetened beverages to chronic disease to be important in determining whether or not to purchase sugar-sweetened beverages.

135. Reasonable consumers were likely to be deceived, and were in fact misled, by Defendants' misrepresentations and omissions. Reasonable consumers relied on Defendants' actions.

136. Coca-Cola knows or reasonably should have known that the promotion, marketing and sale of its sugar-sweetened beverages was and is deceptive.

137. Plaintiff has suffered injury in fact as a result of Defendant' unlawful, unfair, and/or deceptive practices because Plaintiff has incurred costs and diverted resources educating the public and public servants about Defendants' material misrepresentations and omissions.

138. Moreover, as a direct and proximate result of Defendants' fraudulent misrepresentations and active concealment, the consumer public has suffered and will continue to suffer substantial injuries and damages.

139. All of the wrongful conduct alleged herein occurred, and continues to occur, in the business of selling sugar-sweetened beverages. Defendants' wrongful conduct is part of a general practice that is still being perpetuated and repeated throughout the State of California and nationally.

140. Plaintiff requests that this Court enter such orders or judgments as may be necessary to enjoin Defendants from continuing their unfair and deceptive business practices, and to provide such other relief as set forth below.

SECOND CLAIM

Violations of the California False Advertising Law, CAL. BUS. & PROF. CODE § 17500, *et seq.*

141. Plaintiff realleges and incorporates by reference all paragraphs alleged herein.

142. California Business & Professions Code §§ 17500, *et seq.* (the "FAL"), broadly proscribes deceptive advertising in this State. The FAL makes it unlawful for any corporation or association intending to sell products or to induce the public to make purchases to make any statement in connection therewith which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading.

143. When a corporation or association has a duty to disclose material facts about a product or about potential purchases of a product, representations to consumers without disclosure of such material facts violates the FAL.

144. As alleged herein, Coca-Cola's advertising and both Defendants' promotion of sugar-sweetened beverages creates the impression that their consumption is not linked to obesity, type 2 diabetes, and cardiovascular disease, that it can be "balanced" with activity so as to be

healthful, and that it provides "essential" and healthful hydration. Defendants failed to disclose in their promotion and advertising campaigns that scientific consensus about sugar-sweetened beverages is to the contrary of each of these claims when they had a duty to make such disclosure.

145. Defendants' misrepresentations and omissions are material because reasonable consumers would consider the omitted facts to be important in determining whether or not to purchase sugar-sweetened beverages.

146. Reasonable consumers were likely to be deceived, and were in fact misled, by Defendants' misrepresentations and omissions.

147. Defendants know or reasonably should have known that statements they made in the promotion, marketing and sale of sugar-sweetened beverage products were and are deceptive.

148. Plaintiff has suffered injury in fact as a result of Defendants' unlawful, unfair, and/or deceptive practices because Plaintiff has been required to incur costs and divert resources educating the public and policy makers about the inadequacy and misleading nature of Defendants claims and material omissions about sugar-sweetened beverages.

149. All of the wrongful conduct alleged herein occurred, and continues to occur, in the business of selling sugar-sweetened beverages. Defendants' wrongful conduct is part of a general practice that is still being perpetuated and repeated.

150. Plaintiff requests that this Court enter such orders or judgments as may be necessary to enjoin Defendants from continuing their false advertising and other false statements, and provide such other relief as set forth below.

THIRD CLAIM

Intentional Breach of Special Duty

151. Plaintiff realleges and incorporates by reference all paragraphs alleged herein.

152. Defendants assumed a special duty to protect the consumer public when they actively misrepresented that the wellbeing of consumers was an industry priority and that the science they presented was objective, reliable, and demonstrated no link between sugar-sweetened beverages and obesity, type 2 diabetes, and cardiovascular disease.

153. Defendants also undertook a special duty by funding and organizing deceptive exercise-focused campaigns around California, the United States, and globally.

154. Continuing to date, Defendants' spokespersons have repeatedly announced that research is underway showing that sugar-sweetened beverages and obesity, type 2 diabetes, and cardiovascular disease are not linked, and moreover that obesity is caused instead by lack of exercise and "balance." These actions were and remain a part of Defendants' campaign of disinformation designed to obscure the evidence that sugar-sweetened beverages are linked to obesity, type 2 diabetes, and cardiovascular disease.

155. Defendants did not make these representations gratuitously, rather, they were made to combat the emerging scientific consensus about the consumption of sugar-sweetened beverages and, more specifically, to protect profits from the sale of sugar-sweetened beverages.

156. Defendants also represented that the well-being of their consumers was one of their primary concerns.

157. Further, Defendant Coca-Cola represented repeatedly that it does not advertise to children.

158. Each of these undertakings was designed to, among other purposes, cause consumers to believe that they could continue to consume sugar-sweetened beverages on a routine and often daily basis healthfully.

159. In making these representations, Defendants assumed duties to the public and Plaintiff.

160. Defendants had a duty to disclose the whole truth about the link between sugar-sweetened beverages and obesity, diabetes, and cardiovascular disease, and, by extension, the truth about the science of "balance." Defendants breached this duty.

161. Defendants could have reasonably foreseen the risk of harm to Plaintiff and the public. Defendants knew and/or could foresee that their actions would result in continued substantial consumption of sugar-sweetened beverages by the public and/or large portions thereof—especially children and less-educated populations and consumers.

162. The very purpose behind the assumption of this duty was simultaneously to promote the purchase and consumption of sugar-sweetened beverages, and to prevent or delay regulatory activities designed to curb such purchase and consumption.

163. Defendants' intentional breach of their assumed duties therefore influenced the conduct of Plaintiff to its detriment.

164. As a direct, foreseeable, and proximate cause of Defendants' intentional breach of their specially assumed duties, the public continued to consume sugar-sweetened beverages when they would not otherwise, and Plaintiff has been forced to expend and divert its resources to fight these trends and inform consumers of the truth.

FOURTH CLAIM

Negligent Breach of Special Duty

165. Plaintiff realleges and incorporates by reference all paragraphs alleged herein.

166. Defendants knew or should have known that the special duties that they assumed were important to consumer and to Plaintiff, and their failure to carry out these duties would substantially increase the risk of harm to Plaintiff.

167. Defendants have breached and continue to breach their special duties, have failed to exercise reasonable care in the performance of their special duties, and this has substantially increased the risk of harm to Plaintiff.

168. As a direct and proximate result of Defendants' negligent breach of their specially assumed duty of care, Plaintiff has suffered and continue to suffer substantial injuries and damages for which it is entitled to recover.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court enter a judgment against Defendants and in favor of Plaintiff, as follows:

A. Declare, adjudge and decree the conduct of Defendants as alleged herein to be unlawful, unfair, and/or deceptive, and in violation of the Unfair Competition Law;

B. Declare, adjudge and decree the conduct of Defendants as alleged herein to be a violation of the Fair Advertising Law;

C. Declare, adjudge and decree the conduct of Defendants as alleged herein to be a violation of their special duties;

D. Enjoin Defendants from continuing the unfair and deceptive promotion, marketing and sale of sugar-sweetened beverages, including any claim that sugar-sweetened beverages are not linked to obesity, diabetes, or cardiovascular disease;

E. Enjoin Defendant Coca-Cola from continuing the promotion, marketing and sale of its sugar-sweetened beverages to children under 12, directly or indirectly;

F. Require Defendants to disclose, disseminate, and publish all research previously conducted, directly or indirectly, through agents, affiliates, officers, directors, employees, and all persons acting in concert with them, that relates to the impact of sugar-sweetened beverage consumption on health;

G. Require Defendants to disclose, disseminate, and publish all research previously conducted, directly or indirectly, through agents, affiliates, officers, directors, employees, and all persons acting in concert with them, that relates to the impact of exercise on health and obesity, as contrasted with consumption of sugar-sweetened beverages, or any other caloric intake;

H. Require Defendants to fund a corrective public education campaign to reduce the consumption of sugar-sweetened beverages;

I. Require Defendants to prominently post on their websites that the consumption of sugar-sweetened beverages can lead to obesity, diabetes, and cardiovascular disease.

J. Award Plaintiff reasonable attorneys' fees and costs; and

K. Award Plaintiff such other further and different relief as the nature of the case may require or as may be determined to be just, equitable, and proper by this Court.

JURY TRIAL DEMAND

Plaintiff demands a jury trial on all causes of action so triable.

Date: January 4, 2017

Respectfully submitted,

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Counsel for Plaintiff The Praxis Project

Exhibit 25

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

DENISE CECELIA SIMPSON, et al Plaintiffs, v. JOHNSON & JOHNSON, et al, Defendant.	:	Civil Action No. 2016 CA 1931 B

Washington, DC
January 13, 2017

The above-entitled action came on for a hearing before the Honorable MARISA DEMEO, Associate Judge, in Courtroom Number 311, commencing at approximately 2:35 p.m.

THIS TRANSCRIPT REPRESENTS THE PRODUCT OF AN OFFICIAL REPORTER, ENGAGED BY THE COURT, WHO HAS PERSONALLY CERTIFIED THAT IT REPRESENTS THE TESTIMONY AND PROCEEDINGS OF THE CASE AS RECORDED.

APPEARANCES:

On behalf of the Plaintiff:
James Green, Esquire
Patrick Lyons, Esquire

On behalf of Defendant PCPC:
James Billings-Kang, Esquire

On Behalf of Defendant Imerys:
Angela Hart-Edwards, Esquire

On Behalf of Defendant Johnson & Johnson:
Chad Coots, Esquire

Sherry T. Lindsay, RPR (202) 879-1050
Official Court Reporter

P R O C E E D I N G S

THE DEPUTY CLERK: This is calling Denise Cecelia Simpson versus Johnson & Johnson, 2016 CA 1931 B. Parties please --

THE COURT: Parties can you state your names for the record.

MR. LYONS: Good morning, Your Honor. My name is Patrick Lyons and I represent the plaintiff, Ms. Denise Simpson.

MR. GREEN: Good afternoon, Your Honor. My name is James Green. I also represent Ms. Simpson.

THE COURT: All right. Good afternoon.

MR. BILLINGS-KANG: And good afternoon, Your Honor.

Oh, if you will, please.

MS. HART-EDWARDS: Good afternoon, Your Honor. Angela Hart-Edwards for Imerys.

Is it okay if we sit --

THE COURT: Sure. That is fine.

MR. COOTS: Good afternoon. Chad Coots representing Johnson & Johnson.

THE COURT: Okay. Good afternoon.

MR. BILLINGS-KANG: Good afternoon, Your Honor. James Billings-Kang on behalf of the Personal Care Products Council.

discovery, so we could certainly brief this issue further. But I'd say, I do not believe that the burden has shifted to the plaintiff to proving its causes of action because PCPC has not met that prima facie burden, which is in the statute. Thank you, Your Honor.

THE COURT: All right. There were just a couple of points that I want to go back to my chambers to take a quick look at. And then I will be back. If the parties can just return in 20 minutes, at a quarter to 4:00. We'll stand in recess until then.

MR. LYONS: Thank you, Your Honor.

MR. BILLINGS-KANG: Thank you, Your Honor.

(Recess taken.)

THE DEPUTY CLERK: Calling Denise Cecelia Simpson versus Johnson & Johnson 2016 CA 1931.

THE COURT: All right. Good afternoon. All parties are present. Thank you for your patience. All right. So just for the record, the Court is, of course, using the statutory language, DC Code 16-5502 on special motion to dismiss, specifically looking at subsection B, "If a party filing a special motion to dismiss under the section makes a prima facie showing that the claim at issue arises from an act in furtherance of a right of advocacy on issues of public interest, then the motion shall be granted, unless the responding party demonstrates that the claim is likely

to succeed on the merits, in which case the motion shall be denied."

So one of the issues that didn't come out as strongly in the briefs, but clearly came out in terms of the arguments is burden, who has the burden. And so the Court just wants to cite to the case that the parties have referenced, the Competitive Enterprise Institute versus Mann case, which came out in December of 2016 by the DC Appellate Court, 2016 DC.App Lexis 435, which states under the District's Anti-SLAPP Act, the party filing a special motion to dismiss must first show entitlement to the protections of the act by making a prima facie showing that the claim at issue arises from an act in furtherance of the right of advocacy on issues of public interest, citing to the code. Once that prima facie showing is made, the burden shifts to the nonmoving party, usually the plaintiff, who must demonstrate that the claim is likely to succeed on the merits. If the plaintiff cannot meet that burden, the motion to dismiss must be granted and the litigation is brought to a speedy end. So the Court is using that statute and that framework as interpreted by the Court of Appeals in terms of the process of where the analysis starts and where it goes in terms of burden. If, in fact, the prima facie showing is established.

The Court also noted during oral argument -- so I

wanted to just make sure I made a point of addressing it -- there was back and forth about the use of California law. And so -- the Abbas District Court case had language in it that said, "In construing the Act, the Court cannot rely on guidance from the DC Court of Appeals, which has not yet published an opinion in interpreting the statute." Of course, this was I believe a 2013 case, so this was prior to some of the more recent litigation and decisions that have come up by the Court of Appeals. And then the District Court had said, Where, as here, the substantive law of the forum state is uncertain or ambiguous, the job of federal court is carefully to predict how the highest court of the forum state would resolve the uncertainty or ambiguity. With this in mind, the Court notes that the committee report prepared on the Anti-SLAPP Act emphasize that the statute followed the model set forth in a number of other jurisdictions. The DC Court of Appeals has accorded great weight to such reports in interpreting other DC statutes. Therefore, where necessary and appropriate, the Court will look to decisions from other jurisdictions, particularly California, which has a well developed body of case law interpreting a similar California statute for guidance and predicting how the DC court of Appeals would interpret the District's Anti-SLAPP statute.

Of course, the plaintiff points out that the

Circuit Court actually affirmed on different grounds and specifically said that the first issue before the Court is whether a Federal Court exercising diversity jurisdiction may apply the DC Anti-SLAPP Act's special motion to dismiss provision. The answer is no. Federal Rules of Civil Procedure 12 and 56 establish the standards for granting pretrial judgment to defendants in cases in Federal Court. A Federal Court must apply those Federal Rules instead of the DC Anti-SLAPP Act's special motion to dismiss provision. So technically as a matter of law, this Court would not cite to the District Court case. First of all, it wouldn't be precedent for this Court anyway, as the parties know. If anything, it would be persuasive, since they are not an appellate court to this Court. And then in light of the fact that the Circuit Court said District Court really shouldn't have ruled on the issue of Anti-SLAPP anyway. This Court doesn't decide this matter based on the District Court Abbes language. Nevertheless, I read it. And the Court actually agrees with what the District Court said. I understand that I have no basis to cite to it, since in essence, it was reversed, it was abrogated by the Circuit Court. But what this Court does know is what the DC Court of Appeals ordinarily does do and as it did in Mann itself when it was looking at the issues that were raised in the Mann case that was decided in 2016. For example, in

footnote 31, it did an analysis of what Colorado has done. It also talked about what other states have done. For example, the Mann case said other -- the Appellate Court, said other states have adopted similar approaches. California's Anti-SLAPP statute, which requires a showing that there is a probability that the plaintiff will prevail on the claim has been interpreted as requiring the plaintiff to state and substantiate a legally sufficient claim, et cetera. I am not going to cite the full language, because, obviously, there was a really different issue that was being contested in Mann, separate and apart from what is the really contested issue here. The point being that to the extent that this DC Court of Appeals has not specifically ruled on the legal issue that is facing this trial Court, this Court does look to other jurisdictions where this Court finds language to be similar, although not identical. The Court concedes that and plaintiff makes that point. But I found the language of the California Anti-SLAPP statute to be sufficiently similar. And the amount of litigation on Anti-SLAPP challenges at the California courts to be of such volume that this Court did find California court interpretations of California's Anti-SLAPP statute to be beneficial and persuasive, recognizing again it is not identical language. But it was similar enough that this Court did look to California law to be of help to this Court

in terms of trying to determine what the DC Court of Appeals ultimately, would interpret. Obviously, the DC Court of Appeals is the only ones who can tell me, ultimately, how they would interpret it. All I can do is do my best to make a proper interpretation and then the Court of Appeals can instruct this Court whether it got it right or got it wrong.

So the Court just -- this Court just wanted to highlight a couple of issues related to the burden and the California law because those were matters that I had not focused on extensively in preparing for today's hearing.

All right. Give me just a moment.

So turning first to whether the defendant PCPC, who is the party who has filed this special motion to dismiss has made a prima facie showing that the claim at issue arises from an act in furtherance of the right of advocacy on issues of public interest, the Court focuses first on -- while the Court understands that full phrase must be analyzed, much of the debate, both in the briefs and in the oral arguments, focused on the definition of "on issues of public interest." And as I just a moment ago explained, since the DCCA has not yet ruled on the specific issue, this Court -- our statute when looking at the committee report has been modeled after Anti-SLAPP statutes in other jurisdictions. And the Court -- this Court found California's Anti-SLAPP statute to be sufficiently similar

to provide this Court some analysis that this Court found to be helpful. So I turned to the California courts for guidance on the issue, finding the language to be similar and similar enough to provide guidance. In Choose Energy versus American Petroleum Institute 87 F.Supp.3d 1218, Northern District of California 2015, the US District for the Northern District of California held that the defendant trade association's conduct fell within the protection of Anti-SLAPP because its conduct was noncommercial in nature and addresses energy policy, an issue that is currently the subject of pending legislative efforts and one of public concern. The Court further noted that an issue of public interest is an issue in which the public is interested. In LA Taxi Cooperative Inc. versus Independent Taxi Owners' Association of Los Angeles, 239 Cal.App.4th at 918, the Court held that commercial speech about a specific product or service is not a matter of public interest within the meaning of the Anti-SLAPP statute even if the product category is the subject of public interest and the products are regulated by public agencies. That was citing to Consumer Justice Center versus TriMedica International, 107 Cal.App4th at 595.

In this case, the LA Taxi case, the Court found that commercial speech was not protected by the Anti-SLAPP statute, because it was about a specific taxicab company,

not general public transportation by taxi companies. As the Court has listened very carefully to each side of the argument, it really -- plaintiff's arguments focused primarily on this -- call it logical thinking which is if the trade association is representing members and the members have commercial interests, therefore the Court must conclude that the trade association is a commercial interest, as opposed to a public interest. However, the Court distinguishes between when a trade association is promoting a specific product or the benefits of a specific product versus when a trade association is speaking more generally about products and the health and safety of those products as opposed to a specific commercial product named.

The Court does find in this case that PCPC has made a prima facie showing that its alleged acts were made in furtherance of the right of advocacy on issues of public interest. So I am focusing now on the public interest component. This is because plaintiff's complaint does not allege that PCPC made any representations regarding a particular product, only about the safety of talc in general. Further, defendant PCPC is a nonprofit trade association. It does not manufacture, design or sell any products. As a result, PCPC does not have, this Court concludes, a commercial interest to protect. While plaintiff argues that PCPC does represent the commercial

organizations, that is Johnson & Johnson and Imerys, which are profit-seeking corporations, this Court finds that PCPC's own speech is not commercial in nature. Further, PCPC's alleged acts fit squarely within the plain meaning of the statute of issues of public interest. The statute defines public interest to mean, an issue related to health or safety. Here, the safety of talc is clearly an issue related to health or safety.

I analyzed the public interest component first, because I actually think that was of most import in terms of the debate between the parties. That, obviously, is the issue that would need to be resolved by the Court of Appeals should this matter be appealed. All of the issues would need to be resolved, but that one is clearly an issue of first impression.

The Court now moves backwards in terms of the -- whether it is the -- this is an issue that arises from an act in furtherance of the right of advocacy. I took it a little bit out of order, just so that the Court could address the most contentious issue first. And now I turn to the first part.

In the briefs, the Court would conclude that the plaintiff concedes that if PCPC's advocacy was based on issues of public interest rather than on issues of private commercial interest, then at least some of the advocacy of

PCPC would meet this element. Although, in its briefs, plaintiff further argues that statements and actions among PCPC and its members, the other defendants, would not meet the element.

The statute defines act in furtherance of the right of advocacy on issues of public interest in three ways, as the parties have noted. One, a written or oral statement made in connection with an issue under consideration or review by a legislative or judicial body or any other official proceeding authorized by law. This is under the section 16-5501(1)(A)(i). Here, the complaint alleges that PCPC formed the talc interested party task force, a lobbying group regarding the safety of talc in response to a study regarding the safety of talc and that PCPC submitted scientific reports to government agencies. Defendant argues that this allegation clearly constitutes an act in furtherance of the right of advocacy in accordance with the first potential definition of what qualifies and the Court agrees. The Court finds that the alleged act meets the definition as PCPC submitted reports to government agencies.

The Court looks at the second manner in which it might be established that the issue arises from an act in furtherance of the right of advocacy, a written -- that is number two, a written or oral statement made in a place open

to the public or public forum in connection with an issue of public interest. This is section 16-5501 (1)(A)(ii). The complaint alleges that PCPC released information regarding the safety of talc to the public. The defendant argues that this constitutes an act in furtherance of the right of advocacy. Under the second definition, the Court does agree with defendant. The Court finds that the alleged acts meet the definition, as PCPC did release this information about the safety of talc to the public.

Looking at the third potential way that this part of the element can be established, any other expression or expressive conduct that involves petitioning the government or communicating views to members of the public in connection with an issue of public issues. The complaint alleges PCPC petitioned the government and communicated with the public regarding the safety of talc. The defendant argues this is an act in furtherance of the right of advocacy. Under this third catchall definition, the Court agrees, PCPC's actions fall within the catchall definition. So under any of the three, the Court finds that plaintiff meets the elements. The Court finds that the allegations in plaintiff's complaint fit within the definition of act in furtherance of the right of advocacy. And further having found that they are on issues of public interest, I find that the entire prima facie showing has been established by

the plaintiff. While plaintiff does argue both in her briefs and oral arguments and in her complaint that PCPC and the other defendants acted in concert to collectively defend talc use and that these statements, in which they were directed to the other defendants, that is, PCPC's statements to the other defendants, that those would not be acts in furtherance of a right of advocacy. The plaintiff fails to show what these statements were or how they would further her underlying claims. This Court find that plaintiff's additional argument fails.

This Court, in light of the full analysis of the elements that are required for the prima facie showing, which is the plaintiff's burden initially, this Court does conclude that the prima facie showing that a claim -- that the claim at issue arises from an act in furtherance of the right of advocacy on issues of public interest has been met. The burden has been met by the plaintiff. That brings the Court to then the motion shall be granted, unless the responding party demonstrates that the claim is likely to succeed on the merits, in which case the motion shall be denied.

So the -- going back to the Mann case for a moment -- again, citing to the Mann case, 2016 DC.App. Lexis 435, decided on December 22nd, 2016, the Court of Appeals said that we conclude that in considering a special motion

to dismiss, the Court evaluates the likely success of the claim by asking whether a jury properly instructed on the applicable legal and constitutional standards could reasonably find that the claim is supported in light of the evidence that has been produced or proffered in connection with the motion. This standard achieves the Anti-SLAPP Act's goal of weeding out meritless litigation by ensuring early legal review of the legal sufficiency of the evidence, consistent with First Amendment principles while preserving the claimant's right to a jury trial. The Court also said that our analysis begins with the language of the statute, which requires that to prevail in opposing a special motion to dismiss, the opponent must demonstrate that the claim is likely to succeed on the merits, as neither the phrase nor any of its components is defined in the statute, we look to the language of the statute by itself to see if the language is plain and admits of no more than one meaning. Although we can be confident that on the merits refers to success on the substance of the claim, the meaning of the requirement that the opponent demonstrate that the claim is likely to succeed is more elusive. Use of the word demonstrate indicates that once the burden has shifted to the claimant. The statute requires more than mere reliance on allegations in the complaint and mandates the production or proffer of evidence that supports the claim. This interpretation is

supported by another provision in the act, section 16-5502(C) that states discovery upon the filing of a special motion to dismiss until the motion has been disposed of, unless it appears likely that targeted discovery will enable the plaintiff to defeat the motion and that the discovery will not be unduly burdensome. If evidence were not required to successfully oppose a special motion to dismiss under section 16-5502(B), there would be no need for a provision allowing targeted discovery for that purpose. Moreover, unless something more than argument based on the allegations in the complaint is required, the special motion to dismiss created by the Act would be redundant in light of the general availability in all civil proceedings, regardless of the nature of the claim of motions to dismiss under Rule 12(B)(6).

The precise question the Court must ask, therefore, is whether a jury properly instructed on the law, including any applicable heightened fault and proof requirements could reasonably find for the claimant on the evidence presented. So the Court turns to the claims here, that is, the -- because the burden now shifts to whether the responding party has demonstrated that the claim is likely to succeed on the merits, as I have defined it by the Court of Appeals, how the Court of Appeals tells this Court how I must analyze it. The plaintiff here must offer evidence on

the negligence claim, that is the first claim, of the existence of a duty, violation of a standard of care, and injury resulting as a proximate cause of the violation. Here, plaintiff alleges that PCPC voluntarily undertook a duty of care to plaintiff by promulgating standards, norms and bylaws that govern control or inform the manufacturing, design, labeling of its member companies. That is the complaint, paragraph 79. Plaintiff further alleges that PCPC had the means and authority to control the safety, standards of the other defendants but breached its duty by failing to ensure that they complied with the standards. Defendant argues that the allegations are unsupported and the Court agrees with the defendant's position.

The plaintiff has failed to establish if the jury was properly instructed on the law, including any applicable heightened fault and proof requirements, the Court has to ask could a jury reasonably find for the claimant on the evidence presented? Here, the plaintiff has failed to establish that PCPC had any duty of care to her. Furthermore, defendant submits an affidavit by showing that PCPC has no authority to regulate its members and thus it could not have prevented the sale of products. Plaintiff presents nothing to counter that. Using the standard from the Mann decision, the Court finds that on the claim of negligence a jury properly instructed on the law could not

reasonably find for the claimant on the evidence presented.

Turning to the fraud claim. Plaintiff must offer evidence establishing, one, a false representation; two, in reference to a material fact; three, made with knowledge of its falsity; four, with intent to deceive; and, five, action is take in reliance upon representation. Plaintiff has failed to address the specific elements and how she would succeed on the merits. Defendant has argued both its actions were protected under the First Amendment under Noerr-Pennington doctrine and, further, plaintiff has no evidence that defendant made any representations with the knowledge of its falsity and is unlikely to have any evidence that she relied on statements made by PCPC prior to using talc. The Court agrees that plaintiff has not put forward sufficient evidence on the two elements of fraud highlighted by defendant to establish a likelihood of success on the fraud claim, specifically that there needs to be sufficient evidence where a jury properly instructed on the law, could reasonably find for the claimant on evidence presented on the issue of the element of -- that PCPC made with knowledge of its falsity, whatever statement it was. And there is not sufficient evidence that a reasonable juror could find for the claimant on that element. And, further, there is not sufficient evidence presented by the plaintiff on the element where a reasonable juror could -- a jury

could reasonably find for the claimant on the element of -- that action was taken in reliance upon the representation, by -- that is, action taken by the plaintiff in reliance upon the representation by defendant PCPC. So the Court finds using the standard taken from Mann that a jury properly instructed on the law, could not reasonably find on the fraud claim for the claimant on the evidence presented.

This brings the Court to the conspiracy claim. Plaintiff must offer evidence establishing an agreement between two or more persons to participate in an unlawful act or in a lawful act in an unlawful manner, an injury caused by an unlawful overt act or performed by one of the parties to the agreement, pursuant to and in furtherance of the common scheme. In addition, civil conspiracy depends on the performance of some underlying tortious act. It is thus not an independent action. It is rather a means for establishing a vicarious liability for the underlying tort.

Plaintiff has failed to address the specific elements of conspiracy. Defendant argues plaintiff cannot present any admissible evidence that PCPC either performed an unlawful act or a lawful act in an unlawful manner or reached an agreement with one or more of the other defendants, which was part of a common scheme for one of the codefendants to commit an unlawful overt act against the plaintiff. The Court agrees with the defendant. Plaintiff

has not presented sufficient evidence on the conspiracy claim to establish a likelihood of success on the merits. In other words, should a -- if a jury properly instructed on the law were presented with the evidence that the plaintiff has presented to this Court at this stage of this motion, the jury could not reasonably find for the claimant on the claim of conspiracy.

In essence, in plaintiff's brief, it just seems to have foregone any argument on these points on the issue of likelihood of success. But the Court is obligated, in my opinion, to go through the entire analysis. Instead plaintiff argues that she would be prejudiced without additional limited discovery as provided for under the Act, which, the Act does clearly provide that when it appears -- and this is under 16-5502(C)(2), when it appears likely that targeted discovery will enable the plaintiff to defeat the motion and that the discovery will not be unduly burdensome, the Court may order that specified discovery be conducted. Such an order may be conditioned upon the plaintiff paying any expenses incurred by the defendant in responding to such discovery. Here, plaintiff -- it is this Court's assessment that plaintiff has not demonstrated what targeted discovery would be needed to defeat the motion. Further, defendant states and plaintiff not only did not oppose the statement in its briefs but in court acknowledged that plaintiff has

already received thousands upon thousands of pages of discovery in other similar litigation and even in this very litigation. And despite having received all of that discovery, there doesn't appear to this Court to be any demonstration by the plaintiff of what additional targeted discovery would assist the plaintiff in defeating the motion. Seeing that the plaintiff did not oppose the defendant's arguments that it could not succeed under the claims, but instead requested additional discovery, the Court finds that plaintiff cannot establish likelihood of success on the underlying claims and the Court is not ordering additional discovery as plaintiff has not demonstrated what targeted discovery would be necessary to defeat the motion, nor that additional discovery will likely enable the plaintiff to defeat the motion.

So looking at the statute as whole, again, the Court first found that the plaintiff did establish its -- and presented its prima facie showing that the claim at issue arises from an act in furtherance of the right of advocacy on issues of public interest, the motion to dismiss must be granted unless the responding party demonstrates that the claim is likely to succeed on the merits. I have found that the responding party has not demonstrated that the claim is likely to succeed on the merits. So it is mandatory that the motion be granted. The exception being

if it appears likely that targeted discovery will enable the plaintiff to defeat the motion and that the discovery will not be unduly burdensome, the Court may order that specified discovery be conducted, however, this Court has concluded that it will not approve targeted discovery finding for the reasons that I have already stated. That presents the Court with the one outcome that the statute tells me to do and that is I am granting the special motion to dismiss by PCPC.

So let's turn briefly in light of that to the question of attorneys' fees. I will take brief argument on that. I will hear from PCPC first.

MR. BILLINGS-KANG: Thank you, Your Honor. I think that point is very clear in terms of a presumptive award of attorneys' fees. It is mandated by the statute and that is a question that was considered by the Court of Appeals in Doe against Burke, not the 2014 opinion, but the 2016 opinion, in which the Court interpreted the statute to entitle the moving party who prevails to a presumptive award of reasonable attorney fees on request. And, Your Honor, we have made that request respectfully. And we would ask that the Court grant that motion. Thank you.

THE COURT: All right.

Plaintiff.

MR. LYONS: Your Honor, there is a provision that -- there is presumptive award of attorney fees in cases

in which motion to dismiss is granted, unless special circumstances exist. I do believe -- and plaintiff's position is that this is a special circumstance. This is an issue, as Your Honor mentioned, of first impression, has not been litigated before. And plaintiff in filing its complaint had no idea that a motion to dismiss based on the Anti-SLAPP statute would be filed, did not anticipate this issue. And we are not specifically filing this lawsuit with the SLAPP provisions in mind. And we do believe there are special circumstances given that this is the first time this issue has been brought before the Court and a matter of first impression and that attorneys' fees should not be granted in this case.

THE COURT: Okay.

MR. LYONS: Thank you, Your Honor.

THE COURT: So the Court notes the standards the attorneys cited to is the same standard the Court has referenced in making a decision here, DC Code 16-5504, "The Court may award a moving party who prevails in whole or in part on a motion brought under section 16-5502 or section 16-5503, the cost of litigation, including reasonable attorneys' fees." And cited to by defendant, Doe v. Burke and the language referenced by plaintiff, that Court has held that DC Code 16-6504(A) entitles the moving party who prevails on a special motion to quash or dismiss to a

presumptive award of reasonable attorneys' fees on request unless special circumstances would render such an award unjust.

In the Doe case itself, the Court of Appeals did not find special circumstances to render such an award unjust, despite noting that the losing parties' attorneys were employed by a public interest organization, that the losing party was represented pro bono and that the losing party had rejected an earlier settlement offer. The Court awarded the prevailing party its attorneys' fees. So I have heard the argument by plaintiff that this is a matter of first impression, but this Court does not find that that falls under this Court's interpretation of what would constitute special circumstances. And so the Court is going to follow the presumptive nature of the award and I am granting an award of reasonable attorneys' fees, since it has been requested by defendant. And defendant, you can have -- how many -- do you need ten days?

MR. BILLINGS-KANG: Ten days, Your Honor, is sufficient.

THE COURT: Ten days from today to make a filing so that the Court can determine whether what you are requesting are reasonable attorney fees.

All right. As you noted, I do have a court reporter. I know you have been writing furiously, but if

anyone needs the transcript, I have asked her to be here in light of the unique nature of my ruling. Okay.

Anything further from plaintiff at this time?

MR. LYONS: Nothing further, Your Honor.

THE COURT: Anything further from defendant?

MR. BILLINGS-KANG: Nothing further, Your Honor. Thank you very much.

THE COURT: Thank you. Parties are excused and thank you for accommodating my schedule.

MR. BILLINGS-KANG: Thank you, Your Honor.

(Proceedings adjourned.)