SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST JUDICIAL DEPARTMENT

NEW YORK STATEWIDE COALITION OF HISPANIC CHAMBERS OF COMMERCE; THE NEW YORK KOREAN-AMERICAN GROCERS ASSOCIATION; SOFT DRINK AND BREWERY WORKERS UNION, LOCAL 812, INTERNATIONAL BROTHERHOOD OF TEAMSTERS; THE NATIONAL RESTAURANT ASSOCIATION; THE NATIONAL ASSOCIATION OF THEATRE OWNERS OF NEW YORK STATE; and THE AMERICAN BEVERAGE ASSOCIATION, Petitioners-Respondents, For a Judgment Pursuant to Articles 78 and 30 of the Civil Practice Law and Rules, - against - THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE; THE NEW YORK CITY BOARD OF HEALTH; and DR. THOMAS FARLEY, in his Official Capacity as Commissioner of the New York City Department of Health and Mental Hygiene, Respondents-Appellants.	**New York County** **Index No. 653584/12** **NOTICE OF MOTION FOR LEAVE TO FILFE BRIEF AS *AMICI CURIAE***

PLEASE TAKE NOTICE THAT, upon the annexed affirmation of Brian L. Bromberg, dated March 25, 2013, and the materials attached thereto, the National

Association of Local Boards of Health, the American Public Health Association, the National Association of County and City Health Officials, the Public Health Association of New York City, ChangeLab Solutions, the Public Health Law Center, the Health Officers Association of California, Jennifer Pomeranz, Director of Legal Initiatives of the Rudd Center for Food Policy at Yale University, Prof. Lawrence O. Gostin of the O'Neill Institute for National and Global Health Law at Georgetown University, Prof. Peter D. Jacobson, Prof. Lindsay F. Wiley, Prof. Wendy Parmet, Prof. Lance Gable and Prof. Micah Berman will move this Court at the Supreme Court Appellate Division, First Department, located at 27 Madison Avenue, New York, New York 10010, on April 3, 2013 at 10:00 a.m., or as soon thereafter as counsel may be heard, for an order granting the above-named public health organizations and public health law professors leave to file the attached *amicus curiae* brief in the above-captioned matter.

Dated: New York, New York
March 25, 2013

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SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST JUDICIAL DEPARTMENT

NEW YORK STATEWIDE COALITION OF HISPANIC CHAMBERS OF COMMERCE; THE NEW YORK KOREAN-AMERICAN GROCERS ASSOCIATION; SOFT DRINK AND BREWERY WORKERS UNION, LOCAL 812, INTERNATIONAL BROTHERHOOD OF TEAMSTERS; THE NATIONAL RESTAURANT ASSOCIATION; THE NATIONAL ASSOCIATION OF THEATRE OWNERS OF NEW YORK STATE; and THE AMERICAN BEVERAGE ASSOCIATION, Petitioners-Respondents, For a Judgment Pursuant to Articles 78 and 30 of the Civil Practice Law and Rules, - against - THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE; THE NEW YORK CITY BOARD OF HEALTH; and DR. THOMAS FARLEY, in his Official Capacity as Commissioner of the New York City Department of Health and Mental Hygiene, Respondents-Appellants.	**New York County** **Index No. 653584/12** **AFFIRMATION IN SUPPORT OF MOTION BY THE NATIONAL ASSOCIATION OF BOARDS OF HEALTH, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, THE PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY, CHANGELAB SOLUTIONS, THE PUBLIC HEALTH LAW CENTER, THE HEALTH OFFICERS ASSOCIATION OF CALIFORNIA, JENNIFER POMERANZ OF THE RUDD CENTER FOR FOOD POLICY AT YALE UNIVERSITY, PROF. LAWRENCE O. GOSTIN OF THE O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN UNIVERSITY, PROF. PETER D. JACOBSON, PROF. LINDSAY F. WILEY, PROF. WENDY PARMET, PROF. LANCE GABLE AND PROF. MICAH BERMAN FOR LEAVE TO APPEAR AS *AMICI CURIAE***

BRIAN L BROMBERG, an attorney duly licensed to practice law before the courts of the State of New York, affirms the following under penalty of perjury:

1. I am a principal of Bromberg Law Office, P.C. I represent the proposed *amici curiae* in this matter.

2. The National Association of Local Boards of Health, the American Public Health Association, the National Association of County and City Health Officials, the Public Health Association of New York City, ChangeLab Solutions, the Public Health Law Center, the Health Officers Association of California, Jennifer Pomeranz, Director of Legal Initiatives of the Rudd Center for Food Policy at Yale University, Prof. Lawrence O. Gostin of the O'Neill Institute for National and Global Health Law at Georgetown University, Prof. Peter D. Jacobson, Prof. Lindsay F. Wiley, Prof. Wendy Parmet, Prof. Lance Gable and Prof. Micah Berman (collectively, "the Public Health Entities and Professors") respectfully request that this Court grant them leave to file as *amicus curiae* in support of Respondents-Appellants.

3. In support of this motion, affirmant states that the purpose of the Public Health Entities and Professors' *amicus* brief is to aid the court in understanding the public health benefits of Amendment § 81.53 (the "Portion Cap Rule") and to place passage of the Rule—and in particular the Rule's incremental and partial nature—in the context of the history of the New York City Board of Health's efforts to promote the health of and prevent disease among New York City residents.The proposed *amici* are experts in public health governance and in the importance of developing, implementing and testing new regulations in one locality in order to advance, incrementally, the national effort to improve public health. Their brief would provide the Court with a deeper understanding of the overlapping authority of various local, state and

federal regulatory bodies and of the resulting fragmentation that is typical of public health law. That framing will provide important historical background that is directly relevant to the legal analysis of New York City's Portion Cap Rule.

4. The Supreme Court's concern over the partial and incremental nature of this Rule reflects unfamiliarity with the general trajectory for the development of public health law when novel public health issues necessitate action. The Portion Cap Rule reflects precisely the sort of measured, initial step appropriate to serve the dual goals of (1) reducing consumption of the sugary beverages so closely associated with obesity and (2) testing the strengths and weaknesses of one particular approach by beginning with a narrow, partial law that might later be expanded with parallel action by other local entities or adopted more broadly at the state or federal level.

5. In light of extensive scientific evidence detailing the health hazards associated with consuming large portions of sugary drinks and consumer behavior research demonstrating that over-consumption is closely linked to large default portion sizes, these proposed *amici* seek leave to file in support of the Board of Health's authority to regulate the conduct of the food service establishments under its jurisdiction in order to reduce consumption of beverages that are demonstrably linked with the increasing prevalence of obesity and associated diseases.

6. Like other public health regulatory schemes developed over time, the regulatory response to the health crisis associated with obesity must develop over time. The proposed brief of these *amici* would demonstrate historically, scientifically and legally that the Portion Cap Rule is a reasonable step in the effort to control chronic diseases and to oversee the food supply of the city, pursuant to the power vested in the Board of Health by the New York City Charter. *See* N.Y.C. Charter §§ 1043, 558(b)–(c), 556(c)(2), (c)(9).

7. The National Association of Local Boards of Health (NALBOH) informs, guides, and is the national voice for the boards that govern health departments and shape public health policy. Driven by a mission to strengthen and improve public health governance, NALBOH interacts with member boards, affiliates, and other state and national partners to advance leadership, board development, health priorities, and public health policy. NALBOH, in collaboration with the Centers for Disease Control and Prevention and other partners, has identified the Six Functions of Public Health Governance as a model of performance for boards of health and other governing bodies. NALBOH connects with public health governing bodies to help them fulfill these governance functions, including exercising their legal authority and developing policies that protect, promote, and improve public health.

8. The American Public Health Association (APHA) is the oldest and most diverse organization of public health professionals in the world. Founded in 1872, APHA represents a broad array of health providers, educators, environmentalists, policymakers, and health officials working at all levels within and outside government. APHA aims to protect all Americans and their communities from preventable, serious health threats, and strives to ensure that community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States. APHA's goal is for the United States to become the healthiest nation in one generation.

9. The National Association of County and City Health Officials (NACCHO) is the voice of the approximately 2,800 local health departments across the country. These city, county, metropolitan, district, and tribal departments work every day to ensure the safety of the water we drink, the food we eat, and the air we breathe. Local health departments help create and maintain

conditions in communities that support healthier choices in areas such as diet, exercise, and tobacco. They lead efforts that prevent and reduce the effects of chronic diseases, such as diabetes and cancer.

10. The Public Health Association of New York City (PHANYC) is a diverse organization of health and other professionals who are committed to public health, including the overall health of the population. Since 1936, PHANYC has been working for improved health for the city's people. Throughout, PHANYC has been a catalyst informing consumers and providers of health care about public health issues; advocating for improved public health measures and a more responsive and equitable health care system; and influencing public health policy.

11. ChangeLab Solutions is a nonprofit organization dedicated to promoting healthy communities nationwide. ChangeLab Solutions develops legal and policy tools to create lasting change, working with advocates, public officials, and others who want to improve public health conditions where they live, learn, work, and play, especially for those who are highest risk because they have the fewest resources. ChangeLab Solutions houses the National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN) an initiative that provides technical assistance to communities across the country that are working to reverse the childhood obesity epidemic.

12. The Public Health Law Center is a public interest legal resource center dedicated to improving health through the power of law. Located at the William Mitchell College of Law in Saint Paul, Minnesota, the Center helps local, state, and national leaders promote public health by strengthening public policies. The center also serves as the National Coordinating Center of

the Network for Public Health Law, which offers specialized legal technical assistance to health departments nationwide on a wide range of issues relating to public health law, authority, and practice. The Public Health Law Center and its programs have filed amicus briefs in numerous state and federal cases involving significant questions of public health authority.

13. The Health Officers Association of California (HOAC) represents public health physicians responsible for all 61 California city and county health jurisdictions. Their mission is to promote and improve public health practices in the State of California through increasing knowledge about the cause, prevention and cure of diseases, conditions or states detrimental to the health of the people. HOAC's mission also includes promotion of legislation to accomplish these objectives.

14. Jennifer Pomeranz, JD, MPH is the Director of Legal Initiatives at the Yale University Rudd Center for Food Policy & Obesity (Rudd Center). The mission of the Rudd Center is to improve the world's diet, prevent obesity and reduce weight stigma by establishing connections between sound science and public policy, developing targeted research and expressing a dedicated commitment to real change.

15. Lawrence O. Gostin, JD, LLD, is a University Professor, O'Neill Chair in Global Health Law, and the Director of the O'Neill Institute for National and Global Health Law at Georgetown University (O'Neill Institute). The O'Neill Institute responds to the need for innovative solutions to the most pressing national and international health concerns and emphasizes the importance of public and private law in health policy analysis. The essential vision for the O'Neill Institute rests upon the proposition that the law has been, and will remain,

a fundamental tool for solving critical health problems in our local, national, and global communities.

16. Peter D. Jacobson, JD, MPH, is Professor of Health Law and Policy in the Department of Health Management and Policy, University of Michigan School of Public Health, and Director of the Center for Law, Ethics, and Health.

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20. Micah L. Berman, JD is the former director of the Center for Public Health and Tobacco Policy, which provides policy support to the New York State Department of Health on tobacco control and chronic disease prevention issues. As of this August, he will be an Assistant

[1] All university names are provided for purposes of identification only. The professors themselves are *amici*; their universities are not.

Professor of Health Policy and Law at The Ohio State University's College of Public Health and Moritz College of Law.

21. Attached hereto as Exhibit A is a true and correct copy of the proposed brief of the Public Health Entities.

WHEREFORE, for the reasons set forth above, I respectfully request that the Public Health Entities and Professors' motion for leave to file a brief as *amici curiae* be granted.

Dated: New York, New York
March 25, 2013

Brian L. Bromberg (BB: 6264)
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Exhibit A

Sup. Ct., N.Y. Co.
Index No. 653584/12

To be argued by
Brian L. Bromberg

NEW YORK SUPREME COURT
APPELLATE DIVISION: FIRST DEPARTMENT

NEW YORK STATEWIDE COALITION OF HISPANIC CHAMBERS OF COMMERCE; THE NEW YORK KOREAN-AMERICAN GROCERS ASSOCIATION; SOFT DRINK AND BREWERY WORKERS UNION, LOCAL 812, INTERNATIONAL BROTHERHOOD OF TEAMSTERS; THE NATIONAL RESTAURANT ASSOCIATION; THE NATIONAL ASSOCIATION OF THEATRE OWNERS OF NEW YORK STATE; and THE AMERICAN BEVERAGE ASSOCIATION,

Petitioners-Respondents,

For a Judgment Pursuant to Articles 78 and 30 of the Civil Practice Law and Rules,

- against -

THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE; THE NEW YORK CITY BOARD OF HEALTH; and DR. THOMAS FARLEY, in his Official Capacity as Commissioner of the New York City Department of Health and Mental Hygiene,

Respondents-Appellants

BRIEF OF *AMICI CURIAE* THE NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE NATIONAL ASSOCIATION

OF COUNTY AND CITY HEALTH OFFICIALS, THE PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY, CHANGELAB SOLUTIONS, THE PUBLIC HEALTH LAW CENTER, THE HEALTH OFFICERS ASSOCIATION OF CALIFORNIA, JENNIFER POMERANZ OF THE RUDD CENTER FOR FOOD POLICY AT YALE UNIVERSITY, PROF. LAWRENCE O. GOSTIN OF THE O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN UNIVERSITY, PROF. PETER D. JACOBSON, PROF. LINDSAY F. WILEY, PROF. WENDY PARMET, PROF. LANCE GABLE, AND PROF. MICAH BERMAN.

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March 25, 2013

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Amici curiae are leading public health organizations and professors of public health law. They submit this brief in support of respondents-appellants' appeal of an Order declaring invalid and enjoining and restraining implementation and enforcement of § 81.53 of the New York City Health Code. Section 81.53 restricts the portion size for sugary beverages sold at restaurants and is better known as the Portion Cap Rule.

INTEREST OF *AMICI CURIAE*

The following *amici* are experts in public health governance and in the importance of developing, implementing and testing new regulations in one locality in order to advance, incrementally, the national effort to improve public health. Together, *amici* urge the Court to respect the authority of New York City's public health agencies and officials to regulate the conduct of the food service establishments under their jurisdiction in order to reduce consumption of foods and beverages that are demonstrably linked with the increasing prevalence of obesity and associated diseases.

The National Association of Local Boards of Health (NALBOH) informs, guides, and is the national voice for the boards that govern health departments and shape public health policy. Driven by a mission to strengthen and improve public health governance, NALBOH interacts with member boards, affiliates, and other state and national partners to advance leadership, board development, health

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of this August, he will be an Assistant Professor of Health Policy and Law at The Ohio State University's College of Public Health and Moritz College of Law.

PRELIMINARY STATEMENT

The obesity epidemic is arguably the most pressing public health crisis of our time. The New York City Board of Health (BOH) initiated a new approach in the ongoing struggle to restrain the forces that are fueling this epidemic. It did so by establishing a cap on the maximum portion size of non-alcoholic, high-calorie, low-nutrient sugary drinks available for sale in food service establishments subject to the jurisdiction of Article 81 of the New York City Health Code (the "Portion Cap Rule"). In light of extensive scientific evidence detailing the health hazards associated with consuming large portions of sugary drinks and consumer behavior research demonstrating that over-consumption is linked to large default portion sizes, *amici curiae* support the BOH's regulation as a reasonable step to control chronic diseases and to oversee the food supply of the city, pursuant to the power vested in it by the New York City Charter. *See* N.Y.C. Charter §§ 1043, 558(b)–(c), 556(c)(2), (c)(9).

The purpose of this brief is to demonstrate that the Portion Cap Rule reflects an incremental approach to addressing the complex epidemic of obesity, consistent with the BOH's historic practice of tackling complex health problems in a step-

wise manner. Further, this brief shows that courts have consistently approved as reasonable this type of incremental approach to pressing public health issues.

Both the history of the BOH and the legal authority analyzing a regulatory agency's power to proceed in small steps confirm that the BOH has not been, and is not as a matter of law, limited to an all-or-nothing approach. Although the Portion Cap Rule does not prevent all industry strategies that encourage people to consume excessive quantities of high-calorie beverages, there is every reason to anticipate that it will be effective in reducing consumption in the regulated restaurants. The Rule should be upheld as a crucial first step towards reducing consumption of the high-calorie beverages that are a major contributor to obesity.

I. ARGUMENT

A. The Complexity of Public Health Problems Often Requires Public Health Agencies to Advance An Incremental Approach to Disease Prevention

The Supreme Court invalidated the Portion Cap Rule, which the New York City Board of Health (BOH) had adopted by a vote of eight to zero with one abstention, in part because the court did not fully appreciate the incremental nature of public health regulation and the role of initial, relatively limited initiatives in laying the groundwork for more comprehensive regulation. That lack of understanding, and associated misapplications of the law, resulted in erroneous

determinations both that the Rule is arbitrary and capricious and that the Rule was based not on public health considerations but on economic, political and social considerations. Order and Judgment, *N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, Index No. 653584/12, at 13, 35 (Sup. Ct., N.Y. Cty. Mar. 11, 2013). These *amici* submit that the Rule is an entirely rational response, far from arbitrary, to the widespread public health challenge posed by overconsumption of sugar, including from sugary drinks.

This brief provides a framework for understanding the typical way in which public health regulation in a new area unfolds and how courts have dealt with such challenges in the past. Simply put, public health regulation is incremental, partial, even piecemeal. And that is entirely permissible, no matter how unsatisfying or untidy it may be, for petitioners have not shown—and cannot show—that the Rule is unsupported by *any* evidence that it is likely to be effective in reducing consumption of sugary beverages. *See Consolation Nursing Home, Inc. v. Comm'r of N.Y. State Dep't of Health*, 85 N.Y.2d 326, 331–32 (1995) (articulating standard). That there are other measures that also might be effective, or that might be more effective, is not a legitimate basis for invalidating the Rule.

Given the multi-factorial nature of threats to the public's health, an incremental approach is not only legal, but often necessary. When new health

threats arise—such as the emergence of HIV or a dramatic rise in the prevalence of type 2 diabetes—public health agencies cannot fulfill their statutory obligation to protect the public's health if they wait to develop a comprehensive regulatory response. For many complex health problems, it may take decades before the epidemiological evidence points to a comprehensive solution. In such cases, public health agencies must rely upon the evidence before them in developing an initial, albeit incremental and under-inclusive, response. Critically, such first regulatory steps often serve as a "laboratory" for health researchers and regulators, furnishing important evidence that can be used to guide subsequent steps and, in some cases, comprehensive regulation.[2]

The fragmentary nature of the vast majority of public health law is also attributable to the fact that responsibility for protecting the public's health is shared by federal, state, and local governments.[3] Additionally, because conditions

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[2] *Cf.* ALEXANDER C. WAGENAAR & KELLI A. KOMRO PUB. HEALTH LAW RESEARCH PROGRAM METHODS MONOGRAPH SERIES, NATURAL EXPERIMENTS: DESIGN ELEMENTS FOR OPTIMAL CAUSAL INFERENCE 24 (2011), *available at* http://publichealthlawresearch.org/sites/default/files/WagenaarKomroPHLR-MethodsModule.pdf (concluding that "results from actual field implementations of laws and regulations are more persuasive to policy-makers, public health practitioners, and citizens, facilitating diffusion of successful approaches to other jurisdictions, resulting in major improvements in population health"); Scott Burris et al., *Making the Case for Laws that Improve Health: A Framework for Public Health Law Research*, 88 MILBANK Q. 169, 185–88 (2010) (explaining how changes in law can form the basis for research regarding the law's efficacy and guide policy development).

[3] *See* INST. OF MED., FOR THE PUBLIC'S HEALTH: REVITALIZING LAW AND POLICY TO MEET NEW CHALLENGES 27 (2011), *available at* http://books.nap.edu/openbook.php?record_id=13093 ("In

affecting the public's health are often under the purview of "non-health" sectors such as agriculture or transportation, "[p]ublic health responsibilities at both the state and local levels generally reside in multiple agencies, in addition to the public health agency."[4] The result is that public health regulation typically involves multiple governmental actors taking complementary, incremental steps to address those components of the threat that are within their purview. The New York City BOH has acted to regulate the food service establishments that are subject to its jurisdiction under Article 81. Regulation of other businesses that sell sugary drinks (such as convenience and grocery stores) and of the alcoholic beverages that contribute to obesity would require a broader approach that includes additional local or state agencies with primary jurisdiction over those matters. As is appropriate for a local administrative body with limited jurisdiction, this initial rule is a modest one, to be built on incrementally once it has been evaluated.

B. The New York City Board of Health Historically Has Adopted an Incremental Approach in Carrying Out its Powers and Duties

The history of the New York City BOH reflects the important role entrusted to it by the New York City Charter. From its inception, the BOH has operated

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the United States, governmental public health responsibilities and roles exist at three different levels: federal, state/tribal, and local/municipal."); *cf.* James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J.L. & HEALTH 309, 312 (1998) ("[E]ach conception of public health objectives, whether local or national, relies to an extent on the particular governmental structure supported by federalism interpretations.").

[4] INST. OF MED., *supra* note 3 at 14, 29.

under a broad legal mandate to address a wide range of significant threats to the health of the city's residents. As is typical of public health regulation generally, the BOH's initial responses to health threats have often been partial and incremental.

In 1866, New York State created the first "effective" municipal board of health in the nation, the Metropolitan Board of Health, charged with protecting the health of the residents of New York City and Brooklyn.[5] *See* An Act to Create a Metropolitan Sanitary District and Board of Health, 1866 N.Y. Laws 114. Although the City had boards of health before 1866, they lacked the stable administrative structure and broad powers granted to the Metropolitan Board. With the establishment of the Metropolitan Board, the State recognized the need for a board of health with broad jurisdiction and the capacity to respond with expertise and alacrity to emerging and evolving health threats. Over time, the Metropolitan Board of Health became a model for health departments around the nation.[6] Under the City Charter, the BOH is now entrusted with, *inter alia*, "supervis[ing] the reporting and control of communicable and chronic diseases and conditions hazardous to life and health . . . ." N.Y.C. Charter § 566(c)(2).[7]

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[5] JOHN DUFFY, THE SANITARIANS: A HISTORY OF AMERICAN PUBLIC HEALTH 120 (1990).
[6] *Id.*
[7] To advance its mission, the BOH is charged with issuing health regulations. N.Y.C Charter § 558(b). The Department of Health and Mental Hygiene (DOHMH) has authority to enforce the Health Code as promulgated by the BOH. *Id.* § 556(a)(1).

In this case, the Supreme Court's assertion that "the intention of the legislature with respect to the Board of Health" has been "to protect the citizens of the city in providing regulations that prevent and protect against communicable, infectious, and pestilent diseases," Order and Judgment, *N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene*, Index No. 653584/12, at 27 (Sup. Ct., N.Y. Cty. Mar. 11, 2013), is misguided and historically inaccurate, as is the Petitioners' assertion that the Portion Cap Rule represents "a dramatic departure from the powers traditionally exercised by the Department of Health." Pet. at 22. (A copy of the Petition has been reproduced in the Record on Appeal at 46-103.)

For example, at the time of the 1866 cholera outbreak that prompted the creation of the BOH, the relationship between cholera and the water supply was neither fully understood nor fully accepted.[8] The BOH's early actions were based in part on the then-dominant miasma theory of disease, which considered unsanitary environmental conditions to be the source of diseases like cholera and supported regulation of economic activity, such as mandating "[c]losed drainage

[8] *See* CHARLES E. ROSENBERG, THE CHOLERA YEARS: THE UNITED STATES IN 1832, 1849, AND 1866, at 200 (1987).

and sewage systems, supplemented by garbage collection, public baths, and [public] housing," as an appropriate disease control measure.[9]

Throughout the cholera outbreaks of 1866 and 1892, the newly created BOH adopted an incremental approach to environmental sanitation. The BOH began to investigate complaints filed by private citizens with the help of police officials and newly hired sanitary inspectors. Thousands of complaints alleging unsanitary conditions were individually assessed and addressed in the months and years that followed.[10] According to figures reported by the Department of Health, it "summarily seized over 1,197,950 pounds of meat, fish, fruit, vegetables, and milk during the [1866] epidemic. It also claimed to have inspected over 39,000 tenement buildings."[11] As the outbreak grew, the BOH employed rapid response and targeted application of resources in an incremental fashion. These measures met with some success in the control of cholera, and more broadly in the overall improvement of health in the city.

This example of addressing cholera (improperly characterized by the Supreme Court) not only demonstrates that the BOH has historically exercised its power beyond the realm of infectious disease control pursuant to the microbial

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[9] *See* Mervyn Susser & Ezra Susser, *Choosing a Future for Epidemiology: I. Eras and Paradigms*, 86 AM. J. PUB. HEALTH 668, 669 (1996).
[10] ROSENBERG, *supra* note 8 at 202–03.
[11] N.Y.C. HEALTH DEP'T, REPORT FOR THE YEAR ENDING DECEMBER 31, 1892, at 34 (1893).

theory of disease, but also shows that the BOH has adopted incremental solutions since its origin.

In more recent years, the BOH has continued to take an incremental approach to addressing a wide range of public health threats. For example, in 2005 the BOH adopted a regulation requiring clinical laboratories that report electronically to the Department of Health and Mental Hygiene (DOHMH), but not manually, to report the results of hemoglobin A1C tests (which are used to diagnose diabetes and to monitor management of the disease). 24 RCNY Health Code § 13.07. This regulation, designed to help track and ultimately control the diabetes epidemic, represented a classic incremental step in addressing a serious threat. The regulation did not require reporting of all laboratory tests relevant to diabetes control, nor by all laboratories. Rather, the regulation represented one small, innovative step taken by the Board to address the diabetes epidemic.

Also in 2005, the DOHMH embarked on a campaign to reduce consumption of trans fats, in light of evidence that heart disease is the leading cause of death among city residents and trans fat consumption was known to increase heart disease risk. As in the case of its efforts to reduce consumption of sugary drinks, the DOHMH began with a public education campaign and called on restaurant

owners to voluntarily eliminate trans fat from their menus.[12] When the voluntary program proved unsuccessful, the BOH voted to ban trans fats in restaurant food in 2006 via an amendment to Article 81. *See* 24 RCNY Health Code § 81.08. Notably, the trans fat ban applies only to *artificial* trans fats, in spite of evidence linking naturally occuring trans fats to heart disease. The measure also applies only to restaurants and does not extend to grocery or convenience stores, although those establishments also sell food containing trans fats. New York City was the first major U.S. city to take this action, but several additional jurisdictions quickly followed the BOH's lead.[13] Recent studies have concluded that trans fat bans in New York City and elsewhere have sharply reduced consumption of these unhealthy fats among fast-food customers.[14]

In 2006, the BOH voted to implement nutrition guidelines for group day care facilities in an effort to improve nutrition and physical activity in these centers. Under the requirements, children over eight months old may receive no more than six ounces of 100% juice each day and children over two are only served 1% or

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[12] Press Release, N.Y.C. Dep't of Health & Mental Hygiene, Health Department Asks Restauranteurs and Food Suppliers to Voluntarily Make an Oil Change and Eliminate Artificial Trans Fat (Aug. 10, 2005), *available at* http://www.nyc.gov/html/doh/html/pr/pr083-05.shtml.
[13] *See* Nat'l Conference of State Legislatures, *Trans Fat and Menu Labeling Legislation* (Jan. 2013), http://www.ncsl.org/issues-research/health/trans-fat-and-menu-labeling-legislation.aspx.
[14] *See, e.g.*, Sonia Y. Angell et al., *Change in Trans Fatty Acid Content of Fast-Food Purchases Associated with New York City's Restaurant Regulation: A Pre-Post Study*, 157 ANNALS INTERNAL MED. 81 (2012).

skim milk. *See* 24 RCNY Health Code § 47.61. Although the nutrition standards adopted by the BOH would benefit all children in organized day care, they do not cover family day care establishments, which are regulated by the State.

In 2008, the BOH amended Article 81 to require all chain restaurants with fifteen or more food service establishments nationally to make statements showing calorie content in a precise manner set forth in the rule. Notably, the calorie labeling rule applies only "to menu items that are served in portions the size and content of which are standardized," 24 RCNY Health Code § 81.50(b), even though many nonstandardized menu items, such as customized pizzas, have a very high calorie content that is likely to be misjudged by consumers in the absence of labeling. The rule is also limited to chain restaurants, even though non-chain restaurants serve foods that are high in calories and low in nutritional value. *Id.* § 81.50(a)(1). Again, the BOH was at the vanguard of the movement to impose calorie labeling requirements as an incremental measure to control obesity and related chronic diseases. After the BOH's initial effort in 2006, several additional jurisdictions followed suit and, in 2010, a similar requirement was included in the federal Affordable Care Act (ACA).[15] Under the BOH's (and ACA's) calorie-labeling rule, not all restaurants on the same block are treated the same. And not all

[15] *See* Nat'l Conference of State Legislatures, *supra* note 13.

foods at the same restaurant are treated the same. But that does not detract from the fact that the rule is a reasonable first step toward informing consumers of the caloric content of their meals and thereby reducing obesity. The BOH need not regulate with a heavier hand in order to regulate at all; it may prioritize and move incrementally to protect public health.

C. Courts Consistently Have Upheld the BOH's Authority to Exercise its Broad Authority in an Incremental Manner

Courts consistently have recognized the discretion of the BOH to use its powers incrementally to address many types of public health threats. Challenges to BOH regulations alleging them to be under-inclusive have been rejected repeatedly by New York courts. In *Fougera & Co. v. City of New York*, the Court of Appeals upheld the powers of the BOH to require the registration of ingredients for patent medicines. 224 N.Y. 269 (1918). Addressing a challenge that this regulation was arbitrary because it required disclosure only to public health officials, the court stated "[i]t is not important that the ordinance fails to compel disclosure to all the world. Laws are not invalid because they fall short of the maximum of attainable efficiency." *Id.* at 278.

Likewise, courts have affirmed the power of local public health officials to adapt and modify regulatory and enforcement strategies as dictated by evidence and good public health practice. Recognizing that enactment and refinement of

regulation over time is inherent in the public health system, the Court of Appeals has explained that public health regulation "in general presents a situation where flexibility and the adaptation of the legislative policy to infinitely variable conditions constitute the essence of the program." *Chiropractic Ass'n of N.Y., Inc. v. Hilleboe*, 12 N.Y.2d 109, 120 (1962) (finding that the New York State Public Health Council had the authority to determine which professionals could administer x-rays); *see also N.Y. State Soc'y of Surgeons v. Axelrod*, 77 N.Y.2d 677, 683–84 (1991) (finding that the BOH had discretion whether to include HIV infection on a list of reportable sexually transmissible diseases).

Additionally, an important line of cases has upheld incremental regulatory actions by state and local officials against equal protection claims. In a 1955 case challenging an Oklahoma law regulating who could sell eyeglasses, the U.S. Supreme Court explained that "[legislative] reform may take one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind." *Williamson v. Lee Optical of Okla.*, 348 U.S. 483, 489 (1955). Drawing on this precedent, a subsequent decision in New York upheld a mandatory seatbelt law, stating "[w]hen a State regulates a problem it is not under any obligation to regulate all phases of it or every class of acts or actors involved in it. . . . [O]n the contrary, the State may regulate partially or one step at a time

without violating the 14th Amendment's equal protection clause." *Wells v. State*, 130 Misc.2d 113, 121 (N.Y. Sup. Ct., Steuben Cty. 1985).

Likewise, the court in *Carl Ahlers, Inc. v. City of New York* found no violation of the equal protection clause when the BOH regulated liquid and frozen eggs but not other egg products, holding, "'It is no requirement of equal protection that all evils of the same genus be eradicated or none at all' . . . . 'The legislature may select one phase of one field and apply a remedy there, neglecting the others.'" 59 Misc. 2d 634, 637 (N.Y. Sup. Ct., N.Y. Cty. 1969) (quoting *Ry. Express Agency, Inc. v. People of State of New York*, 336 U.S. 106, 110 (1949); *Williamson*, 348 U.S. at 489).

These historical examples affirming the deference afforded to health regulations, and to those promulgated by the New York City Board of Health in particular, have great relevance to the case at hand. Much like the nineteenth-century efforts to control cholera through regulation of sanitation, the Portion Cap Rule seeks to regulate the food environment to control a major risk factor for obesity and related health conditions. Just as the BOH in the 1860s sought to take incremental steps to respond to the threat of cholera, so in the 2010s the Board has taken initial—rather than comprehensive—steps to stem the tide of obesity by regulating an activity under its jurisdiction: the sale of sugary beverages in portion

sizes that reasonably could be expected to lead to excessive consumption. In both cases the incremental nature of the Board's initial response evinces not arbitrary administrative action but sound public health practice.

The Portion Cap Rule is an initial effort to reduce the adverse health impacts of overconsumption of sugary drinks that has been brought about, in no small part, by the beverage industry's long-established practices aimed at increasing the demand for and profits from the sale of unhealthy drinks. The industry has done so by, among other things, increasing portion sizes. But as the history of BOH regulation attests, this sort of initial foray is a typical example of the incremental nature of public health regulation. The test is not whether a more robust restriction would be preferable, for that is a decision within the purview of the regulatory agency, not the courts.

D. The Portion Cap Rule Is a Reasonable and Promising Step Taken Pursuant to the Board's Power and Duty to Control Chronic Disease

The Portion Cap Rule follows the incremental approach typical of public health regulation. With this regulation the BOH has taken an important, evidence-based step towards addressing chronic diseases that indisputably pose a major threat to the health of New Yorkers. While the Rule does not apply to every venue in which sugary drinks may be purchased and consumed and does not regulate all food products associated with obesity, it marks a reasoned, incremental response

by the BOH as well as the DOHMH to a serious epidemic facing the City, one well within these entities' celebrated tradition and legal grant of authority.

The Portion Cap Rule is reasonably designed to promote reduced consumption of high-calorie, low-nutrient beverages by reducing the default portion size and putting the onus on consumers who wish to consume larger quantities to take affirmative steps to do so. Supposed "carve-outs" for "fruit juices, milkshakes, and certain milk-based coffee drinks" are legitimately aimed at exempting drinks that provide significant nutritional value from nutrients other than sugar, such as protein, fiber, or calcium—not "interest group carve-outs," as asserted by the petitioners. Pet. at 31.

The Portion Cap Rule is applicable to the food service establishments that fall within the jurisdiction of Article 81, and enforcement of the Portion Cap Rule is tied to Article 81 inspection. As stated above, measures to regulate the sale of sugary drinks in other retail establishments (such as convenience stores and grocery stores) would require a response designed to address the distinct issues raised in those settings by the city or state agencies with primary responsibility and expertise in their operations and responsibility for enforcement.

E. The Portion Cap Rule Was Adopted After Careful Consideration of Evidence Supporting the View that Restricting Portion Size Is a Compelling Strategy to Reduce Consumption of Sugary Beverages

Before the Portion Cap Rule was adopted, the DOHMH provided the BOH with a summary of the arguments raised by detractors of the Rule, including the argument that the proposed restriction would be ineffective. Department's Memorandum to the Board, Dated September 6, 2012, Regarding Its Summary and Response to the Public Hearing and Comments Received Relating to Health Code § 81.53. (A copy of the Department's Memorandum has been reproduced in the Record on Appeal at 1418–41.) The BOH's review of the measure's potential efficacy therefore included consideration of extensive evidence that consumers overwhelmingly gravitate towards the default option,[16] that the portion size for fountain drinks at restaurants has grown astronomically,[17] and that larger portions lead to increased consumption and calorie intake.[18]

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[16] *See* R. at 1423 (citing Alberto Abadie & Sebastien Gay, The Impact of Presumed Consent Legislation on Cadaveric Organ Donation: A Cross-Country Study, 25 J. HEALTH ECON. 599 (2006); Stefano DellaVigna & Ulrike Malmendier, *Paying Not to Go to the Gym*, 96 *AM. ECON. REV.* 694 (2006); Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116 Q.J. ECON. 1149 (2001)).

[17] *See* Lisa R. Young & Marion Nestle, *Portion Sizes and Obesity: Responses of Fast-Food Companies*, 28 J. PUB. HEALTH POL'Y 238 (2007); McDonald's, *McDonald's USA Nutrition Facts for Popular Menu Items*, http://nutrition.mcdonalds.com/getnutrition/nutritionfacts.pdf (last visited Mar. 23, 2013).

[18] *See* R. at 1422 (citing Julie E. Flood, Liane S. Roe & Barbara J. Rolls, *The Effect of Increased Beverage Portion Size on Energy Intake at a Meal*, 106 J. AM. DIETETIC ASS'N 1984 (2006));

The DOHMH also responded to arguments that the Rule would be of no value because customers would be able to circumvent the Rule by buying more than one beverage, getting a free refill, or buying a larger drink in an unregulated outlet. But testimony presented to the BOH suggested otherwise.

> How much we consume is hugely influenced by the portion in front of us . . . Consumers respond to what the 'default' choice is, or the option that is the path of least resistance . . . We know that convenience drives many food purchases, particularly fast food purchases. If it becomes harder to carry two or more cups, people will be less likely to do so.

Department's Memorandum to the Board at 6 (quoting Brian Elbel, PhD, MPH, Assistant Professor of Medicine and Health Policy at New York University School of Medicine).

Even the possibility that some consumers might choose to purchase multiple drinks does not make the Rule itself ineffective. The Rule is an untried and untested step, aimed at changing industry practices that set the default, and is a reasonable approach worthy of testing.

The standard here is whether challengers can show that there is no evidence at all to support the BOH's determination that the Rule will be effective in reducing overconsumption of unhealthy beverages in restaurants. *See Consolation*

Samara Joy Nielsen & Barry M. Popkin, *Patterns and Trends in Food Portion Sizes, 1977-1998*, 289 JAMA 450 (2003).

Nursing Home, Inc. v. Comm'r of N.Y. State Dep't of Health, 85 N.Y.2d 326, 331-32 (1995) (party arguing regulation is arbitrary and capricious bears "the heavy burden of showing that the regulation is unreasonable and unsupported by any evidence"). They cannot do so.

In summary, the actions taken by the BOH to respond to threats to the public's health have applied reasonable assessments of the risks posed by these threats and reasonable steps to alleviate those risks. The Supreme Court's suggestion that such an incremental approach is invalid threatens to paralyze public health agencies. Rather than take modest, yet important, steps for fear of being "arbitrary," such agencies would be forced to choose between doing nothing and implementing blanket regulations that may have negative externalities. An incremental approach is not only desirable but necessary for effective and prudent public health regulation.

II. CONCLUSION

For the foregoing reasons, we urge the Court to find for respondents-appellants and dismiss petitioners-respondents' motion for declaratory relief and a permanent injunction.

Dated: March 25, 2013

Respectfully submitted,

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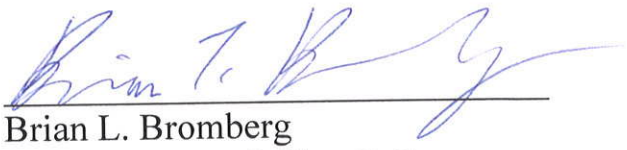

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SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST JUDICIAL DEPARTMENT

New York County
Index No. 653584/2012

NEW YORK STATEWIDE COALITION OF HISPANIC CHAMBERS OF COMMERCE; THE NEW YORK KOREAN-AMERICAN GROCERS ASSOCIATION; SOFT DRINK AND BREWERY WORKERS UNION, LOCAL 812, INTERNATIONAL BROTHERHOOD OF TEAMSTERS; THE NATIONAL RESTAURANT ASSOCIATION; THE NATIONAL ASSOCIATION OF THEATRE OWNERS OF NEW YORK STATE; and THE AMERICAN BEVERAGE ASSOCIATION,

Petitioners-Respondents,

For a Judgment Pursuant to Articles 78 and 30 of the Civil Practice Law and Rules,

- against -

THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE; THE NEW YORK CITY BOARD OF HEALTH; and DR. THOMAS FARLEY, in his Official Capacity as Commissioner of the New York City Department of Health and Mental Hygiene,

Respondents-Appellants.

NOTICE OF MOTION, SUPPORTING AFFIRMATION, AND EXHIBITS IN SUPPORT OF THE MOTION OF THE NATIONAL ASSOCIATION OF BOARDS OF HEALTH, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, THE PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY, CHANGELAB SOLUTIONS, THE PUBLIC HEALTH LAW CENTER, THE HEALTH OFFICERS ASSOCIATION OF CALIFORNIA, JENNIFER POMERANZ OF THE RUDD CENTER FOR FOOD POLICY AT YALE UNIVERSITY, PROF. LAWRENCE O. GOSTIN OF THE O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN UNIVERSITY, PROF. PETER D. JACOBSON, PROF. LINDSAY F. WILEY, PROF. WENDY PARMET, PROF. LANCE GABLE AND PROF. MICAH BERMAN FOR LEAVE TO APPEAR AS *AMICI CURIAE*

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Signature (Rule 130-1.1a)

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