TACKLING THE OBESITY EPIDEMIC: A PROPOSAL TO ENACT A FEDERAL EXCISE TAX ON SUGAR-SWEETENED BEVERAGES

by
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Abstract

Rising obesity rates in the United States are both a growing public health concern and an increasing burden on the U.S. economy, leading to higher expenditures on health care and disability insurance, decreased worker productivity, and other societal costs. One significant contributor to the obesity epidemic is the consumption of added sugars. This capstone proposes to enact a federal excise tax of $0.01 per ounce on caloric sweetened beverages to reduce obesity rates, and to use the revenue to offset the federal costs of health care.

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MEMORANDUM

FOR: Director, Domestic Policy Council

FROM: Laura Cylke

SUBJECT: Proposal to Enact a Federal Excise Tax on Sugar-Sweetened Beverages

DATE: August 31, 2016

Action-Forcing Event

Several major health insurance providers have recently pulled out of the health care exchanges established under the Patient Protection and Affordable Care Act (Public Law 111-148), citing financial losses resulting from a higher proportion of sick versus healthy individuals purchasing plans.[1] This exodus from the insurance marketplace reflects the negative impact of rising health care costs on insurance companies, individuals, and the taxpaying public. Health care costs have been on the rise over the past several decades across the entire U.S. population, but have increased even more sharply among the obese. Obesity, and the numerous serious medical conditions associated with obesity, pose an added economic burden on insurance providers, the insured, and the American taxpayer, in a health care system that is already struggling to provide affordable services in the face of these increasing costs.

[1] Nathan Bomey, "Aetna's exit deals blow to Obamacare, patients," *USA Today*, August 16, 2016, http://www.usatoday.com/story/money/2016/08/16/aetna-obamacare-affordable-care-act-exchanges/88825798/.

Statement of Problem

More than one-third of adults in the United States are considered to be obese.[2] Obesity is not only an individual and public health concern—increasing one's risk of developing numerous serious illnesses, such as type 2 diabetes, coronary heart disease, and stroke[3]—but also a growing economic concern, as obesity is associated with higher spending on health care and disability insurance, decreased worker productivity, and other indirect costs.

Estimates vary regarding the magnitude of the economic impact of obesity, but research consistently supports the finding that obesity is associated with higher levels of spending on health care and other negative economic consequences. One widely-cited study attributed $147 billion in medical costs in 2008—or 10 percent of all health care spending (including Medicare, Medicaid, and private insurance)—to obesity.[4] Another study assessing the causal effect of obesity on health care spending estimated that obesity raises an individual's annual medical expenditures by $2,741, resulting in an additional $209.7 billion in health care spending each year—or 20.6 percent of all health expenditures.[5]

This spending is not just borne by the obese, but by the American taxpayers in the form of higher spending on Medicare, Medicaid, and disability payments. Increasing obesity rates are responsible for an estimated 17 percent of the growth in Medicare

[2] Cynthia L. Ogden et al., "Prevalence of Childhood and Adult Obesity in the United States, 2011-2012," *The Journal of the American Medical Association* 311, no. 8 (2014): 809, doi:10.1001/jama.2014.732.
[3] "What Are the Health Risks of Overweight and Obesity?," National Heart, Lung, and Blood Institute, https://www.nhlbi.nih.gov/health/health-topics/topics/obe/risks.
[4] Eric A. Finkelstein et al., "Annual Medical Spending Attributable to Obesity: Payer- And Service-Specific Estimates," *Health Affairs* 28, no. 5 (2009): 822, doi:10.1377/hlthaff.28.5.w822.
[5] John Cawley and Chad Meyerhoefer, "The medical care costs of obesity: An instrumental variables approach," *Journal of Health Economics* 31, no. 1 (2012): 227, doi:10.1016/j.jhealeco.2011.10.003.

spending on diabetes between 1987 and 2011,[6] and obesity contributes to 8.5 percent of annual expenditures on Medicare and 11.8 percent of annual expenditures on Medicaid.[7] Further, Social Security Disability Insurance (SSDI) applicants are approximately 40 percent more likely to be obese than the overall working age population.[8]

In addition to the direct health care costs, there are other economic impacts associated with obesity. Obesity contributes to an estimated 450 million additional sick days taken by full-time workers, costing approximately $153 billion each year in lost productivity—a figure that does not include part-time employees or "presenteeism," a term for employees that are physically present at the office but are less productive due to illness.[9] Hospitals and other medical facilities must also make special accommodations for obese patients—for example, purchasing expensive equipment such as ceiling lifts—or risk injury to their own workforce of nurses.[10]

Although the upward trend in obesity appears to have leveled off in the past decade,[11] health care expenses continue to grow across the entire U.S. population and even stable obesity rates will contribute to these increasing costs. The Congressional Budget Office (CBO) projected a 65 percent increase in per capita spending on health

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[6] Lindsay Allen, Ken Thorpe, and Peter Joski, "The Effect of Obesity and Chronic Conditions on Medicare Spending, 1987-2011," *PharmacoEconomics* 33, no. 7 (2015): 695, doi:10.1007/s40273-015-0284-9.
[7] Eric A. Finkelstein et al., "Annual Medical Spending Attributable to Obesity: Payer- And Service-Specific Estimates," *Health Affairs* 28, no. 5 (2009): 829, doi:10.1377/hlthaff.28.5.w822.
[8] Jody Schimmel Hyde, *The Prevalence of Obesity Among Recent Applicants to Federal Disability Programs*, DRC Brief No. 2016-03, (Washington, DC, Mathematica Center for Studying Disability Policy, 2016), 2, https://www.disabilitypolicyresearch.org/-/media/publications/pdfs/disability/2016/drc-obesity-brief-2016-03.pdf.
[9] Dan Witters and Sangeeta Agrawal, "Unhealthy U.S. Workers' Absenteeism Costs $153 Billion," *Gallup*, October 17, 2011, http://www.gallup.com/poll/150026/unhealthy-workers-absenteeism-costs-153-billion.aspx.
[10] Elizabeth Whitman, "Obesity in America: As Healthcare Costs Rise, Hospitals Weigh New Ways of Caring for Larger Patients," *International Business Times*, March 6, 2016, http://www.ibtimes.com/obesity-america-healthcare-costs-rise-hospitals-weigh-new-ways-caring-larger-patients-2325147.
[11] Cynthia L. Ogden et al., "Prevalence of Childhood and Adult Obesity in the United States, 2011-2012," *The Journal of the American Medical Association* 311, no. 8 (2014): 809, doi:10.1001/jama.2014.732.

care between 2007 and 2020, based on the assumption that obesity rates remain steady during this time period; however, whereas health care spending on obese adults was 38 percent higher than normal weight adults in 2007, CBO projected this gap in spending would increase to 69 percent by 2020.[12] Higher obesity rates among children may further accelerate these economic impacts, as obese children and youth experience the negative health effects of obesity at an even earlier age and rely on SSDI for a greater number of years.[13]

History

The upward trend in obesity rates among the U.S. population can be tracked beginning in the 1950s and 1960s. While this trend may have been slowly emerging even before this time, public health policy in the first half of the twentieth century was primarily focused on the opposite end of the spectrum—preventing malnutrition and ensuring a food supply sufficient to feed the population.[14] However, since the middle of the century, obesity rates have skyrocketed, climbing from roughly 13 percent in the early 1960s, to 23 percent in the early 1990s, to nearly 31 percent by 2000,[15] as measured

[12] Congressional Budget Office, *Economic and Budget Issue Brief: How Does Obesity in Adults Affect Spending on Health Care?*, by Noelia Duchovny and Colin Baker (Washington, DC, September 2010), 9, https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/118xx/doc11810/09-08-obesity_brief.pdf.
[13] Jody Schimmel Hyde, *The Prevalence of Obesity Among Recent Applicants to Federal Disability Programs*, DRC Brief No. 2016-03, (Washington, DC, Mathematica Center for Studying Disability Policy, 2016), 4-5, https://www.disabilitypolicyresearch.org/-/media/publications/pdfs/disability/2016/drc-obesity-brief-2016-03.pdf.
[14] Theodore K. Kyle, Emily J. Dhurandhar, and David B. Allison, "Regarding Obesity as a Disease: Evolving Policies and Their Implications," *Endocrinology and Metabolism Clinics of North America* 45, no. 3 (2016): 512, doi:10.1016/j.ecl.2016.04.004.
[15] Cheryl D. Fryer, Margaret D. Carroll, and Cynthia L. Ogden, "Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults: United States, 1960-1962 through 2011-2012," *NCHS Health E-Stats* (2014), http://www.cdc.gov/nchs/data/hestat/obesity_adult_11_12/obesity_adult_11_12.pdf.

using currently accepted standards of obesity (Body Mass Index > 30).[16] Although Body Mass Index and other standards for healthy weight based on gender, height, and age have been used for decades, the current standard used in the United States was formally presented in the *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*, which was published in 1998 by the National Heart, Lung, and Blood Institute and closely aligned with the classification proposed by the World Health Organization in 1995.[17]

The dramatic and universal increase in the weight of the U.S. population has had a significant economic impact. Health care spending in the United States has increased exponentially across the entire population, both in real dollars and as a share of U.S. gross domestic product (GDP). Since 1960, annual expenditures on health care have grown from 5 percent of GDP to 17.5 percent of GDP in 2014.[18] However, health care spending has grown more rapidly among the obese as compared to normal weight adults. One study attributed 27 percent of the growth in per capita health care spending between 1987 and 2001 to the increase in obesity rates across the U.S. population.[19] In a more recent study, CBO estimated that between 1987 and 2007 spending per capita on health care among the obese increased by 111 percent, compared to 65 percent among normal

[16] "Defining Adult Overweight and Obesity," Centers for Disease Control and Prevention, https://www.cdc.gov/obesity/adult/defining.html.
[17] Marina Komaroff, "For Researchers on Obesity: Historical Review of Extra Body Weight Definitions," *Journal of Obesity* 2016 (2016): 7, doi:10.1155/2016/2460285.
[18] "National Health Expenditures Summary, CY 1960-2014," Centers for Medicare and Medicaid Services, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.
[19] Kenneth E. Thorpe et al., "The Impact of Obesity on Rising Medical Spending," *Health Affairs* 23 (2004): 484, doi:10.1377/hlthaffW4.480.

weight adults, and attributed more than half of the growing gap in health care spending between obese and normal weight individuals to obesity-related diseases.[20]

Although there are many factors that have contributed to the growth in obesity rates, one of the major contributors has been the continuing decline in the production costs of food and the resulting decrease in food prices, in conjunction with the increase in the availability of pre-packaged, processed foods that require less preparation and often contain more calories, sugar, salt, and fat than food prepared from scratch.[21] Food expenditures as a percentage of disposable income has steadily but dramatically decreased since the 1930s, from approximately 25 percent to less than 10 percent in 2009.[22] While food costs have declined, average per capita caloric intake has increased roughly 25 percent since 1970—an increase that is often attributed to the growing prevalence of fast food and other convenience foods,[23] higher consumption of sodas and other sugary beverages,[24] and lower relative costs of such food and beverages in comparison to their more nutritious alternatives. For example, the average price of soda in the United States is 62 percent lower than milk.[25]

Despite the evident increases in obesity rates throughout the second half of the twentieth century, it was not until the 1990s that obesity started to be recognized as a

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[20] Congressional Budget Office, *Economic and Budget Issue Brief: How Does Obesity in Adults Affect Spending on Health Care?*, by Noelia Duchovny and Colin Baker (Washington, DC, September 2010), 6, https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/118xx/doc11810/09-08-obesity_brief.pdf.
[21] Michael Pollan, *Cooked* (New York: Penguin Press, 2013), 8-9.
[22] Roland Sturm and Ruopeng An, "Obesity and Economic Environments," *CA: A Cancer Journal for Clinicians* 64, no. 5 (2014): 342, doi:10.3322/caac.21237.
[23] James E. Tillotson, "America's Obesity: Conflicting Public Policies, Industrial Economic Development, and Unintended Human Consequences," *Annual Review of Nutrition* 24, no. 1 (2004): 637.
[24] Sara N. Bleich et al., "Increasing consumption of sugar-sweetened beverages among US adults: 1988-1994 to 1999-2004," *American Journal of Clinical Nutrition* 89, no. 1 (2009): 372, doi:10.3945/ajcn.2008.26883.
[25] David M. Kern et al., "Neighbourhood variation in the price of soda relative to milk and its association with neighbourhood socio-economic status and race," *Public Health Nutrition* (2016): 1, doi:10.1017/S1368980016001579.

major public health problem not only inside the medical community and in academic journals,[26] but also within governmental and political institutions. In 1990, Congress passed the National Nutrition Monitoring and Related Research Act of 1990 (Public Law 101-445), which required the publication of "nutritional and dietary information and guidelines for the general public" every five years and the adoption of these guidelines by all federal agencies. The Nutrition Labeling and Education Act (Public Law 101-535) was signed into law in the same year and mandated that nutritional content be displayed on packaged foods. Both legislative actions showed a nascent recognition of a growing public health issue and the importance of nutrition in addressing this problem.

In 2001, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* was published by the Department of Health and Human Services, for which one of the central principles was to "promote the recognition of overweight and obesity as major public health concerns."[27] However, while it included recommendations for individuals, communities, and health care providers to respond to this problem, there was no concrete policy associated with the call to action. A subsequent report was issued in 2010, *The Surgeon General's Vision for a Healthy and Fit Nation*, which also outlined several opportunities in the home, work, and school environments and within the medical community to prevent obesity. However, as with the 2001 publication, there was no substantive plan behind this 2010 vision. Further, the report showed that little progress had been made to stop or reverse the trend of increasing

[26] Roland Sturm and Ruopeng An, "Obesity and Economic Environments," *CA: A Cancer Journal for Clinicians* 64, no. 5 (2014): 338, doi:10.3322/caac.21237.
[27] U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001* (Rockville, MD: Government Printing Office, 2001), V.

obesity rates, and instead pointed towards their continued escalation since the issuance of the 2001 call to action.

First Lady Michelle Obama launched the "Let's Move!" campaign in 2010 in an effort to raise awareness of and implement programs to address childhood obesity. While the First Lady's campaign has resulted in some tangible accomplishments, such as improving nutrition standards for school meals and updating the nutrition labeling on packaged foods, [28] there has been limited legislative or policy action at the federal level specifically targeting obesity rates among the U.S. population. Further efforts at the federal level have generally been directed towards the recipients of federal funding in the form of various pilot programs and studies, with the greatest focus on the Supplemental Nutrition Assistance Program (SNAP). For example, the Food and Nutrition Service within the U.S. Department of Agriculture conducted a year-long "Healthy Incentives Pilot" in 2011 to determine the effect of financial incentives on fruit and vegetable consumption among SNAP participants.[29]

The United States is not alone in this growing problem, as the prevalence of overweight and obesity has become a global epidemic. Several countries have successfully enacted national policies aimed at stemming this growth. One popular approach has been the imposition of additional taxes on foods high in fat and sugar, which has occurred in countries such as Hungary, France, and Mexico.[30] While similar "sin" taxes have not been adopted in the United States on a national level, a federal tax on

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[28] "Accomplishments," Let's Move!: America's Move to Raise a Healthier Generation of Kids, http://www.letsmove.gov/accomplishments.

[29] United States Department of Agriculture, Food and Nutrition Service, *Evaluation of the Healthy Incentives Pilot (HIP): Final Report*, by Susan Bartlett et al. (Washington, DC, September 2014), 1-3, http://www.fns.usda.gov/sites/default/files/HIP-Final.pdf.

[30] Roland Sturm and Ruopeng An, "Obesity and Economic Environments," *CA: A Cancer Journal for Clinicians* 64, no. 5 (2014): 347, doi:10.3322/caac.21237.

sugar-sweetened beverages has been proposed by multiple academic researchers in health care, as well as policymakers seeking to reduce federal health care spending. CBO's 2008 *Budget Options* included a federal excise tax of $0.03 per 12 ounces on sugar-sweetened beverages as one measure to increase federal revenue.[31] In 2009, Congress considered a federal excise tax as a part of the discussion on the Patient Protection and Affordable Care Act, but it was ultimately taken off the table after heavy lobbying by the beverage industry.[32]

There have been isolated cases of "sin" taxes being considered at the local level, which have also focused on sugary drinks. One of the most well-known examples is former New York Mayor Bloomberg's infamous 2012 assault on Big Gulps—a tax on all sugary beverages larger than 16 ounces—which was ultimately struck down by a New York court because it was deemed to have been inappropriately instituted by the city's Board of Health rather than enacted by the City Council.[33] A small number of other cities have enjoyed greater success in enacting laws through their local legislatures; most notably, Berkeley, California, and Philadelphia, Pennsylvania, were successful in levying excise taxes on sugar-sweetened beverages in 2014 and 2016, respectively. Several other cities have proposed similar measures for consideration in 2016.[34]

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[31] Congressional Budget Office, *Budget Options, Volume 1: Health Care*, (Washington, DC, December 2008), 192, https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-healthoptions.pdf.

[32] Nicole L. Novak and Kelly D. Brownell, "Role of Policy and Government in the Obesity Epidemic," *Circulation* 126, no. 19 (2012): 2349, doi:10.1161/CIRCULATIONAHA.111.037929.

[33] Chris Dolmetsch, "New York Big-Soda Ban Rejected by State's Highest Court," *Bloomberg*, June 26, 2014, http://www.bloomberg.com/news/articles/2014-06-26/new-york-big-soda-ban-rejected-by-n-y-top-court-as-overreach.

[34] Margot Sanger-Katz, "Soda Tax Passes in Philadelphia. Advocates Ask: Who's Next?," *New York Times*, June 16, 2016, http://www.nytimes.com/2016/06/17/upshot/soda-tax-passes-in-philadelphia-advocates-ask-whos-next.html.

Background

Currently, 34.9 percent of the adult U.S. population and 16.9 percent of children are obese.[35] Multiple studies have attempted to quantify the economic burden of obesity, reaching varying conclusions. However, one meta-analysis of research on the direct medical costs of obesity conducted since 2008 found that, on average, these studies have reported an additional $1,901 in individual expenditures and $149.4 billion in overall health care spending each year.[36] Based on historical trends in the growth of obesity rates and medical costs, annual health care costs could increase an additional $66 billion by 2030.[37] Although some have contended that higher medical costs caused by obesity are offset by the shorter average lifespan among the obese, Finkelstein et al. found this hypothesis to be false, contending that lifetime medical expenditures on obesity "impose a substantial drain on scarce health-care resources."[38]

Adding to the projected economic burden is the indication that obesity is developing at progressively younger ages, extending the number of years that younger generations will experience obesity-related diseases and other negative effects.[39] In addition to the projected growth in health care spending attributable to obesity, one study

[35] Cynthia L. Ogden et al., "Prevalence of Childhood and Adult Obesity in the United States, 2011-2012," *The Journal of the American Medical Association* 311, no. 8 (2014): 806, doi:10.1001/jama.2014.732.
[36] David D. Kim and Anirban Basu, "Estimating the Medical Care Costs of Obesity in the United States: Systematic Review, Meta-Analysis, and Empirical Analysis," *Value in Health* 19, no. 5 (2016): 610, doi:10.1016/j.jval.2016.02.008.
[37] Y. Claire Wang et al., "Health and economic burden of the projected obesity trends in the USA and the UK," *The Lancet* 378, no. 9793 (2011): 818, doi:10.1016/S0140-6736(11)60814-3.
[38] Erik A. Finkelstein et al., "The Lifetime Medical Cost Burden of Overweight and Obesity: Implications for Obesity Prevention," *Obesity* 16, no. 8 (2008): 1847.
[39] Sarah S. Casagrande, Andy Menke, and Catherine C. Cowie, "Cardiovascular Risk Factors of Adults Age 20-49 Years in the United States, 1971-2012: A Series of Cross-Sectional Studies," *PLoS One* 11, no. 8 (2016): 8, doi:10.1371/journal.pone.0161770.

estimated the millennial generation would experience nearly $1 trillion in lost wages across their lifetime due to obesity, with the greatest financial burden falling on women.[40]

The relationship between obesity and gender, race, socioeconomic status, and other demographics is complex; however, there is a greater prevalence of obesity among low-income women[41] and children.[42] The causes and consequences of obesity among these groups are likely intertwined: low-income women are unable to afford healthy food (e.g., fresh produce, lean proteins) and instead rely on cheaper food that is less nutritious and higher in calories; this results in an increased risk of overweight and obesity,[43,44] leading to higher medical expenses, some which is funded through federal programs such as Medicaid and the Children's Health Insurance Program due to the socioeconomic status of the women and children.

Aside from socioeconomic status, there are a myriad of other factors that contribute to obesity, ranging from genetics to environment to food costs, among many others. At the most basic individual level, the cause of overweight and obesity is an "energy imbalance" resulting from the consumption of more calories than expended on a daily basis.[45] One significant source of calories in the U.S. diet is added sugars.

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[40] Shari L. Barkin et al., "Millennials and the World of Work: The Impact of Obesity on Health and Productivity," *Journal of Business and Psychology* 25, no. 2 (2010): 241, doi:10.1007/s10869-010-9166-5.
[41] Cynthia L. Ogden et al., "Obesity and Socioeconomic Status in Adults: United States, 2005-2008," *NCHS Data Brief*, no. 50 (2010), http://www.cdc.gov/nchs/data/databriefs/db50.pdf.
[42] "The prevalence of obesity among low-income children aged 2 through 4 years, by state and income, 2011," Centers for Disease Control and Prevention, https://www.cdc.gov/obesity/data/prevalence-obesity-childhood.html.
[43] Vanessa M. Oddo et al., "The impact of changing economic conditions on overweight risk among children in California from 2008 to 2012," *Journal of Epidemiology and Community Health* 70, no. 9 (2016): 878, doi:10.1136/jech-2015-207117.
[44] Sarah S. Casagrande, Andy Menke, and Catherine C. Cowie, "Cardiovascular Risk Factors of Adults Age 20-49 Years in the United States, 1971-2012: A Series of Cross-Sectional Studies," *PLoS One* 11, no. 8 (2016): 11, doi:10.1371/journal.pone.0161770.
[45] Institute of Medicine of the National Academies, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*, ed. Dan Glickman et al. (Washington, DC: The National Academies Press, 2012), 117.

According to the recently-published *2015-2020 Dietary Guidelines for Americans*, added sugars account for more than 13 percent of the average daily caloric intake, of which nearly half (47 percent) comes from beverages, such as sodas, sweetened juices, and energy drinks.[46] Consumption of these beverages increase calorie intake without providing commensurate nutritional benefit, resulting in weight gain.[47]

In an effort to encourage consumers to make healthier food choices, the U.S. Food and Drug Administration (FDA) has recently implemented a number of changes to increase transparency of the nutritional content of food served in restaurants and sold in grocery stores and vending machines. For example, in 2014 the FDA finalized regulations requiring nutritional information to be posted for chain restaurant menus and foods sold in vending machines, as required by the Affordable Care Act.[48] In 2015 the FDA made a final determination regarding the safety of partially hydrogenated oils—the main source of trans fats in food—and required they be removed from processed food.[49] Most recently, in 2016 the FDA unveiled an updated "Nutrition Facts" label for packaged foods that more prominently displays calorie content, revises the serving size to better reflect an actual portion consumed in a sitting, and includes a new requirement to display "added sugars." The menu labeling requirements will go into effect in 2017, while the

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[46] U.S. Department of Health and Human Services and U.S. Department of Agriculture, *2015-2020 Dietary Guidelines for Americans*, 8th ed. (Washington, DC, December 2015), 54, https://health.gov/dietaryguidelines/2015/resources/2015-2020_Dietary_Guidelines.pdf.
[47] World Health Organization, *Guideline: Sugars intake for adults and children* (Geneva, Switzerland, 2015), 1, http://www.who.int/nutrition/publications/guidelines/sugars_intake/en/.
[48] U.S. Food and Drug Administration, "FDA finalizes menu and vending machine calorie labeling rules," news release, November 25, 2014, http://www.fda.gov/newsevents/newsroom/pressannouncements/ucm423952.htm.
[49] U.S. Food and Drug Administration, "FDA Tasks Step to Remove Artificial *Trans* Fats from Processed Foods," news release, June 16, 2015, http://www.fda.gov/Food/NewsEvents/ConstituentUpdates/ucm449145.htm.

nutritional labeling requirements and ban on the use of trans fats in packaged foods will go into effect in the summer of 2018.[50]

As the factors contributing to obesity are numerous, so are the stakeholders with an interest in the issue. At the federal level, there are multiple government agencies that oversee programs and policies that may affect obesity rates, each "operating under different—and sometimes conflicting—laws and legal mandates."[51] Within the Department of Health and Human Services (HHS), three agencies play a key role in the issue. The Centers for Disease Control (CDC) provides national-level surveillance and strategic guidance on obesity as a public health problem and supports research on the issue.[52] The FDA regulates the ingredients, packaging, and labeling for most foods, as well as prescription and over-the-counter drugs and dietary supplements.[53] The Centers for Medicare and Medicaid Services oversee not only the Medicare and Medicaid programs, but the Health Insurance Marketplaces established under the Affordable Care Act—all of which are affected by the growing costs of increasing obesity rates.[54]

In addition to the programs implemented by HHS and its component agencies, the U.S. Department of Agriculture (USDA) is responsible for the development of policy and execution of programs related to food and nutrition. Within the USDA, the Food and

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[50] "Changes to the Nutrition Facts Label: Compliance Dates of Other Nutrition Initiatives," U.S. Food and Drug Administration, http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm385663.htm.

[51] James E. Tillotson, "America's Obesity: Conflicting Public Policies, Industrial Economic Development, and Unintended Human Consequences," *Annual Review of Nutrition* 24 (2004): 623.

[52] "Division of Nutrition, Physical Activity, and Obesity: About Us," Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/nccdphp/dnpao/division-information/aboutus/index.htm.

[53] "What does FDA regulate?," U.S. Food and Drug Administration, http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194879.htm.

[54] "The Center for Consumer Information and Insurance Oversight: Health Insurance Marketplaces," Centers for Medicare and Medicaid Services, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces.

Nutrition Service oversees federal food assistance programs, such as SNAP and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In addition, the Center for Nutrition Policy and Promotion develops and issues the federal recommended dietary guidelines and oversees the Food and Nutrition Information Center, which serves as the government's central repository for nutrition statistics and information.

State and local government agencies also play an important role in establishing programs and enacting policies at the local level that impact obesity. For example, regulations enacted at the state level dictate the authorities of local public health departments to restrict or incentivize healthier food options.[55] Local governments can support the development of parks, recreational facilities, and other infrastructure that encourage an active lifestyle among their populations, and limit unhealthy food options offered in public venues.[56]

Congress also has a significant responsibility in enacting laws that influence federal, state, and local regulations, programs, and policies related to the issue of obesity. Similar to the diffuse responsibility at the federal level, several congressional committees have jurisdiction over health care issues. The House Committee on Agriculture and Senate Committee on Agriculture, Nutrition, and Forestry have oversight of laws relating to nutrition, including SNAP, and other programs under the USDA. The Senate Committee on Health, Education, Labor, and Pensions and the House Committee on

[55] Jennifer L. Pomeranz, "The Unique Authority of State and Local Health Departments to Address Obesity," *American Journal of Public Health* 101, no. 7 (2011): 1192, doi:10.2105/AJPH.2010.300023.
[56] "Healthy Communities: What Local Governments Can Do To Reduce and Prevent Obesity," Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/obesity/downloads/CDC_Healthy_Communities.pdf.

Energy and Commerce have oversight of most of the functions of HHS, including FDA and CDC, while the Senate Committee on Finance and the House Committee on Ways and Means have jurisdiction over the revenue and spending related to health care and social services programs, including Social Security, Medicare, and Medicaid, as well as broader responsibility for all revenue-raising measures. While the majority of health care related spending stems from these mandatory programs, the House and Senate Committees on Appropriations provide funding for the staffing and operations of the Departments and agencies that administer these programs.

The limited action that has occurred in either the House or Senate on the issue of obesity has primarily involved hearings that have tangentially touched on the problem. For example, the House Committee on Agriculture has conducted hearings on issues such as the *2015 Dietary Guidelines for Americans*, SNAP, and food incentive programs; similarly, the Senate Committee on Agriculture, Nutrition, and Forestry has held hearings in support of programs to further improve childhood nutrition. In the 114th Congress, legislation has been introduced in both the House and Senate to eliminate a federal tax deduction for food marketing to children; however, neither chamber has held a hearing on the bills.[57] In the House, Representative Rosa DeLauro has also sponsored legislation which would impose a federal excise tax on sugar-sweetened beverages and use the revenue for obesity prevention and other programs to reduce the effects of obesity. However, the bill only has four cosponsors and has stalled since referral to the committees of jurisdiction (Ways and Means and Energy and Commerce).[58]

[57] Stop Subsidizing Childhood Obesity Act, H.R. 5232, 114th Cong. (2016), https://www.congress.gov/bill/114th-congress/house-bill/5232/all-actions.
[58] Sugar-Sweetened Beverages Tax Act of 2015 (the SWEET Act), H.R. 1687, 114th Cong. (2015), https://www.congress.gov/bill/114th-congress/house-bill/1687/text.

Outside of the government, multiple stakeholders from the food and beverage industry, including fast food and chain restaurants and food and beverage manufacturers, have a considerable interest in the laws and policies that may be considered in an effort to reduce obesity rates. These groups, represented by major lobbying organizations such as the National Restaurant Association, the Grocery Manufacturers Association, and the American Beverage Association, have responded with mixed reactions to the recent changes and other proposals related to nutrition labeling. The National Restaurant Association, for example, expressed public support for the FDA's regulations requiring nutrition labeling on restaurant menus.[59] In contrast, the Grocery Manufacturers Association and the American Beverage Association have resisted recent changes implemented by the FDA regarding the inclusion of "added sugars" on the revised nutrition label for packaged foods.[60,61] The beverage industry has also lobbied heavily against recent proposals for taxes on sugar-sweetened beverages; for example, Coca-Cola Company, PepsiCo, and the American Beverage Association spent a combined $37.8 million in lobbying in 2009 when a soda tax was proposed for inclusion in the Affordable Care Act.[62]

[59] National Restaurant Association, "National Restaurant Association Statement about Release of Menu Labeling Regulations," news release, November 24, 2014, http://www.restaurant.org/Pressroom/Press-Releases/National-Restaurant-Association-Statement-about-Re.
[60] Roberto A. Ferdman, "The crucial FDA nutrition label battle you probably don't know about, but should," *The Washington Post*, July 2, 2014, https://www.washingtonpost.com/news/wonk/wp/2014/07/02/the-crucial-fda-nutrition-label-battle-you-probably-dont-know-about-but-should/.
[61] Annie Gasparro and Mike Esterl, "FDA Approves New Nutrition Panel That Highlights Sugar Levels," *The Wall Street Journal*, May 20, 2016, http://www.wsj.com/articles/fda-approves-controversial-changes-to-nutrition-facts-panel-1463750195.
[62] Daniel G. Aaron and Michael B. Siegel, "Sponsorship of National Health Organizations by Two Major Soda Companies," *American Journal of Preventive Medicine* 51, no. 6 (2016): 5, doi:10.1016/j.amepre.2016.08.010.

Policy Proposal

The policy proposal is to enact a federal excise tax of $0.01 per ounce (adjusted annually for inflation) on sugar-sweetened beverages, the revenue from which would be applied towards the costs of federal health care spending. The proposed tax is similar to the SWEET Act introduced by Representative DeLauro in the current Congress. It is also comparable to proposals that have been widely proposed by public health experts and considered by various states and localities within the United States, including the tax that was successfully enacted in Berkeley, California, in 2012.

The tax would apply to all beverages and commodities used to produce beverages (e.g., syrups, powders, and other similar goods) that contain caloric sweeteners, but would not apply to beverages that contain only naturally-occurring sugars, such as milk and juices comprised of 100 percent fruits and vegetables, or calorie-free sweeteners. The tax would be imposed on beverage manufacturers at the time of sale to a distributor, retailer, or other vendor. As with other federal excise taxes, this amount would be reported and remitted quarterly to the Internal Revenue Service (IRS). The collections would be deposited into the Treasury, from which the funding would be drawn to offset mandatory spending on federal health care costs.

The policy proposal requires Congress to pass legislation to amend the Internal Revenue Code and establish the new tax. The bill would originate in the House Committee on Ways and Means, from which all revenue generating measures must be initiated in Congress. Upon enactment, the IRS would be responsible for issuing regulations to further define and implement the legislation, and enforcing compliance with these regulations.

Although difficult to project the precise costs, a new tax would create an additional administrative burden at the federal level to implement and provide the necessary oversight. One study estimated it would cost $51 million in the first year and $430 million over 10 years to implement a similar tax; however, it did not specify the activities included in this cost estimate.[63]

Estimates also vary in terms of the projected revenue that would be realized through a federal tax. The average size of a soda of 20 ounces,[64] which would yield $0.20 in tax revenue. In 2008, CBO assessed a federal excise tax of $0.03 per 12 ounces would generate $50.4 billion in revenue over 10 years; the same size beverage would generate $0.12 in tax revenue under the current proposal.[65] In 2010, the Bipartisan Policy Center estimated that a $0.01 per ounce excise would generate $156 billion in revenue over nine years, or more than $17 billion annually.[66]

Policy Analysis

Several studies have shown that an excise tax on caloric sweetened beverages will reduce consumption of such beverages, thereby reducing obesity and economic costs. The magnitude of these effects varies based on a number of factors, including the size of

[63] Michael W. Long et al., "Cost Effectiveness of a Sugar-Sweetened Beverage Excise Tax in the U.S.," *American Journal of Preventive Medicine* 49, no. 1 (2015): 116, doi:10.1016/j.amepre.2015.03.004.
[64] National Heart, Lung, and Blood Institute, "Serving Sizes and Portions," We Can! Ways to Enhance Children's Activity and Nutrition, https://www.nhlbi.nih.gov/health/educational/wecan/eat-right/distortion.htm.
[65] Congressional Budget Office, *Budget Options, Volume 1: Health Care*, (Washington, DC, December 2008), 192, https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-healthoptions.pdf.
[66] Bipartisan Policy Center, *Restoring America's Future: Reviving the Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System* (November 2010), 67, http://cdn.bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf.

the tax and the estimated elasticity of demand—that is, the response by consumers to the increase in price.

The elasticity of demand for caloric sweetened beverages is difficult to assess because a national-level tax has not been implemented in the United States to provide direct evidence. Assuming no substitution effect, one study estimated that a $0.01 per ounce excise tax would reduce consumption by 24 percent, resulting in an average weight loss of five pounds per year.[67] However, one weakness of the proposed policy is that consumers may substitute consumption of caloric sweetened beverages with other, untaxed beverages that contain a comparable number of calories, such as 100 percent fruit juices and milk.

Nevertheless, even assuming that a reduction in the consumption of caloric sweetened beverages will be offset by other caloric beverages, research has shown that such substitutions will not completely counteract these effects. For example, a 2010 study by the USDA Economic Research Service found the strongest substitute to caloric sweetened beverages was bottled water, followed by fruit juices and artificially-sweetened beverages. The study estimated that a 10 percent increase in price would dampen sales by 12.6 percent and, after accounting for the offset in caloric reductions resulting from the consumption of fruit juices and other untaxed beverages, assessed that these substitutions would still result in a net decrease in daily calorie consumption.[68] Another study found that a $0.01 per ounce tax would reduce consumption by 15 percent.

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[67] Tatiyana Andreyeva, Frank J. Chaloupka, and Kelly D. Brownell, "Estimating the potential taxes on sugar-sweetened beverages to reduce consumption and generate revenue," *Preventive Medicine* 52, no. 6 (2011): 415-416, doi:10.1016/j.ypmed.2011.03.013.

[68] United States Department of Agriculture, Economic Research Service, *Taxing Caloric Sweetened Beverages: Potential Effects on Beverage Consumption, Caloric Intake, and Obesity (ERR-100)*, by Travis A. Smith, Biing-Hwan Lin, and Jonq-Ying Lee, (Washington, DC, July 2010), 8-10, http://ers.usda.gov/webdocs/publications/err100/8311_err100_1_.pdf.

After factoring in a 40 percent substitution with consumption of untaxed caloric beverages, this research estimated the tax would lead to a 1.5 percent decrease in the number of obese adults.[69] In a real world example, Mexico observed a 12 percent drop in purchases of caloric sweetened beverages one year after the implementation of a 1 peso per liter (a 10 percent price increase) excise tax.[70]

Opponents of taxes on caloric sweetened beverages have argued that excise taxes are inherently regressive in nature, as lower income households spend a higher percentage of their total income on food and drink purchases and are therefore disproportionately affected by such a tax.[71] This argument is largely predicated on the finding that, despite the imposition of excise taxes on cigarettes, smoking has remained particularly high among lower income populations.[72] However, because the elasticity of demand for caloric sweetened beverages is less certain, it is unclear that cigarette taxes offer a suitable comparison.

In addition, as beverages with added caloric sweeteners do not provide any nutritional benefit, the regressive nature should not be viewed as significant drawback and may in fact lead to a greater behavior change among lower income populations. In fact, given obesity rates are higher among lower income women and children, an excise tax may be particularly effective in reducing consumption of a significant source of

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[69] Y. Claire Wang et al., "A Penny-Per-Ounce Tax on Sugar-Sweetened Beverages Would Cut Health and Cost Burdens of Diabetes," *Health Affairs* 31, no. 1 (2012): 201-202, doi:10.1377/hlthaff.2011.0410.
[70] M. Arantxa Colchero et al., "Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study," *BMJ* 352 (2016): 5, doi:0.1136/bmj.h6704.
[71] Margot Sanger-Katz, "A New Policy Disagreement Between Clinton and Sanders: Soda Taxes," *New York Times*, April 22, 2016, http://www.nytimes.com/2016/04/23/upshot/a-new-policy-disagreement-between-clinton-and-sanders-soda-taxes.html.
[72] Laura Dwyer-Lindgren et al., "Cigarette smoking prevalence in US counties: 1996-2012," *Population Health Metrics* 12, no. 5 (2014): 10, doi:10.1186/1478-7954-12-5.

calories—and thereby reducing obesity—among this demographic.[73] A study on the effects of the Berkeley excise tax showed a 21 percent reduction in consumption of caloric sweetened beverages in low-income neighborhoods, while similar neighborhoods in nearby cities without a comparable tax observed a 4 percent increase.[74] As this group is most likely to be reliant on government-funded health care, these effects may further reduce the federal health care costs associated with obesity.

Along with reducing caloric intake and obesity rates, another significant benefit of an excise tax on caloric sweetened beverages is that it will generate revenue, which can in turn be used to offset the negative externality posed by obesity in the form of increased health care costs. Furthermore, the associated reduction in sugar consumption may result in lower overall health care costs. In addition to the estimates reported by CBO and the Bipartisan Policy Center, several other studies have projected the revenue and health care cost savings of a $0.01 per ounce excise tax, with estimates ranging from $12.5[75] to $15.8 billion[76] in annual revenue and $17.1[77] to $23.6 billion[78] in reduced health care costs over 10 years due to a decrease in the prevalence of diabetes and cardiovascular disease. It is important to note that while the primary goal of the proposed excise tax is to reduce obesity rates by reducing the consumption of beverages with added caloric

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[73] Rudd Center for Food Policy and Obesity, *Sugar Sweetened Beverage Taxes: An Updated Policy Brief*, by Roberta R. Friedman and Kelly D. Brownell (October 2012), 6, http://www.uconnruddcenter.org/files/Pdfs/Rudd_Policy_Brief_Sugar_Sweetened_Beverage_Taxes(1).pdf.
[74] Jennifer Falbe et al., "Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption," *American Journal of Public Health* 106, no. 10 (2016): 1869, doi:10.2105/AJPH.2016.303362.
[75] Michael W. Long et al., "Cost Effectiveness of a Sugar-Sweetened Beverage Excise Tax in the U.S.," *American Journal of Preventive Medicine* 49, no. 1 (2015): 116, doi:10.1016/j.amepre.2015.03.004.
[76] Tatiyana Andreyeva, Frank J. Chaloupka, and Kelly D. Brownell, "Estimating the potential taxes on sugar-sweetened beverages to reduce consumption and generate revenue," *Preventive Medicine* 52, no. 6 (2011): 415, doi:10.1016/j.ypmed.2011.03.013.
[77] Y. Claire Wang et al., "A Penny-Per-Ounce Tax on Sugar-Sweetened Beverages Would Cut Health and Cost Burdens of Diabetes," *Health Affairs* 31, no. 1 (2012): 202, doi:10.1377/hlthaff.2011.0410.
[78] Michael W. Long et al., "Cost Effectiveness of a Sugar-Sweetened Beverage Excise Tax in the U.S.," *American Journal of Preventive Medicine* 49, no. 1 (2015): 116, doi:10.1016/j.amepre.2015.03.004.

sweeteners, the tax would raise more revenue to offset the economic burden of obesity if it is less effective at achieving this goal.

One potential weakness of the policy proposal is that beverage manufacturers may not pass along the full burden of the tax to the consumer, and instead choose to absorb some or all of the cost. However, early evidence from a similar tax imposed in Berkeley, California, shows that beverage manufacturers are unlikely to absorb the entire cost. Three months after the implementation of a tax on caloric sweetened beverages, the average price of sodas increased by 69 percent and by 47 percent for all taxed beverages, while there was no significant price increase in other untaxed beverages.[79] Thus, it is reasonable to expect that at least some of the effect of national-level tax will be observed and felt by the consumer.

Assuming beverage manufacturers pass on at least some of the tax burden on to consumers, one major advantage of an excise tax is that the tax is immediately evident to consumers in the form of higher sticker prices. In contrast, a sales tax results in a price increase at the register and may be less noticeable if it is only one component of a larger purchase. Further, by indexing the tax to inflation, the effect of the tax will not diminish with an increase in the prices of food and other untaxed beverages.[80]

Although few studies have assessed the economic costs of an excise tax on caloric sweetened beverages, the beverage industry has contended that it would have a negative financial impact on beverage manufacturers, bottlers, and retailers and lead to significant

[79] Jennifer Falbe et al., "Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption," *American Journal of Public Health* 106, no. 10 (2016): 1869, doi:10.2105/AJPH.2016.303362.
[80] Rudd Center for Food Policy and Obesity, *Sugar Sweetened Beverage Taxes: An Updated Policy Brief*, by Roberta R. Friedman and Kelly D. Brownell (October 2012), 4, http://www.uconnruddcenter.org/files/Pdfs/Rudd_Policy_Brief_Sugar_Sweetened_Beverage_Taxes(1).pdf.

job loss. For example, the beverage industry estimated that the 2008 proposal from then-Governor David Paterson of New York to increase taxes on sugar-sweetened beverages by 18 percent would lead to 160,000 jobs lost within the state.[81] Similarly, multiple beverage associations and distribution companies have filed a lawsuit against the city of Philadelphia for its recently-passed excise tax on beverages, asserting it will result in annual revenue loss to the state ranging from $2.7 to $7.8 million because of a decrease in soda sales.[82] However, these major food and beverage manufacturers and retailers also produce other beverages, such as artificially-sweetened drinks and bottled water, and may in fact see an increase in the sales of these other products. For example, the significant decrease (21 percent) in consumption of caloric sweetened beverages among low-income populations in Berkeley following the enactment of an excise tax was matched by a concurrent 63 percent increase in the sales of bottled water—providing some economic offset to the decline in soda sales.[83]

Political Analysis

The policy proposal faces several political hurdles, including those inherent in the political process and those specific to the current political environment. From a practical standpoint, passing legislation through two chambers of Congress is a challenge irrespective of party control—Republican or Democrat, unified or divided. Only a small

[81] Sarah A. Wetter and James G. Hodge Jr., "Taxing Sugar-Sweetened Beverages to Lower Childhood Obesity," *Journal of Law, Medicine & Ethics* 44, no. 2 (2016): 360, doi:10.1177/1073110516654129.
[82] Nancy Fink Huehnergarth, "Beverage Industry Sues to Block Philadelphia's Soda Tax," *Forbes*, September 14, 2016, http://www.forbes.com/sites/nancyhuehnergarth/2016/09/14/beverage-industry-sues-to-block-philadelphias-soft-drink-tax/.
[83] Jennifer Falbe et al., "Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption," *American Journal of Public Health* 106, no. 10 (2016): 1868, doi:10.2105/AJPH.2016.303362.

fraction of bills that are introduced in Congress are enacted into law. Since 1973, the high watermark for Congressional action was the 100th Congress, during which 7 percent (761) of bills introduced were signed into law.[84] The simple, yet critical issue of timing provides an added hurdle. With both Congress and the presidency entering a lame duck session, there is likely to be strong resistance from conservative Republicans to any legislative action, including even those typically regarded as "must pass" bills (e.g., funding for the federal government).[85] This is compounded by the intense opposition by the current Republican majority in both chambers of Congress to any initiative that may be construed as supporting or furthering "Obamacare," the repeal of which has been identified as a top priority of the Republican Party.[86]

A further political impediment to successful enactment of the proposed policy is the general unpopularity of new taxes, thus making them difficult to support politically for fear of backlash from one's constituency. However, there are strategies to make tax proposals more publicly acceptable and politically palatable. For example, public support for a tax on beverages with added caloric sweeteners increases significantly when the revenue is targeted at health care for low-income children and obesity prevention efforts for children and adults.[87] In Philadelphia, the tax on sugar-sweetened beverages

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[84] "Bills: Statistics and Historical Comparison," GovTrack.us, https://www.govtrack.us/congress/bills/statistics.

[85] Amber Phillips, "Why conservatives want to cancel Congress's lame-duck session, explained," *The Washington Post*, March 30, 2016, https://www.washingtonpost.com/news/the-fix/wp/2016/03/30/why-conservatives-want-to-cancel-congresss-lame-duck-session-explained.

[86] Republican National Committee, *Republican Platform 2016*, 36, https://prod-cdn-static.gop.com/static/home/data/platform.pdf.

[87] Kelly D. Brownell and Thomas R. Frieden, "Ounces of Prevention – The Public Policy Case for Taxes on Sugared Beverages," *The New England Journal of Medicine* 360, no. 18 (April 2009): 1807, doi:10.1056/NEJMp0902392.

ultimately gained the support and passage by the city council after earmarking the revenue for other purposes, such as education improvements.[88]

The Republican Party in particular has made reduced taxation a central issue of the Party's platform.[89] Assuming Republicans retain control of at least the House of Representatives in the 2016 elections, it will be difficult to persuade Congress to take up the proposal to tax caloric sweetened beverages given the reticence by Republicans to enact new taxes. However, the proposed tax could be pursued within a more comprehensive tax reform package that promises to reduce both corporate and individual income tax rates, and apply the revenue from the beverage tax to offset these cuts. This approach would garner greater support from Republicans for the policy proposal in exchange for reduced tax rates—a major political and policy "win" for the Party.

The policy proposal may also be incorporated into a broader attempt to reform entitlement programs—the rising costs of which pose an increasing strain on the federal budget. Annual health care spending (including Medicare and Medicaid) now exceeds Social Security spending and represents a greater contribution to the growing federal debt.[90] Any effort to reduce the federal debt must include reforms to these programs. If current Republican Party leadership remains in place for the 115th Congress, there may be an opportunity to leverage a powerful figure in the legislative branch as a champion. Speaker of the House Paul Ryan has developed a proposal to repeal the Affordable Care Act and implement a new health care model that includes Medicare and

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[88] Margot Sanger-Katz, "Making a Soda Tax More Politically Palatable," *New York Times*, April 3, 2016, http://www.nytimes.com/2016/04/04/upshot/making-a-soda-tax-more-politically-palatable.html.
[89] Republican National Committee, *Republican Platform 2016*, 1-2, https://prod-cdn-static.gop.com/static/home/data/platform.pdf.
[90] Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026* (Washington, DC, January 2016), 156, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook_OneCol-2.pdf.

Medicaid reforms.[91] While it may be a long shot, the proposed excise tax on caloric sweetened beverages could potentially be pursued as one component of a larger package to restructure these programs.

Beyond the political challenges and unpopularity of introducing a new tax, this proposal would also face obstacles in Congress as a result of aggressive lobbying by the beverage industry. Heavy lobbying during the Affordable Care Act debate was effective at killing the inclusion of a similar tax in the final bill.[92] Since that time, the beverage industry has continued to lobby against state and local proposals for excise taxes on sugar-sweetened beverages, spending almost $5 million over a four month period to lobby against the Philadelphia tax.[93]

Within the food and beverage industry, Coca-Cola Company was both the highest campaign contributor and the top lobbying client during the 2016 election cycle, spending a combined $7.6 million in lobbying and campaign contributions. PepsiCo ranked ninth and third, respectively, spending a total of $2.8 million.[94] Coca-Cola Company and PepsiCo's contributions were roughly even among both Republicans and Democrats; however, over the past 20 years, the majority of campaign contributions from the food and beverage industry (at least 70 percent) have been made to Republicans.[95] Similarly, unions—traditionally strongly supportive of Democratic Party candidates—

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[91] Speaker of the House Paul Ryan, *A Better Way: Our Vision for a Confident America*, https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.
[92] Nicole L. Novak and Kelly D. Brownell, "Role of Policy and Government in the Obesity Epidemic," *Circulation* 126, no. 19 (2012): 2349, doi:10.1161/CIRCULATIONAHA.111.037929.
[93] Nancy Fink Huehnergarth, "Big Soda Has a Terrible, Horrible, No Good, Very Bad Day as Philadelphia's Soda Tax Passes," *Forbes*, June 16, 2016, http://www.forbes.com/sites/nancyhuehnergarth/2016/06/16/big-sodas-has-a-terrible-horrible-no-good-very-bad-day-as-philadelphias-soda-tax-passes/.
[94] "Food and Beverage," OpenSecrets.org: Center for Responsive Politics, https://www.opensecrets.org/industries/indus.php?ind=N01
[95] Ibid.

have also spoken out against proposals to tax beverages. Teamsters opposed the tax proposed by the city of Philadelphia, citing concerns that it would result in job loss in the region.[96] As elected representatives rely on these contributions to support their re-election, it will be difficult to persuade Members of Congress to support legislation that would hurt these donors.

Recommendation

The recommendation is for the Obama Administration to pursue enactment of the proposed excise tax on caloric sweetened beverages as a continuation and expansion of current obesity prevention efforts, as well as a means for partially subsidizing reforms to entitlement programs.

Obesity is arguably the greatest challenge confronting the U.S. health care system and the health and well-being of the population. The rising costs of health care and the need for entitlement reforms to address the growing federal debt create an added urgency to take action to combat this health crisis. Given the Obama Administration's persistent pursuit of reforms to health care policy and ardent support for obesity reduction and prevention initiatives, President Obama should urge enactment of this policy proposal.

Despite the significant economic benefits of the proposed tax, due to the considerable political hurdles it is unlikely to be successfully enacted during the upcoming lame duck session of Congress and will also face challenges in the 115th Congress. However, by introducing this initiative now, President Obama will set the

[96] *Teamsters Union*, "Soda Tax is not a Solution for Philadelphia" (blog), March 2, 2016, https://teamster.org/blog/2016/03/soda-tax-not-solution-philadelphia.

stage for future action under the next Administration—working with a potentially more favorable political environment in Congress—and will ensure the President receives credit for introducing the proposal on the national stage.

Although the precise economic impact of this policy proposal is difficult to forecast, multiple studies have projected that a federal excise tax would provide substantial economic benefits. The benefits of its successful implementation would have a more lasting, long-term societal effect—in the form of increased tax revenue and reduced health care costs—than the potential costs—in the form of reduced soda sales and associated job loss—which are as yet unproven and may be offset by increased sales of other beverages.

Given the political obstacles to enactment, it is imperative that the proposal have the backing of a high-profile public figure. The bully pulpit of the Presidency would provide immediate public visibility to this proposal and its potential economic and societal benefits. Childhood obesity prevention has been the hallmark policy initiative of First Lady Michelle Obama—the importance of which the Administration will certainly attempt to instill in the next Administration. The First Lady's efforts have yielded policy successes during her time in office, and the enactment of an excise tax could be proposed to the next Administration as a next step in furthering this initiative.

Support within Congress is also necessary for the successful enactment of this policy proposal. The proposal faces two principal political hurdles: the strong opposition to Obamacare among Republicans and the general unpopularity of new taxes. However, it is possible to overcome this resistance by specifically targeting the revenues to Medicare and Medicaid programs—which are the focus of Republican cost-saving

objectives—rather than broadly applying them towards all federal health care costs. The city of Philadelphia provides a model for such an approach, as the city was able to successfully enact a soda tax by targeting the funds towards politically popular initiatives. Directing the revenue from the proposed federal tax towards Medicare and Medicaid could increase the public and political appeal of the tax if it is promoted as a means to reduce both the federal costs of these programs and the costs to Medicare and Medicaid beneficiaries.

Curriculum Vitae

Laura Cylke is from Arlington, Virginia. Ms. Cylke currently works for the U.S. House of Representatives Committee on Appropriations. Prior to her employment in the legislative branch, Ms. Cylke worked for U.S. Customs and Border Protection. Ms. Cylke holds a Bachelor of Arts in Public Policy from the College of William and Mary.