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July 13, 2011

Federal Trade Commission
Office of the Secretary, Room H-113 (Annex W)
600 Pennsylvania Ave N.W.
Washington, D.C. 20580

Re: Interagency Working Group on Food Marketed to Children: Proposed Nutrition Principles: FTC Project No. P094513

To The Interagency Working Group:

On behalf of the American Heart Association (AHA), including the American Stroke Association (ASA) and over 22.5 million AHA and ASA volunteers and supporters, we appreciate the opportunity to provide comments on the proposed nutrition principles for foods marketed to children. The AHA commends the Interagency Working Group for proposing a robust set of principles and standards for foods and beverages marketed to children to guide volunteer industry efforts. These standards are evidence-based and will prioritize children's health, support parents who want to assure their children are eating healthy diets, and urge industry to take accountability for the foods they are promoting to children and families.

The obesity epidemic in children is an enormous societal problem with far reaching consequences. Currently, 32% of children are obese or overweight.ⁱ Inappropriate consumption of low nutrient, high calorie foods contributes to energy imbalance and poor health. Consequently, the AHA sees no ethical, political, scientific, or social justification for marketing and advertising low-nutrient, high-calorie foods to children and supports efforts to diminish its occurrence in the United States.

General Comments

A recent reportⁱⁱ from Packaged Facts, a market research firm, predicts a 40% growth in sales of products targeting two to twelve year- olds by 2015, exposing 43 million children in this age bracket to the accompanying marketing and advertising used to promote those products. According to the report, this demographic represents about one-seventh of the population, a \$10 billion market, and is the most influential demographic for marketers as these young people are establishing life-long dietary habits and brand loyalty.ⁱⁱⁱ This illustrates why it is more important than ever that industry is accountable for the quality of the foods they are marketing and promoting to children.

Television and other electronic media have a pervasive influence on children's lives in the United States. Young people see more than 40,000 advertisements per year on television alone.^{iv} They are also bombarded with carefully crafted marketing tactics employed in multiple environments such as the Internet, magazines, schools, product placements, incentive programs, video games, social networking sites, podcasts, and cell phones, all designed to improve brand recognition and increase sales. A recent study showed that although food advertising was not all-pervasive on popular kids' websites, the foods that were promoted were primarily candy, cereal, quick-serve restaurant foods, and snacks.^v By developing a presence with these established and emerging technologies, the food industry is reaching children in a domain where parents have little or no oversight or consent.

Although many European countries rigidly control or ban food advertising to children,^{vi} it is not well regulated in the United States. In 2006, the FTC obtained data from the food industry through a compulsory process and found that the 44 major food and beverage marketers spent \$1.6 billion to promote their products to children under 12 and adolescents ages 12 to 17 in the United States.^{vii} Brand licensing is becoming more and more pervasive, where a program or its licensed characters are used to promote purchase of a particular food. Grocery store shelves are filled with examples such as Captain Jack Sparrow on cereals and Dora the Explorer on sugary fruit snacks. One study showed that the majority of cereals marketed to children (66%) did not meet national nutrition standards and were especially high in energy, added sugars and sodium when compared to cereals marketed to adults.^{viii}

Current voluntary industry efforts for the Children's Food and Beverage Advertising Initiative use inconsistent nutrition standards that allow industry to create strategic loopholes to qualify certain products that are less healthful, but represent a significant part of their product portfolio and profits. The existing standards also do not use consistent definitions for children-directed media. The AHA ultimately advocates for federal regulatory oversight of foods marketed and advertised to children. However, in the interim, as long as there is third party, non-governmental oversight and a voluntary initiative, the AHA believes there should be robust enforcement and a uniform set of science-based nutrition standards that guide industry regarding the foods and beverages they should market and advertise to children.

Nutrition Principles

The AHA is very supportive of the two overarching nutrition principles proposed by the Interagency Working Group (IWG): 1) to encourage children, through advertising and marketing, to choose foods that make a meaningful contribution to a healthful diet and 2) minimize consumption of foods with significant amounts of nutrients and other dietary factors that could have an adverse impact on health or weight, specifically, calories (energy), sodium, saturated fat, *trans* fat, and added sugars. Industry should manufacture and produce food that meets these principles and take seriously its role in influencing dietary choices made by children and families. It is important to require marketed foods to satisfy both criteria – promoting healthy foods while at the same time limiting nutrients of concern. We do think it is important to promote foods rather than nutrients because this helps avoid fortification concerns where industry would be putting a positive nutrient in an otherwise unhealthy food. Most important, we feel that calories should be added to the second principle in light of today's obesity epidemic and the need to limit portion sizes, not only important as a cut-off, but also important for the portion sizes that can be displayed in advertisements and promotional materials.

The IWG recommends that industry focus its efforts on those categories of foods that are most heavily marketed directly to children, such as breakfast cereals, carbonated beverages, sports drinks, energy drinks, restaurant foods and snack foods and over the long term encompass all

foods. The AHA, however, believes the standards should apply to ALL foods and beverages from the beginning, not just the categories most heavily marketed to children.

The IWG should consider the health impact of both sports drinks and energy drinks on children.^{ix} Sports drinks and energy drinks are different products. Sports drinks, which contain carbohydrates, minerals, electrolytes and flavoring, are intended to replace water and electrolytes lost through sweating during exercise. Sports drinks can be helpful for young athletes engaged in prolonged, vigorous physical activities, but in most cases they are unnecessary on the sports field or the school lunchroom. Calories range from 0 to 80 per 8 oz. Energy drinks contain substances not found in sports drinks that act as stimulants, such as caffeine, guarana and taurine. Caffeine – by far the most popular stimulant – has been linked to a number of harmful health effects in children, including effects on the developing neurologic and cardiovascular systems. Calories range from 3 to 140 per 8 oz. The AHA agrees with the AAP that energy drinks should not be consumed by children and therefore these products should not be marketed to this age group.

The IWG sets a goal that all foods and beverages within the categories most heavily advertised or otherwise marketed directly to children and adolescents would meet the nutrition principles by the year 2016. The AHA believes that this timeline is too long. After all, these are not standards for school meals or competitive foods where children are served these foods every day when they are in school. This is guidance about what foods can be marketed specifically to children -- a higher bar because the underlying premise is that only healthy foods should be marketed to children, influencing dietary habits and dietary patterns over a lifetime. A two-year timeline for implementation would be more reasonable and industry can reformulate products or modify their advertising over time to meet the standards. Typically the timeline for product reformulation is about 18 months and advertising strategy is 6 months so a two-year timeline seems reasonable and in the meantime, industry can stop marketing foods that do not meet the standards until reformulation occurs. If industry does not choose to comply with these standards, then it will be clear that voluntary efforts are not successful and there will be greater rationale and evidence for legislation and regulation.

Nutrition Principle A: Meaningful Contribution to a Healthful Diet

The IWG describes two options for Nutrition Principle A and the AHA supports Option 2 where specific minimum contributions are proposed for each of the listed food groups with a few suggested revisions. If we are going to have to move to regulation in the future, it will be important to abide by what is currently regulated as closely as possible. The AHA encourages the agencies to continue to do food modeling exercises to capture implementation realities. The AHA considers these proposed principles as a “pilot test” for future regulation and so recommends the following revisions:

- Fried foods such as French fries and fried chicken should not be allowed to qualify even if they have the recommended food groups.
- The lean protein group should not be separated into separate categories with beans, seeds, nuts, and eggs and lean meats. By splitting them this way, a meal can easily satisfy the criteria without any fruits, vegetables, whole grains, or low-fat dairy. Beans could be listed with both lean proteins and vegetables as they are in the Dietary Guidelines. If the Working Group is reluctant to combine these lean proteins together, then it should require at least one fruit or vegetable and one whole grain with the meal or entree.

- For the whole grain amount, the Working Group should also include a minimum fiber requirement, requiring that the foods contain at least 1.1g of fiber per 10g of carbohydrate or use the FDA's definition for a "good source" of fiber and require whole grain foods to contain at least 10% of the daily value for fiber.
- In the definition of meat, the Interagency Working Group uses extra lean. We are supportive and want to confirm that this refers to the regulatory definition.
- Fruit juice should be defined as 100% juice or 100% juice diluted with water with no added sugar and the IWG should consider limiting calories to no more than 120 kcal/per 8 fl oz and require at least 10% Daily Value for three nutrients.
- Low/No fat milk, juice as defined above, and water are the only beverages that should be allowed to be marketed to children. Milk should contain no more than 130 kcal/8 fluid oz. to minimize the amount of added sugars in used flavored products.
- Consider using the tighter regulatory definition for fruits and vegetables to avoid questionable products being counted toward the positive food requirement.

Although both of the proposed options are meant to be used by industry to determine if foods qualify, consumers should also be able to have some sense of industry's compliance with the criteria. Agencies and public health organizations will have to be third party oversight to determine if voluntary efforts are working. Option 2 provides the best opportunity for this, although compliance will still not be very easy to discern for some of the food groups. The Interagency Working Group should prioritize transparency as much as possible throughout the recommendations.

Nutrition Principle B: Nutrients To Limit

Nutrition Principle B proposes targets for limiting the amount of sodium, saturated fat, *trans* fat, and added sugars. There is no recommendation for total fat and the AHA supports this exclusion. We have one serious concern however – that there are no calorie limits proposed. Tantamount to addressing the childhood obesity epidemic is limiting portion sizes across the diet. Based on limits for children and adolescents^x the AHA proposes a calorie limit for individual foods of 150 kcals for younger children (2-11) and 200 kcal for adolescents/teenagers, 300 kcal/entrée for 2-11 year olds and 400 kcal/entrée for adolescents/teenagers (12-17) and 500 kcal/meal for 2-11 year olds and 600 kcal/meal for adolescents/teenagers (12-17). The AHA also proposes making the saturated fat limit at 7% of calories with an explicit exemption for nuts, seeds, nut butters, fish, 1% milk, and non-fried vegetables. The AHA supports the recommended target for *trans* fat at 0 (<0.5) grams per Reference Amounts Customarily Consumed (RACC) for individual foods and 0 (<0.5) grams per labeled serving size for main dishes and meals. Similar to the definition for main dishes and meals, we would suggest adding "and per labeled serving size" after RACC for individual foods.

The AHA also applauds the Interagency Working Group for making recommended limits for added sugars. In order to make this recommendation easier to implement and enforce, the AHA reiterates its request that FDA add a line for added sugars to the Nutrition Facts panel. In the meantime, the AHA has developed draft criteria based on our scientific statement^{xi} on added sugars for our Food Certification program. We would be glad to share those with the Interagency Working Group when they are finalized.

The AHA applauds the very strict proposed sodium standards. These are congruent with the AHA's goal of a population intake of no more than 1500 mg/day for children and adults by 2020. However,

we believe the proposed timeline of 2016 for the interim levels and 2021 for final levels is too distant and will miss an entire generation of children. The sodium limits should be held to the same timeline as all the other principles. The AHA recommends two years for compliance, understanding that this will be difficult for industry to implement.

Proposed Definition of Marketing Targeted to Children and Adolescents

AHA supports the broad definitions proposed by the IWG of what constitutes marketing to children. It is important to encompass all of the ways industry reaches young consumers. As the Working Group is aware, industry's reach goes far beyond television and print advertising to the Internet, product placement in movies and video games, email and text messaging, and character licensing and toy co-branding.

In addressing the general questions posed by the Working Group, the AHA will focus on the nutrition principles questions since we feel we have the greatest expertise to respond here. We will leave it to others to comment on the marketing definitions as outlined by the FTC.

Questions for Comment

(1) Congress directed the Working Group to develop proposed nutrition principles for foods marketed to children and adolescents up to the age of 17. Does the prevalence of obesity in both children and adolescents warrant the same approach to limits on food marketing for both age groups? Given the wide age range, should there be two sets of nutrition principles, one for younger children (2-11 years) and one for adolescents (12-17 years), based on differences in the nutritional needs and recommended caloric intake of adolescents compared to younger children?

The AHA feels it is important that these principles apply to all children and adolescents up to the age of 17. As the nutrition principles are proposed, they can apply across the age groups because food groups to encourage are consistent with the Dietary Guidelines for Americans and the cut-offs for nutrients to avoid are applicable for the U.S. population (age 2 and above). Prevention of obesity beginning at the youngest ages is essential since growing data document that older children experience increasingly greater difficulty losing weight. Having one set of principles will help streamline implementation, but raising consciousness regarding portion size and not exceeding energy needs is paramount to weight control in these vulnerable age groups. Thus, we do recommend that the Working Group consider adding calorie limits to Nutrition Principle B and these would ideally differentiate between 2-11 year olds and 12-17 year olds.

(2) The Working Group recognizes that companies often engage in brand advertising and marketing, without reference to a specific food product in the brand line. How should the nutrition principles be adapted to accommodate advertising and marketing of a general brand or an entire product line as opposed to specific food products or menu items?

The AHA recommends that the Working Group propose specific guidelines around brand advertising so that industry cannot bypass the standards by marketing a brand rather than specific food products. The AHA recommends that 100% of foods/beverages in a particular brand meet the proposed nutrition principles to market the brand.

(3) The proposed nutrition principles do not include a separate proposal setting targets for nutrients to encourage, including specific nutrients of concern as identified in the 2010 DGA, such as calcium, potassium, fiber, magnesium, and vitamins A, C, and E.⁴⁹ Should the Working Group recommendations include targets for nutrients to encourage and, if so, how should

the recommendations address the issue of nutrients added to foods through fortification as opposed to nutrients that are inherent in foods?

The AHA supports the idea of promoting foods to be encouraged (in appropriate serving sizes) rather than nutrients because this helps avoid fortification concerns where industry would be putting a positive nutrient into an otherwise unhealthy food. Also, consumers can put principles into context more easily when focused on foods versus nutrients since foods are what they are consuming. By requiring low-fat dairy for example, calcium will be included in the diet, whole grains will contribute fiber, nuts and seeds contribute vitamin E, and fruits and vegetables bring vitamins A and C. The AHA feels that the IWG's proposed approach requiring positive food groups AND avoiding nutrients of concern is adequate enough to capture the types of foods that should be marketed to children while avoiding the very controversial area of nutrient fortification.

(4) The proposed nutrition principles do not include limits on portion size or calories for foods marketed to children. Should the Working Group recommendations address portion size or calories directly or is over-consumption adequately addressed by the recommendations that all foods marketed to children make a meaningful contribution to a healthful diet and minimize consumption of saturated fat, *trans* fat, and added sugars?

As stated above, we feel a serious omission from Nutrition Principle B is calorie limits. With childhood obesity, overconsumption, and sedentary behavior, limiting portion sizes and calorie intake across the diet must be a priority. Encouraging that individual calorie needs, including children's calorie needs, become more familiarized especially among parents, represents a major strategy towards helping everyone take a more proactive role in energy balance. Based on limits for children and adolescents^{xii} and work we have done with other nutrition standards for children in schools, the AHA proposes a calorie limit of 150 kcals for younger children (2-11) and 200 kcal for adolescents/teenagers for individual foods, 300 kcal/entrée for 2-11 year olds and 400 kcal/entrée for adolescents/teenagers (12-17) and 500 kcal/meal for 2-11 year olds and 600 kcal/meal for adolescents/teenagers (12-17). This would limit the sizes of foods and beverages that can be displayed in advertisements and promotions.

Food Categories

(5) The Working Group proposal recommends that the industry focus its efforts on improving the nutrition profile of products that fall within ten specific categories of foods most heavily marketed to children. While this approach would address a substantial majority of all products marketed directly to children, some foods marketed directly to children do not fall within any of the specified categories. Examples include hot dogs, jams and jellies, and sauces and dressings. Are there specific food products or categories of foods that should be added to or dropped from the proposed list? What are the advantages and disadvantages of focusing on the most heavily marketed foods rather than on all foods marketed to children?

It is very important that implementation be straightforward and streamlined. As noted by the IWG, there are foods marketed to children that fall out of the categories most heavily marketed but need to be included. It is important that industry, as well as interested consumer groups, have an easy understanding of what foods must qualify to minimize any confusion. Parents should feel confident that these principles apply across the board. In principle alone, the proposed standards should apply to ALL foods, not only the ones most heavily marketed to children.

Main Dishes/Meals

(6) The Working Group is seeking comment on the proposed adjustments to the nutrition principles for main dish and meal products. For instance, should main dishes and meals make meaningful contributions from at least two and three food groups respectively, as proposed under Principle A? Should the targets set under Principle B be tied to a 100-gram amount, a labeled serving, a 40-gram portion, or some combination of these? What would be the advantages or disadvantages of using a 100-gram basis to set food group contributions and nutrient targets for all individual foods, main dishes, and meals?

The AHA supports the idea that main dishes and meals should contribute at least two and three food groups respectively. We also support using the current regulatory definition for main dishes and meals for consistency. One concern we have, as mentioned above, is that the lean protein group is currently separated out by beans, seeds, nuts, eggs and lean meats. We support consolidating them as they are in the Dietary Guidelines and MyPlate so that a meal cannot qualify without at least one fruit, vegetable, or whole grain. Beans could be listed with both lean proteins and vegetables as they are in the Dietary Guidelines. If the IWG is reluctant to combine the lean proteins together, then it should require at least one fruit or vegetable and one whole grain with the meal or entree. Under Principle B, targets tied to the 100 gram amount will be more accurately measured.

(7) The Working Group also seeks comment on alternative approaches to address the marketing of children's meals by restaurants. One possible approach would be to recommend that a minimum number of the offerings on a children's menu be healthier and that at least two out of three components of the meals marketed to children meet certain nutrition principles that make them healthier choices. What would be the advantages or disadvantages of such an approach? Are there other approaches to the marketing of children's meals by restaurants that the Working Group should consider?

Consideration of restaurant meals marketed to children is extremely important as the number of meals consumed outside the home has reached an all-time high. Restaurants should be encouraged to market and make available healthy meals to children and their parents and promote healthful choices. People typically underestimate the calories in the foods and beverages they consume and this is another important reason for integrating calorie limits into the nutrition principles.^{xiii} Eating out is no longer just a "treat" for most people. Over the last three decades, the percent of food consumed away from home has increased from 18 percent to 32 percent of total calories.^{xiv} Foods eaten away from home typically are served in overly large portion sizes and are higher in energy density, fat, salt, and sugar compared to food eaten at home^{xv} resulting in adverse health consequences such as Type 2 diabetes, elevated blood pressure, hypercholesterolemia, and obesity.^{xvi} Research has documented a positive association between eating out and increased body weight.^{xvii} The AHA supports any efforts to help consumers make healthier food choices in restaurants. The IWG should require that all children's meals meet the nutrition principles as outlined. This would be important especially for meals that include toy giveaways. Additionally, if the restaurant engages in brand advertising/marketing without referencing a specific meal, then all the meals on the children's menu should be required to meet the criteria to qualify.

Nutrition Principle A

(8) Under both the Option 1 and Option 2 proposals for Principle A, companies can aggregate contributions from more than one of the specified food categories to meet the meaningful amount targets for individual foods. Does this approach diminish the meaningful contribution to the diet by allowing small contributions from multiple food groups? Should the principle recommend that the entire contribution come from one food group?

We feel it is important to allow for the aggregation so that combination foods like low-fat yogurt with fruit or whole grain cereal bars with other food components might qualify if they meet all the other criteria. When combined with the entire range of proposed principles, we feel it is acceptable to allow for the aggregation. This is another area, however, that shows the need for further food modeling exercises to confirm that there are not any critical gaps or inconsistencies with foods allowed under the proposed principles.

(9) The list of food groups that make a meaningful contribution to a healthful diet under Principle A includes both the basic food groups to encourage as identified in the 2010 DGA – fruits, vegetables, whole grains, fat-free and low-fat milk products – as well as other food categories that are compatible with an overall healthful diet – fish, lean meat and poultry, beans, nuts and seeds, and eggs. Are there food categories that should be added to or eliminated from Principle A?

As mentioned above, we feel the lean protein group should be consolidated and beans can be listed with this group or with vegetables.

(10) The 2010 DGA recommend consuming a variety of vegetables, especially dark-green and red and orange vegetables and beans and peas. Given that children consume starchy vegetables disproportionately to other subgroups like dark-green and red and orange vegetables, should Principle A include recommendations for specific subgroups of vegetables?

Since these are principles for food marketing, rather than nutrition standards for foods served in school or in other environments, we recommend a prohibition against fried foods, but keeping the remaining language as proposed. That would eliminate fried potatoes, the major concern in the starchy vegetables category for children, without making the proposed principles overly complex for implementation.

(11) The Working Group has included two possible approaches for Principle A. What are the advantages and disadvantages of Option 1 (based on weight) and Option 2 (based on amounts per RACC)?

The AHA supports Option 2, basing the criteria on amounts per RACC, to allow for consistency in assessing serving size and also making the proposed principles congruent with current regulatory efforts and definitions. Ultimately, RACC definitions need to be updated with more current food survey data to make them even more relevant.

(12) The food contribution amounts proposed in Option 2 are calculated based on a 2,000 calorie daily diet and assume four eating occasions per day. Should this calculation be adjusted to reflect children's caloric needs and eating patterns?

Yes, it is important to adjust these calculations down to accommodate the calorie limits more appropriate for children i.e. the mid-point between the calorie range for 2-17 year olds (1000 kcal-2200 kcal) which equals 1600 kcal. Concerns about inadequate energy intake among most of America's children are part of a bygone era and while of course some children depend upon the calorie intake from school foods etc, the majority of children are now at risk for overweight and obesity. A careful and continuous monitoring of children's dietary intake and BMI should go hand in hand to assure the best balance between a calorie adjusted environment and sufficient nutrients to support normal growth and development. It is recognized that 2,000 kcal is the basis for regulatory definition at this time, but if calorie limits are added to Principle B based on requirements for this age group, then this will at least partially satisfy the need to adjust for children's caloric needs.

Nutrition Principle B

(13) Principle B provides that any nutrients naturally occurring as part of the food contributions under Principle A are not counted toward the proposed limits for specific nutrients under Principle B. This exemption is intended to resolve any inherent inconsistencies between Principle A and Principle B. At the same time, the Working Group recognizes that the calculations involved in partially “netting out” certain nutrients would entail a detailed knowledge of the product recipe or formulation and make it difficult for any third party to verify whether a product meets Principle B. Are there alternative approaches the Working Group should consider in reconciling the provisions of Principles A and B?

The AHA does not have a proposed alternative, but thinks that third party verification is important to determine the effectiveness of voluntary efforts. We support the idea that nutrients naturally occurring as part of the food contributions under Principle A are not counted toward the proposed limits for specific nutrients under Principle B since this resolves inconsistencies between the two principles.

(14) Under Principle B, the proposed nutrient targets for individual foods are generally tied to the RACC. The proposal recommends that individual foods with a small RACC (30 grams or less), meet the targets for saturated fat, *trans* fat, added sugars, and sodium per 50 grams (with the exception of the interim sodium value of 210 milligrams per serving). What are the implications of this approach in particular for smaller serving foods like cereals or for foods marketed in smaller children’s portions? What would be the advantages and disadvantages of tying Principle B recommendations to labeled serving instead of the RACC?

RACC is the better approach from a regulatory standpoint because RACC standardizes the serving sizes across different foods and calculates the amount of food customarily consumed per eating occasion based on data set forth in national food consumption surveys. There is a distinct need to update RACC based on newer surveillance data and the AHA encourages the FDA to do this as soon as possible. Additionally, RACC is difficult to understand for the general public and could create confusion for third party oversight. Working off of labeled serving size would make the system easier for any oversight. However, from a science, accuracy and regulatory perspective RACC is the better approach. The AHA bases its Food Certification program off of RACC and supports the Interagency Work Group’s effort to do it here.

(15) Are there other nutrients or ingredients not currently included in Principle B that the Working Group should recommend be limited in foods marketed to children? If so, what is the evidence regarding the nutrition and health justification for including the nutrient or ingredient?

As we have mentioned, we believe it is imperative to add calorie limits to individual foods, entrees, and meals in Principle B. Over the last three decades, the number of eating occasions enjoyed by most Americans combined with increasing portion sizes has been a contributing factor to the excessive energy consumption in the U.S. population.^{xviii} Portion size should be incorporated into all of our policy efforts and throughout our federal dietary guidance. There is clear evidence that sugar sweetened beverages are positively associated not only with risk of overweight and obesity but also reduced nutrient density in children. Everything possible should be done to help reduce or eliminate the high prevalence of sugar sweetened beverage intake, especially among the youngest children.

(16) The Working Group proposal recommends a target for added sugars for foods marketed to children. What are the advantages and disadvantages of the proposal for limiting added sugars content as opposed to total sugars content?

The disadvantage is that it is more difficult to verify because added sugars are not currently on the food label. The AHA encourages FDA to add added sugars to the Nutrition Facts Panel to help consumers understand that these should be limited in the diet. However, even though it will be challenging for third party oversight, it is very important that the proposed principles for foods marketed to children include an added sugars criteria, highlighting the importance of minimizing added sugars in the diet, and eliminate the marketing of sugar-sweetened beverages, candy, and other foods that have little or no nutritional value but are high in calories. Parents need the reassurance that industry is not promoting these foods and beverages to their children.

(17) The Working Group proposal recommends an interim goal for limiting sodium content for foods marketed to children of 210 milligrams per serving for individual foods and 450 milligrams per serving for main dishes and meals, with a target date of 2016. Is there a nutrition-based rationale for an alternative interim goal for sodium that the Working Group should consider? The Working Group's final value for sodium is 140 milligrams per RACC for individual foods and 300 milligrams per serving for main dishes and meals, with a target date of 2021. Is there a nutrition-based rationale for an alternative final goal on sodium that the Working Group should consider?

The AHA applauds the strict proposed sodium standards. These are congruent with the AHA's goal of a population intake of no more than 1500 mg/day for children and adults by 2020. The AHA believes the proposed timeline of 2016 for the interim levels and 2021 for final levels is too far out and will miss a generation of children. The AHA would recommend that the IWG make the sodium timeline consistent with the other nutrition principles and change it to two years.

General Feasibility/Marketplace Impact of Proposed Nutrition Principles

(20) Do the proposed nutrition principles create incentives for manufacturers to reformulate a food product in a manner that would diminish the nutritional quality of the product? If so, are there revisions to the proposed nutrition principles that would reduce or eliminate those incentives?

The AHA hopes that industry will take this opportunity voluntarily to adopt these nutrition principles and reformulate as needed to develop individual foods, meals, and entrees that qualify. Some criteria such as those for sodium will take longer and will be more difficult to achieve, but hopefully remain aspirational for food companies that want to take the ethical, committed approach to food marketing. We have experience in our own Heart Check program that the standards have motivated industry to reformulate products to meet the requirements for certification.

(21) Many food products currently in the marketplace may require substantial reformulation to meet the proposed principles. The Working Group recognizes that such reformulation may present both technical challenges and challenges relating to the palatability and consumer acceptance of the food. What impact will reformulation challenges have on manufacturers' incentive and ability to improve the nutritional quality of the foods they market to children to meet the proposed principles? Given these challenges, what would be the best approach to encourage the greatest participation from the food industry? Should the Working Group develop principles that would encompass a broader range of foods? For example, should the Working Group consider alternative principles drawn from federal food labeling regulations defining the nutrient content claim "healthy" or setting nutrient disclosure levels for other nutrient content claims?

The AHA maintains that the IWG should uphold these robust principles since they are creating voluntary cut-offs for foods and beverages marketed to children, not foods that are actually served to children. Despite the technical challenge for reformulation, the underlying premise is an important one in light of our obesity epidemic, overconsumption of unhealthy foods and nutrients,

and sedentary behavior -- only healthy foods in appropriate portion sizes should be marketed to children. The IWG should keep these science-based principles intact and uniform.

(22) The Working Group proposes that industry work to fully implement the proposed nutrition principles for all foods within the categories most heavily marketed to children by the year 2016, with a target of 2021 for final sodium reductions. The Working Group does not propose any specific implementation process or interim goals for meeting this target date, but encourages individual companies to develop a workable plan for incremental implementation. Are these appropriate target dates for full implementation of the principles and should the Working Group recommend specific interim goals?

The AHA believes that the proposed timelines are too long. A two-year timeline for implementation would be more credible for the general public. Industry can reformulate products over time to meet the standards with product reformulation taking about 18 months and advertising strategy taking about 6 months. In the meantime, industry can stop marketing foods until reformulation can happen. If industry does not choose to comply with these standards, then it will be clear that voluntary efforts are not successful and there will be greater rationale and evidence for legislation and regulation.

Definition of Food Marketing Targeted to Children

(23) The Working Group's proposed voluntary principles apply similarly broad definitions of what constitutes marketing to children ages 2-11 years and adolescents ages 12-17 years. In the case of adolescents, those marketing definitions are more likely to result in limits on food marketing in media that is also reaching a substantial adult audience. What would be the advantages or disadvantages of applying the proposed nutrition principles only to those marketing techniques that are more narrowly focused on adolescents, for example, by limiting the scope to in-school marketing and social media, such as the Internet, digital, word of mouth, and viral marketing? If the range of covered marketing techniques is narrower for adolescents than for younger children, what techniques should be encompassed and why?

The AHA supports applying the broad definitions of what constitutes marketing to all children and adolescents 2-17 years old. Even though adolescents are more aware of marketing techniques and how industry is trying to reach them, we need to apply broadly the basic principle that it is unethical to market unhealthy food and beverages to the next generation of adults.

Conclusion

Currently, 32% of children in the US are obese or overweight. The downstream health and economic consequences of inaction are enormous and justify a strong response. The AHA applauds the IWG for proposing such robust, science-based nutrition principles for foods marketed to children. These can serve as the basis for current voluntary efforts and, if needed, regulation and legislation in the future. We recommend that the IWG require that these principles cover all foods and beverages marketed to children in a two-year time frame. Additionally, calorie limits should be included under Nutrition Principle B and we ask the IWG to consider our other recommendations throughout these comments. Most important, the IWG should submit a robust report to Congress despite industry pressure to withdraw these principles and conduct further study. These are truly important steps forward in federal nutrition policy. The food industry should be encouraged to contribute favorably to the education and positive behavioral changes required to reduce portion sizes, reduce energy dense-nutrient poor food intake and enhance knowledge of energy needs among all individuals, especially children. The health of our nation's children is dependent on an unwavering commitment from the federal government in addition to work by

individuals, families, community groups, and the public health sector to address contributing factors to our nation's obesity epidemic.

If you have any questions or need any additional information, please do not hesitate to contact Laurie Whitsel, PhD, Director of Policy Research at 724-238-0272 or via email at Laurie.Whitsel@heart.org.

Sincerely,

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ⁱ Ogden CL, Carroll MD, Flegal KM. High body mass index for age among US children and adolescents, 2003-2006. *JAMA*. 2008;299(20):2401-2405.

ⁱⁱ Packaged Facts. Kids Food and Beverage Market in the U.S. May 1, 2011. Report summary available at: <https://www.packagedfacts.com/Kids-Food-Beverages-2706876/>.

ⁱⁱⁱ Andreyeva T, Rashad I, Harris JL. Exposure to food advertising on television: Associations with children's fast food and soft drink consumption and obesity. *Economics and Human Biology* 9 (2011) 221–233.

^{iv} Committee on Communications, American Academy of Pediatrics. Children, adolescents, and advertising. *Pediatrics*. 2006; 118:2563-2569.

^v Alvy LM, Calvert SL. Food marketing on popular children's web sites: a content analysis. *Journal of the American Dietetic Association*. April 2008. 108(4):710-713.

^{vi} Linn S, Novosat CL. Calories for sale: food marketing to children in the twenty-first century. *AAPSS*. January 2008; 615:133-155.

^{vii} Federal Trade Commission. Marketing food to children and adolescents: a review of industry expenditures, activities, and self-regulation: a Federal Trade Commission Report to Congress. July 2008. accessed at <http://www.ftc.gov/opa/2008/07/foodmkting.shtm> on August 11, 2008.

^{viii} Schwartz MB, Vartanian LR, Wharton CM, Brownell KD. Examining the nutritional quality of breakfast cereals marketed to children. *Journal of the American Dietetic Association*. April 2008; 108(4): 702-705.

^{ix} American Academy of Pediatrics. Clinical Report – Sports Drinks and Energy Drinks for Children and Adolescents – Are they Appropriate? *Pediatrics*. May 29, 2011.

^x Gidding S, Dennison B. et al., Dietary recommendations for children and adolescents: A guide for practitioners: A consensus statement from the American Heart Association. *Circulation*. 2005;112:2061-2075.

^{xi} Johnson, R. K., L. J. Appel, et al. (2009). "Dietary sugars intake and cardiovascular health: a scientific statement from the American Heart Association." *Circulation* 120(11): 1011-20.

^{xii} Gidding S, Dennison B. et al., Dietary recommendations for children and adolescents: A guide for practitioners: A consensus statement from the American Heart Association. *Circulation*. 2005;112:2061-2075.

^{xiii} Burton, S., Creyer, EH, Kees, J., Huggins, K. Attacking the obesity epidemic: the potential health benefits of providing nutrition information in restaurants. *American Journal of Public Health*. 2006; 96:1669-1675.

^{xiv} Guthrie JF, Lin BH, Frazao E. Role of food prepared away from home in the American diet, 1977-78 versus 1994-96; changes and consequences. *Journal of Nutrition Education and Behavior*. 2002; 34:140-150.

^{xv} Nielsen SJ, Popkin BM. Patterns and trends in food portion sizes, 1977-1998. *JAMA*. 2003; 289; 450-453.

^{xvi} Lichtenstein AH, Appel LJ, Brands M, Carnethon M, Daniels S, Franch HA, Franklin B, Kris-Etherton P, Harris WS, Howard B, Karanja N, Lefevre M, Rudel L, Sacks F, Van Horn L, Winston M, Wylie-Rosett J. Diet and lifestyle recommendations revision 2006, *Circulation*. 2006; 114: 82-96.

^{xvii} Wootan M & Osborn M (2006) Availability of nutrition information from chain restaurants in the united states. *American Journal of Preventive Medicine* 30: 266–8.

^{xviii} Duffey, KJ, Popkin, BM. Energy Density, Portion Size, and Eating Occasions: Contributions to Increased Energy Intake in the United States, 1977–2006. *PLoS Med*. 2011. 8(6): e1001050.