ACHI
INSPIRING HEALTHY ACTS

MENU LABELING REGULATIONS

Caloric and Nutrition Policymaking Through the Affordable Care Act

Introduction

Obesity rates in the United States have increased drastically over the last few decades. According to the Centers for Disease Control and Prevention, survey data for the period of 2017–March 2020 found that 41.9% of American adults were experiencing obesity, up from 30.5% in survey data for 1999–2000.[1] Between 2018 and 2021, the number of states with at least 35% of residents experiencing obesity nearly doubled, rising from nine to 16.[2]

Arkansas's adult and child obesity rates are some of the highest in the nation. In 2020, 36.4% of Arkansas adults were classified as obese (body mass index, or BMI, of 30+), and 30.9% were overweight (BMI of 25–29.9).[3] A report on Arkansas children's BMI levels found that in the 2020–2021 school year, more than 1 in 4 (26%) public school-aged children were classified as obese.[4]

Increased caloric intake is a known contributor to increased obesity rates.[5] Approximately 36% of American adults consume fast food on any given day,[6] and American households spend more than 40% of their total food budget on food prepared outside the home.[7] Fast food is associated with higher calories and larger amounts of carbohydrates, saturated fats, and sugars.[8]

Policymakers have sought to ensure consumers have access to point-of-purchase nutritional information by enacting legislation requiring federal oversight of nutrition and menu labeling. In 1990, Congress passed the Nutrition Labeling and Education Act, which required the addition of nutrition labels to all food displayed and sold at retail establishments in the United States.[9] However, the act exempted food prepared and sold in restaurants from labeling requirements. In 2010, Congress included provisions in the Patient Protection and Affordable Care Act (ACA) to address menu labeling at restaurants and other similar retail establishments. Section 4205 of the

ACHI
INSPIRING HEALTHY ACTS

ACA amended section 403(q) of the Food, Drug, and Cosmetic Act of 1938, which governs nutritional labeling requirements, and required the disclosure of calorie content and nutrition information in certain establishments.[a,10] This explainer will discuss which esablishments are covered by the ACA menu labeling requirements, what the establishments are required to do, implementation and enforcement challenges, effectiveness of menu labeling policies, complementary state and local policy actions, and possible future policy directions.

WHAT IS A COVERED ESTABLISHMENT?

The ACA states that all "covered establishments" must register with the Food and Drug Administration (FDA) to comply with menu labeling guidelines. A covered establishment is defined as "a retail establishment that offers for sale restaurant-type food" and currently operates 20 locations doing business under the same name and offering essentially the same menu items. The FDA initially estimated that approximately 298,000 covered establishments in the United States would be required to comply with menu labeling laws.[11]

Covered Establishments Examples:
Bakeries Coffee Shops Convenience Stores Delicatessens Amusement Parks Bowling Alleys Movie Theaters Ice Cream Shops /Confectionaries Mall Food Counters Food Take-Out/Delivery Grocery Stores Supermarkets Quick-Service Restaurants Table-Service Restaurants

A covered establishment must pass the primary business test, meaning that the primary role of the establishment is to sell food for immediate consumption. Transportation vehicles, such as planes or trains, or establishments without fixed locations (e.g., food trucks) are exempt from the rule.

WHAT ARE THE MENU LABELING REQUIREMENTS?

Covered establishments must provide, for all standard restaurant-type food: [10]

- The number of calories contained in each standard menu item as usually prepared and offered for sale on a menu or menu board (the calorie declaration must be "adjacent to" the name of the standard menu item, so as to be "clearly associated" with each item).

[a] In addition to addressing menu labeling, the ACA required calorie declarations for food sold in vending machines. These two parts of the law remain distinct, however, as they have different regulations and compliance dates.

- A succinct statement concerning suggested daily intake posted prominently on the menu or menu board designed to enable the public to understand, in the context of a total daily diet, the significance of the calorie information provided on menus and menu boards.
- Additional nutrition information for standard menu items in a written form ("written nutrition information"), available on the premises, which must be made available to consumers upon request.
- A prominent, clear, and conspicuous statement on the menu or menu board regarding the availability of the written nutrition information.
- The number of calories (per item or per serving) on a sign adjacent to self-service food and food on display. This food includes food sold at salad bars, buffet lines, cafeteria lines, or similar self-service facilities, and self-service beverages and food on display that is visible to consumers.

Covered establishments must also ensure that calorie ranges for combination meals are clearly displayed adjacent to the menu option.[12] If a menu lists two choices for menu items in a combination meal, the calorie totals for both options must be displayed, separated by a slash (e.g., 300/450 calories). If a menu lists three or more choices for a combination meal, the calories must be declared in a range (e.g., 300–450 calories).

Restaurants not considered covered establishments may voluntarily register with the FDA to report menu labeling for their establishments. Registration with the federal government means that establishments can avoid local requirements, which are often more restrictive and broader in scope than the existing federal guidelines (e.g., sodium labeling).

Implementation

Although the ACA was passed in 2010, compliance with menu labeling requirements was not required until 2018, largely due to industry pushback over proposed regulations. The industry expressed concerns over the expense of implementation, confusion about definitions, and the shortness of compliance timelines. To allow ample time for compliance, the FDA made May 7, 2018, the official compliance date, but indicated that the first year of implementation would be focused on education and outreach.[13]

In April 2020, in response to the global COVID-19 pandemic, the FDA issued temporary guidance encouraging compliance with ACA menu labeling requirements but indicating that it did not expect covered establishments to meet the requirements during the pandemic. This flexibility is effective through the end of the federal public health emergency, which remained in effect as of July 2022.

Enforcement

The FDA enforces menu labeling regulations in much the same way it enforces other consumer product regulations, through either inspections or consumer complaints. If an inspection is conducted and nutritional labeling is found to be excluded or incorrect, the FDA will raise compliance concerns with the establishment's management either on-site or post-inspection. Consumers can aid with enforcement by submitting complaints to the FDA but must provide evidence of potential noncompliance. Complaints may prompt an inspection of the establishment.

The FDA's final rule for menu labeling indicates that failure to comply with the labeling requirements renders the food as misbranded under the Food, Drug, and Cosmetic Act. Penalties for noncompliance depend on the nature of the violation and range from a warning letter to criminal prosecution for intent to defraud. However, in supplemental guidance to industries issued in 2018, the FDA said the goal of implementation is to "ensure compliance among covered establishments in a cooperative manner" and that the agency does not intend to "penalize or recommend the use of criminal penalties for minor violations."[14]

ACHI
INSPIRING HEALTHY ACTS

Evidence of Effectiveness

The FDA has said menu labeling can motivate consumers to purchase more lower-calorie food products, as well as educate and empower individuals to make healthier selections when consuming restaurant food. However, studies conducted in real-world settings have thus far not shown any significant reduction in calories consumed as a result of menu labeling.[15] Some studies conducted in laboratory settings with similar goals saw a reduction in overall calories, but these effects may underestimate consumer behavior and choices in a real-world setting.[16]

One study examined a King County, Wash., menu labeling requirement that the county enacted prior to the ACA requirement and found that the results were mixed. Some restaurants, such as taco chains and coffee shops, saw an increase in the percentage of customers who reported awareness of the calories in menu items (an average increase from 18.8% of customers to 58.3% over the first six months, further increasing to 61.7% by 18 months) and an overall decrease in calorie consumption per visit (no difference on average over the first six months, but an average 100-calorie decrease by 18 months). Other places, such as burger joints, saw no overall decrease in calorie consumption.[17] In a study examining the long-term effects of menu labeling in New York City, researchers found no statistically significant change in the number of calories in food purchased by customers after five years of required menu labeling, despite an increase in customers reporting they were aware of and utilized calorie information when ordering.[18]

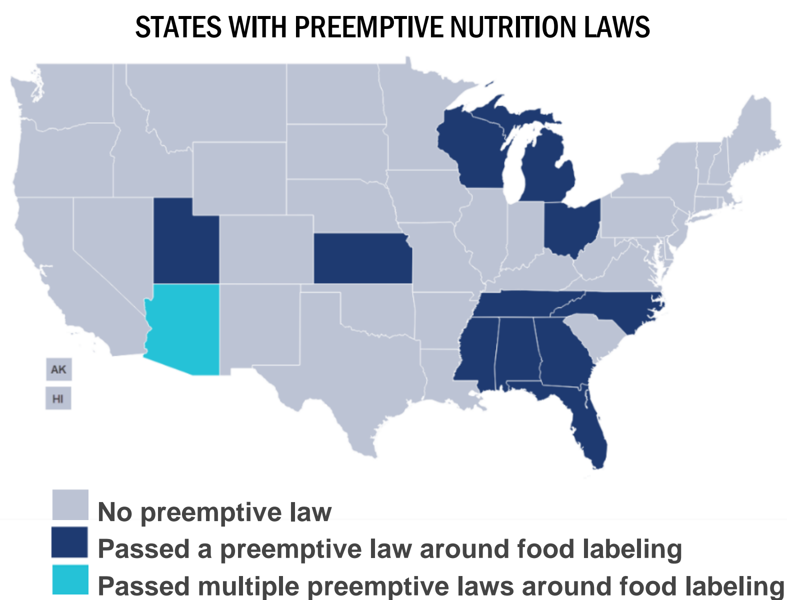
In response to customers who are choosing lower-calorie options with increased access to calorie information, some restaurants are adapting menus to include lower-calorie options. Studies evaluating mean calories for core menu items and newly introduced menu items post-menu labeling requirements found that overall mean calories of core menu items did not change, but there was a slight decline in overall calories for new menu items.[19, 20] Other nutritional components, such as sodium levels, were found to decrease in U.S. chain restaurants over time.[21] This suggests that policy changes around menu labeling could result in more change for the restaurant industry than for individual consumers.

State/Local Policy Actions

Prior to the ACA requirement, state and local governments were enacting their own menu labeling and other food- and beverage-related policies. In 2008, New York City restricted the amount of trans fatty acids (or trans fat) allowed in restaurant dishes and required calorie labeling on chain restaurant menus.[14] In the same year, California became the first state to pass menu labeling requirements for restaurants.[22] A crop of other states — Maine, Massachusetts, Oregon, New Jersey, and Tennessee — enacted similar statewide menu labeling requirements.[23] Since then, many localities have enacted policies regarding sugar-sweetened beverage taxation, school nutrition programs, and meal incentives such as children's toys. For example, in 2010 and 2011, Santa Clara County, Calif.,[24] and San Francisco[25] banned the use of children's toys in meals with excess calories and required that the default children's beverage, i.e., the drink that comes with a child's meal if no alternative is requested, be water or low-fat milk.

The food industry has pushed back against these local efforts, prompting states to pass laws that preempt local authority. From 2008 to 2018, 12 states passed 13 preemptive laws[b] focusing on food labeling and nutrition.[26]

STATES WITH PREEMPTIVE NUTRITION LAWS



[b] Preemption, or ceiling preemption, refers to federal or state laws or regulations that set a maximum standard that lower-level governments may not exceed (Institute of Medicine, 2011).

ACHI
INSPIRING HEALTHY ACTS

Conclusion

Establishing a national standard for menu labeling in retail food establishments has provided momentum for transparency of nutritional information. With point-of-purchase access to nutritional information, customers can make informed decisions regarding their caloric intake.

Current literature does not show long-term effectiveness in menu labeling as an intervention for obesity reduction, suggesting that menu labeling alone may not be enough to create effective and lasting change to the average calorie consumption of most Americans. Additional study of the effectiveness of these policies is needed, particularly given that enforcement has not been an FDA priority and the pandemic has created additional setbacks in ensuring compliance.

In the absence of preemptive state legislation prohibiting localities from regulating in this area, cities and counties can complement federal efforts by extending menu labeling requirements to establishments not subject to federal requirements. Localities can also explore policies regarding meal incentives and default beverages, as well as nutritional policies outside restaurant settings, such as schools and day care programs. Restaurants not subject to the federal menu labeling requirements can also take action by voluntarily registering with the FDA and implementing menu labeling on their own. Providing more transparency in restaurant settings, thus creating more nutritional awareness, is an important step in arming individuals with actionable information, but more comprehensive policy change is necessary to influence individual and industry behaviors that can impact the obesity epidemic and lead to improvements in health.

[1] Centers for Disease Control and Prevention. (2021, February 11). Adult Obesity Facts. cdc.gov/obesity/data/adult.html
[2] Centers for Disease Control and Prevention. (2016, January 1). Number of states with high obesity prevalence rises to sixteen. cdc.gov/media/releases/2021/s0915-obesity-rate.html
[3] Farberman, R. (2021, September 15). State of obesity 2021: Better policies for a healthier America. Trust for America's Health. tfah.org/report-details/state-of-obesity-2021/
[4] Arkansas Center for Health Improvement. (2022). Assessment of childhood and adolescent obesity in Arkansas: Year 18 (Fall 2020–Spring 2021). achi.net/wp-content/uploads/2022/02/220222A-Year-18-2020-21-Arkansas-BMI-Report-FINAL.pdf
[5] McCroy, M.A., Fuss, P.J., Hays, N.P., Vinken, A.G., Greenberg, A.S., & Roberts, S.B. (1999, November). Overeating in America: Association between restaurant food consumption and body fatness in healthy adult men and women ages 19 to 80. *Obes Res*, 7(6):564-571. doi.org/10.1002/j.1550-8528.1999.tb00715.x
[6] Fryar, C., Hughes, J., Herrick, K., & Ahluwalia, N. (2018). Fast food consumption among adults in the United States, 2013–2016. cdc.gov/nchs/products/databriefs/db322.htm
[7] Todd, J.E., & Mancino, L. (2010, June 1). Eating out increases daily calorie intake. ers.usda.gov/amber-waves/2010/june/eating-out-increases-daily-calorie-intake/#:~:text=Eating%20dinner%20out%20increases%20intake
[8] Pomeranz, J.L., & Brownell, K.D. (2008). Legal and public health considerations affecting the success, reach, and impact of menu-labeling laws. *Am. J. Public Health*, 98(9), 1578–1583. doi.org/10.2105/ajph.2007.128488
[9] Nutrition Labeling and Education Act of 1990, 21 § 301 (1990). congress.gov/bill/101st-congress/house-bill/3562
[10] Food and Drug Administration. (2014, December). Food labeling; Nutrition labeling of standard menu items in restaurants and similar retail food establishments. federalregister.gov/documents/2014/12/01/2014-27833/food-labeling-nutrition-labeling-of-standard-menu-items-in-restaurants-and-similar-retail-food
[11] US Department of Health and Human Services. (2014). Food labeling; nutrition labeling of standard menu items in restaurants and similar retail food establishments; calorie labeling of articles of food in vending machines; final rule. govinfo.gov/content/pkg/FR-2014-12-01/pdf/2014-27833.pdf
[12] US Food and Drug Administration. (2018, July 11). Questions and answers on the menu and vending machines nutrition labeling requirements. fda.gov/food/food-labeling-nutrition/questions-and-answers-menu-and-vending-machines-nutrition-labeling-requirements
[13] US Food and Drug Administration. (2019, August 13). FDA's implementation of menu labeling moving forward. US Food and Drug Administration. fda.gov/food/food-labeling-nutrition/fdas-implementation-menu-labeling-moving-forward
[14] US Department of Health and Human Services. (2018). Menu labeling: Supplemental guidance for industry. fda.gov/files/food/published/Menu-Labeling-Supplemental-Guidance-for-Industry-PDF.pdf
[15] Cantu-Jungles, T., McCormack, L., Slaven, J., Slebodnik, M., & Eicher-Miller, H. (2017). A meta-analysis to determine the impact of restaurant menu labeling on calories and nutrients (ordered or consumed) in U.S. adults. *Nutrients*, 9(10), 1088. mdpi.com/2072-6643/9/10/1088
[16] Long, M.W., Tobias, D.K., Cradock, A.L., Batchelder, H., & Gortmaker, S.L. (2015). Systematic review and meta-analysis of the impact of restaurant menu calorie labeling. *Am. J. Public Health*, 105(5), e11–e24. doi.org/10.2105/ajph.2015.302570
[17] Krieger, J.W., Chan, N.L., Saelens, B.E., Ta, M.L., Solet, D., & Fleming, D.W. (2013). Menu labeling regulations and calories purchased at chain restaurants. *Am. J. Prev. Med.,* 44(6), 595–604. doi.org/10.1016/j.amepre.2013.01.031
[18] Cantor, J., Torres, A., Abrams, C., & Elbel, B. (2015). Five years later: Awareness of New York City's calorie labels declined, with no changes in calories purchased. *Health Affairs*, 34(11), 1893–1900. doi.org/10.1377/hlthaff.2015.0623
[19] Bleich, S.N., Wolfson, J.A., & Jarlenski, M.P. (2015). Calorie changes in chain restaurant menu items. *Am. J. Prev. Med.*, 48(1), 70–75. doi.org/10.1016/j.amepre.2014.08.026
[20] Grummon, A.H., Petimar, J., Soto, M.J., Bleich, S.N., Simon, D., Cleveland, L.P., Rao, A., & Block, J.P. (2021). Changes in calorie content of menu items at large chain restaurants after implementation of calorie labels. *JAMA Netw. Open*, 4(12), e2141353. jamanetwork.com/journals/jamanetworkopen/fullarticle/2787598
[21] Wolfson, J.A., Moran, A.J., Jarlenski, M.P., & Bleich, S.N. (2018). Trends in sodium content of menu items in large chain restaurants in the U.S. *Am. J. Prev. Med.*, 54(1), 28–36. doi.org/10.1016/j.amepre.2017.08.018
[22] California Conference of Directors of Environmental Health. (2009). California menu labeling guidelines. co.monterey.ca.us/home/showpublisheddocument/15132/636159481962030000
[23] National Conference of State Legislatures. (2013, January). Trans fat and menu labeling legislation. ncsl.org/research/health/trans-fat-and-menu-labeling-legislation.aspx

[24] NPR. (2010, April 29). California town bans toys in happy meal. npr.org/templates/story/story.php?storyId=126386935#:~:text=Transcript-,Parents%20know%20the%20promise%20of%20a%20new%20toy%20draws%20children,in%20Santa%20Clara%20County%2C%20California.

[25] Otten, J.J., Saelens, B.E., Kapphahn, K.I., Hekler, E.B., Buman, M.P., Goldstein, B.A., Krukowski, R.A., O'Donohue, L.S., Gardner, C.D., & King, A.C. (2014). Impact of San Francisco's toy ordinance on restaurants and children's food purchases, 2011–2012. *Prev. Chronic Dis.*, 11(140026). cdc.gov/pcd/issues/2014/14_0026.htm

[26] Pomeranz, J.L., Zellers, L., Bare, M., & Pertschuk, M. (2019). State preemption of food and nutrition policies and litigation: Undermining government's role in public health. *Am. J. Prev. Med.*, 56(1), 47–57. doi.org/10.1016/j.amepre.2018.07.027