

Denver Law Review Forum

Volume 95

Article 10

2-1-2018

The Healthy, Hunger-Free Kids Act: The Fight Must Go On

Jenny Nelson

Jessica Nelson

Follow this and additional works at: <https://digitalcommons.du.edu/dlrforum>

Recommended Citation

Jenny Nelson & Jessica Nelson, The Healthy, Hunger-Free Kids Act: The Fight Must Go On, 95 Denv. L. Rev. F. (2018), available at <https://www.denverlawreview.org/dlr-online-article/2018/2/1/the-healthy-hunger-free-kids-act-the-fight-must-go-on.html?rq=The%20Healthy%2C%20Hung>

This Article is brought to you for free and open access by Digital Commons @ DU. It has been accepted for inclusion in Denver Law Review Forum by an authorized editor of Digital Commons @ DU. For more information, please contact jennifer.cox@du.edu, dig-commons@du.edu.

THE HEALTHY, HUNGER-FREE KIDS ACT: THE FIGHT MUST GO ON

INTRODUCTION

In December of 2010, then-President Barack Obama signed the Healthy, Hunger-Free Kids Act (the Act)—a bill spearheaded by Michelle Obama that passed with bipartisan support—intending to reduce childhood obesity, childhood hunger, and improve the overall health and well-being of children in the U.S. The Act accomplishes this by, inter alia, instructing the United States Department of Agriculture (USDA) to implement nutrition guidelines for school lunches.¹ The new standards, based on recommendations from the Institute of Medicine, included “more whole grains, fruits and vegetables, lean protein and low fat dairy, as well as less sugar, fat, and sodium.”² The program had many positive effects.³ However, after President Donald Trump took office, Sonny Perdue, Secretary of Agriculture, issued a Proclamation relaxing the nutritional guidelines put in place by the USDA during the previous Administration.⁴ First, instead of requiring all grains offered with school meals to be at least 51% whole grain,⁵ the Proclamation allows schools to serve non-whole-grain-rich products.⁶ Second, instead of requiring schools to meet a three-tier targeted timeline for sodium reduction in meals—the final reduction being met in 2022⁷—schools are deemed compliant with sodium reductions so long as they meet the first target from 2014.⁸ Finally, now schools may serve flavored 1% fat milk,⁹ discontinuing the requirement that flavored milk be fat-free.¹⁰

This Article will focus on arguing for a return to the original nutrient guidelines in place prior to the changes made by the current Secretary of

1. REMARKS BY THE PRESIDENT AND FIRST LADY AT THE SIGNING OF THE HEALTHY, HUNGER-FREE KIDS ACT, 2010 WL 5066794, at *1–2 [hereinafter REMARKS BY THE PRESIDENT & FIRST LADY].

2. *FACT SHEET: Healthy, Hunger-Free Kids Act School Meals Implementation Release No. 0098.14*, U.S. DEP’T OF AGRIC. (June 1, 2017), <https://www.fns.usda.gov/pressrelease/2014/009814>.

3. Ethan A. Bergman, et al., *School Lunch Before and After Implementation of the Healthy, Hunger-Free Kids Act*, 38 J. CHILD NUTRITION & MGMT. 1, 8 (2014), https://schoolnutrition.org/uploadedFiles/5_News_and_Publications/4_The_Journal_of_Child_Nutrition_and_Management/Fall_2014/SchoolLunchBeforeandAfterImplementationHealthyHungerFreeKidsAct.pdf.

4. U.S. Dep’t of Agric., Secretary Sonny Perdue, Proclamation Letter on USDA Commitment to School Meals (May 1, 2017) [hereinafter Perdue].

5. *Nutrition Standards for School Meals*, SCH. NUTRITION ASS’N, https://schoolnutrition.org/uploadedFiles/About_School_Meals/What_We_Do/Nutrition-Standards-for-School-Meals.pdf (last visited Jan. 26, 2018).

6. Perdue, *supra* note 4.

7. SCH. NUTRITION ASS’N, *supra* note 5.

8. Perdue, *supra* note 4.

9. *Id.*

10. SCH. NUTRITION ASS’N, *supra* note 5.

Agriculture. After providing a background of the Act in Section (I), this Article will argue that, moving forward, the changes made to the nutritional guidelines—and the apparent lack of concern for maintaining a strong position on children’s nutrition in schools—negatively impact the U.S. by posing (II) a public health risk, (III) an economic risk, and (IV) a national security problem.

I. HEALTHY, HUNGER-FREE KIDS ACT

The Act has numerous sections, but the sections relevant to this Article are the nutritional guidelines for school lunches. Recognizing that childhood obesity negatively affects the physical and mental health of children, the U.S. economy, and our military service, the Act works by implementing nutrition guidelines for school lunches to help make sure our nation’s future—the children—are provided with nutrient-dense lunches so they can compete with their peers anywhere in the world.¹¹ In other words, the Act strives to make sure children have the tools they need for success in school and in life.¹²

Oppositionists of the Act and supporters of the new changes argue the following: (A) the “regulations have proven to be burdensome and unworkable for schools to implement”; (B) the new regulations resulted in increased food waste and costs due to uneaten discarded foods;¹³ and (C) fewer students are participating in the school lunch programs.¹⁴

A. Burdensome and Unworkable Regulations

First, although there have been some challenges with implementation, “[S]chool meals are now healthier than ever and challenges are expected to resolve over time as school food service and students adjust to the changes.”¹⁵ In 2014, “93% of schools in the National School Lunch Program . . . met . . . nutritional standards” according to USDA data.¹⁶ This 14% increase since 2009–2010¹⁷ illustrates a successful adjustment to the guidelines. Further, regarding breakfast and lunch requirements, six in ten program directors reported only “few or no ongoing obstacles” meeting

11. REMARKS BY THE PRESIDENT & FIRST LADY, *supra* note 1, at *2-5.

12. REMARKS OF FIRST LADY MICHELLE OBAMA AT THE FIRST ANNIVERSARY OF *LET’S MOVE!* (Feb. 9, 2011).

13. Erin Mundahl, *GOP Congress Prepares to Roll Back School Lunch Programs*, INSIDESOURCES (Jan. 31, 2017), <http://www.insidesources.com/gop-congress-prepares-roll-back-school-lunch-changes/>.

14. Alexandra Sifferlin, *Healthier School Lunch Rules Are Working, Study Finds*, TIME (Jan. 4, 2016), <http://time.com/4163451/healthier-school-lunch-study/>.

15. *FACTS: Healthy, Hunger-Free Kids Act: A Healthy Recipe for School Nutrition*, AM. HEART ASS’N, https://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_473373.pdf (last visited Nov. 13, 2017).

16. *Id.*

17. *Id.*

breakfast requirements, and four in ten reported the same for lunch.¹⁸ What oppositionists must recognize is that change does not happen overnight, and as with all changes, critics must allow time for adjustment. If no such time is allowed, programs with tremendous potential to produce great outcomes, like those implemented as a result of the Act, may not have the opportunity to succeed and make a meaningful impact.

B. Increased Costs and Food Waste

Second, the extensive media coverage about the program's financial burdens are countered by a USDA analysis showing a \$200 million revenue gain since the new standards went into effect,¹⁹ and a study finding 84% of program directors saw rising or stable combined revenue in the previous year.²⁰ Further, many programs found success using different strategies to encourage students to eat healthier.²¹ For example, creative and fun games can "counter plate waste and increase fruit and vegetable consumption."²² Moreover, studies show the use of taste tests with students and the practice of redistributing uneaten, unopened foods are some of the most effective ways to decrease food waste.²³ However, only between 38%–44% of programs use strategies like these.²⁴ Additionally, other scholars have found "the new requirements . . . have not resulted in increased food waste."²⁵ Thus, this Article suggests portions of increased food waste could be offset by implementing creative games, redistribution of food, and taste testing, and it is the responsibility of programs directors, not the children, to do so. Accordingly, the failure to do so, and any corresponding food waste seen, is not properly attributed to the Act.

C. Declining Student Participation

Finally, contrary to reports about declining participation, in programs that utilized salad bars and where food was prepared from scratch, "[S]tudent participation rose or was unchanged from SY 2011-12 to 2014-15."²⁶ Decreased participation was seen primarily where commercially prepared foods were purchased or there were limited menu options²⁷ – again, all factors at the control of program directors. Additionally, declining participation in school lunch programs started in 2007 and continued

18. *School Meal Programs Innovate to Improve Student Nutrition*, PEW CHARITABLE TRUSTS (Dec. 7, 2016), <http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/school-meal-programs-innovate-to-improve-student-nutrition>.

19. AM. HEART ASS'N, *supra* note 15.

20. PEW CHARITABLE TRUSTS, *supra* note 18.

21. *Id.*

22. AM. HEART ASS'N, *supra* note 15.

23. PEW CHARITABLE TRUSTS, *supra* note 18.

24. *Id.*

25. Juliana F.W. Cohen, et al., *Impact of the New U.S. Department of Agriculture School Meal Standards on Food Selection, Consumption, and Waste*, 46 AM. J. PREVENTATIVE MEDICINE 388, 394 (Apr. 2014).

26. PEW CHARITABLE TRUSTS, *supra* note 18.

27. *Id.*

through the recession, before the Act went into effect in 2012.²⁸ Moreover, after implementation from 2012 to 2013, the School Nutrition Association found, in a study of Washington State Elementary schools, that the Act “had a positive effect on the nutrient makeup of NSLP meals, both selected and consumed.”²⁹

II. PUBLIC HEALTH RISK

Failure to keep in place the nutritional guidelines the Act established presents a public health risk to students now and as they mature into adulthood. This Section will detail the effects of each nutrient change the USDA authorized, and explain why the decision is harmful. After a short discussion of the current obesity and hunger issues in the U.S. in Section (A), the three nutrient changes are discussed. The changes are as follows: (B) adoption of less restrictive standards for whole grains; (C) postponement of further sodium restrictions; and (D) allowance to serve flavored, 1% fat milk.

A. Current Childhood Obesity/Overweight and Hunger Status in the U.S.

To highlight the current obesity epidemic and hunger status in the U.S., and to clarify why the original guidelines put in place by the Act are so important, consider the fact that approximately one child in every three children in America is considered to be overweight or obese.³⁰ Further, one child in five children currently experiences food-insecurity, which is defined as a lack of dependable nutritious food sources.³¹ Moreover, it is important to recognize that childhood obesity can occur in a child without adequate access to nutrient-dense foods.³² Unhealthy diets lacking nutritious food contribute to about 30% of the cases of obesity and overweight in children.³³ As such, school meals are critically important because they provide up to half of a student’s caloric intake each day.³⁴ Given that over 31 million children partake in the National School Lunch Program, schools have an inherent responsibility to provide healthy and nutritious meals to

28. AM. HEART ASS’N, *supra* note 15.

29. SCH. NUTRITION ASS’N, *supra* note 5.

30. Nancy Brown, *Conquering the Double Burden: Protecting Children from Obesity and Hunger*, HUFFINGTON POST (Dec. 18, 2015, 11:48 AM), <https://www.huffingtonpost.com/nancy-brown/conquering-the-double-bur b 8838488.html>.

31. *Id.*

32. *Id.* (“The face of food insecurity in our country is an overweight child without access to nutritious food.”).

33. Lindsey Haynes-Maslow & Jeffrey K. O’Hara, PhD, *Lessons from the Lunchroom: Childhood Obesity, School Lunch, and the Way to a Healthier Future*, UNION CONCERNED SCIENTISTS, <https://www.ucsusa.org/sites/default/files/attach/2015/02/lessons-from-the-lunchroom-report-ucs-2015.pdf> (last visited Jan. 26, 2018).

34. REMARKS BY THE PRESIDENT & FIRST LADY, *supra* note 1, at *1–2.

children and to teach healthy eating habits that will extend into adulthood.³⁵ Thus, the recent changes may pose irreversible effects to the long-term health of future children.

B. Adoption of Less Restrictive Standards for Whole Grains

The 2015–2020 Dietary Guidelines for Americans recommend that at least half of grains consumed are whole grains.³⁶ With the USDA's new changes, schools are no longer required to serve 51% whole grains in school lunches.³⁷ This change is problematic because whole grains are a rich source of fiber, minerals (iron, magnesium, and selenium), and B vitamins (folic acid, thiamin, riboflavin).³⁸

First, it is important to understand, at baseline, the difference between a whole and a refined grain. A whole grain kernel contains components of the entire grain: the endosperm, the germ, and the bran.³⁹ The bran is the outermost layer rich in fiber, B vitamins, antioxidants, phytochemicals, and minerals like iron, copper, zinc, and magnesium.⁴⁰ The germ—the part of the grain where growth occurs—has many healthy fats and antioxidants⁴¹ and the endosperm is dense in carbohydrates and only contains trace amounts of vitamins.⁴² As a comparison, non-whole grains, or refined grains, have been “milled,” and stripped of many nutrients, leaving the carbohydrate-dense endosperm.⁴³ Thus, refined grains have little to no fiber content with less than 50% of the B vitamins and approximately 10% of the vitamin E found in its whole grain counterpart.⁴⁴ Granted, while refined grains can be “enriched” and some nutrients can be added back in, it is not possible to add back in fiber and phytochemicals, which play a role in digestive health and may reduce chances of cancers, respectively.⁴⁵ The American Institute for Cancer Research emphasizes the role phytochemicals play in preventing DNA damage, reducing cancer cell growth rate, initiating cell death of potentially cancerous cells, and decreasing inflammation in the body that would otherwise propagate cancer growth.⁴⁶

35. Margo G. Wootan, *The Healthy, Hunger-Free Kids Act: One year Later*, 27.1 NASN SCH. NURSE 18, at 1 (Jan. 2012).

36. *High Blood Pressure*, CTR. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/bloodpressure/faqs.htm> (last visited Jan. 26, 2018).

37. Perdue, *supra* note 4.

38. *The Nutrition Source*, HARVARD SCH. PUB. HEALTH, <https://www.hsph.harvard.edu/nutritionsource/whole-grains/> (last visited Jan. 26, 2018).

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

43. HARVARD SCH. PUB. HEALTH, *supra* note 38.

44. *Id.*

45. *Id.*

46. *Phytochemicals: The Cancer Fighters in Your Foods*, AM. INST. CANCER RES., http://www.aicr.org/reduce-your-cancer-risk/diet/elements_phytochemicals.html?referrer=https://search.yahoo.com/ (last visited Jan. 26, 2018).

With a diet rich in whole grains, one's satiety is likely to be fulfilled for a longer period of time due to the fiber content within the bran.⁴⁷ Moreover, fiber has been found to assist in reducing the speed of starch breakdown into glucose, which in turn makes blood glucose levels more stable.⁴⁸ Thus, children who consume more fiber will not experience a sharp spike in blood sugar and feel a sugar high and crash like that felt after candy consumption. In turn, fiber content may play a role in preventing overeating, thereby mitigating the obesity epidemic.

Second, the equilibrium of blood sugar levels and possible improvement of insulin sensitivity maintained with whole grain consumption is an important factor in reducing the likelihood of children contracting type 2 diabetes.⁴⁹ Type 2 diabetes is a disease which was historically seen as only "adult-onset," but it is losing this reputation due to its increasing prevalence in children.⁵⁰ In normal levels of blood sugar, the body responds by releasing insulin into the bloodstream, signaling cells to uptake the glucose for use in cellular processes.⁵¹ However, type 2 diabetes occurs when blood sugar levels have been chronically high for a prolonged period of time and the body can no longer respond to these levels, thereby becoming "insulin resistant."⁵² By stabilizing blood sugar levels with whole grain consumption and recognizing the potential contribution of fiber to increasing insulin sensitivity, it may be possible to prophylactically combat or delay the onset of type 2 diabetes in the future generations of children and adults. Thus, keeping the original standards set forth by the Act can only aid this process.

Finally, in addition to lowering the likelihood of overeating, whole grains have been shown to have a positive health impact on cardiovascular disease, digestive health, and cancers.⁵³ For example, whole grains may lower cholesterol and triglyceride levels, both of which contribute to an overall lessened cardiovascular disease risk.⁵⁴ For instance, an average of two and a half servings per day (e.g. one serving = one slice bread) of whole grains is associated with a 21% reduction in cardiovascular disease—an umbrella term that includes heart attacks, artery problems, and stroke.⁵⁵ Additionally, the fiber in whole grains is important in reducing constipation, keeping stool soft, and lowering the risk of diverticulitis, a

47. HARVARD SCH. PUB. HEALTH, *supra* note 38.

48. *Id.*

49. *Id.*

50. Haynes-Maslow & O'Hara, PhD, *supra* note 33, at 2.

51. *Diabetes*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444> (last visited Jan. 26, 2018).

52. *Id.*

53. HARVARD SCH. PUB. HEALTH, *supra* note 38.

54. *Id.*

55. *Id.*

painful inflammation of the colon.⁵⁶ Moreover, there is a notable 21% cumulative reduced risk of colorectal cancer when eating a diet rich in whole grains.⁵⁷ Although these protective effects may mitigate potential disease pathologies, the likelihood of children showing, for example, symptoms of digestive problems or cardiovascular disease is low because these symptoms usually present themselves in adulthood. However, to reduce the chance of children entering adulthood with a higher chance of contracting these health problems, it is important to instill healthy eating habits at a young age. Although changes to children's health resulting from the original guidelines in the Act may not present themselves for many years, it is crucial to allow time for the Act to do what it was implemented to do: to improve the long-term health and well-being of children across the U.S.

C. Postponement of Further Sodium Restrictions

The Act resulted in a three-tiered sodium reduction criteria for schools to achieve over a period of approximately ten years, with reductions mandated in 2014, 2017, and 2022.⁵⁸ However, the new changes deem schools compliant if they meet the first sodium criterion from 2014.⁵⁹ Between each tier, there is anywhere from a 100 mg to 300 mg reduction of sodium for breakfast and lunch meals.⁶⁰ For example, in 2014, the sodium intake for school lunches was set at 1,420 mg for ages nine through twelve, to be reduced to 740 mg by 2022.⁶¹ Furthermore, sodium intake in lunch meals for ages K through five was to decrease from 1,230 mg to 640 mg over the tiered protocol.⁶² Thus, both of these reductions would change the initial sodium intake from 2014 to 2022 by almost half. Given that the USDA recommends less than or equal to 2,300 mg of sodium per day,⁶³ reducing the total sodium intake for one meal to a value less than 1,000 mg as the Act would have done is significant and would mitigate excess sodium intake.

The Center for Disease Control found that 90% of children aged six through eighteen eat excess amounts of sodium daily, and one in six children aged eight through seventeen have raised blood pressure.⁶⁴ Although

56. *Id.*

57. *Id.*

58. *Sodium Targets in the National School Lunch Program*, SCH. NUTRITION ASS'N, https://schoolnutrition.org/uploadedFiles/5_News_and_Publications/1_News/2015/06_June/Sodium%20Final%20White%20Paper%206_8_15.pdf (last visited Jan. 26, 2018).

59. *Id.* at 1.

60. *Id.* at 3.

61. *Id.*

62. *Id.*

63. SCH. NUTRITION ASS'N, *supra* note 58, at 4.

64. *Reducing Sodium in Children's Diets*, CTR. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vitalsigns/children-sodium/index.html> (last visited Jan. 26, 2018).

evidence for sodium reduction in children and high blood pressure is limited and one study even found no blood pressure difference between a diet of 3,450 mg/day and 1,725 mg/day, there are some studies showing an association between sodium intake and blood pressure increase.⁶⁵ For example, the National Health and Examination Study among U.S. children and adolescents found that blood pressure increased by 1.0 mm Hg systolic blood pressure with an additional 1,000 mg of sodium intake.⁶⁶

Further, although factors such as weight reduction in children may play a more substantial role in blood pressure reduction as compared to sodium intake, it is important to view this element of diet as a collective and consider its potential health benefit in the future.⁶⁷ Many studies have found an association in adults between excess sodium intake and elevated blood pressure.⁶⁸ For example, in the Dietary Approaches to Stop Hypertension (DASH) diet, rich in vegetables and fruits, individuals with and without already diagnosed high blood pressure were assigned to either associated low, intermediate, or high levels of sodium intake.⁶⁹ Participants with hypertension on the high sodium level increased their systolic blood pressure by 11.5 mm Hg and participants without hypertension at baseline experienced an increased in 7.1 mm Hg systolic.⁷⁰ By providing lower sodium foods at a young age, schools can play a role in combating high blood pressure into adulthood and instill healthy eating habits that will last a lifetime from a young age.

D. Allowance to Serve Flavored, 1% Fat Milk

Allowing schools to serve 1% fat-flavored milk in lunches instead of fat-free is a lesser public health risk when compared to the changes to whole grain consumption and sodium intake. However, an argument exists for the unnecessary lifetime cumulative added fat and cholesterol to children. To illustrate the nutrition differences in fat-free versus 1% fat-flavored milk, TruMoo Milk is used as an example.

One cup of TruMoo 1% fat chocolate milk contains 140 calories, 2.5 g fat, 15 mg cholesterol, 20 g carbohydrates, and 8 g protein, whereas one cup of TruMoo fat-free chocolate milk contains 0 g fat, 5 mg cholesterol, 20 g carbohydrates, and 8 g protein.⁷¹ Although, the carbohydrate and protein totals are equal, a difference exists in the calories, fat, and cholesterol content. Limiting cholesterol and fat intake in childhood may be beneficial

65. SCH. NUTRITION ASS'N, *supra* note 58, at 2.

66. *See id.*

67. *Id.* at 2.

68. *See* Svetkey LP, et. al., *Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet*. *DASH-Sodium Collaborative Research Group*, 344 *NEW ENGL. J. MED.* 3 (Jan. 2001).

69. *Id.*

70. *Id.*

71. *Products*, TRUMOO, <https://trumoo.com/products/> (last visited Jan. 26, 2018).

to prevent unwanted weight gain in addition to lowering the risk for heart disease into adulthood.⁷²

III. ECONOMIC RISK

In addition to a public health risk, the new changes made regarding nutritional guidelines in school lunches pose an economic threat to the U.S. Those in favor of the new changes argue that mandating whole grain consumption, reducing sodium intake, and limiting milk selection in schools could be costly;⁷³ however, the costs associated with poor health may be greater.

Obesity-related healthcare costs the U.S. an estimated \$210 billion annually, which equates to 16.5% of the *total* healthcare costs of the nation.⁷⁴ Further, these costs are paid for via public health insurance programs, military health insurance programs, and notably higher premiums on private health insurance.⁷⁵ Thus, it is not just the obese or overweight patient feeling the consequences of their bad health but also the taxpayers.

First, the Global Health Institute of Duke estimated the direct medical costs of childhood obesity, finding that between \$12,660 and \$19,000 additional lifetime medical costs were attributed to a prospective ten-year-old obese child relative to a ten-year-old normal weight child.⁷⁶ Moreover, extrapolating into the future based on the number of ten-year-olds currently residing in the U.S., lifetime medical costs fell between \$9.4 and \$14 billion for that age cohort alone.⁷⁷ To put that into perspective, \$9.4 billion is sixty-two times the approximate funding for the nationwide Fresh Fruit and Vegetable Program from 2012 and 2013.⁷⁸

Second, another way to view the benefits of reducing obesity is to look at the costs in terms of education. For instance, given the average yearly estimate for college is \$16,930, reducing one case of childhood obesity in the U.S. would fund more than one year of a college.⁷⁹

Finally, in terms of the effect of high blood pressure on our nation, the Center for Disease Control found that 75 million American adults—or approximately every one in three adults—have hypertension and are at risk for heart disease and stroke.⁸⁰ Furthermore, in the U.S. in 2011 the estimated cost attributed to healthcare services, medications, and missed days

72. *Cholesterol in Childhood*, AM. ACAD. OF PEDIATRICS, <http://pediatrics.aappublications.org/content/101/1/141> (last visited Jan. 26, 2018).

73. Mundahl, *supra* note 13.

74. Haynes-Maslow & O'Hara, PhD, *supra* note 33, at 7.

75. *Id.* at 2.

76. Eric Andrew Finkelstein, et al., *Lifetime Direct Medical Costs of Childhood Obesity*, 113 J. AM. ACAD. PEDIATRICS 854 (2014).

77. *Id.* at 860.

78. *Id.*

79. *Id.*

80. CTR. DISEASE CONTROL & PREVENTION, *supra* note 36. The American Heart Association and the American College of Cardiology recently reported upcoming changes to guidelines for high

of work due to hypertension was \$46 billion.⁸¹ Advocating and mandating nutrition guidelines in children's school meals may help to reduce economic costs in the future.

IV. NATIONAL SECURITY PROBLEM

Abandoning efforts to both encourage healthy eating and impose strict nutritional standards for school lunches poses not only a public health and economic risk but also a national security problem because many young adults are too overweight and out of shape to serve in the military.⁸² For illustration, in 2011 during a speech regarding her *Let's Move!* campaign, Michelle Obama said the following:

[N]early 27 percent of 17-24 year-olds are too overweight to serve in our military. . . . [During a visit to an Army training facility in Fort Jackson in South Carolina, she learned] the recruits are overweight, they're out of shape, and they're far more likely to injure themselves in basic training.⁸³

Consider the following statement from *Retired Major General Tracy Strevey, Jr., MD, the former Commander of the U.S. Army Health Services Command*:

We all know that obesity rates among children have increased dramatically in recent decades. This is not only a serious health concern for these children, it has also affected who can join the military: more than one in five young Americans is too overweight to enlist; and being overweight or obese is the leading medical reason why young adults cannot join the military...We are at an important juncture. Schools are capable of serving healthier foods and the vast majority are already doing so. Congress should resist efforts to derail continued implementation of science-based nutrition guidelines for school meals and snacks. Together, we can make sure that America's child obesity crisis does not become a national security crisis.⁸⁴

Weight restrictions have been a part of military culture since 1887 with the purpose of obtaining armies that are healthy and can take on the

blood pressure. These new changes will encompass a larger number of individuals. For example, the cutoff for high blood pressure was reduced to 130/80 mm Hg from 140/90 mm Hg due to an augmented risk for cardiovascular disease. Susan Scutti, *Nearly half of Americans now have high blood pressure, based on new guidelines*, CNN (Nov. 14, 2017), <http://www.cnn.com/2017/11/13/health/new-blood-pressure-guidelines/index.html>.

81. CTR. DISEASE CONTROL & PREVENTION, *supra* note 36.

82. REMARKS OF FIRST LADY MICHELLE OBAMA, *supra* note 12.

83. *Id.*

84. *Support for Healthy Meals Standards Continue to Grow*, U.S. DEP'T OF AGRIC. (June 1, 2017), <https://www.fns.usda.gov/pressrelease/2014/012714> (quoting *Retired Major General Tracy Strevey, Jr., MD, former Commander of U.S. Army Health Services Command*).

demands of war.⁸⁵ However, these weight restrictions are becoming increasingly more difficult to meet. For example, the rate of seventeen- to twenty-year-olds who were overweight and ineligible for enlistment between 1988 to 1994, depending on the branch, was 13% to 18% for men and 17% to 43% for women, compared to 20% to 26% of seventeen- to nineteen-year-old men and similar numbers to the above percentages for women in 2007.⁸⁶ This, illustrates a significant increase in the rate for men. Moreover, in the last decade, 17.9% to 54.4% of non-prior-service civilian men, and 20.8% to 54.9% of non-prior-service civilian women, ages seventeen to forty-two, were not eligible for enlistment because they exceeded weight limits.⁸⁷ This is significant because about “90% of non-prior service applicants for enlistment are 17 to 24 years of age.”⁸⁸

The increase in obesity seen in the U.S. today may pose many different threats to the U.S. military.⁸⁹ First, it may be more difficult to recruit without lessening weight restrictions because the recruit target group sizes with eligible applicants are shrinking.⁹⁰ Second, it may become increasingly difficult to obtain a culturally and ethnically diverse military because the prevalence of obesity and overweight varies depending on race.⁹¹ Third, since the prevalence of ineligible individuals as determined by weight also varies by branch, some branches may find it more difficult than other branches to recruit physically qualified applicants.⁹² Finally, although the maximum age for applicants was recently increased, the effort has proven less effective than desired because about “half of adults in the upper age rangers are overweight for enlistment.”⁹³

These effects are being felt across professions. For example, a study of emergency responders found that, out of 380 recruits, 43.8% were overweight and 33.0% were obese.⁹⁴ Furthermore, due to the nature of work that emergency responders encounter regularly, any health condition impacting a responder also carries a risk of compromising the safety of colleagues and the community.⁹⁵ Likewise, a health condition impacting members of the military could jeopardize their safety, the safety of their peers, and the safety of those around them.

85. Col Grover K. Yamane, *Obesity in Civilian Adults: Potential Impact on Eligibility for U.S. Military Enlistment*, 172 MILITARY MEDICINE 1160 (Nov. 2007).

86. *Id.* at 1162.

87. *Id.* (noting numbers are dependent on the specific branch and age range).

88. *Id.*

89. Note, this is not an exhaustive list.

90. Yamane, *supra* note 33, at 1163–64.

91. *Id.*

92. *Id.*

93. *Id.*

94. Antonios J. Tsismenakis, et al., *The Obesity Epidemic and Future Emergency Responders*, 17 OBESITY 1648 (Aug. 2009).

95. *Id.*

Finally, recall the military recruits referenced above in Michelle Obama's speech. These students were born when public schools started cutting physical education and sports programs.⁹⁶ This suggests the lack of effort to encourage physical fitness may have partially enabled the rise in obese and overweight citizens. Accordingly, given the lasting effects seen today from abandoning a strong position on physical education in schools, it is apparent that abandoning strict nutritional guidelines may have a similarly lasting adverse effect, not only on military recruits but on youth as a whole. As such, it is imperative that the U.S. implement programs and laws that aid in the fight against obesity in young people.

V. CONCLUSION

Reducing sodium intake, serving only fat-free-flavored milk, and increasing the requirement of whole grains in schools to 51% were aspects of the Act that intended to combat childhood obesity and childhood hunger and to spread nutritional knowledge to our future generations of children to make them more physically and mentally prepared to succeed. A large component of the argument against the recent changes implemented by the USDA derives not only from the current risks for childhood obesity and nutritional deficits but also from the health risk to these children in adulthood. Given that obese children and teens are more likely to remain obese into adulthood, it is critical to implement dietary changes early on so healthy habits are formed.⁹⁷

Accordingly, our children and our country's future are already at risk because of the prevalence of obesity and overweight Americans. Thus, pieces of legislation, like the Healthy Hunger-Free Kids Act, are exceptionally important to mitigate the current and future effects of obesity and poor health felt across the nation.

Jenny Nelson & Jessica Nelson***

96. REMARKS OF FIRST LADY MICHELLE OBAMA, *supra* note 12.

97. Finkelstein et al., *supra* note 76, at 855.

* Jenny Nelson is an Associate Editor for the *Denver Law Review* and a December 2017 Juris Doctor Candidate at the University of Denver Sturm College of Law.

** Jessica Nelson holds a Bachelor of Science in Human Biology and a minor in Nutrition and Health Promotion from the University of Southern California.