

The State of Obesity:

**BETTER POLICIES FOR
A HEALTHIER AMERICA**

2024

SPECIAL FEATURE:

The Food Environment and Systems



Acknowledgments

Trust for America's Health is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority.

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View this report online at [tfah.org/stateofobesity2024](https://www.tfah.org/stateofobesity2024).

The State of Obesity

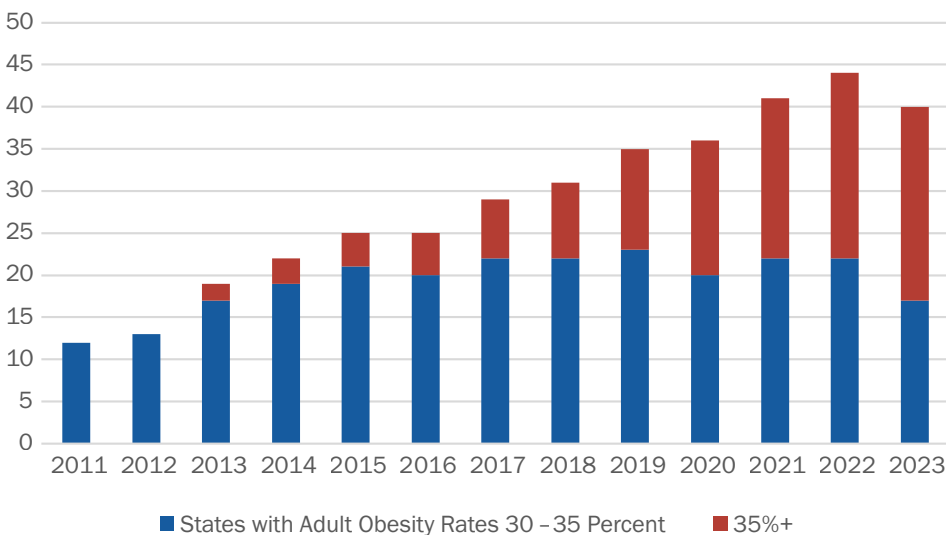
LIST OF ACRONYMS AND ABBREVIATIONS

Addressing Conditions to Improve Population Health program	ACTion	National Health and Nutrition Examination Survey	NHANES
American Indian and Alaska Native	AI/AN	National School Lunch Program	NSLP
Behavioral Risk Factor Surveillance System	BRFSS	Native Hawaiian and other Pacific Islander	NHOPI
Body Mass Index	BMI	New Markets Tax Credit	NMTC
Centers for Disease Control and Prevention	CDC	President’s Council on Sports, Fitness & Nutrition	PCSFN
Centers for Medicare & Medicaid Services	CMS	Preventive Health and Health Services Block Grant	PHHS
Child and Adult Care Food Program	CACFP	Racial and Ethnic Approaches to Community Health program	REACH
Child Tax Credit	CTC	Safe Routes to School	SRTS
Community Eligibility Provision	CEP	School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students	SBP
Community Health Needs Assessment	CHNA	School Breakfast Program	SBP
Dietary Guidelines Advisory Committee	DGAC	SNAP EBT Modernization Technical Assistance Center	SEMTAC
Division of Nutrition, Physical Activity, and Obesity	DNPAO	SNAP-Education	SNAP-Ed
Early Care and Education	ECE	Social Determinants of Health	SDOH
Electronic Benefits Transfer	EBT	Special Milk Program	SMP
Federal Poverty Level	FPL	Special Supplemental Nutrition Program for Women, Infants, and Children	WIC
Fiscal Year	FY	State Physical Activity and Nutrition	SPAN
Food is Medicine	FIM	Summer Electronic Benefits Transfer for Children	SEMTAC
Fresh Fruit and Vegetable Program	FFVP	SUN Bucks Summer Food Service Program	SFSP
Front-of-package	FOP	Supplemental Nutrition Assistance Program	SNAP
Fruit and Vegetable Cash Value Voucher	CVV	Trust for America’s Health	TFAH
Glucagon-like Peptide-1	GLP-1	U.S. Department of Agriculture	USDA
Good Health and Wellness in Indian Country program	GHWIC	U.S. Department of Health and Human Services	HHS
Gus Schumacher Nutrition Incentive Program	GusNIP	U.S. Department of Transportation	DOT
Health-Related Social Needs	HRSN	U.S. Food and Drug Administration	FDA
Healthy Food Financing Initiative	HFFI	U.S. Preventive Services Task Force	USPSTF
High Obesity Program	HOP	USDA’s Food and Nutrition Service	FNS
In Lieu of Services	ILOS	World Health Organization	WHO
National Diabetes Prevention Program	National DPP	Youth Risk Behavior Survey	YRBS

Introduction

Obesity in the United States is a serious and growing public health threat—with rising rates across states, ages, sexes, racial/ethnic groups, and income over decades.^{1,2,3,4,5,6} The causes and drivers of obesity are complex and multifactorial, and include national nutrition and dietary trends as well as social and economic conditions that influence the health and well-being of Americans (e.g., limited access to affordable, nutritious food and physical activity, poverty, and discrimination).^{7,8,9} New 2023 state-level data from the Behavioral Risk Factor Surveillance System (BRFSS) show considerable variation in state-level adult obesity rates in 2023 and in state-level trends from 2022 to 2023. Long-term trends continue to show increasing rates of adult obesity across the country (see Figure 1).^{10,11}

FIGURE 1: Number of States with Adult Obesity Rates At 30 Percent or Higher, 2011–2023



Source: TFAH analysis of BRFSS data¹²

Note: Data were not available for two states in 2023, one state in 2021, and one state in 2019.

In addition to obesity, diabetes rates have been increasing—along with other diet-related cardiovascular diseases and cancers—and are among the leading causes of death each year in the United States.^{13,14} Nutrition and diet quality are linked to many chronic diseases and overall mortality, yet in recent decades, there have been increases in ultra-processed food consumption and decreases in fruit and vegetable consumption.^{15,16,17} In this year’s State of Obesity report, Trust for America’s Health (TFAH) presents a special feature that explores these consumption changes and the larger food environment and systems in the

United States that shape Americans’ dietary intake every day—including the national food supply, variation in local food systems and access by community, the influence of advertising, and the effects of policy and regulatory efforts, as well as future opportunities for policymakers to consider.

In addition to the special feature, this report includes a section that reviews the latest data available on adult and childhood obesity rates (see page 21), a section that examines key current programs and emerging policies (page 34), and, finally, a section that outlines recommended policy actions (page 67).

FAST FACTS ABOUT OBESITY IN THE UNITED STATES

National Adult Obesity Rate, 2017–2020: **41.9 percent**

Change in Adult Obesity Rate from 1999–2000 to 2017–2020: **37 percent increase**

National Youth Obesity Rate, 2017–2020: **19.7 percent**

Change in Youth Obesity Rate from 1999–2000 to 2017–2020: **42 percent increase**

Source: NHANES⁴⁶

Note: 2017–2020 is latest available data.

Number of States with Adult Obesity Rates Above 35 Percent, 2023: **23**

Number of States with Adult Obesity Rates Above 35 Percent, 2013: **2**

Source: BRFSS.⁴⁷

WHY DOES TFAH FOCUS ON OBESITY?

Obesity and other diet-related chronic diseases have been increasing across the United States for decades. They pose a serious public health threat as obesity is associated with a range of physical and mental health conditions at the population-level, higher mortality, as well as higher healthcare costs and productivity losses.^{18,19,20}

(1) Obesity increases the risk of a range of diseases and conditions for adults—including higher rates of type 2 diabetes, high blood pressure, heart disease, stroke, COVID-19, arthritis, depression, sleep apnea, liver disease, kidney disease, gallbladder disease, pregnancy complications, and many types of cancer—and an overall risk of higher mortality.^{21,22,23,24,25,26,27,28,29,30,31,32,33,34}

(2) Children with obesity are also at greater risk for certain diseases, like type 2 diabetes, high blood pressure, and depression, and a child with obesity is more likely to have obesity as an adult.^{35,36,37,38,39} Children with obesity also have a higher risk of hospitalization and severe illness from COVID-19.⁴⁰

(3) Individuals with obesity have higher medical costs than lower-weight individuals. A 2021 study found that obesity accounted for \$170 billion in higher medical costs annually in the United States.⁴¹ This includes billions in extra costs to the Medicare and Medicaid programs.^{42,43} Indirect, or nonmedical, costs from obesity also run into the billions due to missed time at school and work, lower productivity, premature mortality, and increased transportation costs.^{44,45}

SUMMARY OF 2024 STATE OF OBESITY RECOMMENDATIONS

TFAH offers recommendations for federal, state, and local policymakers and other stakeholders each year. Our goal—ensuring that every community can support healthy lifestyles for all—requires a systems-level approach, including public policy changes across key sectors to ensure healthy choices are available and easy for everyone. A systems approach includes reducing longstanding structural and historic inequities, targeting obesity prevention programs to communities with the highest needs, and scaling and increasing evidence-based initiatives that create the healthy community environments to support optimal health and promote healthy behaviors and outcomes.

See below for a summary of TFAH's recommendations; the full list of recommendations begins on page 67.

1. Advance health equity by strategically dedicating federal resources to efforts that reduce obesity-related disparities and related conditions by:

- Increasing funding for Centers for Disease Control and Prevention (CDC) chronic disease and obesity prevention programs, including State Physical Activity and Nutrition, Racial and Ethnic Approaches to Community Health, and Healthy Tribes;
- Expanding the Social Determinants of Health program at CDC to support multisector collaborations to address upstream drivers of chronic disease;
- Instituting economic policies that reduce poverty at a population level;
- Prioritizing health equity in planning and decision-making at federal agencies; and
- Adapting federal grantmaking practices to ensure that the community-based organizations that are best able to conduct obesity prevention activities can navigate federal funding mechanisms.

2. Decrease food and nutrition insecurity while improving nutritional quality of available foods by:

- Guaranteeing the Healthy School Meals for All program and, in the interim, encouraging Community Eligibility Provision participation;
- Maintaining the progress of the final 2024 school nutrition meal standards, and working to fully align them with science-based recommendations;
- Maintaining eligibility, increasing the value of benefits, and ensuring there are no new participation barriers in the Supplemental Nutrition Assistance Program (SNAP);
- Improving diet quality in SNAP through voluntary pilot programs, and supporting programs that promote and incentivize healthy eating, like SNAP-Ed and the Gus Schumacher Nutrition Incentive Program;
- Expanding access to the Special Supplemental Nutrition Program for Women, Infants, and Children for young children and postpartum women, and ensuring robust funding for the expanded fruit and vegetable benefit increase;
- Creating a mandatory front-of-package label for packaged foods to help consumers make informed choices;
- Bolstering the Child and Adult Care Food Program by allowing a third meal service option, increasing reimbursements, simplifying administration, and continuing funding for nutrition and wellness education;
- Expanding support for programs that promote maternal and child health, including breastfeeding support;
- Improving the nutrition quality of the food that government agencies provide by uniformly implementing the Food Service Guidelines for Federal Facilities;

- Incentivizing healthy food options, like adding healthful corner stores, and supporting community gardens and farmers' markets through community design; and
- Increasing outreach to eligible families to apply for school meals and other nutrition assistance programs.

3. Change the marketing and pricing strategies that lead to health disparities by:

- Closing tax loopholes and eliminating business cost deductions for advertising of unhealthy food and beverages to children on television, online, and places frequented by children;
- Discouraging unhealthy food and drink options by enacting sugar-sweetened beverage taxes—and using the revenue to reduce health and socioeconomic disparities;
- Incorporating strategies into local wellness policies that reduce unhealthy food and beverage marketing and advertising to children and adolescents, like by prohibiting coupons, sales, and advertising around schools; and
- Studying the impacts of food marketing in the digital space on young children.

4. Make physical activity and the built environment safer and more accessible for all by:

- Increasing federal education funding to support health and physical education, as well as programs that promote social-emotional learning and improve health outcomes for children;

- Codifying and funding the update of the Physical Activity Guidelines for Americans every 10 years;
- Boosting funding for active transportation projects like pedestrian and biking infrastructure and recreational trails in addition to adding flexibilities and increasing technical assistance to ensure all communities are able to access funding;
- Making physical activity safer by making Safe Routes to Schools, Vision Zero, Complete Streets, and non-infrastructure projects eligible under the Highway Safety Improvement Program;
- Identifying innovative methods for conducting physical education and prioritizing physical activity during schooltime;
- Working locally to make community spaces more conducive and safer for physical activity, active transportation, and outdoor play;
- Adopting and implementing Complete Streets principles; and
- Encouraging outdoor play and activity for children via state and federal programs and additional park development for communities most in need.

5. Work with the healthcare system to close disparities and gaps in clinic-to-community settings by:

- Increasing access to health insurance coverage by expanding Medicaid and making marketplace coverage even more affordable;

- Clarifying to health insurers that obesity-related preventive healthcare services must be covered with no patient cost-sharing like all other grade A or B U.S. Preventive Services Task Force recommendations as required by current law, and ensuring continued free preventive coverage if legal challenges alter the current requirements;
- Expanding the capacity of healthcare providers and payers to screen and refer individuals to social services and care coordination, to sufficiently reimburse and increase capacity for social services, and to better integrate social-needs data into medical records;
- Re-implementing CDC's Childhood Obesity Research Demonstration program to inform how to translate U.S. Preventive Services Task Force recommendations into lifestyle and clinical interventions;
- Addressing root causes of health disparities by enacting the Health Equity and Accountability Act;
- Requiring Medicare and Medicaid to cover obesity-related services, such as obesity and nutritional counseling and treatments, and providing additional funding to offer these services;
- Prioritizing social and structural determinants of health in communities with high levels of obesity through community-directed goals and strategies, as well as evidence-based programs; and
- Enabling Medicaid waivers to allow community-based organizations to be reimbursed for chronic disease prevention activities, to further incentivize cross-sector collaboration.

WHAT IS OBESITY AND BMI?

Public health and healthcare sectors define “obesity” as a disease where an individual’s body fat and body-fat distribution exceed the level considered healthy.^{48,49} Body mass index (BMI) is a metric often used as a proxy for body fat because it is correlated with cardiometabolic risk, and it is simple and inexpensive to determine—no invasive tests, specialized equipment, or prior diagnoses required—and thus more universally available. BMI is a useful screening measure at the individual level to help clinicians decide which patients need additional assessment for chronic disease, and a useful population health measure to assess the distribution of BMI in populations so that resources can be targeted to certain geographic areas, groups, or others disproportionately affected by low or high weight for health.⁵⁰

Using BMI as a measure of obesity has several important considerations. First, the formula for calculating BMI as originally designed is not representative of all peoples.⁵¹ Secondly, BMI does not perfectly correlate with body fat—for example, muscular individuals often have lower body fat than their BMI would suggest—or risk for chronic disease; though BMI does correlate as well or better than other noninvasive, widely available measures.⁵² For individuals, a more holistic understanding of family/personal history, lifestyle factors, body fat, and body fat distribution are important to assessing cardiometabolic risk. On a population level, the risk that occurs at different BMIs vary by sex and race/ethnicity. For example, certain populations of Asian Americans have higher risks of cardiometabolic diseases at lower BMIs, and Black Americans have lower risks at higher BMIs. Some researchers have suggested adjusting BMI thresholds to estimate cardiometabolic risks more accurately in different populations.⁵³

The use of BMI by the public health and healthcare sectors has been a recent topic of discussion—including a focus on its use as a diagnostic measure in the medical setting, as well as its historic, discriminatory origins and modern connection with weight-based stigma.^{54,55} In June 2023, the American Medical Association House of Delegates voted to adopt a new policy that outlines the limitations of BMI as an individual-level metric,

supports additional education for physicians around BMI, and recommends BMI be used in conjunction with other measures in a clinical setting.⁵⁶

BMI is calculated by dividing a person’s weight (in kilograms) by their height (in meters) squared. The BMI formula for measurements in pounds and inches is:

$$\text{BMI} = \left(\frac{\text{Weight in pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$$

For adults, BMI is associated with the following weight classifications:

BMI LEVELS FOR ADULTS AGES 20 AND OVER	
BMI Level	Weight Classification
Below 18.5	Underweight
18.5 to < 25	Healthy weight
25 to < 30	Overweight
30 and above	Obesity
40 and above	Severe Obesity

Medical professionals measure childhood obesity differently, comparing a child’s BMI with children of the same age and sex in a reference population that accounts for typical changes during growth and development. A child’s BMI is expressed as a percentile relative to children from the reference population of the same age and sex based on growth charts developed by CDC using nationally representative height and weight data from American children from 1963 to 1965 and from 1988 to 1994.⁵⁷

BMI LEVELS FOR CHILDREN AGES 2-19	
BMI Level	Weight Classification
Below 5th percentile	Underweight
5th to <85th percentile	Healthy weight
85th to < 95th percentile	Overweight
95th percentile and greater	Obesity
120 percent of the 95th percentile or greater OR a BMI of 35 or above	Severe Obesity

The State of Obesity

SPECIAL FEATURE: The Food Environment and Systems

Nutrition and diet quality are essential components of a healthy lifestyle, and healthy eating (e.g., consuming more fruits and vegetables) is associated with lower rates of obesity, other chronic diseases, cancers, and mortality.^{58,59,60,61,62,63,64}

The food that people eat depends on their surrounding food environment—defined by United Nations Committee on World Food Security as “the physical, economic, political and socio-cultural contexts in which consumers engage with the food system to make their decisions about acquiring, preparing and consuming food.”⁶⁵ In other words, consumption patterns are influenced systematically by a wide range of factors—like availability, accessibility, affordability, palatability, and desirability—which are, in turn, shaped by a variety of local, state, federal, and international factors. This section looks at several components that affect food consumption patterns in the United States: the changing national food supply, variation in local food systems and access within communities, the influence of advertising and other commercial determinants of health, and the effects of policy and regulatory efforts, as well as opportunities for policymakers to make the food environment healthier and more conducive to nutritious eating. There are many additional factors that affect food availability and costs—like local food production and farming, agricultural subsidies, climate change impacts, and supply-chain disruptions—beyond the scope of this special feature.

A. CHANGING FOOD SUPPLY AND ULTRA-PROCESSED FOODS

There have been problematic changes in the U.S. diet over the last few decades, with more consumption of food made away from home, reduced consumption of minimally processed and unprocessed foods, and increased consumption of ultra-processed foods, which have little intact natural ingredients but are lower cost, readily accessible, convenient, preserved for extended shelf life, and hyper-palatable.^{66,67,68,69,70,71,72,73} A 2023 study estimated that almost three-quarters of the food supply in the United States was ultra-processed.⁷⁴

Over the past decade, there has been a growing body of evidence about the connection between the consumption of ultra-processed foods and a variety of adverse health outcomes—including an increased risk of obesity, overweight, and abdominal obesity; type 2 diabetes; overall cancer risk and breast cancer risks; cardiovascular disease; anxiety and other mental disorders; and overall mortality.^{75,76,77,78,79,80} The evidence includes meta-analyses combining findings from multiple studies and dose-response evidence (i.e., higher ultra-processed food consumption corresponds to worse health outcomes), both of which point toward a causal relationship.^{81,82,83,84} A recent British Medical Journal meta-analysis also found that within the group of ultra-processed foods, some may be worse than others, with especially strong associations between higher mortality and consumption of ultra-processed meat, poultry, and seafood.⁸⁵

Other studies provide insights into how ultra-processed foods may affect health by looking at how ultra-processed foods change nutrition and consumption

habits within daily life. For example, several studies find consumption of ultra-processed foods are linked with lower nutritional quality. A 2021 meta-analysis found that higher ultra-processed food consumption correlates with lower consumption of unprocessed (e.g., fruit and vegetables) and less-processed foods and worse nutritional quality of diet, including “an increase in free sugars, total fats, and saturated fats, as well as a decrease in fiber, protein, potassium, zinc, and magnesium, and vitamins A, C, D, E, B12, and niacin.”⁸⁶ Another study found that ultra-processed foods were responsible for 90 percent of added sugar calories consumed.⁸⁷

Additionally, a randomized controlled study from researchers at the National Institutes of Health (NIH) matched nutritional profiles for two diets (ultra-processed and unprocessed) and found immediate changes in consumption habits and diet quality among participants. The participants placed on the ultra-processed diet ate about 500 additional calories per day compared with those on the unprocessed diet. Participants on the ultra-processed diet also gained an average of 0.9 pounds after two weeks; by contrast, participants on the unprocessed diet lost an average of 0.9 pounds after two weeks.⁸⁸ The study author notes: “Though we examined a small group, results from this tightly controlled experiment showed a clear and consistent difference between the two diets. ... This is the first study to demonstrate causality—that ultra-processed foods cause people to eat too many calories and gain weight.”⁸⁹

B. LOCAL FOOD SYSTEMS AND COMMUNITY ACCESS

Eating healthy depends on being able to get healthy foods near home, as well as at workplaces, schools, childcare, and other care settings. Having healthy food at home depends on availability, accessibility, and affordability in local communities as well as on individual/family circumstances.

Local availability of a variety of healthy foods that meet the preferences and needs of local shoppers—including items like healthy prepared foods, ready-to-eat fruit and vegetables, and culturally appropriate foods—is a critical starting point to healthy eating, whether it takes the form of a full-service grocery store, farmers' market, and/or other well-stocked store. Not all Americans have equal availability of healthy foods locally. Longstanding societal challenges and equity issues, like structural racism and poverty, shape community context and available choices around healthy food.^{90,91} For decades, research has found lower income areas and areas with more Black residents have fewer grocery stores and less healthy food access.⁹² Rural residents also experience some unique challenges, including areas with extremely limited food retailers in local areas. (See page 34 for more on federal programs aimed at increasing access to healthy food in under-resourced areas.)

Additionally, store or market accessibility—that is, if the store or market is easy to get to (e.g., close to shoppers, accessible via active or public transportation, etc.) and has convenient hours—is important. For

example, if a farmers' market is the main source of quality, varied, or affordable fresh fruits and vegetables in a neighborhood but is only open once a week and not year-round, it may not actually be accessible depending on someone's work, school, or childcare schedule. (See page 53 for more on the importance of the built environment and active transportation.)

Finally, affordability of healthy foods can be a major barrier for many Americans. Healthy foods are generally more expensive, and research has found that individuals with lower incomes tend to eat a less nutritious diet due to the higher cost.^{93,94,95,96} In 2022, 12.8 percent—or 17 million—of U.S. households were food insecure (i.e., not having enough food for an active, healthy life for all household members).⁹⁷ Some groups are more likely to have food insecurity than others, including households with children (17.3 percent food insecure), Black households (22 percent food insecure), and Hispanic households (21 percent food insecure) in 2022.⁹⁸ Food insecurity also varies by urbanization, with large cities (15.3 percent food insecure) and rural areas (14.7 percent food insecure) having higher rates of food insecurity compared with suburban areas (10.5 percent food insecure).⁹⁹

Increases in food prices in the last few years—due to inflation, food-chain supply, and other causes—further underscores the importance of affordability of foods and the critical role of safety-net food and nutrition programs, like the Supplemental

Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), school meals, and food banks and pantries.^{100,101} Ensuring these programs support healthy eating by providing nutritious options and/or providing sufficient benefits to enable healthy purchases is also key. For example, in 2021, the U.S. Department of Agriculture (USDA) modernized the Thrifty Food Plan—which estimates the cost of a healthy diet and is used to calculate SNAP benefits—to better reflect current food costs and eating habits.¹⁰² As a result, the average SNAP benefit increased by 21 percent beginning in October 2021.¹⁰³ Prior to these changes, a 2021 survey found that 61 percent of SNAP recipients said the cost of nutritious foods was a barrier to eating a healthy diet.¹⁰⁴ Evaluations of the effects of the Thrifty Food Plan adjustment are ongoing, with early findings suggesting the plan may have helped prevent higher food insecurity related to recent inflation.¹⁰⁵ (See page 38 for more on food and nutrition support programs.)

In addition to considering availability, accessibility, and affordability of healthy food options as a standalone concern, it is also important to compare it with the number, variety, cost, and convenience of local alternative food options. Research suggests that the density of stores that sell fast food and junk food as compared with healthier food is a more important single factor than having a local grocery store.^{106,107}

C. ADVERTISING AS A COMMERCIAL DETERMINANT OF HEALTH

Decisions and actions by food and beverage companies and related businesses shape the food available across the nation and influence purchasing decisions, preferences, and consumption patterns of consumers. These kinds of decisions and actions by private-sector actors which “affect people’s health, directly or indirectly, positively or negatively” are collectively called commercial determinants of health.¹⁰⁸ For example, commercial determinants of health can include what kinds of products to make and distribute; the price and packaging of products; the specific ingredients, recipes, and nutrition of the various products; and the marketing and advertising of these products—as all shape and influence consumption. Likewise, grocery store decisions on stocking, placement, and pricing are also important factors.

Advertising is one major way companies influence and encourage consumption. The food and beverage industry spends billions of dollars every year on advertising in the United States—with an estimated 80 percent of advertising promoting unhealthy choices, such as fast food, sugary drinks, and candy.¹⁰⁹ These marketing messages are communicated through traditional television advertising, product packaging, and increasingly via digital platforms.¹¹⁰ A recent meta-analysis of the impact of food and beverage marketing on children’s and adolescents’ eating behavior found that a variety of marketing mediums—including television, digital, and package marketing—are associated with significant increases in food intake, choice, preference, and purchase requests.¹¹¹



As with television, food advertising on digital platforms is highly prevalent and an area that the public health field has been raising as an emerging issue in needing greater attention. In 2021, food and beverage companies spent \$5.5 billion just on search engine marketing and \$3.5 billion on social media marketing.¹¹² Like with television, this advertising is also dominated by ads for unhealthy products.¹¹³ Another new and concerning aspect of digital food marketing is social media influencer marketing—a \$13.8 billion industry and growing.¹¹⁴ A recent study of popular “made-for-kids” child-influencer YouTube videos found that two-thirds of the videos featured food and 38 percent contained a branded food or beverage, of which three-quarters were candy, sweet or salty snacks, sugary drinks, or ice cream.¹¹⁵ A second study found that children who viewed influencers promoting unhealthy snacks increased their immediate intake of unhealthy food, while influencer promotion of healthy food had no effect.¹¹⁶

An additional concerning aspect of food marketing is the

disproportionate focus on marketing for unhealthy foods—including candy, sugary drinks, and fast food—on Black and Hispanic consumers. Advertising for unhealthy food accounted for three-quarters of television ad spending directed at these demographic groups.¹¹⁷ Another study found that Black youth see approximately 75 percent more television ads for fast food than their white peers.¹¹⁸

A further example of racial inequities in advertising is the particular focus on the Hispanic community in advertising for “toddler milk”—products similar to baby formula that have added sugars and are not recommended by the American Academy of Pediatrics or Dietary Guidelines for Americans.^{119,120} These drinks are often cross-promoted with infant formula, resulting in consumer confusion and the dangerous practice of feeding these drinks to infants, even though they do not meet infants’ unique nutritional needs.¹²¹ A 2021 study found that Hispanic parents are more likely to have purchased toddler milk than non-Hispanic parents.¹²²

D. POLICY PROGRESS AND OPPORTUNITIES

The food and beverage industry, food stores, and other related businesses shape the food supply and environment in the United States in many critical ways. These companies also work within a system guided by policies and standards at the national, state, and local levels. In recent decades, there have been important steps to improve food quality and nutrition through different approaches. Some have focused on improving the nutritional quality of the food supply and diets, others have improved nutrition labels to better enable consumer decision-making, and others have improved nutrition for certain populations through updated standards and expanded access.

Examples of these policy steps from the last decades are below.

Improving nutrition quality of the food supply and diets

- **Trans fats:** Eating artificial trans fats (also called partially hydrogenated oils) increases bad cholesterol, reduces good cholesterol, and has been linked to an increased risk of heart disease, stroke, and type 2 diabetes.¹²³ In 2015, the U.S. Food and Drug Administration (FDA) reclassified artificial trans fats as unsafe and prohibited it as a food additive, with final compliance taking effect in 2021.¹²⁴
- **Sodium:** High sodium consumption increases risks for high blood pressure, heart disease, and stroke; average sodium intake for adults in the United States is well above recommended limits; and more than 70 percent of sodium intake is from packaged and prepared foods.^{125,126,127} To help improve nutrition, reduce

preventable diet-related chronic disease, and reduce excess sodium intake, FDA took an important step in 2021 and issued voluntary guidance to the food industry on sodium-reduction targets by 2024. The goal is a gradual reduction of sodium in commercial recipes and production.¹²⁸ An evaluation of the first two years showed promising decreases in sodium levels, particularly in the combined packaged and restaurant food categories.¹²⁹ In August 2024, FDA issued draft guidance on the second phase of voluntary sodium-reduction targets, which builds on the initial targets.¹³⁰

- **Added sugar:** Sweetened beverages are the top source of added sugars consumed in the United States.¹³¹ Over the last decade, several cities have implemented taxes of 1 to 2 cents per ounce on sugar-sweetened drinks to reduce added sugar consumption, including: Berkeley, California (2015); Oakland, California (2017); Philadelphia, Pennsylvania (2017); Seattle, Washington (2018); and San Francisco, California (2018). These taxes have reduced sales and consumption of sugary beverages in the short and long term.^{132,133,134,135,136,137}
- **Healthy food access:** Access to nutritious food is a critical step to healthy eating. Some local governments have improved access through a variety of policies, including encouraging: (1) new grocery stores to open by offering tax incentives and grant programs, particularly in under-resourced areas;

(2) existing convenience stores to carry healthier food options through grants and other programs; and (3) more farmers' markets/stands in communities by opening city property to vendors, assisting with permitting, and conducting advertising. Research shows that 29 percent of communities have at least one of these policies, which is the same as the previous survey in 2014.¹³⁸ Federally, there are a number of initiatives to increase healthy food access. For example, the Healthy Food Financing Initiative provides grant funding and technical assistance for programs that increase access to healthy food in under-resourced communities, helping to reduce food insecurity, revitalize low-income neighborhoods, and build a more equitable food system.

Empowering consumers through better labeling and education

- **Nutrition Facts labels:** Clear and actionable information is key to making nutrition labels accessible and helpful to consumers as they make food-purchasing decisions. Major updates to packaged food labels went into effect in 2020–2021, making them easier-to-read, providing more accurate serving sizes, and including added sugars.^{139,140} One study found that those who read the new added-sugar information on nutrition labels made healthier food choices.¹⁴¹

- **Restaurant menu labeling:** Since the 1970s, Americans have increasingly eaten food prepared away from home, making accessing nutrition information in restaurants increasingly important.¹⁴² Requirements for menus in large chain restaurants to include calorie counts went into effect in 2018.¹⁴³ A study found that the new rule led

to a decrease in average calories, saturated fat, and sugar in fast food meals.¹⁴⁴

- **Dietary Guidelines by life stage:**

Nutrition requirements vary by life stage, and understanding the different needs is a necessary to meet them. USDA and the U.S. Department of Health and Human Services (HHS) published Dietary Guidelines for Americans, 2020–2025, which includes science-based recommendations on healthy eating for all life stages, including infancy, toddlerhood, childhood, adolescence, pregnancy, lactation, and older adulthood. This was the first time the Guidelines included recommendations for infants and toddlers.¹⁴⁵

- **Family education programs:**

About one in five American youth have obesity, a figure that has been increasing over decades.^{146,147} The Centers for Disease Control and Prevention (CDC) Family Healthy Weight Programs are comprehensive, family-based lifestyle-change programs that include children who are overweight or have obesity and their families. The programs are offered in healthcare, community, or public health settings and focus on education and skill-building around nutrition and physical activity to help families live a healthy lifestyle. Evaluations of the Family Healthy Weight Programs have found that they have been successful in reducing or stabilizing a child's weight, as well as a range of other positive outcomes, including reduced parent or caregiver weight; improved nutrition, physical activity, and associated healthy behaviors; and improved metabolic markers.¹⁴⁸

Raising nutritional quality and access in schools, institutions, and nutrition programs

- **Expanding nutrition programs in schools and care facilities:** Millions of children and adults attend childcare centers, afterschool programs, adult daycare centers, and shelters every year.¹⁴⁹ The 2004 WIC Reauthorization law expanded the Fresh Fruit and Vegetable Program (FFVP), the Summer Food Service Program, and the Child and Adult Care Food Program (CACFP) to more schools, programs, and centers.¹⁵⁰ FFVP was further expanded nationwide in 2008.¹⁵¹ Research shows that FFVP increases students' consumption of fresh produce and is associated with a meaningful reduction in obesity for participating children.^{152,153,154,155}

- **School meal nutrition standards:** About 30 million children across the country eat school meals each day.¹⁵⁶ The Healthy, Hunger-Free Kids Act of 2010 strengthened nutritional requirements for USDA Child Nutrition Programs, increased funding for school meal programs, strengthened school wellness policy requirements, and created the Community Eligibility Provision (CEP), which allows schools to provide universal free school meals in high-poverty communities.¹⁵⁷ Research finds that new nutrition requirements reduced the prevalence of obesity among school lunch participants.¹⁵⁸ Some of these provisions have been expanded and updated in recent years. In September 2023, USDA changed the threshold for CEP to expand the option to more high-need communities.¹⁵⁹ And, in April 2024, USDA issued a final rule updating

standards for Child Nutrition Programs to more closely align with the current Dietary Guidelines for Americans and includes changes like limits on added sugars and sodium.¹⁶⁰

- **CACFP nutrition standards:** More than 4 million adults and children eat at childcare centers, afterschool programs, adult daycare centers, and shelters every year.¹⁶¹ A federal rule aligning CACFP meal patterns with dietary guidelines as required by the Healthy, Hunger-Free Kids Act went into effect in 2017.¹⁶² An evaluation of CACFP found that participation in the program may reduce the prevalence of obesity.¹⁶³

- **Healthy School Meals for All:** Universal school meal programs around the world have been found to be positively associated with increased food security and improved nutrition.¹⁶⁴ In response to an increase in food insecurity among households with children during the COVID-19 pandemic, Congress authorized the USDA to provide waivers for all schools to offer free universal school meals from March 2020–June 2022.¹⁶⁵ During this time, participation in the National School Lunch Program increased while stigma around the program decreased.¹⁶⁶ Since 2022, several states (California, Colorado, Maine, Massachusetts, Michigan, Minnesota, New Mexico, and Vermont) passed laws establishing free school meals for all students.^{167,168,169,170} Preliminary research suggests that universal school meals may decrease obesity prevalence among students.¹⁷¹

- **WIC food package:** More than 6 million pregnant women, mothers, infants, and children participate

in WIC each year.¹⁷² A federal rule overhauling the WIC food packages went into effect in 2009, adding fruits, vegetables, and whole grain products as well as incentives to promote breastfeeding.¹⁷³ After these nutritional requirements were strengthened, obesity rates among children in the program declined.^{174,175} In April 2024, USDA issued a final rule updating WIC food package standards to better align with the current Dietary Guidelines for Americans and includes making permanent the enhanced Cash Value Benefit for fruit and vegetable purchases, and allowing for more flexibility in purchasing foods that meet cultural or personal preferences and dietary needs.¹⁷⁶

These policies demonstrate that progress and improvement are possible through a variety of approaches and at different levels of government. The United States needs to continue to build on these policies and lessons learned to further shift the nation's food environment towards a healthier food supply and better nutrition and healthy eating for all Americans. Addressing obesity is complex and requires multidimensional strategies and policies, with system and environmental changes, dynamic monitoring and evaluation mechanisms, and time and sustained investment and commitment for these changes to make a difference.

Looking forward, there are additional promising policies currently being developed or enhanced. The 2022

White House Conference on Hunger, Nutrition, and Health led to the National Strategy on Hunger, Nutrition, and Health with the goal to end hunger and increase healthy eating and physical activity by 2030, so that fewer Americans experience diet-related diseases like diabetes, obesity, and hypertension. The whole-of-society strategy includes numerous federal government actions as well as more than 100 stakeholder commitments across private, nonprofit, and governmental sectors.¹⁷⁷

Key proposed federal policies include FDA's next set of improvements to food package labeling—including front-of-package (FOP) nutrition labels that highlight key nutrition components and a “healthy” symbol to be used on foods that meet certain nutritional requirements—to help consumers make choices. In 2022, FDA issued a proposed rule updating the existing definition of “healthy” to align with current science-based Dietary Guidelines for Americans and has been conducting consumer research about FOP labels and “healthy” symbols to best meet shoppers' needs.^{178,179} FDA has found many consumers often prefer simpler labels and, for consumers with less nutrition knowledge, symbols are particularly helpful in identifying healthy options.^{180,181}

Additional specific recommendations can be found in the Recommendations section beginning on page 67.

Q&A with Erin McAleer, Project Bread, Boston, Massachusetts



Erin McAleer is the president and CEO of Project Bread, a position she has held since 2017. McAleer holds a master's degree in social work with a concentration in organizing, public policy, and administration from Boston College.

TFAH: What does food insecurity look like in the communities you serve and how does Project Bread respond?

Ms. McAleer: Project Bread is a food security organization. We serve all of Massachusetts. Our goal is not to just alleviate hunger and food insecurity now but to put solutions in place to permanently solve the hunger crisis. We focus both on direct service and on policy and systems change.

In Massachusetts about 25 percent of families with children are food insecure. They struggle with the basic need of providing food for their family. We identify the barriers that families face and how to address them through work with community and legislative partners and through policy and systems change. Hunger is a systemic issue, so it requires systemic solutions.

We have a number of programs to help families with their basic food needs. Every summer, we support meal sites all over the state through the Summer Eats program to make sure kids are able to access meals during the summer months, which can be a time of hunger for many kids. We run the Food Source Hotline, which serves about 20,000 households annually. People can call in toll-free and access a host of resources. And we have a healthcare partnerships program where hospitals and health centers are sending patients with food insecurity needs to us, and we work one-on-one with those patients for six months to ensure access to nutritious food and provide kitchen supplies and nutrition-related counseling and cooking classes.

These programs are focused on meeting people's immediate needs, but

they are also designed to lead to more sustainable systems and policy change. Within the Summer Eats program, we are advocating for policies to make that program more accessible, and we are advocating for complementary policies. For example, Summer EBT [electronic benefits transfer] is now available in Massachusetts and 36 other states. On the healthcare side, we are connecting referred patients with federal nutrition programs, like the Supplemental Nutrition Assistance Program, SNAP, but we know they are not enough. SNAP benefits often run out before the end of the month, so we are also giving people grocery store gift cards while they are in the program.

TFAH: Tell me more about the people you serve. What are the barriers to food security?

Ms. McAleer: Economics is number one, not being able to afford food whether that's any food at all or food that's culturally relevant, that you know your family will eat, or that's healthy and nutritious. People are making trade-offs. Massachusetts is an incredibly expensive state to live in; the costs of housing and childcare are extremely high. Food often becomes the trade-off. When it comes to food choices, people are making economic decisions. Families want to buy fruits and vegetables and protein, but a box of cereal lasts a lot longer.

Other factors include language barriers to accessing resources, perceived stigma around using federal nutrition programs, systemic racism and stereotyping in the public eye, and a lack of awareness about program eligibility and the available benefits.

Within our healthcare program, we get people signed up for SNAP and WIC and provide grocery gift cards, and when we do, we can see that people are eating more fruits and vegetables. Both food security and nutrition security are rooted in economic security. It comes down to what a family can afford, and healthy food is more expensive.

TFAH: Project Bread’s work is grounded in the concept of providing “more than food.” Please say more about that.

Ms. McAleer: I could sit down with the smartest minds in America to discuss food insecurity, and most people would immediately go to donated food as the solution. Their question is how do we get more donated food to people who are hungry? I get that. But that’s a challenging narrative because it ignores the systemic nature of this issue. When 25 percent of families in Massachusetts are food insecure it’s not just about donated food. We need much more large-scale, sustainable solutions. We’ve been saying that for a long time and the pandemic really revealed it. Our “more than food” focus is meant to address the economic barriers to food security, but we also need to recognize other barriers. For example, some of the people we work with don’t have a functioning kitchen or a refrigerator; dropping off a week’s supply of food for them to store and cook won’t work for them. Transportation so people can get to a grocery store or a farmers’ market is also a key issue.

It’s really about changing the narrative in the anti-hunger space that the solution is more than donated food. I’m not dismissing that donated food

is part of it. Food banks and food pantries do incredible work. But we’ve seen this shift to food pantries being the front line in the narrative and they can’t be. They don’t have the bandwidth in terms of staff, funding, space, and equipment to do so. Food pantries should be for emergencies, not how people shop on a weekly basis.

TFAH: This year, TFAH’s State of Obesity report includes a special feature on the food environment. What are the most critical factors of any food environment, and how does a food environment impact food consumption and ultimately health?

Ms. McAleer: Again, it all goes back to economics. Our program focus is at the individual level: Will people have access to food? Will it be affordable? That being said, we do try to influence the food environment. This summer, through the Summer Eats program, we are purposefully bringing breakfast and lunch to where kids are—to pools, parks, playgrounds, and libraries.

We believe our solution, a focus on giving people the tools to cope with the overall food environment, is more within reach right now. As opposed to changing the overall food environment.

We support all the efforts and partners working on changing the larger food system, but we believe the more immediately solvable problem is making sure families have the economic resources to be able to purchase food in the same system that you and I shop in.

Last year, we launched our Council of Experts with Lived Experience. The council is a first of its kind for a food security nonprofit. It convenes community members who offer insights

on policy and communication for our programs and advocacy work, allowing us to hear the community’s perspective as we develop long-term solutions.

TFAH: Are you encouraged by some of the action steps being taken by industry, government, and the healthcare sector? For example, front-of-package labeling, reduced added sugar in products, and the food-is-medicine movement.

Ms. McAleer: We are spending a lot of our energy on the food-is-medicine movement, and we’re really excited about it. For 15–20 years, we’ve been partnering with health centers because they are such an important access point. We know that people are more likely to disclose to their healthcare provider that they are dealing with food insecurity. Years ago, we set up a secure portal to pilot a program so healthcare providers could refer food-insecure patients to Project Bread. In 2020, we expanded the program to work one on one with patients for six months. We purposely focus on federal nutrition programs because of the scale of their impact. SNAP cards allow people to buy food of their choice. Kids are in school, so school meal programs are important. But overall, our goal is to provide people with sustainable resources and give them knowledge so when their six months in our program is completed, they have a functioning kitchen, and they have the knowledge that they learned in cooking classes or one-on-one through their work with a nutritionist or dietitian.

In 2020, Massachusetts received a 1115 waiver from the federal government to allow the state to pay for food and nutrition support through the

Medicaid program. This was an opportunity to greatly expand our services. Patients are referred to us through a secure portal; we've served over 12,000 patients since 2020. Patients are assigned a coordinator who speaks their language (we are really intentional about hiring program staff who speak the most common languages spoken in the state) who then connects them to SNAP and WIC, kitchen equipment, grocery store gift card programs, nutritional counseling, cooking classes, all of that.

Healthcare is one of our biggest systems in the United States so integrating food access into it is powerful. Plus, it moves food security away from charity; giving people access to healthy food to improve healthcare outcomes and costs. When we think about solving hunger in Massachusetts, the food-is-medicine strategy is a main pillar because of the scale of the healthcare sector and because it's a trusted access point. Our healthcare partnerships program is showing really positive outcomes. One of the findings from our program that really pleased us is that patients within the program are more compliant with their health plan.

TFAH: If you had the opportunity to set federal policy in response to the hunger crisis what would you do?

Ms. McAleer: In Massachusetts before the pandemic, the rate of household food insecurity was about 8.9 percent. In May of 2020, we saw it spike to well over 20 percent. Then the federal government put several programs in place, like universal free school meals, the SNAP program was expanded, and the childcare tax credit was put in place. All of these solutions put money in people's pockets and food insecurity

went down. But then as the public health emergency receded, these programs were rolled back, and we saw food insecurity rates start to increase.

Hunger is a solvable problem if we strengthen the safety net through programs like the Child Tax Credit. We are proud that Massachusetts still has universal free school meals, but every state in the nation should. The SNAP program is the most effective solution to hunger, but it's not strong enough: there's too many people who aren't eligible who could use it, and the benefit runs out too quickly each month.

In terms of SNAP, we need to make the benefits more robust, and we need more people to be able to access the program. Unfortunately, the discussion in Washington, DC, today is about limiting SNAP, not expanding it. That's why we need the advocacy and partnership of those in healthcare to help demonstrate [the benefits of] giving people more purchasing power to food. Yes, there's a cost to it, but the healthcare cost savings associated with it is much greater.

My goal is that any American, during a challenging time, doesn't have to worry about food. There would be a program to ensure that every family can go to the grocery store and put food on the table. It's a social safety net around food. It won't be forever but when you're going through a hard time, there would be a program you can access to help you afford food. Doing so would make America a stronger nation. We are not strong when 25 percent of our people are worrying about the basic need for food. We can do better.

This interview was edited for length and clarity.

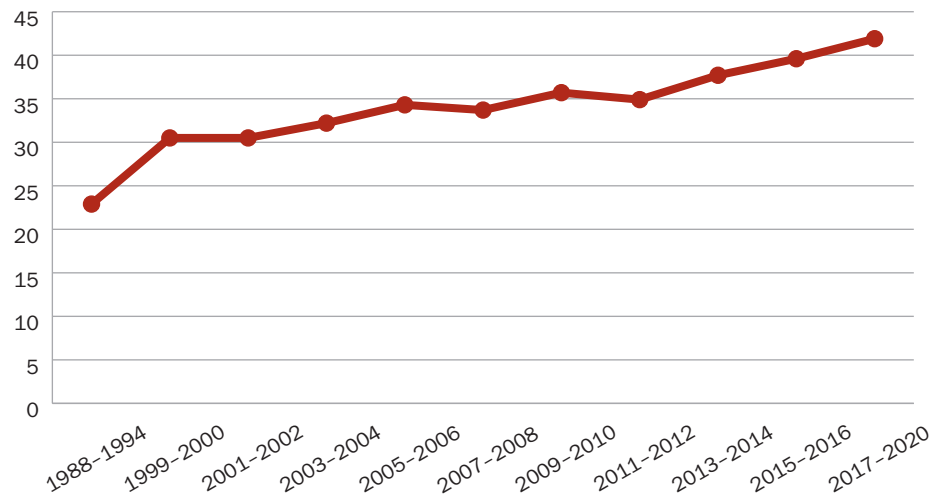
The State of Obesity

Section II: Obesity-Related Data and Trends

A. TRENDS IN ADULT OBESITY

The National Health and Nutrition Examination Survey (NHANES) and the Behavioral Risk Factor Surveillance System (BRFSS) both show long-term trends of rising obesity rates among adults in the United States.^{182,183,184,185} The latest NHANES data, from 2017–2020, found the adult obesity rate passing 40 percent nationally.¹⁸⁶

Figure 2: Percent of Adults with Obesity, 1988–2020



Source: NHANES

NHANES usually releases data every two years. The 2019–2020 NHANES data collection, however, was disrupted by the COVID-19 pandemic as it uses in-person physical examinations to determine participants’ height, weight, and other physical measures. As of September 2024, at the time this report publication, the 2021–2023 NHANES survey has not yet been released, though it is expected later in fall 2024.¹⁸⁷ This means the most

recent NHANES data available is a combination of data from the 2017–2018 and 2019–March 2020 surveys. Since BRFSS polls individuals about their health via telephone, data collection was able to continue through the pandemic, and the most recently released BRFSS is from 2023.¹⁸⁸

This subsection provides the most recent data on adult obesity rates by state and demographics.

DATA SOURCES FOR ADULT OBESITY MEASURES

1. The National Health and Nutrition

Examination Survey (NHANES) is the source for the national obesity data in this report. As a survey, NHANES has two main advantages: (1) it examines a nationally representative sample of Americans ages 2 and older; and (2) it combines interviews with physical examinations. The limitations of the survey include a time delay from collection to reporting and a small survey size (approximately 5,000 interviews) that is not designed to be used for state or local data.¹⁸⁹ The most recent NHANES data are from a combination of the 2017–2018 and 2019–2020 NHANES surveys.

2. The Behavioral Risk Factor

Surveillance System (BRFSS) is the source for state-level adult obesity

data in this report. As a survey, BRFSS has three major advantages: (1) it is the largest ongoing telephone health survey in the world (approximately 450,000 interviews per year); (2) each state survey is representative of the population of that state; and (3) the survey is conducted annually, so new obesity data are available each year.¹⁹⁰ The main limitation of the survey includes its use of self-reported weight and height, which result in underestimates of obesity rates due to people's tendency to over-report their height and under-report their weight. Also, the sample sizes in some states are too small to be useful for providing estimates about certain racial and ethnic groups. The most recent BRFSS data is from 2023.

I. State trends (BRFSS)

Recently released BRFSS data show considerable variation in state-level adult obesity rates in 2023 and in state-level trends from 2022 to 2023. Longer-term trends continue to show increasing rates.

According to TFAH's analysis of the 2023 BRFSS data, states ranged from a low of 24.9 percent in Colorado and 23.5 percent in the District of Columbia to a high of 41.2 percent in West Virginia and 40.1 percent in Mississippi.

Other key findings from the recently released data include:

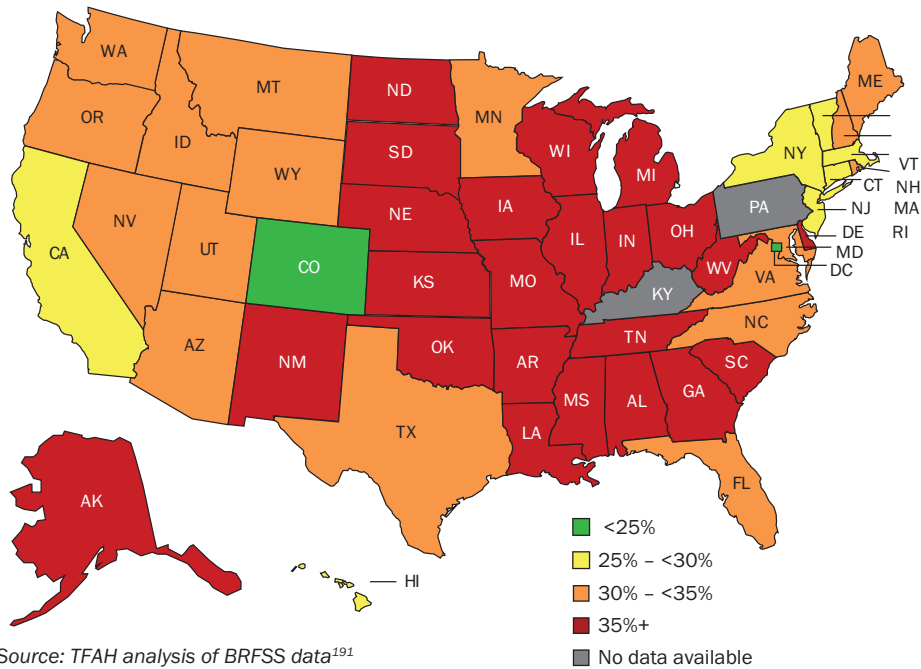
- Between 2022 and 2023, three states (Alaska, Arkansas, and Oregon) had statistically significant increases in

their adult obesity rates. No states had statistically significant decreases in 2023, though 27 state plus the District of Columbia did have lower rates in 2023 as compared with 2022.

- In the prior five years (2018–2023), 28 states had statistically significant increases in their obesity rate.
- In 2023, the adult obesity rate was at or above 35 percent in 23 states. In comparison, 2013 was the first year that any states had an adult obesity rate higher than 35 percent (see Figure 1 on page 5).

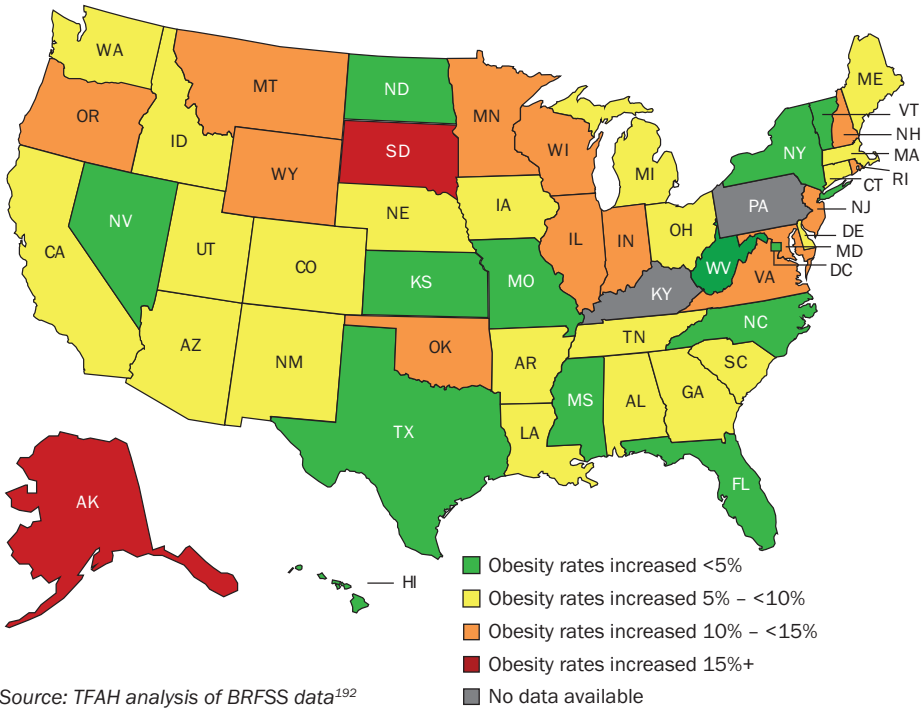
For additional state-level data from BRFSS, see charts on pages 26–28.

Map 1: Adult Obesity Rate by State, 2023



Source: TFAH analysis of BRFSS data¹⁹¹

Map 2: Change in Adult Obesity Rate by State, 2018–2023



Source: TFAH analysis of BRFSS data¹⁹²

WHY ARE REPORTED NATIONAL OBESITY RATES HIGHER THAN STATE-BY-STATE RATES?

How is it that only 23 states have adult obesity rates exceeding 35 percent, yet the national obesity rate is 41.9 percent? It's because the two rates are from separate surveys with different methodologies and were conducted in different years. State obesity rates are from the BRFSS, which collects self-reported height and weight through landline and cellular telephone surveys. Research has demonstrated that people tend to overestimate their height and underestimate their weight. One study found that, due to this phenomenon, the BRFSS may underestimate obesity rates by 16 percent.¹⁹³ NHANES, from which the national obesity rate is derived, calculates its obesity rate based on measurements obtained through in-person physical examinations. Accordingly, the higher rates found by NHANES are a more accurate reflection of obesity in the United States.¹⁹⁴ NHANES does not have state-level data, which is why TFAH also uses BRFSS data.

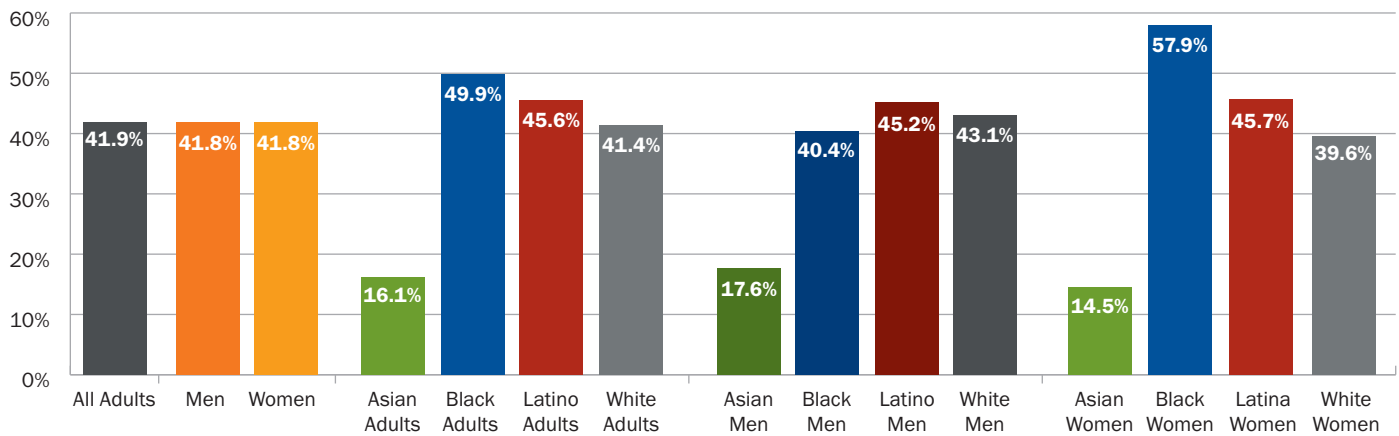
II. Demographic trends

Obesity rates diverge along a number of demographic measures, including race/ethnicity, income, education, and geography. While obesity rates depend on many factors—from economic and community effects, to cultural and marketing influences, and individual-level behaviors—all are inexorably linked with the social, economic, and environmental conditions that

individuals experience. Broader equity issues, like structural racism, poverty, and community context shape daily life and available choices around healthy food, physical activity, education, jobs, financial security, etc. (together, these are often called the “social determinants of health”), which systematically affect people’s weight and health.¹⁹⁵ See Appendix on

page 77 for state-level indicators that track some of these structural factors, including community conditions (e.g., poverty rate), the built environment, active transportation, and food systems (e.g., percentage of children who live in neighborhoods with sidewalks/walking paths), as well as state policies that improve conditions (e.g., universal free school meals).

FIGURE 3: Percent of Adults with Obesity Overall, and by Race/Ethnicity and Sex, 2017–2020



Source: NHANES¹⁹⁶

- Race/ethnicity: Racial/ethnic disparities in obesity rates are significant (see Figure 3).**

- According to 2017–2020 NHANES data, Black Americans had the highest rate of obesity (49.9 percent) for adults ages 20 and higher, followed by Hispanic (45.6 percent), white (41.4 percent), and Asian (16.1 percent) adults.
 - More than half—57.9 percent—of Black women had obesity. That is the highest sex and race/ethnicity combination included in NHANES—and an 18-percentage point difference compared with

white women (39.6 percent). In contrast, Black men had an obesity rate of 40.4 percent, which is lower than white men (43.1 percent).¹⁹⁷

- Asian adults overall had much lower rates of obesity than any other race/ethnicity reported in NHANES. Other studies have shown variation in obesity rates among different ethnicities and national origins within the population. For example, the 2023 National Health Interview Study found that Native Hawaiian and other Pacific Islander adults ages 18 and older had self-reported obesity rates of 40.1 percent, while Asian adults had an obesity rate of

13.3 percent (and whites had a 33.5 percent obesity rate).¹⁹⁸

- There is also evidence suggesting that Asian people should have lower BMI cutoffs for overweight and obesity measures than other races and ethnicities, because they have higher health risks at lower BMIs. This includes a higher risk for type 2 diabetes and other metabolic diseases at lower BMIs.¹⁹⁹ Since a high BMI is a factor in determining whether to test for diabetes, fewer Asian individuals are tested and diagnosed by healthcare providers.²⁰⁰ An estimated 40 percent of Asian people with diabetes have not been

diagnosed, which is much higher than the overall population.²⁰¹

- It is also important to note that many national surveys, including NHANES, do not report data on health measures for American Indian and Alaska Native (AI/AN) people. This gap in the data highlights the need for more attention and resources to advance equitable data collection and reporting for populations of smaller sizes. The surveys that do exist do not gather or present findings by Tribal Nations. Available data show that the AI/AN population has very high rates of obesity. The 2023 National Health Interview Survey, which is based on self-reported height and weight, finds 45.1 percent of AI/AN adults had obesity, which is slightly higher than Black adults in that survey (42.8 percent) and substantially higher than white adults (33.5 percent).²⁰²
- Of note, in March 2024, the Office on Management and Budget issued updated standards on federal data collection and reporting on racial and ethnic data. Key changes include combining race/ethnicity into one question and adding Middle Eastern or North African in the racial/ethnic categories listed. This is the first update in more than 25 years and an important step in improving federal data collection and reporting.²⁰³
- **Income and education: Obesity rates were lower among adults living in higher-income households and adults with college degrees.**
- In 2017–2020, 43.9 percent of adults living in households with incomes at or below 130 percent of the federal poverty level (FPL) had obesity, 46.5 percent of adults in households

at 130–350 percent of FPL had obesity, and 39 percent of adults in households above 350 percent FPL had obesity.²⁰⁴ FPL varies by household size and is updated each year. For example, for an individual in 2024, FPL is an annual income of \$15,060 and for a family of four, FPL is an annual income of \$27,750.²⁰⁵ The trends varied by sex, with men in the below-130 percent FPL income category having lower obesity rates (38.6 percent) than men in the middle-income (43.9 percent) and higher-income (42.4 percent) categories. For women, the data shows obesity rates in the lower-income category at 47.9 percent, middle-income category at 48.8 percent, and higher-income category at 35.1 percent.²⁰⁶

- In 2017–2020, 40.1 percent of adults with less than a high school education had obesity compared with 46.4 percent of adults with a high school diploma and 34.1 percent of college graduates.²⁰⁷
- **Rural/Urban: Rural regions have higher rates of obesity and severe obesity.**
- According to 2016 BRFSS data, adult obesity rates were 19 percent higher in rural regions than they were in metro areas. More than one-third (34.2 percent) of adults in rural areas had self-reported obesity compared with 28.7 percent of metro adults.²⁰⁸
- Similarly, a CDC analysis of NHANES data found that adults (ages 20 and older) who lived in the most urban areas of the country (large “metropolitan statistical areas”) had the lowest obesity rates in 2013–2016.²⁰⁹

TABLE 1: Adult Obesity Rates and Related Health Indicators, 2023

States	Obesity		Overweight & Obesity		Diabetes		Physical Inactivity		Hypertension	
	Percent of Adults With Obesity	Rank	Percent of Adults With Obesity or Were Overweight	Rank	Percent of Adults with Diabetes	Rank	Percent of Adults Who Were Physically Inactive	Rank	Percent of Adults with Hypertension	Rank
Alabama	39.2	5	72.0	3-T	16.1	4	28.4	6	45.5	2
Alaska	*35.2 +/- 1.8	22	68.4 +/- 1.8	28-T	8.9 +/- 1.0	46	20.5 +/- 1.6	37-T	34.4 +/- 1.8	25-T
Arizona	31.9	33	66.4	34-T	11.4	28-T	20.5	27-T	33.8	29
Arkansas	*40.0 +/- 1.8	3	71.9 +/- 1.7	5	14.8 +/- 1.3	6-T	32.1 +/- 1.7	2	43.2 +/- 1.8	5
California	27.7	45	64.0	44	11.8	24-T	21.1	33-T	31.1	46
Colorado	24.9	48	59.8	48	8.4	47	16.4	47	27.5	49
Connecticut	29.4	41	65.8	37-T	9.7	40	23.9	23	33.1	34
Delaware	35.7	17	71.4	7-T	13.6	8	25.0	17-T	38.5	9
D.C.	23.5 +/- 2.2	49	57.1 +/- 2.7	49	7.3 +/- 1.2	49	14.5 +/- 2.1	49	29.2 +/- 2.4	47
Florida	30.1	40	65.7	39-T	13.0	11-T	24.0	22	37.0	14-T
Georgia	35.0	23	68.7	26	12.9	13	24.2	21	35.9	19
Hawaii	26.1	47	60.5	47	11.1	31	21.1	33-T	32.8	36
Idaho	31.0	35	66.7	33	9.8	39	19.9	42	31.8	41
Illinois	36 +/- 1.9	12-T	*71.0 +/- 1.7	11	12.2 +/- 1.3	20	20.5 +/- 1.6	37-T	33.9 +/- 1.8	27-T
Indiana	37.8	7-T	71.2	10	13.4	9	23.8	24	38.4	10-T
Iowa	37.8 +/- 1.4	7-T	72.1 +/- 1.3	2	11.2 +/- 0.8	30	23.5 +/- 1.2	25	34.6 +/- 1.3	22
Kansas	35.9	15-T	69.2	20-T	11.5	27	24.5	20	34.5	23-T
Kentucky	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Louisiana	39.9	4	72.0	3T	16.2	3	29.8	4-T	43.9	4
Maine	32.6	32	67.9	30	11.4	28-T	21.9	29-T	36.2	16-T
Maryland	34.1	26	68.8	24-T	12.4	17-T	21.9	29-T	36.2	16-T
Massachusetts	27.4	46	62.6	46	10.2	38	21.4	32	31.5	43
Michigan	35.4	19	68.8	24-T	12.4	17-T	25.0	17-T	37.3	12-T
Minnesota	33.3 +/- 1.2	29-T	67.5 +/- 1.2	31	10.7 +/- 0.8	34-T	*21.7 +/- 1.1	31	31.2 +/- 1.1	44-T
Mississippi	40.1	2	71.7	6	17.2	2	33.5	1	46.8	1
Missouri	35.3	20-T	69.6	17-T	12.6	14-T	27.3	7	37.0	14-T
Montana	30.5	38	65.7	39-T	9.4	43-T	19.3	44	32.5	38
Nebraska	36.6	10	71.4	7-T	10.8	32-T	23.0	27	33.4	33
Nevada	30.8	36	66.4	34-T	11.8	24-T	24.9	19	34.9	21
New Hampshire	32.8	31	68.4	28-T	9.3	45	20.4	40-T	33.7	30-T
New Jersey	28.9 +/- 1.4	42	64.8 +/- 1.5	41	10.7 +/- 0.9	34-T	22.8 +/- 1.3	28	34.4 +/- 1.5	25-T
New Mexico	35.3	20-T	69.2	20-T	12.4	17-T	23.1	26	34.5	23-T
New York	28.0	44	64.1	43	10.7	34-T	25.2	15	32.6	37
North Carolina	34.0	27	68.9	23	12.5	16	21.1	33-T	38.4	10-T
North Dakota	35.6	18	71.3	9	9.6	42-T	20.4	40-T	31.9	40
Ohio	36.4 +/- 1.2	11	69.6 +/- 1.2	17-T	13.1 +/- 0.8	10	25.6 +/- 1.1	12	37.3 +/- 1.2	12-T
Oklahoma	38.7	6	70.6	13	12.6	14-T	29.8	4-T	39.2	8
Oregon	*33.6 +/- 1.6	28	67.0 +/- 1.7	32	10.8 +/- 1.1	32-T	18.6 +/- 1.4	45	33.7 +/- 1.6	30T
Pennsylvania	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Rhode Island	31.6 +/- 1.4	34	66.3 +/- 2.0	36	11.9 +/- 1.2	22-T	25.7 +/- 1.8	10-T	33.9 +/- 1.9	27-T
South Carolina	36 +/- 3.1	12-T	69.8 +/- 1.4	16	*15.1 +/- 1.0	5	25.5 +/- 1.3	13	39.4 +/- 1.4	7
South Dakota	36.0	12-T	70.3 +/- 2.9	14	*11.9 +/- 2.0	22-T	25.3 +/- 2.9	14	35.4 +/- 3.1	20
Tennessee	37.6	9	70.7	12	14.8	6-T	25.1	16	41.1	6
Texas	34.4	24	69.4	19	13.0	11-T	26.4	8	32.9	35
Utah	30.2 +/- 1.2	39	64.5 +/- 1.3	42	7.7 +/- 0.6	48	15.0 +/- 0.9	48	27.7 +/- 1.1	48
Vermont	28.8	43	63.5	45	9.4	43-T	19.6	43	32.4	39
Virginia	34.3	25	68.6	27	12.0	21	21.0	36	36.1	18
Washington	30.6	37	65.8	37-T	9.6	41-T	17.5	46	31.2	44-T
West Virginia	41.2 +/- 1.8	1	73.2 +/- 1.7	1	18.3 +/- 1.3	1	31.6 +/- 1.7	3	45.4 +/- 1.8	3
Wisconsin	35.9	15-T	70.1	15	11.6	26	25.8	9	33.5	32
Wyoming	33.3 +/- 1.9	29-T	69.1 +/- 1.9	22	10.7 +/- 1.1	34-T	25.7 +/- 1.7	10-T	31.7 +/- 1.7	42

SOURCE: TFAH analysis of Behavioral Risk Factor Surveillance System data

NOTE: For rankings, 1 = Highest Rate, and 51 = Lowest Rate; T = Tie. Red and * indicate state rates that significantly increased between 2022 and 2023; Green and ** indicate state rates that significantly decreased between 2022 and 2023; Bold indicates state rates that significantly increased between 2018 and 2023. Hypertension data is collected bi-annually; this data is from 2023. Data from Kentucky and Pennsylvania were not available for 2023.

TABLE 2: Adult Obesity Rates by Race/Ethnicity, 2021–2023

States	American Indian/ Alaska Native*		Asian*		Black*		Latino*		White*	
	Percent of AI/AN Adults With Obesity	Rank	Percent of Asian Adults With Obesity	Rank	Percent of Black Adults With Obesity	Rank	Percent of Latino Adults With Obesity	Rank	Percent of White Adults With Obesity	Rank
Alabama	43.1	13	n/a	--	49.6	1	36.1	25	36.0	10
Alaska	37.3 +/- 3.3	26	23.9	1	38.7	27	34.6	35	32.4	25-T
Arizona	48.1	3-T	13.1	22	39.9	23	38.1	12	28.8 +/- 1.2	38
Arkansas	35.4 +/- 8.7	29	15.2	12	48.2 +/- 3.7	3	35.6	29-T	37.4	3-T
California	36.2	27	11.6	28-T	37.5	28	35.9	27	25.7	45
Colorado	33.6	35	11.6	28-T	29.5	42-T	30.9	47	23.7 +/- 0.8	46
Connecticut	29.1	42	13.3	19-T	41.9	22	36.0	26	28.2	41
Delaware	34.4	32	15.6 +/- 6.6	9	44.9	11	34.0	36	34.1 +/- 1.5	18
D.C.	n/a	--	11.5 +/- 4.8	31	37 +/- 2.4	29	28.3 +/- 4.9	48	13.5 +/- 1.4	48
Florida	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Georgia	23.4	43	16.0	7	43.8	13-T	33.5	41	32.6	22-T
Hawaii	n/a	--	17.8	5	28.1	44	32.1	45-T	20.1 +/- 1.4	47
Idaho	44.5	9	n/a	--	31.0	40-T	36.2	23-T	31.3 +/- 0.9	30-T
Illinois	32.4	38	10.0	38	42.5	19-T	41.3	2	33.3	20-T
Indiana	34.7	31	10.3	36	44.7	12	40.5	5	37.0	6
Iowa	48.1	3-T	13.0	23-T	39.4	25	37.5	16	37.4 +/- 0.8	3-T
Kansas	45.6	7	12.1	26	39.5	24	39.0	9	35.5	13
Kentucky	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Louisiana	38.3	23	17.3	6	47.1	7-T	36.8	20-T	36.6 +/- 1.2	7
Maine	41.2	18	n/a	--	31.9	38	34.8	34	32.4	25-T
Maryland	31.9	39-T	14.3	13	42.5	19-T	35.7 +/- 2.4	28	31.1 +/- 0.9	32
Massachusetts	31.0	41	11.2	33	35.1	36	35.3	32	27.1	44
Michigan	31.9	39-T	10.2	37	42.5	19-T	39.3	7	34.4	17
Minnesota	42.1	17	19.7	4	35.7	35	33.9	37	33.3 +/- 0.7	20-T
Mississippi	n/a	--	n/a	--	47.1	7-T	41.2	3	35.2	16
Missouri	32.7	37	11.6	28-T	43.1	17	37.7	14	35.9 +/- 1.0	11
Montana	39.0	22	n/a	--	n/a	--	38.5	11	30.0	35-T
Nebraska	40.4	19	15.3	11	36.2	34	37.1	17-T	36.3 +/- 0.8	9
Nevada	37.5	24-T	20.8 +/- 7.4	3	36.3	33	35.5	31	30.9	33-T
New Hampshire	n/a	--	9.4	39	33.7	37	40.4	6	31.7	29
New Jersey	n/a	--	13.3	19-T	36.6	31	33.6	40	28.1 +/- 1.1	42
New Mexico	42.3	15-T	15.5	10	43.3	16	37.9	13	27.9 +/- 1.6	43
New York	34.2	33	14.1	14	36.5	32	33.0	42	28.7	39
North Carolina	37.5	24-T	11.4	32	48.1	4	33.7	39	31.8	28
North Dakota	47.1 +/- 5.6	5	23.0	2	27.1	45	33.8	38	35.3 +/- 1.0	15
Ohio	35.9	28	13.7	16	43.6	15	36.4	22	37.2	5
Oklahoma	45.2	8	13.4	17-T	47.5	5	42.4	1	38.2	2
Oregon	43.3	10	13.4	17-T	31.1	39	38.6	10	31.3 +/- 1.0	30-T
Pennsylvania	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Rhode Island	42.4	14	14.0	15	38.9	26	34.9	33	29.8 +/- 1.2	37
South Carolina	42.3	15-T	12.2	25	45.6	10	32.7	44	32.6	22-T
South Dakota	46.1	6	n/a	--	31.0	40-T	37.0	19	36.5 +/- 1.9	8
Tennessee	33.2	36	n/a	--	47.4	6	36.8	20-T	35.7	12
Texas	39.6	20	13.0	23-T	43.8	13-T	39.2	8	32.5	24
Utah	43.2	11-T	10.6	35	29.5	42-T	36.2	23-T	30.0 +/- 0.8	35-T
Vermont	33.7	34	11.0	34	25.9	46	32.9	43	28.3	40
Virginia	35.3	30	13.2	21	46.6	9	32.1	45-T	33.7	19
Washington	43.2	11-T	11.7	27	36.8	30	37.6	15	30.9	33-T
West Virginia	48.9 +/- 13.0	1	n/a	--	42.8	18	37.1	17-T	41.0 +/- 1.0	1
Wisconsin	48.5	2	15.9	8	48.4	2	35.6	29-T	35.4	14
Wyoming	39.5 +/- 9.8	21	n/a	--	n/a	--	40.7	4	32.2 +/- 1.2	27

SOURCE: TFAH analysis of Behavioral Risk Factor Surveillance System data

NOTE: For rankings, 1 = Highest Rate, and 51 = Lowest Rate; T= Tie.

* For race/ethnicity data, three years of data are needed for sufficient sample size; 2021–2023 data were used here. Some data are not available due to an insufficient sample size or missing annual data.

TABLE 3: Adult Obesity Rates by Sex and Age, 2023

States	Male		Female		Ages 18-24		Ages 25-44		Ages 45-64		Ages 65+	
	Percent of Men With Obesity	Rank	Percent of Women With Obesity	Rank	Percent With Obesity	Rank	Percent With Obesity	Rank	Percent With Obesity	Rank	Percent With Obesity	Rank
Alabama	37.8	6-T	40.7	5	26.1	8	42.4	4	45.7	4	33.6	12-T
Alaska	35.9 +/- 2.5	11-T	34.3 +/- 2.7	26	22.8	14	35.6	22-T	41.4 +/- 3.1	20	32.7 +/- 3.3	22
Arizona	32.1	29-T	31.6	33	20.8	22	34.2	31	38.2	31	27.2 +/- 2.0	40
Arkansas	38.4	2	41.7	4	29.2 +/- 7.1	1	44.0	2	45.3	5	34.2 +/- 2.5	9
California	28.4	44	26.9	47	14.9	45	30.2	41	32.7	46	23.4 +/- 2.2	48
Colorado	24.5	48	25.3	48-T	13.0 +/- 3.1	49	23.4	48	31.7	47	23.8	47
Connecticut	28.8	43	30.0	40	14.1	48	32.3	36-T	33.9	42-T	27.1	41
Delaware	33.6	21	37.7 +/- 3.1	12	20.1	25-T	37.5	17	42.6	13	33.0	17
D.C.	19.4	49	27.2 +/- 3.3	46	17.3	40	20.6 +/- 3.3	49	30.9	48	25.9 +/- 3.8	45
Florida	30.9	35-T	29.3	41	19.9	29	28.6	46	36.5	36	28.4	33
Georgia	31.7	32	38.2	11	19.6	32	35.4	24-T	43.3	11	32.1	26
Hawaii	26.9	47	25.3 +/- 2.1	48-T	21.3	19-T	29.2	44	29.6 +/- 2.6	49	20.5 +/- 2.4	49
Idaho	30.9	35-T	31.0 +/- 2.3	35	20.1	25-T	31.3	40	36.1	37	30.6 +/- 2.7	29
Illinois	35.9	11-T	36.0	20	17.7	39	37.8	16	41.2	22	35.8 +/- 3.8	2
Indiana	35.2	17	40.5	6	25.5	11	40.4	9	42.5	14-T	35.3	3
Iowa	37.0 +/- 1.9	9	38.6 +/- 2.0	10	26.4	6	39.5	10	43.9	8	34.8 +/- 2.2	5-T
Kansas	35.7	16	36.1	18-T	22.5	15	38.5	12	41.3	21	33.9 +/- 2.2	10
Kentucky	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Louisiana	38.0	4-T	41.8	3	26.6 +/- 5.8	5	41.9	6	46.1	3	36.1	1
Maine	31.8 +/- 1.8	31	33.5	29	22.2	16	34.5	28	37.3	34	29.6 +/- 1.6	32
Maryland	32.8 +/- 1.8	26	35.2	23-T	22.0	17	34.4	29-T	39.6 +/- 2.1	26-T	32.0 +/- 1.9	27
Massachusetts	27.0	46	27.8	45	16.5	41	27.0	47	32.9	45	26.1	43-T
Michigan	33.3	24	37.5	13-T	19.8	30-T	36.7	19	42.5	14-T	32.8	18-T
Minnesota	33.4	22-T	33.1 +/- 1.7	31	20.0	27-T	33.3	32	39.1	29	32.5	23
Mississippi	38.0	4-T	42.0	2	26.2	7	43.7	3	48.4	1	32.2 +/- 4.1	25
Missouri	34.5	19-T	36.1	18-T	19.8	30-T	36.4	20	42.5	14-T	32.8 +/- 2.5	18-T
Montana	30.0	39	30.9	36-T	21.3	19-T	29.5	43	35.7	39	29.9	31
Nebraska	36.6	10	36.6	16-T	19.1	34	38.9	11	42.8	12	35.1	4
Nevada	29.6 +/- 4.0	40	32.0	32	18.8 +/- 7.3	36	32.0	38-T	37.0	35	26.4 +/- 4.3	42
New Hampshire	34.7	18	30.7 +/- 2.4	38	18.1	38	34.4	29-T	39.5	28	28.0	35
New Jersey	29.2 +/- 2.0	42	28.6 +/- 2.1	43	14.3	47	29.7 +/- 2.8	42	33.9	42-T	27.8	37
New Mexico	37.4	8	33.3	30	25.9	10	42.2	5	39.0	30	27.5	38
New York	27.3	45	28.7	42	15.8	44	28.7	45	33.3	44	26.1	43-T
North Carolina	31.4	34	36.6	16-T	14.6	46	35.0	27	41.7	19	32.3	24
North Dakota	35.8 +/- 2.3	13-T	35.2	23-T	21.8 +/- 5.2	18	38.2	13	40.2 +/- 2.9	25	34.8 +/- 2.5	5-T
Ohio	35.8	13-T	37.0 +/- 1.8	15	20.6	23	38.1	14	43.4	10	33.7	11
Oklahoma	38.2	3	39.3	9	26.8	3	41.8	7	45.2	6	32.8 +/- 2.4	18-T
Oregon	33.1 +/- 2.3	25	34.2	27	21.3	19-T	32.8 +/- 2.7	34	39.6 +/- 3.0	26-T	33.2 +/- 3.2	16
Pennsylvania	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--	n/a	--
Rhode Island	31.6	33	31.5	34	19.3	33	35.8	21	35.8	38	27.3	39
South Carolina	32.3	28	39.6	7	26.0	9	35.4	24-T	44.3	7	31.4	28
South Dakota	37.8	6-T	34.1 +/- 4.6	28	23.1	13	37.9	15	42.4	17	33.3	15
Tennessee	35.8	13-T	39.4	8	27.6	2	40.5	8	41.8	18	33.4	14
Texas	33.4	22-T	35.5	22	20.4	24	35.3	26	40.8	24	32.8	18-T
Utah	30.1	38	30.2	39	16.4	42	32.0	38-T	37.4	33	27.9	36
Vermont	29.4	41	28.1	44	15.9	43	32.6	35	34.0	41	24.4 +/- 2.6	46
Virginia	32.6	27	35.9	21	18.7	37	37.2	18	38.1	32	33.6	12-T
Washington	30.4	37	30.9	36-T	18.9	35	32.3	36-T	34.9	40	28.1	34
West Virginia	40.1 +/- 2.7	1	42.2 +/- 2.5	1	26.7	4	46.4 +/- 3.9	1	47.4 +/- 3.0	2	34.7 +/- 2.6	7
Wisconsin	34.5	19-T	37.5	13-T	20.0	27-T	35.6	22-T	43.6 +/- 2.0	9	34.3 +/- 1.6	8
Wyoming	32.1 +/- 2.5	29-T	34.7 +/- 2.8	25	23.7 +/- 6.5	12	32.9 +/- 3.9	33	41 +/- 3.2	23	30.0 +/- 2.4	30

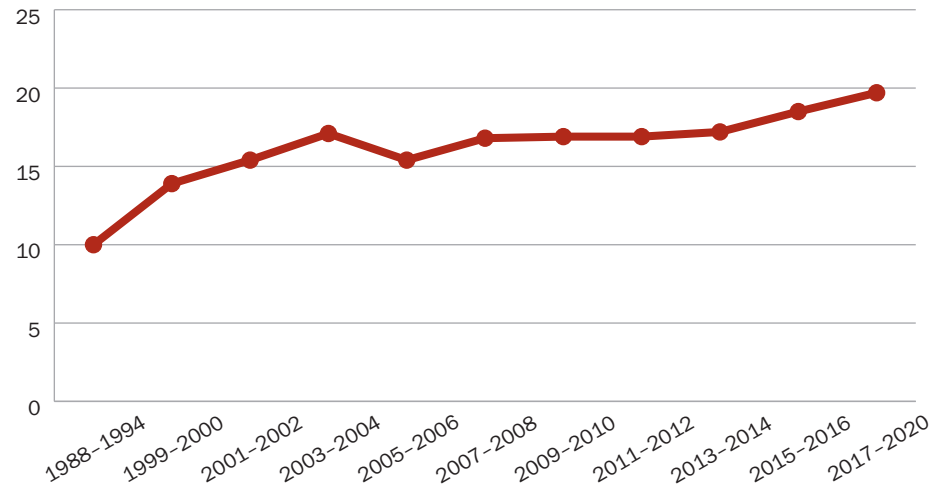
Source: TFAH analysis of BRFSS data²¹⁰

NOTE: For rankings, 1 = Highest Rate, and 51 = Lowest Rate; T= Tie. Data from Kentucky and Pennsylvania were not available for 2023.

B. TRENDS IN YOUTH OBESITY

As with adults, obesity has been rising among children for decades. Between the inaugural 1976–1980 NHANES survey and the 2017–2020 survey, obesity rates for children ages 2 to 19 more than tripled, from 5.5 to 19.7 percent.^{211,212} This section includes the latest data available on childhood obesity. As with adults, this report relies on multiple surveys to better understand the full picture of childhood obesity.

Figure 4: Percent of Youth with Obesity, 1988–2020



Source: NHANES

DATA SOURCES FOR CHILDHOOD OBESITY MEASURES

- 1. NHANES** is the primary source for national obesity data on adults and on children ages 2 to 19 in this report. NHANES is particularly valuable in that it combines interviews with physical examinations, including measured heights and weights, while also covering a wide age range of Americans. The downsides of the survey include a time delay from collection to reporting and samples that do not break out local data. The most recent NHANES data are from a combination of the 2017–2018 and 2019–2020 NHANES surveys since data collection was disrupted by the COVID-19 pandemic. The 2021–2023 NHANES survey is expected to be released in fall 2024.²¹³
- 2. The WIC Participant and Program Characteristics Report** is a biennial census of low-income mothers and young children (under the age of 5) that WIC serves.²¹⁴ Because obesity disproportionately affects individuals with low incomes, early childhood is a critical time for obesity prevention, and the data provide valuable information for evaluating the effectiveness of programs aimed at reducing obesity rates and health disparities. The most recent public WIC data on obesity are from 2020. The 2022 WIC data do not include obesity data due to in-person data-collection issues related to the COVID-19 pandemic, though it is expected to be included again in the 2024 survey.²¹⁵
- 3. The National Survey of Children’s Health** surveys parents of children about aspects of their children’s health, including height and weight for children ages 6 to 17. An advantage of this survey is that it includes state-level data. A disadvantage is that height and weight data are parent-reported, not directly measured.²¹⁶ The most recent data are from the 2021–2022 survey. This iteration expanded the age range for reporting weight status to children ages 6 to 17, from ages 10 to 17 in previous years.^{217,218}
- 4. The Youth Risk Behavior Survey (YRBS)** measures health behaviors, including eating habits and physical activity behaviors, as well as weight status (determined from self-reported height and weight), among students in grades 9 to 12. As in other surveys that use self-reported data to measure obesity, this survey likely underreports the true rates.²¹⁹ YRBS officials conduct the survey in odd-numbered years; 2021 is the most recent dataset available, though the 2023 survey is expected in 2024.²²⁰ The 2021 survey includes state-level samples for 44 states plus three U.S. territories, two tribal areas, the District of Columbia, and select large urban school districts, as well as a separate national sample.²²¹

I. National Youth Obesity Rates (NHANES)

The most recent national data, the 2017–2020 NHANES survey, found that 19.7 percent of youth ages 2 through 19 had obesity.²²² The data show variation in obesity prevalence by demographic and socioeconomic groups:

- **Race/ethnicity: Black and Hispanic youth had higher rates of obesity than their Asian and white peers.** Obesity prevalence for Asian youth was 9 percent, Black youth 24.8 percent, Hispanic youth 26.2 percent, and white youth 16.6 percent in 2017–2020.

- **Sex: Boys are slightly more likely to have obesity than girls.** In 2017–2020, 20.9 percent of boys had obesity, and 18.5 percent of girls had obesity.

- **Age: The prevalence of obesity increases with age.** In 2017–2020, 12.7 percent of children ages 2 to 5, 20.7 percent of children ages 6 to 11, and 22.2 percent of children ages 12 to 19 had obesity. Between the 1976–1980 NHANES survey and the 2017–2020 survey, the percentage of children ages 2 to 19 with obesity

overall tripled, with the obesity rates of teens ages 12 to 19 quadrupling.²²³

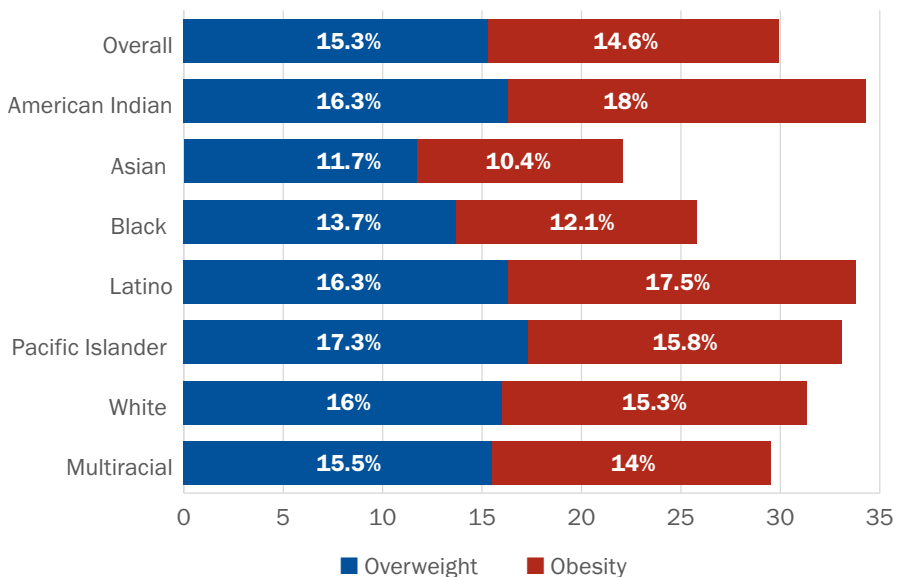
- **Household income: Children in households with lower incomes have higher rates of obesity.** In 2017–2020, 25.8 percent of children living in households with incomes below 130 percent of FPL had obesity, 21.2 percent of children in households at 130–350 percent of FPL had obesity, and 11.5 percent of children in households above 350 percent FPL had obesity.²²⁴

II. Young WIC Participants, Ages 2 to 4 (WIC Program Data)

In 2020, 14.6 percent of children ages 2 to 4 in the WIC program had obesity, and 15.3 percent were overweight.

The percentage of children who were overweight or had obesity increased between 1992 and 2008, then decreased between 2010 and 2020 after a 2009 change in the WIC benefits to allow for healthier food options, including fruits, vegetables, seafood, and whole grains (see page 45 for more on WIC). American Indian and Hispanic children were the most likely to be overweight or have obesity compared with other races/ethnicities.^{225,226} (See Figure 5 for the most recent data by race/ethnicity as well as the chart on page 33 for state-level data.)

FIGURE 5: Percent of Children Ages 2–4 in the WIC Program Who Are Overweight or Have Obesity, by Race/Ethnicity, 2020



Source: USDA Food and Nutrition Service²²⁷

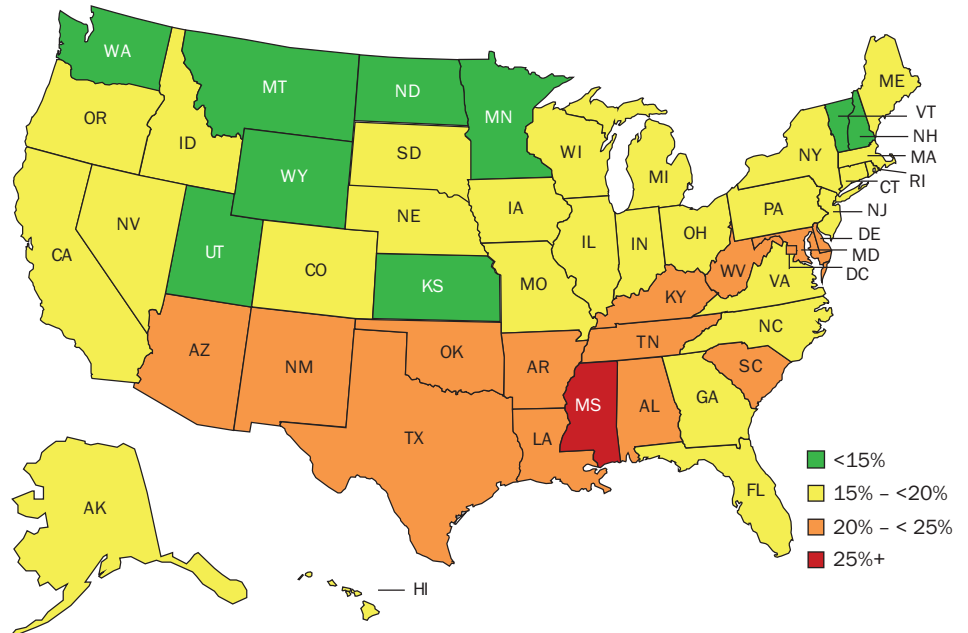
III. Obesity Rates in Children and Teenagers, Ages 6 to 17 (National Survey of Children's Health)

The National Survey of Children's Health 2021–2022 survey reported that, nationwide, 18.1 percent of children ages 6 to 17 had obesity and another 15.6 percent were overweight.²²⁸ (Note: this year's survey has an expanded age range surveyed for obesity questions to include children ages 6 to 17 when previous years only included ages 10 to 17.)

Other takeaways:

- Boys had higher rates of obesity (20.5 percent) than girls (15.6 percent).
- Obesity rates varied by racial/ethnic groups: 29.6 for AI/AN children, 12.4 for Asian children, 25.2 for Black children, 23.7 percent for Hispanic children, 13.9 percent for white children, and 17.6 percent for multi-racial children.
- Children in households with higher incomes had lower rates of obesity. In 2021–2022, children in households where income was 400 percent of FPL or greater had a 10.9 percent obesity rate; those in 200–399 percent FPL had an 18.8 percent obesity rate; 100–199 percent FPL had a 22.3 percent obesity rate; and 0–99 percent FPL had a 25.9 percent obesity rate. The lowest-income group had well over twice the rate of the highest-income group.

Map 3: Percent of Youth Ages 6–17 With Obesity, by State, 2021–2022



Source: National Survey of Children's Health²³⁰

- Obesity rates also varied by state. The states with the highest rates of obesity for children ages 6 to 17 were Mississippi (26.1 percent), Kentucky (24.6 percent), and New Mexico (24.2 percent); the states with the lowest rates of obesity were Vermont (11.6 percent), Minnesota (13.1 percent), and Utah (13.1 percent). (See chart on page 33 for more state data.)²²⁹

IV. High School Obesity Rates (YRBS)

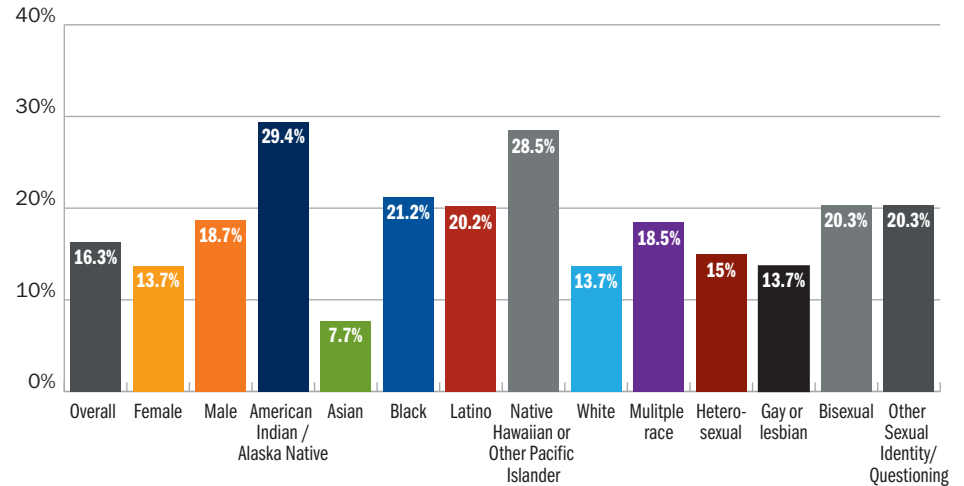
According to 2021 YRBS data, 16.3 percent of high school students (grades 9 to 12) nationwide had obesity and 16.0 percent were overweight. Obesity levels in 2021 were slightly higher than in 2019 (15.5 percent with obesity) and show an increase in the long-term; in 1999, obesity rates among high schoolers participating in the survey were at 10.6 percent.^{231,232} Other takeaways:

- The prevalence of obesity among high school students in different states varied considerably, from 10.2 percent in Utah to 26.9 percent in West Virginia.
- There were also stark differences in obesity rates across demographic

groups. Male students (18.7 percent) had higher obesity rates than female students (13.7 percent); bisexual (20.3) and questioning students (20.3 percent) had higher obesity rates than gay or lesbian (13.7) and heterosexual (15.0 percent) students; and AI/AN, Black, Hispanic, and Native Hawaiian/Pacific Islander students (all above 20 percent) had higher obesity rates than white (13.7 percent) and Asian (7.7 percent) students (see Figure 4).

See page 33 for state-by-state data on obesity, overweight, and physical activity levels among high school students.

FIGURE 6: Percent of High School Students with Obesity by Select Demographics, 2021



Source: Youth Risk Behavior Survey²³³

TABLE 4: Youth Obesity Rates and Related Health Indicators

States	Young Children: Obesity, 2020	Children and Teenagers: Obesity and Physical Activity, 2021-2022			High School (HS) Students: Obesity, Overweight, Physical Activity, 2021		
	Percent of Low- Income Children Ages 2-4 With Obesity	Percent of Children Ages 6-17 With Obesity	Ranking	Percent of Children Ages 6-17 Who Participated in 60 Minutes of Physical Activity Every Day	Percent of HS Students With Obesity	Percent of HS Students Who Were Overweight	Percent of HS Students Who Were Physically Active 60 Minutes Every Day of the Week
Alabama	15.6	23.3	47	22.2	13.9	18.7	25.3
Alaska	20.1	17.7	28	29.7	n/a	n/a	n/a
Arizona	13.3	20.0	37	17.3	14.9	16.6	22.0
Arkansas	13.9	21.1	40-T	21.3	19.4	16.3	25.6
California	17.0	16.9	24	18.3	n/a	n/a	n/a
Colorado	8.8	15.2	11	20.2	10.6	12.8	22.1
Connecticut	14.6	17.8	29-T	21.5	15.1	16.6	21.7
Delaware	18.5	20.5	39	21.0	17.0	15.4	21.6
D.C.	12.9	21.1	40-T	19.2	20.4	16.9	16.9
Florida	13.5	15.4	13	18.0	16.4	16.5	22.5
Georgia	13.1	16.8	23	19.2	17.0	18.8	23.2
Hawaii	11.0	19.2	35	16.3	14.9	14.0	23.1
Idaho	11.8	15.5	14	21.7	11.9	12.2	18.4
Illinois	16.4	17.6	25-T	27.0	15.6	14.8	24.1
Indiana	13.9	17.6	25-T	23.2	17.6	14.8	19.2
Iowa	16.0	15.7	15-T	26.0	15.8	16.0	29.2
Kansas	12.8	14.9	9	23.3	17.0	18.4	27.1
Kentucky	15.4	24.6	50	21.6	19.6	16.2	25.3
Louisiana	13.7	22.0	44	18.6	18.7	17.8	24.0
Maine	14.3	16.4	22	24.5	15.0	14.4	22.5
Maryland	16.9	20.1	38	18.8	16.0	15.3	19.6
Massachusetts	16.8	15.3	12	18.4	13.6	15.2	23.5
Michigan	13.8	19.6	36	21.7	15.6	14.3	22.3
Minnesota	11.8	13.1	2-T	24.9	n/a	n/a	n/a
Mississippi	14.4	26.1	51	20.7	23.2	18.5	25.5
Missouri	12.7	16.1	20	24.5	16.9	16.2	28.0
Montana	10.9	13.9	4	27.7	11.8	14.0	25.9
Nebraska	16.0	15.0	10	25.1	19.2	15.4	30.6
Nevada	11.9	16.0	19	13.3	15.9	18.0	19.4
New Hampshire	16.0	14.1	7	23.8	13.3	13.7	22.9
New Jersey	15.4	15.7	15-T	18.9	13.8	15.7	22.1
New Mexico	12.7	24.2	49	17.7	20.0	17.9	26.4
New York	13.8	18.3	32	20.1	16.1	15.4	19.4
North Carolina	14.8	19.0	34	17.0	19.0	13.7	19.1
North Dakota	15.6	14.6	8	26.3	16.3	15.6	30.3
Ohio	13.0	17.8	29-T	22.7	18.8	13.4	25.8
Oklahoma	13.2	21.4	43	19.5	17.6	16.8	32.4
Oregon	14.7	15.7	15-T	22.1	n/a	n/a	n/a
Pennsylvania	13.8	16.3	21	23.5	17.3	14.5	21.1
Rhode Island	16.5	18.2	31	17.0	15.5	17.2	21.2
South Carolina	13.1	23.0	46	21.3	17.9	16.9	24.0
South Dakota	15.6	17.6	25-T	23.8	16.6	15.3	28.2
Tennessee	14.9	21.2	42	20.1	18.3	15.3	23.0
Texas	15.8	22.3	45	15.8	22.1	17.2	25.7
Utah	8.8	13.1	2-T	17.6	10.2	12.1	21.7
Vermont	14.5	11.6	1	25.4	13.6	14.0	28.0
Virginia	15.6	15.9	18	17.9	16.4	15.3	21.9
Washington	14.8	14.0	5-T	18.1	n/a	n/a	n/a
West Virginia	16.4	24.1	48	26.3	27.0	17.4	22.7
Wisconsin	15.2	18.8	33	23.1	13.5	16.1	28.0
Wyoming	11.8	14.0	5-T	26.1	n/a	n/a	n/a

SOURCE: WIC
Participants and Program
Characteristics Survey,
USDA

SOURCE: National Survey of Children's Health, HRSA
NOTE: For rankings, 1 = Highest Rate, and 51 = Lowest Rate.
T= Tie.

SOURCE: Youth Risk Behavior Survey, CDC

The State of Obesity

Obesity-Related Policies and Programs

A. ECONOMICS OF WHAT WE EAT AND DRINK

The cost of food is an important factor for many Americans when making purchasing decisions, and affordability of nutritious foods can be a major barrier to eating healthily.^{235,236,237,238} Economic policies, such as financial incentives or disincentives, can influence behaviors and improve health outcomes. They include programs that improve access to healthy foods and taxes to discourage or disincentivize the consumption of unhealthy foods and beverages.

I. Fiscal and Tax Policies that Promote Healthy Eating: Beverage Taxes, Healthy Food Financing Initiative, and New Markets Tax Credit

Beverage Taxes

Sugary beverages are the leading source of added sugars in the U.S. diet, and excess intake is associated with multiple chronic conditions, including obesity, heart disease, kidney disease, and type 2 diabetes.²³⁹ Excise taxes on sugary beverages (typically 1–2 cents per ounce) are an effective intervention to discourage consumption^{240,241,242,243,244} and incentivize manufacturers to reduce the added sugar content in their products, particularly when the taxed amount is proportional to the amount of added sugar in the drink.²⁴⁵ Additionally, sugary beverage tax revenue is often dedicated to addressing obesity or other public health priorities, which can further reduce health and socioeconomic disparities, nutrition insecurity, and obesity and chronic disease rates.^{246,247,248}

In December 2023, the World Health Organization called on its member countries to increase taxes on sugary

beverages.²⁴⁹ At least 108 countries (out of 195 total countries) currently impose a beverage tax.^{250,251} However, no U.S. states and only seven U.S. cities have imposed excise taxes on sugary beverages, with the most recent cities of Seattle and San Francisco implementing such taxes in 2018.²⁵² Political momentum for beverage taxes has stalled in recent years.^{253,254,255}

Healthy Food Financing Initiative (HFFI)

HFFI was created by the 2014 Farm Bill and reauthorized by the 2018 Farm Bill, to provide loans, grants, and technical assistance for programs that increase access to fresh, healthy, affordable food in under-resourced communities, helping to reduce food insecurity, revitalize low-income neighborhoods, and build a more equitable food system.²⁵⁶ USDA estimates that nearly 13 percent of U.S. households are food insecure, meaning they are uncertain of having enough food to meet the needs of all household members throughout the year due to a lack of money or resources.²⁵⁷ HFFI is a public-private partnership funded by USDA and administered by the Reinvestment Fund, an independent community development financial institution.²⁵⁸

In August 2023, USDA, through American Rescue Plan funding, provided \$40 million to expand HFFI to include local and regional public-private partnerships, called the Local and Regional Healthy Food Financing Partnerships Program. The expanded program provides technical and financial assistance to food retailers and food enterprises that are focused

on improving access to fresh, healthy, and affordable food in underserved communities.^{259,260} In April 2024, the Reinvestment Fund supported programs in rural, urban, and tribal communities across 20 states and Washington, DC.²⁶¹

HFFI funds efforts such as:

- The North Flint Food Market, a project started by the North Flint Reinvestment Corporation to bring affordable, fresh food to North Flint, Michigan, used HFFI funding to kick-start the store's construction and renovation;²⁶² and
- A Red Circle used HFFI funding to create the People's Harvest Community Grocery Store, a full-service grocery store expected to open in Summer 2025 in North St. Louis County, Missouri. People's Harvest aims to promote affordability, improve health outcomes, strengthen local food systems, and create economic development opportunities for the community.²⁶³

On November 16, 2023, the Further Continuing Appropriations and Other Extensions Act of 2024 was signed into law, extending authorized programs from the 2018 Farm Bill, including HFFI, through September 2024.²⁶⁴ Congressional supporters of HFFI, meanwhile, have introduced legislation to provide \$5 million in mandatory funding per fiscal year (FY) and require the USDA secretary to conduct and publish a short- and long-term impact evaluation of the program.²⁶⁵

New Markets Tax Credit (NMTC)

Established as part of the Community Renewal Tax Relief Act of 2000, the NMTC incentivizes taxpayers to invest in communities experiencing disadvantages—such as those that have high unemployment or low average

income—that also have the goal of improving health equity.²⁶⁶ The credits are competitively awarded by the U.S. Treasury's Community Development Financial Institutions Fund. NMTC-funded projects are expected to create jobs or otherwise improve the lives of residents by, for example, improving access to healthcare services, local and regional healthy foods, places for physical activity, or economic opportunity.

Recent NMTC-funded projects include:

- Operation Food Search in Overland, Missouri, is increasing its programming and impact through renovations of its headquarters, allowing it to expand its reach to serve more members of the community. Services include providing food, nutrition and education, as well as advocating for policies that address food insecurity.²⁶⁷
- GLOW Healthy Living Campus in Batavia, New York, will replace the current YMCA building and provide residents with a blended wellness, fitness, and full-service primary care medical facility, doubling the number of people served annually.²⁶⁸
- A new Food Bank of Central and Eastern North Carolina will be built in Wilmington, North Carolina, tripling the size of Wilmington's old location, allowing the food bank to expand its service region, create new jobs, and more effectively fight food insecurity.²⁶⁹

In September 2023, the Community Development Financial Institutions Fund awarded \$5 billion in credits to 102 community development entities.²⁷⁰ Since its inception, the NMTC has invested \$76 billion in low-income communities.²⁷¹

The NMTC is currently authorized at \$5 billion annually through 2025.²⁷²

Research Roundup: New Insights and Analysis

Research helps give new insights and analysis into understanding the causes and consequences of obesity, as well as effective ways to prevent and treat obesity. A few examples of recent studies across the field of obesity and chronic disease, nutrition, and physical activity are below.

Impact of the Affordable Care Act Medicaid Expansion on Weight Loss among Community Health Center Patients with Obesity

Annals of Family Medicine, January 2023

This study sought to assess whether individuals who have obesity and receive care in community health centers—which provide healthcare to underserved communities—are more likely to lose weight in Medicaid expansion states, compared with those in non-expansion states. They found that weight management among patients receiving care in community health centers was greater among patients residing in expansion states than those in non-expansion states, particularly among people of color.²⁷³

Association of Food Deserts and Food Swamps with Obesity-Related Cancer Mortality in the U.S.

JAMA Oncology, May 2023

Researchers investigated the odds of higher obesity-related mortality rates in U.S. counties with food deserts (less access to grocery stores and farmers' markets) or food swamps (greater access to fast food and convenience stores than grocery stores and farmers' markets). The ecologic cross-sectional study found that U.S. counties with higher percentages of persons living in food deserts and food swamps had higher obesity-related cancer

mortality compared with counties with fewer food deserts and food swamps. After adjusting for age, race, and poverty rates, there was an almost 30 percent increase in the odds of higher obesity-related cancer mortality among counties with high food swamp scores. Researchers concluded that sustainable approaches to combating obesity and cancer in underserved communities should include providing access to healthier food options.²⁷⁴

Effectiveness of Lifestyle Nutrition and Physical Activity Interventions for Childhood Obesity and Associated Comorbidities among Children from Minority Ethnic Groups: A Systematic Review and Meta-Analysis

Nutrients, May 2023

This global study sought to examine the effectiveness of lifestyle interventions, such as physical activity, nutrition, and behavioral counseling, among ethnic minority children in Western high-income countries through a systematic review and meta-analysis of the current literature. Researchers found that lifestyle interventions targeting communities of color that focused on BMI outcomes were not effective. However, they concluded that incorporating obesity-related comorbidity measures/outcomes with BMI within culturally tailored lifestyle interventions could be critical to the prevention of obesity-related complications of noncommunicable diseases in high-risk ethnic minority children with overweight or obesity. They also noted the need for more family-level obesity intervention studies, developed in partnership with minority ethnic communities.²⁷⁵

Rural-Urban Differences in Overweight and Obesity, Physical Activity, and Food Security among Children and Adolescents

Preventing Chronic Diseases, October 2023

Researchers sought to examine rates and association of food security, physical inactivity, and overweight or obesity among urban and rural children and adolescents in the United States. Findings suggest that, after adjusting for sociodemographic factors, there are still important differences across groups. Children and adolescents living in rural areas, non-Hispanic Black children, children with special healthcare needs, and low/moderate-income children and adolescents had higher odds of overweight or obesity. Non-Hispanic Black children, girls, children with special healthcare needs, and children living in households where English was not the primary spoken language had higher odds of physical inactivity. Hispanic children, children with special healthcare needs, children residing in a single caregiver household, children from households with low and moderate incomes, and children in households where English was not the primary spoken language had higher odds of food insecurity. This study provides insights to inform the creation of equitable healthy weight, diet, and physical activity interventions for children and adolescents in rural and urban settings.²⁷⁶

Residential Structural Racism and Prevalence of Chronic Health Conditions

Journal of American Medical Association, December 2023

This cross-sectional ecological study sought to assess whether residential structural racism indicators are associated with chronic health conditions, particularly

chronic kidney disease, diabetes, and hypertension, across 150 neighborhoods in Durham County, North Carolina. The researchers examined indicators of structural racism that were both global (e.g., percentage of white residents, economic-racial segregation, and area deprivation) and discrete (e.g., access to childcare centers, bus stops, tree cover, violent crime reporting, police shootings, impervious areas [i.e., percentage of an area where groundwater is unable to drain due to artificial structures and pavement], evictions, election participation, income, poverty, education, unemployment, and health insurance coverage). Both global and discrete indicators of structural racism were found to be associated with a greater prevalence of chronic kidney disease, diabetes, and hypertension by neighborhood. The researchers noted that future studies could help to improve an understanding of the mechanisms through which local factors may influence community health.²⁷⁷

Perceived Stress from Childhood to Adulthood and Cardiometabolic End Points in Young Adulthood: An 18-Year Prospective Study

Journal of the American Heart Association, January 2024

Researchers sought to study how perceived stress patterns from childhood to adulthood impact cardiometabolic risk. The study found that higher perceived stress scores during adulthood were associated with increased overall cardiometabolic risk. They also found that individuals with consistently high adolescence-to-adulthood perceived stress patterns had greater overall cardiometabolic risk in adulthood than those with low perceived stress,



including greater odds of having obesity. This study stresses the importance of promoting healthy coping strategies for stress management in adolescence to help manage and potentially reduce cardiometabolic risk, including risk of obesity, in adulthood.²⁷⁸

Cost Effectiveness of Calorie Labeling at Large Fast-Food Chains Across the U.S.

American Journal of Preventive Medicine, January 2024

In 2018, requirements for calorie labeling of standard menu items were implemented at large restaurant chains across the United States, aimed at educating and empowering individuals to make healthier choices while eating out and incentivizing the restaurant industry to develop or promote lower-calorie

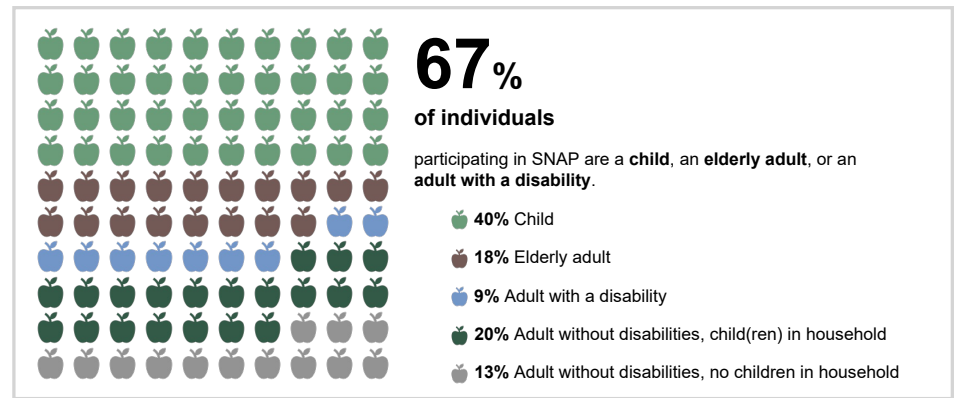
menu items. Researchers estimated the health impact and cost-effectiveness of the new calorie labeling requirement in the United States over the first decade that it has been in effect (2018–2027). Using a microsimulation model, the study found that calorie labeling is estimated to prevent 550,000 cases of obesity in 2027 alone, including 41,500 cases of childhood obesity, and save an average of \$22.60 in healthcare costs for every \$1 spent by society on national calorie-labeling implementation costs. This study concluded that fast food chain calorie labeling is a low-cost and cost-saving intervention to improve long-term population health among all racial and ethnic and income groups in the United States.²⁷⁹

B. NUTRITION ASSISTANCE, STANDARDS, AND EDUCATION

USDA's 16 nutrition assistance programs serve one in four Americans and promote food security (access to sufficient food for an active, healthy life at all times) and nutrition security (consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being).^{280,281} These programs enable individuals and families to access nutritious foods and support better health and health equity across the nation. Some programs, such as the National School Lunch Program (NSLP), provide nutritious foods directly to participants, while others, such as SNAP, provide funds that can be used to purchase groceries.

American consumers have seen an increase in grocery prices in recent years, driven by an increase in prices across the food supply chain (e.g., production, processing, and retail) and a surge in consumer demand.²⁸² Increased spending on food due to higher prices may increase reliance on federal food and nutrition assistance programs and charitable food-sector programs (e.g., food banks) for many Americans. The federal emergency flexibilities and allotment to USDA's nutrition assistance programs related to the COVID-19 public health emergency—including increases to benefits for certain enrollees and added benefits to children who would have received free or reduced school meals—ended by spring 2023.²⁸³

Most people who participate in SNAP are children, older adults, or people with disability



Source: USDA Food and Nutrition Service²⁸⁷

I. Federal Hunger and Nutrition Assistance: SNAP, Child Nutrition Programs, and WIC Supplemental Nutrition Assistance Program (SNAP)

SNAP, formerly called “food stamps,” is the nation’s largest nutrition assistance program in both participation and federal funding. It helps feed more than 42 million low-income people each year by providing them with funds on an electronic benefits transfer (EBT) card that can be used to buy groceries.²⁸⁴ Forty percent of SNAP households include children and 18 percent include older adults.²⁸⁵ SNAP plays a critical role in combating hunger and food insecurity, while also reducing poverty, improving health and economic outcomes, supporting low-wage workers, and bolstering individuals and families during economic instability.²⁸⁶

SNAP is administered by USDA's Food and Nutrition Service (FNS), with the cost of administering the program shared between the federal government and the states.²⁸⁸ SNAP benefits can be used to buy any food with the exception of hot prepared foods; vitamins,

medicine, or supplements; live animals; nonfood items; and alcohol or tobacco.²⁸⁹ Nine states participate in the Restaurant Meals Program, which allows certain enrollees—individuals experiencing homelessness, who have a disability, or are age 60 or older—to use SNAP benefits to purchase hot, prepared food from participating restaurants.²⁹⁰

SNAP benefit amounts are tied to the Thrifty Food Plan, a USDA calculus of the minimum cost of groceries needed for a healthy, budget-conscious diet for a family of four.²⁹¹ USDA adjusts the cost of the food plans annually for inflation using the Consumer Price Index.²⁹² USDA is required to re-evaluate the Thrifty Food Plan every five years, with the next re-evaluation anticipated in 2026.²⁹³ For FY 2024, the Center on Budget and Policy Priorities estimates that the average SNAP benefit is \$189 per person per month, or \$713 for a family of four.²⁹⁴

In June 2023, Congress passed the Fiscal Responsibility Act of 2023, which adds new eligibility restrictions to SNAP. The law increases the number of individuals without dependents who

must meet specific work requirements in order to participate in SNAP for more than three months in a three-year period (commonly known as “the time limit”). In October 2023, the time limit requirement expanded from ages 18–49 to ages 18–52, and will increase again, to ages 18–54 in October 2024.^{295,296} The legislation also created exceptions to the time limit for certain individuals without dependents: those experiencing homelessness, veterans, and youth ages 18 to 24 who have aged out of foster care.²⁹⁷ Further restrictions on SNAP benefits could negatively impact a person’s ability to access needed nutrition assistance.

In 2019, USDA began implementation of a SNAP Online pilot program, which was authorized in the 2014 Farm Bill, to test online ordering and payment for SNAP purchases.²⁹⁸ Since that time, SNAP Online has become available in all 50 states and Washington, DC. Furthermore, FNS has established a cooperative grant project between USDA FNS and the National Grocer’s Association Foundation, called SNAP EBT Modernization Technical Assistance Center to provide information and technical assistance to those who are interested or to those who are in process of enrolling in the SNAP Online pilot.^{299,300}

FNS also awards competitive Process and Technology Improvement Grants annually to support state agency, community-based, and faith-based partners’ efforts to develop and implement technology-based projects that improve the quality and efficiency of SNAP application and eligibility determination systems.³⁰¹ Each year, FNS offers up to \$5 million in Process and Technology Improvement Grants for projects that support the modernization of SNAP customer

service and client communications; improve administrative infrastructure; or invest in technology that allow for easier enrollment and collaboration with other assistance programs.³⁰² These grants help to improve access to SNAP by ensuring more timely and accurate benefits for enrollees.

SNAP has an educational component called SNAP-Education (SNAP-Ed) that funds nutrition and obesity prevention programs and initiatives for SNAP enrollees and other individuals in low-income communities. SNAP-Ed’s classes, campaigns, and policy and environmental change initiatives help people stretch food budgets, prepare healthy meals, and lead physically active lives.³⁰³ Recent examples of SNAP-Ed activities include:

- **Merrymeeting Gleaners.** This gleaning or excess harvesting partnership group in midcoastal Maine partnered with Maine farmers who share their harvest surplus with community members experiencing food insecurity. Through SNAP-Ed support, Merrymeeting Gleaners collects and distributes quality produce that would otherwise go to waste to community sites across the state to address nutrition security.³⁰⁴
- **Reno Extension,** at the University of Nevada. This SNAP-Ed implementing agency is empowering preschoolers in Nevada to learn about healthy foods and to participate in more structured physical activities aimed at building healthy habits into adolescent and adult years.³⁰⁵
- **The Turtle Island Tales Family Wellness Program.** This is a program for low-income, SNAP-eligible American Indian families created by Montana State University Center for American Indian and Rural

Health Equity that focuses its home-based, family-level, direct education interventions on providing culturally appropriate skills and tools to support making healthy lifestyle choices.³⁰⁶

Congress funded SNAP at \$122.38 billion for FY 2024, including \$521 million for SNAP-Ed.^{307,308}

Congress is considering changes to SNAP through the 2024 Farm Bill. There is also a bipartisan effort in Congress to pass the SNAP Nutrition Security Act of 2023, which would require USDA to report SNAP nutrition data to Congress in its annual report and require a SNAP sales report on affordability every four years (including types of products typically purchased with SNAP resources).³⁰⁹ The bill sponsors hope that its passage would provide data to improve diet quality and nutrition security, while leading anti-hunger groups are concerned that the data will be used to reduce or restrict SNAP purchases in the future.^{310,311}

Debates around changes to SNAP are also occurring at the state level, with some states widening access to SNAP and others looking to restrict access or change eligibility requirements.³¹²

The federal government is also considering changes to SNAP that would change how benefits are calculated, which would decrease the value of benefits over time.³¹³

The Gus Schumacher Nutrition Incentive Program (GusNIP)

The GusNIP portfolio includes three grant programs for state and local governments and nonprofits. The programs include (1) nutrition incentives to encourage SNAP participants to purchase and consume more fruits and vegetables, (2) produce prescriptions, and (3) technical

assistance and evaluation to improve GusNIP programs.³¹⁴ Nutrition-incentive projects support point-of-purchase incentives, specifically for SNAP participants, such as 1:1 purchasing (e.g., “spend \$10 and get \$20 worth of produce”). Produce prescriptions projects support healthcare providers writing “fruits and vegetables prescriptions” that can be redeemed for fresh produce for patients who are low-income, food insecure, and often have a diet-related chronic disease.^{315,316}

From 2019 to 2023, GusNIP has provided over \$290 million in funding to more than 200 projects throughout the United States. An analysis of the program’s impact for September 2022–August 2023 found that the nutrition-incentive and produce prescription programs improved participant food and nutrition security, and participants ate more fruits and vegetables than the average adult.³¹⁷ GusNIP programs also generated over \$107 million in economic benefits during that time for surrounding local economies, a 25 percent increase over the previous year.^{318,319}

Established in its current form by the 2018 Farm Bill, GusNIP is the successor to the Healthy Incentives Pilot and Food Insecurity Nutrition Incentive grant programs and is administered by USDA National Institute of Food and Agriculture with support from FNS.^{320,321} GusNIP was authorized \$56 million in total program funding for FY 2024 and beyond in the 2018 Farm Bill.³²² Given the support from more than 600 farm, food, and health leaders to expand and strengthen GusNIP,³²³ there are currently several bills in Congress that could increase annual funding for GusNIP and strengthen the program, including reducing the partnering organizations’ required federal match requirements.

Child Nutrition Programs

USDA Child Nutrition Programs provide nutritious meals and snacks to children, adolescents, and some adults.³²⁴ These programs are federally funded and administered by FNS and state agencies. The major Child

Nutrition Programs are described in the table below. The Child Nutrition Programs operate in multiple settings, including public and private schools, daycare centers, after-school programs, and residential childcare institutions.³²⁵

TABLE 5: MAJOR USDA CHILD NUTRITION PROGRAMS

National School Lunch Program (NSLP)	NSLP is the nation's second-largest nutrition assistance program, providing healthy lunches to America's school-age children since 1946. ³²⁶ NSLP is the largest of the Child Nutrition Programs, feeding an average of nearly 29 million children per day in FY 2023, ³²⁷ and serving nutritious meals to school-age children at low or no cost. ³²⁸
School Breakfast Program (SBP)	SBP serves nutritious breakfasts to school-age children at low or no cost, feeding an average of nearly 15 million children per day in FY 2023. ^{329,330}
Special Milk Program (SMP)	Schools that do not participate in either NSLP or SBP—or offer half-day pre-kindergarten and kindergarten programs for students who do not participate in school meals programs—can participate in SPM, which reimburses schools for providing milk. ³³¹
Child and Adult Care Food Program (CACFP)	CACFP reimburses participating childcare centers, daycare homes, after-school programs, children residing in emergency shelters, and adult daycare centers for the cost of nutritious meals and snacks. ³³²
Summer Food Service Program (SFSP)	SFSP provides free healthy meals and snacks to school-age children in low-income communities when school is not in session. ³³³
Summer Electronic Benefits Transfer for Children (or "SUN Bucks")	SUN Bucks provide funds to families with eligible school-age children in participating states to buy groceries during the summer months. ³³⁴
Fresh Fruit and Vegetable Program (FFVP)	FFVP provides fresh fruits and vegetables to students at eligible elementary schools during school days in an effort to increase consumption of fresh, unprocessed produce. ³³⁵
Patrick Leahy Farm to School Grant Program	The Farm to School Grant Program helps improve access to healthy local foods in schools through field trips, school gardens, and sourcing local food for school meals. ³³⁶

Food served through the Child Nutrition Programs must meet federal nutrition standards, making school meals some of the healthiest foods that American children eat, while also lowering food and nutrition insecurity, alleviating poverty, improving health outcomes, and boosting learning and development for school-age children and their families.^{337,338,339} School meals have also been linked to lower BMI and lower prevalence of obesity, particularly since the nutrition standards were strengthened following passage of the Healthy, Hunger-Free Kids Act

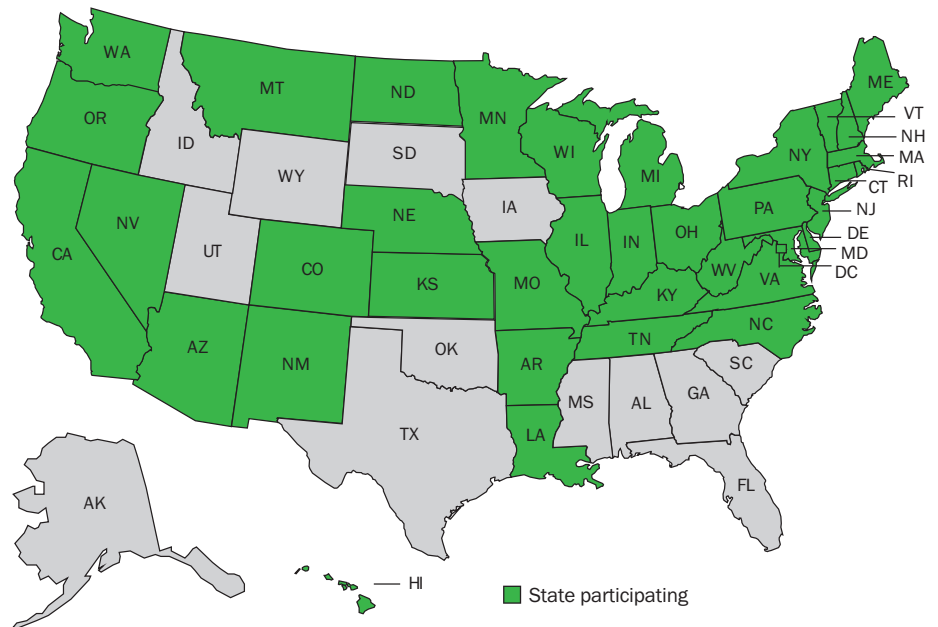
of 2010.^{340,341,342,343} Although various congressional and administrative actions have weakened some nutrition standards for school meals set out in the Healthy, Hunger-Free Kids Act, these programs tend to have bipartisan support in Congress, and there have been multiple legislative and administrative efforts to improve on the program's success.³⁴⁴

To support school-age children from low-income families during the summer months, FNS provides two complementary programs to increase food and nutrition security:³⁴⁵

- SFSP provides free nutritious meals and snacks to school-age children during the summer months when school is not in session.³⁴⁶ These meals are provided in a central, supervised site, such as a school or community center, and often accompanied by an enrichment activity.³⁴⁷ However, in certain rural communities where in-person, congregate meal service is not available, school-age children have access to grab-and-go or delivered meals.³⁴⁸
- SUN Bucks (previously Summer EBT) provides funds to families to buy groceries.³⁴⁹ SUN Bucks began as a pilot program in a few states more than a decade ago and served as the basis for Pandemic EBT, which provided a monthly grocery benefit to families with children eligible for free and reduced-price meals

during pandemic-related childcare and school closures.³⁵⁰ As part of the FY 2023 omnibus spending bill, Congress made Summer EBT permanent beginning in summer 2024, after data showed the program helped to reduce child hunger and improve diet quality.^{351,352} However, states have to opt in to participate in the program and pay a portion of the program’s administrative fees. During summer 2024, 37 states, the District of Columbia, all five U.S. territories, and two tribes were expected to participate in the program (see map below), offering nearly 21 million eligible individuals a SUN Bucks benefit of \$120 per child.^{353,354} For future years, the benefit amount will be indexed to inflation, and additional states and tribes may choose to participate.³⁵⁵

Map 4: Summer 2024 SUN Bucks Participation



Source: USDA Food and Nutrition Service³⁵⁶

Note: In addition, to the states and District of Columbia noted in the map above, Cherokee and Chickasaw Nations, and the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands also participated in SUN Bucks in summer 2024.

Recent Administrative and Legislative Action for Child Nutrition Programs

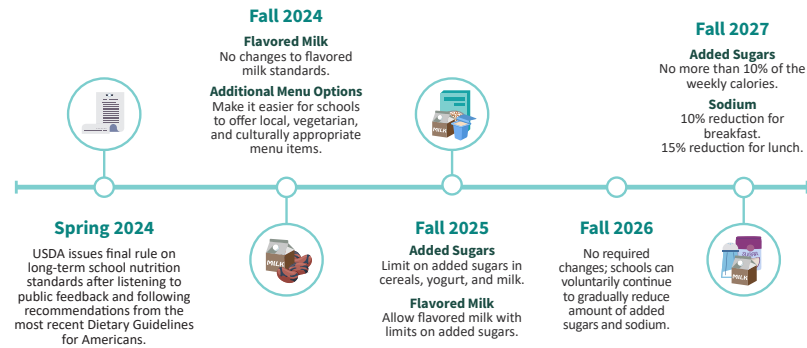
There has been important work to improve nutrition quality and to expand school meals to more children across the United States over the last year. In April 2024, USDA finalized a rule to better align school and CACFP nutrition standards with the latest Dietary Guidelines for Americans, most notably by gradually reducing allowable levels of added sugars and sodium in the NSLP and SBP to improve nutrition security for school-age children.^{357,358} The rule also provides new menu-planning flexibilities (e.g., supporting more plant-based and culturally-inclusive meals) and makes changes to program operations (e.g., supporting local food purchases).³⁵⁹ The rule took effect July 1, 2024, but FNS will gradually phase in the required changes over time (see graphic below). Program operators are not required to make changes until school year 2025/26 at the earliest.³⁶⁰

The CEP is a reimbursement alternative for schools that serve high proportions of low-income children and participate in NSLP and SBP. CEP gives eligible schools the option to offer no-cost meals to all enrolled students without collecting household income applications by sharing eligibility data among select federal assistance programs.³⁶² USDA finalized a rule in September 2023 that lowered the minimum identified student percentage^{363,364} necessary to participate in CEP from the threshold of requiring 40 percent of students to be eligible for free meals without an application to 25 percent of students. Lowering this minimum percentage allows more districts and schools to serve free meals to all students, while also streamlining program administration.³⁶⁵

USDA Food and Nutrition Service
U.S. DEPARTMENT OF AGRICULTURE

IMPLEMENTATION TIMELINE FOR UPDATING THE SCHOOL MEAL STANDARDS FINAL RULE

School meals will continue to include fruits and vegetables, emphasize whole grains, and give kids the right balance of nutrients for healthy, tasty meals. For the first time, schools will focus on products with less added sugar, especially in school breakfast.



USDA is an equal opportunity provider, employer, and lender.

April 2024

Source: USDA Food and Nutrition Service³⁶¹

Multiple studies have shown that offering school meals at no cost to all students, often referred to as Healthy School Meals for All, reduces school absenteeism, has a potentially protective effect on BMI, and advances health equity by removing barriers to consistent access to nutritious foods for students in lower-income households.³⁶⁶ In addition, the Community Preventive Services Task Force, recommended Healthy School Meals for All to increase student participation in the school meal programs and reduce school absenteeism.^{367,368} During the COVID-19 pandemic, USDA temporarily gave states the flexibility to offer nutritious meals to all students, at no cost and regardless of household income, through pandemic-related child nutrition waivers.³⁶⁹ After these waivers expired, some states—including California, Maine, Colorado, Minnesota, New Mexico, Vermont,

Michigan, and Massachusetts—passed Healthy School Meals for All policies in 2022 to provide meals to all students regardless of income.³⁷⁰ These states cover the difference in cost between federal reimbursements and the cost of providing nutritious meals for all participating students.

With funding from USDA, in December 2023 the Food Research & Action Center awarded \$1.1 million in competitive grants to five organizations to research barriers and identify strategies to improve equitable access to healthy foods in the federal Child Nutrition Programs.³⁷¹ The initial grantees for the project, called the Equitable Access in Child Nutrition Programs project, are two universities, a public health agency, and two nonprofits.³⁷² These organizations will focus on systemic, social, and environmental barriers for

certain populations that are eligible for Child Nutrition Programs but who do not participate, as well as the cultural relevance of school meal programs for eligible populations using an equity lens.³⁷³

In June 2024, FNS awarded \$2.3 million in grants to five organizations through the Supporting the Use of Traditional Indigenous Foods in the Child Nutrition Programs Cooperative Agreement. The awardees were selected to provide regionally focused training and technical assistance to school nutrition professionals on procurement, preparation, and crediting of traditional indigenous foods in the Child Nutrition Programs.³⁷⁴ They will develop culturally relevant nutrition education materials for students and train school staff on providing students nutrition education on traditional indigenous foods.³⁷⁵

USDA has solicited comments on the interim final rule, Establishing the Summer EBT Program and Rural Non-Congregate Option in the Summer Meal Programs, that codifies the non-congregate meal service for rural populations and SUN Bucks program in the Code of Federal Regulations, as required by the Consolidated Appropriations Act, 2023.³⁷⁶ The comment period for the interim rule was extended through August 27, 2024, to allow interested stakeholders to provide comments related to the program's implementation during summer 2024.

Child Nutrition Programs Funding

The FY 2024 appropriations bill provided \$33.3 billion for the Child Nutrition Programs, including:

- \$16.6 billion for the NSLP;
- \$6.1 billion for the SBP, and \$3 million for program expansion grants;
- \$4.2 billion for CACFP, plus \$46 million for CACFP training and technical assistance;
- \$859 million for the SFSP, and \$2.5 billion for SUN Bucks benefits;
- \$10 million for school meal equipment grants;
- \$18 million for Team Nutrition grants to provide nutrition education to school children;
- \$5 million for Farm to School grants, and \$6.4 million for the Farm to School Tactical Team, which helps school districts and community partners implement the program; and
- \$6.6 million for the Special Milk Program.^{377,378}

THE CHILD TAX CREDIT AND FOOD INSECURITY

The American Rescue Plan, enacted in March 2021 in response to the COVID-19 pandemic, temporarily expanded the Child Tax Credit (CTC) from July through December 2021, to help families with children cover basic living expenses, such as groceries, utilities, and housing, through advanced federal monthly payments.^{379,380} The CTC, which typically reduces the federal yearly tax owed by families for each qualifying child under age 17 by \$1,000,³⁸¹ was temporarily increased to \$3,000 per child per year for children ages 6 and over and \$3,600 per child per year for children under age 6.³⁸² The CTC helped families cope financially during the pandemic, reduced U.S. child poverty by 46 percent—lifting 2.9 million children out of poverty—and played an important role in reducing food and nutrition security, even with high unemployment during the pandemic.^{383,384}

The initial CTC payments led to a 25 percent decline in food insufficiency—defined as sometimes or often not having enough to eat—among low-income families with children, particularly among families with incomes below \$35,000.³⁸⁵ The expanded

CTC sunset at the end of 2021, leading to a doubling of child poverty in the United States between 2021 and 2022, an increase of 5.2 million more children living in poverty in 2022.³⁸⁶ U.S. food insufficiency increased among families with children by 25 percent between late December 2021 and early January 2022 (when the CTC expansion sunset) and July 2022.³⁸⁷

In January 2024, a bipartisan tax package was introduced that would expand CTC benefits in a phased-in rate for low-income households—mainly those households making between \$20,000 and \$40,000 a year—to \$1,800 per child in 2023, \$1,900 per child in 2024, and \$2,000 per child in 2025, with adjustments for inflation beginning after 2023.^{388,389} The bill, if passed, would benefit an estimated 16 million children in low-income families, would lift as many as 400,000 children out of poverty, and would benefit one in three Black and Hispanic children under age 17 in the first year alone.³⁹⁰ Passage of the bill would also likely have a positive impact on food security for families with children.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC provides supplemental healthy foods, nutrition education and counseling, breastfeeding support, and healthcare referrals to low-income, nutritionally at-risk pregnant, postpartum, and breastfeeding women, as well as to infants and children up to age 5.³⁹¹ The federal government funds the program through a federal grant and USDA's FNS works with state and local agencies to administer it.³⁹² WIC celebrated its 50th anniversary in 2024. The program is one of the nation's largest nutrition assistance programs and helps provide food and nutrition security to 6.6 million mothers and young children,³⁹³ serving about half of all infants born in the United States.³⁹⁴

WIC participation is associated with improved birth outcomes, lower infant mortality, better child cognitive development, increased purchases of healthier foods, and improved diets for pregnant women and children.³⁹⁵ WIC has also been found to reduce racial and ethnic disparities in health outcomes among children.³⁹⁶ The WIC food packages must meet high nutritional standards, and studies have found that, after these nutritional requirements were strengthened in 2009, obesity rates among children in the program declined.^{397,398,399} Although a recent study shows a slight increase in child obesity rates from 2016 to 2020, that is still below the 2010 rate.⁴⁰⁰ On the economic side, a 2019 study found that each \$1 spent on prenatal WIC services in California resulted in Medicaid savings of \$1.24–\$6.83 due to improved birth outcomes.⁴⁰¹

In April 2024, USDA released a final rule updating the WIC food packages to align them with the

Dietary Guidelines for Americans, 2020-2025, and recommendations from the National Academies of Sciences, Engineering, and Medicine. Specifically, the final rule codified the temporary increase in the monthly fruit and vegetable cash value voucher (CVV) (\$24 for children, \$43 for pregnant and postpartum women, \$47 for breastfeeding women); reduced juice amounts for all participants, and allowed for juice to be substituted for an increased CVV; reduced the maximum milk allowance; required 75 percent of all cereals to meet whole grain requirements; and added canned fish to food packages for children.⁴⁰² The increase in the CVV took effect on June 17, 2024, while most of the other food package changes must be implemented by April 2026.⁴⁰³

WIC actively promotes breastfeeding through peer-counseling programs, an enhanced food package, and longer program eligibility for breastfeeding participants compared with postpartum participants who are not breastfeeding.⁴⁰⁴ WIC participants' breastfeeding rates have been steadily climbing over the past decade. In 2013, 29.5 percent of infants in the program were breastfed, compared with 37.3 percent in 2022, a growth rate of 26 percent.⁴⁰⁵ The program's breastfeeding support services, which include peer counseling, seem to be particularly helpful. For example, a 2024 study examining the Minnesota WIC's breastfeeding peer-counselor program found that it was effective in increasing the proportion of WIC participants breastfeeding at three and six months, with the strongest impacts in rural communities.⁴⁰⁶

There are several federal programs outside of WIC that also support and promote breastfeeding including Health Resources and Services Administration’s maternal and child health programs. These programs—including the Maternal and Child Health Block Grant, Healthy Start Program, and Children’s Healthy Weight State Capacity Building program—provide lactation counseling, employer and employee education, health and safety information, and breastfeeding supplies.⁴⁰⁷

Despite its successes, WIC struggles to enroll participants: only half of eligible people participate in the program with participation rates highest for infants and non-breastfeeding postpartum individuals.⁴⁰⁸ By racial and ethnic group, participation is highest for Hispanic individuals (64 percent of those eligible) and lowest for non-Hispanic white individuals (38 percent of those eligible).⁴⁰⁹

Participation barriers include:

- The cost and time for appointments, including applying to receive benefits, attending clinic appointments, reloading EBT cards, and shopping for groceries (WIC benefits can only be spent online in a limited number of states with pilot programs);
- Common misunderstandings about eligibility rules (e.g., child eligibility through age 5); and
- Language and cultural barriers that make it difficult for some people to navigate the enrollment process.^{410,411}

USDA has been working to reduce these barriers by streamlining and modernizing the program. In February 2023, FNS released a proposed rule that would modernize WIC by allowing WIC benefits to be used to purchase groceries online, without the presence of a cashier.⁴¹² The proposed rule also allows states to develop and test new instruments, such as mobile payments, and allow for the remote issuance of WIC benefits, including allowing participants to reload their benefit cards without visiting a clinic.⁴¹³ As of June 2024, the proposed rule had not yet been finalized.

As WIC is a discretionary program, decisions about WIC funding are made by Congress on an annual basis, and the program is not guaranteed to have sufficient funding to serve all who are eligible and wish to participate. In FY 2024, WIC was at risk of not being fully funded for the first time in more than 25 years. The potential funding shortfall resulted from multiple factors, including faster than anticipated participation growth, increased food costs, and inaccuracies in funding predictions.⁴¹⁴ Without full funding, state WIC programs would have been required to have waiting lists, reduce hours, and potentially cut benefits as a last resort.⁴¹⁵ WIC needed an increase in funding of about \$1 billion for FY 2024, totaling about \$7 billion in funds, to remain fully funded. The Consolidated Appropriations Act, 2024 provided full WIC funding.⁴¹⁶

WHITE HOUSE CHALLENGE TO END HUNGER AND BUILD HEALTHY COMMUNITIES

In March 2023, the White House Challenge to End Hunger and Build Healthy Communities (or “the Challenge”) was launched. The Challenge called on stakeholders across the nation to advance the goals of ending hunger and reducing diet-related diseases by 2030, while also reducing disparities, through \$8 billion in commitments that were announced in conjunction with the September 2022 White House Conference on Hunger, Nutrition, and Health and the release of the associated National Strategy.⁴¹⁷ Since the Challenge was announced, more than 140 additional nonprofits, philanthropic groups, companies, health systems, insurers, academia, trade/professional associations, sports leagues, player associations, state governments, tribal communities, and cities have committed to an additional \$1.7 billion in investments toward one or more of the National Strategy’s five pillars:^{418,419}

1. Improve food access and affordability.
2. Integrate nutrition and health.
3. Empower all consumers to make and have access to healthier choices.
4. Support physical activity for all.
5. Enhance nutrition and food security research.

Some of the external commitments include:⁴²⁰

- Fourteen sports leagues and players associations signed agreements with the President’s Council on Sports, Fitness, & Nutrition to expand access to physical activity, promote healthy lifestyles, and integrate messaging and education around nutrition.
 - Food Forward, a produce-recovery and hunger-relief nonprofit, will recover fresh fruits and vegetables from public orchards, farmers’ markets, and other outlets that would otherwise go to waste and distribute the produce free of charge to individuals experiencing food insecurity.
 - The National Association of Chronic Disease Directors committed \$2 million to implement health equity trainings, install volunteers in 20 state health departments to support food insecurity and physical activity efforts, and provide training and workforce development programs on food insecurity to states, among other commitments.
- A whole-of-government approach is also being used for the Challenge, with several federal agencies, including USDA, FDA, and the Centers for Medicare & Medicaid Services releasing rules and guidance to support efforts to reach the Administration’s goal, including:⁴²¹
- USDA finalized a rule that allows 3,000 more school districts in high-need areas to make healthy school meals available at no cost to students during the school year.
 - FDA conducted a study to inform a proposed rule to help consumers more easily identify healthy foods by standardizing an FOP system for food packages.
 - HHS approved several state-based Medicaid section 1115 demonstration waivers to test coverage of nutritional assistance, medically tailored meals, and other health-related social needs in Medicaid.

II. Childcare and Education Settings: Head Start, Farm to Educational Settings, Local School Wellness Policies, and Smart Snacks in Schools

Head Start

Head Start helps prepare preschool-age children from low-income families to succeed in school by providing educational, health, nutrition, and social services to them and their families. The program includes Early Head Start, which serves infants, toddlers, and pregnant women and families.⁴²² The Office of Head Start, within the Administration for Children and Families at HHS, manages the program on the federal level and provides oversight to local communities, who serve more than a million children each year through Head Start grants.⁴²³

Head Start programs address food insecurity by providing free meals and nutrition support to their participants via CACFP, NSLP, or SBP.⁴²⁴ The program also supports breastfeeding and provides free infant formula to families.⁴²⁵ Since 2016, federal standards have required the program to actively engage in obesity prevention both in the classroom and through its family partnership process.⁴²⁶

Children who participate in Head Start are healthier than their peers. One study found that children who entered Head Start with high or low weight status were significantly more likely to be a healthy weight range by kindergarten than a comparison group.^{427,428} A more recent study found that children with BMIs classified as having obesity at the beginning of the Head Start program year significantly

reduced their BMI during the program year, particularly if they entered Head Start at an earlier age.⁴²⁹

The FY 2024 omnibus appropriations bill included \$12.27 billion for Head Start, a \$275 million increase over FY 2023.^{430,431}

Farm to Educational Settings

The Child Care and Development Block Grant assists low-income families with the cost of high-quality childcare. It is funded by the federal government and administered by the states.⁴³² To receive federal funding, Early Care and Education (ECE) providers must meet state-mandated early childhood education health and safety requirements, which often include nutrition and physical activity benchmarks.⁴³³

One way that ECE providers can meet nutritional requirements is through Farm-to-ECE programs. Farm-to-ECE activities can include school gardens, farm visits, eating locally grown produce, and education about food and farming.^{434,435} These programs help encourage children at an early age to eat more fresh fruits and vegetables and to develop lifelong healthy eating habits, while at the same time supporting local farmers.

Congress provided \$8.7 billion for the Child Care and Development Block Grant for FY 2024, a nearly \$725 million increase over the FY 2023 funding level.^{436,437}

K–12 Local School Wellness Programs

The federal government requires every school district that participates in one or more federal Child Nutrition Programs to develop and implement a local school wellness policy that promotes the health of students and addresses childhood obesity through supportive school nutrition and physical activity environments.⁴³⁸ These policies are required to:

- Establish nutrition education, nutrition promotion, and physical activity goals;
- Include nutrition guidelines for all foods and beverages available on campus; and
- Limit food marketing to those products that meet the Smart Snacks in Schools nutrition standards.⁴³⁹

School districts are required to assess their local wellness policies every three years;⁴⁴⁰ however, the most recent due date fell in June 2020, during the height of the pandemic. Recognizing that administrators might need additional time to complete this requirement, USDA provided waivers of the requirement through the 2022/23 school year.⁴⁴¹

Smart Snacks In Schools

All food sold at schools—including food sold in vending machines, at school stores, and at school fundraisers—must meet the Smart Snacks in Schools federal nutrition standards.⁴⁴² Snacks sold after school hours, food intended to be eaten off school property, or food provided for free—for example, cupcakes brought in for a student’s birthday—do not have to comply. States can also exempt infrequent school fundraisers from the standards.⁴⁴³ The guide for Smart Snacks, which include the federal nutrition standards, is under revision to reflect the Child Nutrition Programs: Meal Patterns Consistent With the 2020-2025 Dietary Guidelines for Americans final rule—discussed previously in the Child Nutrition Programs section of this report.⁴⁴⁴ Largely, the rule gradually reduces added sugars and sodium in Smart Snacks; continues to allow fat free, low-fat, flavored, and unflavored milk; aligns whole grain requirements for entrée items with the updated school meal pattern requirements; and exempts bean dips from the total fat standard in the Smart Snacks regulations.⁴⁴⁵ Like the other Child Nutrition Programs’ final rule changes, FNS will gradually phase in the requirements over time to allow program operators to make changes to their menus for school years 2025/26 through 2027/28.⁴⁴⁶

III. Dietary Guidelines, and Packaged Food and Menu Labels

Dietary Guidelines for Americans

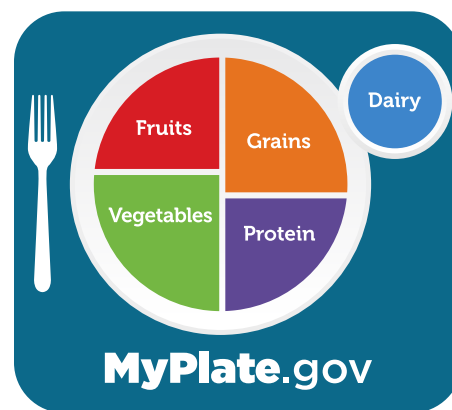
The *Dietary Guidelines for Americans*—issued jointly by USDA and HHS—provide the public with evidence-based guidance about healthy eating, serve as a resource for policymakers and health professionals, and provide the foundation for the federal government’s nutrition programs. The guidelines are revised every five years to keep pace with the latest scientific research about nutrition, with the most recent edition published in December 2020.⁴⁴⁷ It focuses on healthy eating for all life stages, including infancy, toddlerhood, childhood, adolescence, pregnancy, lactation, and older adulthood.⁴⁴⁸

In January 2023, USDA and HHS announced the appointment of nutrition and public health experts to the 2025 Dietary Guidelines Advisory Committee (DGAC), which will review the evidence to inform the 2025–2030 edition of the *Dietary Guidelines for Americans*.⁴⁴⁹ The committee is tasked with examining the evidence through a health equity lens to ensure the guidelines are relevant to people of all ethnic, racial, socioeconomic, and cultural backgrounds.⁴⁵⁰ With support from USDA and HHS staff, the DGAC is reviewing the evidence through systematic reviews, food pattern modeling, and data analyses to respond to previously identified scientific questions. The DGAC’s scientific report is expected to be released in fall 2024. During 2025, USDA and HHS will develop the *Dietary Guidelines for Americans 2025-2030*, informed by the 2025 DGAC’s report, public

comments, and agency reviews, as well as separate scientific review panel efforts to examine evidence on adult alcohol consumption and health, and how sustainability considerations could potentially be incorporated.

MyPlate is a simplified nutrition guide based on the Dietary Guidelines for Americans. The MyPlate icon—which includes dairy, fruits, vegetables, grains, and proteins (see graphic below)—serves as a graphic representation of a healthy diet, intended to provide an easy-to-follow visual to help Americans eat healthier. MyPlate also offers a suite of interactive online tools, including the Start Simple with the MyPlate app and the myplate.gov website. The app allows users to choose healthy food goals, track their progress, and earn badges, while the website provides recipes, tip sheets on healthy eating, and inspiring videos.⁴⁵¹

My Plate Graphic



Source: USDA⁴⁵²

Unfortunately, most Americans do not follow the *Dietary Guidelines*, with the average American diet scoring a 59 out of 100 on the Healthy Eating Index—a

measure of how closely a diet aligns with the Guidelines.⁴⁵³ Individuals face a range of educational, economic, environmental, and policy barriers to healthy eating. Common barriers, particularly for Americans with lower incomes, include affordability of nutritious foods, lack of time to prepare meals from scratch, no or limited transportation to the grocery store, and no storage for fresh and cooked foods.⁴⁵⁴ It is critical that efforts to improve Americans’ diets address these factors.

Packaged Food Labels

To help consumers make informed decisions, FDA requires that manufacturers include Nutrition Facts labels on most packaged food.⁴⁵⁵ The rules governing these labels were updated in 2016 to make the labels easier to read and to include important information, such as added sugars.⁴⁵⁶ Nutrition Facts labels are typically found on the back of packages, while manufacturers often include other nutritional or health claims on the front of packages, where they are more likely to catch a consumer’s eye and can quickly impact purchasing decisions.⁴⁵⁷ Such FOP labels are not mandatory, and while health claims must comply with FDA rules to ensure accuracy,^{458,459} they can be misleading.⁴⁶⁰ Unlike some countries, the United States does not have a mandatory FOP labeling system or require warning labels on unhealthy foods.^{461,462} Such systems can positively influence consumer purchasing decisions as well as spur industry to improve the nutritional quality of their products.^{463,464,465}

In 2022, FDA began conducting research to inform its development of an FOP label system, issued a notice on further plans to study draft FOP designs with consumers, issued draft guidance on dietary guidelines for labeling packaged foods, and released a proposed rule that would allow foods to be labeled as “healthy” only if they contain food from a major food group and have limited amounts of sodium, saturated fat, or added sugars.^{466,467,468,469} In November 2023, FDA held a virtual meeting and series of listening sessions on strategies to help reduce added sugar consumption in the United States.⁴⁷⁰ More than 3,300 individuals participated in that meeting, with key themes being raised around the need to:⁴⁷¹

- Simplify information on labels and research to better understand consumer behavior;
- Educate consumers about added sugars/sweeteners, as well as the impact marketing tactics have on added sugar consumption;
- Reformulate foods to reduce added sugar content and create innovative strategies and collaborations to do so; and
- Improve health equity through greater access to healthier food options for underrepresented communities.

Menu Labels

Since 2018, large chain restaurants and vending machine operators have been required to disclose nutritional information about their products,

including calorie counts.^{472,473} This allows consumers to make more informed choices when they eat out, which is important, as consumers tend to underestimate calorie levels in out-of-home meals, and food prepared outside the home often has more calories than food prepared at home.^{474,475,476} Menu labels can also lead consumers to choose healthier menu options and incentivize restaurants to offer healthier menu choices.^{477,478,479} A national microsimulation study of the health impact of these changes found that over five years, a national menu calorie-labeling law could prevent nearly 14,700 cardiovascular disease events and over 21,500 type 2 diabetes cases, while saving the healthcare system \$260 million.⁴⁸⁰ A recent quasi-experimental cohort study found that in restaurants with calorie labels, fewer calories were purchased by consumers, suggesting that consumers are sensitive to menu calorie information (although there were differences in associations by location).⁴⁸¹

A loophole in the regulation is that third-party delivery services—whose use has proliferated in recent years—often fail to include calorie counts on their platforms.⁴⁸² There have been significant efforts among public health advocates to ask FDA to clarify that the menu-labeling rule applies to large third-party food-ordering and -delivery platforms (e.g., Uber Eats, DoorDash), which would require them to provide calorie information for chain restaurants and other retailers at the point of purchase; however, the agency has yet to act.⁴⁸³

STATE, LOCAL, AND TRIBAL MODELS FOR IMPROVING NUTRITION AND PHYSICAL ACTIVITY

State, local, and tribal governments all play an important role in improving health in their communities. A few examples are below.

Expanding Food Access for Native and Non-Native Children

USDA expanded and made permanent their COVID-era Summer EBT program, SUN Bucks. The program allows states to access federal funds to ensure eligible students receive meals throughout the summer.⁴⁸⁴ Eligible students are those already enrolled in SNAP, Temporary Assistance for Needy Families, or the Food Distribution Program on Indian Reservations, with participating families receiving an additional \$40 per eligible child per month. While most states and territories accepted the funds and built out related programming, 13 did not.⁴⁸⁵ In some states that declined to administer the program, tribes in those state have accepted the funds to serve not just enrolled members of their tribes, but non-Native children living in their service areas. For example, Cherokee Nation, Chickasaw Nation, and Muscogee (Creek) Nation have agreed to provide SUN Bucks, even though the State of Oklahoma has not.⁴⁸⁶

Promoting Physical Activity through Complete Streets

Missouri had numerous localities featured as SmartGrowth America's strongest Complete Streets policies (i.e., policies that support safe and accessible streets and transit networks) for 2023.⁴⁸⁷ Missouri Complete Streets is led by the state's Department of Health and Senior Services, which provides funding to municipalities to develop their own Complete Streets programming.⁴⁸⁸ The policies implemented by the Missouri cities of Rogersville, Joplin, and Riverside all ranked within the top 10 for 2023. Joplin was highlighted for prioritizing historically disconnected neighborhoods that are predominately Black and for incorporating multiple community engagement approaches to prioritize locations within the city.⁴⁸⁹

Increasing Equitable Access to WIC

Several communities are using funds from USDA's WIC Community Innovation and Outreach Project to support innovative outreach strategies to increase participation and equity in the WIC program.⁴⁹⁰ Initially awarded in 2023, 36 entities across 32 states are pursuing a range of strategies in different communities. Among the dozens of grantees, they include Portuguese-speaking families and immigrants (New Jersey), Black families in the aftermath of natural disasters (Louisiana), Hispanic and rural WIC participants with barriers to participation

who need cost-effective Spanish-language materials (Nebraska), and immigrants of Middle Eastern and North African descent who need culturally and linguistically appropriate WIC materials (Michigan).⁴⁹¹

Newest State Nutrition Supports in Medicaid 1115 Waivers

New York and Delaware are the most recent states with approved Medicaid 1115 waivers that address nutrition needs for families.⁴⁹² New York prioritizes addressing health-related social needs overall, including providing nutrition supports for individuals with complex healthcare needs, such as children with certain health risks or conditions, or pregnant individuals and their families.⁴⁹³ Delaware's waiver includes formalizing a pilot program providing medically appropriate shelf-stable food boxes or two home-delivered meals per day to postpartum low-income mothers up to 12 weeks following the birth of their child.⁴⁹⁴ These efforts address the physical and mental health issues faced by mothers who were are insecure during the postpartum period.

Sustainable, Equitable Programs for Safe Routes to School

Several communities have focused on strategic thinking related to safe routes to school. Among other strategies, Arlington County and Arlington Public Schools in Virginia are prioritizing reducing inequities in safety around schools, including by identifying that more crashes took place in areas with greater racial diversity or lower-income levels.⁴⁹⁵ A New Jersey high school is installing a "Student Bike Oasis" to encourage eco-friendly bike rides to and from school and to promote bicycle safety. The oasis is a weather-protected shelter with native plants, a maintenance station, and seating to promote more biking opportunities for students.⁴⁹⁶

Expanding Indigenous Food Sovereignty Pipeline

With funds from USDA's Office of Tribal Relations, North Dakota State University established the Indigenous Food Sovereignty Emerging Leaders Program. The program is a three-week summer program for indigenous students ages 18–24 years old from across the nation to pursue careers in the field of indigenous food sovereignty. The innovative program improves how culturally appropriate public health services in indigenous communities function as well as how they are delivered, all with a focus on tenets of indigenous food sovereignty.⁴⁹⁷

C. COMMUNITY POLICIES AND PROGRAMS

I. Built Environment: Community Design, Transportation, and Land Use; Housing Impacts; Safe Routes to Schools

The conditions in which one is born, lives, learns, works, plays, worships, and ages can impact the ability to reach one's full health potential.⁴⁹⁸ Structural discrimination, such as residential segregation and systemic underinvestment in certain communities, also adversely impact health outcomes and further contribute to health disparities.^{499,500,501,502,503} Many aspects of the built environment—the human-made structures in the environment where people live and work—steer Americans into a sedentary lifestyle by making it easy or necessary to travel by car, while not supporting walking, rolling, or bicycling (also called active transportation) or recreation. How a neighborhood is designed, its walkability (i.e., sidewalks and crosswalks), safety, and access to clean air, parks, other green spaces, and healthy food outlets are all strong environmental predictors of physical activity and a healthy weight.^{504,505,506,507,508,509,510}

Community Design, Transportation, and Land Use

Health should always be top of mind when making community design, transportation, and land-use choices. Policymakers can promote active lifestyles by:

- Promoting safe, affordable, and accessible active transportation and public transit options rather than reliance on automobiles in communities;^{511,512}
- Adopting Complete Streets policies, which ensure streets and networks are designed to be safely and equitably used by all—including people of all ages and abilities and those traveling by car, foot,

bicycle, wheelchair, or other mobility device—by building and maintaining sidewalks, trails, and protected bike lanes, and by installing safety features, such as streetlights, speed bumps, traffic signals, crosswalks, roundabouts, and shade trees;^{513,514,515}

- Support land-use and zoning policies that support walkability, a range of housing options, accessible daily destinations (e.g., grocery stores, parks, schools, neighborhood-scale businesses, etc.), and public transportation networks;⁵¹⁶
- Building and maintaining playgrounds, parks, and other green spaces, which support physical activity, social connection, and decrease air pollution;^{517,518}
- Investing in high-quality, accessible public transportation infrastructure, which is associated with higher levels of physical activity, as people often walk or bike to and from public transportation;⁵¹⁹ and
- Adopting Safe Routes to School policies, which provide funding to programs and projects focused on empowering communities to walk and bike to school by building safer infrastructures to increase physical activity for students.^{520,521}

Community design, transportation, and land-use policies and programs are especially important for several populations. For example, research has shown that populations of color and those with low socioeconomic status⁵²² have less access to parks and green space.^{523,524,525} Ensuring all people can safely walk, cycle, and roll and connect to public-transit networks

in their communities is particularly critical to community design and land-use policies: a 2022 study found that Black and Hispanic Americans have disproportionately higher traffic-fatality rates per mile while walking or cycling.^{526,527} The disparities are particularly acute for Black cyclists, whose death rate is more than four times the rate for white cyclists.⁵²⁸

The 2021 Infrastructure Investment and Jobs Act (P.L. 117-58; also known as the Bipartisan Infrastructure Law) and the Inflation Reduction Act (P.L. 117-169) provide federal funding to improve communities' active transportation networks, including by addressing air-quality, safety, and transportation inequities.⁵²⁹ The U.S. Department of Transportation (DOT) offers multiple federal funding opportunities, some funded by the 2021 Infrastructure Investment and Jobs Act, to help improve community design, transportation, and land use in the United States, including grants that improve conditions for bicycling, walking, and shared micromobility, reconnecting communities fragmented by past infrastructure decisions, and local projects that improve roadway safety.^{530,531}

Housing Impacts

To build thriving, equitable communities, it is critical to have a variety of housing sizes and affordability options in proximity to jobs, schools, grocery stores, and healthcare services for people of all ages and demographics. Since housing makes up a large part of land use in a community, it affects the space available for transportation and recreation in those communities, as well as the ability of older adults to age in place.⁵³² Generally, poor street connectivity and sprawling, low-density housing (e.g., single-family housing on



large lots) separated from commercial development increases reliance on automobiles and encourages sedentary behavior.⁵³³ In contrast, communities with better street connectivity, greater housing supply and diversity, and a mix of residential and commercial land use in close proximity encourage active transportation.^{534,535}

Communities that suffer from issues like deteriorating infrastructure, high crime, and poverty also typically have high rates of obesity.^{536,537,538} The U.S. Department of Housing and Urban Development's Choice Neighborhood program provides flexible funding to help local communities with distressed public housing transform their neighborhoods. The agency has announced \$10 million for Choice Neighborhood Planning Grant awards in FY 2024.⁵³⁹

Safe Routes to School (SRTS)

Walking, rolling, or biking to and from school is an easy way for children and adolescents to make physical activity part of their daily routine. However, the rise of car-dependent

neighborhoods, concerns about traffic and crime, and changing social norms have converged to reduce the number of children who walk to school.⁵⁴⁰

The SRTS program, funded through DOT, encourages active travel to school by funding state and local awareness campaigns and safety improvements, such as crosswalks, sidewalks, and bike lanes.^{541,542} Research has found that SRTS initiatives are cost-effective and associated with a significant increase in active transportation to and from school.⁵⁴³ Studies have also found that students who walk or bike to school when they are young are more likely to continue the habit of using active modes of transportation when they are older.⁵⁴⁴

Since 2015, SRTS has supported projects in 17,000 schools, benefiting nearly 7 million students.⁵⁴⁵ The Bipartisan Infrastructure Law codified and expanded the program to benefit high schools and to allow the Highway Safety Improvement Program, in addition to the Transportation Alternatives Program, to fund SRTS projects.^{546,547}

II. CDC State and Community Initiatives

The Division of Nutrition, Physical Activity, and Obesity (DNPAO) leads the obesity prevention efforts at CDC. In FY 2024, DNPAO's total budget was \$118 million, a fraction of CDC's total \$9.2 billion budget to promote health and prevent chronic disease.^{548,549}

CDC's major programs that support obesity prevention on a community level are discussed in more detail below.

State Physical Activity and Nutrition (SPAN)

DNPAO's SPAN program funds state, territorial, and tribal interventions to increase physical activity and improve nutrition.⁵⁵⁰ The projects focus on:

- Making physical activity safe and accessible for all;
- Making healthy food choices easier through the promotion of food service and nutrition guidelines, as well as the expansion of existing fruit and vegetable incentive vouchers and produce prescription programs;
- Providing continuity of care in breastfeeding support; and
- Strengthening obesity prevention standards in ECE settings.⁵⁵¹

From 2018–2023, SPAN grants impacted the lives of tens of millions of people in 16 states, including reaching:

- More than 8 million people with improved food service guidelines;
- Approximately 19 million people with more opportunities to be physically active;
- Over 1.7 million people with access to breastfeeding continuity of care; and

- Nearly 300,000 employees with access to breastfeeding worksite lactation support.⁵⁵²

The current five-year funding cycle began on September 30, 2023. DNPAO has \$75.5 million in total funding available over the five-year period and has granted 17 awards.⁵⁵³

Despite the effectiveness of the SPAN program, there is not, however, enough funding to launch SPAN in all 50 states, the District of Columbia, and 14 U.S. territories. HHS estimates that an additional \$72 million (for a total of \$130 million) would be needed to expand the program to all 50 states, the District of Columbia, and 14 territories.⁵⁵⁴

High Obesity Program (HOP)

HOP funds land-grant universities that work in partnership with their local communities via Cooperative Extension Services to increase access to healthier foods and promote physical activity in counties where more than 40 percent of adults have obesity.⁵⁵⁵

The funded initiatives are required to address community-level strategies to improve nutrition, physical activity, or obesity-related health disparities.⁵⁵⁶

Like the SPAN grants, the current five-year HOP round began on September 30, 2023, and will continue through 2028.⁵⁵⁷ The 2024 HOP grants have \$16.5 million in funding and have been awarded to 16 land-grant universities.^{558,559}

Current activities funded by HOP:

- A partnership between Iowa State University Extension and Outreach and local partners in six Iowa counties are (1) increasing food

and nutrition security through the promotion of food services and nutrition guidelines, as well as through the expansion of fruit and vegetable voucher incentive and prescription programs; and (2) providing access to safe and accessible physical activity by connecting transportation networks to everyday destinations.⁵⁶⁰

- Initiatives at the Ohio State University College of Food, Agricultural, and Environmental Sciences focus on promoting Ohio's Good Food Here food service and nutrition guidelines and expanding the Produce Perks fruit and vegetable voucher incentives, as well as improving safe access to physical activity and strengthening ECE programs in rural communities in Lawrence and Fayette County.⁵⁶¹
- The Be Wild, Be Wonderful, Be Healthy expanded program at the Center for ActiveWV in the West Virginia University College of Applied Human Sciences, which along with community coalitions and partners, focuses on implementing approaches that improve access to healthy foods and opportunities for physical activity in eight counties in West Virginia, including through the implementation of a Family Healthy Weight Program.⁵⁶²
- The AIM for CHangE program at the Mississippi State University Extension Service, and its community coalitions, received a second round of funding to allow it to continue to open new food pantries, expand existing food pantries, create ride-sharing programs, improve community parks and buildings, and install community gardens.⁵⁶³

Preventive Health and Health Services Block Grant (PHHS)

The PHHS block grant provides states, territories, and tribes with flexible funding to address local public health needs.⁵⁶⁴ In FY 2020, the most recent year for which CDC has published data by topic area, states spent \$149 million in PHHS grant funds, including \$9.5 million on nutrition and \$2.8 million on physical activity.⁵⁶⁵

A few examples of PHHS-funded activities include:

- The American Samoa government is reducing obesity in the territory among children and adolescents

through a Community Wellness Program conducted by a local wellness organization.⁵⁶⁶

- The Michigan Department of Health and Human Services partnered with Taste the Local Difference to increase fresh fruit and vegetable consumption in Detroit by using PHHS and SNAP funding to connect SNAP-eligible communities to local farmers who are committed to providing online access to their produce.⁵⁶⁷
- The Oklahoma State Department of Health adopted the Go Nutrition and

Physical Activity Self-Assessment for Child Care toolkit—which provides education, practice, policy, and environmental assistance to childcare providers on nutrition, physical activity, and oral health—and is working to increase the number of childcare providers in the state that utilize the resource to enhance nutrition and physical activity opportunities in ECE programs in Oklahoma.⁵⁶⁸

PHHS received \$160 million in funding in FY 2024, the same amount as in FY 2023.⁵⁶⁹

TABLE 6: SELECT OBESITY-RELATED FUNDING OPPORTUNITIES FROM CDC

Name	Grant Number	Goal	Length	Number of Grants	Annual Size	Total Program Funding
State Physical Activity and Nutrition (SPAN) Program ^{570,571}	23-0012	Improve nutrition and physical activity at the state and local level	5 years beginning September 30, 2023	Recipients in 17 states	Average one-year award amount: \$880,000	\$75.5 million over 5 years (2023–2028)
High Obesity Program (HOP) ^{572,573}	23-0013	Increase access to healthy foods and safe places for physical activity in high-obesity areas	5 years beginning September 30, 2023	16 land-grant universities in states with eligible counties	Average one-year award amount: \$712,000	\$57 million over 5 years (2023–2028)
Preventive Health and Health Services (PHHS) Block Grant ^{574,575,576}	23-2304	Provide each state with flexible support to address its most important health needs	Annual	61, including 50 states, DC, 2 American Indian tribes, 5 U.S. territories, and 3 freely associated states	\$9.5 million on nutrition and \$2.8 million on physical activity in FY 2020	\$160 million in FY 2023
Racial and Ethnic Approaches to Community Health (REACH) ^{577,578}	23-0014	Reduce racial and ethnic health disparities in chronic disease	5 years beginning September 30, 2023	50 state and local health departments, tribes, universities, and community-based organizations	Average one-year award amount: \$1,112,000, of which \$722,000 is for projects that must include nutrition and physical activity	\$228 million over 5 years (2023–2028), of which \$148 million is for projects that must include nutrition and physical activity
School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students (Healthy Schools program) ⁵⁷⁹	23-0002	Increase students' physical activity, healthy dietary behaviors, and self-management of chronic health conditions, as well as promote health equity and reduce disparities	5 years beginning in 2023	State education and health agencies, universities, and one tribal nation in 20 states	Average one-year award amount: \$390,000	\$31.5 million over 5 years (2023–28)

Racial and Ethnic Approaches to Community Health (REACH)

REACH is a CDC program aimed at reducing health disparities and achieving health equity among communities with the highest burden of chronic disease. REACH funds community-based organizations, universities, local health departments, tribal organizations, and cities to develop and implement evidence-based practices and culturally appropriate resources that address the root causes of chronic disease, including obesity.⁵⁸⁰

REACH celebrated its 25th anniversary in 2024. Since 1999, REACH grantees have impacted millions of people, including improving access to healthy foods, places to be physically active, breastfeeding support, and community-clinical linkages. The 2018–2023 REACH grantees impact includes:

- More than 3.3 million people have better access to healthy food and beverages;
- Approximately 8.6 million people have more opportunities to be physically active; and
- Over 1.2 million people have access to breastfeeding continuity of care.⁵⁸¹

The current five-year REACH grantees include 50 state and local health departments, tribes, universities, and community-based organizations in 32 states.⁵⁸² The five-year (2023–2028) funding for the core REACH grants is \$228 million, of which \$148 million must be for projects that include nutrition and physical activity.⁵⁸³

For example, REACH funding is helping:

- The Wellness Strategies for Health team in Alaska to develop and



implement culturally tailored interventions for tribal communities to support nutrition and reduce obesity,⁵⁸⁴

- Washington University in St. Louis and the St. Louis Integrated Health Network to deliver medically tailored meals to individuals' homes, provide safe and accessible physical activity through connecting active and transit transportation networks to common destinations, and improve access to family-centered, culturally relevant family healthy weight programs for the local Black community living in the St. Louis Promise Zone,⁵⁸⁵ and
- Penn State College of Medicine in Pennsylvania to promote healthier food choices, connect active and transit transportation networks to provide safe and accessible physical activity, and promote nutrition and physical activity in ECE settings to decrease obesity and other chronic conditions among central Pennsylvania's Hispanic communities.⁵⁸⁶

More than one-third of REACH's total funding is dedicated to the Healthy Tribes collection of programs, including the Cultural Approach to Good Health and Wellness in Indian Country (GHWIC) program, which

focuses on health promotion and chronic disease prevention in AI/AN communities.⁵⁸⁷ GHWIC's long-term goals include reducing death and disability from chronic diseases, including prediabetes, diabetes, and obesity, among AI/AN communities.⁵⁸⁸ The program funds 28 awards to tribes, tribal organizations, and urban Indian organizations and provides approximately 100 subawards to expand the reach of GHWIC and support smaller, often rural, tribal communities.⁵⁸⁹ From FY2019–2022, GHWIC activities reached more than 285,000 AI/AN community members with culturally tailored nutrition, physical activity, breastfeeding support, and obesity prevention programs.⁵⁹⁰ Applications for the next round of GHWIC grants closed in June 2024, and CDC anticipates making up to 30 awards available, ranging from \$300,000–\$1,145,000 each.⁵⁹¹

REACH received \$69 million in funding in FY 2024—including \$24 million for Healthy Tribes—the same level of funding in 2023.⁵⁹² Providing greater funds for the program would allow CDC to further reduce chronic diseases, including obesity, for racial and ethnic communities that bear the highest burden of such diseases.

School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students (Healthy Schools Program)

CDC's Healthy Schools Program has two cooperative agreements that help address chronic diseases among youth, including obesity prevention. Research suggests that holistic school programs can promote positive health behaviors and learning.^{593,594} The first of these cooperative agreements provides funding to state education and health agencies, universities, and tribal nations to establish programs and policies to help students in underserved communities increase physical activity, make healthier food choices, and manage chronic health conditions, including obesity.⁵⁹⁵

For example, the Kentucky Department of Education has set up the Whole School, Whole Community, Whole Child model—a CDC framework for addressing health in schools—to be used as a guide to coordinate and collaborate partnerships and awareness of the connections between health and academic achievement in their districts and schools.⁵⁹⁶ Building on the 2018–2023 funding cycle, the 2023–2028 round of Healthy Schools five-year grants will provide funding to 19 states and one tribal recipient district, with an average grant of \$390,000 per year.^{597,598} Total funding for the five-year grants is \$39 million.⁵⁹⁹

The second cooperative agreement, the National Initiative to Advance Health Equity in K-12 Education by Preventing Chronic Disease and Promoting Healthy Behaviors, funds six national organizations to provide technical

assistance and training to schools and school staff on emotional well-being, school health services, out-of-school time, and school administrative support in underserved communities.⁶⁰⁰ The funding for the current five-year cycle (2022–2027) has \$2.4 million per year.⁶⁰¹

National Diabetes Prevention Program (National DPP)

Because obesity is a common risk factor for developing type 2 diabetes,⁶⁰² obesity and diabetes prevention are interlinked. The National DPP is a public-private partnership aimed at preventing and delaying the estimated 98 million Americans with prediabetes from developing type 2 diabetes.⁶⁰³ A key component of the National DPP is its research-based lifestyle-change program that includes a lifestyle coach, a CDC-approved curriculum, and one year of group support with in-person, online, or combination program offerings.^{604,605} Participants in this type of lifestyle-change program can cut their risk of developing diabetes by 58 percent—or up to 71 percent for those over the age of ^{605,606}

In FY 2024, the National DPP received \$37.3 million in funding, the same as FY 2023.⁶⁰⁷

Physical Activity Guidelines

Regular physical activity lowers the risk of a wide range of diseases and health conditions, including obesity, infectious diseases, type 2 diabetes, cardiovascular disease, cancer, and anxiety and depression, and it contributes to overall health, including improved brain health and strong bones and muscles.^{608,609,610,611} In 2018,

HHS published its second edition of *Physical Activity Guidelines for Americans*, which provides recommendations about the amount and type of physical activity necessary at each phase of the lifecycle to improve health and reduce the risk of chronic disease.⁶¹² Key recommendations include:

- Children ages 3 to 5: Be physically active throughout the day.
- Youth ages 6 to 17: Engage in 60 minutes or more of moderate-to-vigorous activity per day, including muscle-strengthening physical activity at least three days a week and bone-strengthening physical activity at least three days a week.
- Adults: Engage in at least 150 minutes (2.5 hours) of moderate-to-vigorous activity or 75 minutes (1.25 hours) of vigorous aerobic activity per week; and perform muscle-strengthening exercises two or more days per week.⁶¹³
- Older adults: When physically able, older adults should follow the adult recommendations. As part of their weekly activity, older adults should include balance training as well as aerobic and muscle-strengthening activities.⁶¹⁴

In 2022, the most recent data available, CDC research found that only 22.5 percent of American adults met both aerobic and muscle-strengthening guidelines during leisure time.⁶¹⁵ People of color and individuals with lower incomes were less likely to meet both guidelines than white people and those with higher incomes.^{616,617} HHS recently released a Physical Activity Guidelines

midcourse report, which highlights the importance of physical activity among adults ages 65 years and older to help prevent and manage chronic diseases, and presents evidence-based strategies for increasing physical activity in this population.⁶¹⁸ In contrast with the *Dietary Guidelines for Americans*, which are required by law to be updated every five years,⁶¹⁹ there is no congressional mandate to update the *Physical Activity Guidelines* on a regular basis.

Active People, Healthy Nation

Active People, Healthy Nation is a CDC-led initiative to help 27 million Americans become more physically active by 2027.⁶²⁰ It coordinates and engages stakeholders at the national, state, and community levels to increase physical activity in order to meet the following goals:⁶²¹

- Move 15 million adults from inactive to some daily moderate-intensity activity;
- Move 10 million adults from some physical activity to meeting the minimum physical activity aerobic guideline; and
- Move 2 million young people from some physical activity to meeting the minimum physical activity aerobic guideline.

The initiative's strategies include seven evidence-based strategies founded on equitable and inclusive access: (1) community design for physical activity; (2) access to places for physical activity; (3) school and youth programs; (4) community-wide campaigns; (5) social supports; (6) individual supports; and (7) prompts to encourage physical activity.⁶²²

Social Determinants of Health Programs

A number of other CDC programs support initiatives that prevent obesity and promote healthy living:

- CDC’s National Center for Chronic Disease Prevention and Health Promotion’s Advancing Health Equity for Priority Populations with or at Risk for Diabetes program funds efforts to decrease the risk for type 2 diabetes among adults with prediabetes and improve self-care practices, quality of care, and early detection of complications among people with diabetes.⁶²³ Additionally, this funding supports the implementation of evidence-based, family-centered childhood obesity interventions as a type 2 diabetes risk-reduction strategy.⁶²⁴ CDC awarded \$411 million to fund 77 grantees over five years beginning in June 2023.⁶²⁵
- Another National Center for Chronic Disease Prevention and Health Promotion program, the Social Determinants of Health Accelerator Plans, funds state, local, territorial, and tribal jurisdictions to develop multisector, implementation-ready plans that improve social determinants of health (SDOH) and chronic disease outcomes among those experiencing health disparities and inequities. The plans must address at least two of the five SDOH domains: (1) community-clinical linkages, (2) built environment, (3) social connectedness, (4) tobacco-free policy, and (5) food and nutrition security. There were 15 grantees for the 2023–2024 cycle and a total award of \$1.86 million.⁶²⁶
- The Addressing Conditions to Improve Population Health (ACTion) program awarded \$7.5 million in grants over three years, starting in FY 2023, to five state and local governments for projects that implement policy, system, and environmental change interventions that address SDOH to reduce disparities, risk factors, and inequities related to chronic disease. ACTion focuses on four SDOH domains: (1) built environment, (2) social connectedness, (3) community-clinical linkages, and (4) food and nutrition security.^{627,628}

- Hospitals Promoting Breastfeeding, funded at \$9.75 million for FY 2024, helps strengthen lactation supports and reduce breastfeeding inequities.⁶²⁹

- National Early Child Care Collaboratives, which is funded at \$5 million in FY 2024, is an initiative that helps ECE programs for young children implement obesity prevention strategies.⁶³⁰

PRESIDENT’S COUNCIL ON SPORTS, FITNESS & NUTRITION (PCSFN) PARTNERSHIP WITH SPORTS LEAGUES AND PLAYER ASSOCIATIONS

The PCSFN is a federal advisory committee focused on promoting healthy eating and physical activity for all people, regardless of background or ability. An October 2023 executive order extended the work of the PCSFN through September 30, 2025.⁶³¹ In February 2024, the PCSFN announced an historic partnership with major sports leagues and players associations to promote and increase access to physical activity, integrate education and messaging around nutrition, and promote an overall healthy lifestyle to the millions of people throughout the

United States.⁶³² Through the partnership and commitments from organizations like Major League Baseball, Major League Soccer, Major League Soccer Players Association, the National Basketball Association, the National Football League, the National Hockey League, National Women’s Soccer League, and the Women’s National Basketball Association, among others, PCSFN and its partners hope to find other ways to effectively reach a range of communities to improve physical activity, healthy eating, and food and nutrition security.

D. HEALTHCARE COVERAGE AND PROGRAMS

I. Anti-Obesity Medications

In 2021, several years after it was approved to treat diabetes, FDA approved a class of weekly injectable medications called glucagon-like peptide-1 (GLP-1) agonists to treat obesity.⁶³³ This class of medication has an active ingredient that mimics a hormone that controls appetite and has proved to be far more effective and have fewer side effects than previous obesity medications.^{634,635} GLP-1 agonist medications offer a critical option for individuals living with obesity and severe obesity who need and want a pharmaceutical treatment option. They also have proved effective at improving outcomes for individuals with type 2 diabetes and cardiovascular disease, and, in March 2024, FDA approved the first GLP-1 agonist medication to treat cardiovascular disease in adults with obesity or overweight.^{636,637,638,639}

Research on long-term patient outcomes (e.g., cancer), side effects (e.g., nausea), outcomes after stopping GLP-1 medications, sustaining lowered body weight, and comparative effectiveness for different populations and versions of medication is ongoing, as this class of medications are still relatively new and there are many unknowns.^{640,641} The next iterations of medications are currently in drug trials, including dual and triple agonists (which target other hormones in addition to GLP-1), oral versions, and monthly injectables, with new options likely coming in the next few years.⁶⁴²

The number of Americans taking GLP-1 agonist medications has climbed rapidly over the last few years. A May 2024 KFF Health Tracking Poll found that 12 percent of adults in the United States report having ever taken a GLP-1

medication and 6 percent report current usage. More than half of adults, including insured adults, who have taken GLP-1 medications say it was difficult to afford the cost.⁶⁴³ A 2023 study found the listed prices of these medications is \$936–\$1,349 per 30-day supply (annual price \$11,388–\$16,413), though rebates may reduce the costs of some brands.

Public health insurance programs have seen GLP-1 agonist medication prescriptions and costs rise as well. Medicare spending on the most common GLP-1 medications has increased from \$57 million in 2018 to \$5.7 billion in 2022. These costs only include patients being treated for diabetes and cardiovascular risk, since Medicare does not cover medications for obesity.⁶⁴⁴ Medicaid spending has likewise increased, with GLP-1 medication costs rising from \$124 million in 2019 to \$1.1 billion in 2022. This spending includes individuals with diabetes and cardiovascular risk in all states (like Medicare) as well as obesity treatment in some states.⁶⁴⁵ It is important to note that since GLP-1 medications are expensive, these costs are disproportionately high compared with the number of individuals with prescriptions. For example, in 2022, GLP-1 medications represented 0.2 percent of all Medicaid prescriptions, yet they accounted for 1.3 percent of Medicaid medication spending before rebates.⁶⁴⁶

Availability, equitable access, and affordability of these lifetime medications, as well as other safe and effective obesity treatment options, will continue to be key issues for healthcare and public health sectors to consider in the coming years.

II. Medicare and Medicaid

The public health insurance programs Medicare and Medicaid, which provide health insurance coverage for more than 144 million Americans,⁶⁴⁷ bear a large burden of the medical costs of obesity and its related chronic diseases in the United States. It is estimated that over the 2024–2033 10-year budget window, the total projected federal government expenditures on direct obesity-related health costs will be \$4.1 trillion.⁶⁴⁸ Medicare and Medicaid—administered by the Centers for Medicare & Medicaid Services (CMS)—provide coverage for a range of services to help prevent and reduce obesity, including screenings, nutrition and physical activity education and counseling, prescription medications to treat obesity, and bariatric surgery, if appropriate.^{649,650} Eligibility for services depends on factors including an individual’s BMI and comorbidities such as cardiovascular disease risk.

Medicare

Medicare is the federal health insurance program for Americans ages 65 and over and some people with disabilities. Traditional Medicare provides the following obesity-related benefits:

- Obesity screening by primary care providers;⁶⁵¹
- Intensive behavioral therapy for beneficiaries with an obesity diagnosis;⁶⁵²
- The Medicare Diabetes Prevention Program for beneficiaries with prediabetes;⁶⁵³ and
- Bariatric surgery for beneficiaries with a BMI of 35 kg/m² or higher who have an obesity-related disease and have been unsuccessful with previous weight-loss attempts.^{654,655}

Traditional Medicare only covers intensive behavioral therapy appointments that take place in a primary care setting, which is not the setting in which many providers of this service work, and thus creates a major barrier to nutrition therapy treatment for patients. For example, Medicare does not cover nutrition counseling provided by registered dietitians, who often have the most training and expertise to provide these services.⁶⁵⁶ In addition, Medicare does not cover weight-loss programs or meal-delivery services, although some Medicare Advantage (Medicare Part C) plans do.⁶⁵⁷ Covered Medicare obesity-related treatments have relatively low uptake, largely due to cost-sharing requirements (particularly for bariatric surgery) and provider-related policy barriers.^{658,659}

Largely, Medicare is prohibited by federal law from covering medications for obesity.⁶⁶⁰ However, on March 20, 2024, CMS released guidance regarding Medicare Part D coverage of chronic weight-management products or anti-obesity medications that have other indications, such as diabetes and certain cardiovascular diseases. Specifically, the guidance clarifies that anti-obesity medications that have received FDA “approval for an additionally medically accepted indication ... can be considered a Part D drug for that specific use.”⁶⁶¹ For example, a GLP-1 agonist that receives FDA approval for diabetes treatment or reduce cardiovascular risks would be covered.⁶⁶² A recent analysis, based on 2020 Medicare data, indicates that 7 percent (3.6 million) of Medicare beneficiaries had a cardiovascular disease and obesity or overweight diagnosis in 2020 and could be eligible for coverage of a GLP-1 like Wegovy under Medicare.⁶⁶³

Medicaid

Medicaid provides health insurance for adults and children with low incomes, pregnant women, older adults, and individuals with disabilities in the United States.⁶⁶⁴ It is jointly funded by the states and the federal government and administered by the states, which results in geographic variation in both Medicaid eligibility and coverage.

For children and adolescents, states must provide Medicaid coverage for all medically necessary obesity services through the Early and Periodic Screening, Diagnostic and Treatment benefit.⁶⁶⁵ For adults, states have the option to provide coverage for obesity treatment, and most states offer coverage for at least one obesity-related treatment.⁶⁶⁶ In 2024, of the 51 state Medicaid programs (including DC):

- 49 cover some form of bariatric surgery;
- 50 cover some form of intensive behavioral therapy;
- 29 cover nutritional counseling; and
- 14 cover one or more FDA-approved medications for the treatment of obesity.⁶⁶⁷

In addition to the above benefits, the National DPP is offered by 28 states and the District of Columbia as a covered benefit at varying levels to at least some beneficiaries with prediabetes.⁶⁶⁸

Medicaid offers a higher federal match for states that cover all preventive treatments rated A or B by the U.S. Preventive Services Task Force (USPSTF) without cost-sharing,⁶⁶⁹ which include:

- Obesity screening for children and adolescents six years and older, and referring those with obesity to intensive, multicomponent, family-centered behavioral interventions (Grade B);⁶⁷⁰

- Referring adults with a BMI of 30 or above to intensive, multicomponent, behavioral interventions (Grade B);⁶⁷¹
- Offering behavioral counseling that promotes healthy weight gain and prevention of excess gestational weight gain during pregnancy (Grade B);⁶⁷²
- Diabetes screening and referral for preventive interventions for adults ages 35 to 70 years who have overweight or obesity (Grade B);⁶⁷³ and
- Offering behavioral counseling interventions for cardiovascular disease prevention in adults with cardiovascular risk factors (Grade B).⁶⁷⁴

USPSTF updated recommendations in June 2024 to provide or refer children and adolescents six years or older with a high BMI (≥ 95 th percentile for age and sex) to comprehensive, intensive behavioral interventions.⁶⁷⁵ They are also currently reviewing evidence to update its recommendations regarding weight management in⁶⁷⁶ behavioral counseling interventions for adults.⁶⁷⁷

The Federal Medicaid Drug Rebate Program requires Medicaid to cover all participating manufacturer FDA-approved drugs; however, there is an exception for coverage of medications for obesity. Thirty-two states offer no coverage for obesity medications, and the states that do often provide limited coverage with restrictions.⁶⁷⁸ More state Medicaid programs may look to cover FDA-approved medications for the treatment of obesity in the coming years. Medicaid utilization of obesity

medications has increased 600 percent between 2019 (160,700 prescriptions) to 2022 (1.2 million prescriptions).⁶⁷⁹ There is concern, however, that these medications may create added pressure on state Medicaid budgets in FY 2025.^{680,681} States have begun putting utilization management techniques in place, such as requiring dietary counseling or an obesity treatment plan prior to covering a GLP-1 agonist therapeutic class of medications, particularly for obesity.⁶⁸²

Another trend among state Medicaid programs is coverage of food-based initiatives using the Medicaid Section 1115 demonstration waiver process.⁶⁸³ In November 2023, CMS released a Health-Related Social Needs (HRSN) Framework and Informational Bulletin to encourage states to address enrollees' HRSN or unmet, adverse social conditions that contribute to poor health and are a result of underlying SDOH, including food insecurity.⁶⁸⁴ As of February 2024, eight states have been approved for 1115 demonstrations under the HRSN Framework, with 11 states already having approval for similar provisions prior to the release of the HRSN Framework (although with a narrower scope) and six states pending approval for SDOH-related 1115 waivers at CMS.⁶⁸⁵ Nutrition supports or benefits typically approved by CMS in 1115 demonstration waivers include nutrition counseling, produce/nutrition prescriptions, home-delivered meals, and grocery provisions and support for individuals with specific nutrition-

sensitive health conditions or health risks.^{686,687} These state demonstrations have the opportunity to improve food and nutrition security and other diet-related conditions among Medicaid enrollees. States can also receive approval for Medicaid managed care plans to cover otherwise non-covered services, such as nutrition services, as medically appropriate under the “in lieu of services” (ILOS) authority. Under CMS guidance, ILOS can be used by Medicaid managed care plans to “strengthen access to care by expanding settings options and address certain Medicaid enrollees’ HRSNs in order to reduce the need for future costly state plan-covered services.”⁶⁸⁸ An example includes offering medically tailored meals for targeted populations receiving home and community-based services to prevent the need for nursing facility care.

Individuals with Medicaid are more likely to have obesity than individuals with private insurance.^{689,690} Therefore, it is critical for Medicaid to provide full coverage for all evidence-based obesity treatments. Unfortunately, few states cover all four categories of obesity-related treatments in any capacity.⁶⁹¹ In addition, as of June 4, 2024, nearly 23 million Medicaid enrollees have been disenrolled from Medicaid, due to the Medicaid continuous enrollment provision⁶⁹² being discontinued on March 31, 2023,⁶⁹³ making it harder for these individuals to access needed obesity treatments and other healthcare services.

III. Healthcare and Hospital Programs: Food is Medicine, Medical Education, Community Benefits Programs, and Breastfeeding Programs

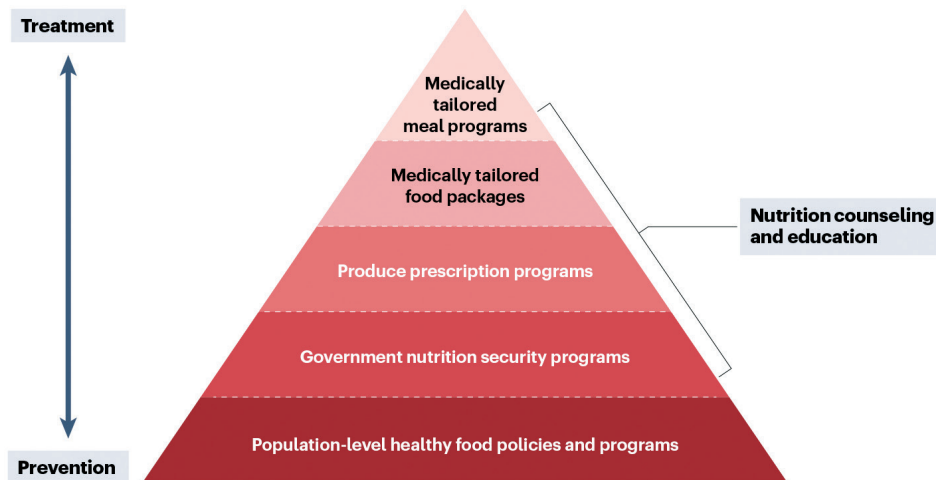
U.S. spending on healthcare reached \$4.5 trillion in 2022, the most recent year for which data is available, accounting for more than 17 percent of the nation’s gross domestic product.⁶⁹⁴ Hospitals and other healthcare facilities have a key role to play in preventing and reducing obesity. Potential strategies include food is medicine programs, healthcare provider training and continuing education, patient education and health promotion, sponsoring community benefit programs, and breastfeeding promotion.

Food is Medicine

The medical and scientific communities increasingly understand that obesity has complex causes that include poor nutrition and food insecurity, and that when healthcare providers treat obesity, they must incorporate nutrition education and access into their treatment plans. While there has been longstanding evidence that diet is key to prevention and treatment of many chronic conditions, the concept of “food is medicine” (FIM) (or “food as medicine”)—the incorporation of food-based health interventions into healthcare and public health programs—has gained traction in recent years.^{695,696}

The programs and initiatives in the FIM pyramid (see graphic above), from population-level to individual-level, are complementary. At the base of the pyramid are population-level programs and policies that may include partnerships among public health, healthcare, and other sectors. Examples of these interventions include consumer education, nutrition standards for food procurement, or tax credits for healthy food options in stores. The next level has nutrition assistance programs, like

A Food is Medicine Framework



Source: Mozaffarian, Blanck, Garfield, Wassung, and Petersen.⁶⁹⁷

SNAP and WIC, that are aimed toward improving food and nutrition security across the country. The programs at the top of the pyramid are more intensive interventions by a healthcare team for individuals with existing diet-related diseases and limitations on activities of daily living.^{698,699}

Examples of FIM services include:

- Medically tailored meal programs, which are prepared meals, often for individuals with diet-related chronic conditions and limitations of daily living, that are tailored to an individual’s health conditions and dietary needs and often home-delivered;
- Produce prescription programs, where healthcare providers give written instructions or “prescriptions” to patients to eat more produce or other healthy foods;
- Healthcare system referrals to government nutrition programs, such as SNAP and WIC;

- Population-level programs and policies that support healthy food choices; and
- Nutrition education and teaching-kitchen programs.^{700,701}

Research has shown that implementation of FIM interventions could both save lives and healthcare costs. For example, a study found that national implementation of medically tailored meal programs in Medicare, Medicaid, and private insurance for individuals with a diet-related condition and daily-living limitations could prevent 1.6 million hospitalizations and save \$13.6 billion in healthcare costs in one year.⁷⁰² Another study found that national implementation of produce prescription programs for people with diabetes and food insecurity could prevent nearly 300,000 cardiovascular events.⁷⁰³

As part of its whole-of-government effort to reduce obesity and other diet-related diseases, the federal government, state governments, and

nongovernmental organizations are expanding their investment in food-based health interventions. In January 2024, HHS hosted its first-ever Food is Medicine Summit and released new FIM principles that address public education, policy change, and integration of nutrition into HHS programs.⁷⁰⁴ HHS also announced three public-private partnerships that are key to advancing its work on FIM. As described in the Medicaid section above, HHS has also encouraged state Medicaid programs to pilot FIM initiatives and has released an informational bulletin on addressing HRSN, such as food insecurity, using Section 1115 funding.^{705,706} Additional nonprofit, industry, and philanthropic organizations, including the American Heart Association and the Rockefeller Foundation, have also made sizable commitments to FIM research and programs.^{707,708}

Medical Education, Training, and Best Practices

Healthcare provider training and continuing education on obesity prevention and treatment is limited or nonexistent. Most medical schools do not provide the level of nutrition education required by the National Research Council, and one-third of medical schools have no obesity education program.^{709,710} In March 2023, the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and the American Association of Colleges of Osteopathic Medicine hosted a summit on nutrition in medical education with the goals of identifying what residents need to know about nutrition and how nutrition in graduate medical education fits into the continuum of medical education, from undergraduate medical education through clinical practice and

continuing medical education.⁷¹¹ In addition, the Accreditation Council for Graduate Medical Education is expected to review its Common Program Requirements in 2024 and 2025 and could address nutrition education in graduate medical education.⁷¹²

Many health professionals lack training and competency in nutrition-related issues and knowledge of and confidence in treating obesity.^{713,714,715} Surveys have shown that healthcare providers who are better trained to address nutrition and obesity also feel more comfortable referring their patients to interventions. For example, in one national survey, cardiologists who participated in continuing medical education focused on nutrition were more likely to refer their patients to a dietitian or nutrition professional.⁷¹⁶ Importantly, medical school training and continuing education should also address the full range of effective treatments for obesity, including nutrition counseling, intensive behavioral therapy, bariatric surgery, and pharmacological options.

It is critical that obesity education includes training about the complex, multifactorial causes of the disease and the importance of providing nonjudgmental care that is free from weight bias and discrimination, which can itself impact patient health. Weight stigma can have psychological, social, and physical health consequences and can also lead to adverse employment, education, and healthcare outcomes for people with obesity.⁷¹⁷ Healthcare providers should screen and refer their patients for unmet social needs—such as food insecurity, unstable housing, and domestic violence—which all increase the risk of developing chronic disease, including obesity.^{718,719,720}

In addition to following clinical guidelines, hospitals and other healthcare facilities can also promote healthy environments for patients, visitors, and staff by:

- Serving healthy and nutritious food and beverages onsite;
- Sponsoring workplace wellness programs and nutrition classes;
- Reimbursing employees' exercise-related expenses;
- Providing onsite fitness centers; and
- Designating a private space where employees can breastfeed or express milk.^{721,722,723}

Community Benefit Programs

To maintain their tax-exempt status, nonprofit hospitals—which constitute 58 percent of community hospitals in the United States⁷²⁴—must conduct community health needs assessments (CHNA) at least every three years to determine their community's specific health needs and implement a plan to address them.⁷²⁵ A study published in 2023 found that obesity was identified as a community health need in 71 percent of respondents' CHNAs.⁷²⁶

Some examples of CHNA initiatives:

- Mount Sinai Beth Israel Diabetes Center, through their Diabetes Prevention Program, partnered with YMCA of Greater New York to reduce the risk of type 2 diabetes through education and motivation for those with diabetes or who are at risk.⁷²⁷
- Avita Health System and the local Crawford County Health Department in Ohio developed worksite wellness programs, including providing template policies for businesses to adopt, to increase physical activity among adults in the community.⁷²⁸



- CHI Saint Joseph Health Hospital in Kentucky hosts two walking events per year, where community members can walk with physicians to learn more about healthy lifestyles, enhance health knowledge, and create social connections.⁷²⁹

Breastfeeding Programs

A significantly lower risk for childhood obesity for children who are breastfed are among the many health benefits of breastfeeding.^{730,731,732,733} The American Academy of Pediatrics and the World Health Organization (WHO) recommend exclusive breastfeeding for about the first six months of age and continued breastfeeding with complementary foods up to two years of age or longer.^{734,735} Among infants born in the United States in 2021, 84 percent were ever breastfed, and 27 percent were still exclusively breastfeeding at six months.⁷³⁶ There are significant disparities in breastfeeding rates, with fewer non-Hispanic Black infants (75 percent) ever breastfed, fewer WIC-eligible infants (75 percent) ever breastfed, and younger mothers ages 20–29 years (80 percent) being less likely to ever breastfeed.⁷³⁷ Research shows that, for example, Black mothers have more barriers to breastfeeding,

including less peer, family, and social support; insufficient education and support in healthcare settings; and more concerns about employment.⁷³⁸

The Baby-Friendly Hospital Initiative, a joint program of the WHO and the United Nations Children's Fund (UNICEF), is a global program to support the implementation of the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes.⁷³⁹ In the United States, Baby-Friendly USA is the accrediting body that designates a hospital as "Baby-Friendly" when they offer the optimal level of care for infant feeding.⁷⁴⁰ Hospitals that participate in the program, through the support of the Baby-Friendly Hospital Initiative, provide caregiver education and training to initiate and continue breastfeeding beyond the hospital setting. The education also addresses the safe preparation and feeding of infant formula for caregivers of infants who have a medical indication or who have made an informed decision to use infant formula.⁷⁴¹ About one in four infants in the United States is born at one of more than 500 facilities designated as Baby Friendly, compared with fewer than 3 percent in 2007.⁷⁴²

The State of Obesity

Recommendations

Neighborhood environments can have a large impact on food and nutrition security, opportunities to be physically active, and wellness. For example, low-income neighborhoods in urban areas are less likely to have full-service grocery stores, and the convenience stores and smaller shops that do exist in those neighborhoods are less likely to carry healthy food options, such as a variety of fruits and vegetables.⁷⁴³ In addition, people living in low-income rural communities face challenges to food and nutrition security, including long driving distances to access grocery stores and a lack of infrastructure to be physically active. These non-medical drivers of health contribute more to health outcomes than healthcare interventions,⁷⁴⁴ which is critically important in understanding how policymakers should be prioritizing efforts in health promotion, including nutrition security and obesity prevention. Identifying the history, context, and unique needs of communities is imperative to implementing programs and policies that will improve the health and quality of life for community members.

While these issues can be addressed at the individual level, it is more cost effective and equitable to create healthy communities for all people. As such, each yearly *State of Obesity* report includes recommended programs and policies that would move the United States and communities forward to a more equitable public health and food system.

This section focuses on recommendations for federal, state, and local governments in five areas:

- (1) Advance health equity by strategically focusing on efforts that reduce obesity-related disparities and related conditions.
- (2) Decrease food and nutrition insecurity while improving nutritional quality of available foods.
- (3) Change the marketing and pricing strategies that lead to health disparities.
- (4) Make physical activity and the built environment safer and more accessible for all.
- (5) Work with the healthcare system to close disparities and gaps in clinic-to-community settings.

1. Advance Health Equity by Strategically Dedicating Federal Resources to Efforts that Reduce Obesity-Related Disparities and Related Conditions.

Obesity prevention strategies must be centered in equity. As the main funder of community-based obesity prevention activities, the federal government plays a critical role in creating resources and programs that can prevent and reduce obesity. In any policymaking, equity should be prioritized by:

- (a) Providing additional funding to communities most impacted by obesity, particularly those with low historic investment and structural inequities related to poverty, structural racism, and other social and economic factors to create a foundation of flexible funding, resources, and technical assistance tailored to a community's specific needs.
- (b) Supporting continued education opportunities for government employees to be trained in the importance of resource allocations, inclusive language, community outreach, and equitable implementation of projects in historically underinvested communities.

Recommendations for the federal government:

- **Increase capacity to prevent obesity and related chronic diseases.**

Congress should significantly increase funding for the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC) to improve the nation's prevention of obesity and related chronic diseases. This

investment should include at least \$130.42 million in FY 2025 for CDC's Division of Nutrition, Physical Activity, and Obesity to ensure its State Physical Activity and Nutrition program grants have sufficient funding to reach all 50 states as well as U.S. territories and tribal communities for implementation of effective multisector campaigns to prevent and reduce obesity. Funding should also be allocated to ensure national obesity surveillance systems can effectively gather information about race/ethnicity and other demographic data in order to better tailor programs and funding.

- **Increase funding for equitable obesity-related initiatives.** Congress should increase funding for initiatives that center on equity, such as CDC's Racial and Ethnic Approaches to Community Health (REACH) program, which delivers locally driven, effective, and culturally appropriate programs to those who bear a disproportionate burden of chronic disease. The Healthy Tribes program is in part funded through REACH and provides tribal organizations with resources, technical assistance, and evidence-based policies so that each grantee can create unique chronic disease prevention programs that center on tribal history, traditions, and beliefs. TFAH recommends at least \$102.5 million for REACH and Healthy Tribes in FY 2025 to expand these effective approaches to additional communities.

- **Support multisector collaborations that address the social determinants of health.**

Research shows a strong connection between the non-medical drivers of health, also referred to as the social determinants of health (SDOH), and risk of obesity and other health conditions, yet there has been little federal funding for public health approaches to address SDOH.^{745,746} Congress should expand funding to \$100 million in FY 2025 for the SDOH program at CDC to fund meaningful multisector partnerships between public health and partners that address economic opportunity, housing, transportation, and access to nutritious foods. The Improving Social Determinants of Health Act would authorize the creation of such a program at CDC and should be signed into law.

- **Address economic factors that contribute to obesity.** Poverty is a significant contributor to obesity and chronic disease. Congress should support programs that both reduce poverty and improve health. Multifaceted approaches, including increasing the minimum wage, expanding the child tax credit and Earned Income Tax Credit, and creating access to safe, healthy, and affordable housing can reduce poverty and improve population health.^{747,748,749} For further discussion of TFAH's policy recommendations on economic well-being, see the report Promoting Health and Cost Control in States.⁷⁵⁰

- **Prioritize health equity in federal agency goals planning.** All relevant divisions at the U.S. Department of Health and Human Services (HHS), the U.S. Department of Transportation (DOT), and U.S. Department of Agriculture (USDA) should implement and continue to publicly report on an annual basis the progress for their Agency Equity Action Plans.⁷⁵¹ In addition, HHS, DOT, USDA, and any federal agencies that work to prevent obesity and the development of chronic diseases should prioritize policies, programs, and resources that reduce health disparities and advance health equity.

- **Adapt federal grantmaking practices to account for differential needs, resources, and capacity.** Federal agencies that support obesity and chronic disease prevention efforts should prioritize communities with the greatest health-related needs and utilize health impact assessments, disease burden, historical underfunding, and social context when determining grantmaking eligibility criteria for competitive grant mechanisms. Community-based organizations can be well-situated to implement obesity prevention activities in impacted communities but may also need technical assistance or flexibility to meet the procedural requirements of federal grants, such as upfront financial barriers and limited operating budgets. In

particular, the Agency Equity Action Plans call for increasing awareness and providing help to organizations to navigate federal funding opportunities, provide technical assistance throughout the application process, and make federal funding applications simpler and easier to navigate, all of which are policies that all agencies in the federal government should implement.⁷⁵²

Recommendations for state/local government:

- **Assess and implement a living wage policy.** A living wage is the hourly wage necessary to meet a person or family's basic needs given the local cost of living. The living wage draws upon geographic location and the cost of basic necessities, such as the minimum food, childcare, health insurance, housing, transportation, and other basic necessities and the minimum employment earnings necessary to meet basic needs while maintaining self-sufficiency.⁷⁵³ States can establish a living wage law and cover workers or sectors not covered by the federal minimum wage, including domestic service workers and tipped workers.
- **Create or strengthen a child tax credit.** To build upon the federal child tax credit (CTC), a number of states have followed suit and enacted CTC programs of their own.⁷⁵⁴ States should consider implementing new or strengthening existing CTC policies.

2. Decrease Food and Nutrition Insecurity While Improving Nutritional Quality of Available Foods.

Individuals who are food insecure are more likely to live with obesity and other nutrition-related diseases. Federal nutrition assistance programs play a major role in the food and nutrition security of millions of Americans. In 2023, the Supplemental Nutrition Assistance Program (SNAP) helped 42.2 million people⁷⁵⁵ with an average monthly benefit of \$340,⁷⁵⁶ while the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provided healthy foods and nutrition services to 6.6 million participants.⁷⁵⁷ Critically, SNAP helps people be healthier and is linked to reduced healthcare costs.⁷⁵⁸ However, millions more people are eligible but not signed up for these critical benefits.⁷⁵⁹ Additional funding is necessary for outreach to increase participation rates and to address systemic factors that prohibit complete nutrition security.

Recommendations for the federal government:

- **Enact Healthy School Meals for All.** Congress should make Healthy School Meals for All (a program created in response to the COVID-19 pandemic) permanent as a step to end child hunger and ensure access to healthy foods. Doing so would provide free meals to children regardless of income, eliminate school meal debt and lunch shaming, reduce program financial loss⁷⁶⁰ and administrative costs, and incentivize local food procurement. Congress should also increase funding for outreach to ensure children and families eligible for school meals and SUN Bucks (formerly called Summer Electronic Benefits Transfer) are enrolled.⁷⁶¹

- **Strengthen school nutrition standards.** USDA should maintain the progress of the final 2024 school nutrition meal standards and work to fully align them with science-based recommendations. Congress should provide USDA the resources necessary to offer technical assistance, training, and peer-to-peer learning collaboratives. USDA should also consider performance-based incentives and should work with industry to provide foods that meet the new standards in phases to allow schools adequate time to adjust to improved nutrition levels.

- **Encourage Community Eligibility Provision enrollment and expand eligibility.** The Community Eligibility Provision (CEP) has allowed over 33,000 schools, about one in three of the schools that participate in school meals, to offer them at no charge to all students.⁷⁶² CEP provides meals for all enrolled students if 25 percent or more of students are directly certified for free school meals, and schools are reimbursed according to the percentage of directly certified children. Participating schools report that CEP improves children's access to healthy meals, reduces paperwork for parents and schools, and makes school meal programs more efficient.⁷⁶³ Congress should appropriate additional funding to increase meal reimbursements to further incentivize schools to implement CEP.⁷⁶⁴

- **Create a mandatory front-of-package label for packaged foods to help consumers make informed choices.** The U.S. Food and Drug Administration (FDA) should swiftly move forward in implementing a mandatory front-of-package nutrition label system for packaged foods, a key recommendation from the White House National Strategy on Hunger, Nutrition, and Health.⁷⁶⁵ Front-of-package labels have been proven to help consumers make better choices by putting simplified, essential nutrition information on the front of packaged food products.^{766,767}

- **Enhance SNAP benefits.** Congress should protect the update to the Thrifty Food Plan, which increased pre-pandemic SNAP benefits by 21 percent, and continuously review the effectiveness of the benefit level.⁷⁶⁸ Congress should also oppose any legislative or regulatory efforts that would effectively limit SNAP eligibility or that would diminish or create any other barriers to participating, such as imposing additional work requirements or time limits or eliminating broad-based categorical eligibility. In addition, Congress should require and provide more resources to states for translation and outreach services for people applying for SNAP who have limited English proficiency.⁷⁶⁹

- **Increase healthy food benefits in SNAP.** Congress should double investments in SNAP-Ed, and USDA should continue to strengthen the highly effective Gus Schumacher Nutrition Incentive Program, which supports nutrition projects that increase fruit and vegetable purchases among SNAP beneficiaries.
- **Increase access to WIC.** Congress should expand access to WIC for young children up to age 6 and postpartum women up to two years postpartum, extend certification periods to streamline clinic processes, partner more closely with Head Start to enhance child retention, and allow WIC benefits to be remotely loaded onto benefits cards. These steps will modernize the WIC program to make it more flexible and allow more families to access WIC's effective interventions by reducing duplicative paperwork requirements for both the participants and service providers.
- **Protect the value of benefits in WIC.** WIC has proved effective at reducing obesity and promoting good health,^{770,771} in part due to the 2009 changes to the food package to align the nutritional quality of WIC foods with independent scientific recommendations from the National Academies.^{772,773} Congress should protect the increase in the overall value of the WIC benefit.
- **Expand access to the Child and Adult Care Food Program (CACFP).** Low-income preschoolers attending CACFP-participating childcare centers are less likely to have obesity than similar children attending nonparticipating

centers.⁷⁷⁴ Congress should bolster CACFP by allowing a third meal service option, increasing reimbursements to support healthier standards, streamlining administrative operations, and continuing funding for CACFP nutrition and wellness education.

- **Expand support for maternal and child health, including breastfeeding.** Congress should increase funding and access for programs that promote maternal and child health and breastfeeding support, such as CDC's Hospitals Promoting Breastfeeding program; Maternal, Infant, and Early Childhood Home Visiting; and the WIC Breastfeeding Peer Counseling Program.⁷⁷⁵ Breastfeeding has been shown to contribute to multiple positive health outcomes, including the prevention of childhood obesity.⁷⁷⁶ Congress should increase funding for the Health Resources and Services Administration's Title V Block Grant, which supports state maternal and child health priorities, including breastfeeding, nutrition, and physical activity.^{777,778}
- **Promote healthy food options through procurement policies.** When government agencies establish policies to improve the nutrition of the food they purchase and provide, they can improve public health and serve as an example for the private sector to provide healthy food.⁷⁷⁹ Federal and other facilities should improve the nutritional quality of the food they provide by uniformly implementing the Food Service Guidelines for Federal Facilities.⁷⁸⁰

Recommendations for state/local government:

- **Support access to healthy school meals.** States and localities should continue strengthening school nutrition standards by working to align with the Dietary Guidelines for Americans. Additionally, states and school districts should partner with out-of-school providers, community partners, and food banks to ensure children have access to food when they are not in school. Schools should continue flexibilities that will expand access to nutrition for students, such as second-chance breakfast, breakfast on-the-go, and breakfast in classrooms, while following CDC's Whole School, Whole Community, Whole Child framework, which provides information on the components of a school nutrition environment.⁷⁸¹
- **Community design should encourage healthy food options.** Local communities should incentivize—through land-use planning, zoning, and property tax credits—grocery stores, healthy corner stores, community gardens, food marts, and farmers' markets to locate or renovate in areas with limited access to nutritious foods and meet certain requirements for the amount of healthy food they provide.
- **Allocate resources to increase outreach and awareness of eligibility for nutrition assistance programs.** State agencies responsible for providing other benefits to families, such as unemployment insurance, Temporary Assistance for Needy Families, Medicaid, WIC, or SNAP, should ensure that parents or guardians are aware of all of the USDA Child Nutrition Programs that are available to families in their jurisdiction.

3. Change the Marketing and Pricing Strategies that Lead to Health Disparities.

From infancy through adulthood, Americans are exposed to effective advertising via television, radio, digital, and retail ads encouraging the consumption of fast food, soda, and calorie-dense, low-nutrient food products. While these messages reach virtually all populations, companies disproportionately market to children of color.^{782,783}

There is now a substantive and growing body of evidence showing that increasing the price, through excise taxes, of unhealthy items like sugary drinks reduces consumption (similar to pricing strategies that helped decrease the smoking rates), especially when that revenue funds programs and services that improve population health.^{784,785} Policies in several communities show clear evidence that this approach works to reduce the consumption of sugary drinks.^{786,787}

Recommendations for the federal government:

- **End unhealthy food marketing to children.** Congress should close tax loopholes and eliminate business-cost deductions related to the advertising of unhealthy food and beverages to children on television,

the internet, social media, and places frequented by children, like movie theaters and youth sporting events. Researchers project that eliminating advertising subsidies for unhealthy foods and beverages would prevent approximately 17,000 cases of obesity over a decade.⁷⁸⁸

- **Study the impacts of food marketing in the digital space.** The Federal Trade Commission, FDA, and USDA should convene an interagency working group to learn how to best limit children's exposure to unhealthy food marketing online, both in school and outside of school.
- **Improve accuracy of information about nutrition for children.** FDA should establish clear and consistent labeling requirements for "toddler milks," many of which have misleading labels that can confuse parents into buying nutritionally inferior products for their young children.⁷⁸⁹ FDA should also examine the need to regulate marketing strategies in retail environments, both in-person and online, that may be promoting inaccurate information about products to children.

- **Discourage overconsumption of sugar.** Federal, state, and local governments should increase the price of sugary drinks, through an excise tax, with tax revenue allocated to local efforts to reduce health and socioeconomic disparities, nutrition security, and obesity prevention programs. Another strategy to lower sugar consumption is making the tax amount proportional to the sugar amount in drinks, thereby incentivizing companies to reformulate and reduce the sugar content in their products.

Recommendations for state and local governments:

- **Reduce unhealthy food marketing to children at the local level.** Local education agencies and communities should consider incorporating strategies in their local wellness policies that further reduce unhealthy food and beverage marketing and advertising to children and adolescents, like by prohibiting coupons, sales, and advertising around schools and school buses, as well as by banning sugary drinks as branded sponsors of youth sporting events.⁷⁹⁰

4. Make Physical Activity and the Built Environment Safer and More Accessible for All.

While many individuals can take measures to be active, there are often larger social, economic, and environmental barriers that communities should address, such as modifying community design so it is easier and safer for people to walk, bike, or roll for recreation or transportation purposes; strengthening public transportation options; ensuring that children have daily opportunities for physical activity inside and outside of school; and creating accessible recreational options for people of all ages, racial and ethnic backgrounds, abilities, and incomes. Obstacles to physical activity are disproportionately greater in those communities where social and economic conditions have resulted in a lack of safe space for physical activity due to a variety of barriers, such as fewer recreational facilities, underfunded school systems, car-dependent transportation, and both overt discrimination and structural racism. For example, Black individuals may experience dread, anxiety, and hypervigilance while attempting to exercise, especially in predominantly white neighborhoods, due to a fear for their own safety.⁷⁹¹

Recommendations for the federal government:

- **Fund programs that support physical education and healthier schools.** Given the positive connection between increasing physical activity levels and improving mental health,⁷⁹² Congress should increase funding for the Student Support and Academic Enrichment grant program (under Every Student Succeeds Act Title IV, Part A) to \$2 billion in FY 2025 to make it easier for schools to implement physical activity opportunities. The Student Support and Academic Enrichment grant recipients can use the funding to support health and physical education, among other activities. Congress should expand funding for programs that promote social-emotional learning and improve health outcomes for children, such as CDC's Healthy Schools program.
- **Prioritize evidence-based physical activity guidelines.** Congress should pass and appropriate funding for the Promoting Physical Activity for Americans Act to require HHS to publish Physical Activity Guidelines for Americans at least every 10 years based on the most current scientific and medical knowledge, including information for population subgroups, as needed. Appropriations should also fund communication, dissemination, and support for the guidelines. Since the release of the first Physical Activity Guidelines for Americans in 2008, the vast majority of Americans (74 percent of men, 81 percent of women, and 80 percent of adolescents) do not meet these recommendations.⁷⁹³ The Guidelines were last updated in 2018.
- **Fund active transportation in all communities, with a focus on equity.** The Infrastructure Investment and Jobs Act sets aside funding for states and communities to develop Complete Streets plans. DOT should set strong guidance on what qualifies for a Complete Streets plan developed with federal money. Congress should ensure that funding for active transportation projects—like pedestrian and biking infrastructure, recreational trails, and Safe Routes to Schools—included in the Infrastructure Investment and Jobs Act are properly utilized. Local matching requirements for active transportation projects should be made more flexible to ensure that all communities, regardless of their resource level, have an equitable opportunity to receive funding. DOT can help by encouraging states to take advantage of technical assistance programs to help low-income, rural, and other high-need communities apply for and implement active transportation, planning, and multimodal projects. Congress should ensure that all federal infrastructure bills mandate state adoption of Complete Streets principles as a condition for the receipt of federal funding for major transportation projects.
- **Make physical activity safer.** DOT should add Safe Routes to Schools, Vision Zero, Complete Streets, and non-infrastructure projects as eligible initiatives of the Highway Safety Improvement Program. DOT should conduct national road safety audits to identify high-risk intersections and other hazards. States and large cities with higher rates of pedestrian deaths should implement safety improvement projects.

Recommendations for state/local governments:

- **Prioritize schooltime physical activity.** States and local education agencies should identify innovative methods to deliver physical activity every day, such as partnering with out-of-school providers for before- and after-school activity, implementing active recess or class-based activities, and more. States should consider using the Every Student Succeeds Act Title I and/or IV funding for physical education and other physical activity opportunities.⁷⁹⁴
- **Make local spaces more conducive to physical activity.** Local school districts and states should evaluate schoolyard suitability and enhance schoolyard spaces to account for active play, outdoor classroom space, school gardens, access to nature, and mitigation of urban heat islands. Shared-use agreements should allow for schoolyards and other school recreation facilities to be open to communities outside of school hours.
- **Make communities safer for physical activity and active transportation.** States and cities should enact Complete Streets and other complementary streetscape design policies to improve active transportation and to increase outdoor physical activity opportunities.
- **Encourage outdoor play.** States should build on the successful federal Every Kid Outdoors program—which provides fourth graders with a free-entry park pass for themselves and their families to visit federal public lands—to include state-managed lands and/or to expand to other age groups, and the federal government should extend the program to more ages. State and local policymakers and funders should support park development in high-need areas, prioritizing equity and community engagement when planning park development or updates.

5. Work with the Healthcare System to Close Disparities and Gaps in Clinic-to-Community Settings.

There are significant disparities in access to healthcare by sex, age, race, ethnicity, education, and family income.^{795,796} Health insurance and access to care are foundational to obesity prevention and treatment as well as to overall health. The following recommendations are in addition to the principal belief that all individuals in the United States, regardless of race, ethnicity, income, immigration status, or any other factor, deserve and should have access to quality healthcare.

Recommendations for the federal government:

- **Expand access to healthcare coverage.** Congress, the Administration, and state lawmakers should continue to expand access to and improve affordability of health insurance, including extending marketplace subsidies that are set to expire after 2025,⁷⁹⁷ and extending incentives for the expansion of Medicaid in remaining states.
- **Enforce U.S. Preventive Services Task Force (USPSTF) recommendations for obesity prevention.** While there is a current legal challenge being decided by the courts (*Braidwood Management, Inc. v. Becerra*), the law as it was enacted and is currently in effect requires most insurance plans to cover recommended preventive services with an A or B grade from the USPSTF with no cost-sharing. There are several grade A or B obesity-related USPSTF recommendations, including referrals for intensive behavioral interventions for adults and children, with varying implementation or uptake of these

recommendations across insurers.⁷⁹⁸ HHS, the U.S. Department of Labor, and the U.S. Treasury Department should jointly communicate to insurers that they must continue to require coverage of grade A and B recommendations by publishing Frequently Asked Questions, a form of correspondence that the departments have previously done on other USPSTF recommendations. Insurance plans should also incorporate quality measures that incentivize screening and counseling for overweight and obesity, with an emphasis on prevention. With an outstanding legal challenge that could eliminate the availability of recommended preventive services for millions of Americans, Congress should guarantee access to recommended preventive services, if necessary.

- **Re-Implement the Childhood Obesity Research Demonstration.** Congress should appropriate funding to allow CDC to re-start the Childhood Obesity Research Demonstration program to inform how to translate USPSTF recommendations into lifestyle and clinical interventions.
- **Expand opportunities for public health and healthcare coordination.** HHS, payers, healthcare facilities, public health, and Congress should strengthen opportunities to expand the capacity of healthcare providers and payers, social service providers, and public health officials to use data to inform population public health interventions.

- **Address root causes of health disparities.** Congress should pass the Health Equity and Accountability Act, a comprehensive bill that broadly addresses healthcare disparities and aims to improve the health and well-being of communities of color, rural communities, and other underserved populations across the United States.⁷⁹⁹
- **Expand Medicare coverage of weight-management and obesity-related services.** Medicare should expand coverage of obesity-related services, such as obesity and nutritional counseling provided by registered dietitians,⁸⁰⁰ anti-obesity medications, and bariatric surgery.

Recommendations for state/local governments:

- **Expand Medicaid eligibility to provide insurance coverage to more people.** States that have not yet expanded Medicaid should leverage the established incentives in the American Rescue Plan Act to ensure coverage of as many individuals as possible.
- **Prioritize strategies to address health-related social needs.** States, insurers, and healthcare facilities should follow the Centers for Medicare & Medicaid Services guidelines and requirements on addressing patients' health-related social needs, and public health departments should partner with social service agencies, healthcare insurers, hospital systems, and community organizations to address social determinants. Such efforts could include promoting evidence-based policies that improve community conditions; supporting community-desired interventions;

providing technical assistance and referral strategies to improve the use of electronic health records; establishing referrals to and funding for the National Diabetes Prevention Program, ParkRx, and other community-based programming; employing community health workers and promotores de salud in low-resourced areas to provide culturally and linguistically appropriate health education and to connect residents with relevant safety-net and social-support resources; and aligning state and local efforts to national initiatives (such as CDC's Million Hearts).

- **Cover adult and pediatric weight-management and obesity-related services in Medicaid.** Medicaid should reimburse providers for evidence-based comprehensive pediatric weight-management programs and services, such as Family-Based Behavioral Treatment programs and Integrated Chronic Care Models.⁸⁰¹ State Medicaid

programs should also expand coverage of obesity-related services, such as obesity and nutritional counseling provided by professionals like registered dietitians, anti-obesity medications, and bariatric surgery.

- **Build and support capacity of community-based partners through Medicaid.** State Medicaid agencies should consider seeking 1115 waivers or state plan amendments that would allow Medicaid state agencies or managed care organizations to reimburse community-based organizations for chronic disease prevention activities in order to further incentivize cross-sector collaboration (e.g., food is medicine and fruit and vegetable prescriptions). State Medicaid agencies can also provide targeted technical assistance to further build the capacity of community-based organizations to engage with healthcare entities.

The State of Obesity

Obesity-Related Indicators and Policies By State

The appendix covers indicators spanning state-level conditions, policies, and performance measures across five themes: (1) Community Conditions; (2) Built Environment and Active Transportation; (3) Food Insecurity; (4) Nutrition Assistance Programs, and (5) Childcare and School Nutrition. Some of the indicators are updated annually and are regularly included in the State of Obesity report, while others are based on one-time reports or were included this year because they particularly relate to the report's special feature. The data included are the most recent available, although some items have a substantial delay before release.



Community Conditions

	Poverty (2022)		Educational Attainment (2022)	Health Insurance Coverage (2022)
	What percentage of residents live below 100 percent of the poverty level? ¹	What percentage of children live below 100 percent of the poverty level? ²	What percentage of people 25 and over do not have a bachelor's degree or higher? ³	What percentage of residents ages 0-64 are uninsured? ^{4*}
Alabama	14%	18%	71%	10%
Alaska	10%	13%	69%	12%
Arizona	13%	19%	67%	13%
Arkansas	17%	23%	75%	10%
California	11%	14%	63%	8%
Colorado	8%	9%	10%	8%
Connecticut	10%	14%	58%	6%
Delaware	9%	15%	64%	7%
D.C.	13%	17%	35%	3%
Florida	14%	18%	66%	14%
Georgia	12%	14%	65%	14%
Hawaii	9%	13%	65%	4%
Idaho	8%	12%	68%	10%
Illinois	10%	13%	62%	8%
Indiana	10%	12%	70%	8%
Iowa	9%	12%	68%	5%
Kansas	11%	14%	64%	10%
Kentucky	17%	25%	72%	7%
Louisiana	17%	22%	73%	8%
Maine	10%	13%	64%	8%
Maryland	9%	12%	56%	7%
Massachusetts	10%	12%	53%	3%
Michigan	12%	16%	68%	6%
Minnesota	8%	10%	61%	5%
Mississippi	18%	21%	75%	13%
Missouri	11%	16%	68%	10%
Montana	10%	13%	65%	10%
Nebraska	8%	7%	65%	8%
Nevada	12%	15%	73%	13%
New Hampshire	8%	10%	59%	6%
New Jersey	9%	12%	57%	8%
New Mexico	20%	31%	70%	10%
New York	13%	19%	60%	6%
North Carolina	14%	19%	64%	11%
North Dakota	10%	15%	68%	8%
Ohio	10%	11%	68%	7%
Oklahoma	17%	24%	72%	14%
Oregon	10%	14%	64%	7%
Pennsylvania	11%	13%	65%	7%
Rhode Island	8%	11%	60%	5%
South Carolina	13%	18%	67%	11%
South Dakota	9%	10%	68%	10%
Tennessee	11%	13%	69%	11%
Texas	14%	18%	66%	19%
Utah	6%	7%	62%	9%
Vermont	9%	11%	56%	5%
Virginia	8%	8%	58%	8%
Washington	9%	10%	61%	7%
West Virginia	16%	17%	75%	7%
Wisconsin	7%	9%	67%	7%
Wyoming	7%	7%	70%	14%
Total	12%	15%	64%	10%

Sources and Notes:

1. US Census Bureau. "POV-11. Poverty Status by State." August 2023. <https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-11.html>. Accessed July 18, 2024.
2. US Census Bureau. "POV-11. Poverty Status by State." August 2023. <https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-11.html>. Accessed July 18, 2024.
3. US Census Bureau. "S1501 Educational Attainment" [https://data.census.gov/table?q=population%20by%20educational%20attainment&t=Education:Populations%20and%20People&g=010XX00US,\\$0400000](https://data.census.gov/table?q=population%20by%20educational%20attainment&t=Education:Populations%20and%20People&g=010XX00US,$0400000). Accessed July 18, 2024.
4. Kaiser Family Foundation. "Health Insurance Coverage of Nonelderly 0-64" <https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&sort=Model=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed July 18, 2024.

* Kaiser Family Foundation estimates based on U.S. Census Bureau's American Community Survey.

Built Environment and Active Transportation

	Neighborhood Sidewalks and Parks (2021-2022)		Complete Streets Policy Strength (2022)	Walking/Biking/Safe Routes to School Criteria (2022)	Making Strides Indicator Overall Score (2024)
	What percentage of children live in neighborhoods with sidewalks/walking paths? ^{1*}	What percentage of children live in neighborhoods with parks/playgrounds? ¹	How strong is a state's Complete Streets policy score? ^{2*} (Score out of 20)	Do the state's school siting guidelines contain criteria that encourage or require consideration of walking, biking, or Safe Routes to School? ²	What is the state's overall Making Strides score—a Built Environment and Active Transport indicator? ^{2**} (Score out of 200)
Alabama	50%	51%	0		38
Alaska	70%	71%	0	✓	60
Arizona	86%	81%	0	✓	87
Arkansas	55%	57%	0		41
California	90%	84%	20	✓	174
Colorado	91%	89%	18	✓	172
Connecticut	71%	81%	16	✓	123
Delaware	74%	68%	11	✓	107
D.C.	98%	90%	11		135
Florida	75%	70%	8	✓	145
Georgia	61%	62%	13		87
Hawaii	84%	87%	11	✓	132
Idaho	77%	73%	0		96
Illinois	86%	87%	3		128
Indiana	70%	66%	11		88
Iowa	82%	80%	15		90
Kansas	78%	77%	0		149
Kentucky	64%	60%	13	✓	73
Louisiana	59%	59%	15		93
Maine	61%	71%	12	✓	124
Maryland	80%	83%	11	✓	120
Massachusetts	86%	84%	19	✓	150
Michigan	74%	77%	14		145
Minnesota	80%	87%	16	✓	149
Mississippi	43%	45%	5		52
Missouri	70%	71%	2		26
Montana	72%	76%	0		64
Nebraska	87%	80%	0		32
Nevada	90%	80%	16		99
New Hampshire	63%	75%	0		37
New Jersey	88%	92%	13	✓	148
New Mexico	78%	75%	1		53
New York	81%	87%	13	✓	62
North Carolina	59%	59%	11		86
North Dakota	79%	78%	0	✓	55
Ohio	78%	77%	0	✓	107
Oklahoma	53%	63%	0	✓	74
Oregon	82%	82%	6		142
Pennsylvania	72%	78%	9	✓	98
Rhode Island	80%	82%	11	✓	94
South Carolina	53%	54%	10		80
South Dakota	81%	81%	0		53
Tennessee	52%	57%	13		96
Texas	76%	75%	5		79
Utah	93%	89%	6	✓	106
Vermont	67%	75%	8	✓	102
Virginia	73%	76%	12	✓	108
Washington	79%	77%	16		162
West Virginia	50%	56%	14	✓	45
Wisconsin	74%	81%	7		54
Wyoming	83%	78%	0	✓	69
Total	76%	76%		25 states	

Sources and Notes:

1. Park or Playground: Child and Adolescent Health Measurement Initiative. "Interactive Data Query: National Survey of Children's Health (2022–Present)", 2022. <https://nschdata.org/browse/survey/all-states?q=10656> Accessed July 18, 2024.

Sidewalks or walking paths: Child and Adolescent Health Measurement Initiative. "Interactive Data Query: National Survey of Children's Health (2022–Present)" 2022. <https://nschdata.org/browse/survey/all-states?q=10657> Accessed July 18, 2024.

* Data is from the National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau.

2. Safe Routes Partnership (2024). "Making Strides 2024: State Report Cards on Support for Walking, Bicycling, and Active Kids and Communities". [Report data shared prior to public release]. <https://www.saferroutespartnership.org/blog/previewing-2024-making-strides-state-report-cards>.

*Complete Streets policy strength scores range from 0-20. 0 indicates a state has not adopted a Complete Streets policy. For states with a policy, points from 1 to 20 are awarded, with more points awarded for stronger policy.

**The report cards for each state summarize a total of 26 indicators spanning four core topic areas: Complete Streets and Active Transportation Policy and Planning, Federal and State Active Transportation Funding, Safe Routes to School Funding and Supportive Practices, and Active Neighborhoods and Schools. In each of these topic areas, states can play a significant role—through policies, funding, and other support—in increasing the number of children and adults walking, bicycling, and being physically active. Each state is given an overall score out of 200.

Food Insecurity					Nutrition Assistance Programs	
	Food Insecurity (2022)		Food Insecure Above SNAP Threshold (2022)	Average Cost Per Meal (2022)	SNAP Participation (2020)	Special Supplemental Nutrition Program for WIC Participation (2021)
	What percentage of households experience low or very low food security? (Average 2020-2022) ¹	What percentage of children (under 18) are food insecure? ²	What percentage of food insecure people in the state fall above the Supplemental Nutrition Assistance Program (SNAP) threshold? ³	What is the average cost per meal in the state? ³	What percentage of people eligible participate in the Special Nutrition Assistance Program (SNAP)? ⁴	What percentage of people eligible participate in the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC)? ^{5*}
Alabama	12%	23%	61%	\$3.91	81%	50%
Alaska	10%	17%	63%	\$4.70	81%	51%
Arizona	10%	19%	53%	\$3.68	74%	52%
Arkansas	17%	24%	61%	\$3.55	62%	35%
California	10%	17%	44%	\$4.05	66%	67%
Colorado	9%	14%	52%	\$4.13	76%	46%
Connecticut	10%	15%	51%	\$4.27	89%	46%
Delaware	12%	18%	55%	\$3.96	87%	48%
D.C.	10%	15%	41%	\$4.88	93%	59%
Florida	11%	19%	46%	\$4.13	73%	49%
Georgia	11%	18%	68%	\$3.95	72%	40%
Hawaii	9%	21%	54%	\$5.01	83%	56%
Idaho	11%	15%	69%	\$4.19	79%	44%
Illinois	11%	16%	58%	\$3.98	100%	36%
Indiana	11%	18%	65%	\$3.54	73%	61%
Iowa	9%	15%	60%	\$3.80	85%	55%
Kansas	10%	19%	67%	\$3.86	70%	46%
Kentucky	13%	21%	38%	\$3.49	65%	59%
Louisiana	15%	25%	58%	\$3.79	83%	37%
Maine	10%	19%	52%	\$4.19	90%	55%
Maryland	10%	16%	51%	\$4.16	85%	55%
Massachusetts	9%	13%	47%	\$4.41	100%	61%
Michigan	12%	18%	44%	\$3.74	85%	59%
Minnesota	7%	14%	47%	\$4.23	76%	62%
Mississippi	12%	24%	61%	\$3.69	62%	47%
Missouri	15%	19%	66%	\$3.84	8%	40%
Montana	12%	17%	48%	\$3.83	79%	43%
Nebraska	12%	19%	59%	\$3.71	78%	58%
Nevada	12%	21%	47%	\$3.88	84%	48%
New Hampshire	6%	13%	59%	\$4.11	79%	54%
New Jersey	9%	13%	55%	\$4.19	72%	51%
New Mexico	11%	22%	45%	\$3.71	100%	35%
New York	11%	19%	42%	\$4.20	82%	53%
North Carolina	11%	20%	45%	\$3.91	74%	62%
North Dakota	8%	14%	51%	\$3.84	66%	53%
Ohio	12%	20%	64%	\$3.78	81%	39%
Oklahoma	14%	24%	65%	\$3.77	84%	52%
Oregon	11%	17%	45%	\$4.19	100%	61%
Pennsylvania	10%	17%	49%	\$4.05	100%	41%
Rhode Island	9%	15%	57%	\$4.24	100%	88%
South Carolina	15%	18%	63%	\$3.80	69%	54%
South Dakota	9%	18%	65%	\$3.94	80%	41%
Tennessee	12%	18%	65%	\$3.97	84%	54%
Texas	16%	23%	55%	\$3.45	69%	41%
Utah	11%	15%	75%	\$3.79	74%	50%
Vermont	8%	15%	57%	\$4.34	96%	37%
Virginia	9%	14%	48%	\$4.06	77%	72%
Washington	8%	16%	52%	\$4.28	94%	49%
West Virginia	14%	21%	41%	\$3.52	94%	51%
Wisconsin	10%	17%	49%	\$3.91	92%	53%
Wyoming	11%	19%	67%	\$3.90	49%	44%
Total	11%	19%	36%	\$3.99	78%	51%

Sources and Notes:

1. Matthew Rabbit, P. et al. "Household Food Security in the United States in 2022" USDA Economic Research Service, 325: 1-53, October 2023. <https://doi.org/10.32747/2023.8134351.ers>.
2. Feeding America. "Food Insecurity among the Child Population in the United States" <https://map.feedingamerica.org/county/2022/child>. Accessed July 18, 2024.
3. Feeding America. "Food Insecurity among the Overall Population in the United States" <https://map.feedingamerica.org/>. Accessed July 18, 2024.
4. Karen Cunyngnam. "Empirical Bayes Shrinkage Estimates of State Supplemental Nutrition Assistance Program Participation Rates: Fiscal Year 2018 to Fiscal Year 2020" U.S. Department of Agriculture, Food and Nutrition Service, August, 2023. <https://www.mathematica.org/publications/2018-2020-empirical-bayes-shrinkage-estimates-of-state-supplemental-nutrition-assistance-program>. Accessed July 18, 2024.
5. U.S Food and Drug Administration. "National and State Level Estimates of WIC Eligibility and Program Reach in 2021" November 2023. <https://www.fns.usda.gov/research/wic/eligibility-and-program-reach-estimates-2021>. Accessed July 18, 2024.

*These values capture eligibility and participation across all WIC participant categories (infants, children, and women).

Nutrition Assistance Programs Continued

	WIC Breastfeeding Performance Measurements (FY 2022)	Medicaid Waivers for Nutrition Support Programs (2024)	Medicaid Food Insecurity Screening and Referral Programs (2024)	Farm to Food Bank Project Funding (FY 2024)	TEFAP Food Costs (FY 2023)
	What is the percentage of breastfed infants (fully or partially breastfed) among Women, Infant, and Children (WIC) participants in the state? ¹	Does the state have an approved or pending 1115 Medicaid waiver addressing nutrition support or food-related programs? ²	What states have food insecurity screening and referral programs? ^{3*}	Which states are conducting a Farm to Food Bank project? ^{4*}	What is the total cost of food delivered to states under the Emergency Food Assistance Program (TEFAP)? ^{5*}
Alabama	11%				\$18,406,259
Alaska	49%				\$2,034,628
Arizona	33%		√	√	\$25,001,514
Arkansas	16%	√		√	\$12,816,499
California	42%	√	√	√	\$147,813,121
Colorado	40%		√	√	\$17,881,559
Connecticut	39%				\$8,088,206
Delaware	37%	√	√	√	\$5,145,516
D.C.	46%		√		\$2,518,618
Florida	41%			√	\$75,631,602
Georgia	31%	√			\$33,069,840
Hawaii	53%	√	√	√	\$4,153,769
Idaho	46%			√	\$4,842,053
Illinois	34%	√		√	\$44,137,178
Indiana	32%				\$25,452,559
Iowa	33%		√	√	\$7,414,915
Kansas	34%	√			\$7,023,955
Kentucky	26%			√	\$18,500,132
Louisiana	22%			√	\$22,104,250
Maine	35%		√	√	\$6,091,360
Maryland	45%	√			\$10,304,338
Massachusetts	41%	√	√		\$23,111,811
Michigan	27%		√	√	\$37,567,105
Minnesota	41%				\$13,813,536
Mississippi	17%				\$13,852,200
Missouri	26%			√	\$18,796,315
Montana	37%				\$2,011,576
Nebraska	36%		√		\$4,447,834
Nevada	34%		√		\$14,189,958
New Hampshire	37%		√	√	\$2,683,375
New Jersey	47%	√			\$27,238,784
New Mexico	40%	√			\$9,792,553
New York	51%	√			\$74,897,886
North Carolina	27%	√	√	√	\$31,477,422
North Dakota	33%		√		\$2,204,203
Ohio	15%		√	√	\$40,054,149
Oklahoma	19%		√		\$16,776,147
Oregon	41%	√	√	√	\$12,582,442
Pennsylvania	22%	√		√	\$40,792,361
Rhode Island	33%				\$2,689,477
South Carolina	24%		√		\$19,141,772
South Dakota	33%				\$3,079,977
Tennessee	32%		√		\$24,996,172
Texas	59%			√	\$128,127,763
Utah	44%				\$6,363,039
Vermont	52%	√			\$1,817,334
Virginia	26%		√	√	\$17,176,044
Washington	47%	√	√	√	\$23,615,269
West Virginia	19%		√	√	\$7,886,734
Wisconsin	28%		√	√	\$13,351,316
Wyoming	36%			√	\$1,895,943
Total	37%	17 states	23 states and DC	26 states	\$1,162,555,026

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Childcare and School Nutrition

	Obesity Prevention in Early Care and Education (2022)	School Lunch Index Score (2024)	School Breakfast Program (2022-2023)	SUN Bucks (2024)	Community Eligibility Provision (2022-2023)	Universal Free School Meals (as of April 2024)
	How well do the state's licensing regulations for child care centers support high-impact obesity prevention standards? ^{1*} (Score out of 100)	What is the state's School Lunch Index Score (representing healthiness of school lunch)? ² (Score out of 100)	What percentage of the children in the School Lunch Program are in the School Breakfast Program? ³	Did the state participate in SUN Bucks (previously known as Summer EBT) in 2024? ^{4*}	What percentage of eligible districts have adopted the community eligibility provision? ^{5*}	Which states have passed or are considering legislation for universal free school meals? ^{6**}
Alabama	75	45	56%		50%	
Alaska	71	41	50%		83%	
Arizona	52	53	46%	√	69%	√b
Arkansas	72	51	63%	√	58%	
California	48	56	55%	√	79%	√a
Colorado	71	45	41%	√	35%	√a
Connecticut	55	65	45%	√	78%	√b
Delaware	77	43	56%	√	74%	√b
D.C.	74	Not Available	76%	√	98%	√b
Florida	69	50	46%		67%	
Georgia	69	65	57%		84%	
Hawaii	67	69	30%	√	100%	√b
Idaho	31	35	40%		47%	
Illinois	62	50	44%	√	61%	√b
Indiana	42	52	44%	√	41%	
Iowa	65	55	33%		20%	√b
Kansas	46	49	39%	√	22%	
Kentucky	61	54	64%	√	97%	
Louisiana	71	35	56%	√	91%	√b
Maine	60	70	59%	√	66%	√a
Maryland	71	58	54%	√	61%	√b
Massachusetts	44	71	45%	√	76%	√a
Michigan	69	52	53%	√	56%	√a
Minnesota	66	58	40%	√	55%	√a
Mississippi	70	44	59%		77%	
Missouri	51	57	54%	√	62%	√b
Montana	64	42	51%	√	64%	√b
Nebraska	63	50	34%	√	37%	√b
Nevada	67	54	52%	√	93%	√b
New Hampshire	70	55	32%	√	20%	
New Jersey	61	59	54%	√	50%	√b
New Mexico	69	41	68%	√	91%	√a
New York	60	57	50%	√	79%	√b
North Carolina	74	52	57%	√	72%	√b
North Dakota	50	66	36%	√	100%	√b
Ohio	50	49	48%	√	82%	√b
Oklahoma	62	48	52%		43%	√b
Oregon	46	48	49%	√	91%	√b
Pennsylvania	45	56	52%	√	60%	√b
Rhode Island	74	62	44%	√	61%	√b
South Carolina	54	45	58%		79%	√b
South Dakota	37	52	30%		82%	√b
Tennessee	83	56	59%	√	79%	√b
Texas	81	43	54%		61%	
Utah	70	46	23%		88%	
Vermont	72	62	64%	√	89%	√a
Virginia	71	65	55%	√	96%	√b
Washington	80	48	44%	√	99%	√b
West Virginia	49	47	82%	√	95%	
Wisconsin	69	46	41%	√	55%	√b
Wyoming	41	40	36%		100%	
Total	62	N/A	51%	37 states and DC	68%	8 states passed; 27 states and DC considering

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