ISSUE REPORT

The State of Obesity:

BETTER POLICIES FOR A HEALTHIER AMERICA 2025

SPECIAL FEATURE: Emerging Science and Policy Considerations for Ultra-Processed Foods

OCTOBER 2025

Trust for America's Health
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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.

REPORT AUTHORS

Molly Warren, S.M.
Senior Health Policy Researcher and Analyst
Trust for America's Health

Madison West*
Government Relations Manager
Trust for America's Health
**Ms. West was a member of the TFAH staff through August 2025.*

CONTRIBUTORS

Ilse Argueta, MPH
Policy Development Manager
Trust for America's Health

Dara Alpert Lieberman, MPP
Director of Government Relations
Trust for America's Health

Michelle DelFavero, MOT, MPH
Consultant

Vinu Ilakkuvan, DrPH
Consultant

Sarah Ketchen Lipson, Ph.D., Ed.M.
Associate Professor
Boston University School of Public Health
Principal Investigator
The Healthy Minds Network

Melissa Maitin-Shepard, MPP
Consultant

REVIEWERS

This report has benefited from the insights and expertise of the following external reviewers. Their review does not necessarily constitute an endorsement of the report's findings or recommendations by the reviewer or their organization. TFAH thanks the reviewers for their time and assistance.

William Dietz, M.D., Ph.D.
Director of Research and Policy for the Global Food Institute, Director of STOP Obesity Alliance, and Professor
Milken Institute School of Public Health, George Washington University

Philip Kahn-Pauli, M.A.
Director of Legislative Affairs
Center for Science in the Public Interest

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Dariush Mozaffarian, M.D., MPH, DrPH
Director of the Food is Medicine Institute
Friedman School of Nutrition Science and Policy, Tufts University

Aviva Musicus, Sc.D.
Science Director
Center for Science in the Public Interest

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Editor's note: *Editorial work on the report was completed in August 2025, with select updates made in September. The content reflects the status of ongoing and proposed federal actions as of that time.*

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LIST OF ACRONYMS AND ABBREVIATIONS

Addressing Conditions to Improve Population Health program	ACTion
American Indian and Alaska Native	AI/AN
Behavioral Risk Factor Surveillance System	BRFSS
Body mass index	BMI
Centers for Disease Control and Prevention	CDC
Centers for Medicare & Medicaid Services	CMS
Child and Adult Care Food Program	CACFP
Children's Food and Beverage Advertising Initiative	CFBAI
Community Development Financial Institutions Fund	CDFI Fund
Community Eligibility Provision	CEP
Community Health Needs Assessments	CHNA
Division of Nutrition, Physical Activity, and Obesity	DNPAO
Division of Population Health	DPH
Early care and education	ECE
Electronic benefits transfer	EBT
Federal poverty level	FPL
Fiscal year	FY
Food and Nutrition Service	FNS
Food is medicine	FIM
Fresh Fruit and Vegetable Program	FFVP
Front-of-package	FOP
Fruit and vegetable cash value voucher	CVV
Glucagon-like peptide-1	GLP-1
Good Health and Wellness in Indian Country	GHWIC
Gus Schumacher Nutrition Incentive Program	GusNIP
Healthy Food Financing Initiative	HFFI
High Obesity Program	HOP
Human Foods Program	HFP
In lieu of services	ILOS
Indian Health Service	IHS
Local Agriculture Market Program	LAMP
Local Food for Schools	LFS
Local Food Purchase Assistance	LFPA
National Diabetes Prevention Program	National DPP
National Center for Chronic Disease Prevention and Health Promotion	NCCDPHP
National Health and Nutrition Examination Survey	NHANES
National Institutes of Health	NIH
National School Lunch Program	NSLP
New Markets Tax Credit	NMTC
One Big Beautiful Bill Act	OBBBA
Perfluoroalkyl and polyfluoroalkyl substances	PFAS
Preventive Health and Health Services	PHHS
Racial and Ethnic Approaches to Community Health	REACH
Safe Routes to School	SRTS
School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students	Healthy Schools
School Breakfast Program	SBP
SNAP-Education	SNAP-Ed
Special Milk Program	SMP
Special Supplemental Nutrition Program for Women, Infants, and Children	WIC
State Physical Activity and Nutrition	SPAN
Summer Electronic Benefits Transfer for Children	Summer EBT/ SUN Bucks
Summer Food Service Program	SUN Meals
Supplemental Nutrition Assistance Program	SNAP
The Emergency Food Assistance Program	TEFAP
Trust for America's Health	TFAH
United Nations Children's Fund	UNICEF
U.S. Department of Agriculture	USDA
U.S. Department of Health and Human Services	HHS
U.S. Department of Transportation	DOT
U.S. Department of Veterans Affairs	VA
U.S. Food and Drug Administration	FDA
U.S. Preventive Services Task Force	USPSTF
World Health Organization	WHO
Youth Risk Behavior Survey	YRBS

Introduction

Obesity and other chronic diseases are a serious, complex, and long-standing public health issue in the United States. They are influenced by many factors, including nutrition and dietary trends as well as social, economic, and environmental conditions that affect health and well-being (e.g., limited access to affordable, nutritious food and physical activity, poverty, and discrimination).[1,2,3,4,5] In 2025, the Trump Administration has voiced concerns about chronic disease and nutrition, created the Make America Healthy Again Commission with the stated goal of addressing childhood chronic disease, and taken steps to reduce artificial dyes in the food supply.[6,7,8] At the same time, the administration has initiated significant restructuring, eliminated programs, laid off members of the workforce, and restricted congressional appropriated funds across the federal government, including funds for many health agencies and programs that directly address obesity, chronic disease, and nutrition.[9,10,11,12,13] For example the president's fiscal year (FY) 2026 budget request proposes the near total elimination of the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention, which includes cornerstone programs that fund state and local efforts to address and prevent obesity, diabetes, heart disease and stroke, and other chronic diseases.[14,15]

FAST FACTS ABOUT OBESITY IN THE UNITED STATES

National Adult Obesity Rate, 2021–2023:
40.3 percent

Change in Adult Obesity Rate from 1999–2000 to 2021–2023:
32 percent increase

National Youth Obesity Rate, 2021–2023:
21.1 percent

Change in Youth Obesity Rate from 1999–2000 to 2021–2023:
52 percent increase

Sources: NHANES[16,17,18]

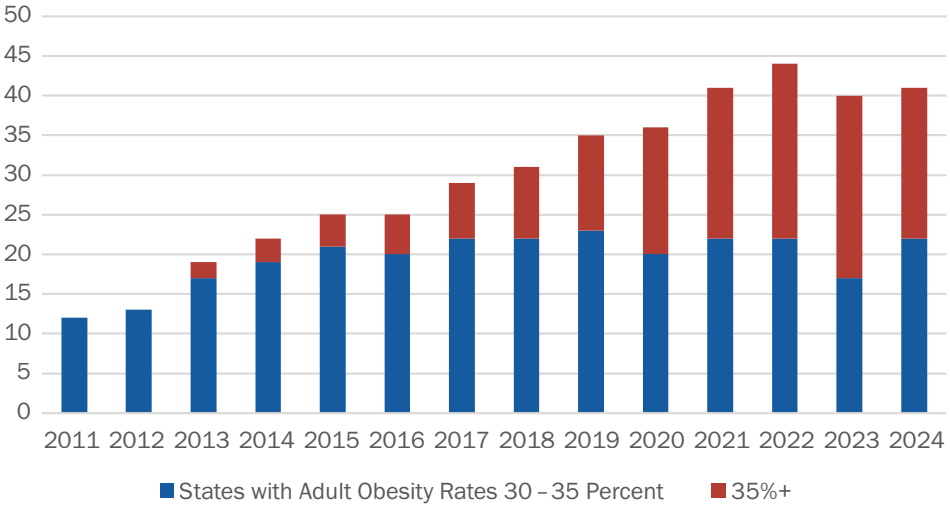
Number of States with Adult Obesity Rates Above 35 Percent, 2024: **19**

Number of States with Adult Obesity Rates Above 35 Percent, 2014: **3**

Source: TFAH analysis of BRFSS data[19]

Over the last few decades, the United States has seen a long-term trend of rising adult obesity rates.[20,21] In recent years, the data show a more level trend. According to the most recent national data from the National Health and Nutrition Examination Survey, there was no statistically significant change in adult obesity rates between 2013–2014 and 2021–2023.[22] New 2024 state-level data from the Behavioral Risk Factor Surveillance System also show a more level trend with no states having a statistically significant change in their adult obesity rates between 2023 and 2024 (see Figure 1 below and more results on page 26).[23,24]

FIGURE 1: Number of States with Adult Obesity Rates at 30 Percent or Higher, 2011–2024



Source: TFAH analysis of BRFSS data[25]

Note: Data were not available from Tennessee for 2024, Kentucky and Pennsylvania for 2023, Florida for 2021, and New Jersey for 2019

Nutrition and diet quality are linked to obesity, other chronic diseases, and overall mortality, yet in recent decades, the American diet quality has been poor, with low consumption of fruits and vegetables and high consumption of ultra-processed foods.[26,27,28,29] In this year's *State of Obesity* report, Trust for America's Health (TFAH) presents a feature section on ultra-processed foods, the state of the science considering their health effects, current policies related to ultra-processed foods, and considerations and next steps in addressing consumption of ultra-processed foods and improving U.S. nutrition and diet quality.

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 22), a section that examines key current programs and emerging policies (page 38), and, finally, a section that outlines recommended policy actions (page 81).

WHY DOES TFAH FOCUS ON OBESITY?

Obesity and other diet-related chronic diseases have been increasing across the United States for years. They pose a significant public health problem as obesity and other diet-related chronic diseases are associated with a range of physical and mental health conditions at the population-level as well as higher mortality.[30,31,32]

(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, arthritis, depression, sleep apnea, liver disease, kidney disease, gallbladder disease, severe COVID-19, pregnancy complications, and many types of cancer—and an overall risk of higher mortality.[33,34,35,36,37,38,39,40,41,42,43,44,45,46]

(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.[47,48,49,50,51] Children with obesity also have a higher risk of hospitalization and severe illness from COVID-19.[52]

Additionally, obesity causes higher medical costs at the individual and societal levels. A 2021 study found that obesity accounted for $170 billion in higher medical costs annually in the United States.[53] This includes billions in extra costs to Medicare and Medicaid.[54,55] 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.[56,57] A 2024 report estimated that obesity and overweight created $425.5 billion in economic costs to U.S. businesses and employees in 2023.[58]

SUMMARY OF 2025 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 eliminating longstanding structural and historic inequities, targeting obesity prevention programs to communities with the highest needs, and scaling and increasing evidence-based initiatives that create healthy community environments to support optimal health and promote healthy behaviors and outcomes.

See a summary of TFAH's recommendations below; the full recommendations are on page 81.

Strategically Dedicate Federal Resources to Efforts that Reduce Obesity and Related Conditions.

- Congress and the U.S. Department of Health and Human Services (HHS) should retain and strengthen the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC) to maintain and improve the nation's prevention of obesity and related chronic diseases.

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

- Congress should reverse cuts to the Supplemental Nutrition Assistance Program (SNAP), eliminate work requirements, and refrain from shifting the cost burden for the SNAP program to states that have limited budgets.
- Congress and the U.S. Department of Agriculture (USDA) should ensure full funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and increase access to WIC for young children and postpartum women.
- Congress should enact healthy school meals for all as a step to end child hunger and to increase access to healthy foods.
- USDA should maintain the progress of the final 2024 nutrition meal standards and work to fully align them with science-based recommendations.
- The Food and Drug Administration (FDA) should create and implement a mandatory front-of-package nutrition label system for packaged foods to help consumers make informed choices.

Change the Marketing and Pricing Strategies that Lead to Poor Health Outcomes.

- Congress and state and local governments should close tax loopholes to reduce advertising of unhealthy foods to children.

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

- Congress should fund programs that support physical education and healthier schools, such as the Student Support and Academic Enrichment grant program.
- Congress and the U.S. Department of Transportation should enable active transportation in all communities through Complete Streets, Safe Routes to Schools, and related policies.

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

- Congress should reverse cuts to Medicaid and marketplace subsidies to ensure that people have access to obesity prevention and treatment.
- HHS and other departments should strengthen and enforce the U.S. Preventive Services Task Force recommendations for obesity prevention.
- Medicare should expand coverage of weight management and obesity-related services, such as obesity and nutritional counseling, obesity medications, and bariatric surgery.

SPECIAL FEATURE: Emerging Science and Policy Considerations for Ultra-Processed Foods

Each year, Trust for America's Health (TFAH) includes a special feature section in our annual *State of Obesity* report to highlight a single critical issue within the wider subject area of obesity, chronic disease, and nutrition. Recent topics include the U.S. food environment and systems, and food and nutrition insecurity. This year, the feature focuses on ultra-processed foods. Important new research and an emerging scientific understanding of the health effects of ultra-processed foods, including obesity, has been growing in recent years, and, along with these new insights, there has been heightened interest from health researchers, advocates, policymakers, and the public on the topic.

Over the past few decades, youth and adult obesity rates have increased, and the U.S. diet has shown several concerning trends linked with poor health outcomes: more consumption of food made away from home, low consumption of fruits and vegetables, and high consumption of ultra-processed foods.[59,60,61,62,63,64,65,66] A recent study from the National Center on Health Statistics found that ultra-processed foods made up 55 percent of calories consumed by Americans ages 1 and older in 2021–2023. Notably, both youth and adults had statistically significant decreases in the proportion of calories from ultra-processed foods consumed between 2017–2018 and 2021–2023: youth consumption decreased from 65.6 to 61.9 percent of calories and adult consumption decreased 56.0 to 53.0 percent of calories.[67]

These dietary patterns are a product of more than individual choices. They are systematically influenced by the availability, accessibility, affordability, palatability, and desirability of local foods—which are, in turn, shaped by a variety of local, state, federal, and international factors.[68,69,70,71,72] Shifting consumption toward healthier dietary patterns requires a broad look at Americans' food environment and at the economic, social, and environmental conditions that shape the choices they make about their food. As part of the focus on ultra-processed foods, the United States must also proactively promote healthy, affordable whole food options, reduce barriers to healthy eating for all Americans, and work towards a healthier food environment overall.

This section has three subsections: (A) Emerging Science of Ultra-Processed Foods, (B) Current Policies Related to Ultra-Processed Foods, and (C) Considerations and Next Steps in Addressing Consumption of Ultra-Processed Foods and Improving Nutrition and Diet Quality.

HOW ARE PROCESSED AND ULTRA-PROCESSED FOODS DEFINED?

In 2017, a group of Brazilian nutrition researchers proposed the NOVA food classification system as a way to group foods by level of physical, biological, and chemical processes prior to consumption for research purposes.[73] It has been adopted widely by researchers and has become a common definition of processed and ultra-processed foods. Not all research on diet and nutrition uses the NOVA classification method, and there are important limitations and critiques of it, including difficulty in applying the definition consistently.[74,75]

The four NOVA food groups are:

1. **Unprocessed or minimally processed foods** are natural plants, fungi, algae, and animal products with no processing—or only minor processing to enable preservation, storage, and/or consumption. This group includes fresh, dry, or frozen fruits, vegetables, grains, legumes, meat, fish, and milk.
2. **Processed culinary ingredients** are group 1 foods that are then processed into durable products for cooking. This group includes oils, butter, sugars, and salt.
3. **Processed foods** are a combination of Group 1 and 2 foods that are processed through preservation techniques or cooking to increase palatability or durability. These foods usually have only a handful of ingredients, which are often edible themselves, and are recognizable versions of Group 1 foods. This group includes canned vegetables and fish, fruits in syrup, cheeses, and fresh breads.
4. **Ultra-processed foods** have little or no intact Group 1 foods but primarily consist of group 2 foods combined with industrial food derivatives (e.g., casein, lactose, whey gluten, hydrogenated oils, hydrolyzed proteins, soya protein isolate, maltodextrin, corn syrup), and additives (e.g., preservatives, antioxidants, stabilizers, dyes, flavors, non-sugar sweeteners, processing aides). This group includes packaged breads, cookies, sweetened breakfast cereals, margarines, sauces and spreads, carbonated drinks, hot dogs, hamburgers, and pizzas.[76]

A. EMERGING SCIENCE OF ULTRA-PROCESSED FOODS

A growing body of evidence connects the consumption of ultra-processed foods with a variety of adverse health outcomes—including an increased risk of obesity, overweight, and abdominal obesity; type 2 diabetes; cardiovascular disease; overall cancer risk and breast cancer risk; depression and anxiety; Parkinson's Disease and dementia; impaired male reproductive health; and overall mortality.[77,78,79,80,81,82,83,84,85,86] The research includes meta-analyses combining findings from multiple studies, dose-response evidence (e.g., consumption of more ultra-processed foods is associated with worse health outcomes), and short-term randomized controlled trials, all of which point toward a causal relationship.[87,88,89,90]

These toplines do not explain how or what it is about ultra-processed foods that harm human health. Many questions underlie the headlines: Do ultra-processed foods increase calorie consumption, and are those additional calories the main problem? Is it processing generally—or a specific type of processing (e.g., loss of intact natural food structure)—that is problematic? Or is it certain nutrients (e.g., salt, sugar), chemical additives, or packaging contaminants that are more often found in ultra-processed foods that cause harm? Is it the serving size, convenience, or marketing that leads to unhealthy consumption? And are all ultra-processed foods unhealthy, or is there a subset that is primarily driving the adverse effects? Or is the consumption of ultra-processed foods acting as a proxy for less healthy eating and nutrition generally?

Recent scientific research has started answering these questions. Several studies link the consumption of ultra-processed foods with lower nutritional quality. A 2021 meta-analysis found that higher consumption of ultra-processed foods correlates with a lower consumption of unprocessed nutrient-dense foods (e.g., fruit, vegetables) and less-processed foods, as well as with a 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."[91] Another study found that ultra-processed foods were responsible for 90 percent of added-sugar calories consumed in the United States.[92]

Other recent research looked at the health effects of different types of ultra-processed foods instead of treating them as a singular group. Together, these studies suggest that certain kinds

of ultra-processed foods seem to be particularly harmful to health while others actually show health benefits. A few examples include:

- A 2023 study looking at consumption of ultra-processed foods and type 2 diabetes risk found an elevated type 2 diabetes risk for a number of subgroups within the ultra-processed category: refined breads; sauces, spreads, and condiments; artificially and sugar-sweetened beverages; animal-based products; and ready-to-eat mixed dishes. The researchers also found that other subgroups were associated with lower type 2 diabetes risk: cereals; dark and whole-grain breads; packaged sweet and savory snacks; fruit-based products; and yogurt and dairy-based desserts.[93]
- A 2024 systematic review and meta-analysis of ultra-processed foods and cardiovascular disease outcomes also found consumption of processed meats and artificially and sugar-sweetened beverages to be associated with elevated cardiovascular risk, while other kinds of ultra-processed foods—including whole-grain breads, cold cereals, and yogurts—were associated with lower cardiovascular risk.[94]
- Another 2024 meta-analysis found especially strong associations between the consumption of ultra-processed meat, poultry, and seafood, and higher overall mortality.[95]

Additional insights on how ultra-processed foods change individuals' calorie consumption and body weight come from four randomized controlled studies. The first study from National Institutes of Health (NIH) researchers, from 2019, matched nutritional profiles for two diets (ultra-processed and unprocessed) and found changes in calorie intake among participants. Over a two-week period, the participants placed on the ultra-processed diet ate about 500 additional calories per day compared with when they were placed on the unprocessed diet. Participants on the ultra-processed diet also gained an average of 2 pounds after two weeks; by contrast, the same participants on the unprocessed diet lost an average of 2 pounds after two weeks.[96] 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 ... that ultra-processed foods cause people to eat too many calories and gain weight."[97]

A follow-up NIH study, which began in 2022 and is scheduled to run through the end of 2025, has been testing additional diets to further understand how ultra-processing interacts with energy density (i.e., calories per gram of food) and hyper-palatability in foods.[98] They are testing whether the mechanism driving weight gain in the first NIH study was the high energy density and hyper-palatability of ultra-processed foods, and not the processing itself. Participants in the follow-up study are eating four kinds of diets each for one week: (1) minimally processed foods with low energy density and low hyper-palatability; (2) ultra-processed foods with high energy density and high hyper-palatability; (3) ultra-processed foods with high energy density and low hyper-palatability; (4) ultra-processed foods with low energy density and low hyper-palatability. The interim findings from the first half of the study, presented at the NIH–U.S. Food and Drug Administration (FDA) Nutrition Regulatory Science Workshop in December 2024, showed substantially higher calorie intake for diets No. 2 and No. 3 (the two diets with ultra-processed foods with high energy density).[99] Body weight changes corresponded with calorie intake findings, with participants gaining weight on diets No. 2 and No. 3, and losing weight on diets No. 1 and No. 4. However, body fat decreased only with the minimally processed diet, No.1, and not diet No.4 (ultra-processed foods with low energy density and low hyper-palatability), suggesting there could be metabolic effects related to the ultra-processed foods.[100]

The third randomized study, from Japan in September 2024, placed participants—all men and all with overweight/obesity—on either an ultra-processed foods or non-ultra-processed foods diet for one week.[101] After a two-week interim break, participants then followed the alternate diet for a week. The two diets were matched for total calories and macronutrient levels. Researchers found that participants ate 800 additional calories and gained 2.4 additional pounds in the week they followed the ultra-processed foods diet compared with the non-ultra-processed foods diet.[102]

Finally, the most recent randomized study, published in August 2025, comes from England. The study compared weight loss for participants placed on an ultra-processed foods diet versus participants placed on a minimally-processed foods diet—both following U.K. dietary guidelines. The researchers found that participants lost significant amounts of weight on both diets after eight weeks.[103] The minimally processed foods diet showed lower calorie intake, greater weight loss, and several improved body composition measures (e.g., body fat percentage) that were not seen with the ultra-processed foods diet. Participants

regarded both diets similarly on hunger and contentment ratings but gave the minimally processed foods diet significantly lower "flavors and tastes," "delivery and preparation," and cravings ratings.[104] These findings align with the previous trials that saw ultra-processed foods diets leading to higher calorie intake and higher body weight. The findings also raise some new considerations about the role of flavor and preparation.

The four randomized controlled studies provide clear evidence that ultra-processed foods overall, and perhaps certain ultra-processed foods specifically, substantially increase calories consumed, at least in the short-term. Notably, these effects occurred without participants' conscious awareness: hunger and fullness were the same. Thus, something about ultra-processed foods leads to an imperceptible, to the consumer, increased calorie intake. Importantly, these trials show that an increase in calories is not the only mechanism for harms from ultra-processed foods. For example, these studies intentionally matched the nutritional contents or guidelines across diets—where in reality ultra-processed foods have much higher levels of these nutrients of concern.

Another avenue of research has been the investigation of the long-term health effects of additives found in ultra-processed foods and packaging contaminants. Examples include: certain emulsifiers that adversely affect the gut microbiome, artificial sweeteners associated with higher cardiovascular disease risk, and perfluoroalkyl and polyfluoroalkyl substances (PFAS) linked to a wide-range of conditions, including immune system and liver damage.[105,106,107,108,109]

Together, the scientific research provides some answers about why ultra-processed foods are associated with poor health outcomes. First, many studies tie ultra-processed foods to lower nutritional quality and higher energy density. Second, growing evidence from long-term observational studies show certain kinds of ultra-processed foods are particularly harmful while others may be healthy. Third, four randomized controlled studies provide clear evidence that ultra-processed foods substantially increase calories consumed, at least in the short-term, and potentially cause other adverse effects. And, fourth, early research suggests that certain additives and packaging contaminants are associated with long-term adverse health outcomes.

Continuing to study these and other gaps in research is essential to understanding more about the metabolic and other effects of ultra-processed foods and distinguishing between harmful and healthy food products, to ultimately inform future nutrition recommendations and policy actions. This includes building on the important nutrition research supported and conducted by NIH. Notably, in May 2025, FDA and NIH announced a new joint Nutrition Regulatory Science Program, focused on accelerating a comprehensive nutrition research agenda to inform food and nutrition policies and to improve Americans' diets, and ultra-processed foods is one of their priority issue areas.[110]

WHAT DOES THE MAKE AMERICA HEALTHY AGAIN COMMISSION SAY ABOUT ULTRA-PROCESSED FOODS?

In February 2025, President Donald Trump issued an Executive Order establishing the Make America Healthy Again Commission. The Commission comprises 14 federal administration officials, with the secretary of the U.S. Department of Health and Human Services (HHS) as chair, and the assistant to the president for domestic policy as executive director.[111]

The initial focus of the Commission was to "advise and assist the President on how best to exercise his authority to address the childhood chronic disease crisis," and directed the committee to study the issue and submit to the president a *Make our Children Healthy Again Assessment* within 100 days and a *Make Our Children Healthy Again Strategy* within 180 days.[112] The Commission publicly released the *Make Our Children Healthy Again Assessment* in May 2025.[113] The *Make Our Children Healthy Again Strategy* was shared with the president in August 2025 and released publicly in September 2025.[114,115]

The *Make Our Children Healthy Again Assessment* from May 2025 is a wide-ranging report highlighting several issues that it connects to childhood chronic illness: ultra-processed foods, chemical exposure, technology, and medical overuse. The Assessment notes the rise of ultra-processed foods over the last several decades, the role of poor diet and nutrition as risk factors for chronic illness, and the association between ultra-processed foods and lower dietary nutritional quality, increased calorie intake, and presence of certain food additives. It also suggests the food system, nutritional research and marketing, the *Dietary Guidelines for Americans*, and several federal programs are areas that could be improved in relation to ultra-processed foods and nutrition.[116]

The *Make Our Children Healthy Again Strategy* outlines four approaches to address the issues identified in the Assessment: advancing research, realigning incentives, increasing public awareness, and fostering private sector collaborations. The Strategy includes a wide list of activities related to ultra-processed foods, nutrition, and food safety, including supporting more nutrition and metabolic research, issuing the 2025 *Dietary Guidelines for Americans* and instituting an education campaign, reducing artificial food dyes and creating additional reviews of chemical additives in foods, and determining a federal definition of ultra-processed food.[117]

Experts and advocates have raised concerns about the *Make Our Children Healthy Again Assessment's* scientific integrity, citing the inclusion of fictitious studies and misinterpretation of real ones. Public health experts have also criticized the *Make Our Children Healthy Again Strategy*, which was informed by the earlier Assessment, for lacking concrete regulatory proposals. Many recommendations are framed as voluntary actions by industry and other sectors, rather than enforceable policies.

B. CURRENT POLICIES RELATED TO ULTRA-PROCESSED FOODS

Currently, there are no federal statutes or regulations that define or regulate ultra-processed foods specifically in the United States.[118] Officials have discussed both in recent years and have taken steps recently toward creating a federal definition of ultra-processed foods. In July 2025, HHS, FDA and the U.S. Department of Agriculture (USDA) issued a request for information for "data and information to help develop a uniform definition of ultra-processed foods ... for human food products in the U.S. food supply," with comments due in October 2025.[119]

State legislators have also shown an increased interest in ultra-processed foods and have introduced a number of bills in 2025.[120] There has been limited legislative movement, though one bill in California, Assembly Bill 1264, passed the State Assembly in June 2025. The bill also passed the State Senate's Education, Environmental Quality, Appropriations, and Health Committees, and was sent to the full State Senate for consideration on September 9, 2025.[121] The proposed legislation directs California's Office of Environmental Health Hazard Assessment to define "particularly harmful ultra-processed foods" and then phase them out of schools.[122]

American policymakers have taken steps to improve nutrition that indirectly address but do not directly consider ultra-processed foods, to varying degrees of success. Over the last decade, federal agencies have implemented the *Dietary Guidelines for Americans* recommendations to increase healthy whole foods (i.e., unprocessed and minimally processed foods) and decrease foods with high added sugar, sodium, and saturated fat (which make up an estimated 84 percent of all ultra-processed foods).[123] For example, FDA redesigned the Nutrition Facts labels to include added sugars, and USDA added a new fruit and vegetable benefit to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) food package. Most recently, USDA approved a new type of nutrition waiver for the Supplemental Nutrition Assistance Program (SNAP) in 11 states, as of August 2025. The new waivers restrict enrollees from using program funds to purchase certain foods, most often soda and candy, which are ultra-processed foods.[124]

States and localities have also worked to improve nutrition for their residents, including through boosting access to healthy foods (e.g., universal healthy school meals in nine states) and reducing consumption of unhealthy foods (e.g., sweetened beverage taxes in nine localities). See sidebar on page 16 for more on these policies.

Globally, a small number of countries have instituted policies related to ultra-processed foods. The most common policy is to include consumption recommendations in the country's dietary guidelines. For example, in Brazil, the dietary guidelines explicitly encourage consumption of unprocessed and minimally processed foods and suggest limiting processed foods and avoiding ultra-processed foods.[125,126] Other countries that mention ultra-processed foods in their dietary guidelines include Belgium, Ecuador, France, Israel, the Maldives, Peru, and Uruguay.[127,128,129,130]

Brazil also caps the amount of ultra-processed foods allowed in public school meals—as of February 2025, the limit is 15 percent of food provided, and it is set to reduce to 10 percent in 2026—and requires front-of-package warnings for all packaged foods with high contents of added sugar, sodium, or saturated fat.[131,132]

As of November 2023, Colombia requires special warning labels and taxes on certain ultra-processed foods and drinks. Ultra-processed foods (defined in the law as "edible products formulated from food-derived substances along with additives") include a warning label and are taxed if they also exceed unhealthy sugar, sodium, or saturated fat thresholds. The tax started at 10 percent in 2023 and increased to 15 percent in 2024 and 20 percent in 2025. Ultra-processed sugary drinks are taxed by volume depending on the amount of added sugar they contain (i.e., higher sugar content has a higher tax rate). The tax rate for drinks began in 2023 with subsequent increases in 2024 and 2025, and then adjusted for inflation thereafter. The law includes tax exemptions for certain traditional Colombian foods.[133,134] One early analysis of food purchases found a decrease of 5 percent for ultra-processed foods and drinks in 2023 compared with 2021.[135]

RECENT INITIATIVES ON FOOD ADDITIVES AND ARTIFICIAL DYES

Discussion about improving the American diet sometimes pair ultra-processed foods with food additives and artificial dyes. Though ultra-processing, food dyes and other additives overlap in many of the same foods, they are not synonymous. Additives are a wide category—there are thousands of additives in foods, including some that are definitively harmful and prohibited from the food supply (e.g., trans fats) and others that are naturally occurring components of foods (e.g., agar from seaweed).[136] In recent years, several specific additives and dyes have become a marker of ultra-processing and sometimes used as by lawmakers as a proxy definition.[137]

In the past year, the U.S. federal government has taken action to reduce certain additives. In January 2025, FDA removed its authorization to use the dye Red No. 3 in foods, dietary supplements, and ingested pharmaceutical drugs starting in 2027.[138] In April 2025, FDA announced that it intends to start the process of removing authorization for two more artificial food dyes, that it will be authorizing alternative natural food dyes soon, and that major food producers agreed to voluntarily remove another eight petroleum-based artificial food dyes by 2027.[139]

Some companies have also voluntarily pledged to phase out all artificial food dyes. For example, in June 2025, Kraft Heinz announced it would remove all artificial food dyes and only use natural colors by 2028. Kraft Heinz says this change will affect 10 percent of its products.[140,141] In July 2025, the International Dairy Foods Association announced that U.S. commercial ice cream companies would eliminate seven artificial food dyes from retail ice cream products made with real milk by 2028.[142]

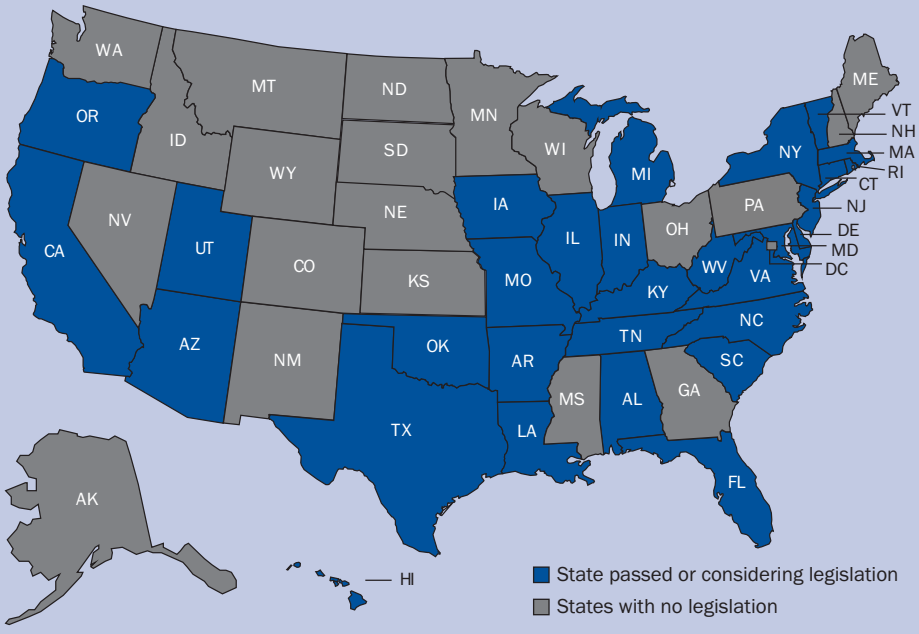
A number of states also have proposed and enacted legislation related to food dyes and other additives. As of April 2025, the Association of State and Territorial Health Officials found that 30 states were considering new legislation on food dyes and additives in the 2025 legislative year. This includes 26 bills prohibiting certain additives in any food, 45 bills restricting certain additives in schools, and nine bills requiring warning labels for certain additives or establishing commissions to make related recommendations.[143]

Some of the legislation that have become laws this year include:

- In Arizona, an April 2025 law prohibits "ultra-processed foods" from school meals starting in the 2026–2027 school year. Ultra-processed foods are defined in the legislation as any food or beverage containing one of seven food dyes or four other additives.[144,145]
- In West Virginia, a March 2025 law prohibits seven food dyes from school meals as of August 2025 and also prohibits the same seven dyes and two preservatives from any food items in the state as of 2028.[146]
- In Texas, a June 2025 law requires food and beverage products containing 44 artificial food dyes and additives to prominently display a newly developed warning label starting in 2027 (i.e., "WARNING: This product contains an ingredient that is not recommended for human consumption by the appropriate authority in Australia, Canada, the European Union, or the United Kingdom").[147]

Together, these federal and state laws and voluntary food and beverage industry pledges suggest that a few specific additives will be reduced or eliminated from the food supply in coming years. The health implications of these changes will need to be studied.

Map 1: State Action Prohibiting Additives and Dyes in Food, April 2025.



Source: ASTHO[148]

SELECT NUTRITION EFFORTS TIED INDIRECTLY TO ULTRA-PROCESSED FOODS

In the last decade, policymakers and officials have taken steps to increase consumption of healthy, unprocessed and minimally processed foods, and to reduce the consumption of foods high in added sugar, sodium, and saturated fat. These policies can reduce the consumption of ultra-processed foods, even if they are not explicitly named. As policymakers consider how to address ultra-processed foods, it is important to also continue to strengthen the policies that improve the nutrition and food environments overall. A few examples of nutrition efforts that are indirectly tied to the consumption ultra-processed are below.

- **Science-Based Dietary Recommendations to Guide Nutrition Standards:** Nutrition requirements vary by age, and understanding the different needs is necessary to meet them. In 2020, USDA and 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.[149] The *Dietary Guidelines for Americans* are important because they are the foundation for food standards for many public programs, such as WIC and school meals. In contrast, little evidence has shown that the guidelines influence broader consumer behavior change.[150,151,152]
- **Strengthening School Meal Standards and Expanding Access for Children:** About 30 million children across the country eat school meals each day.[153] 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.[154] Research finds that 2010 nutrition requirements increased the nutritional quality of meals and reduced the prevalence of obesity among school lunch participants.[155,156] 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 communities.[157] And, in April 2024, USDA issued a final rule updating standards for USDA Child Nutrition Programs to more closely align with the current *Dietary Guidelines for Americans*; it includes changes like new added sugars limits and stricter sodium limits.[158]
- **Improving Diet Quality for Children in WIC:** More than 6 million pregnant women, mothers, infants, and children participate in WIC each year.[159] 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.[160] After these nutritional requirements were strengthened, diet quality improved—including large increases in consumption of "beans and greens" and whole grains—and obesity rates among children in the program declined.[161,162,163] In April 2024, USDA issued a final rule updating WIC food package standards to better align with the current *Dietary Guidelines for Americans*; made permanent the enhanced cash value benefit for fruit and vegetable purchases; and granted more purchasing flexibility for foods that meet cultural or personal preferences and dietary needs.[164]
- **Reducing Sweetened Beverage Consumption with Taxes:** Sweetened beverages, which are ultra-processed foods, are the top source of added sugars consumed in the United States.[165] 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); Albany, California (2017); Oakland, California (2017); Boulder, Colorado (2017); Philadelphia, Pennsylvania (2017); Seattle, Washington (2018); San Francisco, California (2018), and Santa Cruz, California (2025). Navajo Nation also implemented a 2 percent tax on "minimal-to-no nutritional value food items", which includes sweetened beverages, in 2015.[166] Research shows the taxes have reduced sales and consumption of sweetened beverages, and improved health outcomes.[167,168,169,170,171,172,173]

C. CONSIDERATIONS AND NEXT STEPS IN ADDRESSING CONSUMPTION OF ULTRA-PROCESSED FOODS AND IMPROVING NUTRITION

Raising the nutritional and diet quality in the United States is critical to the health and well-being of Americans in the decades to come. Studies suggest poor diet is responsible for 500,000 deaths and $1.1 trillion in additional healthcare spending and lost productivity costs every year in the United States.[174] The nation should continue ongoing efforts to improve nutrition quality; promote whole foods; decrease consumption of foods high in added sugar, sodium, and saturated fat; remove barriers to healthy eating; and work toward a healthier food environment overall—and also consider what additional policies and regulations directly related to ultra-processed foods may be beneficial. Since ultra-processed foods make up a large portion of food purchased in the United States—a 2025 study estimated that more than half of calories consumed in the United States were ultra-processed—new policies or regulations could have far-reaching impacts.[175]

Current nutrition policies and regulations in the United States and abroad provide examples of policies that could potentially reduce consumption of ultra-processed foods or certain kinds of ultra-processed foods that are particularly harmful. It is important to note that this is new policy territory, and the evidence and data on effects are largely nonexistent. Nutrition experts' views on the likely benefits and costs vary widely. Some examples that have been proposed include:

- Improving consumer understanding of ultra-processed foods and their health effects through the *Dietary Guidelines for Americans* and other educational efforts;
- Amending food nutrition labeling to note when packaged food is classified as ultra-processed;
- Limiting marketing of ultra-processed foods to children across print, digital, and television;
- Creating financial incentives and disincentives (i.e., subsidies and taxes) to encourage purchases of unprocessed or minimally processed foods and discourage purchases of ultra-processed foods;
- Improving nutrition standards for school and child nutrition programs to increase consumption of unprocessed or minimally processed foods and reduce consumption of ultra-processed foods, as well as new financial incentives and funding to boost capacity for "made-from-scratch" cooking at schools and other institutions;
- Altering benefits in food security and nutrition assistance programs to increase consumption of unprocessed or minimally processed foods and reduce consumption of ultra-processed foods; and
- Encouraging voluntary reductions by the food industry or instituting restrictions or prohibitions on particularly harmful types of food processing, ingredients, or subgroups of ultra-processed foods.

Each of these policies have challenges. A critical consideration when designing new policies is limiting unintended consequences. Real logistical and economic advantages come from ultra-processed foods in a nation that spans 3.8 million square miles and has a population of more than 340 million

More research is needed to better understand the biological mechanisms by which ultra-processed foods may impact health. This research, which will need to be multidisciplinary in nature, will provide the evidence base needed to inform dietary guidance, policies, and programs to promote health and prevent disease.

people.[176,177] Any policy that aims to reduce consumption of ultra-processed foods substantially needs to also ensure there are sufficient alternative food options for everyone that are available, affordable, safe, and healthy. Otherwise, policies could increase food prices, create more food or nutrition insecurity, and lead to less healthy substitutes.

Another complex step in making policies related to ultra-processed foods is to determine a definition and—before any regulation of ultra-processed foods is possible—how to operationalize the definition so it can be applied clearly and consistently across the current food supply and any future products. Recently, there has been an important step toward a definition in the United States; HHS, FDA, and USDA issued a request for information in July 2025 as they develop a definition for ultra-processed foods.[178] Accurately classifying foods when using a definition like NOVA's, though, may require supplementary information in addition to the ingredients and nutritional information producers currently share. For example, food with additives used for preservative reasons are classified as "processed," while additives used for cosmetic or palatability reasons are considered "ultra-processed" under NOVA criteria.[179] These challenges are not insurmountable—there are definitions for other complex categories of foods, including sugar-sweetened beverages, candy, and junk food in the United States, and other countries have definitions for ultra-processed foods—but it does pose a test to policymakers to balance public interest and nutrition research with logistical difficulties and industry concerns.

Policymakers should continue to carefully consider definitions, policies, and regulations related specifically around ultra-processed foods — and at the same time also continue to move forward on other recent efforts to improve U.S. nutrition and maximize the consumption of healthy, unprocessed, and minimally processed foods. These policies could reduce the consumption of ultra-processed foods, even if they are not explicitly named, including by:

- Improving nutritional quality of the food supply by building on recent efforts to reduce consumption of added sugar, sodium, and saturated fat, which overlap substantially with ultra-processed foods;
- Empowering consumers through better labeling and education, including front-of-package labels that highlight nutrients of concern;
- Raising nutritional quality and access in schools, institutions, and nutrition programs to increase availability and consumption of healthy, unprocessed, and minimally processed foods; and
- Increasing the affordability and accessibility of healthy, whole foods for all Americans.

The other critical policy that lawmakers should move forward with immediately is increasing federal funding and capacity for nutrition research, including ultra-processed foods and metabolic research. More research is needed to better understand the biological mechanisms by which ultra-processed foods may impact health. This research, which will need to be multidisciplinary in nature, will provide the evidence base needed to inform dietary guidance, policies, and programs to promote health and prevent disease.

Interview with Jessica Gould, RD, SNS

***Jessica Gould** is the Director of Nutrition and Warehouse for the Littleton, Colorado, Public Schools.*

TFAH: Let's begin by asking you to describe the Littleton (CO) School District and your role there.

Ms. Gould: I have been the Director of Nutrition and Warehouse for Littleton Public Schools for almost 11 years. Our district is just shy of 14,000 students. We have 21 schools, two of which are charter schools that we transport food to and nineteen have full kitchens. Eighteen percent of our students qualify for free or reduced-price meals. Under Colorado's community eligibility provision* (CEP) we have eleven CEP schools and nine non-CEP schools. We provide breakfast at all of our schools except one of the charter schools and lunch at all of them.

TFAH: What is the importance of school-provided meals for the students you serve?

Ms. Gould: Kids don't always have the opportunity to influence how their day starts. It might be because some families can't afford to provide nutritious meals or for some families it's because parents are pulled in so many directions. I see our meal service as setting kids up for success. We all know that you can't learn when you are hungry. That's our mission - to provide the support through nutritious foods for our students so they all have the same opportunities to learn, grow, and thrive in school.

TFAH: There are a lot of pressures on school systems right now – increasing levels of food insecurity, increasing food costs, and reduced federal funding for nutrition assistance programs. What strategies do you employ to meet your program's mission?

Ms. Gould: Yes, we certainly are feeling these pressures. Districts do a lot of things to try to manage these challenges. We are very thoughtful about how we plan our menus. One thing that we specifically do is to try to use an ingredient in multiple ways. That helps our procurement – larger orders ensure that we are able to get the products we need, and at better prices. If you have a good core ingredient you can use it in multiple different recipes.

Having a central warehouse also allows us to take advantage of discounted, surplus or bonus commodities. That very much impacts our bottom line.

We also sell a la carte items - that helps us bring in additional revenue. Some people have concerns about snack items being sold in schools. I like to remind them the snack items we sell follow the Smart Snacks regulations and are more nutritionally sound than many of the snacks kids bring from home. This includes our snack items being sold in appropriate portion sizes.

Another thing we try to do as much as possible is make some of the ingredients we use from scratch but that's not always possible in all of our schools. This summer we built a central production kitchen. We plan to make some of our sauces and our bakery items from scratch at the central location. That will help us improve the nutritional quality of what we are serving in terms of sugar, sodium and fat content and use of whole grains.

Looking at your buying power is another important thing to do. School districts can work with other school districts on joint purchasing agreements to save on the unit cost of a food item.

TFAH: What is the status of Colorado's Healthy School Meals for All Program?

Ms. Gould: Colorado voters adopted a Healthy School Meals for All program in 2022. The issue today is that the revenue to support the program isn't enough to cover the program costs so this November there will be second ballot measure to strengthen the funding for the program. If it doesn't pass, the state may determine to provide free meals to all at CEP schools only.

TFAH: What role do school meals for all play in the community's overall food security, nutrition, and health promotions goals?

Ms. Gould: First, the stigma that's often associated with receiving free meals goes away very quickly, which is delightful to see. Before the Healthy School Meals for All program, students who were eligible for free meals didn't want them because it wasn't the cool thing to do. Our participation, students eating school meals, has increased exponentially. Our students see it as a normal thing to eat meals at school versus do your parents have the money to pay for your meals. Another benefit is what kids are eating. Packed lunches, for example, often start out at the beginning of the school year with lots of healthy ingredients but get less healthy as the school year continues whereas the nutritional value of our meals is consistent. Kids are getting fruits and vegetables; they are getting whole grains, low fat proteins, and milk.

TFAH: A special feature within our report discusses ultra processed foods and their role in the obesity crisis. How do you think about the role of ultra processed foods in school meals? What are the challenges to reducing the amount of ultra-processed foods in your school system?

Ms. Gould: First, there are a lot of different definitions for ultra processed foods. That in and of itself is challenging. We need to better understand what the target is. Based on some definitions, hummus might be an ultra-processed food due to the stabilizers in it or the food we process in our central kitchen could be considered ultra processed.

It is important to understand that many school districts depend on processed foods for a handful of reasons. It could be that breakfast is delivered to classrooms so it needs to be packaged, or it could be related to the district's ability to hire staff to prepare food.

If the direction is to limit the use of ultra-processed foods in school meals, there needs to be funding to go with that. If you are using ultra-processed foods because you can't afford to hire food preparation staff then you need funding to be able to hire that staff and that assumes that you are going to be able to find them if you can afford to hire them.

TFAH: New limits on added sugar in breakfast cereals, yogurt, and flavored milks are included in federal nutrition standards for school meals that take effect this school year. Are they improving your program?

Ms. Gould: The breakfast cereals, yogurt and flavored milks that we offer all have been updated or previously met the new limits on added sugar. I think it is important to mention that the products that we serve (for example, the cereals) are not always the same products families buy in the grocery store. Our products have been formulated specifically to meet our meal standards and many times are significantly lower in sugar than what a family can purchase at the store. For us, our baked goods that we bake in our schools are what we have worked to modify or we are serving less of them to meet these new standards. The crux of all of this is that school nutrition programs want to be able to reduce sugar in the meals we serve and to make food from scratch but doing so takes money. We want to make positive changes but need funding to be able to do so.

TFAH: To what degree is local food part of your program?

Ms. Gould: We focus a lot on local foods and the local food system. We've built strong partnerships with local farmers and local food manufacturers. The buying power of the school district can help support the local food environment. We want to use bulk buying with budgeting to be able to buy local and support local food systems as often as we can.

TFAH: You are a member of the Board of Directors of the School Nutrition Association and in that role have spoken to members of Congress about school nutrition programs. What did you tell them? What do you wish they understood better?

Ms. Gould: Many times when we are on Capitol Hill speaking to members of Congress or their staff it's a fairly basic conversation. We help them understand what school nutrition teams do. We want them to understand what we want to be able to do to support students and how they can help

us continue to do the good work we are doing. I'm sure to talk about the fact that students are our future and that we need to make sure we are investing in our future. It's about ensuring that all of our programs are appropriately funded so we can achieve all of the things we are asked to do.

When I meet with members of the Agriculture Committee I'll get into more specifics about removing some of the red tape that complicates our mission to provide students with amazing meals. I'd like to see some changes so departments like mine can focus on feeding students and spend less time on administrative work. There is a lot of duplicative work that goes on behind the scenes of our programs. I also emphasize funding and our local foods program, both which the legislators have a direct connection with.

TFAH: Same question about your conversations with state legislators.

Ms. Gould: In Colorado we are in a budget shortfall, so cuts are being made. Education in the state is already underfunded so we want to make sure we aren't taking away from other parts of education funding. But, we still need to stand up for our students' nutritional needs. When Healthy School Meals for All was passed we told our families that we would be feeding all kids in the state for free. When I speak to state legislators now, I ask them to help me do that. There's a lot on the line with the upcoming ballot I mentioned earlier and the long-term funding of our program.

TFAH: Are you worried about the proposed changes to the SNAP program and how that could increase demands on your program?

Ms. Gould: Yes, 100 percent. Reduced numbers of families enrolling in or staying in the SNAP program will affect our budget because that's one of the ways we certify eligibility for free school meals, which is a concern for our CEP status. Additionally, it all comes down to ensuring kids have access to good nutrition. If their family isn't getting assistance through SNAP, they are going to come to school hungry. We will need to find a way to feed them that may include kids' incurring negative balances [costs of unpaid meals] and unfortunately that becomes a new stigma that gets attached to a child as they make their way through the school system.

TFAH: Any closing thoughts?

Ms. Gould: For my team and me it's all about serving kids the nutritious meals they need. We serve delicious food, it's nutritious and prepared with love, and as we plan our meals we're thinking about what kids actually want to eat while meeting our regulations. Child nutrition professionals across the country are in this career because they care, because they understand what it takes to serve nutritious meals that students want to eat, and because they see the value of investing in our country's future. We need the support of everyone to help advocate for the funding to carry out our mission.

**Community eligibility provision (CEP) determines the percentage of a school's student population eligible for free meals (absent universal free meals programs) using eligibility measures from other programs such as SNAP or Medicaid.*

This interview was conducted in August 2025. It has been edited for length and clarity.

Obesity-Related Data and Trends

Obesity and other diet-related chronic diseases have been increasing across the United States for several decades.[180] They pose a serious public health threat as obesity is associated with higher mortality and a range of adverse health effects at the population-level.[181,182,183] This section reviews adult and youth obesity prevalence from the latest available surveys across several data sources and demographic and geographic data where available.

WHAT IS OBESITY AND BMI?

Public health and healthcare sectors define "obesity" as a disease in which an individual's body fat and body-fat distribution exceed the level considered healthy.[184,185] 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. The current best practice for diagnosing obesity is BMI plus body fat or waist measurement (i.e., waist-to-height ratio). BMI is also useful as population health measure to assess the distribution of BMI in populations so that resources can be targeted to certain geographic areas, groups, or others disproportionally affected by low or high weights for health.[186]

Using BMI as a measure of obesity has several important considerations. First, the formula for calculating BMI was originally designed for research purposes and designed using measurements from Belgian men.[187,188] Secondly, BMI does not perfectly correlate with body fat—for example, muscular individuals often have lower body fat than their BMI would suggest—or the risk for chronic disease; though BMI does correlate as well or better than other noninvasive, widely available measures.[189] 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 of developing chronic disease occurs at different BMIs that 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.[190]

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 stigmas.[191,192] In June 2023, the American Medical Association House of Delegates voted to adopt a new policy that (a) outlines the limitations of BMI as an individual-level metric, (b) supports additional education for physicians around BMI, and (c) recommends BMI be used in conjunction with other measures in a clinical setting.[193] In January 2015, the Lancet Diabetes & Endocrinology Commission—an internal group of 58 experts in obesity—issued a consensus statement defining clinical obesity as well as diagnostic criteria to aid medical decision-making and treatment.[194]

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 (kilogram/meter^2)	**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

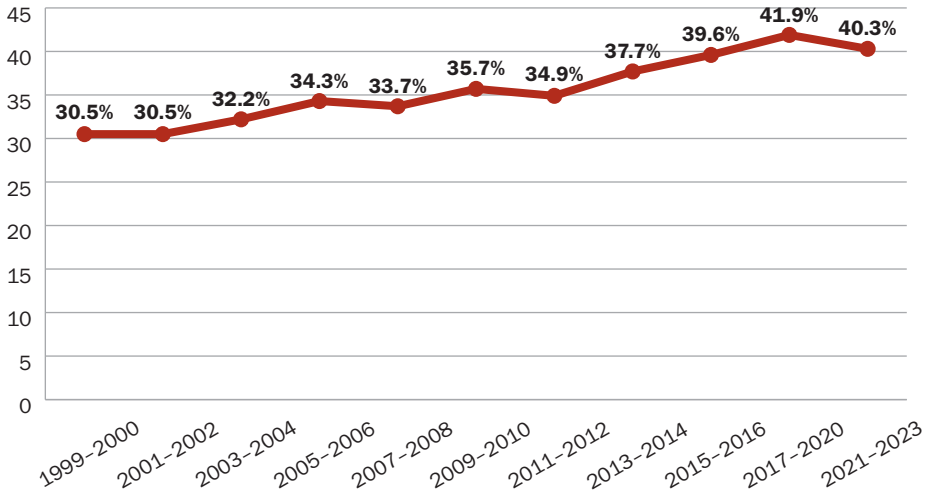
Medical professionals measure youth obesity differently, comparing a child's BMI with children of the same age and sex in a reference population that accounts for typical changes during growth and development. A child's BMI is expressed as a percentile relative to children from the reference population 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.[195] In 2022, the National Center for Health Statistics released percentiles beyond the 97th percentile for youth using height and weight data from 1988 to 2016.[196]

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

A. TRENDS IN ADULT OBESITY

The latest National Health and Nutrition Examination Survey (NHANES) data, from 2021–2023, found the adult obesity rate was 40.3 percent nationally, just below the 2017–2020 estimate of a 41.9 percent adult obesity rate.[197] The latest Behavioral Risk Factor Surveillance System (BRFSS) data, from 2024, also show a relatively stable trend with no states having statistically significant changes in adult obesity rates between 2023 and 2024.[198] Both NHANES and BRFSS still show long-term trends of rising obesity rates among adults in the United States.[199,200,201,202] (See Figures 1 and 2.) This subsection provides the most recent data on adult obesity rates by state and demographics.

Figure 2: Percent of Adults with Obesity, 1999–2023



Source: NHANES[203,204,205]

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.[206] The most recent NHANES data are from the August 2021–August 2023 survey. For adults, the 2021–2023 survey included an overall rate, as well as adult rates by age, sex, and education-level.[207] The 2021–2023 adult data did not include rates by race/ethnicity or income, as it did in previous years. In a youth 2021–2023 NHANES data release, authors note that the COVID-19 public health emergency impacted the survey design and sample size for certain racial/ethnic groups, which could explain the lack of data for adult groups as well.[208]

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.[209] 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 are from 2024.

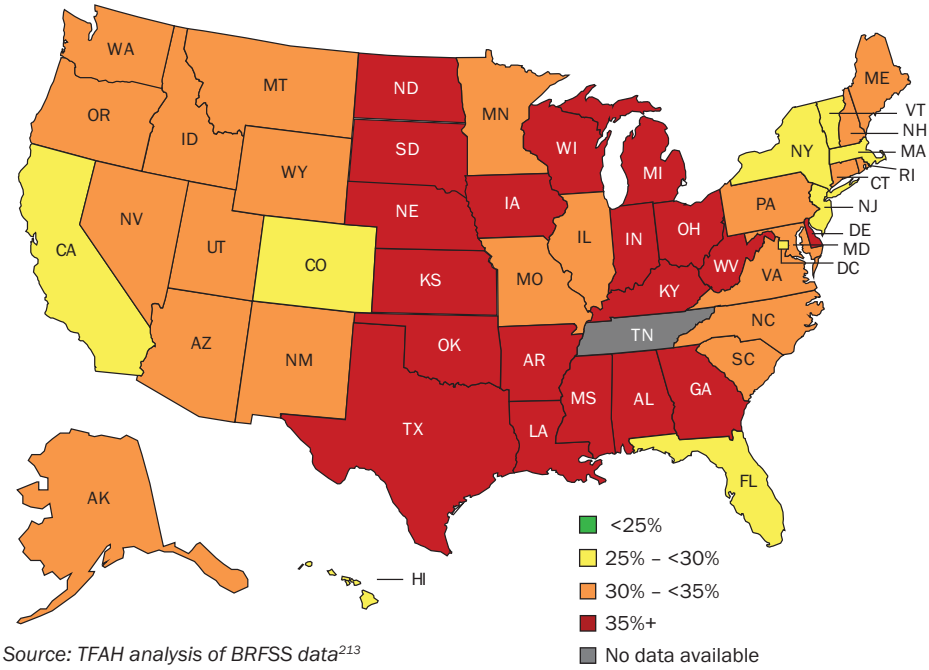
I. State Trends (BRFSS)

The 2024 BRFSS data found 19 states had adult obesity rates at or above 35 percent, 22 states had adult obesity rates between 30 and 35 percent, and nine states had obesity rates below 30 percent.[210] State-level obesity rates varied from a low of 25.0 percent in Colorado to a high of 41.4 in West Virginia, according to 2024 BRFSS data.[211] Other key findings from the recently released data include:

- Between 2023 and 2024, no states had statistically significant increases or decrease in their obesity rates. Non-significant changes were mixed across states with 28 states having higher rates in 2024 and 20 states having lower rates in 2024.
- Over the prior five years (2019–2024), 18 states had statistically significant increases in their obesity rates.
- In 2024, the adult obesity rate was at or above 35 percent in 19 states, a decrease from 2023 when 23 states were at or above 35 percent. This is the first time there has been a decrease in the number of states at or above 35 percent. The number had been increasing since 2013, when the first states reached the 35 percent threshold (see Figure 1).
- Also, for the first time since this data series started in 2011, no state had an adult obesity rate below 25 percent.[212]

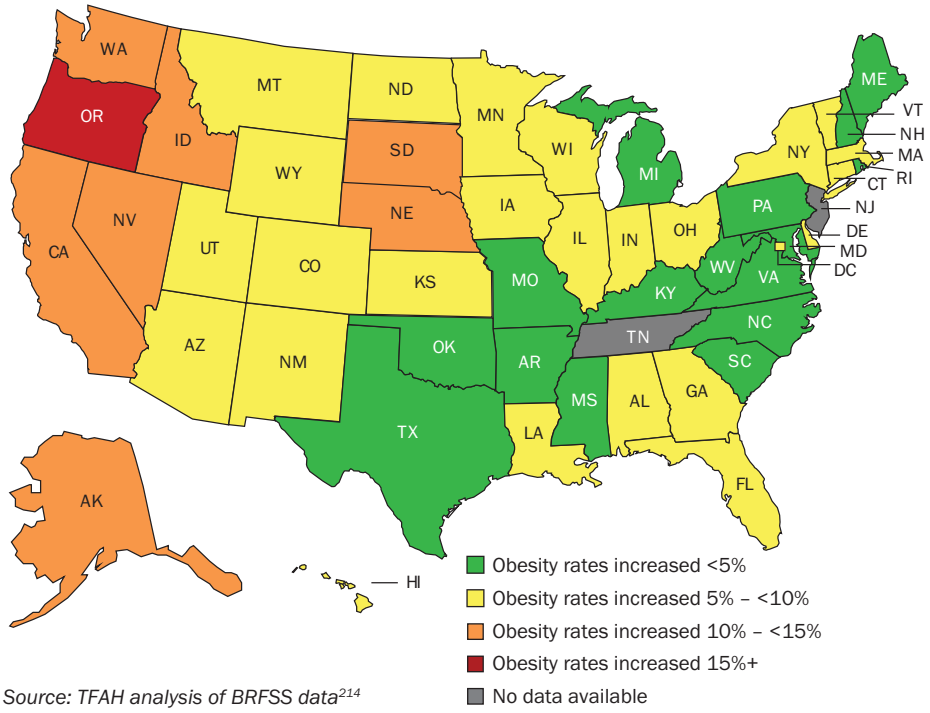
For additional state-level BRFSS data on obesity rates, obesity rates across demographic groups, and other chronic disease measures, see charts on pages 28–30.

Map 2: Adult Obesity Rate by State, 2024



Source: TFAH analysis of BRFSS data[213]

Map 3: Percent Change in Adult Obesity Rate by State, 2019–2024



Source: TFAH analysis of BRFSS data[214]

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

How is it that only 19 states have adult obesity rates exceeding 35 percent, yet the national obesity rate is 40.3 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.[215] NHANES, from which the national obesity rate is derived, calculates its obesity rate based on heights and weights obtained through in-person physical examinations. Accordingly, the higher rates found by NHANES are a more accurate reflection of obesity in the United States.[216] NHANES does not have state-level data, which is why TFAH also uses BRFSS data.

TABLE 1: Adult Obesity Rates and Related Health Indicators, 2024

	Obesity		Overweight & Obesity		Diabetes		Physical Inactivity		Hypertension	
States	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	**38.9 +/- 1.8**	4	**72.6 +/- 1.7**	4	15.1 +/- 1.2	5	27.5 +/- 1.6	4-T	45.5	2
Alaska	34.0	27	68.2	29-T	**9.5**	44	17.8	44	34.4 +/- 1.8	25-T
Arizona	33.3	29	67.5	35	11.9	27	21.4	23	33.8	29
Arkansas	38.9	5	73.0	2	**15.0**	6	28.0	3	43.2 +/- 1.8	5
California	**29.1**	44	64.5	45	**12.7**	20-T	19.7	35	31.1	46
Colorado	25.0	50	**61.8**	48	**8.3**	50	14.7	49	27.5	49
Connecticut	32.0	36	67.9	32	12.0	26	19.4	38	33.1	34
Delaware	36.6	15-T	70.2	14	13.7	12	24.3	8	38.5	9
D.C.	25.5 +/- 2.0	49	57.6 +/- 2.3	50	8.7 +/- 1.2	48-T	12.8 +/- 1.5	50	29.2 +/- 2.4	47
Florida	**29.6**	42	65.5	40	12.1	25	23.7	11	37.0	14-T
Georgia	35.4	19	69.6	17	13.1	17	22.6	15	35.9	19
Hawaii	27.0 +/- 1.6	47-T	60.1 +/- 1.8	49	11.6 +/- 1.1	32	21.0 +/- 1.5	27-T	32.8	36
Idaho	**32.7 +/- 1.9**	31-T	**67.4 +/- 2.0**	36	9.3 +/- 1.1	45	19.5 +/- 1.7	37	31.8	41
Illinois	**34.2**	24-T	**68.6****	26	**12.9**	19	22.7*	14	33.9 +/- 1.8	27-T
Indiana	**38.4**	6	**71.2**	8-T	**14.7**	7	24.1	9	38.4	10-T
Iowa	**36.6**	15-T	**72.0**	5-T	**11.4**	34-T	21.3	24-T	34.6 +/- 1.3	22
Kansas	**37.6**	7-T	70.7	13	**12.7**	20-T	22.0	16-T	34.5	23-T
Kentucky	37.2	10	70.8	11-T	**16.7**	2	27.5	4-T	n/a	--
Louisiana	**39.2**	3	72.0	5-T	**15.8**	3	27.4	6	43.9	4
Maine	33.2 +/- 1.2	30	67.3 +/- 1.2	37-T	11.4 +/- 0.7	34-T	20.8 +/- 1.0	32-T	36.2	16-T
Maryland	32.7 +/- 1.2	31-T	**68.9 +/- 1.2**	21-T	**12.6 +/- 0.8**	22-T	18.7 +/- 1.0	39	36.2	16-T
Massachusetts	27.0	47-T	62.7	47	**9.6**	43	18.2	42-T	31.5	43
Michigan	36.1	17	68.7	24-T	**13.8**	11-T	21.6	20-T	37.3	12-T
Minnesota	**32.3**	34-T	**67.8**	33	**10.1**	40	17.0**	45	31.2 +/- 1.1	44-T
Mississippi	40.4	2	72.9	3	15.4	4	30.2	1	46.8	1
Missouri	34.6	20-T	68.7	24-T	11.5	33	23.8	10	37.0	14-T
Montana	**31.0 +/- 1.4**	40-T	65.2 +/- 1.5	41	**8.7 +/- 0.8**	48-T	18.3 +/- 1.2	41	32.5	38
Nebraska	**37.6 +/- 1.2**	7-T	**71.5 +/- 1.2**	7	10.5 +/- 0.7	38	20.8 +/- 1,0	32-T	33.4	33
Nevada	34.2	24-T	68.3	27-T	14.2	8	21.9	18	34.9	21
New Hampshire	31.1 +/- 1.8	38-T	68.3 +/- 1.8	27-T	10.1 +/- 0.9	39	18.2 +/- 1.5	42-T	33.7	30-T
New Jersey	27.7	46	64.8	43	11.1	36	21.5	22	34.4 +/- 1.5	25-T
New Mexico	34.5 +/- 2.5	22-T	**71.1 +/- 2.3**	10	12.6 +/- 1.6	22-T	21.2 +/- 2.1	26	34.5	23-T
New York	29.5	43	64.7	44	12.5	24	23.1	13	32.6	37
North Carolina	34.5	22-T	69.2	19	13.8	11-T	19.6	36	38.4	10-T
North Dakota	36.8 +/- 1.6	13-T	71.2 +/- 1.6	8-T	**10.6 +/- 0.9**	37	21.1 +/- 1.4	27-T	31.9	40
Ohio	**36.9**	12	70.0	15	13.3	15-T	21.7	19	37.3 +/- 1.2	12-T
Oklahoma	36.8	13-T	70.8	11-T	13.4	14	26.7	7	39.2	8
Oregon	**33.5**	28	**68.0**	31	**11.8**	29-T	18.4	40	33.7 +/- 1.6	30T
Pennsylvania	34.2	24-T	68.9	21-T	**13.3**	15-T	22.0	16-T	n/a	--
Rhode Island	31.1	38-T	**67.3**	37-T	11.7	31-T	21.3**	24-T	33.9 +/- 1.9	27-T
South Carolina	34.6	20-T	69.1	20	14.1	9	20.9	31	39.4 +/- 1.4	7
South Dakota	37.0 +/- 3.2	11	68.8 +/- 3.2	23	11.7 +/- 2.1	31-T	21.6** +/- 2.5	20-T	35.4 +/- 3.1	20
Tennessee	--	--	--	--	--	--	--	--	41.1	6
Texas	35.6	18	69.9	16	13.6	13	23.6	12	32.9	35
Utah	**31.0**	40-T	64.9	42	8.8	47-T	15.9	47	27.7 +/- 1.1	48
Vermont	**29.0**	45	**63.5**	46	8.8	47-T	15.5	48	32.4	39
Virginia	32.3	34-T	67.7	34	**13.0**	18	21.0	27-T	36.1	18
Washington	**31.5**	37	**66.0**	39	10.0	41-T	16.5	46	31.2	44-T
West Virginia	41.4 +/- 1.6	1	74.0 +/- 1.5	1	**18.4 +/- 1.2**	1	28.5** +/- 1.4	2	45.4 +/- 1.8	3
Wisconsin	37.4	9	69.5	18	11.8	29-T	21.0	27-T	33.5	32
Wyoming	**32.5 +/- 1.8**	33	**68.2 +/- 1.9**	29-T	**10.0 +/- 1.0**	41-T	20.4** +/- 1.5	34	31.7 +/- 1.7	42

SOURCE: TFAH analysis of BRFSS data

NOTE: Data were not available from Tennessee for 2024. For rankings, 1 = Highest Rate, and 51 = Lowest Rate; T = Tie. Red and * indicate state rates that significantly increased between 2023 and 2024. Green and ** indicate state rates that significantly decreased between 2023 and 2024; **Bold** indicates state rates that significantly increased between 2019 and 2024. Hypertension data is collected bi-annually; this data is from 2023.

TABLE 2: Adult Obesity Rates by Race/Ethnicity, 2022–2024

	American Indian/ Alaska Native*		Asian*		Black*		Latino*		White*	
States	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	42.7	14-T	11.6	33-T	49.1	1	33.2	42	35.8	13
Alaska	38.3	24	21.8	2	38.7	27	36.1	24-T	32.9	24
Arizona	50.5	3	14.5	14-T	35.6	37-T	39.1	3	29.3 +/- 1.1	37
Arkansas	42.7 +/- 8.5	14-T	13.7	19-T	47.6 +/- 3.4	2	35.6	29-T	37.4	5
California	41.8	17-T	12.7	26-T	38.1	28	36.5	21-T	25.7	45
Colorado	35.5	32-T	11.0	39-T	28.4	44	31.2	46	23.6	46
Connecticut	35.5	32-T	11.8	30-T	40.4	23	37.1	17-T	28.9	39-T
Delaware	25.1	44	16.0 +/- 6.4	8-T	46.2	5	31.7	45	35.6 +/- 1.5	15
D.C.			11.0 +/- 4.4	39-T	37.3 +/- 2.3	31	26.9 +/- 4.7	48	14.7 +/- 1.4	48
Florida	36.7	26	13.1	25	39.5	26	30.7	47	29.1	38
Georgia	22.3	45	14.9	11	44.2	13	34.7	32-T	33.4	20
Hawaii	25.7	43	18.7	6	34.9	40	33.5	40-T	19.4 +/- 1.4	47
Idaho	45.3	7	10.5	42-T	26.2	46	35.7	27-T	31.9 +/- 1.0	28-T
Illinois	34.6	35	11.6	33-T	43.1	16	38.7	6-T	33.6	18
Indiana	30.4	40	11.0	39-T	44.4	12	38.3	9	38.2	2
Iowa	50.6	2	12.4	29	40.3	24	38.1	10	37.5 +/- 0.8	4
Kansas	43.2	12	13.2	24	41.9	20	39.0	4-T	36.0	12
Kentucky	—	—	—	—	—	—	—	—	—	—
Louisiana	36.5	27	13.4	23	47.3	4	39.0	4-T	36.6 +/- 1.2	9
Maine	42.1	16	19.7	5	36.9	32	34.2	37	33.0	23
Maryland	29.7	41	12.7	26-T	41.3	21	36.5 +/- 2.3	21-T	30.7 +/- 0.9	33
Massachusetts	33.0	38	11.6	33-T	35.4	39	34.3	35-T	27.1	44
Michigan	37.1	25	11.3	38	43.4	15	39.8	2	35.0	16-T
Minnesota	44.6	8	20.3	3	35.6	37-T	34.6	34	33.2 +/- 0.7	21
Mississippi					47.4	3	34.7	32-T	36.5	10
Missouri	36.2	28-T	14.4	16	42.5	18	34.8	31	35.0 +/- 1.0	16-T
Montana	41.2	20	13.6	21-T			34.3	35-T	29.7	36
Nebraska	41.8	17-T	14.8	12	36.7	34	37.9	12-T	36.9 +/- 0.8	7-T
Nevada	35.5	32-T	22.5 +/- 8.1	1	37.4	30	36.9	19	31.3	32
New Hampshire			9.0	44	32.1	41	38.7	6-T	31.8	30-T
New Jersey	28.3	42	14.0	17	37.7	29	33.6	39	27.4 +/- 1.1	43
New Mexico	40.9	21	8.6	45	42.2	19	38.5 +/- 2.3	8	28.2 +/- 1.8	42
New York	35.9	30	14.5	14-T	36.2	36	33.5	40-T	28.9	39-T
North Carolina	35.7	31	11.6	33-T	45.3	8	35.7	27-T	31.8	30-T
North Dakota	46.6 +/- 5.9	5	17.2	7	27.6	45	35.6	29-T	35.7 +/- 1.0	14
Ohio	33.1	37	13.7	19-T	42.8	17	35.9	26	37.1	6
Oklahoma	42.9	13	10.5	42-T	45.8	6-T	42.1	1	37.6	3
Oregon	45.6 +/- 9.9	6	14.7 +/- 4.0	13	31.0	42	37.9	12-T	32.6 +/- 1.0	25
Pennsylvania	—	—	—	—	—	—	—	—	—	—
Rhode Island	39.2	23	15.2	10	36.8	33	36.1 +/- 3.0	24-T	30.3 +/- 1.2	34
South Carolina	31.8	39	7.7	46	45.2	9	33.7	38	32.4	26-T
South Dakota	41.3	19	20.2	4	29.1	43	37.1	17-T	36.3 +/- 2.0	11
Tennessee	—	—	—	—	—	—	—	—	—	—
Texas	43.8	11	13.6	21-T	43.7	14	37.6	15	33.5	19
Utah	40.5	22	11.8	30-T	40.2	25	36.6	20	29.8 +/- 0.7	35
Vermont	36.2	28-T	11.4	37	22.6	47	32.1	44	28.3	41
Virginia	33.2	36	11.8	30-T	45.8	6-T	32.2	43	33.1	22
Washington	44.1	9-T	12.7	26-T	36.3	35	37.8	14	31.9	28-T
West Virginia	52.7	1	13.8	18	45.1	10-T	36.5 +/- 8.5	23	41.4 +/- 1.0	1
Wisconsin	48.2	4	16.0	8-T	45.1	10-T	37.3	16	36.9	7-T
Wyoming	44.1 +/- 10.0	9-T			40.5	22	38.0	11	32.4 +/- 1.1	26-T

SOURCE: TFAH analysis of BRFSS 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; 2022–2024 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, 2024

	Male		Female		Ages 18-24		Ages 25-44		Ages 45-64		Ages 65+	
States	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	36.5	10	41.3 +/- 2.4	3	29.2 +/- 6.5	2	42.8	4	43.6	9	32.8 +/- 2.8	16
Alaska	33.7	21	34.4 +/- 2.9	27	19.9	31	35.4	24-T	40.0	25	30.8 +/- 3.2	24
Arizona	33.3	23-T	33.3	30-T	24.0	11-T	36.6	21	37.7	33	28.6 +/- 3.1	38
Arkansas	38.7	2	39.1 +/- 2.4	7	28.7	3	43.8	3	44.7 +/- 2.9	6	30.7 +/- 2.4	25
California	29.0	44-T	29.2	46	17.7	40T	30.8	44	34.5	44	24.5 +/- 2.5	48
Colorado	23.9	49	26.1	49	14.5	50	26.4	48	29.5	50	22.0	49
Connecticut	30.9	39	33.2	35	18.3	37	33.9	32-T	37.6	34	29.1	34-T
Delaware	34.7	17-T	38.5	10-T	27.3 +/- 8.7	5-T	34.3	29-T	44.4	7	34.2	9
D.C.	20.9 +/- 2.7	50	29.6 +/- 2.9	44	16.8	45	24.4	50	32.0	47	24.6	47
Florida	30.0	41	29.3	45	21.3	27	31.3	41-T	33.2	46	27.0	42
Georgia	32.8	27-T	37.9	14	21.8	22-T	38.5	18-T	40.8	21	30.4	27-T
Hawaii	29.0 +/- 23	44-T	24.9 +/- 2.2	50	23.0	16-T	30.5	45	31.4 +/- 2.9	48	19.5 +/- 2.2	50
Idaho	34.7	17-T	30.5	28-T	21.8	22-T	34.3	29-T	36.4	38	32.0	18
Illinois	32.0	31	36.3	21	22.4	18	33.1	36	40.7	22-T	32.9	14-T
Indiana	36.4	11	40.6 +/- 1.6	4	27.3	5-T	39.8	10	43.9	8	35.7	1
Iowa	35.9	12	37.4	15-T	17.2	42-T	40.1	8	43.4	10	34.8 +/- 2.1	6
Kansas	36.6	9	38.6	9	25.7	9	41.3	7	42.1	15	33.6 +/- 2.0	11
Kentucky	34.9	16	39.5	6	26.7	8	39.9	9	41.3	19	33.3 +/- 2.6	12
Louisiana	37.9	4	40.5	5	28.1	4	42.5	5	44.9	5	32.9	14-T
Maine	33.2	25	33.3	30-T	19.8	32	35.4	24-T	38.1	32	30.4 +/- 1.7	27-T
Maryland	30.6	40	34.7 +/- 1.7	26	17.2	42-T	34.1	31	38.6	30	29.7	31
Massachusetts	27.6	47	26.4	48	15.1	49	25.5	49	35.1	41-T	24.9	45
Michigan	33.9	20	38.5	10-T	21.2	28	39.1	14	41.7	17	33.1	13
Minnesota	31.4	37-T	33.3	30-T	17.8	39	32.9	37-T	38.3	31	31.4	19-T
Mississippi	38.0	3	42.7	1	21.6	25	45.3	1	47.9 +/- 4.1	2	34.9	5
Missouri	35.1	14-T	34.1 +/- 2.2	29	23.0	16-T	35.4	24-T	41.4	18	31.0 +/- 2.5	22
Montana	31.5 +/- 2.0	35-T	30.3 +/- 2.1	41-T	20.3	29	30.9	43	37.5 +/- 2.6	35	28.9 +/- 2.1	37
Nebraska	37.8	5-T	37.4 +/- 1.8	15-T	21.7	24	39.5	13	45.3	4	34.4	8
Nevada	33.5	22	35.1 +/- 4.4	24-T	22.3	19-T	36.0	22-T	39.6	27	30.0 +/- 5.0	29
New Hampshire	31.7	33	30.3 +/- 2.5	41-T	19.4	34	32.0	40	35.1	41-T	29.0 +/- 2.0	36
New Jersey	27.0	48	28.3	47	15.7	48	29.8	46	31.0	49	25.8	43
New Mexico	33.1	26	36.0 +/- 3.6	22	24.9	10	38.8	17	42.5 +/- 4.7	14	24.7 +/- 3.3	46
New York	29.1	43	30.0	43	19.5	33	31.3	41-T	34.6	43	25.4	44
North Carolina	32.5	29-T	36.4	20	15.9	47	36.9	20	42.8 +/- 3.1	13	29.6	32
North Dakota	37.8 +/- 2.2	5-T	35.7 +/- 2.5	23	23.1	14-T	39.0 +/- 3.1	15	43.2 +/- 2.8	11-T	35.2	4
Ohio	35.1	14-T	38.7	8	23.1	14-T	38.9	16	41.9	16	34.6	7
Oklahoma	35.3	13	38.3	12	19.3	35-T	39.6	11-T	45.8	3	30.9 +/- 2.1	23
Oregon	32.8 +/- 2.0	27-T	34.3	28	27.2	7	33.8 +/- 2.6	34	38.9	29	29.8 +/- 2.6	30
Pennsylvania	33.3	23-T	35.1	24-T	20.0	30	34.4	28	41.0	20	32.5	17
Rhode Island	29.3	42	33.0	36	17.7	40T	33.9	32-T	35.8	40	28.3 +/- 2.9	40
South Carolina	32.5	29-T	36.7	18	23.8	13	36.0	22-T	40.2	24	31.1	21
South Dakota	36.8	8	37.2 +/- 5.0	17	18.2	38	42.3	6	40.7	22-T	35.6 +/- 6.2	2
Tennessee	--	--	--	--	--	--	--	--	--	--	--	--
Texas	34.6	19	36.6	19	22.3	19-T	39.6	11-T	39.8	26	30.5	26
Utah	31.5	35-T	30.5	38-T	16.6	46	33.4	35	37.1	36	29.5	33
Vermont	27.7	46	30.4	40	19.3	35-T	29.0	47	34.1	45	27.8	41
Virginia	31.4	37-T	33.3	30-T	16.9	44	34.6	27	36.6	37	31.4	19-T
Washington	31.6	34	31.3	37	21.5	26	32.9	37-T	36.0	39	28.4	39
West Virginia	40.3 +/- 2.4	1	42.5 +/- 2.2	2	34.5	1	44.2 +/- 3.4	2	48.1 +/- 2.6	1	33.8 +/- 2.2	10
Wisconsin	36.9	7	38.0	13	24.0	11-T	38.5	18-T	43.2	11-T	35.5	3
Wyoming	31.8 +/- 2.5	32	33.3 +/- 2.7	30-T	22.0	21	32.9 +/- 3.7	37-T	39.5 +/- 3.1	28	29.1 +/- 2.3	34-T

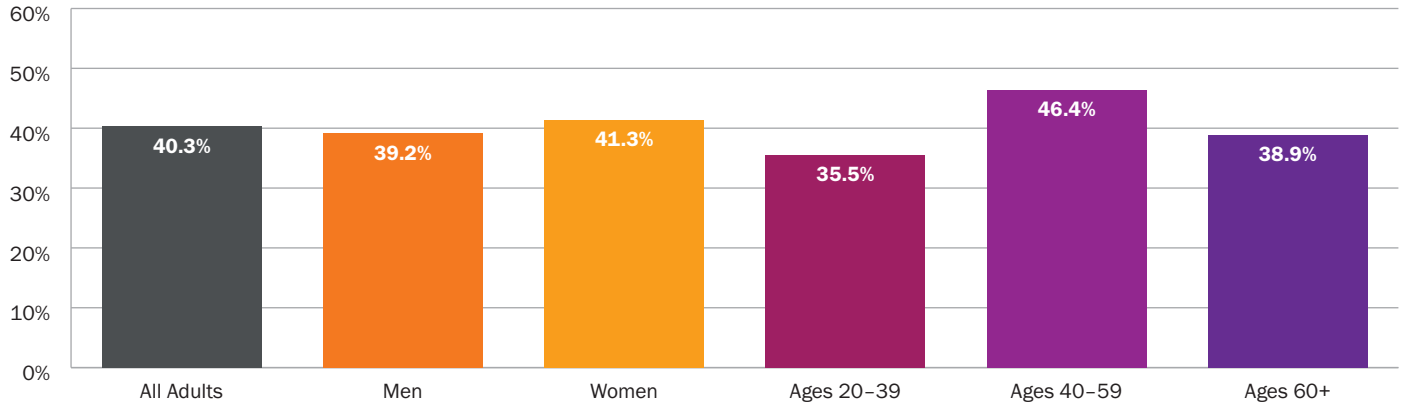
Source: TFAH analysis of BRFSS data[217]

NOTE: Data were not available from Tennessee for 2024. For rankings, 1 = Highest Rate, and 51 = Lowest Rate; T= Tie.

II. Demographic Trends

Obesity rates differ across a number of demographic measures, including age, education, race/ethnicity, income, and geography. (See Figure 3.) While obesity rates depend on many factors, economic and community context shape Americans' daily life and available choices around healthy food, physical activity, education, jobs, stress, financial security, etc., which systematically affect people's weight and health.[218] See Appendix on page 91 for state-level indicators that track some of these factors, including community conditions (e.g., poverty rates), 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 Sex and Age, 2021–2023



Source: NHANES[219,220]

- **Sex: Obesity rates are similar for men and women ages 20 and older in the United States.**
- According to 2021–2023 NHANES data, 39.2 percent of men and 41.3 percent of women had obesity, a non-statistically significant difference.[221]
- **Age: Middle-age adults had higher obesity rates than younger and older adults.**
- In 2021–2023, 46.4 percent of adults ages 40–59 had obesity, a statistically significantly higher rate than adults ages 20–39 (35.5 percent) and adults ages 60 and older (38.9 percent).[222]
- **Education: Obesity rates were lower among adults with college degrees.**
- In 2021–2023, 31.6 percent of college graduates had obesity, a statistically significantly lower rate than adults with a high school diploma (44.6 percent) or some college (45.0 percent). [223]
- **Race/ethnicity: Racial/ethnic disparities in obesity rates are significant.**
- The 2021–2023 NHANES data brief did not include information by racial/ethnic group.[224] The previous NHANES survey, from 2017–2020, showed important variation by racial/ethnic group: 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 slightly lower than white men (43.1 percent) though not a statistically significant difference.[225]

- 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 U.S. Asian 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 the overall obesity rate for all Asian adults was 13.3 percent (and whites had a 33.5 percent obesity rate).[226]
- 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 BMI levels. This risks includes a higher risk for type 2 diabetes and other metabolic diseases at lower BMIs.[227] Because a high BMI is a factor in determining whether to test for diabetes, fewer Asian individuals are tested and diagnosed by healthcare providers.[228] An estimated 40 percent of Asian people with diabetes have not been diagnosed, which is a much higher rate of undiagnosed illness than within the overall U.S. population.[229]
- It is also important to note that many national surveys, including previous NHANES surveys, do not report data on health measures for American Indian and Alaska Native (AI/AN) people. 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 that 45.1 percent of AI/AN adults had obesity, which was slightly higher than Black adults in that survey (42.8 percent) and substantially higher than white adults (33.5 percent).[230] 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.

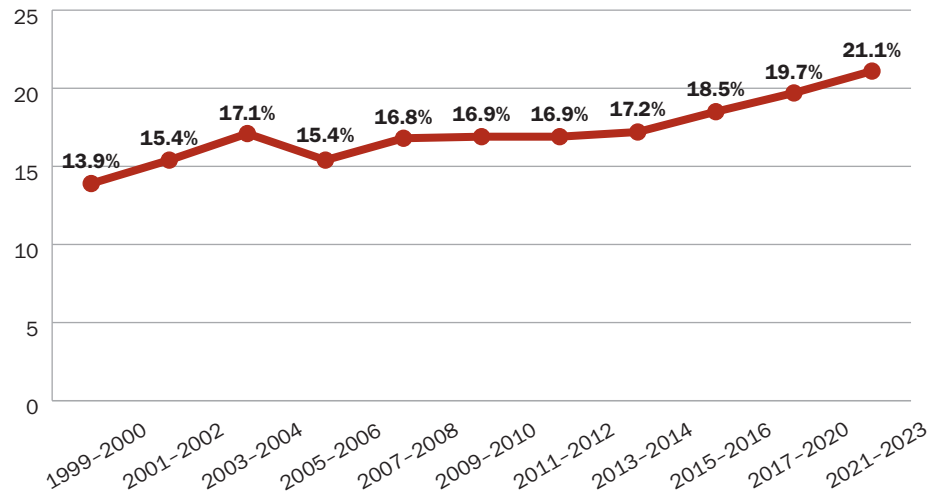
- **Income: Adults in higher income households have lower obesity rates.**
- According to 2017–2020 NHANES data, 43.9 percent of adults living in households with incomes at or below 130 percent of the federal poverty level (FPL) had obesity, 46.5 percent of adults in households at 130–350 percent of FPL had obesity, and 39.0 percent of adults in households above 350 percent FPL had obesity.[231] 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.[232] The trends vary by sex. For men, those in the below-130 percent FPL income category had an obesity rate of 38.6 percent, compared with 43.9 percent of men in the middle-income and 42.4 percent of men in the higher-income categories. In contrast, the data shows women in the lower-income category (47.9 percent) and middle-income category (48.8 percent) had a statistically significantly higher rate of obesity than women in the higher-income category (35.1 percent).[233]

- **Rural/urban: Adults in rural areas have higher rates of obesity than adults in metro areas.**
- A 2023 NORC study found that 48 percent of adults in non-metro areas have obesity, versus 41 percent of adults with obesity in metro areas. The study also found that rural residents have increased risk of death from diabetes, heart disease, and cancer—all linked to obesity.[234]
- Older studies found the same pattern, including a study using 2016 BRFSS data that found that adult obesity rates were 19 percent higher in rural regions than they were in metro areas, and a CDC analysis of 2013–2016 NHANES data that found adults who lived in the most urban areas of the country had the lowest obesity rates.[235,236]

B. TRENDS IN YOUTH OBESITY

The most recent national data, from the 2021–2023 NHANES survey, found that 21.1 percent of youth ages 2 to 19 had obesity. This is slightly above the 2017–2020 survey findings of 19.7 percent. As with adults, obesity has been rising among children over the long-term too: between the 1999–2000 NHANES survey and the 2021–2023 survey, obesity rates for children ages 2 to 19 increased by 52 percent.[237] (See Figure 4.) 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, 1999–2023



Source: NHANES[238]

DATA SOURCES FOR CHILDHOOD OBESITY MEASURES

1) NHANES is the primary source for national obesity data on adults and on youth ages 2 to 19 in this report. NHANES is particularly valuable because it combines interviews with physical examinations, including measured heights and weights. 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 data are from the August 2021–August 2023 NHANES survey, which for youth includes an overall obesity rate as well as rates by sex and race/ethnic groups (e.g., Black boys, Black girls, Hispanic boys, Hispanic girls, white boys, white girls).[239,240] The previous survey, from 2017–2020, also includes obesity rates by race/ethnicity, age, and household income.[241] Report authors note that the 2021–2023 cycle was impacted by the COVID-19 public health emergency, which could explain some of different demographics reported: "Due to COVID-19, [NHANES] had design changes and smaller sample sizes for certain race/Hispanic origin groups." [242]

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.[243] 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 obesity data is expected to be included again in the 2024 survey.[244]

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.[245] The most recent data are from the 2022–2023 survey. This is the second year that the survey has used the expanded the age range for reporting weight status to children ages 6 to 17 (from ages 10 to 17 in previous years).[246,247,248]

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.[249] YRBS officials conduct the survey in odd-numbered years; 2023 is the most recent dataset available. The 2023 survey includes samples for 39 states, five U.S. territories, three tribal areas, and 21 local school districts, as well as a separate national sample.[250]

I. National Youth Obesity Rates (NHANES)

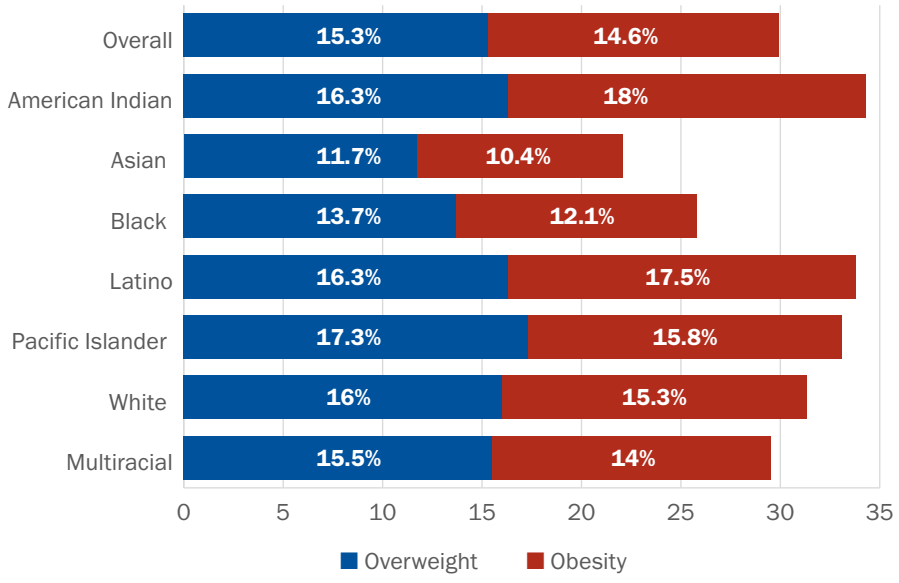
The 2021–2023 NHANES survey found that 21.1 percent of all youth ages 2 through 19 had obesity. Data from this and previous NHANES surveys show important variations in obesity prevalence across demographics. Note: The 2021–2023 NHANES survey had data for youth overall and by race/ethnicity and sex, but no other demographic factors. For other demographic groups—age, sex, race/ethnicity, and household income—data from the 2017–2020 NHANES survey are presented.

- **Race/ethnicity and sex:** In 2021–2023, Black boys had the highest rate of obesity at 38.1 percent, followed by Black girls at 29.9 percent and Hispanic boys at 29.8 percent. On the lower end of the spectrum, Hispanic girls had a rate of obesity at 23.1 percent, white boys at 18.7 percent, and white girls at 15.7 percent. Hispanic girls, white boys, Black girls, and Black boys had statistically significant increases in their obesity rates.[251]
- **Age: The prevalence of obesity increases with age.** In 2017–2020, 12.7 percent of youth ages 2 to 5, 20.7 percent of youth ages 6 to 11, and 22.2 percent of youth ages 12 to 19 had obesity.[252] Between the 1976–1980 and the 2017–2020 NHANES surveys, the percentage of youth ages 12 to 19 with obesity more than quadrupled.[253,254]
- **Sex: Boys had slightly higher rates of obesity compared with girls.** In 2017–2020, 20.9 percent of boys had obesity, and 18.5 percent of girls had obesity.[255]
- **Race/ethnicity: Black and Hispanic youth had higher rates of obesity than their Asian and white peers.** Obesity prevalence for Asian youth was 9.0 percent, Black youth 24.8 percent, Hispanic youth 26.2 percent, and white youth 16.6 percent in 2017–2020.[256]
- **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.[257]

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 had overweight.[258] The percentage of children with overweight or 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 51 for more on WIC).[259,260] American Indian and Hispanic children were the most likely to be overweight or have obesity compared with other races/ethnicities.[261] (See Figure 5 for current data by race/ethnicity as well as the chart on page 37 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 Service[262]

III. Obesity Rates in Children and Teenagers, Ages 6 to 17

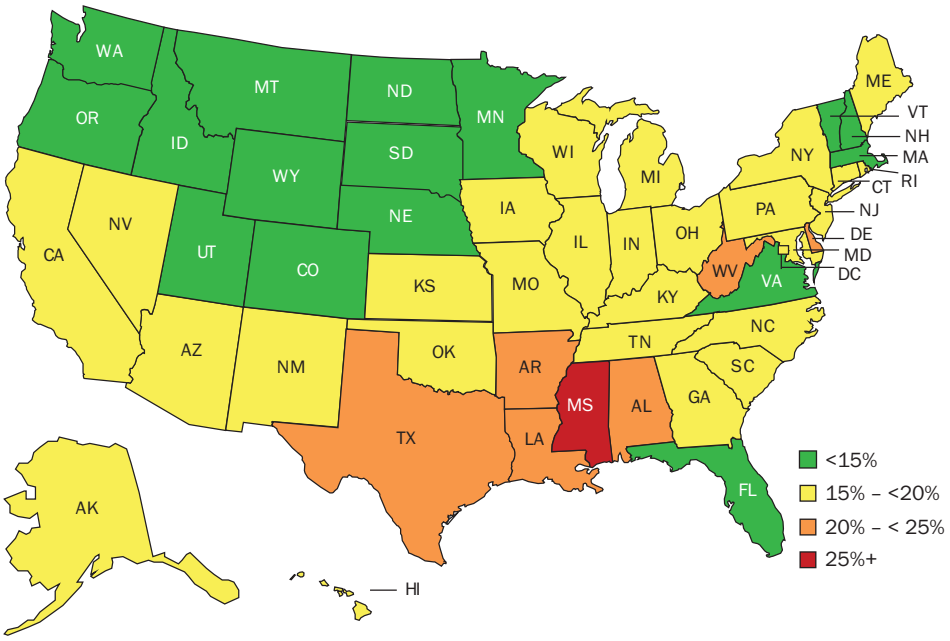
(National Survey of Children's Health)

The National Survey of Children's Health 2022–2023 survey reported that, nationwide, 17.0 percent of children ages 6 to 17 had obesity and another 15.2 percent were overweight.[263]

Other takeaways:

- Boys had higher rates of obesity (19.2 percent) than girls (14.7 percent).
- Obesity rates varied by racial/ethnic groups: 10.6 for Asian children, 23.5 for Black children, 22.2 percent for Hispanic children, and 13.2 percent for white children.
- Children in households with higher incomes had lower rates of obesity. In 2022–2023, children in households where income was 400 percent of FPL or greater had a 10.4 percent obesity rate; those in 200–399 percent FPL had a 17.5 percent obesity rate; 100–199 percent FPL had a 21.7 percent obesity rate; and 0–99 percent FPL had a 23.8 percent obesity rate. The lowest-income group had more than twice the rate of the highest-income group.

Map 4: Percent of Youth Ages 6–17 With Obesity, by State, 2022–2023



Source: National Survey of Children's Health[265]

- Obesity rates also varied by state. The states with the highest rates of obesity for children ages 6 to 17 were Mississippi (25.0 percent), West Virginia (24.1 percent), and Louisiana (23.1 percent); the states with the lowest rates of obesity were New Hampshire (11.2 percent), Vermont (11.2 percent), and Minnesota (11.8 percent). (See chart on page 37 for more state data.)[264]

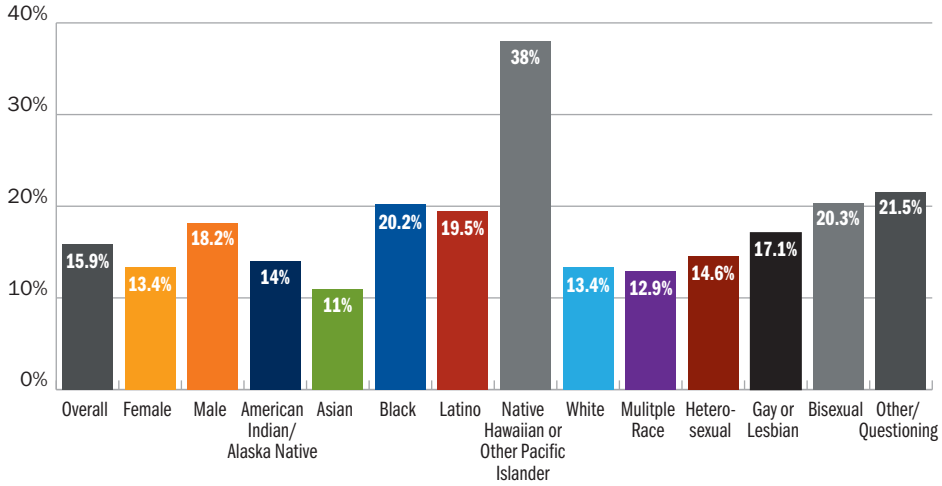
IV. High School Obesity Rates (YRBS)

According to 2023 YRBS data, 15.9 percent of high school students (grades 9 to 12) nationwide had obesity and 14.7 percent were overweight.[266,267] In recent years, obesity levels have been fairly level among high schoolers (15.9 percent in 2023, 16.3 percent in in 2021, and 15.5 in 2019), although there has been a long-term increase. In 1999, the obesity rate among high schooler students was 10.6 percent.[268,269] Other takeaways:

- The prevalence of obesity among high school students in different states varied considerably, from 12.3 percent in New Jersey to 22.1 percent in Kentucky.
- There were also differences in obesity rates across demographic groups. Male students (18.2 percent) had higher obesity rates than female students (13.4 percent); bisexual (20.3) and questioning students (21.5 percent) had higher obesity rates than gay or lesbian (17.1 percent) and heterosexual (14.6 percent) students; and Black, Hispanic, and Native Hawaiian/Pacific Islander students (all above 19 percent) had higher obesity rates than AI/AN (14.0 percent), Asian (11.0 percent), multiracial (12.9 percent), and white (11.0 percent) students.[270] (See Figure 6.)

See page 37 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, 2023



Source: Youth Risk Behavior Survey[271]

TABLE 4: Youth Obesity Rates and Related Health Indicators

	Young Children: Obesity, 2020	Children and Teenagers: Obesity and Physical Activity, 2022–2023			High School (HS) Students: Obesity, Overweight, Physical Activity, 2023		
States	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	22.8	4	20.6			
Alaska	20.1	17.9	19	27.0	17.2	16.3	18.0
Arizona	13.3	18.7	13-T	15.6			
Arkansas	13.9	22.7	5	21.7	21.5	15.8	25.2
California	17.0	16.9	24	18.6			
Colorado	8.8	12.5	47	17.9			
Connecticut	14.6	15.8	29	19.2	14.1	15.6	27.1
Delaware	18.5	20.2	7	17.0	17.8	16.5	22.4
D.C.	12.9	19.5	9	22.9	18.8	16.6	19.2
Florida	13.5	13.8	41	18.6			
Georgia	13.1	17.2	20-T	18.0			
Hawaii	11.0	18.5	15	15.9	14.7	15.1	22.4
Idaho	11.8	14.7	37-T	23.1			
Illinois	16.4	17.0	22-T	22.8	13.5	14.5	23.9
Indiana	13.9	16.3	28	23.2	17.4	15.1	23.3
Iowa	16.0	16.5	26-T	24.0			
Kansas	12.8	15.1	35	20.5			
Kentucky	15.4	18.7	13-T	18.0	22.1	15.3	22.9
Louisiana	13.7	23.1	3	20.7			
Maine	14.3	18.9	12	25.0	15.3	13.9	22.5
Maryland	16.9	16.5	26-T	16.9	15.7	15.4	19.8
Massachusetts	16.8	12.9	46	19.9	13.3	15.0	23.3
Michigan	13.8	15.5	32-T	20.5	16.9	15.5	26.4
Minnesota	11.8	11.8	49	21.9			
Mississippi	14.4	25.0	1	21.5	20.6	18.7	21.7
Missouri	12.7	15.2	34	22.1	15.9	17.0	26.0
Montana	10.9	14.1	39	26.1	14.0	14.6	26.6
Nebraska	16.0	14.0	40	23.9	16.3	13.1	29.3
Nevada	11.9	15.6	30-T	13.4	15.4	17.3	17.3
New Hampshire	16.0	11.2	50-T	23.7	12.5	13.3	22.9
New Jersey	15.4	16.7	25	16.8	12.3	16.7	26.2
New Mexico	12.7	17.2	20-T	15.1	17.5	16.5	28.5
New York	13.8	17.0	22-T	20.0			
North Carolina	14.8	15.6	30-T	18.8	17.1	14.1	23.7
North Dakota	15.6	13.4	44	25.0	16.3	14.7	29.2
Ohio	13.0	18.3	17	21.1	19.8	12.9	25.0
Oklahoma	13.2	19.3	10-T	19.5	17.9	16.5	26.8
Oregon	14.7	14.7	37-T	22.3			
Pennsylvania	13.8	15.5	32-T	22.5	16.6	15.4	29.6
Rhode Island	16.5	19.3	10-T	16.7	15.3	16.1	21.9
South Carolina	13.1	18.1	18	21.0			
South Dakota	15.6	13.1	45	24.4	15.5	13.4	30.3
Tennessee	14.9	19.9	8	20.1	18.0	16.5	18.9
Texas	15.8	21.0	6	17.3	18.5	15.2	24.7
Utah	8.8	12.1	48	16.6	12.6	15.1	19.3
Vermont	14.5	11.2	50-T	24.3	13.7	14.1	27.9
Virginia	15.6	13.7	42	17.6	13.7	15.7	23.9
Washington	14.8	14.8	36	16.7			
West Virginia	16.4	24.1	2	23.0	19.5	17.4	27.8
Wisconsin	15.2	18.4	16	23.3	16.5	15.5	25.1
Wyoming	11.8	13.5	43	24.0			

SOURCES: *WIC Participants and Program Characteristics Survey*[272] *National Survey of Children's Health*[273] *Youth Risk Behavior Survey*[274]

Obesity-Related Policies and Programs

This section covers federal, state, and local policies and programs related to obesity, chronic disease, and nutrition across five subsections: (A) Economics of What We Eat and Drink, (B) Nutrition Assistance, (C) Nutrition Standards and Labels, (D) Community Policies and Programs, and (E) Healthcare Coverage and Programs.

Source: Jetcityimage

OBESITY AND CHRONIC DISEASE FUNDING AND WORKFORCE CUTS

Recent administrative actions, personnel reductions, and departmental reorganizations in federal health agencies have led to the elimination of or significant cuts to several long-standing and impactful obesity-prevention and public health programs, with proposals to extend cuts further. The administration has proposed creation of a new agency, the Administration for a Healthy America, which would consolidate some elements from CDC, SAMHSA, and other HHS agencies. However, under the president's FY 2026 budget proposal, the entire National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) would be eliminated, with the exception of the funding line to address Alzheimer's disease.[278] Below are a few examples of effective obesity-related programs that have been affected or are at risk. For more information about the impact of these changes, see TFAH's *Public Health Infrastructure 2025* report.

1. CDC's Division of Population Health

As part of HHS's reductions in force, much of the Division of Population Health (DPH) workforce was terminated.[275,276,277] DPH focuses on promoting health and well-being and preventing chronic disease for individuals in all life stages through data collection, community-based research, and the development of public health programs.[279] DPH programs include the Prevention Research Centers, the Healthy Tribes Program, the Social Determinants of Health Accelerator Plans, and the Addressing Conditions to Improve Population Health's (ACTion). The Behavioral Risk Factor Surveillance System, which has historically been part of DPH but recently was included in a proposal to move it to a different office within CDC (see more about these programs on pages 65-72).[280,281] The elimination of the DPH and its expert staff would likely result in the closure of programs across the country, loss of technical assistance from CDC, reduction of data visibility and research to inform best practices, and the risk of widening health disparities.

2. CDC Preventive Health and Human Services (PHHS) Block Grant

President Trump's FY 2026 budget request proposes to eliminate the PHHS block grant, which provides states, territories, and tribes funding for local public health projects aligned with Healthy People 2030 objectives (e.g., reduce overweight and obesity by helping people eat healthy and get physical activity).[282,283,284] All states, the District of Columbia, two tribes, five U.S. territories, and three freely associated states (i.e., the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) have received funding under this program, and several have used it for nutrition, physical activity, and obesity-prevention initiatives. In FY 2023, the program provided $146 million in grant funding, including $8.71 million for nutrition and weight status initiatives.[285] The block grant is one of the only flexible sources of funding to enable communities to invest where dollars are needed most.

3. CDC Racial and Ethnic Approaches to Community Health

The Racial and Ethnic Approaches to Community Health (REACH) program provides funding to community-based organizations, universities, local health departments, tribes, tribal organizations, and cities to develop and implement evidence-based practices and culturally tailored resources that address the root causes of chronic disease, including obesity, and advance health equity in communities.[286] Since 1999, REACH grantees have impacted millions of people, including by improving access to healthy foods, places to be physically active, breastfeeding support, and community-clinical linkages. The impact of 2018–2023 REACH grantees' includes: (1) more than 3.3 million people have better access to healthy food and beverages; (2) approximately 8.6 million people have more opportunities to be physically active; and (3) over 1.2 million people have access to breastfeeding continuity of care.[287,288] REACH was funded at $69 million per year in FY 2024 and FY 2025.[289] The president's FY 2026 budget proposes eliminating REACH.[290]

4. NIH's National Diabetes Prevention Program (DPP) Outcomes Study

The National DPP Outcomes Study was canceled in March 2025 after more than 20 years of research, due to federal funding cuts to Columbia University, which administered the research study.[291,292] The National DPP is an evidence-based lifestyle-change program that supports weight loss in order to reduce the risk of type 2 diabetes among individuals with prediabetes. The National DPP outcomes study continues to monitor initial program participants in order to assess the long-term effectiveness of the program. The study found that, 10 years after initial program participation, participants had a 34 percent lower risk of developing type 2 diabetes and reduced cardiovascular risk factors, hemoglobin A1c, and fasting glucose compared with a placebo.[293] The program was even more effective than a common medication in preventing or delaying the development of type 2 diabetes.[294] On July 7, 2025, NIH issued an updated Notice of Award restoring funding to Columbia University and effectively retracting the previous termination. The study is planning to resume clinic activities as soon as possible.[295]

A. ECONOMICS OF WHAT WE EAT AND DRINK

Food availability, prices, and advertising are important aspects of the food environment that influence consumption patterns. For many Americans, the cost of food plays a key role in purchasing decisions, and the price tag of nutritious options can often stand in the way of healthy eating.[296,297,298,299] Economic policies—such as financial incentives to boost access to healthy foods or disincentives like taxes that discourage consumption of less nutritious choices—can influence behaviors and support better health outcomes. Marketing, likewise, plays an influential role in the choices consumers make. This subsection covers information on fiscal and tax policies that promote healthy eating—including beverage taxes, the Healthy Food Financing Initiative, and New Markets Tax Credit—and food and beverage marketing.

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 overconsumption is linked to a range of chronic health conditions, including obesity, heart disease, kidney disease, and type 2 diabetes.[300,301] Excise taxes on sugary beverages (typically 1–2 cents per ounce) are an effective intervention to curb consumption;[302,303,304,305,306,307] lower BMI among certain adults and youth;[308,309] and incentivize manufacturers to curtail added sugar content in their products, especially when the tax is scaled to the amount of added sugar in the drink.[310] In many cases, revenue from these taxes is reinvested in public health initiatives targeting obesity, nutrition, and chronic disease, furthering the policy's nutrition and public health impact.[311,312,313,314]

In December 2024, the World Health Organization (WHO) released a policy brief on the association between consumption of sugary beverages and childhood obesity and highlighted taxation as a cost-effective way to reduce consumption of sugary beverages and promote healthier food environments.[315] As of June 2025, at least 82 national and 17 sub-national taxes have been implemented throughout the world.[316] In the United States, eight U.S. cities and the Navajo Nation have adopted excise taxes on sugary beverages.[317] The most recent sugary beverage tax adoption in the United States is in Santa Cruz, California, which began implementing its tax on May 1, 2025.[318]

Healthy Food Financing Initiative

Established by the 2014 Farm Bill and reauthorized in 2018, the Healthy Food Financing Initiative (HFFI) supports access to fresh, healthy, and affordable food in under-resourced communities, helping to reduce food insecurity, strengthen low-income neighborhoods, and build a stronger food system in underserved communities.[319,320] The financial and technical assistance provided to food retailers through HFFI helps to address the higher costs and barriers to entry in some communities.[321] HFFI operates as a public-private partnership, funded by USDA and administered by the Reinvestment Fund, an independent community development financial institution.[322,323]

Recent HFFI initiatives include:

- In July 2025, USDA and the Reinvestment Fund invested $40.3 million in grant funding for the Local and Regional Healthy Food Financing Partnerships Program supporting initiatives in rural, urban, and tribal communities across 20 states and Washington, DC.[324]
- In November 2024, USDA and the Reinvestment Fund awarded $5.8 million in grant funding to support 45 projects developing or expanding food retail and supply-chain business models in underserved communities through the HFFI Planning Grant Program.[325] The program provides planning grants in 28 states and Washington, DC, with a focus on food retailers in rural, very low-income, and low-access areas.[326]
- In June 2024, USDA and the Reinvestment Fund also launched the HFFI Food Access and Retail Expansion Fund, a $60 million, five-year initiative to support food retail and supply-chain projects that improve access to healthy foods in underserved rural and urban communities.[327] Funded through the American Rescue Plan Act, the program offered $26.5 million in loans, grants, and technical assistance during the 2024–2025 cycle.[328]

HFFI funds efforts such as:

- **Weavers Way Co-op's** new Germantown, Pennsylvania, location used HFFI funding to expand access to fresh, healthy, and organic foods in an underserved Philadelphia neighborhood in May 2024. The project enhances the local food system while promoting increased food access, job creation, and community engagement;[329] and
- **Detroit Food Commons** opened in 2024 due to HFFI's targeted small grants program. The Detroit Food Commons, a 31,000-square-foot

community development project led by the Detroit Black Community Food Sovereignty Network and Develop Detroit, which aim to strengthen local food access and community engagement, while promoting healthy eating, cooperative buying, urban agriculture, and youth engagement in food careers.[330,331]

The Rural Prosperity and Food Security Act of 2024, which would have provided $5 million in annual mandatory funding for HFFI and required the USDA secretary to conduct and publish a short- and long-term impact evaluation of the program, was introduced but not enacted in the last Congress.[332] As of September 2025, this bill has not been reintroduced in the current Congress. The upcoming Farm Bill reauthorization provides further opportunity for policy and funding changes to HFFI.

New Markets Tax Credit

Created under the Community Renewal Tax Relief Act of 2000, the New Markets Tax Credit (NMTC) encourages private investment in communities facing economic challenges, such as those with high unemployment, low average income, or rural populations.[333] The credits are competitively awarded by the U.S. Treasury's Community Development Financial Institutions Fund (CDFI Fund). NMTC-funded projects aim to create jobs and improve quality of life by expanding access to healthcare services, local and regional healthy foods, spaces for physical activity, and broader economic opportunities.[334]

Recent NMTC-funded projects exemplify the program's impact:

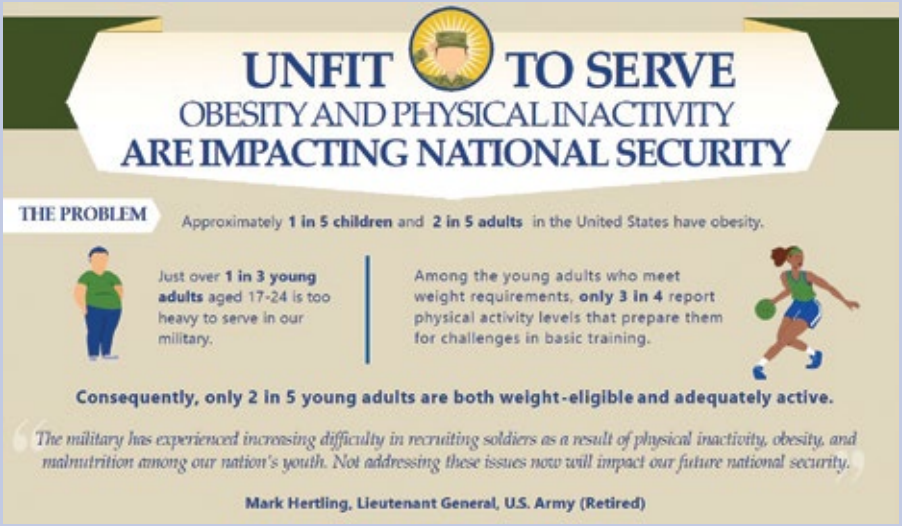
- **Food Bank of the Rockies** in Aurora, Colorado, received funding to expand its distribution center, adding 109,000 square feet to the facility. This expansion has enabled the organization to increase its food distribution capacity to 5 million pounds by 2028 and is expected to support 179 additional full-time jobs, further serving communities across Colorado.[335]
- **Wayman-Palmer YMCA Community Hub** in Toledo, Ohio, is constructing a new 44,100-square-foot facility with support from 2024 NMTC funding. The new hub will significantly improve access to nutrition and physical activity in the neighborhood through expanded fitness facilities and on-site services, including the Toledo Northwest Ohio Food Bank and Head Start preschool programming. The hub will provide integrated health, wellness, and nutrition resources to help address disproportionate health outcomes in the Toledo community. The NMTC was issued in 2024.[336]
- **Operation Food Search** expanded its Overland, Missouri, headquarters, enhancing its capacity to address food insecurity, promote nutrition, and encourage community engagement. The renovation includes a teaching kitchen and a demonstration garden that will help Operation Food Search provide more fresh, healthy food, and nutrition education in the community it serves.[337]

In September 2024, the U.S. Department of Treasury's CDFI Fund awarded $5 billion in credits to 104 community development entities.[338] Since its inception, the NMTC has invested $81 billion in economically distressed communities.[339] Federal investment in the NMTC has led to an eight-to-one return in private-sector investment.[340]

The NMTC was permanently authorized at $5 billion annually as part of One Big Beautiful Bill Act (OBBBA), the 2025 budget reconciliation bill.[341]

MILITARY READINESS AND OBESITY

Being overweight or having obesity is one of the most common reasons young adults are ineligible for military service. An estimated one in three young adults ages 17–24 has a BMI (27.5 kg/m2) that is too high to qualify for military service. When adding physical activity requirements, only about 40 percent of young adults are eligible for military services.[342]



Source: CDC[343]

Additionally, the percentage of service members who have obesity has been rising. The latest data, from 2020, show 19 percent of active-duty services members had obesity, an increase from 16 percent in 2015.[344] This translates to more lost work time and higher healthcare costs. One study found that service members with obesity are more likely to get injured, including 33 percent more likely to suffer a musculoskeletal injury. Among these injured soldiers, 30 percent either never return to active duty or return to duty with limitations.[345] Together, service members miss an estimated 650,000 days of work annually due to overweight and obesity-related issues, which costs the U.S. Department of Defense more than $103 million each year.[346,347] Annually, obesity-related healthcare costs for current and former service members and their families costs the Department of Defense an additional $1.5 billion annually.[348]

II. Food and Beverage Marketing

Food and beverage industry actions shape the food supply and influence consumer purchasing habits, preferences, and consumption patterns.[349] These private-sector choices—such as which products to manufacture and distribute, how to package them, what ingredients to use, and how to market them—influence the broader food environment. Similarly, decisions about retail product placement, stocking, and pricing play a key role in influencing consumer choices.[350]

Marketing is a powerful tool used by the food and beverage industry to influence and drive consumption. The industry spends billions of dollars annually on advertising in the United States, with an estimated 80 percent of advertising dollars spent promoting unhealthy choices like fast food, sugary beverages, and candy.[351,352,353] These marketing messages are communicated through a range of channels, including traditional television ads, product packaging, and increasingly, digital platforms.[354] Studies have found that marketing through television, digital media, and packaging is associated with children's and adolescents' food purchase requests, preferences, and intake.[355,356]

Given First Amendment protections for commercial speech,[357] most food marketing restrictions are self-regulatory and focus on reducing unhealthy food and beverage marketing to youth. For example, the Children's Food and Beverage Advertising Initiative (CFBAI) is a voluntary self-regulatory pledge program through which 21 large food and beverage and fast-food companies have agreed to certain limitations on U.S. television and other platform advertising to children under age 13 and no advertising in elementary and middle schools.[358] CFBAI's latest internal compliance report found that more than 99 percent of CFBAI participants' television ads were either for foods meeting certain nutrition criteria or appeared on programs with children under 13 comprising less than 30 percent of the audience.[359] While strengthened CFBAI commitments have led to reductions in children's exposure to unhealthy food marketing over time,[360] public health experts have identified continued gaps, including exclusions for on-package marketing, in-store displays, sponsorships, and brand marketing.[361] Further, while teenage brain development makes them particularly susceptible to marketing,[362] youth over age 12 are not covered by the voluntary food marketing restrictions.[363] Indeed, a review of recent studies found that teens exposed to unhealthy food and beverage advertising showed high desire and intention to consume the advertised foods.[364]

Marketing has increasingly shifted toward digital platforms, raising concerns about the volume and type of food marketing targeting children and adolescents online. A recent survey found that more than half of Americans have been exposed to food and nutrition content on social media, with nearly 70 percent of those surveyed reporting that they trust the content a lot or a little.[365] These digital campaigns, like their television counterparts, largely feature less nutritious products.[366] An October 2024 report forecasted the consumer packaged goods industry,

which includes food and beverage companies, to be the second-largest digital ad spender in 2024.[367] An estimated $27 billion in digital advertising was expected across the food and beverage industry (including alcoholic and non-alcoholic beverages), with spending anticipated to reach over $30 billion by 2026.[368]

A growing area of concern is social media influencer marketing, projected to reach $33 billion in 2025,[369] where branded products are integrated into user-generated, targeted content.[370,371] A study found that 97 of the top 100 influencers on one social media platform featured food and beverage products in their videos, nearly half of which were branded products. The influencers featuring branded products utilized a wide variety of disclosure methods, and sponsored content was not always clearly labeled, prompting potential consumer confusion.[372] Another study of popular "made-for-kids" child-influencer YouTube videos found that two-thirds featured food and 38 percent included branded food or beverage products, of which three-quarters were candy, snacks, sugary beverages, or ice cream.[373] Research has found that influencers promoting unhealthy snacks prompted an immediate intake of unhealthy food in children, while influencer promotion of healthy food had no effect.[374]

In addition to children, adolescents are particularly susceptible to the promotion of unhealthy and high-calorie foods by social media influencers and unique social media marketing techniques due to the persuasive effects of social media and peer influence.[375]

Another notable trend in food marketing is the targeted advertising of products like candy, sugary beverages, and fast food to specific consumer groups. For example, in 2021, Black youth and adults viewed 9 percent to 21 percent more food and beverage ads than their white peers, when adjusting for time spent watching television.[376]

Targeted advertising strategies are also evident in the promotion to Hispanic viewers of "toddler milk"—products similar to infant formula that have added sugars and are not recommended by the American Academy of Pediatrics or *Dietary Guidelines for Americans*.[377,378] These beverages are often advertised alongside infant formula, which can lead to consumer confusion and the unintended use of toddler milk for infants, even though they do not meet infants' unique nutritional needs.[379] A 2021 study found that Hispanic parents were more likely to purchase toddler milk than non-Hispanic parents,[380] highlighting how advertising messages can negatively shape purchasing decisions and product use.

B. NUTRITION ASSISTANCE

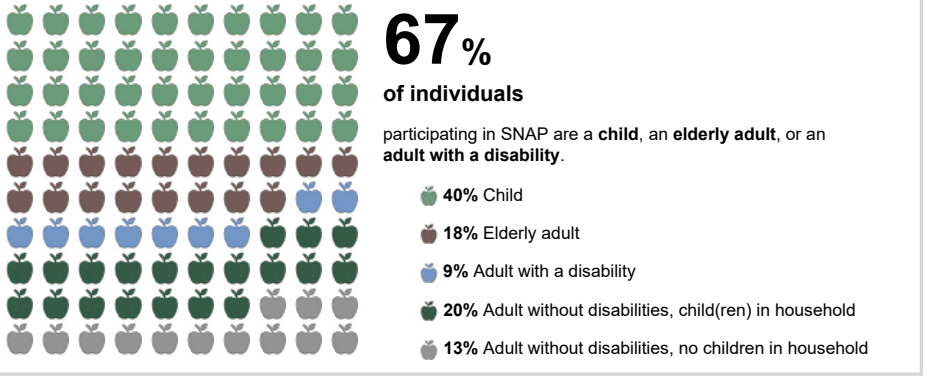
USDA's 16 nutrition assistance programs, including SNAP, child nutrition programs, emergency food assistance programs, and others serve 85 million Americans each year.[381] These programs provide access to nutritious foods for Americans of all ages. Some programs, such as the National School Lunch Program (NSLP) and School Breakfast Program (SBP), provide nutritious foods directly to participants, while others, such as SNAP and Summer Electronic Benefit Transfer (Summer EBT), provide funds that can be used to purchase groceries.

Recent price increases in food and other consumer goods make these programs even more important. Between 2020 and 2024, food prices increased 23.6 percent and are expected to increase another 2.9 percent by the end of 2025.[382,383] Prices for all goods (i.e., overall inflation) increased 2.9 percent between August 2024 and August 2025, further straining Americans' budgets.[384]

At the same time, many of these programs are at risk. For example, USDA cut $1.5 billion in emergency food assistance programs in March 2025, and OBBBA, which was signed into law in July 2025, is estimated to cut $186 billion over 10 years from SNAP, with 5 million Americans estimated to lose at least some benefits.[385,386,387,388]

This subsection covers information on federal hunger and nutrition assistance programs (including SNAP and GusNIP, child nutrition programs, WIC, emergency food assistance programs, and local food programs) and food service in childcare and education settings (including through Head Start, the Child Care and Development Block Grant, K–12 local school wellness policies, and the Smart Snacks program).

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



Source: USDA Food and Nutrition Service[392]

I. Federal Hunger and Nutrition Assistance: SNAP and GusNIP, Child Nutrition Programs, WIC, Emergency Food Assistance Programs, and Local Food Programs

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance (SNAP), formerly called "food stamps," is the nation's largest nutrition assistance program in both participation and federal funding. It helped feed 41.7 million low-income individuals in FY 2024 by providing them with funds to supplement their grocery budget.[389] Four in five SNAP households include at least one individual who is a child, older adult, or person with a disability.[390] SNAP plays a critical role in combating hunger and food insecurity, while stimulating economic growth in communities.[391]

The federal government invested $100 billion in FY 2024 in the SNAP program; 94 percent of that funding went to grocery benefit costs.[393] Since the program's inception, the federal government has covered the cost of grocery benefits.[394] The cost of administering the program is shared between the federal government and the states, approximately equally.[395] SNAP is administered by USDA's Food and Nutrition Service (FNS), and state agencies are responsible for program administration, program integrity, eligibility verification, and monthly benefit allotments.[396] However, as part of OBBBA, some states will be accountable for paying for a percentage of grocery benefits starting in FY 2028.[397]

SNAP benefits can be used to buy any grocery item with the exception of hot prepared foods; vitamins, medicine, or supplements; live animals; nonfood items such as toiletries and hygiene items; and alcohol or tobacco.[398] In nine states, certain SNAP participants—individuals experiencing homelessness, who have a disability, or are ages 60 or older—can use their benefits to purchase hot, prepared food from participating restaurants.[399] Bipartisan legislation has been introduced in both chambers of Congress to allow SNAP dollars to be used to purchase hot foods.[400]

In addition, longitudinal research finds that children with access to greater economic resources, such as through SNAP benefits, before age 5 have better outcomes as adults, including an increased likelihood of economic self-sufficiency, decreased likelihood of incarceration, improvements in neighborhood quality, and an increase in life expectancy.

SNAP grocery benefit amounts are based on the USDA's Thrifty Food Plan, an analysis of the cost for a healthy, budget-conscious diet.[401] The cost of the food plans is adjusted for inflation monthly using the Consumer Price Index.[402] USDA is required to reevaluate the Thrifty Food Plan every five years, with the next re-evaluation anticipated in 2026.[403] For FY 2025, the Center on Budget and Policy Priorities estimates that the average SNAP benefit is $187 per person per month, an average of $6.16 per day.[404]

In addition to improving food security and health for SNAP participants,[405] SNAP benefits local communities. USDA research estimated that each additional $1 invested in SNAP produces a return on investment of approximately $1.50.[406] The report, issued in 2019, found that a $1 billion increase in SNAP benefits would generate an additional $32 million for U.S. agriculture and support nearly 500 agriculture jobs.[407] In addition, longitudinal research finds that children with access to greater economic resources, such as through SNAP benefits, before age 5 have better outcomes as adults, including an increased likelihood of economic self-sufficiency, decreased likelihood of incarceration, improvements in neighborhood quality, and an increase in life expectancy.[408]

ONE BIG BEAUTIFUL BILL ACT (OBBBA) MAKES LARGEST EVER CUTS TO SNAP PROGRAM

OBBBA includes $186 billion in cuts to SNAP over 10 years, the largest reduction to SNAP benefits in the history of the program.[409,410] Savings will be used to reduce overall government expenditures and offset increased investment in other farm programs.[411] Major provisions include:

- Requiring states to cover a portion of the SNAP benefit costs and an increased percentage of administrative costs;
- Disallowing future updates to the Thrifty Food Plan to include SNAP benefit increases beyond inflation adjustments;
- Adjusting the formulas used to determine SNAP benefit amounts, including changes to how certain utility costs and related benefit amounts are considered;
- Extending work requirements for adults without disabilities up to age 64 (up from age 54), eliminating exemptions for caregivers of children ages 14 and older (up from all children under 18), and reducing related state waivers and flexibilities;
- Eliminating the SNAP-Education (SNAP-Ed) obesity prevention and nutrition education program.[412]

According to Center on Budget and Policy Priorities' estimates, these provisions would increase state administrative costs by $27 billion between 2026–2034, and the partial shift to states of food benefit costs could add up to an estimated $4.7 billion for one year, assuming each state paid the minimum amount (based on the lowest level of state error rate and assuming participation and benefits were at 2024 levels).[413] An estimated 5 million SNAP participants would be at risk of losing at least some of their benefits from the work requirement changes alone.[414] In addition to the reductions in SNAP participation, as a result of the automatic eligibility that SNAP participation confers for other federal programs, an estimated 420,000 school-age children per month would lose automatic eligibility for free school meals[415] and hundreds of thousands of pregnant and postpartum women and young children would lose access to WIC program benefits.[416]

Before the OBBBA, individuals meeting SNAP income eligibility requirements already had to meet work requirements or qualify for an exemption in order to participate in SNAP for more than three months in a three-year period. In June 2025, the work requirement applied to individuals ages 18–54 (now changed to age 64), with exemptions for individuals who have dependents under age 18 (now only for dependents under 14), are pregnant, are unable to work due to a physical or mental condition, are experiencing homelessness, are veterans, or are youth ages 18 to 24 who have aged out of foster care.[417,418,419]

The SNAP Online pilot program, which allowed online ordering and payment for SNAP purchases, was authorized in the 2014 Farm Bill and implemented in eight states in 2019–2020.[420] Implementation in additional states accelerated through the COVID-19 pandemic, and it is now available in all 50 states and Washington, DC.[421] USDA's plans for additional SNAP technology modernization includes transitioning its electronic benefits transfer (EBT) card system to a chip card technology and conducting a pilot project in three states testing mobile payments.[422,423]

To help people stretch their food budgets, learn how to prepare healthy meals, and be more physically active, SNAP-Ed funds nutrition promotion and obesity prevention programs and initiatives for SNAP participants and other individuals in low-income communities. SNAP-Ed's classes, social marketing campaigns, and policy and environmental change initiatives help people make healthy food choices and lead physically active lives.[424] At a cost of less than $5 per client per year, SNAP-Ed reaches over 2 million low-income Americans through nutrition education and another 10 million through community collaborations with schools, agriculture, and food pantry partners.[425]

SNAP-Ed is fully federally funded, with each state's share based on the state's historical expenditures in FY 2009 and the state's proportion of SNP participants nationwide.[426] In FY 2025, SNAP-Ed was funded at $536 million.[427] OBBBA completely eliminated funding for the SNAP-Ed program, and funding will close at the end of FY 2025 without congressional action.[428,429]

Recent examples of SNAP-Ed programs include:

- **The University of Florida**, which administers the state's SNAP-Ed program, partnered with more than 500 community organizations to provide nutrition education, cooking and gardening initiatives, physical activity programs, and more in a state where 2.9 million residents experience food insecurity. Of the more than 78,000 school-age children reached through nutrition education classes, 35 percent reported increased vegetable consumption, 37 percent reported reduced sugary beverage intake, and 35 percent reported increased physical activity.[430]
- **Iowa's SNAP-Ed program** partnered with local food pantries, serving 46,000 clients per month to make healthy choices easier.[431] Strategies included marketing healthier options, increasing the variety of fruits and vegetables and making them available in multiple forms, and promoting community resources.[432]
- **Michigan State University Extension**, the state's SNAP-Ed operator, implemented social marketing campaigns promoting the reduction of sugary drinks for kids and increased physical activity among adults. The sugary drinks campaign reached 11,600 individuals, while the physical activity campaign had 19 million impressions over a seven-month period during 2024.[433]

In 2025, USDA approved a new type of SNAP nutrition waiver in several states. These waivers, called "Food Restriction Waivers," allow states to prohibit the benefits from covering certain food purchases. Most states' restrictions are on soda and candy, though some states include a wider variety of foods. As of August 2025, 12 states (Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Nebraska, Oklahoma, Texas, Utah, and West Virginia) have food restriction waivers approved, ready to begin in 2026.[434]

Supporters of the SNAP food restriction waivers argue that limiting certain purchases with SNAP benefits could improve public health outcomes by discouraging the consumption of unhealthy foods. They maintain that such restrictions align SNAP with broader nutrition goals and reduce taxpayer spending on foods linked to obesity and chronic diseases.[435] Opponents of these restrictions argue that such policies, without additional funding incentives for healthier food purchases, stigmatize low-income families and could contribute to food insecurity. They emphasize that restrictions overlook environmental barriers such as the affordability, availability, and accessibility of healthy food and undermine the dignity and autonomy of SNAP recipients.[436]

There is limited research on the effects of this new waiver, and the studies conducted so far show mixed evidence.[437] For example, a 2024 randomly controlled study found that participants who had restrictions on using program funds for particular foods (i.e., sugar-sweetened beverages, sweet baked goods, and candy) did purchase fewer of those particular food items compared with the participants without the restrictions on program funds. Participants with food restrictions as well as a fruit and vegetable incentive purchased the restricted foods items even less. The overall nutritional quality of participants' diet and food security measures, however, ended up being the same across all groups.[438]

The Gus Schumacher Nutrition Incentive Program

The Gus Schumacher Nutrition Incentive Program (GusNIP) was established in its current form by the 2018 Farm Bill and is the successor to the Healthy Incentives Pilot and Food Insecurity Nutrition Incentive grant programs. The program is administered by USDA National Institute of Food and Agriculture with support from FNS.[439,440] GusNIP provides funds to conduct and evaluate projects to increase intake of fruits and vegetables among low-income consumers through incentives and prescriptions.[441] The nutrition incentive component provides point-of-purchase incentives for SNAP participants buying fruits and vegetables.[442] While program designs vary, SNAP participants must either purchase fruits and vegetables with their SNAP dollars to receive the incentive or receive an incentive that can only be used to purchase fruits and vegetables.[443] The produce prescription component supports projects to increase intake of fruits and vegetables, reduce food insecurity, and reduce healthcare service utilization and costs for low-income individuals through fruit and vegetable prescriptions.[444]

Between 2019 and 2024, GusNIP provided more than $330 million in funding for more than 250 projects. A 2024 evaluation of the program's fourth-year impacts found that participation in nutrition incentive projects for six months or more was associated with higher fruit and vegetable intake and improved food security, when compared with participation for a shorter duration.[445] In addition, participation in produce prescription projects was associated with increased fruit and vegetable intake and improved food security at follow-up.[446] Both nutrition incentive and produce prescription participants had greater fruit and vegetable intake than the average American adult.[447] GusNIP programs generated more than $107 million in economic benefits for local economies during a one-year period in 2022–2023.[448]

GusNIP received $56 million in mandatory funding for FY 2025 through the American Relief Act, 2025 (P.L. 118-158), which extended the 2018 Farm Bill programs through September 30, 2025.[449,450]

Child Nutrition Programs

USDA's child nutrition programs provide nutritious meals and snacks to children of all ages and some adults.[451] The child nutrition programs are federally funded and administered by FNS and state agencies and operate in schools, childcare centers and family childcare homes, after-school programs, adult daycare centers, and other locations.[452] Major programs are described in the table below.

TABLE 5: MAJOR USDA CHILD NUTRITION PROGRAMS

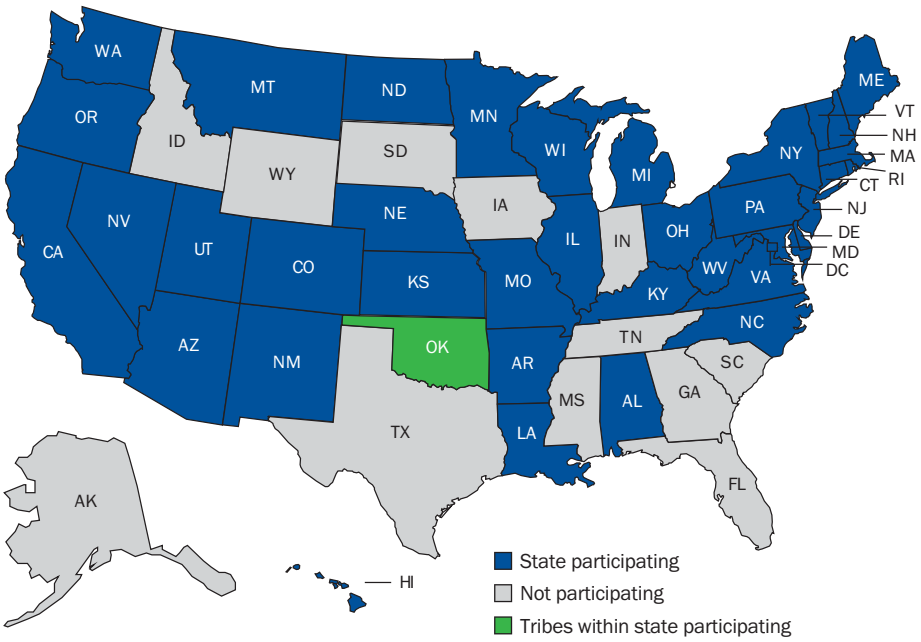
National School Lunch Program (NSLP)	NSLP is the largest child nutrition program and the second-largest nutrition assistance program overall (second only to SNAP), providing healthy lunches to America's school-age children since 1946.[453] NSLP serves nearly 30 million children per school day.[454] Nearly three in four participants receive nutritious meals at no or low cost.[455]
School Breakfast Program (SBP)	SBP serves nutritious breakfasts to school-age children at low or no cost. Though the eligibility criteria for SBP is the same as for NSLP, half as many students participate in SBP. Barriers to participation include stigma, perception of the foods offered, limited time to eat, and other factors.[456] SBP feeds an average of 15.5 million children per school day.[457,458]
Special Milk Program (SMP)	SMP provides milk to children in schools and childcare programs who do not participate in other federal nutrition programs, such as children in half-day pre-kindergarten and kindergarten programs.[459] About 1,600 entities participated in the program in FY 2024.[460]
Child and Adult Care Food Program (CACFP)	CACFP reimburses for nutritious meals and snacks provided to children in childcare centers, family childcare homes, after-school programs, and emergency shelters, and older adults in adult daycare centers.[461]
SUN Meals (Summer Food Service Program)	SUN Meals provides free healthy meals to school-age children in low-income communities during the summer months.[462] Some rural communities offer SUN meals to go.[463]
SUN Bucks (Summer Electronic Benefits Transfer for Children)	SUN Bucks provides a $120 summer grocery benefit for each eligible school-age child in participating states.[464]
Fresh Fruit and Vegetable Program (FFVP)	FFVP provides free fresh fruit and vegetable snacks to students at eligible elementary schools.[465]
Patrick Leahy Farm to School Grant Program	The Farm to School Grant Program helps improve access to healthy local foods in schools, childcare settings, and tribal communities.[466]

Most Child Nutrition Programs have their own evidence-based federal nutrition standards, and research has shown that school meals are more nutritious than foods from other sources, including grocery stores and restaurants.[467] Compared with children consuming meals from home or other sources, children eating school meals had more fruits, vegetables, and milk and fewer desserts, snack items, and other beverages at lunch.[468] Participation in Child Nutrition Programs also reduces food insecurity, improves dietary quality, reduces BMI among young children from low-income households, and sets children up for success in school.[469, 470]

FNS offers two complementary programs to provide school-age children from low-income families with access to nutritious foods during the summer months.[471] Depending on students' geographic location, they may have access to one or both programs:

- **SUN Meals** provides free nutritious meals and snacks to school-age children during the summer months.[472] These meals are typically provided at a central site, such as a school or community center, and accompanied by an enrichment activity.[473] However, in certain rural communities, school-age children have access to SUN Meals to-go, which may include picked up or delivered meals.[474]
- **SUN Bucks** provides funds to buy groceries during the summer months for children eligible for free or reduced-price school meals.[475] During summer 2025, families of children in participating states received $120 per eligible child. While the benefit amounts are adjusted for inflation annually, rounded down to the nearest dollar, there was no change in the benefit amount from summer 2024.[476] SUN Bucks began as a pilot program more than a decade ago and served as the basis for Pandemic EBT, which provided a monthly grocery benefit for children eligible for free and reduced-price meals during pandemic-related childcare and school closures.[477] SUN Bucks was established as a permanent program beginning in summer 2024.[478] Evaluation of the SUN Bucks pilot program showed that it helped reduce food insecurity and improve diet quality.[479] States opt in to participate in the program and pay a portion of the program's administrative fees. During summer 2025, 38 states, the District of Columbia, five U.S. territories, and five tribal nations participated (see map above).[480] Alabama and Utah participated for the first time in 2025.[481] States decide annually whether to participate in the program.

Map 5: Summer 2025 SUN Bucks Participation



Source: USDA Food and Nutrition Service[482]

Note: In addition to the states and District of Columbia noted in the map above, Cherokee Nation, Chickasaw Nation, Choctaw Nation of Oklahoma, Muscogee Creek Nation, and Otoe-Missouria Tribe, and the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands also participated in SUN Bucks in summer 2025.

Research has shown that Healthy School Meals for All are associated with nutrition, health, and academic benefits for students, including improved diet quality, increased food security, improved academic performance, and increased school attendance.

Funding for Child Nutrition Programs

The Full Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4), passed in March 2025 included FY 2024-level funding for agriculture programs during FY 2025.483 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 SUN meals 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 SMP.[484,485]

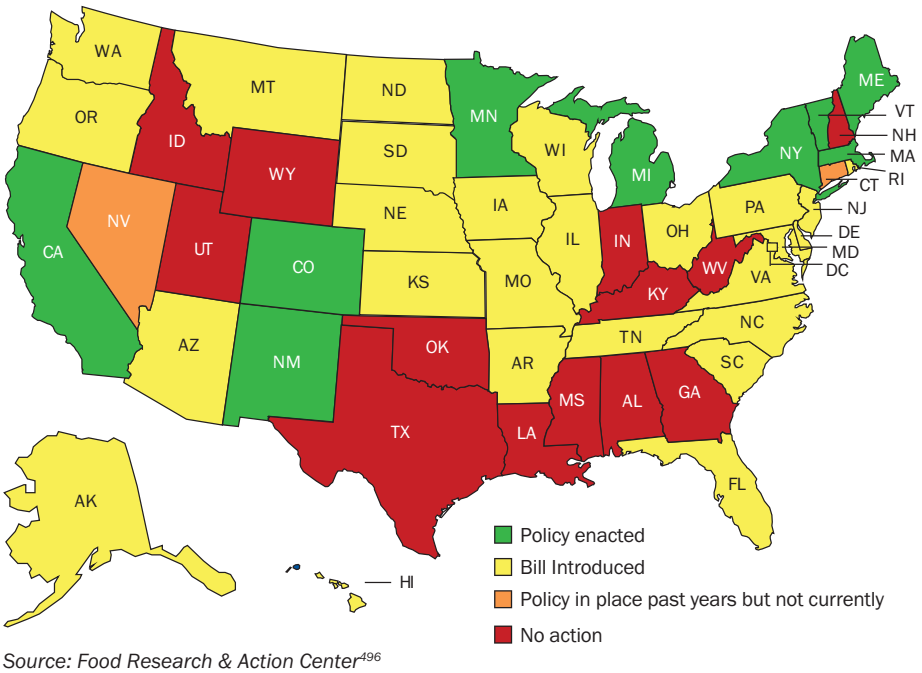
Recent Administrative and Legislative Action on School and Other Child Nutrition Programs

There have been several changes to laws and policies over the past year that impact access to Child Nutrition Programs and the nutritional quality of the foods provided.

In April 2024, USDA finalized a rule updating the school and CACFP nutrition standards to better align with the *Dietary Guidelines for Americans*, including by reducing allowable levels of added sugars and sodium.[486,487] The rule also provides new menu-planning flexibilities and makes changes to program operations.[488] While the rule officially took effect on July 1, 2024, many of the key provisions will not be implemented until school year 2025–2026 or 2026–2027.[489] For example, starting in school year 2025–2026, there will be a limit on added sugars for specific foods, such as breakfast cereals, yogurt, and flavored milk, but an overall limit on added sugars across total weekly calories will not take effect until the following year.[490]

During the COVID-19 pandemic, USDA provided states with the flexibility to offer nutritious meals to all students, at no cost and regardless of household income, through temporary child nutrition waivers.[491] After these waivers expired in summer 2022, several states enacted state-level Healthy School Meals for All policies to provide meals to all students regardless of income.[492] These states cover the difference in cost between federal reimbursements and the cost of providing nutritious meals for all participating students. As of May 2025, nine state—California, Colorado, Maine, Massachusetts, Michigan, Minnesota, New Mexico, New York, and Vermont—had Healthy School Meals for All policies.[493] Research has shown that Healthy School Meals for All are associated with nutrition, health, and academic benefits for students, including improved diet quality, increased food security, improved academic performance, and increased school attendance.[494,495]

Map 6: States with Healthy School Meals for All Programs, May 2025



Source: Food Research & Action Center[496]

From December 2023 through August 2024, USDA solicited comments on the interim final rule, establishing the Summer EBT Program and Rural Non-Congregate Option in the Summer Meal Programs, which codifies the SUN Meals to-go and SUN Bucks programs, as required by the Consolidated Appropriations Act of 2023.[497,498] The final rule, issued in June 2025, removed the requirement, established under the interim rule, for states to coordinate the statewide availability of services across these programs.[499]

The Patrick Leahy Farm to School Program provides funding to incorporate local foods into NSLP, SBP, SUN Meals, CACFP, and other child nutrition programs.[500] Program funds have been used for activities including equipment, trainings, menu item creation and testing, supply-chain strengthening, school gardens, and agricultural field trips.[501] In March 2025, USDA cut $10 million in FY 2025 funding for the program, which had been in existence since 2013.[502]

Special Supplemental Nutrition Program for Women, Infants, and Children

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides healthy foods, nutrition education, breastfeeding support, and healthcare referrals to pregnant, postpartum, and breastfeeding women and infants and children up to age 5 with low incomes who are nutritionally at-risk.[503] The program is funded by the federal government and administered by USDA's FNS, along with state and local agencies.[504] WIC celebrated its 50th anniversary in 2024.

In FY 2024, WIC served 6.7 million individuals.[505] Among children, WIC participation is highest among infants less than 1 year and declines as children age, up to their 5th birthday.[506] Overall, only about half of those who are eligible participate in the program.[507] Participation barriers include the cost and time to apply for benefits, attend clinic appointments, reload EBT cards, and shop for groceries; misunderstandings about program eligibility; dissatisfaction with food options; challenges with benefit redemption; and language and cultural barriers.[508,509]

WIC participation is associated with improved pregnancy and birth outcomes, lower infant mortality, improved infant feeding practices, better maternal and child nutrition status, and improved child cognitive development.[510,511] The WIC food packages must meet evidence-based nutritional standards, and after the requirements were strengthened in 2009, childhood obesity rates among program participants declined.[512,513,514] An economic analysis of prenatal participation in California's WIC program found that for every $1 invested in WIC services, there was about $2.48 in savings from medical, educational, and productivity costs.[515]

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. The final rule permanently increased 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 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.[516] 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.[517] An evaluation of the impact of the increase in the CVV, which had been temporarily increased during the COVID-19 pandemic from $9 to $35 per month for children ages 1–4 in June 2021 and then declined to $24 per month in October 2021, found that the increased CVV was associated with increased benefit redemption and program satisfaction, increased food security, and increased fruit and vegetable intake among individuals with the lowest intakes at baseline.[518]

WIC promotes breastfeeding through peer-counseling programs, an enhanced food package, and longer program eligibility for breastfeeding participants compared with non-breastfeeding postpartum participants.[519] WIC participants' breastfeeding rates have been steadily climbing over the past decade. In 2014, 30 percent of infants in the program were fully or partially breastfed, compared with 42 percent in 2023, a growth rate of more than 25 percent.[520] The percentage of WIC infants who are fully breastfed also increased, from 13 percent in 2014 to 15 percent in 2023.[521] Breastfeeding rates among WIC participants vary by state, with the highest rate of infants being fully breastfed in Vermont (35 percent), compared with 6 percent in Mississippi.[522] However, a review of the evidence found that WIC participation is not associated with an increase in breastfeeding initiation, compared with WIC-eligible nonparticipants.[523] WIC food packages include infant formula for infants who are not fully breastfed.[524] More than half of all infant formula consumed in the United States is by infants in WIC.[525]

In addition to WIC, the Health Resources and Services Administration's maternal and child health programs also support breastfeeding. 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 supplies.[526]

USDA has taken steps to streamline and modernize WIC. In February 2023, FNS issued a proposed rule to modernize WIC by allowing WIC benefits to be used to purchase groceries online, without the presence of a cashier.[527] The proposed rule also allows states to develop and test new instruments, such as mobile payments, and allows for the remote issuance of WIC benefits, including allowing participants to reload their benefit cards without visiting a clinic.[528] As of August 2025, the proposed rule has not yet been finalized. However, in November 2024, FNS entered into a $15 million, four-year cooperative agreement with the National WIC Association, a nonprofit education and advocacy organization, to create a blueprint to modernize WIC management information systems.[529] In March 2025, FNS announced support for a third round of WIC online shopping projects administered by the Center for Nutrition and Health Impact.[530] This summer, the Center announced it has awarded six projects across seven WIC state agencies.[531]

WIC is a discretionary program, with funding allocated annually through the federal appropriations process. As such, 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, but the Consolidated Appropriations Act, 2024, ultimately provided full funding for the program, totaling about $7 billion.[532] WIC received full funding in FY 2025 as well, totaling $7.6 billion.[533] The president's FY 2026 budget request proposes rescinding previously authorized funding for the fruit and vegetable benefit.[534]

Emergency Food Assistance Programs

USDA's food distribution and emergency food assistance programs, including The Emergency Food Assistance Program (TEFAP), the Commodity Supplemental Food Program, the Food Distribution Program on Indian Reservations, USDA Foods in Schools, and disaster assistance provide both ongoing or emergency food assistance and support for American farmers.[535] Each program serves a different population through unique mechanisms.

TEFAP supplements the diets of people with low incomes by providing them with emergency food assistance at no cost. Through TEFAP, USDA purchases

domestically produced foods that are distributed to state agencies and then local agencies, usually food banks and other community-based organizations. These entities then distribute the foods to individuals, either as prepared meals or for household consumption.[536] TEFAP participants who receive food for home consumption must meet statewide income eligibility guidelines, while there is no means test for TEFAP participants receiving prepared meals.[537] About 50 million Americans received assistance from a food bank in 2023, with a large portion of the foods available coming from TEFAP purchases.[538]

In FY 2025, USDA was expected to spend approximately $462.25 million purchasing foods for distribution through TEFAP, along with another $500 million provided under the statutory authority of the Commodity Credit Corporation.[539,540] An additional $262 million worth of surplus foods bought in FY 2024 was also expected to be delivered to states in FY 2025.[541] However, as of March 2025, about $500 million of the Commodity Credit Corporation funds have been cut by USDA.[542,543]

Local Food Programs

USDA has several programs supporting local food research, infrastructure, and markets, including the Local Agriculture Market Program (LAMP), Local Food for Schools Cooperative Agreement Program, Regional Food Business Centers Program, and Local Food Purchase Assistance Cooperative Agreement Program, all of which are administered by USDA's Agriculture Marketing Service.

Created by the 2018 Farm Bill, LAMP consists of a series of grant programs supporting direct producer-to-consumer marketing, local and regional food markets and enterprises, and value-added agricultural products.[544] LAMP programs include the Farmers Market Promotion Program, Local Food Promotion Program, and Regional Food System Partnerships Program.[545] The Local Food Promotion Program funds grants to develop, coordinate, and expand local and regional food businesses and increase access to locally produced agricultural products, as well as planning, implementation, and farm-to-institution grants.[546] In FY 2024 and FY 2025, LAMP was funded at about $26 million per year across the three programs.[547,548]

The Local Food for Schools Cooperative Agreement Program provides funds to states for purchases of domestic local foods for distribution to schools and childcare institutions.[549] In March 2025, USDA cut $660 million in program funding.[550] The Local Food Purchase Assistance Cooperative Agreement Program provides funds for state, tribal, and territorial governments to purchase foods produced within a 400-mile radius or elsewhere within the state to support local, regional, and underserved producers.[551] In March 2025, USDA cut $420 million from the program.[552] For some states, funding has already run out for both programs while other states may be able to continue their programs for longer.[553,554] The funding for these programs was provided through the Commodity Credit Corporation, and together, provided funding for local food purchases in all 50 states, four territories, and 84 tribal governments and supported more than 8,000 producers.

II. Childcare and K–12 Education Settings: Head Start, Child Care and Development Block Grant, K–12 Local School Wellness Policies, and Smart Snacks in Schools

Head Start

Head Start supports early learning and development, health, and family well-being among children ages 0–5 from low-income families.[557] Head Start (for children ages 3–5) and Early Head Start (for pregnant women, infants, and toddlers up to age 3) programs provide child development services in center-based, home-based, or family childcare settings.[558] The Office of Head Start, within the Administration for Children and Families at HHS, manages the federal program and provides oversight to the more than 1,700 agencies that offer Head Start services in local communities.[559]

Supporting nutrition and healthy eating is central to Head Start. Head Start programs must provide nutrition services that meet the dietary needs of each child to support their growth and school readiness. All Head Start grant recipients are required to participate in CACFP;[560] implement snack and meal times in a way that supports children's development and learning, such as by promoting family-style meals, developing children's understanding of how food and nutrition contribute to growth and health, and creating positive eating environments.[561] Head Start programs can also support participant cross-enrollment in other nutrition programs, such as SNAP and WIC.[562]

Research shows that children who participate in Head Start have a lower BMI than their peers. One study found that children who had obesity based on BMI when they entered Head Start had a larger decline in BMI after one year of Head Start participation than a comparison group of non-participants.[563] Another study found that children with obesity at the beginning of the Head Start program year were more likely to reduce their BMI during the program year if they entered Head Start at an earlier age.[564]

In July 2025, HHS announced it will require Head Start programs to check the citizenship or immigration status of children prior to enrollment, a first in the program's 60 year history.[565]

Head Start was funded at $12.27 billion per year in FY 2024 and FY 2025.[566,567,568]

Child Care and Development Block Grant

Funded by the federal government and administered by the states, the Child Care and Development Block Grant provides funds to low-income families to subsidize the cost of high-quality childcare.[569] To receive federal funding, early care and education (ECE) providers must meet state-mandated early childhood education health and safety requirements, including provision of age-appropriate physical activity.[570] Given that children spend many hours in childcare, embedding nutrition and physical activity within ECE settings and systems is critical for childhood obesity prevention.[571]

The Child Care and Development Block Grant was funded at $8.7 billion per year in FY 2024 and FY 2025.[572,573,574,575]

K–12 Local School Wellness Programs

Each school district that participates in one or more of the federal Child Nutrition Programs is required 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.[576] The wellness policy is a written document that guides the school district's efforts to promote students' health, well-being, and ability to learn and is required to:

- Establish nutrition education, nutrition promotion, and physical activity goals, reviewing and considering evidence-based standards;
- Include nutrition guidelines for all foods and beverages available on campus that are consistent with federal requirements;
- Limit food marketing to those products that meet the Smart Snacks in Schools nutrition standards; and
- Describe opportunities for public involvement, public updates, policy leadership, and evaluation plans.[577]

School districts are required to assess their local wellness policies every three years.[578] The review must consider compliance with the policy, comparison to model policies, and progress in attaining policy goals.[579]

Smart Snacks in Schools

Foods sold in schools during the school day, such as foods sold à la carte in the cafeteria, in vending machines, and at school stores, must meet the Smart Snacks in Schools federal nutrition standards.[580] The standards do not apply to snacks sold after school hours, food intended to be eaten off school property, or food provided for free, such as cupcakes brought in for a student's birthday. States can also exempt infrequent school fundraisers from the standards.[581] Required by the Healthy, Hunger-Free Kids Act of 2010, the Smart Snacks interim final rule took effect in school year 2014–2015, and the final rule was published in 2016.[582] The Smart Snacks requirements were updated in 2024 to exempt bean dips (e.g., hummus) from the total fat standard.[583]

C. NUTRITION STANDARDS AND LABELS

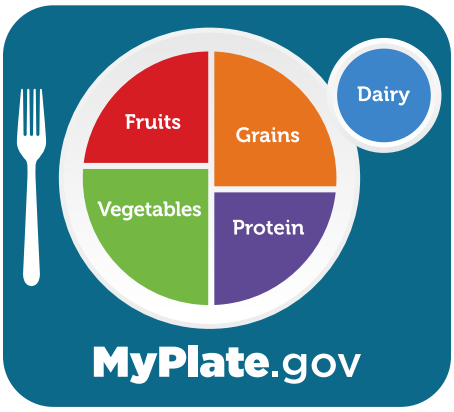
Federal nutrition standards and regulations are important tools in shifting the food supply to be healthier overall, and labels educate and empower individuals to make healthier choices for themselves and their families. This subsection covers information on the *Dietary Guidelines for Americans*, food supply standards and regulations, and nutrition labels, including packaged foods labels and menu labels.

I. *Dietary Guidelines for Americans*

The *Dietary Guidelines for Americans*—issued jointly by USDA and HHS—are the cornerstones of federal nutrition policy. They serve as a resource for policymakers and health professionals and provide the foundation for the federal government's nutrition programs. The guidelines are required by law to be revised every five years to align with current nutrition science. The most recent edition of the *Dietary Guidelines for Americans* was published in December 2020.[584] It recommends following a healthy dietary pattern at all life stages, meeting food group needs with nutrient-dense foods and beverages, while limiting calories, saturated fats, added sugars, sodium, and alcohol.[585]

MyPlate is the consumer-friendly interpretation of the *Dietary Guidelines for Americans*. The MyPlate icon—which includes dairy, fruits, vegetables, grains, and proteins (see graphic)—serves as a graphic representation of a healthy diet, intended to provide an easy-to-follow visual for healthy eating. MyPlate also offers 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 progress, and earn badges, while the website provides recipes, tip sheets, nutrition information, and inspiring videos.[586]

My Plate Graphic



Source: USDA[587]

The process to establish the *Dietary Guidelines for Americans, 2025–2030* began in 2023, when USDA and HHS announced the appointment of nutrition and public health experts to the 2025 Dietary Guidelines Advisory Committee, which reviewed the evidence to inform the 2025–2030 edition of the *Dietary Guidelines for Americans*.[588,589] The Committee utilized systematic reviews, food pattern modeling, and data analyses to respond to previously identified scientific questions. Its scientific report was released in December 2024, with an opportunity for public comments to the departments open between December 2024–February 2025.[590] Two reports on alcoholic beverages and health were also released in early 2025.[591] The *Dietary Guidelines for Americans*, 2025–2030, is expected by the end of 2025.

Most Americans do not follow the guidelines, as the average score on the Healthy Eating Index—a measure of how closely a diet aligns with the guidelines—is 58 out of 100.[592] Individuals face a range of educational, economic, environmental, and policy barriers to healthy eating. Commonly identified barriers include the expense of healthy foods, the lack of time or skills to prepare healthy meals, and the difficulty in accessing healthy foods.[593]

II. Food Supply Standards and Regulation

The FDA's Human Foods Program (HFP) oversees microbiological food safety, food chemical safety, and nutrition. In May 2024, FDA announced its final plans for a reorganization and the creation of HFP, which combines the functions of the former Center for Food Safety and Applied Nutrition and the Office of Food Policy and Response, as well as certain functions of the Office of Regulatory Affairs, into one initiative.[594] The reorganization, effective October 1, 2024, was intended to strengthen the prevention of foodborne illness, elevate the importance of nutrition to reduce diet-related disease, strengthen state partnerships, and

utilize innovation to improve the regulation of the food supply.[595]

In March 2025, 3,500 staff at FDA, including some at HFP, were laid off as part of broader workforce reductions across HHS in alignment with the Trump Administration's executive order, "Implementing the President's 'Department of Government Efficiency' Workforce Optimization Initiative."[596] The HFP layoffs were intended to apply to operational and administrative staff, including those responsible for communications and engagement, and not food safety inspectors.[597,598] Some food safety inspectors were included in the layoffs; however, their jobs were reinstated several weeks later.[599]

A key element of HFP's approach to nutrition includes activities to promote a healthier food supply, including through incentives and support for the reduction of artificial trans-fats, sodium, and added sugar in foods.[600]

In 2015, FDA determined that partially hydrogenated oils, the primary source of artificial trans-fats, are no longer "generally recognized as safe" for use in the U.S. food supply, phasing these products out of the marketplace by January 1, 2021.[601] Eliminating artificial trans-fat is estimated to prevent 10,000–20,000 heart attacks and 3,000–7,000 heart disease-related deaths each year.[602]

FDA has been supporting reductions in sodium in the food supply through voluntary targets for industry. In August 2024, FDA announced its Phase II voluntary sodium-reduction targets through draft guidance for industry.[603] The Phase II targets provide individual three-year targets for sodium reduction across 163 food categories, intended to reduce overall sodium intake to 2,750 milligrams per day.[604] The Phase I targets, issued in 2021, were intended to reduce sodium intake from the current levels of 3,400 milligrams per day to 3,000 milligrams per day.[605] *The Dietary Guidelines for Americans, 2020–2025* recommends limiting sodium intake for most healthy individuals ages 14 years and older to 2,300 milligrams per day.[606] A preliminary evaluation of sodium reduction in the food supply between 2010 and 2022, following finalization of Phase I targets, found that 62 percent of packaged food categories decreased in sodium, while 25 percent increased.[607] Among restaurant food categories, 35 percent decreased in sodium, while 49 percent increased.[608] FDA accepted comments on the Phase II voluntary sodium targets until January 2025, and, as of August 2025, the draft Phase II targets had not been finalized yet.[609]

In May 2025, FDA and NIH announced a new joint Nutrition Regulatory Science Program focused on accelerating a comprehensive nutrition research agenda to inform food and nutrition policies and improve Americans' diets.[610] Initial research priorities include a focus on the harms of ultra-processed foods, the effects of food additives, and the impacts of maternal and infant dietary exposures on health outcomes across the lifespan.[611]

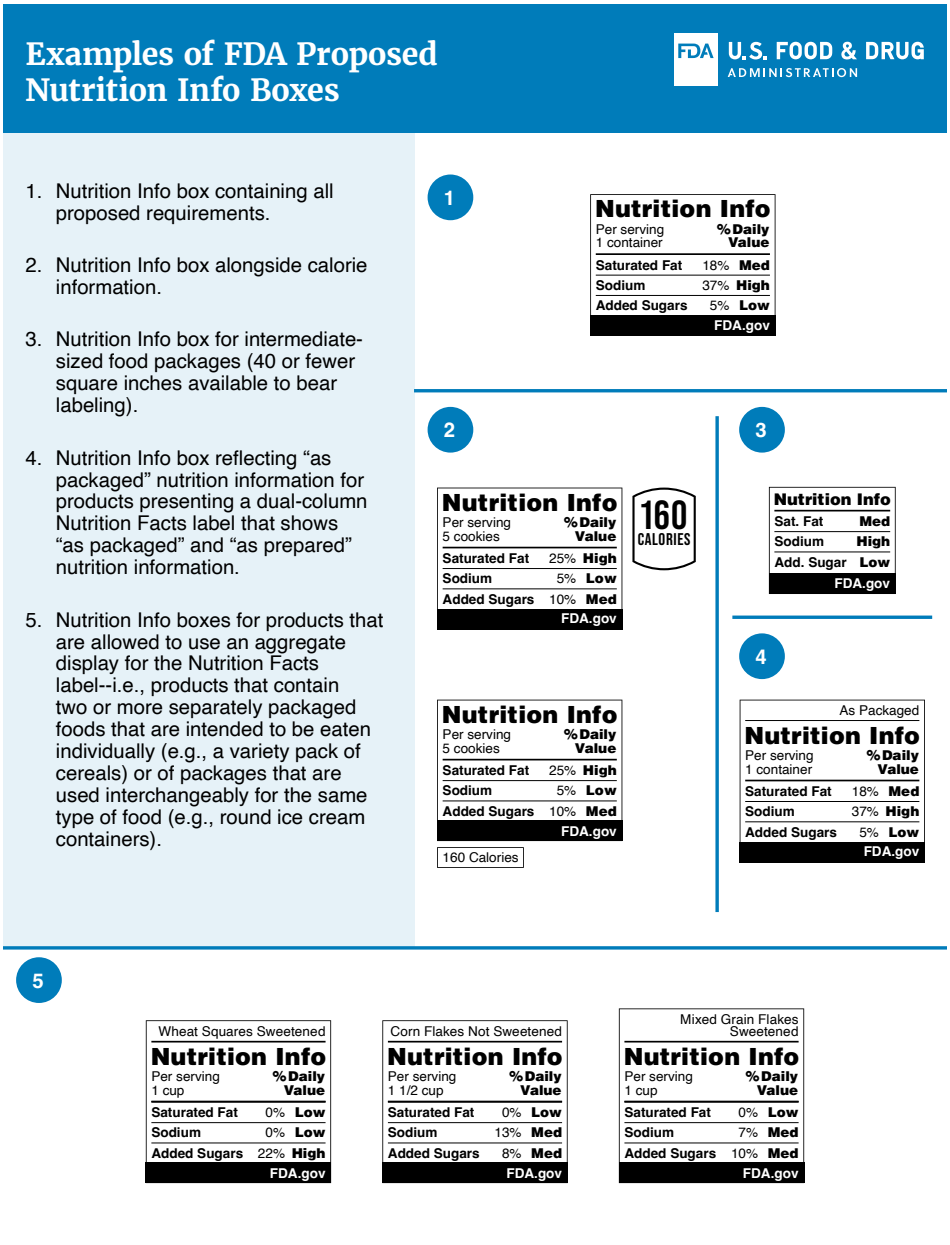
III. Nutrition Labels: Packaged Food Labels and Menu Labels

Packaged Food Labels

To help consumers make informed decisions, FDA requires that most packaged foods include a Nutrition Facts label.[612] The rules governing these labels were updated in 2016 to make the labels easier to read and to better align them with updated nutrition science, including the addition of added sugars.[613] Nutrition Facts labels are typically found on the back of packages, while other nutritional or health claims are often found on the front of packages, where they are more likely to catch a consumer's eye and can quickly impact purchasing decisions.[614]

In January 2025, FDA issued a proposed rule to require front-of-package (FOP) nutrition labeling on most packaged foods. Comments were accepted through July 2025. The proposed FOP nutrition label, called the Nutrition Info box, would state and interpret the relative amounts per serving of the nutrients consumers should limit: saturated fat, sodium, and added sugars. The percent daily value for each nutrient would be described as "low," "medium," or "high."[615] Calories would not be included in the Nutrition Info box but could be voluntarily disclosed separately on the FOP.[616] Research on international FOP labeling systems finds that they can positively influence consumer purchasing decisions and incentivize industry to improve the nutritional quality of their products.[617,618,619] In particular, a 2025 study examining the effects of FOP labeling in Mexico found significant reformulation among the most commonly purchased products that required a warning label based on their nutrient content.[620] Reformulation most commonly reduced sodium, saturated fat, and non-caloric sweeteners.[621]

Examples of FDA Proposed Nutrition Info Boxes



Source: FDA[622]

In December 2024, FDA released a final rule on the use of the "Healthy" claim on food labels. The final rule updates the criteria for use of the term "Healthy" for the first time since the 1990s to align it with modern nutrition science.[623,624] To meet the updated criteria for the claim, a product must contain a certain amount of food from at least one recommended food group or subgroup (e.g., fruit, vegetables, grains, fat-free and low-fat dairy, protein foods) and meet specified limits for added sugars, saturated fat, and sodium. The specific nutrition criteria vary by food category.[625] Examples of products that newly qualify for the "Healthy" claim include salmon, olive oil, eggs, water, and trail mix, while fortified white bread, highly sweetened yogurt, and highly sweetened cereal would no longer qualify.[626,627] Manufacturers could voluntarily begin using the new criteria for a "Healthy" claim on April 28, 2025.[628] FDA has also been exploring the development of a new "Healthy" symbol to indicate to consumers that a product meets the "Healthy" criteria.[629]

Menu Labels

Calorie labeling on chain restaurant menus and vending machines has been required since 2018.[630,631] Chain restaurants must also make additional nutrition information available upon request. Menu labeling allows consumers to make more informed choices when they eat out. One-third of Americans' calories comes from food prepared away from home, with restaurants comprising the largest share of that market.[632,633] Consumers often underestimate the calorie levels of out-of-home meals, and food prepared outside the home often has more calories than food prepared at home.[634,635,636] Menu labels can also lead consumers to choose healthier menu options and incentivize restaurants to offer healthier menu choices.[637,638,639] Certain consumers are more likely to use menu labeling information. A 2024 analysis found that that the following groups were more likely to notice menu labels: women, people with moderate to high incomes, married or partnered individuals, people living in large metropolitan areas, and people in the South, West, and Midwest regions.[640] A national microsimulation study 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.[641]

Third-party delivery services (e.g., Uber Eats, DoorDash)—which have proliferated in recent years—often do not include calorie counts on their platforms.[642] There have been 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, 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.[643]

D. COMMUNITY POLICIES AND PROGRAMS

Many local, state, and federal policies and programs help communities better support healthy eating and physical activity for their residents. This includes accessibility and affordability of foods, availability and safety of physical activity and active transport, and support and educational programs related to nutrition. This subsection includes information on policies and programs that impact communities' built environments (including community design, transportation, and land use; housing; and Safe Routes to School) and CDC's state and community initiatives (including CDC Divisions of Population Health and Nutrition, Physical Activity, and Obesity, and a number of their critical grants, programs, and initiatives).

In 2025, the Trump Administration announced executive orders and other actions that included a reorganization of federal public health programs and significant reductions to program funding and personnel, including some that support local and state efforts and initiatives related to nutrition, obesity, and other chronic diseases as well as physical activity. This section includes recent updates where information is available, though the extent of the changes, including reductions and elimination of programs, personnel, and funding, are often still uncertain.[644]

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

Physical activity helps individuals reduce or maintain weight, lower risks of chronic diseases, and increase health benefits.[645,646] A community's environment can make physical activity easier or more difficult. Aspects of the built environment—the human-made structures in the environment where people live and work—often prioritize car travel and fail to provide adequate infrastructure for active transportation (e.g., walking, rolling, bicycling), physical activity, and recreation. Features like neighborhood walkability (e.g., sidewalks, crosswalks), safety, and access to clean air, parks, green spaces, and healthy food options are powerful environmental factors that can shape a community's levels of physical activity and support healthy weights.[647,648,649,650,651,652,653] Too often, however, chronic underinvestment creates system-level barriers that continue to drive poor health outcomes and widen gaps in health and opportunity.[654,655,656,657,658]

Community Design, Transportation, and Land Use

Health should be a central consideration when making decisions regarding community design, transportation, and land use. Policymakers can support active, healthy lifestyles and improve obesity risks by:

- Expanding safe, affordable, and accessible options for active transportation and public transit to reduce communities' dependence on cars and encourage physical activity;[659,660]
- Adopting and implementing Complete Streets policies, which ensure streets and transportation networks are safe and inclusive for people of all ages and abilities—whether they are traveling on foot or by car, bicycle, wheelchair, or other mobility device. This includes building and maintaining sidewalks, trails, and protected bike lanes as

well as installing safety features such as streetlights, speed bumps, traffic signals, crosswalks, roundabouts, and shade trees;[661,662]

- Supporting land-use and zoning policies that foster walkable neighborhoods with diverse housing options, accessible daily destinations (e.g., grocery stores, parks, schools, local businesses), and strong public transportation networks;[663]
- Creating and maintaining playgrounds, parks, and other green spaces, which promote physical activity, reduce air pollution, and strengthen social connection within communities;[664,665,666]
- Investing in high-quality, accessible public transportation infrastructure, which is linked to more physical activity, as people often walk or bike to and from public-transit stops;[667] and
- Implementing Safe Routes to School policies that fund infrastructure and programs to help students safely walk or bike to school, encouraging lifelong habits of active transportation.[668,669]

Community design, transportation, and land-use policies and programs play a critical role in expanding access and opportunity for populations that have historically faced challenges accessing helpful resources and services, including underserved children, while also improving overall health. Research shows that low-income communities and communities of color often have less access to parks and green space, limiting opportunities for physical activity and well-being.[670,671,672,673] Ensuring all people can safely walk, cycle, roll, and connect to public-transit networks in their communities is strongly influenced by community design and land-use policies. For example, a study found that Black and Hispanic Americans experience disproportionately higher traffic-fatality rates per mile while walking or biking.[674,675] The differences are especially pronounced for Black cyclists, whose fatality rate is more than four times the rate for white cyclists.[676]

Safe Streets and Roads for All—which was established by the 2021 Infrastructure and Jobs Act (P.L. 117-58), with up to $5 billion in funding over five years (2022–2026)—was created to prevent roadway injuries and deaths, including for pedestrians and bicyclists.[677] For example, the Portland, Oregon, metro area was awarded a grant in November 2024 to invest in "walking school buses" and "bike-bus" programs, where children with adult supervision bike to school together to "transform the well-being of children, communities, and our climate."[678]

The 2022 Bipartisan Infrastructure Law and the Inflation Reduction Act (P.L. 117-169) also provided potential funding to enhance active transportation networks and address air-quality, safety, and transportation inequities in communities across the country.[679,680] The U.S. Department of Transportation (DOT) administers a range of federal funding opportunities, including those aimed at enhancing conditions for bicycling, walking, and scooters; reconnecting communities divided by past infrastructure decisions; and supporting local projects that improve roadway safety and promote equitable transportation access.[681,682] In April 2025, DOT changed its transportation grant formulas to deprioritize projects that remove driving lanes, which in turn reduces funding for projects aiming to promote safe active transportation.[683]

ECONOMIC BENEFITS OF WALKABLE COMMUNITIES AND PARKS

In addition to boosting physical activity, there are economic benefits to creating thriving, walkable communities that encourage active transportation and recreation. While just over 1 percent of the geographic area of the 35 largest U.S. metropolitan areas are walkable urban areas, use of this land generates 20 percent of all U.S. economic output.[684] Commercial or residential properties in walkable urban areas sell or rent for 35–45 percent more than comparable properties in less walkable communities, generating higher property tax revenue and increased demand.[685] Further, while properties in walkable communities are gaining market share, real estate in car-dependent suburban communities is losing market share.[686] Changes to local zoning policies or regulation may be needed to change community design to promote active transportation and recreation.

Adding parks and opportunities for active recreation in communities also provides economic benefits. One study found that investment in green space conservation yields a four-to-one return on investment.[687] Local public park agencies generated more than $100 billion in economic activity and supported more than 1 million jobs in 2021.[688]

Safe Routes to School

Walking, rolling, or biking to and from school offers a simple and effective way for children and adolescents to incorporate physical activity into their daily routine. Yet, a combination of car-centric neighborhood design, safety concerns related to traffic and crime, and shifting social norms has led to a decline in the number of children and adolescents using active transportation to get to school.[689,690,691]

The Safe Routes to School (SRTS) program, funded through DOT, promotes active travel to school by supporting state and local safety efforts, ranging from awareness campaigns to infrastructure improvements like crosswalks, sidewalks, and bike lanes.[692,693] Research shows that SRTS initiatives are cost-effective and can significantly increase walking and biking to and from school.[694] Moreover, students who engage in active transportation early in life are more likely to maintain those habits into adulthood.[695]

Between 2015 and 2022, SRTS has supported projects in 17,000 schools, reaching nearly 7 million students.[696] The Bipartisan Infrastructure Law codified and expanded the program to include high schools and allowed additional funding sources, such as the Highway Safety Improvement Program and the Transportation Alternatives Program, to support SRTS projects.[697,698]

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

Alongside the federal government, state, local, and tribal governments and leaders play an important role in improving health in communities. A few examples of actions within the past year of promoting nutrition and physical activity at the community level throughout the nation are listed below.

Tribal Health and Produce Prescription Pilot Program

The Indian Health Service (IHS) is addressing food insecurity and food sovereignty in tribal communities through the IHS Produce Prescription Pilot Program. This program focuses on increasing consumption of fruits, vegetables, and traditional foods and enhancing the community's agricultural capacity to improve nutrition education and healthcare outcomes. In 2023, five tribal organizations were awarded $500,000 annually for five years to implement their own Produce Prescription Pilot Program.[699] This program consists of a partnership among tribes and tribal organizations, including healthcare centers and other grant programs (e.g., the IHS Special Diabetes Program for Indians, CDC's Good Health and Wellness in Indian Country), to design tailored community-led programs that are responsive to the unique nutritional needs and challenges of these communities.[700] As of September 2025, the program continues to function, with cohort meetings scheduled and continuing applications available for 2025.[701]

Local Food Purchasing Programs

On March 17, 2022, as a response to the COVID-19 pandemic, USDA launched two programs to address food insecurity and support access to healthy foods across the nation. The Local Food Purchase Assistance (LFPA) program included $400 million through American Rescue Plan Funds to support states, agencies, territories and tribal governments to enter into non-competitive cooperative agreements with producers and suppliers to distribute food to underserved communities through food banks, food hubs, churches, and schools.[702] The Local Food for Schools (LFS) Cooperative Agreement Program allocated $200 million dollars from the Commodity Credit Corporation for state agencies or territories to procure domestic, local, and unprocessed or minimally processed foods from local farmers and ranchers to distribute them to schools participating in the National School Lunch Program and/or School Breakfast program.[703] While USDA announced continued investment for the LFPA and LFS programs on October 2024, by March 2025 it was announced that the program would end, and FY 2025 funding was canceled.[704] However, this federal program helped states such as New Hampshire and Iowa to launch similar programs, taking lessons from the impact that those investments can have on hunger and food security. In July 2024, then-Governor Chris Sununu of New Hampshire signed into law the Local Food for Local Schools Purchasing Incentive Pilot Program. This program incentivizes school districts to purchase local foods for breakfast and lunch, as well as for Fresh Fruit and Vegetable Program services. Schools participating in the pilot receive reimbursements ranging from $3,000–$25,000 for these purchases.[705] Similarly, in March 2025, the Iowa secretary of agriculture announced the launch of the Choose Iowa Food Purchasing Pilot Program for Schools, which allocates $70,000 to match schools for up to $1,000 for purchases of healthy foods from local farmers and small businesses.[706,707]

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

Food is Medicine Solutions for America's Veterans

In September 2023, the U.S. Department of Veterans Affairs (VA) announced a partnership with the Rockefeller Foundation to expand food is medicine initiatives within VA healthcare facilities.[708] This initiative began with pilot programs at VA Health Administration facilities in Salt Lake City, Utah, and Houston, Texas, and built off an existing project in which veterans were enrolled in the EatWell program in Durham, North Carolina. The EatWell program provides $100 a month to veterans to spend solely on fruits and vegetables.[709,710] In March 2025, the program was expanded to include new pilots in Maryland and New York.[711]

Healthy School Meals for All

Providing free school meals to all students regardless of income ensures that every student has access to nutritious meals every school day.[712] Universal school meal programs around the world have been found to be positively associated with increased food security and improved nutrition.[713] Without universal school meals, students may be prevented from accessing breakfast or lunch at school due to stigma associated with access to free or reduced-cost meals, language barriers, administrative hurdles that hinder families from signing up for the program, or federal income thresholds that keep them from qualifying for free meals even if their families struggle to put food on the table.[714] As a response to the COVID-19 emergency, states were able to offer healthy school meals for all from March 2020 through June 2022.[715,716] With those federal supports ending, several states passed bills to make healthy school meals for all a permanent statewide policy. Currently, nine states provide universal free school breakfast and lunch: California, Colorado, Maine, Massachusetts, Michigan, Minnesota, New Mexico, New York, and Vermont.[717] School meals in the United States also have economic benefits—a 2021 study found the net economic and human health benefits of $21 billion and estimated maximizing student participation, improving nutritional quality, and moving to sustainable and local food procurement would lead to another $10 billion in benefits.[718]

Physical Activity Champions

Several state leaders are focusing on local strategies to encourage physical activity among their residents. For example, on April 16, 2025, West Virginia Governor Patrick Morrisey launched the Mountaineer Mile program in partnership with West Virginia State Parks. This initiative promotes physical activity by encouraging West Virginians to walk at least one mile a day.[719] This initiative demonstrates that state champions can help focus on chronic disease prevention by encouraging people to stay active.

Strengthening State and Local Food Systems

Food systems are complex networks made up of people, institutions, places, and activities that support the growing, processing, transporting, selling, and marketing of food.[720] These networks ultimately influence the types of nutrients and foods that are available and economically accessible to individuals. To support access to healthy foods, some states have implemented policies to impact their local food systems. For example, in 2023, Texas enacted a bill[721] that established a food system security and resiliency planning council, which works to ensure food affordability and accessibility, and to ensure that the local food system is resilient during climate and manmade disasters in the state.[722] In 2024, Delaware established the Delaware Grocery Initiative where the Division of Small Business will provide financial support to increase access to healthy foods by addressing the growing numbers of food deserts in the state.[723] Similarly, in 2023, Illinois established the Illinois Grocery Initiative to provide grants to existing grocers and to encourage new grocery stores to increase food access and address the growing number of food deserts across the state.[724]

Promoting Physical Activity through Complete Streets

Smart Growth America's *The Best Complete Streets Policies 2025* report (i.e., policies that support safe and accessible streets and transit networks) highlighted that it is possible to pass a strong Complete Streets policy regardless of place and size.[725] The top three policies featured by Smart Growth America include San Antonio, Texas; Nashville, Tennessee; and Clyde, Ohio.[726] San Antonio, which had previously adopted a Complete Streets Policy in 2011, worked with community members and partners throughout the city to update its previous policy to better address community needs.[24] The city worked with a multisector coalition that included disability rights groups, active transportation organizations, public health agencies, environmental organizations, and city public works. The initiative focused in part on addressing safety to support people walking, biking, and using transit. Similarly, Nashville adopted a stronger Complete Streets policy to prioritize projects that improve pedestrian safety and address the uneven distribution of resources in the most vulnerable communities.[24] Clyde adopted a Complete Streets policy that prioritize projects in underinvested and underserved locations within the city.[24]

II. CDC State and Community Initiatives

Workforce reductions and funding disruptions significantly impacted chronic disease prevention programs in 2025, with the potential for the complete elimination of critical programs in the future. Beginning in March 2025, HHS terminated employees across CDC, with significant cuts concentrated in CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).[727,728,729,730,731] Despite the passage of appropriations legislation in March 2025, the Office of Management and Budget did not provide full apportionment of funding for many CDC departments, including for chronic disease programs, until late August 2025.[732] These delays prevented CDC from issuing notices of award to states and localities for programs such as cardiovascular disease prevention and diabetes prevention.[733] In addition, the president's FY 2026 budget request proposes elimination of nearly all NCCDPHP funding, with the exception of funding for the Alzheimer's disease program.[734]

Division of Nutrition, Physical Activity, and Obesity

The Division of Nutrition, Physical Activity, and Obesity (DNPAO), part of NCCDPHP, leads CDC's efforts to prevent obesity in the United States. DNPAO's budget was $118 million in FY 2023 and FY 2024.[a,735,736] For FY 2025, Congress allocated HHS level funding; however, there are numerous reports of frozen and delayed disbursements to CDC, and the actual amount of funding that many specific divisions, programs, and funding opportunities have received in FY 2025 is uncertain.[737,738,739,740]

The president's FY 2026 budget request includes the proposed near-total elimination of NCCDPHP, including DNPAO and its flagship programs—the State Physical Activity and Nutrition program, the High Obesity Program, and the Racial and Ethnic Approaches to Community Health.[741] (More on these programs below.) The loss of this CDC division would eliminate a federal entity solely focusing on supporting evidence-based strategies to improve nutrition and increase physical activity in communities across the nation.

State Physical Activity and Nutrition

DNPAO's State Physical Activity and Nutrition (SPAN) program supports state, territorial, and tribal efforts to promote physical activity and improve nutrition.[742] Funded projects focus on:

- Making physical activity safe and accessible for all;
- Making healthy food choices more available by promoting food service and nutrition guidelines;
- Expanding fruit and vegetable incentive vouchers and produce prescription programs;
- Providing continuity of care in breastfeeding support; and
- Strengthening obesity prevention activities in ECE settings.[743]

Between 2018–2023, SPAN grants positively impacted tens of millions of people across 16 states. Key outcomes included:

- Reaching more than 8 million people through improved food service guidelines (i.e., nutrition standards at organization and institutions);

a. DNPAO budget lines include Nutrition, Physical Activity, and Obesity (including High Obesity Rate Counties and Farm to School); Racial and Ethnic Approaches to Community Health (excluding Good Health and Wellness in Indian Country); National Early Child Care Collaboratives; and Hospitals Promoting Breastfeeding.

- Expanding opportunities for approximately 19 million people to be physically active; and
- Providing over 1.7 million people with access to breastfeeding continuity of care.[744]

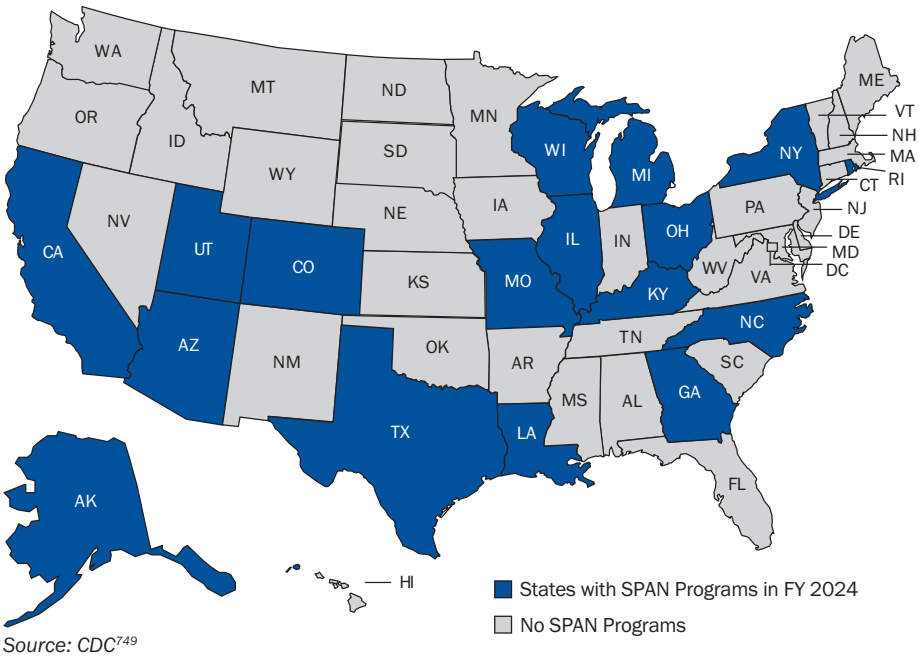
The current five-year SPAN funding cycle began on September 30, 2023.[745] DNPAO awarded 17 grants under this cycle with an expected annual award of states $888,000.[746] Full FY 2025 funding was delayed until late August 2025.[747] SPAN is one of the DNPAO programs proposed for termination in the president's FY 2026 budget request.[748]

High Obesity Program

The High Obesity Program (HOP) provides funding to land-grant universities working in partnership to address obesity and other chronic diseases with their local communities through community extension services.[750] HOP focuses on increasing access to healthier foods and promoting physical activity primarily in rural counties, where more than 40 percent of adults have obesity.[751] Funded initiatives implement community-level strategies aimed at improving nutrition, increasing physical activity, or addressing high obesity rates.[752] Strategies include food service guidelines, fruit and vegetable prescriptions, community design initiatives to increase physical activity, family healthy weight programs, and ECE interventions.[753] HOP celebrated its 10-year anniversary in 2024. Since 2014, HOP has supported obesity reduction programs through nutrition and physical activity strategies, awarding cooperative agreements to land-grant universities nationwide.[754]

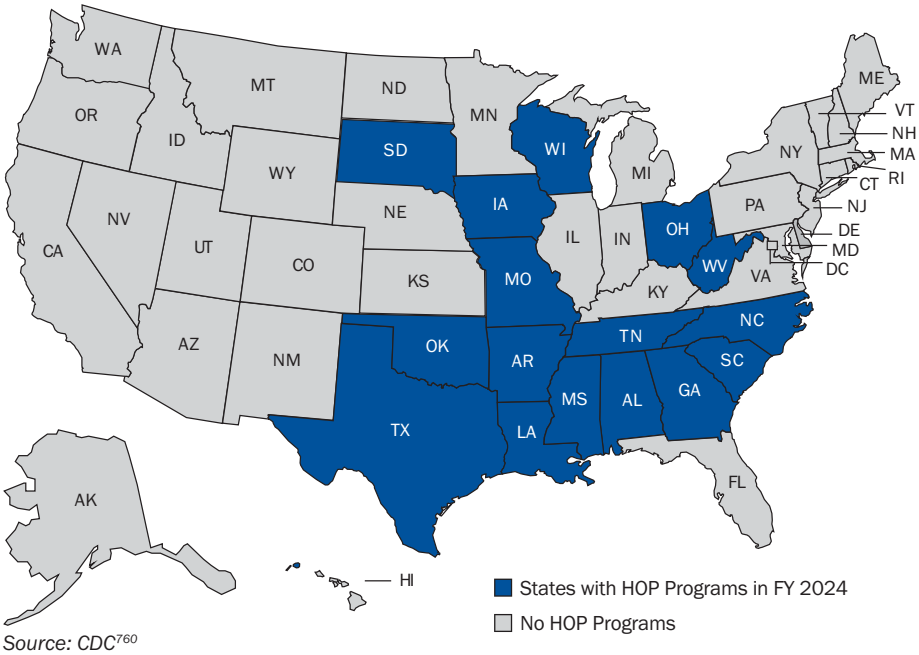
Similar to the SPAN program, the current five-year HOP funding cycle began on September 30, 2023.[755] CDC awarded 16 land-grant universities funding in 2023, with an expected average annual award of $720,000.[756,757] Full FY 2025 funding was delayed until late August 2025.[758] HOP is one of the DNPAO programs proposed for elimination in the president's FY 2026 budget request.[759]

Map 7: States with SPAN Programs in FY 2024



Source: CDC[749]

Map 8: States with HOP Programs in FY 2024



Source: CDC[760]

HOP programs including:

- Auburn University's Living Well Alabama: Thriving Communities project is conducting landscape analyses of food service guidelines in local institutions and preparing to launch fruit and vegetable voucher and produce prescription programs. The team is also using Go Nutrition and Physical Activity Self-Assessment for Child Care to strengthen nutrition, physical activity, and breastfeeding support in ECE settings. Newly funded counties develop active transportation action plans for their communities, while previously funded counties implement the existing plans using low-cost strategies.[761]
- Oklahoma State University's HOP is working with the Oklahoma Food is Medicine Coalition to expand and sustain produce prescription and nutrition voucher incentive programs. The university is also partnering with local partners to promote and expand SRTS and Complete Streets policies into new HOP counties.[762]
- South Carolina's Clemson University's HOP is implementing evidence-based strategies to improve nutrition standards, food service guidelines, and food access. They are also partnering with local groups to establish a Farm to Early Care and Education task force and supporting the implementation of family healthy weight programs in select counties. The university is also collaborating with local teams to develop walkability implementation plans, building on existing efforts where possible.[763]
- Texas A&M AgriLife Extension Service's HOP is continuing its Working on Wellness Environments initiative to enhance nutrition and community design for physical activity in select counties. The team is conducting environmental assessments and priorities with local counties, offering technical assistance and training for local teams when needed, offering trainings on ECE policies to build capacity, and engaging local partners to identify family healthy weight programs.[764]

TABLE 6: OBESITY-RELATED FUNDING OPPORTUNITIES ANNOUNCED BY CDC

Name	Grant Number	Goal	Expected Length	Anticipated Number of Grants	Annual Anticipated Size	Total Anticipated Funding
State Physical Activity and Nutrition (SPAN)[765,766]	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	Up to $75.5 million over 5 years (2023–2028)
High Obesity Program (HOP)[767,768]	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	Up to $57 million over 5 years (2023–2028)
Preventive Health and Health Services (PHHS) block grant[769,770,771]	24-2400	Provide each state with flexible support to address its most important health needs and challenges	Annual	61, including 50 states, DC, 2 American Indian tribes, 5 U.S. territories, and 3 freely associated states	$8.71 million on nutrition and weight status initiative in FY 2023	Up to $160 million in FY 2024
Racial and Ethnic Approaches to Community Health (REACH)[772,773]	23-0014	Improve health, prevent chronic disease, and reduce health disparities among populations with the highest risk, or burden, of chronic disease	5 years beginning August 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	Up to $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)[774]	23-0002	Increase students' physical activity, healthy dietary behaviors, and self-management of chronic health conditions, as well as promote equal access to health and reduce disparities	5 years beginning in 2023	20 state education and health agencies, universities, and one tribal nation	Average one-year award amount: $390,000	Up to $31.5 million over 5 years (2023-28)

**Note: The duration, number, size, annual funds, and total funding for these funding opportunities is based on projected information from the most recent Notice of Funding Opportunities. Program funding is the maximum allowable and dependent on availability of funds. For FY 2025, there are numerous reports of frozen and delayed disbursements to CDC, with many CDC departments not receiving full apportionment of funding until August 2025.*[775,776,777,778]

Racial and Ethnic Approaches to Community Health

The Racial and Ethnic Approaches to Community Health (REACH) program, administered by CDC, focuses on reducing health disparities in communities disproportionately affected by chronic disease. REACH provides funding to community-based organizations, universities, local health departments, tribal organizations, and cities to develop and implement evidence-based practices and culturally tailored resources that address the root causes of chronic disease, including obesity.[779]

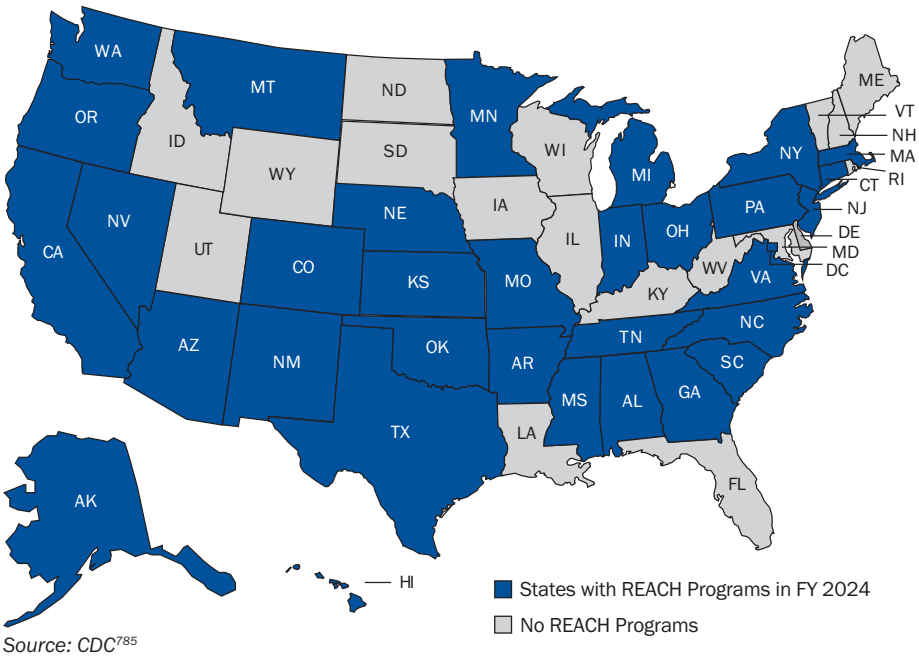
REACH celebrated its 25th anniversary in 2024. Since its launch in 1999, REACH grantees have positively impacted millions of lives by improving access to healthy foods, healthy weight programs, safe spaces for physical activity, breastfeeding support, and stronger community-clinical linkages.

REACH grantees achieved the following outcomes during its 2018–2023 funding cycle:

- 2,311,228 people with increased access to healthier foods;
- 8,612,187 people with increased access to places where they can be physically active;
- 1,278,601 people received community support to start and continue breastfeeding;
- 41,502 patients referred from clinics to community health programs; and
- 1,021,884 employees work in settings with improved smoke and tobacco-free measures.[780]

The current five-year REACH cycle (2023–2028) includes grants to 50 state and local health departments, tribal organizations, universities, and community-based organizations across 32 states.[781] Total funding for the five-year period was expected to be $228 million, with $148 million dedicated specifically to projects that focus on nutrition and physical activity.[782] Full funding for FY 2025 was delayed until late August 2025.[783] The president's FY 2026 budget request recommended eliminating funding for the REACH program.[784]

Map 9: States with REACH Programs in FY 2024



Source: CDC[785]

Some examples of REACH-funded initiatives include:

- Colorado's Foundation for Sustainable Urban Communities is delivering a culturally tailored version of the Mind, Exercise, Nutrition, Do It! (MEND) program in affordable housing communities through the Be Well Health and Wellness Initiative;[786]
- The Mississippi Public Health Institute is partnering with Let's Go Gulf Coast and the Heritage Trails Partnership of the Mississippi Gulf Coast to promote trail and park use through a dedicated app, which will also connect users to local food pantry referrals, thereby supporting both physical activity and food access;[787] and
- The Tennessee Department of Health is partnering with community-based organizations to expand the redemption of vouchers at farmers markets and increasing the nutritional quality of items available at food pantries to improve access to fresh, healthy foods for low-income families while also supporting local farmers.[788]

The REACH program also supports the Cultural Approach to Good Health and Wellness in Indian Country (GHWIC) program, in conjunction with the Healthy Tribes Program within the Division of Population Health.[789]

GHWIC focuses on supporting culturally appropriate and effective public health approaches to promote health and prevent chronic disease in AI/AN communities, with the long-term goal of reducing death and disability from chronic diseases such as prediabetes, diabetes, and obesity.[790]

GHWIC's current funding cycle (2024–2029) granted 29 awards to tribes, tribal organizations, and urban Indian organizations, totaling an expected $103.5 million over the five-year grant cycle.[791,792] GHWIC activities reach more than 115 federally recognized tribes and Urban Indian Organizations, through either direct or indirect funding, with culturally tailored programs promoting nutrition, physical activity, breastfeeding support, and obesity prevention.[793]

Like REACH, GHWIC funding for FY 2025 was not fully apportioned until late August 2025 and is proposed for elimination in the president's FY 2026 budget request.[794,795]

Division of Population Health

Federal public health programs for obesity prevention and health promotion are primarily housed in CDC's NCCDPHP.[796] The NCCDPHP is proposed for near total elimination in the president's FY 2026 budget.[797] Within NCCDPHP, most staff for the Division of Population Health (DPH) have lost their jobs due to reductions in force and other staff cuts.[798] DPH has focused on promoting health and well-being and preventing chronic disease for individuals in all life stages through data collection, community-based research, and the development of public health programs.[799] A few examples of the important chronic disease work in DPH:

- Within DPH, CDC's team responsible for the Healthy Tribes Program, which focused on addressing disproportionately higher rates of chronic disease, including obesity, among AI/AN populations, has been laid off.[800,801,802] Healthy Tribes supported dozens of tribes, villages, urban Indian organizations, tribal organizations, and tribal epidemiology centers through three cooperative agreements (Good Health and Wellness in Indian Country, Tribal Practices for Wellness in Indian Country, and Tribal Epidemiology Centers Public Health Infrastructure) with $32.6 million in expected annual funding.[803,804,805,806]
- The Social Determinants of Health Accelerator Plans, which supported state, local, territorial, and tribal jurisdictions' actionable strategies to improve community conditions among populations facing barriers to health and well-being, are proposed for elimination in FY 2026.[807,808] This program funds state, local, territorial, and tribal jurisdictions to develop multisector plans to improve non-medical factors that influence health and chronic disease outcomes for populations experiencing poor health outcomes.[809] For the 2023–2024 cycle, 15 grantees were awarded a total of $1.86 million.[810] In total, CDC had funded 71 states, communities, and territories to develop accelerator plans.[811]
- The Behavioral Risk Factor Surveillance System—a state-based telephone survey that collects data on Americans' health-related risk behaviors, chronic health conditions, and use of preventive services—was moved from DPH to the Office of the Director of the NCCDPHP.[812]

Preventive Health and Health Services Block Grant

The Preventive Health and Health Services (PHHS) block grant provides states, territories, and tribes with flexible funding to address unfunded or underfunded local public health needs and to identify and fund initiatives that are aligned with Healthy People 2030 objectives.[813] PHHS block grants provide support to all 50 states, the District of Columbia, two tribes, five U.S. territories, and three freely associated states.[814] In FY 2023, the most recent year for which CDC has published data by topic area, states spent $146 million in PHHS grant funds, including $8.71 million on nutrition and weight status initiatives.[815]

A few examples of PHHS-funded programs include:

- The Connecticut Department of Public Health expanded access to the Nutrition and Physical Activity Self-Assessment for Child Care (GO NAPSACC) program. This initiative supports ECE providers in improving nutrition and physical activity environments for young children.[816]
- The Iowa Department of Health and Human Services is collaborating with a public health research organization to analyze obesity-related cancer prevention strategies. The initiative includes identifying evidence-based interventions to combat obesity-related cancers, with a resulting report to guide future programming and resource allocation to improve cancer-related health outcomes in Iowa.[817]
- The Ohio Department of Health created the Creating Healthy Communities initiative, which included funding 22 Ohio counties to use evidence-based strategies to improve food insecurity and physical activity infrastructure.[818]

For FY 2025, Congress allocated level funding to PHHS, though the actual amount disbursed is unclear.[819] The president's FY 2026 budget request has proposed to eliminate PHHS.[820]

School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students

CDC's Healthy Schools Program supports efforts to address chronic disease among youth, including obesity prevention, through two cooperative agreements. Research shows that comprehensive, school-wide programs can effectively promote positive health behaviors and enhance academic achievement, particularly in underserved populations.[821,822,823]

The School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students (Healthy Schools) cooperative agreement funds state education and health agencies, universities, and a tribal nation to establish programs and policies that help students in underserved communities increase physical activity, make healthier food choices, and better manage chronic health conditions, including obesity.[824]

Building on the 2018–2023 funding cycle, the 2023–2028 five-year Healthy Schools cooperative agreements fund 19 states and one tribal recipient district with an expected average grant of $390,000 per year.[825,826] The actual funding disbursed in FY 2025 is uncertain.

As one example of a funded initiative, the Pennsylvania Departments of Education and Health and other partners are using Healthy Schools funding to offer statewide training and to convene a statewide school health coalition. Funding is also supporting implementation of the Whole School, Whole Community, Whole Child model—a CDC framework for addressing health and academic success in schools—in Erie Public Schools, with hopes of expanding the models to other districts in the state.[827]

Another cooperative agreement, the National Initiative to Advance Health Equity in K–12 Education by Preventing Chronic Disease and Promoting Healthy Behaviors, funds six nongovernmental organizations to deliver technical assistance and training to schools and school staff. These efforts focus on emotional well-being, school health services, healthy out-of-school time, and professional development and technical assistance for school staff in underserved communities.[828] The funding for this five-year cycle (2022–2027) was anticipated to be $7.5 million.[829] The actual funding disbursed in FY 2025 is uncertain.

The American Academy of Pediatrics, a professional association of 67,000 pediatricians, provides technical assistance, professional development and training, and intensive project support to develop, implement, and evaluate evidence-based school health policies, practices, and programs. One particular focus area includes improved school-based management of chronic health conditions, many of which are obesity-related.[830]

National Diabetes Prevention Program

Because obesity is a major risk factor for developing type 2 diabetes,[831] efforts to prevent obesity and diabetes are closely connected. The National Diabetes Prevention Program (National DPP) is a nationwide effort to build public-private partnerships among community-based organizations, healthcare organizations, public- and private-sector healthcare payers, employers, faith-based organizations, and government agencies designed to prevent or delay type 2 diabetes among the estimated 98 million Americans living with prediabetes.[832,833]

A core element of the National DPP is its research-based lifestyle-change program, which features a CDC-approved curriculum, support from a trained lifestyle coach, and one year of group support offered through in-person, online, or hybrid formats.[834,835] A clinical trial found that DPP participants reduced their risk of developing type 2 diabetes by 58 percent.[836] A 2022 follow up study of initial program participants more than 20 years after program initiation found a continued reduction or delay in type 2 diabetes development for up to 15 years, although there were no significant differences in heart attacks or strokes.[837]

In FY 2025, Congress allocated National DPP $37.3 million in funding, the same as FY 2024.[838] However, NIH funding for the National DPP Outcomes Study—which examined the effects of DPP participation—was canceled by the administration in March 2025.[839] The study has followed program participants for two decades and continues to provide critical insights into the long-term effects of National DPP, serving as a foundational model for diabetes prevention efforts.[840] In July 2025, NIH issued an updated Notice of Award restoring funding to Columbia University and effectively reversing the previous termination. The study is planning to resume clinic activities as soon as possible.[841]

Physical Activity Guidelines

Regular physical activity reduces the risk of obesity, type 2 diabetes, cardiovascular disease, cancer, infectious diseases, anxiety, and depression, while also supporting brain health and stronger bones and muscles.[842,843,844,845] In 2018, HHS released the second edition of the Physical Activity Guidelines for Americans, offering evidence-based recommendations for the amount and type of physical activity across different phases of the lifecycle to improve health and lower the risk of chronic disease.[846] Key recommendations include:

- Children ages 3 to 5: Be physically active throughout the day.
- Youth ages 6 to 17: Engage in at least 60 minutes of moderate-to-vigorous physical activity daily, including muscle-strengthening activities at least three days a week and bone-strengthening activities at least three days a week.
- Adults: Engage in at least 150 minutes (2.5 hours) of moderate aerobic activity, 75 minutes (1.25 hours) of vigorous aerobic activity per week, or an equivalent combination of moderate and vigorous activity, along with muscle-strengthening activities two or more days per week.[847]
- Older adults: Follow the adult recommendations, as physically able, and incorporate balance training into weekly physical activity, along with aerobic and muscle-strengthening activities.[848]

According to the most recent data available, only 22.5 percent of American adults met both aerobic and muscle-strengthening physical activity guidelines during their leisure time.[849] People of color and those with lower incomes were less likely to meet both guidelines compared with white adults and individuals with higher incomes.[850,851] As noted in the community design, transportation, and land-use subsection on page 61, communities of color have less access to parks and green space and higher traffic-fatality rates while walking or biking—both barriers to safe physical activity.[852,853,854,855]

One in four adults engaged in no physical activity at all outside of work.[856] In 2023, HHS released a *Physical Activity Guidelines* midcourse report, emphasizing the critical role of physical activity among adults ages 65 years and older in preventing and managing chronic diseases.[857] The report presents evidence-based strategies to help increase physical activity in this growing population.[858]

Unlike the *Dietary Guidelines for Americans*, which are required by law to be updated every five years,[859] there is no congressional mandate requiring updates to the *Physical Activity Guidelines*. The next edition of the Physical Activity Guidelines is expected in 2028.[860] Work to develop the 2028 edition of the *Physical Activity Guidelines* is already underway, including through expert collaborations aimed at identifying research topics.[861]

Active People, Healthy Nation

Active People, Healthy Nation is a CDC-led initiative aimed at helping 27 million Americans become more physically active by 2027.[862] The initiative coordinates efforts among stakeholders at the national, state, and community levels to promote physical activity and achieve the following:[863]

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

Active People, Healthy Nation promotes access for all for seven evidence-based strategies: (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.[864]

Other Healthy Communities Initiatives

Several other CDC programs also support initiatives that prevent obesity and promote healthy living, although the status of these programs is unknown due to the recent cancelations of multiple programs and funding delays and freezes:

- **Advancing Health Equity for Priority Populations with or at Risk for Diabetes:** This program funds efforts to lower the risk for type 2 diabetes among adults with prediabetes and to improve self-care practices, quality of care, and early detection of complications among people with diabetes.[865] It also supports evidence-based, family-centered childhood obesity interventions as a strategy to reduce type 2 diabetes risk.[866] The program awarded an anticipated $411 million to 77 grantees over five years, starting in FY 2023.[867]
- **Addressing Conditions to Improve Population Health (ACTion):** Launched in FY 2023, the ACTion program awarded an anticipated $7.5 million over three years (2023–2026) to five state and local governments.[868] The program supports chronic disease-related policy, system, and environmental change interventions across four domains: (1) the built environment, (2) social connectedness, (3) community-clinical linkages, and (4) food and nutrition security.[869,870]
- **Hospitals Promoting Breastfeeding:** Funded at an expected $9.75 million for FY 2024 and FY 2025, this initiative helps strengthen lactation support services and reduce differences in breastfeeding rates.[871] The president's FY 2026 budget request includes the proposed elimination of the program.[872]
- **National Early Child Care Collaboratives:** With $5 million in anticipated funding for FY 2024 and FY 2025, this initiative supports the implementation of obesity prevention strategies for young children.[873] The president's FY 2026 budget request includes the proposed elimination of the program.[874]

E. HEALTHCARE COVERAGE AND PROGRAMS

I. Medicare and Medicaid

Medicare, the public health insurance program for older Americans and some individuals with disabilities, provides coverage for 68.5 million Americans, 90 percent of whom are ages 65 and older.[875] Medicaid, the public health insurance program for low-income Americans, provides coverage to 71.3 million individuals, as of December 2024.[876] These public insurance programs cover a large portion of the medical costs of obesity and its related chronic diseases in the United States. It is estimated that over the 2024–2033 budget window, the federal government will spend $4.1 trillion on obesity-related healthcare.[877]

Medicare

Just under half of all Medicare participants (46 percent) are enrolled in traditional Medicare.[878] Traditional Medicare provides the following obesity-related benefits:

- Obesity screening by primary care providers;[879]
- Intensive behavioral therapy for beneficiaries with an obesity diagnosis;[880]
- Medicare Diabetes Prevention Program for individuals with prediabetes;[881] and
- Bariatric surgery for beneficiaries with a BMI of 35 or higher who have an obesity-related disease and were unsuccessful with previous weight-loss attempts.[882,883]

Traditional Medicare only covers intensive behavioral therapy appointments that take place in a primary care setting, many providers of this service do not work in primary care settings, creating a barrier to treatment for many patients. In addition, Medicare does not cover nutrition counseling for obesity provided by registered dietitians, who often have the most training and expertise to offer these services.[884] As a result of these provider-related policy barriers, cost-sharing requirements for bariatric surgery, and other challenges, covered Medicare obesity-related treatments have relatively low uptake.[885,886] The Treat and Reduce Obesity Act would expand the types of providers eligible to provide intensive behavioral therapy to include other types of physicians, nurse practitioners, physician assistants, and registered dietitians.[887] Another bipartisan bill, the Medical Nutrition Therapy Act,[888] has also been introduced in several previous sessions of Congress with the goal to expand Medicare coverage of nutrition counseling provided by a registered dietitian to individuals with obesity- and other diet-related conditions not currently covered.

Medicaid

Medicaid provides health insurance for adults and children with low incomes, pregnant women, older adults, and individuals with disabilities in the United States.[889] 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. Medicaid participants are more likely to have obesity than individuals with private insurance.[890,891]

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.[892] For adults, states have the option to provide coverage for obesity treatment, and most states offer coverage for at least one obesity-related treatment.[893] 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 obesity treatment.[894]

Among states that provide coverage for these services, many do so with limitations or restrictions based on patient characteristics or other requirements for coverage.[895] No state provides comprehensive coverage of all forms of obesity treatment without limitations or restrictions.[896] In addition, the National DPP is offered by 31 states as a covered benefit at varying levels to at least some beneficiaries with prediabetes.[897]

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.[898] Obesity-related services include:

- Obesity screening for children and adolescents 6 years and older, and referring those with obesity to intensive, multicomponent, family-centered behavioral interventions (Grade B);[899]

- Referring adults with a BMI of 30 or above to intensive, multicomponent, behavioral interventions (Grade B);[900]
- Offering behavioral counseling that promotes healthy weight gain and prevention of excess gestational weight gain during pregnancy (Grade B);[901]
- Diabetes screening and referrals for preventive interventions for adults ages 35 to 70 years who have overweight or obesity (Grade B);[902]
- Offering behavioral counseling interventions for cardiovascular disease prevention in adults with cardiovascular risk factors (Grade B);[903] and
- Providing interventions or referrals, during pregnancy and after birth, to support breastfeeding.[904]

Another trend among state Medicaid programs is coverage of food-based initiatives using the Medicaid Section 1115 demonstration waiver process.[b] As of July 2025, 12 states had approved Section 1115 demonstration waivers to provide nutrition supports.[905] Nutrition supports or benefits typically approved by the Centers for Medicare and Medicaid Services (CMS) in 1115 demonstration waivers include food insecurity screening and referrals to existing programs, nutrition education and counseling, provision of cooking supplies, and food is medicine services, such as medically tailored and home-delivered meals, groceries, food, or produce prescriptions for individuals with specific diet-sensitive health conditions or health risks.[906] These state demonstrations have the opportunity to improve food and nutrition security and other diet-related conditions among Medicaid enrollees.

In November 2023, CMS released a Health-Related Social Needs Framework and Informational Bulletin, which was updated in December 2024, to encourage state Medicaid proposals to address enrollees' health-related social needs or unmet, adverse social conditions that contribute to poor health.[907] This guidance was rescinded by CMS in March 2025, noting that CMS will consider states' applications on a case-by-case basis.[908]

States can also request 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. As of October 2024, 10 states were utilizing ILOS to provide 13 distinct services to address food security and nutrition.[909] Some of these services include medically tailored or home-delivered meals for targeted populations, diabetes prevention and management programs, weight-loss programs, and food or produce prescriptions or vouchers.[910] ILOS are commonly offered to reduce hospital admissions or inpatient care, nursing facility placements, home healthcare, or weight-loss surgery or medications.[911]

ONE BIG BEAUTIFUL BILL ACT (OBBBA) MAKES LARGEST EVER MEDICAID CUTS

OBBBA includes the largest Medicaid cuts in the history of the program, totaling more than $900 billion.[912] Policy changes include introducing work requirements for adults without disabilities and without young children, stricter monitoring of eligibility, new cost-sharing requirements for adults covered by Medicaid expansion, and a rule prohibiting states from increasing provider taxes to help pay for their Medicaid programs.[913]

Recent studies have found that imposing work requirements of an average of at least 20 hours per week could lead to between 4.6 and 5.2 million adults losing Medicaid coverage in 2026,[914] cutting federal funding to states by $33 billion to $46 billion over one year and $362 billion to $504 billion over 10 years.[915] As a result of this reduction in federal funds, states could lose up to 450,000 jobs, and state and local tax revenue could decline by $3.2 to $4.4 billion.[916] With state balanced-budget requirements, most states would be challenged to increase Medicaid state spending to compensate for the cuts in federal spending without reductions in program participation. According to a February 2025 analysis, without any cuts to eligibility, states would have to increase spending on acute care for the nonelderly Medicaid expansion population about 25 percent in 2026 alone, with eight states needing to increase spending more than 30 percent.[917] If states eliminated Medicaid eligibility for its expansion population instead of increasing state-level funding, an estimated 10.8 million people would lose health insurance.[918]

II. Obesity Medications

Glucagon-like peptide-1 (GLP-1) receptor agonists (e.g., semaglutide, liraglutide, tirzepatide) are a class of FDA-approved medications to treat type 2 diabetes, cardiovascular disease, and obesity.[919] This class of medication has an active ingredient that mimics a hormone that regulates blood sugar and controls appetite. Many GLP-1 agonist medications are delivered as a weekly injection, although shorter and longer-term injectable doses and oral forms are also available.[920] GLP-1 agonist medications offer a critical option for individuals living with obesity who need and want a pharmaceutical treatment option.

While initially approved to treat type 2 diabetes, FDA approved the first GLP-1 medication to treat obesity in 2021 and to treat cardiovascular disease in adults with obesity or overweight in 2024.[921,922,923,924] GLP-1s are much more effective than previous obesity medications.[925,926,927] A 2025 systematic review, meta-analysis, and meta-regression of nearly 50 trials found that use of GLP-1 medications led to an average weight loss of about 10 pounds, BMI reduction of more than 2 kilogram per meters squared, and a reduction in waist circumference of 1.8 inches, compared with a placebo.[928] Individuals who benefit the most from treatment are younger, female, without diabetes, with higher baseline weight and BMI but lower baseline hemoglobin A1c, and treated over a longer duration.[929] While individuals using GLP-1 medications commonly report side effects, these side effects are typically mild or moderate, and predominantly gastrointestinal.[930] As this class of medications is still relatively new, research on long-term patient outcomes, implications of stopping GLP-1 medications, and comparative effectiveness of different versions of GLP-1 is ongoing.[931,932] A recent study estimated that, over a lifetime, two common GLP-1 medications (tirzepatide and semaglutide) could avert 45,600 and 32,100 cases of obesity per 100,000 individuals, respectively, along with about 20,900 and 19,200 cases of diabetes, and 10,700 and 8,300 cardiovascular events per 100,000 individuals, respectively.[933]

The number of Americans taking obesity 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 taken a GLP-1 medication, including 43 percent of adults who were told they have diabetes, 26 percent of those told they have heart disease, and 22 percent told that they have overweight or obesity.[934]

A challenge with expanded use of GLP-1 medications is its affordability. The average list price in the United States for a brand-name drug is over $1,000 per month or more,[935,936] although rebates or insurance coverage may reduce the out-of-pocket consumer cost.

Coverage for obesity medications varies by type of insurance. Currently, Medicare is prohibited by federal law from covering medications for obesity.[937] Coverage is allowed for obesity medications that have other medical indications, such as diabetes and certain cardiovascular diseases.[938] For example, a GLP-1 for diabetes treatment or reducing cardiovascular risks could be covered.[939] In 2022, Medicare spending on the most common GLP-1 medications was $5.7 billion.[940]

In November 2024, in recognition of obesity as a disease, CMS issued a proposed rule reinterpreting the statutory exclusion of coverage for weight-loss drugs in Medicare to allow Medicare Part D and Medicaid coverage of obesity medications when used for weight loss or long-term weight maintenance.[941] CMS estimated that this change would have provided coverage of GLP-1 medications to an additional 3.4 million Medicare beneficiaries who do not already have another condition, such as type 2 diabetes or cardiovascular disease, for which the medications are already covered.[942] However, in April 2025, CMS stated that it did not intend to finalize the provisions of the proposed rule related to coverage of obesity medications.[943] A study estimated that expanding Medicare coverage of GLP-1 medications to obesity treatment would have increased spending by approximately $48 billion over 10 years, even after taking healthcare cost savings into consideration.[944]

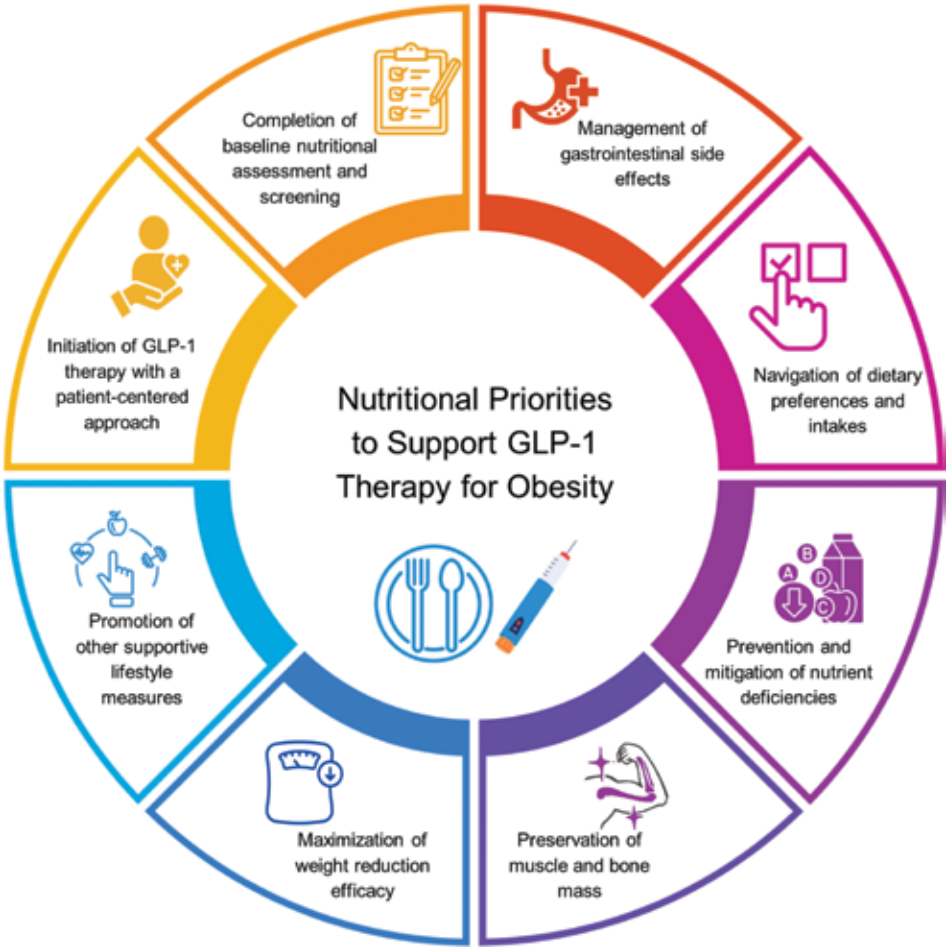
In Medicaid, the Federal Medicaid Drug Rebate Program requires coverage of all participating manufacturer FDA-approved drugs; however, there is an exception for the coverage of obesity medications. Therefore, while all state Medicaid programs must cover GLP-1 medications for diabetes and cardiovascular disease, as of August 2024, only 13 state Medicaid programs covered them for obesity.[945] All states offering coverage are using prior authorization and/or BMI requirements to manage utilization.[946] In 2023, GLP-1s accounted for 0.5 percent of all

Medicaid prescriptions, a 400 percent increase since 2019, and 3.7 percent of gross spending, an increase of more than 500 percent in just four years.[947] While additional state Medicaid programs may offer coverage in the coming years, the cost to state budgets is a top concern.[948] Reasons that states may expand coverage include positive health outcomes and longer-term savings on chronic diseases associated with obesity reduction, a desire to increase medication access for enrollees, recommendations from providers, and the potential for rebate negotiations.[949]

Commercial health insurance coverage of GLP-1 medications for obesity is also limited. While more than 40 percent of adults under age 65 with private insurance (57.4 million people) meet the clinical eligibility criteria for a GLP-1, only about 3 percent of privately insured individuals had an insurance claim for a GLP-1 in 2022.[950] Still, a KFF study found that increased use of GLP-1 medications is a contributor to rising marketplace health plan costs in 2025.[951] However, a April 2025 economic analysis of more than 50 million people in the commercial market, including 139,000 GLP-1 agonist users between 2022–2024, found that those who used GLP-1 medication had a slight initial increase in costs compared with matched controls, but by the end of a two-year period, their costs were lower.[952] In addition, those using GLP-1 medications had a 44 percent decrease in risk of hospitalization from heart disease or stroke during their first two years of medication use.[953]

It is also important to pair GLP-1 medications with wraparound services and supports for comprehensive obesity treatment for patients. Services like nutrition and behavioral therapy can help reduce certain side effects (for example, GLP-1 patients may be at risk of nutritional deficiencies due to calorie reduction and muscle and bone loss, which can be reduced with careful diet management and exercise), support nutritional changes in the long-term, and increase weight reduction after an initial period of weight loss.[954] A joint advisory from the American College of Lifestyle Medicine, the American Society for Nutrition, the Obesity Medicine Association, and the Obesity Society in the *American Journal of Clinical Nutrition* offers a patient-centered framework for adding GLP-1 medication to the current USPSTF-recommended behavioral interventions for weight reduction and weight reduction maintenance for adults with obesity.[955]

Nutritional Priorities to Support GLP-1 Therapy for Obesity



Source: American Journal of Clinical Nutrition[956]

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

U.S. spending on healthcare reached $4.9 trillion, or an average of $14,570 per person, in 2023, the most recent year for which data is available. Healthcare spending accounts for 17.6 percent of the nation's gross domestic product.[957] Hospitals and other healthcare facilities have a key role to play in preventing and reducing obesity. Potential strategies include healthcare provider training and continuing education, food is medicine programs, patient education and health promotion, sponsoring community benefit programs, and breastfeeding promotion.

Medical Education, Training, and Best Practices

Many health professionals lack training and competency in nutrition-related issues and knowledge of and confidence in treating obesity.[958,959,960,961] Surveys have shown that healthcare providers who are better trained to address nutrition and obesity feel more comfortable referring their patients to interventions.[962]

Comprehensive obesity education includes training about the complex, multifactorial causes of the disease and strategies for providing care free from weight bias and discrimination. 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.[963] Importantly, medical school training and continuing education should address the full range of effective treatments for obesity.

Despite the importance of nutrition and obesity education for healthcare providers, most physicians are not adequately trained on these issues. The majority of 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.[964,965] In 2022, the U.S. House of Representatives passed a resolution calling on medical schools, graduate medical education programs, and other health profession training programs to educate healthcare providers on nutrition.[966] In response, the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges, and the American Association of Colleges of Osteopathic Medicine hosted a summit on nutrition in medical education in March 2023 with the goal of identifying what residents need to know about nutrition and how nutrition in graduate medical education fits into the continuum of medical education.[967] These findings were presented in a October 2023 proceedings paper.[968] In April 2024, bipartisan members of Congress sent a letter to ACGME asking them to better incorporate nutrition into graduate medical education.[969] In September 2024, a group of 22 nutrition subject-matter experts and 15 residency program directors published a consensus statement outlining 36 proposed nutrition competencies for medical students and physician trainees.[970] This expert panel further recommended that the nutrition education competencies be evaluated through licensing examinations or board certification examinations,[971] which is not current practice. In addition to physicians, there is a need for other healthcare providers, such as nurses, nurse practitioners, and physician assistants, to improve their nutrition knowledge and training.[972]

Hospitals and other healthcare facilities can also promote nutrition and reduce obesity by creating health-promoting environments for patients, visitors, and staff. Strategies include:

- Serving nutritious foods and beverages, and promoting or subsidizing the healthier options;
- Sponsoring workplace wellness programs that include nutrition, physical activity, and behavioral supports, such as evidence-based lifestyle change interventions;
- Providing onsite fitness centers or reimbursing employees' physical activity-related expenses; and
- Designating a private space where employees can breastfeed or express milk.[973,974,975]

A number of healthcare systems have implemented programs focused on improving the nutritional quality of the foods served to patients, visitors, and staff. Through voluntary initiatives, over 700 hospitals, more than 10 percent of all hospitals nationwide, have set standards for nutrition, food labeling, food marketing, and food preparation.[976] For example, through the Good Food, Healthy Hospitals initiative in Pennsylvania, 63 hospitals across 27 counties have agreed to incorporate purchasing, positioning, pricing, and promotion strategies for healthier choices in patient meals, cafeteria and catering services, and vending.[977,978]

Food is Medicine

While there is 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") has gained traction in recent years.[979] The range of services, interventions, and programs included in the framework varies across definitions, with some focusing on the provision of healthy food to treat or manage specific clinical conditions within the healthcare sector.[980,981] Other definitions include a wider-range of food and nutrition assistance programs aimed at increasing food or nutrition security for certain populations, like those using SNAP or WIC, and additional population-level healthy food policies and programs that reach all Americans.[982]

Examples of FIM services include:[983]

- Medically tailored meal programs, which provide prepared, home-delivered meals tailored to an individual's dietary needs, such as those with diet-related health conditions and limitations on daily living;
- Food or produce prescription programs, which involve written "prescriptions" that can be redeemed for produce or other healthy foods;
- Nutrition education and teaching-kitchen programs.

Most FIM programs utilize registered dietitian nutritionists to tailor the intervention to the individual's needs and preferences and to deliver nutrition education and counseling.[984,985] In addition, social workers can help identify and refer patients with specific social needs, and electronic tools can support efficient screening, referral, and implementation.[986] These individual-level interventions are complementary to population-based strategies, like those described in the previous sections of the reports.

Research has shown that implementation of FIM interventions could improve health outcomes and healthcare costs. For example, national implementation of medically tailored meal programs in Medicare, Medicaid, and private insurance for individuals with a diet-

related condition and daily living limitations has been projected to prevent 1.6 million hospitalizations and save $13.6 billion in healthcare costs in one year.[987] Medically tailored meals have the potential to save costs in 49 of 50 states, with expected cost savings as high as $6,300 per patient.[988] An evaluation of produce prescription programs in nine states found that, after six months, they were effective in increasing participants' fruit and vegetable intake, reducing food insecurity, improving blood pressure among adults with high blood pressure, improving blood glucose control, and reducing BMI among adults with overweight and obesity.[989] The results of a nationally representative survey, published in April 2025, found that two-thirds of individuals thought that FIM should be covered by Medicare or Medicaid, and just over half said it should be covered by private insurance.[990]

The federal government, state governments, and nongovernmental organizations have expanded their investment in food-based health interventions in recent years. In September 2024, HHS released a FIM analytic toolkit. The toolkit included a range of resources, including foundational tools, case studies, information on federal policies and funding opportunities, continuing education resources for healthcare providers, and an analytic framework with priority measurement domains and metrics to support FIM evaluation.[991] Outside of government, the Food is Medicine Coalition, composed of FIM providers, announced an accreditation program for medically tailored meal providers in 2024, ensuring that all accredited providers deliver a consistent, high-quality medically tailored meal intervention,[992] paving the way for increased future coverage. Additional nonprofit, academic, industry, and philanthropic organizations, including the American Heart Association, the Food is Medicine Institute at Tufts University, and the Rockefeller Foundation, continue to lead and invest in FIM research and programs.[993,994,995,996]

Community Benefit Programs

To maintain their tax-exempt status, nonprofit hospitals—which constitute 58 percent of community hospitals in the United States[997]—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.[998] A recent study found that obesity was identified as a community health need in 71 percent of respondents' CHNAs.[999] Some ways that hospitals can partner with food-related community-based organizations to carry out CHNAs include reviewing available food-related community resources, interviewing or surveying local food and nutrition experts, including them in community health data review and health needs prioritization, and inviting them to join the CHNA steering/advisory committee.[1000]

Some examples of CHNA initiatives include:

- SSM Health in Southern Illinois identified food and nutrition insecurity as a leading challenge during its 2024 CHNA. To address these needs, its two hospitals established the onsite Bread Basket Program to provide temporary food assistance and resources for longer-term support. There is also a mobile market program that uses donated funds to purchase nutrient-dense foods for community members from local farms and food vendors.[1001]
- The El Paso Children's Hospital, one of seven children's hospitals in Texas, identified obesity as the top concern in its 2024 CHNA, noting high rates of obesity, prediabetes, and type 2 diabetes in the community it serves. Also deemed a priority in the hospital's 2021 CHNA, the hospital has since hired a registered dietitian, a certified diabetes educator, and a social worker; opened a teaching kitchen, which hosts live classes in partnership with a local community organization and community college culinary arts program; and partnered with another community-based organization to refer individuals with food insecurity to a food pharmacy.[1002]

Breastfeeding Programs

Breastfeeding provides many health benefits for both the mother and the child, including the potential for increased postpartum weight loss for the mother[1003,1004] and a lower risk of childhood obesity for the child.[1005,1006,1007,1008] The American Academy of Pediatrics and the WHO recommend exclusive breastfeeding for about the first six months of age and continued breastfeeding with the intake of complementary foods up to two years of age or longer.[1009,1010] About 83 percent of American infants are breastfed, with just over half of infants (56 percent) receiving any breast milk, and one in four infants being exclusively breastfed at 6 months old.[1011] Differences in breastfeeding initiation exist by racial/ethnic group and by state. Asian Americans are most likely to initiate breastfeeding, while Black Americans have the lowest breastfeeding initiation rate.[1012] Across states, breastfeeding is highest in Oregon, Washington, Alaska, and Colorado and lowest in Alabama, Rhode Island, West Virginia, and Mississippi.[1013] Common barriers to breastfeeding include a lack of in-hospital support, lack of workplace

support, and social/cultural norms.[1014] These barriers are often highest among parents of color. For example, Black parents are more likely to have inadequate workplace parental leave.[1015]

To support increased breastfeeding, the Baby-Friendly Hospital Initiative is a global program to recognize and assist hospitals in giving mothers the information, confidence, and skills to initiate and continue breastfeeding and to safely prepare infant formula, when there is a medical indication to do so or when the mother has made an informed decision not to breastfeed. A joint program of the WHO and the United Nations Children's Fund (UNICEF) encourages implementation of the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes.[1016] About one in four infants in the United States is born at one of about 600 facilities designated as "baby-friendly" by WHO and UNICEF, compared with fewer than 3 percent in 2007.[1017] There are baby-friendly hospitals in all U.S. states, the District of Columbia, and Puerto Rico.[1018]

Federal law also addresses workplace barriers to continued breastfeeding. Under the Fair Labor Standards Act, most workers have the right to a reasonable break time and a private place that is not a bathroom to pump breast milk for a nursing child up to one year after birth.[1019] Research has shown that workplace interventions, including designating spaces for breastfeeding or pumping and co-worker support, have positive impacts on breastfeeding duration, exclusivity, confidence, and support.[1020]

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.

Neighborhood food access in early life and trajectories of child body mass index and obesity

JAMA Pediatrics, November 2024

This study looked at links between neighborhood food access during pregnancy and through early childhood; later, the study assessed BMI and obesity risk at ages 5, 10, and 15. The researchers found higher BMIs, higher obesity risks, and higher severe obesity risks for youth who lived in low-income and low-food-access neighborhoods during their mothers' pregnancy or their early childhood. These findings held true after adjusting individual sociodemographic characteristics and across the three ages studied.[1021]

A digital health behavior intervention to prevent childhood obesity: the greenlight plus randomized clinical trial

JAMA, November 2024

Researchers ran a randomized controlled trial testing whether adding digital interventions—text messaging and a web dashboard linked to health behavior counseling for parents by pediatric primary care clinicians—can improve health outcomes for children in their first two years of life. The study, the Greenlight Plus Trial, took place at six large medical centers across the United States and included a racially and ethnically diverse population. They found that the digital intervention improved the children's weight-for-length trajectory and reduced obesity rates.[1022]

The diabetes prevention program and its outcomes study: NIDDK's journey into the prevention of type 2 diabetes and its public health impact

American Diabetes Association's Diabetes Care, April 2025

This article looks back at the short- and long-term health impact of the Diabetes Prevention Program, which began 1996. After 2.8 years, DPP showed that intensive lifestyle intervention and treatment with metformin reduced the risk of developing diabetes among a high-risk population with prediabetes (58 percent and 31 percent lower risk, respectively). After 21 years, the interventions still showed a positive impact (24 percent and 17 percent lower risk).[1023]

Energy expenditure and obesity across the economic spectrum

PNAS, July 2025

In a cross-sectional study, researchers compared the role of increased calorie intake versus reduced energy expenditure (e.g., physical activity) in rising obesity rates across countries with varying rates of economic development. They found that countries with higher economic development had higher average BMI and body fat, higher calorie intake, higher consumption of ultra-processed foods, and higher energy expenditure. The researchers concluded that the higher calorie intake is a much more important factor than physical activity changes in the rising rate of obesity in countries with higher economic development.[1024]

Recommendations

Federal public health and nutrition systems are in a period of upheaval. The White House appointed a Make America Healthy Again Commission with a stated goal of reducing chronic disease and eliminating childhood chronic disease. At the same time, the administration has proposed significant restructuring of federal agencies and has carried out workforce reductions across the federal government. Due to workforce cuts across the U.S. Department of Health and Human Services (HHS) since the beginning of 2025, a *ProPublica* analysis estimated the Centers for Disease Control and Prevention (CDC) lost at least 15 percent of its staff, the U.S. Federal Drug Administration (FDA) lost 21 percent, and National Institutes of Health (NIH) lost 16 percent.[1025] The U.S. Department of Agriculture (USDA) also lost an estimated 20 percent of its workforce.[1026] The president's FY 2026 budget request proposed cutting more than 50 percent of CDC's overall budget and eliminating 98 percent of the work of the National Center for Chronic Disease Prevention and Health Promotion.[1027] This would lead to the end of support for State Physical Activity and Nutrition Programs and other programs that help states address and prevent diabetes, heart disease and stroke, and other chronic diseases. The administration has also called for restructuring USDA, including reducing the number of Food and Nutrition Service (FNS) hubs and closing the FNS headquarters. The loss of technical assistance, expertise, funding, and epidemiological and research support from the federal government will have significant impacts across the country.

Amid these significant changes, TFAH offers the following policy recommendations for federal, state, and local governments and other sectors in five areas:

1. Strategically dedicate federal resources to efforts that reduce obesity 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 poor health outcomes;
4. Make physical activity and the built environment safer and more accessible for all; and
5. Work with the healthcare system to close disparities and gaps in clinic-to-community settings.

1. Strategically Dedicate Federal Resources to Efforts that Reduce Obesity and Related Conditions.

The federal government plays a critical role in creating resources and programs that can prevent and reduce obesity. Grants and other resources should prioritize funding to communities most impacted by obesity to create a foundation of flexible funding, resources, and technical assistance tailored to a community's specific needs.

Recommendations for the federal government:

- **Congress and HHS should increase capacity to prevent obesity and related chronic diseases.** Congress and HHS should retain the National Center for Chronic Disease Prevention and Health Promotion at CDC and increase funding 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 the implementation of effective multisector campaigns to prevent and reduce obesity.

- **Congress should increase funding for initiatives that reduce health disparities, such as CDC's Racial and Ethnic Approaches to Community Health (REACH) and Healthy Tribes programs, which deliver 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 out of the REACH funding line and provides tribes and 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.

- **The administration should prioritize the preservation of key public health functions that focus on obesity prevention and treatment through identification and implementation of evidence-based interventions, quality standards, and epidemiologic surveillance of chronic diseases.** The National Center for Chronic Disease Prevention and Health Promotion and the Division of Nutrition, Physical Activity, and Obesity provide national guidance, training, grants, technical assistance, and data tools that millions of health professionals rely on.

- **Congress and state policymakers should address economic factors that contribute to obesity.** Poverty is a significant contributor to obesity and other chronic diseases.[1028] Multifaceted approaches, including providing a living wage, further expanding the child tax credit and earned income tax credit, and access to safe, healthy, and affordable housing can reduce poverty and improve population health.[1029,1030,1031] For further discussion of TFAH's policy recommendations on economic well-being, see the report *Promoting Health and Cost Control in States.*[1032]

- **Federal agencies should adapt federal grantmaking practices to increase transparency and 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, and historical underfunding 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, increasing the transparency of the application process helps organizations navigate federal funding opportunities and makes federal funding applications simpler and easier to navigate, which all agencies should implement.

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 on 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.[1033] 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 on the federal child tax credit, a number of states have followed suit and enacted child tax credit programs of their own.[1034] States should consider implementing new or strengthening existing policies. Seventeen states have enacted a child tax credit, including Oklahoma, Maine, and Idaho.[1035]
- **Enhance the state earned income tax credit.** More states can work to make their earned income tax credit (EITC) refundable, similar to the federal government policy. A refundable EITC allows working households to keep the full value of their credit, even if it exceeds their income tax liability. This means the credit can help offset the taxes they owe, and the rest is refunded to them. States can also work to increase their EITC match rate, which refers to the percentage of the federal EITC that a state or local government provides as its own EITC. Research suggests that those living in states with the most generous refundable tax credits experienced significant declines in food insecurity.[1036]

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 critical role in improving food and nutrition security of millions of Americans. In FY 2024, the Supplemental Nutrition Assistance Program (SNAP) helped 41.7 million people[1037] with an average monthly benefit of $187,[1038] while the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provided healthy foods and nutrition services to 6.7 million participants.[1039] Critically, by supporting nutrition security, SNAP helps people be healthier and is linked to reduced healthcare costs.[1040] However, new work requirements mean millions more people are facing administrative hurdles to reaching SNAP benefits, which puts at risk long-term efforts to reduce chronic diseases.[1041]

Recommendations for the federal government:

- **Congress should reverse enacted cuts to SNAP, including newly changed work requirements,** and not shift the cost burden for the SNAP program onto states that have limited budgets. By restricting access to SNAP, families are at higher risk of food and nutrition insecurity and could be more likely to develop nutrition-related chronic diseases.[1042]
- **Congress and USDA should increase healthy food benefits in SNAP.** Congress should reinstate and 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.
- **Congress should ensure full funding for WIC.** WIC has proved effective at reducing obesity and promoting good health,[1043,1044] in part due to the 2009 changes to the food package that align the nutritional quality of WIC foods with independent scientific recommendations from the National Academies.[1045,1046] Congress should ensure there is proper funding to fully fund WIC and uphold the decades long, bipartisan commitment to providing benefits to all families eligible for the program. In addition, Congress should protect the increase in the overall value of the WIC benefit.
- **Congress and USDA should 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 benefit cards. These steps will modernize the WIC program to make it more flexible and will allow more families to access WIC's effective interventions by reducing duplicative paperwork requirements for both the participants and service providers.
- **Congress should make healthy school meals for all permanent as a step to end child hunger and ensure access to healthy foods.** Doing so would provide free healthy meals to children regardless of income, eliminate school meal debt and lunch shaming, reduce program financial loss[1047] and administrative costs, and incentivize local food procurement. Congress should also increase funding for outreach to ensure the enrollment of eligible children and families for school meals and the Summer Electronic Benefit Transfer, referred to as "SUN Bucks".[1048]
- **USDA and Congress should strengthen school nutrition standards.** USDA should maintain the progress of the final 2024 nutrition meal standards and work to fully align them with science-based recommendations. Congress should provide USDA the resources needed to offer technical assistance, training, and peer-to-peer learning collaboratives. USDA should also consider performance-based incentives, and work with industry to provide foods that meet the new standards in phases to allow schools adequate time to adjust to improved nutrition levels.
- **Congress, states, and localities should encourage Community Eligibility Provision (CEP) enrollment and should expand eligibility.** CEP has allowed over 47,000 schools, about half of all schools that participate in school

meals, to offer them at no charge to all students.[1049] CEP provides meals for all enrolled students if 25 percent or more of the 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.[1050] Congress should appropriate additional funding to increase meal reimbursements to further incentivize schools to implement CEP.[1051]

- **FDA should create and implement a mandatory front-of-package nutrition label system for packaged foods to help consumers make informed choices.** Front-of-package nutrition labels have been proven to help consumers make better choices by putting simplified, essential nutrition information on the front of packaged food products.[1052,1053]
- **Federal agencies should 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.[1054] Federal and other facilities should improve the nutritional quality of the food they provide by uniformly implementing the Food Service Guidelines for Federal Facilities.[1055]
- **Congress should expand access to the Child and Adult Care Food Program (CACFP).** Low-income preschoolers attending childcare centers participating in CACFP are less likely to have obesity than similar children attending nonparticipating centers.[1056] 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.
- **Congress should increase 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; Maternal, Infant, and Early Childhood Home Visiting; and the WIC Breastfeeding Peer Counseling Program.[1057] Breastfeeding has been shown to contribute to multiple positive health outcomes, including the prevention of childhood obesity.[1058] 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.[1059,1060]

Recommendations for state/local government:

- **States and localities should support access to healthy school meals.** States and localities should continue strengthening school nutrition standards by working to align them 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 maintain flexibility to expand access to nutrition for students, such as second-chance breakfasts, breakfast on-the-go, and breakfasts in classrooms.
- **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.
- **States should 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 child nutrition programs administered by USDA and available to families in their jurisdiction.

3. Change the Marketing and Pricing Strategies That Lead to Poor Health Outcomes

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.[1061,1062]

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.[1063,1064] Policies in several communities show clear evidence that this approach works to reduce the consumption of sugary drinks.[1065,1066]

Recommendations for the federal government:

- **Congress should decrease 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.[1067]
- **Federal agencies should 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.
- **FDA should improve the accuracy of information about nutrition for children.** As part of FDA's work on front-of-package nutrition labels, the agency should also 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.[1068,1069] 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.
- **Lawmakers should discourage overconsumption of sugar through taxation policy.** 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:

- **Communities should reduce unhealthy food marketing to children at the local level.** Local education agencies and communities should consider incorporating strategies into their local wellness policies that further reduce unhealthy food and beverage marketing and advertising to children and adolescents. Examples include prohibiting coupons, sales, and advertising around schools and school buses, and banning sugary drinks as branded sponsors of youth sporting events.[1070]

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

While individual people can take actions to increase physical activity, 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. For example, communities can strengthen public transportation options, ensure that children have daily opportunities for physical activity inside and outside of school, and create 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 structural discrimination.

Recommendations for the federal government:

- **Congress should fund programs that support physical education and healthier schools.** Given the positive connection between increasing physical activity levels and improving mental health,[1071] Congress should increase funding for the Student Support and Academic Enrichment grant program (under Every Student Succeeds Act Title IV, Part A) to $1.6 billion[1072] 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 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.[1073] The guidelines were last updated in 2018.
- **Congress and the Department of Transportation (DOT) should continue to fund active transportation in all communities, with a focus on those with the greatest need.** The Infrastructure Investment and Jobs Act set aside funding for states and communities to develop Complete Streets plans, but that funding is set to expire. DOT should also set strong guidance on what qualifies for a complete street 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.
- **DOT should take actions to 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 by partnering with out-of-school providers for before and after-school activities, 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.[1074]
- **Localities should enact policies to 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 community members outside of school hours.
- **States and cities should enact Complete Streets and other complementary streetscape design policies to improve active transportation and to increase outdoor physical activity opportunities.**
- **States should 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, engaging community residents to ensure the development meets their needs.

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.[1075,1076] 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:

- **Congress should reverse cuts to Medicaid and marketplace subsidies.** Ensuring that a person has access to and can afford adequate healthcare is fundamental to treating obesity as a chronic disease. Congress should swiftly reverse the cuts to Medicaid, including by maintaining the federal match percentage to pay for the program, and barriers to accessing the program like work requirements.
- **HHS and other federal agencies should strengthen and enforce the U.S. Preventive Services Task Force recommendations for obesity prevention.** Any A or B grade preventive services provided by the U.S. Preventive Services Task Force (USPSTF) should continue to be offered 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.[1077] 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.
- **Congress should renew the Childhood Obesity Research Demonstration.** Congress should appropriate funding to re-start the Childhood Obesity Research Demonstration to inform how to translate USPSTF recommendations into lifestyle interventions and clinical interventions.
- **Expand opportunities for public health and healthcare coordination.** HHS, payors, 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.
- Medicare should expand coverage of weight management and obesity-related services, such as obesity and nutritional counseling provided by registered dietitians, obesity medications, and bariatric surgery.[1078]
- **The Centers for Medicare and Medicaid Services (CMS), and healthcare systems and payers should prioritize strategies to address health-related social needs.** CMS should reinstate its health-related social needs guidelines from 2023[1079] and 2024.[1080] In the interim, states, insurers, and healthcare facilities should continue efforts to manage these underlying non-medical needs of patients. 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; and 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.
- **Congress should 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.[1081]

Recommendations for state/local governments:

- **Ensure all eligible recipients continue to receive Medicaid.** States should work to minimize the amount of eligible people incorrectly removed from Medicaid rolls due to missing paperwork or other administrative issues.
- **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.[1082] State Medicaid programs should also expand coverage of obesity-related services, such as obesity medications, bariatric surgery, and obesity and nutritional counseling provided by professionals like registered dietitians.
- **Build and support the 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.

Appendix: Obesity-Related Indicators and Policies By State

This appendix covers indicators spanning state-level conditions, policies, and performance measures across six themes: (1) Community Conditions, (2) Built Environment and Active Transportation, (3) Food Insecurity, (4) Nutrition Assistance Programs, (5) Childcare and School Nutrition, and (6) Miscellaneous. 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 (2023)		Educational Attainment (2023)	Health Insurance Coverage (2023)
	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?[1]	What percentage of people age 25 and older have a bachelor's degree or higher?[2]	What percentage of residents ages 0–64 are uninsured?[3*]
Alabama	14%	21%	29%	10%
Alaska	10%	10%	32%	12%
Arizona	12%	17%	34%	12%
Arkansas	14%	21%	26%	11%
California	12%	16%	38%	7%
Colorado	9%	9%	46%	8%
Connecticut	8%	11%	43%	7%
Delaware	8%	10%	37%	9%
D.C.	13%	19%	66%	3%
Florida	12%	16%	35%	13%
Georgia	13%	16%	35%	13%
Hawaii	8%	13%	37%	4%
Idaho	9%	8%	32%	11%
Illinois	10%	14%	38%	7%
Indiana	8%	10%	30%	8%
Iowa	8%	10%	32%	6%
Kansas	9%	13%	36%	10%
Kentucky	14%	20%	28%	7%
Louisiana	22%	29%	27%	8%
Maine	7%	12%	37%	8%
Maryland	9%	12%	44%	8%
Massachusetts	9%	10%	48%	3%
Michigan	12%	19%	33%	5%
Minnesota	7%	9%	40%	5%
Mississippi	16%	24%	26%	13%
Missouri	10%	15%	33%	9%
Montana	8%	10%	35%	11%
Nebraska	9%	11%	35%	8%
Nevada	14%	20%	29%	13%
New Hampshire	6%	8%	41%	6%
New Jersey	9%	12%	44%	8%
New Mexico	17%	24%	32%	11%
New York	11%	17%	41%	6%
North Carolina	14%	20%	37%	11%
North Dakota	10%	13%	34%	5%
Ohio	11%	15%	32%	7%
Oklahoma	13%	18%	29%	14%
Oregon	10%	16%	38%	7%
Pennsylvania	10%	16%	35%	7%
Rhode Island	9%	9%	39%	5%
South Carolina	12%	15%	33%	11%
South Dakota	8%	9%	33%	10%
Tennessee	11%	11%	32%	11%
Texas	12%	17%	34%	19%
Utah	6%	5%	38%	9%
Vermont	7%	9%	44%	4%
Virginia	9%	14%	42%	8%
Washington	9%	10%	41%	8%
West Virginia	13%	17%	24%	8%
Wisconsin	9%	13%	34%	6%
Wyoming	9%	9%	30%	13%
Total	**11%**	**15%**	**29%**	**10%**

Sources and Notes:

1. U.S. Census Bureau. "POV-11. Poverty Status by State." August 2024. https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-11.html#10050. Accessed July 11, 2025.
2. U.S. Census Bureau. "S1501 Educational Attainment." https://data.census.gov/table?q=population%20by%20educational%20attainment&t=Education:Populations%20and%20People&g=010XX00US,$0400000. Accessed July 11, 2025.
3. KFF. "Health Insurance Coverage of Nonelderly 0-64" https://www.kff.org/other/state-indicator/nonelderly-0-64/. Accessed July 11, 2025.

*Estimates based on U.S. Census Bureau's American Community Survey.

Built Environment and Active Transportation

	Neighborhood Sidewalks and Parks (2022-2023)		Complete Streets Policy Strength (2024)	Walking/Biking/Safe Routes to School Criteria (2024)	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[2]?	How strong is a state's Complete Streets score?[3]* (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?[3]	What is the state's overall Making Strides score—a Built Environment and Active Transport indicator?[3]** (Score out of 200)
Alabama	52%	53%	0		38
Alaska	69%	68%	0	√	60
Arizona	88%	81%	0	√	87
Arkansas	54%	59%	0		41
California	90%	85%	20	√	174
Colorado	92%	89%	18	√	172
Connecticut	71%	82%	16	√	123
Delaware	75%	68%	11	√	107
D.C.	98%	93%	11		135
Florida	76%	69%	8	√	145
Georgia	62%	63%	13		87
Hawaii	85%	89%	11	√	132
Idaho	77%	71%	0		96
Illinois	86%	87%	3		128
Indiana	72%	67%	11		88
Iowa	82%	79%	15		90
Kansas	79%	78%	0		149
Kentucky	63%	58%	13	√	73
Louisiana	58%	56%	15		93
Maine	60%	71%	12	√	124
Maryland	79%	84%	11	√	120
Massachusetts	86%	87%	19	√	150
Michigan	74%	77%	14		145
Minnesota	81%	86%	16	√	149
Mississippi	45%	46%	5		52
Missouri	69%	70%	2		26
Montana	74%	78%	0		64
Nebraska	89%	83%	0		32
Nevada	92%	80%	16		99
New Hampshire	63%	75%	0		37
New Jersey	88%	90%	13	√	148
New Mexico	81%	73%	1		53
New York	81%	88%	13	√	62
North Carolina	58%	59%	11		86
North Dakota	82%	83%	0	√	55
Ohio	77%	78%	0	√	107
Oklahoma	53%	63%	0	√	74
Oregon	82%	81%	6		142
Pennsylvania	73%	79%	9	√	98
Rhode Island	77%	80%	11	√	94
South Carolina	56%	54%	10		80
South Dakota	80%	78%	0		53
Tennessee	53%	57%	13		96
Texas	79%	77%	5		79
Utah	94%	90%	6	√	106
Vermont	65%	71%	8	√	102
Virginia	73%	76%	12	√	108
Washington	80%	78%	16		162
West Virginia	50%	55%	14	√	45
Wisconsin	75%	83%	7		54
Wyoming	83%	78%	0	√	69
Total	**76%**	**76%**	**N/A**	**25 states**	**NA**

Sources and Notes:

1. National Survey of Children's Health. "Interactive Data Query: In your neighborhood, are there sidewalks or walking paths?" https://nschdata.org/browse/survey/allstates?q=11352. Accessed July 11, 2025.
2. National Survey of Children's Health. "Interactive Data Query: In your neighborhood, is there a park or playground?" https://nschdata.org/browse/survey/allstates?q=11353. Accessed July 11, 2025.
3. Johnson, Kori, Marisa Jones, and Natasha Riveron. "Making Strides 2024: State Report Cards on Support for Walking, Bicycling, and Active Kids and Communities". Safe Routes Partnership, 2024. https://www.saferoutespartnership.org/sites/default/files/resource_files/090624-SR2S-Making-Strides-2024-FINAL.pdf. Accessed September 2, 2025.

*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 for stronger policies.

** Report cards summarize 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.

	Food Insecurity				Nutrition Assistance Programs	
	Food Insecurity (2023)		Food Insecure Above SNAP Threshold (2022)	Average Cost Per Meal (2023)	SNAP Participation (2022)	Special Supplemental Nutrition Program for WIC Participation (2022)
	What percentage of households experience low or very low food security? (Average 2021–2023)[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?[2]	What is the average cost per meal in the state?[2]	What percentage of people eligible participate in SNAP?[3]	What percentage of people eligible participate in the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC)?[4]*
Alabama	12%	22%	52%	$3.50	90%	50%
Alaska	10%	18%	55%	$4.23	73%	53%
Arizona	12%	18%	42%	$3.32	77%	55%
Arkansas	19%	24%	51%	$3.22	59%	40%
California	11%	17%	37%	$3.63	81%	70%
Colorado	10%	14%	48%	$3.73	100%	47%
Connecticut	10%	17%	43%	$3.67	98%	47%
Delaware	11%	18%	45%	$3.54	91%	57%
D.C.	9%	15%	44%	$4.41	100%	47%
Florida	12%	18%	39%	$3.69	81%	53%
Georgia	13%	20%	57%	$3.55	92%	41%
Hawaii	10%	21%	50%	$4.39	81%	61%
Idaho	11%	16%	63%	$3.77	73%	45%
Illinois	12%	16%	49%	$3.58	100%	39%
Indiana	12%	19%	56%	$3.20	89%	60%
Iowa	10%	17%	51%	$3.40	98%	55%
Kansas	11%	18%	60%	$3.42	79%	46%
Kentucky	15%	21%	30%	$3.19	75%	63%
Louisiana	16%	23%	32%	$3.37	99%	37%
Maine	11%	21%	42%	$3.76	94%	58%
Maryland	10%	16%	47%	$3.71	85%	58%
Massachusetts	8%	13%	42%	$3.96	100%	65%
Michigan	13%	19%	37%	$3.37	100%	62%
Minnesota	9%	14%	42%	$3.74	93%	66%
Mississippi	16%	23%	50%	$3.37	74%	46%
Missouri	13%	18%	59%	$3.47	92%	41%
Montana	11%	17%	41%	$3.45	75%	47%
Nebraska	13%	19%	50%	$3.34	93%	63%
Nevada	13%	20%	38%	$3.47	98%	47%
New Hampshire	7%	14%	53%	$3.70	82%	49%
New Jersey	10%	14%	45%	$3.74	91%	53%
New Mexico	13%	23%	24%	$3.32	100%	39%
New York	12%	19%	35%	$3.78	91%	59%
North Carolina	11%	19%	38%	$3.50	95%	64%
North Dakota	9%	14%	46%	$3.43	81%	54%
Ohio	13%	20%	56%	$3.39	99%	41%
Oklahoma	15%	24%	55%	$3.35	98%	52%
Oregon	13%	18%	40%	$3.80	100%	61%
Pennsylvania	11%	18%	41%	$3.61	100%	41%
Rhode Island	10%	15%	44%	$3.80	100%	54%
South Carolina	14%	17%	53%	$3.41	76%	42%
South Dakota	9%	18%	56%	$3.51	84%	57%
Tennessee	12%	20%	55%	$3.60	84%	44%
Texas	17%	22%	44%	$3.11	74%	53%
Utah	11%	17%	66%	$3.44	76%	41%
Vermont	9%	14%	50%	$3.93	99%	73%
Virginia	10%	14%	39%	$3.64	83%	50%
Washington	10%	17%	45%	$3.83	100%	53%
West Virginia	14%	20%	34%	$3.21	98%	57%
Wisconsin	11%	16%	42%	$3.52	100%	54%
Wyoming	13%	21%	59%	$3.51	63%	45%
Total	**12%**	**19%**	**37%**	**$3.58**	**88%**	**54%**

Sources and Notes:

1. Rabbitt, Matthew P., et al. "Household Food Security in the United States in 2023." (Report No. ERR-337). USDA Economic Research Service, September 2024. https://www.ers.usda.gov/publications/pub-details?pubid=109895. Accessed September 2, 2025.
2. Feeding America. "Map the Meal Gap 2025." May 2025. https://map.feedingamerica.org/county/2023/child. Accessed July 11, 2025.
3. Cunnyngham, Karen. "Empirical Bayes Shrinkage Estimates of State Supplemental Nutrition Assistance Program Participation Rates: Fiscal Year 2020 and Fiscal Year 2022." Prepared by Mathematica for USDA Food and Nutrition Service. February 2025. https://www.mathematica.org/publications/empirical-bayes-shrinkage-estimates-of-state-supplemental. Accessed September 2, 2025. .
4. USDA Food and Nutrition Service. "National- and State-Level Estimates of WIC Eligibility and Program Reach in 2022." August 2024. https://www.fns.usda.gov/research/wic/eer-2022. Accessed July 11, 2025.

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

Nutrition Assistance Programs Continued

	WIC Breastfeeding Performance Measurements (FY 2023)	Medicaid Waivers for Nutrition Support Programs (2024)	Medicaid Food Insecurity Screening and Referral Programs (2024)	TEFAP Food Costs (FY 2024)
	What was the percentage of infants in the WIC program breastfeed (fully or partially)?[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]*	What was the state's total estimated food grant under The Emergency Food Assistance Program (TEFAP)?[4]*
Alabama	18%			$6,804,379
Alaska	52%			$905,889
Arizona	37%	√	√	$9,869,284
Arkansas	21%	√		$4,462,359
California	47%	√	√	$55,435,982
Colorado	43%		√	$6,219,934
Connecticut	43%			$4,449,854
Delaware	41%	√	√	$1,265,531
D.C.	45%		√	$1,099,832
Florida	46%	√		$26,470,066
Georgia	36%	√	√	$13,646,456
Hawaii	54%	√	√	$1,613,236
Idaho	51%			$2,078,688
Illinois	39%	√		$17,943,407
Indiana	38%			$8,601,281
Iowa	38%		√	$3,677,906
Kansas	38%	√		$3,521,214
Kentucky	31%			$7,020,383
Louisiana	24%			$7,586,377
Maine	43%		√	$1,486,117
Maryland	49%	√		$6,298,153
Massachusetts	45%	√	√	$8,203,002
Michigan	31%		√	$14,385,616
Minnesota	47%			$6,196,071
Mississippi	21%			$4,847,993
Missouri	31%			$7,526,484
Montana	40%			$1,282,372
Nebraska	41%		√	$2,117,131
Nevada	38%		√	$5,108,565
New Hampshire	42%		√	$1,189,101
New Jersey	51%	√		$10,782,793
New Mexico	42%	√		$3,359,165
New York	54%	√	√	$29,399,574
North Carolina	31%	√	√	$14,164,936
North Dakota	37%			$817,050
Ohio	19%		√	$16,517,466
Oklahoma	24%		√	$5,629,802
Oregon	45%	√	√	$6,060,545
Pennsylvania	25%	√		$17,645,439
Rhode Island	36%		√	$1,258,632
South Carolina	29%		√	$6,920,086
South Dakota	38%			$995,891
Tennessee	37%		√	$9,282,866
Texas	62%		√	$44,219,961
Utah	50%			$3,035,052
Vermont	56%	√	√	$688,193
Virginia	31%		√	$9,864,138
Washington	51%	√	√	$10,156,618
West Virginia	23%		√	$2,849,258
Wisconsin	33%		√	$6,467,473
Wyoming	40%			$750,632
Total	**NA**	**19 states**	**27 states and DC**	**$453,755,410**

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*Total FY24 food grant levels (not including FY23 carryover).

Childcare and School Nutrition

	Obesity Prevention in Early Care and Education (2023)	School Lunch Index Score (2025)	School Breakfast Program (2023–2024)	SUN Bucks (2025)	Community Eligibility Provision (2022–2023)	Universal Free School Meals (as of May 2025)
	How well do the state's licensing regulations for childcare centers support high-impact obesity prevention standards?[1]* (Score out of 100)	What is the state's School Lunch Index Score (representing the 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 in 2025?[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	57	30	59%	√	85%	
Alaska	71	59	55%		86%	√b
Arizona	55	39	52%	√	70%	√b
Arkansas	75	51	66%	√	70%	√b
California	68	45	58%	√	80%	√a
Colorado	76	56	52%	√	82%	√a
Connecticut	65	48	56%	√	80%	√*
Delaware	81	69	63%	√	87%	√b
D.C.	74	70	83%	√	98%	√b
Florida	71	48	48%		73%	√b
Georgia	71	54	62%		83%	
Hawaii	66	76	39%	√	77%	√b
Idaho	32	44	48%		77%	
Illinois	80	34	53%	√	73%	√b
Indiana	50	33	54%		50%	
Iowa	66	40	48%		25%	√b
Kansas	47	38	53%	√	24%	√b
Kentucky	64	47	67%	√	97%	
Louisiana	73	36	59%	√	97%	
Maine	61	57	68%	√	75%	√a
Maryland	73	38	59%	√	83%	√b
Massachusetts	44	53	58%	√	97%	√a
Michigan	73	44	65%	√	72%	√a
Minnesota	65	46	56%	√	41%	√a
Mississippi	69	17	63%		84%	
Missouri	51	27	66%	√	43%	√b
Montana	63	48	60%	√	83%	√b
Nebraska	63	39	47%	√	49%	√b
Nevada	67	42	57%	√	94%	√*
New Hampshire	70	50	47%	√	25%	
New Jersey	79	39	65%	√	54%	√b
New Mexico	69	43	72%	√	100%	√a
New York	74	59	55%	√	99%	√a
North Carolina	76	47	61%	√	82%	√b
North Dakota	49	47	55%	√	100%	√b
Ohio	50	38	59%	√	78%	√b
Oklahoma	72	13	56%		48%	
Oregon	50	63	53%	√	88%	√b
Pennsylvania	48	45	60%	√	72%	√b
Rhode Island	76	62	59%	√	66%	√b
South Carolina	66	59	60%		95%	√b
South Dakota	38	20	49%		100%	√b
Tennessee	83	45	63%		82%	√b
Texas	82	49	60%		65%	
Utah	70	43	36%	√	95%	
Vermont	72	82	68%	√	96%	√a
Virginia	66	64	65%	√	97%	√b
Washington	80	47	52%	√	94%	√b
West Virginia	80	70	87%	√	98%	
Wisconsin	69	35	54%	√	59%	√b
Wyoming	41	40	46%		90%	
Total	**N/A**	**N/A**	**58%**	**37 states and DC**	**74%**	**9 states passed; 26 states and DC considering**

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Miscellaneous				
	Medicaid Coverage of Obesity Medication (as of August 2024)	**Food Additives and Dyes Legislation (as of April 2025)**	**Estimated SNAP Benefit Reductions Due to The One Big Beautiful Bill Act (2025)**	
	Which state Medicaid programs cover GLP-1s for treating obesity?[1]	Which states have passed or considered legislation to prohibit food dyes or other additives?[2]	How many families will lose some or all of SNAP benefits?[3]	What is the average monthly SNAP benefit reduction?[3]
Alabama		√	378,000	$91
Alaska			27,000	$181
Arizona		√	449,000	$135
Arkansas		√	130,000	$75
California	√	√	3,121,000	$190
Colorado			298,000	$88
Connecticut		√	237,000	$193
Delaware	√	√	64,000	$162
D.C.			76,000	$231
Florida		√	1,653,000	$114
Georgia			729,000	$118
Hawaii		√	94,000	$183
Idaho			62,000	$77
Illinois		√	1,102,000	$184
Indiana		√	279,000	$86
Iowa		√	134,000	$83
Kansas	√		92,000	$72
Kentucky		√	265,000	$105
Louisiana		√	406,000	$103
Maine			101,000	$122
Maryland		√	369,000	$150
Massachusetts	√	√	656,000	$192
Michigan	√	√	796,000	$159
Minnesota	√		227,000	$103
Mississippi	√		198,000	$104
Missouri		√	318,000	$89
Montana			43,000	$80
Nebraska			77,000	$99
Nevada			265,000	$167
New Hampshire	√		44,000	$104
New Jersey		√	424,000	$182
New Mexico			246,000	$167
New York		√	1,701,000	$190
North Carolina	√	√	784,000	$118
North Dakota			24,000	$93
Ohio			717,000	$96
Oklahoma		√	330,000	$116
Oregon		√	424,000	$138
Pennsylvania	√		1,059,000	$167
Rhode Island	√	√	88,000	$181
South Carolina		√	299,000	$103
South Dakota			34,000	$105
Tennessee		√	374,000	$93
Texas		√	1,514,000	$83
Utah		√	77,000	$83
Vermont		√	40,000	$94
Virginia	√	√	447,000	$112
Washington			517,000	$150
West Virginia		√	166,000	$85
Wisconsin	√		375,000	$81
Wyoming			15,000	$81
Total	**13 states**	**30 states**	**22.3 million**	**$146**

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1730 M Street, NW, Suite 900
Washington, DC 20036
(t) 202-223-9870
(f) 202-223-9871