ISSUE REPORT | SEPTEMBER 2026

STATE OF OBESITY:

Better Policies for a Healthier America

SPECIAL FEATURE: How the Dietary Guidelines for Americans Shape Food and Nutrition Programs

Trust for America's Health 25 YEARS

Acknowledgments

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View this report online at tfah.org/stateofobesity2026.

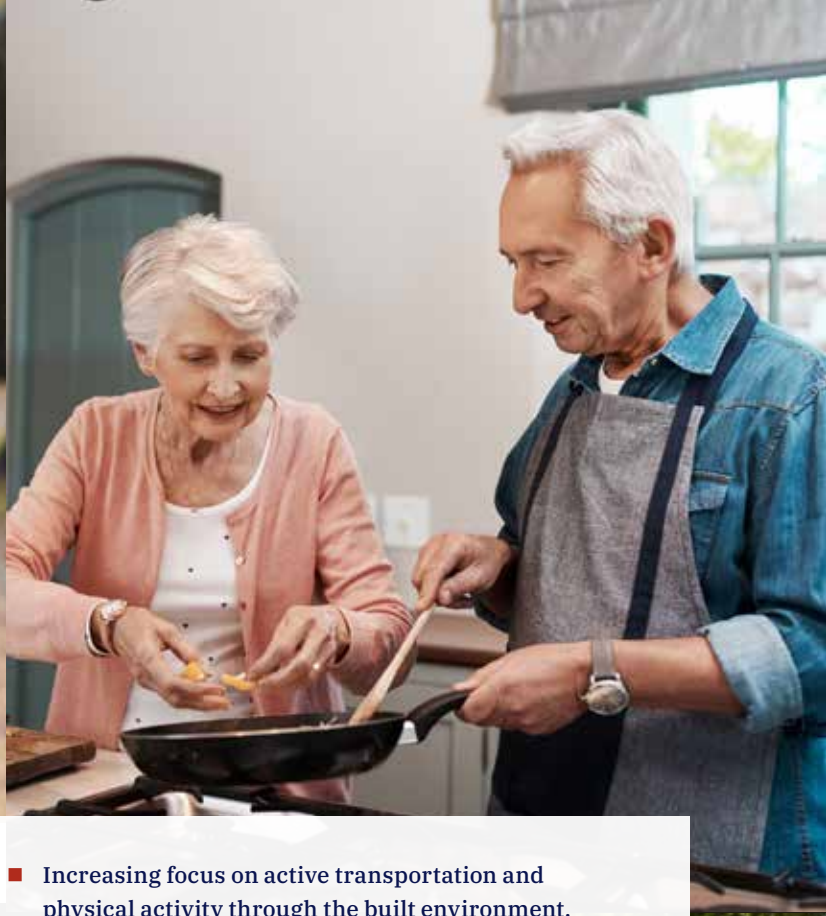
Editor's note: *Editorial work on the report was completed in August 2026, with select updates made in September. The content reflects the status of ongoing and proposed federal actions as of that time.*

LIST OF ACRONYMS AND ABBREVIATIONS

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
Childhood Obesity Research Demonstration	CORD
Children's Food and Beverage Advertising Initiative	CFBAI
Community Development Financial Institutions Fund	CDFI Fund
Community Eligibility Provision	CEP
Community Health Needs Assessment	CHNA
Dietary Guidelines Advisory Committee	DGAC
Division of Nutrition, Physical Activity, and Obesity	DNPAO
Early childhood education	ECE
Earned income tax credit	EITC
Electronic benefits transfer	EBT
Family Healthy Weight Programs	FHWPs
Federal poverty level	FPL
Fiscal year	FY
Food Access and Retail Expansion Fund	FARE Fund
Food and Drug Administration	FDA
Food is medicine	FIM
Fresh Fruit and Vegetable Program	FFVP
Front-of-package	FOP
Fruit and vegetable cash value voucher	CVV
Generally recognized as safe	GRAS
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
In lieu of services	ILOS
Infrastructure Investment and Jobs Act	IIJA
Local Agriculture Market Program	LAMP
Local Food for Schools	LFS
Local Food Purchase Assistance	LFPA
Medically tailored meal	MTM
National CACFP Association	NCA
National Diabetes Prevention Program	National DPP
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
Preventive Health and Health Services Block Grant	PHHS Block Grant
Racial and Ethnic Approaches to Community Health	REACH
Rural Health Transformation program	RHT program
Safe Routes to School	SRTS
School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students	Healthy Schools program
School Breakfast Program	SBP
Seamless Summer Option	SSO
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
Summer Food Service Program	SFSP
Supplemental Nutrition Assistance Program	SNAP
Supplemental Nutrition Assistance Program Education	SNAP-Ed
Surface Transportation Block Grant	STBG
The Emergency Food Assistance Program	TEFAP
Transportation Alternatives Program	TAP
Tribal Epidemiology Centers Public Health Infrastructure	TECPHI
Tribal Practices for Wellness in Indian Country	TPWIC
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. Preventive Services Task Force	USPSTF
World Health Organization	WHO
Youth Risk Behavior Survey	YRBS

LOOKING BACK AT 25 YEARS OF OBESITY AND CHRONIC DISEASE PREVENTION

In 2026, TFAH is celebrating its 25th anniversary, and we are reflecting on the progress and continued challenges related to obesity and chronic disease prevention. Over the last two and a half decades, obesity rates among adults and youth have increased, with adult rates leveling off in recent years. At the same time, there has also been important progress in how the public health, healthcare, and policy fields understand and approach obesity prevention, treatment, and management, including recognizing obesity as a chronic disease; emphasizing social determinants of health, equity, and a more comprehensive policy approach; and acknowledging the harms of weight stigma, bias, and discrimination across our society. There have also been valuable changes to improve access to nutritious foods, physical activity, and obesity treatment for individuals and communities across the country over the last 25 years. While insufficient in scale, funding, and impact, these policy changes have been important and beneficial for certain populations. These policy changes include:



- Improving nutrition standards, and health outcomes, in federal nutrition programs, including through school meal programs, the Child and Adult Care Food Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children.
- Extending youth nutrition programs to reach more school children, including the Community Eligibility Provision, Summer EBT program, and Healthy School Meals for All.
- Improving the nutritional quality of the nation's food supply through the elimination of trans fats, voluntary sodium reduction targets, and recent focus on ultra-processed foods.
- Updating packaged food nutrition labels, adding new restaurant menu labels, and revising the criteria for "healthy" labels to empower consumer decisions.
- Creating new national programs, like the Centers for Disease Control and Prevention's High Obesity Program, to reach areas with high rates of obesity.
- Innovating at state and local levels with policies like Healthy School Meals for All and sugary beverage taxes.
- Increasing focus on active transportation and physical activity through the built environment, including Safe Routes to School and Complete Streets programs.
- Building evidence-based lifestyle interventions and supports for individuals with obesity and chronic disease, including the Childhood Obesity Research Demonstration, the Family Healthy Weight Programs, the National Diabetes Prevention Program, and food is medicine programs.
- Expanding healthcare coverage for obesity treatment, including, in recent years, GLP-1 medications.

As TFAH moves toward the next 25 years, we remain committed to the evidence-based policies and sustained investments that have driven this progress—and to advocating for the public health infrastructure that makes it possible. Protecting and building on these investments will be essential to preventing obesity and chronic disease in the decades ahead.

Introduction

The United States has experienced a long-term trend of rising obesity rates. In recent years, adult obesity trends have leveled off while youth rates continue to rise.[1,2] State-level data from the Behavioral Risk Factor Surveillance System (BRFSS) also show a more stable trend with no states having a statistically significant change in their adult obesity rates between 2023 and 2024.[3] And, new data from 2025 show two states (Louisiana and West Virginia) had statistically significant decreases between 2024 and 2025, and no states had a statistically significant increase *(see Figure 1)***.[4]**

Diet-related chronic diseases, including obesity, are a multifaceted 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., poverty, discrimination, and limited access to affordable, nutritious food and physical activity).[8,9,10,11,12] In 2026, the number of Americans taking obesity medications continued to rise and the Trump Administration maintained chronic disease, nutrition, and physical activity as its stated health priorities, and used the bully pulpit to encourage medical schools to increase nutrition education and schools to improve the nutritional quality of meals.[13,14,15,16] At the same time, the administration started to enact congressionally mandated changes to the Supplemental Nutrition Assistance Program (SNAP) that are reducing enrollment, issued an updated *Dietary Guidelines for Americans* to mixed reviews, and continued to restructure programs and restrict congressionally appropriated funds across the federal government, including to health agencies and programs that address obesity, chronic disease, and nutrition.[17,18,19,20,21,22,23] *(See "Year in Review" sidebar on page 14 for more recent developments.)*

In this year's *State of Obesity* report, Trust for America's Health (TFAH) presents a feature section, "How the Dietary Guidelines for Americans Shape Food and Nutrition Programs," exploring the history and importance of the *Dietary Guidelines* as a model for individuals' dietary decisions and the basis for standards in federal nutrition programs that reach millions of Americans every year. The section concludes by looking ahead to how current and future *Dietary Guidelines* can have a greater positive impact on nutrition and diet quality in the United States.

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 36)*, a section that examines key current programs and emerging policies *(page 56)*, and, finally, a section that outlines recommended policy actions *(page 122)*.

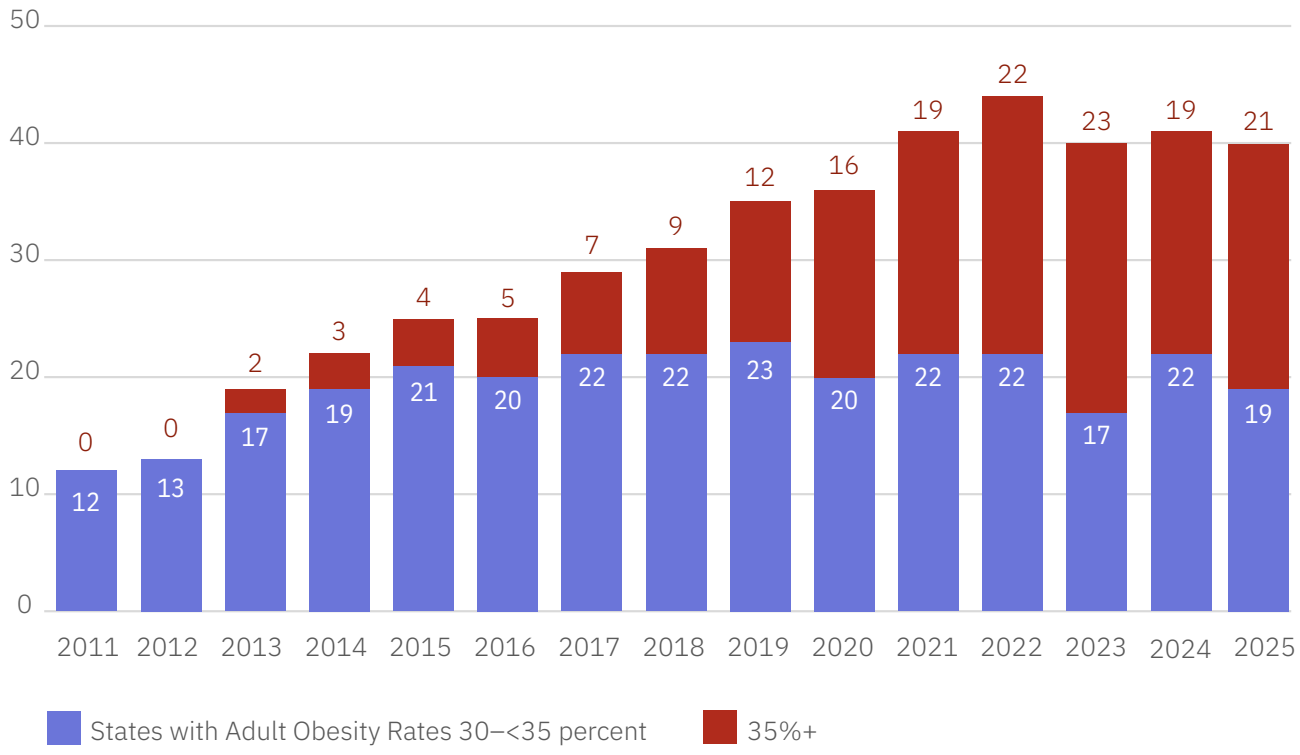
National Obesity Trends, 1999–2023

Facts about Obesity in America

ADULT OBESITY RATE, 2021–2023:	**CHANGE IN ADULT OBESITY RATE FROM 1999–2000 TO 2017–2018:**	**CHANGE IN ADULT OBESITY RATE FROM 2017–2018 TO 2021–2023:**
40.3%	**+ 39%**	**-5%**
YOUTH OBESITY RATE, 2021–2023:	**CHANGE IN YOUTH OBESITY RATE FROM 1999–2000 TO 2017–2018:**	**CHANGE IN YOUTH OBESITY RATE FROM 2017–2018 TO 2021–2023:**
21.1%	**+39%**	**+9%**

Source: NHANES[5,6]

FIGURE 1: Number of States with Adult Obesity Rates At 30 Percent or Higher, 2011–2025



Source: TFAH analysis of BRFSS survey data[7]

Note: Data were not available from California, Mississippi, and Nevada for 2025; Tennessee for 2024; Kentucky and Pennsylvania for 2023; Florida for 2021; and New Jersey for 2019.

WHY DOES TFAH FOCUS ON OBESITY?

Obesity and other diet-related chronic diseases have been increasing across the United States for decades. These chronic diseases pose a significant public health problem given their association with a range of health conditions at the population level, as well as higher mortality rates.[24,25,26]

(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.[27,28,29,30,31,32,33,34,35,36,37]

(2) *Children with obesity are also at greater risk for certain diseases*, like type 2 diabetes and high blood pressure, and a child with obesity is more likely to have obesity as an adult.[38,39,40,41,42] Children with obesity also have a higher risk of hospitalization and severe illness from COVID-19.[43]

Additionally, obesity contributes to higher medical costs at the individual and societal levels. A 2025 study found that obesity-related medical spending in one year exceeded $261 billion in the United States.[44] This includes billions in extra costs to Medicare and Medicaid.[45,46] 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.[47] A 2024 report estimated that obesity and overweight created $425.5 billion in economic costs to U.S. businesses and employees in 2023.[48]

Year in Review

Over the last year, obesity prevention policy and programmatic efforts have continued to shift in response to significant policy changes and a federal workforce upheaval initiated in the first year of the second Trump Administration. The administration has pursued a number of significant regulatory changes and initiatives that continue to influence public health efforts to prevent obesity.

FEDERAL WORKFORCE

The U.S. Department of Health and Human Services (HHS) continued to see significant reductions across the workforce. At the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC), all employees in 21 out of 47 branches received separation notices or were placed on administrative leave by the administration, with five branches later reinstated. Branches affected include the Office of Smoking and Health and the Division of Population Health.[49] Staffing shortages and reductions in 2025 and 2026 have reduced frequency and responsiveness of technical assistance, slowed distribution of grant funding, delayed or paused data analysis, and reduced coordination and knowledge-sharing between grantees.[50]

The U.S. Department of Agriculture (USDA) proposed a restructuring of the Food and Nutrition Service and renamed it the Food and Nutrition Administration as of June 1, 2026.[51] The reorganization plan involves closing regional offices and relocating more than 50 percent of the staff in Washington, DC, to five hub offices in Raleigh, North Carolina; Kansas City, Missouri; Indianapolis, Indiana; Dallas, Texas; and Denver, Colorado. Retailer operations and compliance offices are slated to be moved to Atlanta, Georgia; Dallas, Texas; Los Angeles, California; and New York, New York.[52] Early reports suggest that as many as 80 percent of affected staff will not relocate, which may lead to significant staffing shortages in the agency responsible for administering 16 different federal nutrition programs, including SNAP, the National School Lunch Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[53]

FEDERAL FUNDING CHANGES IN FY 2026

The final fiscal year (FY) 2026 funding bill for the Departments of Labor and HHS was signed into law on February 3, 2026, ending a brief partial government shutdown. Earlier, on November 12, 2025, full-year FY 2026 appropriations were enacted for USDA, including SNAP and WIC, ending the extended 2025 government shutdown.[54,55]

HHS Agencies and Programs:

- **CDC's National Center for Chronic Disease Prevention and Health Promotion** received $1.43 billion in funding in FY 2025 and $1.42 billion in FY 2026.[56]
- **The Division of Nutrition, Physical Activity and Obesity** received reduced funding, from $58.4 million to $54.3 million.[57]
- **The CDC Racial and Ethnic Approaches to Community Health (REACH)** program received flat funding at $69 million but had $3 million shifted from REACH grants to the Good Health and Wellness in Indian Country program.[58]
- **The Social Determinants of Health program at CDC** was eliminated in the FY 2026 budget.[59]

USDA and Food and Drug Administration (FDA) Programs:

- Discretionary budget authority for **USDA's domestic food programs** increased from $8.3 billion in FY 2025 to $8.9 billion in FY 2026.[60]
- **The FDA** was funded at $7.06 billion in FY 2026, an increase of $40.1 million from FY 2025. Funding for the Human Foods Program decreased by $7.3 million relative to FY 2025.[61]
- **SNAP budget authority** decreased from approximately $122.4 billion in FY 2025 to $107.5 billion in FY 2026, likely a result of work requirements and other policies to reduce enrollment instituted by the 2025 One Big Beautiful Bill Act (OBBBA).[62]
- **Mandatory Child Nutrition funding** increased from $33.3 billion to $37.8 billion.[63]

MAJOR LEGISLATIVE ACTIONS

- **Negotiation of a new Farm Bill** is, as of publication, underway in the Senate. The current Senate proposal is similar to a bill passed in the House (H.R. 7567). Significantly, the proposal would not reverse or delay the OBBBA administrative cost shifts in the SNAP program. It also does not enhance reimbursement for nutrition programs like the Gus Schumacher Nutrition Incentive Program (GusNIP).
- **The BUILD America 250 Act**, which as of publication is being negotiated in Congress, would amend and reauthorize major federal transportation programs. Key features include a prioritization of motor vehicle transportation and reduced funding available for active and public transportation. See additional details on page 94.

MAJOR FEDERAL REGULATORY ACTIONS

- **In January 2026, USDA and HHS** published a new edition of the *Dietary Guidelines for Americans*.[64]
- **As of July 2026, USDA and HHS** have stated establishing a federally recognized uniform definition for ultra-processed foods to be a priority, though the definition has been delayed.[65]
- **The National Institutes of Health and FDA** held a Nutrition Regulatory Science Workshop.[66]
- **The Centers for Medicare & Medicaid Services** released nonbinding guidance and a voluntary pledge campaign to improve the nutritional quality of meals delivered to patients in healthcare settings.[67,68]
- **Phase II** voluntary sodium-reduction guidelines are in review at FDA but have not yet been released.[69]
- **FDA** is developing an added sugar-reduction strategy, with deployment anticipated by the end of the year.[70]
- **FDA** is in the process of developing a front-of-package labeling scheme.[71]
- **USDA** has submitted a proposed rule on child nutrition, aligning standards with the new ***Dietary Guidelines for Americans,*** to the Office of Information and Regulatory Affairs.[72]

Summary of Recommendations

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

See a summary of TFAH's recommendations below; the full recommendations are on page 122.

Support public health infrastructure for the planning, implementation, and evaluation of strategies to reduce obesity and improve health.

- Congress and HHS should increase investment and ensure operating capacity in CDC's National Center for Chronic Disease Prevention and Health Promotion and the Division of Nutrition, Physical Activity and Obesity, alongside other divisions and agencies that provide the critical public health infrastructure, coordinating capacity, and expertise needed to successfully address chronic disease.
- Federal grantmaking practices should prioritize transparent guidelines and consistent and predictable delivery of grant funding.
- Policymakers at the state, tribal, territorial, and local levels should support a robust public health infrastructure and workforce to coordinate and convene efforts to address obesity and chronic disease.

Policymakers at all levels should reduce or remove structural barriers to healthy nutrition and physical activity.

- Congress should support programs that address the root causes of poor health, including economic opportunity, housing, transportation, and education. Sustained investments in complete streets programs help make physical activity safe and accessible; expansion of programs like the child tax credit reduces childhood poverty and improves health and well-being.
- State, tribal, and local governments should consider health in all policies. Zoning regulations should support access to affordable housing and healthy foods. Transportation planning should prioritize safe active mobility. Communities should assess the implementation of living wage policies.

Allocate resources and amend policies to improve nutritional quality and reduce nutrition insecurity.

- All levels of government should prioritize reducing nutrition insecurity and making healthy food choices affordable and accessible. The federal government should reverse the changes to the SNAP program in the One Big Beautiful Bill Act that have led to reduced SNAP access for families in need. Congress should invest in school meal programs to improve the quality of nutrition children receive at school.

Alter pricing systems to improve nutritional quality, affordability, and accessibility.

- Policymakers should institute sugary beverage taxes and other similar policies that discourage consumption of unhealthy foods while funding public health initiatives. Conversely, policymakers should promote healthy foods through incentive programs and procurement guidelines.

Support public health education for nutrition and limit marketing that encourages overconsumption of unhealthy foods.

- FDA should implement a front-of-package labeling system that provides consumers with accessible information on the nutritional quality of a food product. Additionally, policymakers at all levels should close tax loopholes to reduce the marketing of unhealthy foods to children.

Support programs that increase access to safe, routine, and equitable physical activity.

- Policymakers should support programs like Academic Enrichment Grants and Every Kid Outdoors that encourage physical activity in childhood, setting children up with a foundation for a healthy, active lifestyle.

Expand access to prevention, screening, and treatment for obesity and related chronic diseases within the healthcare system.

- Policymakers should reverse cuts to Medicaid and marketplace subsidies and strengthen coverage of preventive screening and care.

SPECIAL FEATURE:
How the *Dietary Guidelines for Americans* Shape Food and Nutrition Programs

In 2019, Trust for America's Health (TFAH) began adding 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 ultra-processed foods, the U.S. food environment and systems, and food and nutrition insecurity. This year, the feature focuses on the *Dietary Guidelines for Americans* and how they affect food and nutrition programs in the United States. Updated *Dietary Guidelines for Americans* are released every five years, with the most recent edition, for 2025–2030, released in January 2026.[73]

Improving nutrition and diet quality in the United States is critical to the health and well-being of Americans, and the *Dietary Guidelines for Americans* play an important role now and for the decades to come. This section explores the history and importance of the *Dietary Guidelines for Americans*—how they act not only as a model for individuals to follow as they make dietary decisions for themselves and their families, but also as a foundation for standards for federal food and nutrition programs that reach millions of Americans every year. The section concludes by looking ahead to ways to maximize the impact of the *Dietary Guidelines for Americans* on nutrition and diet quality, including: assuring the recommendations follow scientific evidence and independent expertise; providing schools and nutrition programs with sufficient resources for implementation; ensuring healthy foods are available, affordable, and accessible so all Americans are able to follow the recommendations; and implementing additional nutrition education and awareness campaigns for individuals and families to understand how to eat a more nutritious diet. This section has four subsections: (A) Purpose and History of Dietary Guidelines for Americans, (B) Dietary Guidelines for Americans, 2025–2030, (C) Implications for Food and Nutrition Programs, and (D) Considerations for Future Dietary Guidelines for Americans.

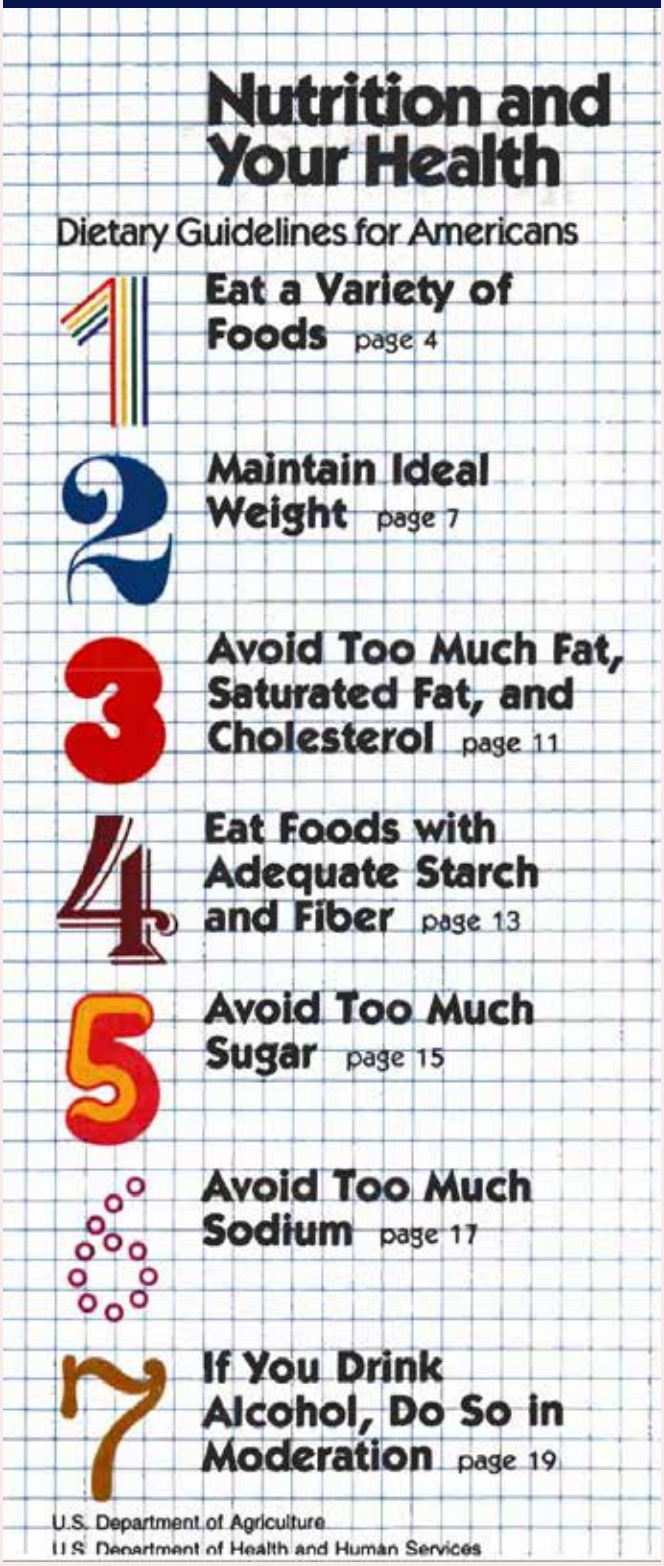
A) Purpose and History of Dietary Guidelines for Americans

The U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) issued the inaugural *Dietary Guidelines for Americans* in February 1980. USDA and HHS have released new editions of the *Dietary Guidelines* every five years since then.[74] The National Nutrition Monitoring and Related Research Act of 1990 codified the joint release by USDA and HHS of the *Dietary Guidelines for Americans* at least every five years.[75]

The first *Dietary Guidelines for Americans* from 1980 starts with the question: "What should you eat to stay healthy?" and its primary goal was to educate and aid Americans in making sound nutritional decisions at the individual level. It focused on seven overarching pieces of guidance on dietary patterns for healthy individuals.[76]

Over the years, the *Dietary Guidelines for Americans* have expanded to include considerations across life stages. For the first time, the *Dietary Guidelines for Americans, 2020–2025* included full recommendations for infanthood, toddlerhood, childhood, adolescence, adulthood, pregnancy, lactation, and older adulthood.[78] The *Dietary Guidelines* have also incorporated visual aids for the public, including the Food Guide Pyramid (1992–2005), MyPyramid (2005–2011), MyPlate (2011–2025), and the New Food Pyramid (2026).[79]

Inaugural ***Dietary Guidelines for Americans***, 1980



Source: USDA and HHS.[77]

Since the beginning, the *Dietary Guidelines for Americans* have been centered on expert evaluation of available scientific evidence. The first issue of the *Guidelines* resulted from a two-year effort of the Joint Coordinating Committee, composed of scientists from the USDA and HHS who reviewed available scientific evidence on nutrition, diet, and health, and translated it to guidance for the public. They were informed by the 1977 congressional report *Dietary Goals for the United States (Second Edition)*, the 1979 Surgeon General report *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, and other evidence.[80,81,82,83]

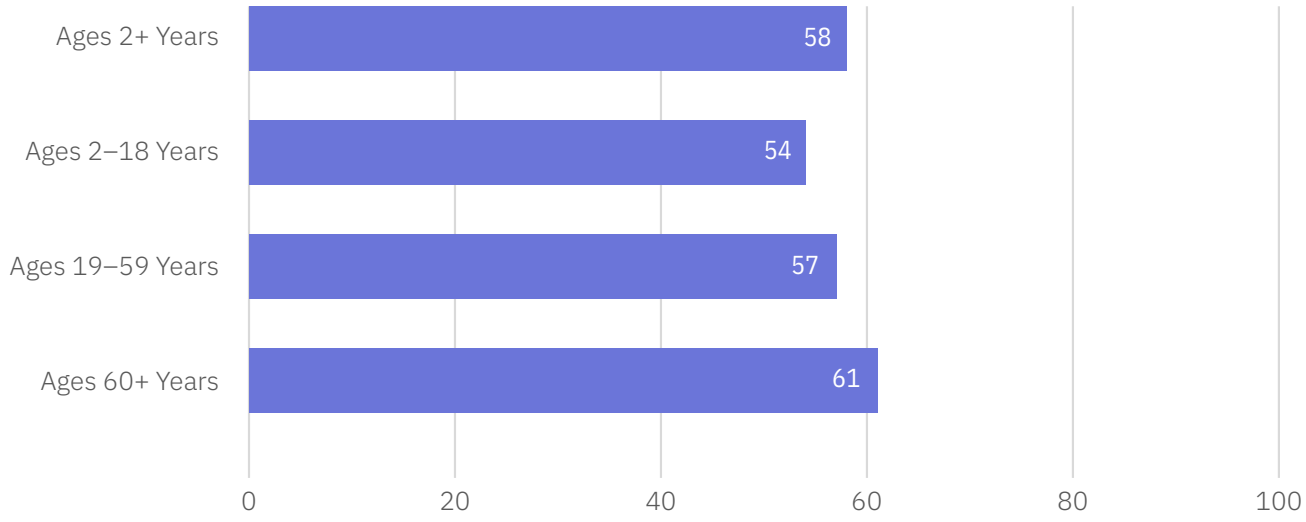
In 1983, USDA and HHS established an independent Dietary Guidelines Advisory Committee (DGAC) composed of nine nutrition experts, as directed by the Senate Appropriations Committee.[84] The DGAC was tasked with evaluating scientific evidence, reviewing public comments, and advising USDA and HHS on how to update the *Dietary Guidelines*. The DGAC issued its 1985 Scientific Report with advice to USDA and HHS in April 1985.[85] Since then, USDA and HHS have formed a new DGAC for each *Dietary Guidelines* update in line with the structure developed in 1985: an independent panel is created to evaluate scientific evidence, review public comments, and advise USDA and HHS through a comprehensive Scientific Report on recommendations for the next iteration of the *Dietary Guidelines*.[86] The National Nutrition Monitoring and Related Research Act of 1990 established the DGAC as a formal federal advisory committee, with governance following the Federal Advisory Committee Act, which regulates federal advisory committee operations and processes to ensure balance and freedom from conflicts of interest.[87]

Despite the longevity of the *Dietary Guidelines for Americans*, the International Food Information Council survey found that, in 2025, fewer than half (44 percent) of American adults reported that they know a lot or a fair amount about the *Dietary Guidelines for Americans*. This is similar to the 2021 survey (46 percent) and higher than the 2011 survey (32 percent).[88] The latest survey found the top considerations around food purchases were taste, price, healthfulness, and convenience.[89]

In fact, evidence shows that the *Dietary Guidelines for Americans* have had limited influence on consumer behavior and that most Americans do not meet the recommended guidelines.[90,91,92] The most recent Healthy Eating Index—based on a 2017–2018 survey of dietary habits and an alignment with the *2020–2025 Dietary Guidelines*—shows the average adult, ages 19 to 59, scoring 57 out of 100, which falls into the "needs improvement" category.[93] (Note: Higher Healthy Eating Index scores correspond with better diet quality, with 100 being fully in line with recommendations. Scores above 80 are considered "good," scores from 51 to 80 are considered "needs improvement," and scores under 51 are considered "poor.")[94]

While the *Dietary Guidelines for Americans* may not be the primary consideration for most Americans when making dietary decisions, the recommendations are the foundation for food and benefits standards for federal programs, which serve millions of Americans each year. See subsection C, on page 24, for more on how the *Dietary Guidelines for Americans* affect food and nutrition programs.

FIGURE 2: Average Healthy Eating Index Scores, by Age Group, 2017–2018



Source: USDA[95]

B) Dietary Guidelines for Americans, 2025–2030

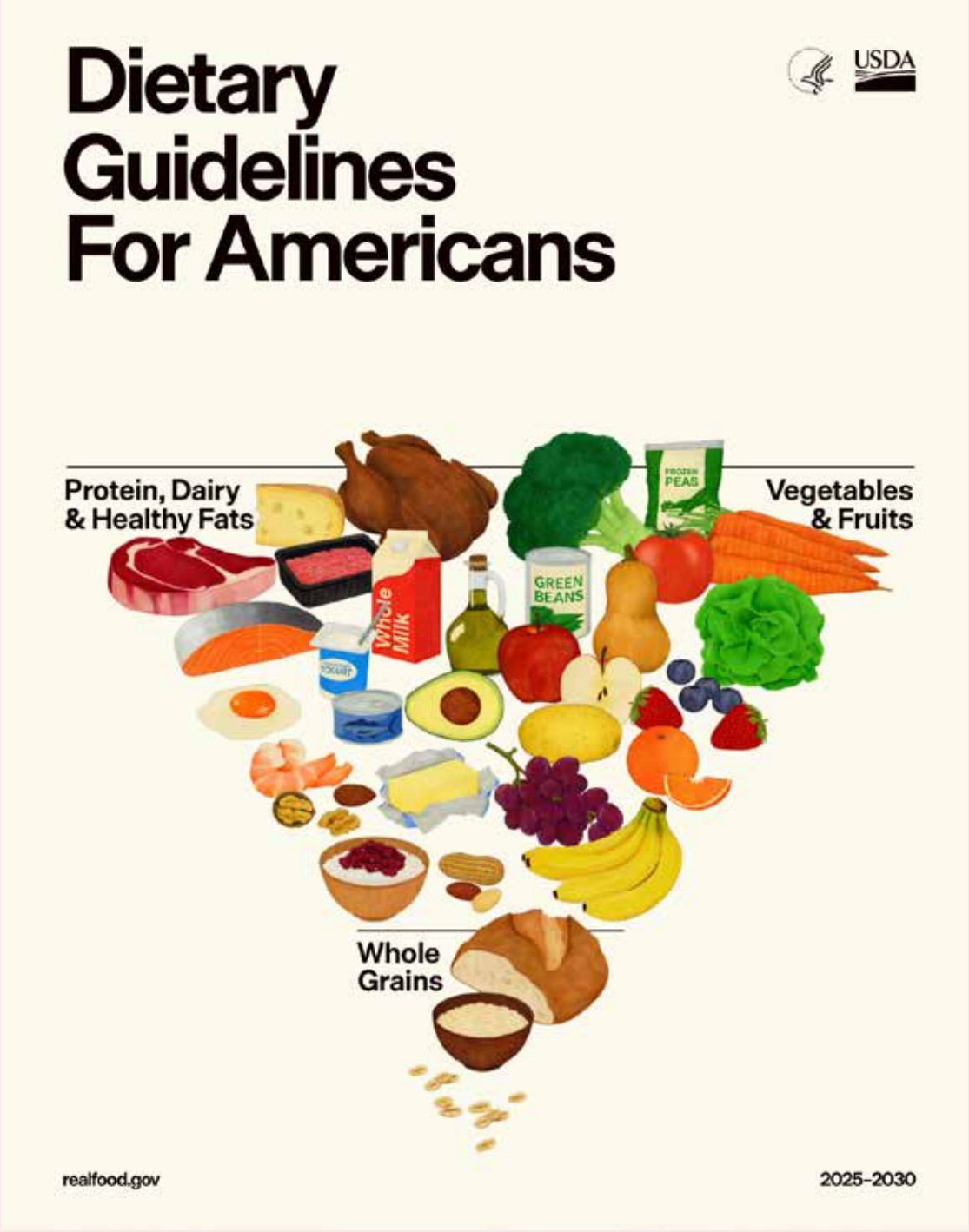
USDA and HHS released the most recent *Dietary Guidelines for Americans, 2025–2030*, in January 2026. Many of the 2025 recommendations are in line with the 2020 edition, including encouraging the consumption of fruits, vegetables, legumes, nuts, and whole grains, and limiting the consumption of saturated fat, added sugars, sodium, and sugar-sweetened beverages. Notable changes to the recommendations in 2025 include: (1) an increase in recommended protein intake; (2) the addition of red meat and full-fat dairy products as healthy protein and fat sources; (3) the elimination of prior recommendations to eat a variety of vegetables across defined subgroups (e.g., dark green; red and orange; beans, peas, and lentils; starchy); (4) a recommendation that children from birth through age 10 consume no added sugars (up from age 2 previously); and (5) a call to limit refined carbohydrates and "highly processed foods."[96,97] The new *Guidelines* were paired with a new visual aid called the "New Food Pyramid" and the slogan of "Eat Real Food."[98]

Nutrition experts and public health advocates offered mixed reviews of the *Dietary Guidelines for Americans, 2025–2030*. Some aspects, like the continued emphasis on consuming whole foods and limiting added sugar and sodium, met broad approval, while other aspects, like the new red meat endorsement and changes to vegetable recommendations, were met with concern by some.[100,101,102] Specifically, the inclusion of full-fat dairy and red meat has been criticized as being in tension with the recommended saturated fat limit and with long-standing evidence that red meat consumption increases the risk of cardiovascular disease and some cancers.[103,104,105] The "New Food Pyramid" visual aid is another point of contention, as it elevates meat and dairy products at the forefront and minimizes whole grains compared with the stated recommendations in the *Guidelines*.[106]

Experts also were alarmed about the process behind the development of the 2025–2030 *Guidelines* as it diverged both from standard procedures and the findings of the 2025 D*ietary Guidelines* Advisory Committee's Scientific Report.[107,108,109] The DGAC issued the Scientific Report in December 2024 for public comment with the intention to inform the 2025–2030 *Guidelines*.[110] USDA and HHS then issued a separate supplemental scientific analysis called "The Scientific Foundation For The Dietary Guidelines For Americans" in conjunction with the release of the 2025–2030 *Guidelines*.[111] The Trump Administration's stated reason for the supplemental analysis was "to address and correct deficiencies identified in the Scientific Report, … which framed its analysis through a health equity lens."[112] Media reports and disclosures raise concerns about financial ties to the beef and dairy industries that the additional analysis's subject-matter experts and review authors appear to hold.[113] In the end, 14 of the DGAC Scientific Report's 56 recommendations were accepted in full, 12 were partially accepted, and 30 were not implemented in the 2025–2030 *Guidelines*.[114]

New editions of *Dietary Guidelines for Americans* should iterate with new evidence on healthy nutrition and dietary patterns—but changes should be grounded in evidence, away from industry or financial conflicts of interest, and driven by an independent DGAC and its recommendations put forth in the Scientific Report.

Dietary Guidelines for Americans, 2025–2030



Source: USDA and HHS[99]

C) Implications for Food and Nutrition Programs

The *Dietary Guidelines for Americans* provide the scientific foundation for federal nutrition policies and standards that, in turn, shape nutrition programs across the country. These programs include the National School Lunch Program (NSLP), which fed an average of 30 million schoolchildren every school day for a total of 4.87 billion lunches in fiscal year (FY) 2025; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which had 6.9 million participants in 2025; and the Child and Adult Care Food Program (CACFP), which served 1.7 billion meals to 4.8 million enrolled children and adults in FY 2025.[115,116]

Reach of Federal Food and Nutrition Programs[117,118]

REACH OF FEDERAL FOOD AND NUTRITION PROGRAMS

NATIONAL SCHOOL LUNCH PROGRAM

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4.87 BILLION

lunches (FY 2025)

CHILD AND ADULT CARE FOOD PROGRAM

SERVED

4.8

MILLION

children and adults

1.7

BILLION

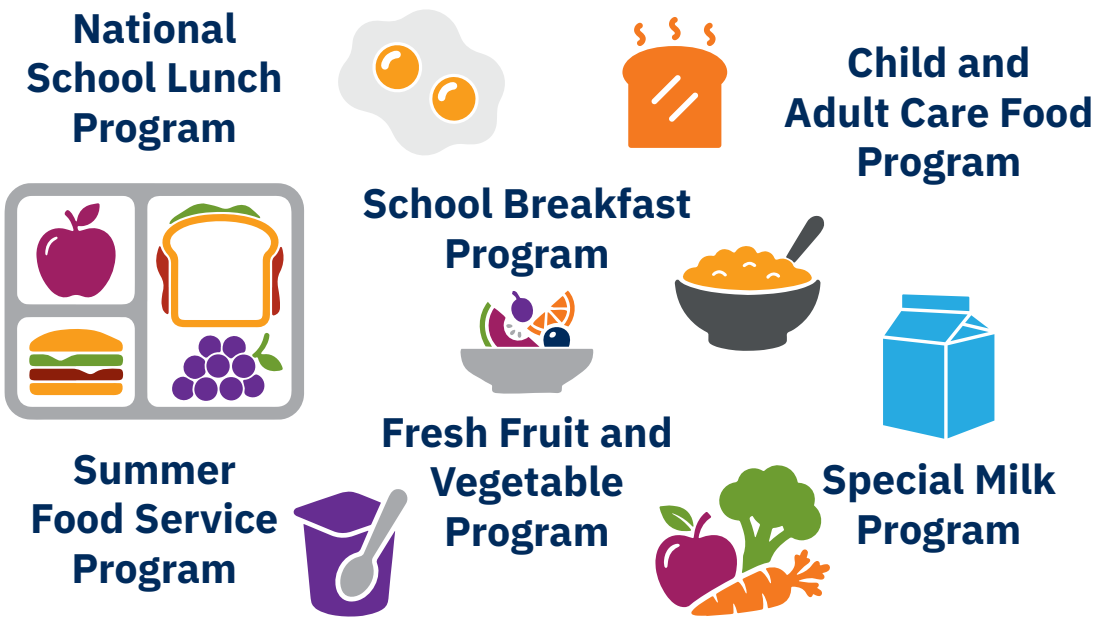
meals (FY 2025)

WIC

had **6.9 MILLION**

PARTICIPANTS (2025)

Nutrition Programs Covered by the Healthy, Hunger-Free Kids Act.[126]



Periodically, since the National School Lunch Act of 1946, Congress has reauthorized and considered changes to child and other nutrition programs.[119] The 1994 reauthorization law, the Healthy Meals for Healthy Americans Act, added the requirement that school meals follow the *Dietary Guidelines for Americans*. USDA guidance through the early 2000s took the form of voluntary recommendations for schools to align with the *Dietary Guidelines*.[120]

The Healthy, Hunger-Free Kids Act of 2010, the most recent reauthorization bill, made major changes to school meal programs and other nutrition programs.[121,122] The law expanded free school meal access in low-income areas (e.g., Community Eligibility Provision), increased schools' reimbursement rate for lunches that meet nutrition standards, created new nutrition standards for snacks and beverages available in schools outside of the school meal programs (e.g., Smart Snacks in Schools), and strengthened nutrition standards for school meals programs and CACFP by requiring them to align with the 2010 *Dietary Guidelines for Americans*. USDA's implementation of this law included rules to increase fruits, vegetables, and whole grains; to decrease sugar, saturated fat, and sodium; and to create maximum levels of calories per meal, with implementation occurring in phases from 2012 to 2023.[123,124,125]

Separately, in 2007, USDA issued a rule overhauling the WIC food packages for the first time since 1980 and aligning them with the *Dietary Guidelines for Americans*.[127] This new food package, with implementation by August 2009, added fruits, vegetables, and whole grain products as well as incentives to promote breastfeeding.[128]

Together, these changes to nutrition standards in federal programs have improved meal quality, improved participant diet quality, and reduced childhood obesity rates among participants. For example, research finds that school meal nutrition requirements increased the nutritional quality of meals and reduced the prevalence of obesity among children who ate school meals.[129,130] After WIC nutritional requirements were strengthened, participant diet quality improved—including large increases in consumption of beans, greens, and whole grains—and obesity rates among children in the program declined.[131,132,133]

Since the Healthy, Hunger-Free Kids Act of 2010 and 2007 WIC food package update, USDA has updated nutrition program standards through rulemaking to align with the concurrent *Dietary Guidelines for Americans*. The most recent nutrition standards revisions for WIC were in 2024. In April 2024, USDA finalized revisions to the WIC food packages to align with the 2020–2025 *Guidelines*, following a proposed rule issued in November 2022. The changes included several that would improve nutrition. For example, the rule increased fruit, vegetable, and whole grain benefits, shifted fruit juice benefits to whole fruit, and added more types of healthy foods to the package (e.g., seafood and more whole grain options).[134,135]

The most recent overarching nutrition standards for school meal programs and CACFP also came in 2024. In April 2024, USDA issued a final rule updating nutrition standards for school meal programs and CACFP to align with the *Dietary Guidelines for Americans, 2020–2025*. Changes included new added sugar limits as a percentage of calories, total added sugar limits for certain items, and simplified sodium limits, with implementation to start with school year 2025–2026.[136]

Other programs are also affected. For example, the *Dietary Guidelines for Americans* inform community health center patient education, nutrition standards for Meals on Wheels and other congregate meal programs for older Americans, military and veteran meal services, the food and nutrition services at hospitals that accept Medicare, CDC's Food Service Guidelines for Federal Facilities, the SNAP-Ed nutrition curriculum (before it was eliminated in the 2025 One Big Beautiful Bill Act), the maximum benefit value in SNAP, Nutrition Facts label design, and the definition of "healthy" for packaged food labels.[137,138,139,140,141,142,143,144,145,146]

As of August 2026, USDA and HHS have not issued new overarching nutrition standards or guidance to align school meals, CACFP, WIC, or other nutrition programs with the 2025–2030 *Dietary Guidelines*, though they have indicated that they will soon and have started instituting targeted updates and voluntary recommendations.

- In February 2026, USDA issued a memo to child nutrition program directors stating that it was actively developing a proposed rule to update nutrition standards to align with the new ***Guidelines***.[147]
- In March 2026, the Centers for Medicare & Medicaid Services (CMS) released a memorandum outlining expected changes to hospital in-patient foods to align with the 2025–2030 ***Dietary Guidelines***, including "Limiting ultra-processed food options for patients," "Elimination of sugar-sweetened beverages unless clinically appropriate in limited scenarios," and "Elimination of refined grains and replacing them with 100% whole grains."[148]
- In May 2026, USDA revised the 2024 standards to add whole- and reduced-fat milk options. USDA cited the 2025–2030 ***Dietary Guidelines*** recommendation of full-fat dairy and the Whole Milk for Healthy Kids Act of 2025 to support the update.[149]
- In August 2026, USDA and HHS announced the Harvest to Hallways initiative that would increase investments for child nutrition programs—including funding for school cafeteria infrastructure and research on improving school meal nutrition—and called for greater state adoption of the optional Pledge for Healthier School Meals where USDA encourages "states and food service companies, with the support of school food authorities, to pledge to make school meals and snack programs healthier."[150] The pledge includes six specific recommendations that align with the 2025–2030 ***Dietary Guidelines***: (1) Replace breakfast pastries with whole-food breakfast options; (2) prepare meat and meat alternates using healthy cooking methods; (3) serve 100% whole grain products; (4) improve smart snacks served in schools; (5) prioritize whole fruit; and (6) serve whole milk.[151,152]

Many ***Dietary Guidelines for Americans, 2025–2030*** recommendations are in line with previous *Guidelines*, though several of the key changes will be difficult to implement in real-world settings due to logistical and resource constraints. For example, reducing processed foods in schools and child and adult care settings requires additional resources, including staff time, kitchen equipment, and potentially major infrastructure renovation or construction, and ensuring no added sugars for children under age 11 may not be feasible as sugar is pervasive across many staple foods (e.g., bread, yogurt, condiments).[153,154,155]
(See sidebar on page 28 for more on school meals, necessary resources, and limitations.)

SCHOOL MEALS: CURRENT AND FUTURE RESOURCE NEEDS

In FY 2025, school meal programs served millions of children every day through the NSLP (average of 30 million participants daily), the School Breakfast Program (SBP) (average of 16 million participants daily), the Special Milk Program (about 16 million half-pints of milk served across the year), and the Summer Food Service Program (average of 2.8 million participants during summertime).[156] However, many of these school programs struggle to provide meals within existing resources. The NSLP reimbursed schools $4.60 per free meal, and the SBP reimbursed schools $2.46 per free meal for the contiguous United States during the 2025–2026 school year. For the school year 2026–2027, reimbursement will increase 3.54 percent, equivalent to $0.16 more per lunch and $0.08 more per breakfast.[157,158,159] The reimbursement rates cover the cost of food as well as staff labor and training, equipment upgrades, and, in some school districts, utilities and other costs.[160]

The School Nutrition Association 2025–2026 survey of 1,240 school meal program directors found that nearly all programs have cost challenges related to food (98 percent), labor (95 percent), and equipment (95 percent), and 70 percent of directors reported reimbursement rates were insufficient to cover actual costs. Both cost issues and concerns about financial sustainability increased since the 2023–2024 survey.[161] Besides inflation adjustments, Congress has never increased the reimbursement rates for the SBP, and the last time Congress increased the reimbursement rate for the NSLP was a $0.06 bonus for lunches meeting *Guidelines* nutrition standards via the Healthy, Hunger-Free Kids Act of 2010.[162,163,164]

Many school systems also are interested in further improving nutrition quality, increasing cooking from scratch, and decreasing ultra-processed food served in their cafeterias—but are again limited by resources. The same School Nutrition Association survey found 99 percent of programs needed more funding to expand scratch cooking and reduce reliance on ultra-processed food in their system, with 79 percent of programs reporting an "extreme need" for more funding to reach these goals. Almost all program directors report that they would also need more staff (94 percent), culinary training (95 percent), and equipment and infrastructure (94 percent) to reach these goals.[165]

In 2020, the Center for Cities and Schools at the University of California at Berkeley investigated the scratch cooking happening at California public schools and the barriers and costs to greater adoption. The researchers surveyed 200 school districts and found 31 percent of schools

reported a high level of scratch cooking, 53 percent reported some scratch cooking, and 16 percent reported little scratch cooking. Schools reported that the top three barriers to scratch cooking were funding for increased staff costs, funding for upgrading facilities/equipment, and funding for increased food costs. The researchers extrapolated how many public schools across the state would need various new or renovated kitchen facilities based on the schools surveyed and estimated it would cost $5.8 billion to make kitchen facilities ready for scratch cooking in all California public schools.[166]

Some schools have been building their capacity for scratch cooking with financial support from private organizations, like The Chef Ann Foundation, which has partnered with schools in several states, including in New York, Virginia, and the District of Columbia. This partnership helps schools develop a plan to increase scratch cooking, provide more access to vegetables, and support recipe and menu development.[167,168] Sufficient and stable funding for schools and access to affordable healthy food options will be key to a successful transition to higher nutritional quality, more scratch cooking, and fewer ultra-processed foods.

D) Considerations for Future Dietary Guidelines for Americans

The *Dietary Guidelines for Americans* are a valuable tool to improve nutrition and diet quality in the United States. Higher nutrition standards in federal nutrition programs have been shown to improve diet quality and health outcomes for participants—and there is the potential to widen their use and reach as an educational tool to aid Americans in making sound nutritional decisions at the individual level, the first goal of the 1980 *Dietary Guidelines for Americans*. To reach the maximum potential of the *Guidelines*, however, policymakers must ensure that future editions follow high scientific and process standards, give nutrition programs and the public access to healthy foods as well as the resources to follow the recommendations, and strengthen the educational components. These considerations include:

- **(1) Reasserting a transparent and independent review process guided by scientific evidence and expert knowledge, separate from financial, political, or industry influence.** A transparent and independent review process—as required by the Federal Advisory Committee Act rules—is important both for ensuring the best possible ***Guidelines*** and recommendations, as well as generating trust in the process and resulting recommendations.
- **(2) Increasing funding and resources for public programs to implement *Dietary Guidelines for Americans* standards.** Additional resources needed include: actionable guidance and technical support for implementation; higher meal reimbursement rates for schools and child and adult care programs; funding for facilities improvements and higher staff costs to increase scratch cooking in schools and other nutrition programs; and WIC packages that include foods aligned with the ***Guidelines*** and that are of sufficient value to cover rising food costs.
- **(3) Ensuring healthy foods are available, affordable, and accessible for all Americans so they can meet the *Dietary Guidelines for Americans* in their daily lives.** Cost and convenience are major barriers to healthy eating in the United States, and a wide variety of policies are needed to shift the food supply toward healthier options and help Americans access nutritious foods—from community design to ensure grocery store access in all communities to policies that make healthy foods more affordable and boost resources for nutrition programs.
- **(4) Improving nutrition education and tools in the United States.** Most Americans are not familiar with the *Guidelines*, but it offers an opportunity to increase nutrition education and to continue efforts to improve the nutrition labels that guide Americans' dietary decisions, including clearer, accessible front-of-package labeling.
- **(5) Sustaining and boosting data-collection efforts to understand the dietary and health impacts of nutrition standards for federal nutrition and food programs, as well as the general public.** Changes to nutrition standards should be evaluated through existing surveys (e.g., National Health and Nutrition Examination Survey) and program-specific evaluations (e.g., NSLP, CACFP).

INTERVIEW WITH ALEXIA THEX, PRESIDENT OF THE NATIONAL CACFP ASSOCIATION

Alexia Thex, M.Ed., is the president of the National CACFP Association (NCA) and leads the association's strategic direction, guiding the advocacy efforts and organizational growth that advance the mission and interests of association members. She holds a Master of Education from the University of Texas at Austin.

TFAH: You serve as president of the NCA. Could you tell us about the organization, how its members inform its policy agenda, and—as NCA marks its 40th anniversary—one change in the food-policy environment or policy success that particularly stands out?

THEX: NCA is the leading national nonprofit organization that supports the CACFP community. We have almost 3,000 members. Our mission is to create professional development, resources about nutrition and the program, and then advocate to strengthen and increase access to the CACFP. We develop our policy priorities based on our members' feedback, the board of directors elected by our membership, and the CACFP community at large. The CACFP wasn't established until more than 20 years after the National School Lunch Act. Later, Congress expanded access to family child care homes, followed by for-profit child care and adult care. Afterschool meal sites and emergency shelters were only added in the late 1990s. Over that span of time, more people have had access to healthy meals and snacks. So, to me, the existence of the program is a policy win.

TFAH: What are you hearing from members about the most pressing nutrition and food-access challenges facing the children, families, and older adults they serve? How are those experiences shaping NCA's advocacy?

THEX: The challenges differ somewhat by site type, but at the operational level, what we're hearing is that food costs are super high. Staffing challenges also continue to affect providers, as recruiting and retaining staff is difficult when wages often do not align with the cost of living. Paperwork requirements continue to grow, and reimbursement has not kept pace with the real cost of preparing and serving meals. On the sponsor level—the organizations that take financial and administrative responsibility for the program—it's similar: increased cost. Right now, fuel costs are high for the monitors who conduct site visits for the program. Over the last decade, more [child and adult care] providers are leaving the program, even though they're eligible. That's due to both increased costs and reimbursement not being enough to cover the cost of all the administrative burden in the program.

We have many advocacy priorities focused on reimbursement, such as eliminating the two-tier reimbursement system, adding reimbursement for an additional meal, and increasing reimbursement by 10 cents for every meal and snack. The child nutrition reauthorization hasn't happened since 2010. It's supposed to happen every five years. We're delayed, but we have some amazing bipartisan champions in both the Senate and the House. I think everybody agrees that children should have nutritious meals and snacks, as well as older adults, it's just moving it forward. We also prioritize addressing the administrative burden of the program. We know the amount of paperwork a provider needs to complete to put lunch on the table is pushing eligible providers off the program. When administrative requirements become too burdensome, providers have

TFAH: It remains uncertain how USDA may align CACFP with the 2025–2030 *Dietary Guidelines*. How do providers typically implement new standards when they are issued? What are providers experiencing as they implement the current standards?

THEX: CACFP operators are child and adult caregivers first and foremost. Their priority is caring for children and older adults every day, and they work hard to provide nutritious meals alongside all of their other responsibilities. They are not necessarily nutritionists. They are not all food-service directors. If you think about the challenges we have communicating nutrition requirements or best practices to consumers, it's the same in the CACFP. The good news is that they really care about the people that they care for and are eager to learn, but it takes repeated technical assistance. When federal changes happen, our team will immediately comb through the rule change to make sure we fully understand it. We then do listening sessions and train sponsors and site operators. We hear what else providers need and put together resources that simplify all the regulations into something that a consumer would understand.

We have a close relationship with USDA and regularly provide feedback and ask how we can better help implement all of these changes and maintain program integrity. We are eager to learn what the upcoming meal pattern updates will be but we don't know what to expect. Everybody wants to eat real food, but it takes investment, time, and a lot of training. For example, questions remain about whether future changes to nutrition guidance could affect CACFP meal requirements, including protein and added sugar standards. Any new requirements in these areas could create operational challenges for child and adult care providers as they work to serve meals that meet program standards. Even with one provider who was really into nutrition, she was opening at 7:30 am, closing at 5:30 pm, and getting up at 5:30 in the morning to cook meals. That's somebody working a 12-hour day, every day. And that's not counting compliance paperwork. We want the meals to be as nutritious as possible, but it's going to require more reimbursement and a lot of technical assistance.

TFAH: To adopt new nutrition guidance, what technical assistance, time, or funding would organizations need to implement future changes successfully, including support or resources from policymakers at any level?

THEX: USDA's SNACS-II study [Study of Nutrition and Activity in Child Care Settings] determined what it really cost centers to put meals on the table: $8.80 for breakfast, $9.70 for lunch, and $6.30 for snack. For centers, that is only 26 percent of the total cost of breakfast, 35 percent for lunch, and 21 percent for snacks. Serving meals that emphasize whole foods, scratch cooking, and less added sugar often requires additional time, labor, and food costs. Repeated technical assistance is necessary and often continues long after the rule is finalized. I spoke with a provider recently who gets up at 5:30 in the morning to cook, opens at 7:30 and doesn't close until 5:30 at night. Twelve hours a day, every day, and that's not even counting compliance paperwork. They receive no additional funding to support this work, even though it is critical to ensuring providers understand and comply with new requirements. Any change or additional rule increases the complexity of the program, requiring reinforcement to navigate the guidance correctly.

TFAH: What recent federal policy or administrative changes have improved the operating or food-service environment for CACFP providers? What additional federal actions would most help providers improve nutrition and serve participants effectively?

THEX: A recent policy success was the milk rule allowing flexibility for whole milk, reduced fat, skim, and nonfat milk to all be served in the CACFP. That was a win on two fronts. One, on the nutrition side, a lot of operators have responded that they think that this will increase the consumption of milk. Two, it helps rural providers and people in food deserts, because providers are often given a program violation or their meals are disallowed and not reimbursed because they are serving the wrong milk. They're not serving the wrong milk because they don't know what the right milk is, they literally don't have access to it and cannot find it in their area. If we look back in a year to this rule, we hope to see fewer findings and disallowances—and hopefully kids drinking more milk.

For improvements, policies to increase reimbursement is number one. Reducing the administrative burden is another. For providers, serving a reimbursable meal involves much more than simply putting food on the table. They often need to gather product documentation, verify meal pattern requirements, determine ounce equivalents, assess whether foods qualify as whole grain-rich, and maintain detailed menu records. That's just for one meal. When you multiply those tasks across multiple meals and snacks every day, the paperwork adds up quickly. In our surveys, providers consistently cite the lack of sufficient reimbursement as a concern, but we also frequently hear that the administrative requirements can outweigh the financial benefit of participation. Reducing that burden would make the program more sustainable and accessible for providers.

TFAH: CACFP is federally funded and generally administered by state agencies, including agencies responsible for education, health, human services, aging, and agriculture. What trends have you observed in state policy and administrative decisions in response to recent federal policy changes? How are state responses helping participating organizations adapt or are they potentially creating additional challenges?

THEX: NCA maintains a close relationship with state agencies. They are a critical piece to the infrastructure of CACFP. The chain goes from USDA to the states down to the institutions, so they play an important role in the system. State agencies can further restrict federal guidelines, so even if a food is creditable by federal guidelines, a state might say you can only serve that three times a week, or you can't serve it at all. We understand that states have to be responsive to their community's unique circumstances and needs, and we are thankful for the work state agencies do to support the CACFP.

Governors and the state legislature can play a key role in supporting both CACFP providers and sponsoring organizations. For example, the USDA has had a waiver for the past several years that states can apply to do one off-site monitoring visit. It saves time, allows more time for technical assistance, and saves costs. Having that one visit is so great, especially for states where there's very few sponsors and they're trying to get 400 miles away or over the mountains, or maybe they have a weather issue. Some states are doing great work. Massachusetts does a lot of training and technical assistance, and in a time where family childcare homes are declining, it's the only state where they are increasing. Washington, DC, has the extra 10-cent reimbursement in every meal and snack through the Healthy Tots Act. There's a number of local food incentives in some states where they're getting 5 cents reimbursed if a provider serves a local fruit or vegetable in a lunch or supper.

TFAH: CACFP operates in settings ranging from family childcare homes and childcare centers to after-school programs, emergency shelters, and adult day care. Are certain settings or populations facing distinct barriers to participating in or implementing the program? What changes would help eligible organizations join and remain in CACFP?

THEX: One of the challenges of the CACFP is that the program occurs in a large variety of sites. For family child care homes, especially for homes receiving the lower Tier II reimbursement rate, the provided reimbursement is just not enough. We also continue to see child care providers and schools that want to participate in the CACFP, but encounter barriers related to site eligibility. For example, a program may be licensed by a State agency to provide child care, yet still be unable to participate because it does not meet USDA's definition of an eligible site type. In some cases, these requirements can prevent otherwise qualified providers from joining the program. Schools that are eligible for afterschool snack and supper face unique barriers as well, such as funding for afterschool programs, staff challenges, and student transportation challenges.

TFAH: What are one or two of the most important actions Congress, USDA, or state policymakers should take to strengthen CACFP and improve nutrition and food access for the people it serves? Is there anything you would like those policymakers to know about CACFP?

THEX: Two important opportunities for Congress are the Child Care Nutrition Enhancement Act and the Early Childhood Nutrition Improvement Act. Together, these bills would strengthen the CACFP by increasing reimbursement, addressing longstanding barriers to participation, streamlining program administration, and modernizing program operations.

Most importantly, they would make it easier for providers to participate in and sustain the program, helping more children gain access to nutritious meals and snacks they deserve.

CACFP might be the most unrecognized of the child nutrition programs and could make an even larger impact with greater investment, especially utilizing these experts, these childcare and adult care providers. There's research out there that the most formative years for healthy outcomes are zero to five. If we wait until school age to start implementing some of these healthy habits, they've already spent five years forming their taste preferences, learning about what they're supposed to eat. By definition, CACFP has a responsibility to teach the children in their care about the food they're eating.

All the caregivers involved in the program engage in both nutrition education and agricultural education. They also address food, exercise, and screen time. Also, with so many children not being able to access SNAP now, providers are being asked to serve a little bit extra. It's not uncommon to have double breakfast on Monday, or a little extra snack on Friday that they're not being reimbursed for. I think changes to SNAP have exacerbated that. Some of our providers are on SNAP themselves while doing detailed work with families and older adults. We visited an adult care setting a few years back, and I still think about the color-coded note cards the provider created to track every individually modified meal. It's amazing work. It's kind of inspirational. And I wish more people knew about it.

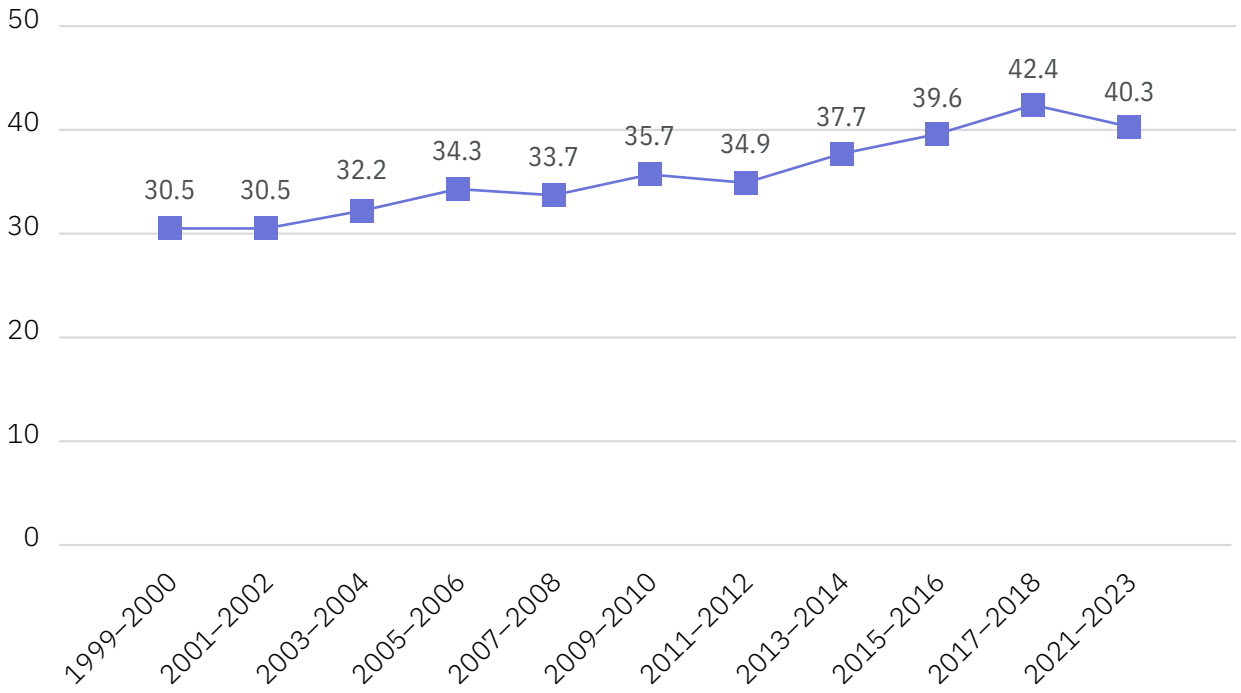
Obesity-Related Data and Trends

Obesity and other diet-related chronic diseases have been increasing throughout the United States for several decades, with stable trends for adult obesity and continuing increases among youth in recent years.[170,171] Obesity poses a serious public health threat as it is associated with higher mortality and a range of adverse health effects at the population level.[172,173,174] This section reviews adult and youth obesity prevalence from the latest available surveys across several data sources and demographic and geographic data where available.

A) Trends in Adult Obesity

The latest National Health and Nutrition Examination Survey (NHANES) data, from August 2021–August 2023, found the age-adjusted adult obesity rate was 40.3 percent nationally, a non-statistically significant change from the 41.9 percent estimate for the combined 2017–March 2020 survey cycle.[175] The latest Behavioral Risk Factor Surveillance System (BRFSS) data, from 2025, show a second year of stable rates for adult obesity, with two states seeing statistically significant decreases between 2024 and 2025, and no states with statistically significant increases.[176] Still, NHANES and BRFSS show substantially higher obesity rates among adults in the United States currently compared with prior decades.[177,178] *(See Figures 1 and 3.)* This subsection provides the most recent data on adult obesity rates by state and demographics.

FIGURE 3: Percent of Adults with Obesity, 1999–2023



Source: NHANES[1]

WHAT IS OBESITY?

Obesity is a chronic, complex condition characterized by excess adiposity. It has multifactorial causes, including genetics, biology, environment, and behavior, and can negatively affect organ and tissue function and increase the risk of other chronic diseases.[180,181,182]

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.[183] BMI is useful as a population health measure to assess the distribution of BMI in populations so that resources can be targeted to certain geographic areas, groups, or others disproportionately affected by low or high weights for health.[184]

At the individual level, clinical guidance recommends using BMI as a screening measure in conjunction with other measures, such as waist circumference, waist-to-height ratio, or direct body-fat assessment. 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.[185] In January 2025, a commission of international experts on obesity issued a consensus statement defining clinical obesity as well as diagnostic criteria to aid medical decision-making and treatment in the Lancet Diabetes & Endocrinology medical journal.[186]

The use of BMI by the public health and healthcare sectors has its limitations and 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.[187,188] First, the formula for calculating BMI was originally designed for research purposes using measurements from Belgian men.[189,190] Second, BMI does not perfectly correlate with body fat or the risk for chronic disease. For example, muscular individuals often have lower body fat than their BMI would suggest. Still, BMI does correlate as well or better than other noninvasive, widely available measures.[191] Third, on a population level, the BMI levels at which the risk of developing other chronic diseases increases can vary by sex and race/ethnicity. For example, certain populations of Asian Americans have higher risks of cardiometabolic diseases at lower BMIs, and some studies suggest Black women may have a lower cardiometabolic risk than white adults at the same BMI levels. Some researchers have suggested adjusting BMI thresholds to estimate cardiometabolic risks more accurately in different populations.[192]

BMI is calculated by dividing a person's weight (in kilograms) by their height (in meters) squared. For adults, BMI is classified into the following categories:

BMI LEVELS FOR ADULTS AGES 20 AND OVER

BMI (KILOGRAMS/METERS^2)	
Below 18.5	Underweight
18.5 to < 25	Healthy Weight
25 to < 30	Overweight
30 and above	Obesity
40 and above	Severe Obesity

Youth obesity is defined differently in order to account for typical changes during growth and development. A child's BMI is expressed as a percentile, ranking a child relative to other children of the same age and sex from the reference population used to create the Centers for Disease Control and Prevention (CDC) growth charts.[193] In 2022, the National Center for Health Statistics released Extended BMI-for-Age Growth Charts, based on nationally representative data from children and adolescents with obesity and additional height and weight data from 1988 to 2016. These charts include four additional growth curves above the 97th percentile and help clinicians plot and monitor growth of children and adolescents with very high BMIs.[194]

BMI LEVELS FOR CHILDREN AGES 2–19

BMI FOR AGE AND SEX	
Below 5th Percentile	Underweight
5th Percentile to < 85th Percentile	Healthy Weight
85th Percentile to < 95th Percentile	Overweight
95th Percentile and above	Obesity
120 percent of 95th Percentile and above, OR a BMI of 35 and above	Severe Obesity

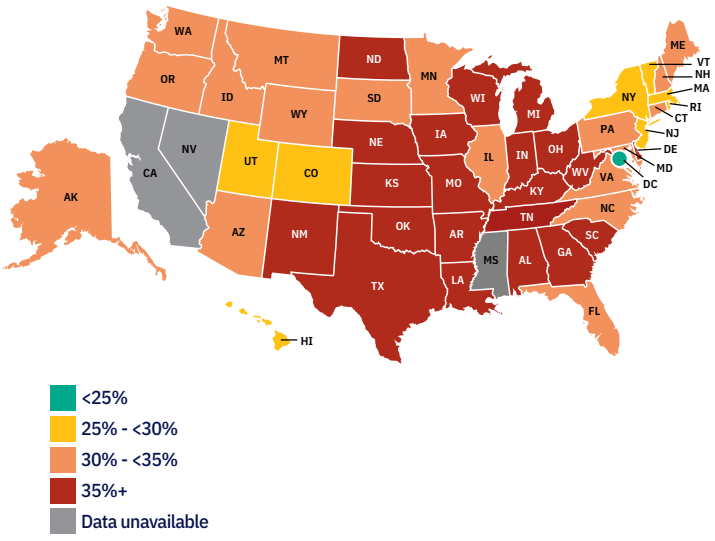
I. STATE TRENDS

The 2025 BRFSS data show a relatively level trend as compared to 2024. Differences between states remain considerable, with a low of 25.7 percent in Colorado and 26.4 percent in Hawaii—as well as 24.2 percent in the District of Columbia—to a high of 39.7 percent in Alabama, 39.1 percent in North Dakota, and 38.8 percent in Kentucky.[195] Other key findings from the recently released data include:

- **In 2025,** the adult obesity rate was at or above 35 percent in 21 states—which is between 2024, when 19 states were at or above 35 percent, and 2023, when 23 states were at or above 35 percent. In comparison, in 2012, no states were at or above 35 percent *(See Figure 1 on page 11)*.
- **For the first time since 2020,** no states had adult obesity rates at or above 40 percent.
- **Between 2024 and 2025,** two states (Louisiana and West Virginia) had statistically significant declines in their adult obesity rates, and no states had a statistically significant increase.
- **Overall, 26 states and the District of Columbia** had lower adult obesity rates and 19 states had higher adult obesity rates in 2025 versus 2024 when also considering non-statistically significant changes. One state (Massachusetts) stayed the same, and four states did not have data in either 2025 (California, Mississippi, and Nevada) or 2024 (Tennessee) for comparison.

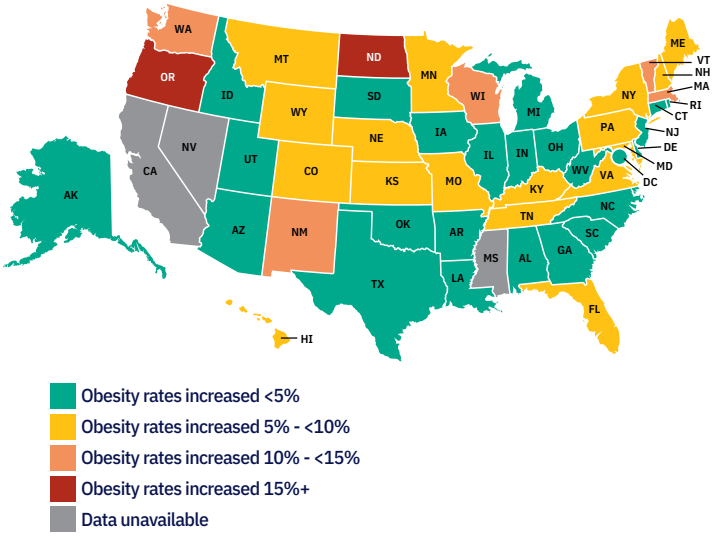
For additional state-level data from BRFSS, see the charts on pages 43–45.

MAP 1: Adult Obesity Rate by State, 2025



Source: TFAH analysis of BRFSS data[197]

MAP 2: Percent Change in Adult Obesity Rate by State, 2020–2025



Source: TFAH analysis of BRFSS data[198]

DATA SOURCES FOR ADULT OBESITY MEASURES

A. **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, including height and weight measurements. 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.[199] The most recent NHANES obesity data are from the August 2021–August 2023 survey. Results from the 2021–2023 survey released included overall obesity prevalence, as well as adult rates by age, sex, race/ethnicity, and education level.[200,201]

B. **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 (more than 400,000 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.[202] The main limitation of the survey includes its use of self-reported weight and height, which results in underestimates of obesity rates due to people's tendency to over-report their height and under-report their weight.[203] 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 2025.[204]

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

How is it that only 21 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 national obesity rates by 16 percent.[205] NHANES, from which the national obesity rate is derived, calculates its obesity rate based on measured heights and weights obtained through in-person physical examinations. Accordingly, the higher rates found by NHANES are generally considered more accurate for national prevalence.[206] NHANES does not have state-level data, which is why TFAH also uses BRFSS data.

TABLE 1: Adult Obesity Rates and Related Health Indicators, 2025

	Obesity		Overweight & Obesity		Diabetes		Physical Inactivity		Hypertension	
States	Percent of Adults With Obesity	Rank	Percent of Adults With Obesity or Overweight	Rank	Percent of Adults with Diabetes	Rank	Percent of Adults Who Were Physically Inactive	Rank	Percent of Adults with Hypertension	Rank
Alabama	**39.7**	1	72.4	4	**15.8**	3	25.8	5	43.3	2
Alaska	33.0 +/- 1.9	29-T	68.0 +/- 1.9	29-T	8.2 +/- 0.9	48	19.2 +/- 1.6	33-T	34.1 +/- 1.8	25
Arizona	32.3 +/- 2.2	34	68.0 +/- 2.1	29-T	**13.3 +/- 1.5**	13	19.6 +/- 1.8	30-T	32.9 +/- 1.9	32-T
Arkansas	36.7	10	69.5	19	14.3	7	27.6	2-T	42.4	3
California	--	--	--	--	--	--	--	49	--	--
Colorado	**25.7**	47	**61.2**	46	**8.8**	46	14.6	47	27.4	48
Connecticut	30.4	38	66.9	34	**11.0**	35	18.5	36	34.4	22
Delaware	36.3 +/- 2.2	14	71.5 +/- 2.1	7	13.9 +/- 1.5	9	22.5 +/- 1.9	16	38.0	9
DC	24.2 +/- 2.3	48	57.3 +/- 2.7	48	9.0 +/- 1.4	44	12.8 +/- 1.9	48	29.6 +/- 2.3	46
Florida	**30.0**	40	66.5	36-T	**13.6**	10-T	24.6	8-T	35.7	20
Georgia	**35.9**	18	**70.6**	12	13.2	14-T	22.4	17-T	37.2	10-T
Hawaii	26.4 +/- 1.4	46	59.3 +/- 1.6	47	11.3 +/- 1.0	32	17.9** +/- 1.2	39	34.2 +/- 1.4	24
Idaho	**32.6**	32-T	66.5	36-T	8.9	45	17.3**	41	31.0	45
Illinois	33.7	24	68.6	24	12.7	18-T	22.9	13-T	33.7	27-T
Indiana	37.5	6	**71.8**	5	13.6	10-T	25.2	6	37.1	12
Iowa	**36.9 +/- 1.3**	9	**71.2 +/- 1.2**	8	**11.6 +/- 0.8**	30	22.2 +/- 1.1	19-T	32.8 +/- 1.1	34
Kansas	**37.3**	8	71.0	10	**12.7**	18-T	20.1	27-T	35.1 +/- 1.2	21
Kentucky	38.8	3	71.8	6	**16.1**	2	27.6	2-T	41.3	5
Louisiana	**35.6 +/- 1.7****	19	69.7 +/- 1.7	17-T	**15.5 +/- 1.2**	4	26.1 +/- 1.6	4	41.5 +/- 1.7	4
Maine	33.0 +/- 1.2	29-T	67.1 +/- 1.3	33	11.4 +/- 0.7	31	21.4 +/- 1.0	24	36.0 +/- 1.1	18-T
Maryland	33.1 +/- 1.2	27-T	67.5 +/- 1.3	32	**12.3 +/- 0.8**	23-T	18.2 +/- 1.0	38	36.6 +/- 1.2	13
Massachusetts	27.0	44-T	62.9	45	10.3	36-T	19.2	33-T	31.2	43
Michigan	35.1	21	69.9	15	**12.5**	21-T	21.2	25	36.5	14
Minnesota	33.1	27-T	68.6	25	10.3	36-T	17.7	40	32.1	38
Mississippi	--	--	--	--	--	--	--	50	--	--
Missouri	36.6	11-T	68.4	26	**12.3**	25-T	23.5	10	36.2	16
Montana	30.3	39	66.4	38	**9.3**	43	16.0**	45	32.2	37
Nebraska	36.0	16-T	69.8	16	**12.2***	25-T	19.8	29	33.2	31
Nevada	--	--	--	--	--	--	--	30	--	--
New Hampshire	31.6 +/- 2.0	35	68.3 +/- 2.0	27	10.1 +/- 1.1	40-T	17.2 +/- 1.6	42	33.6 +/- 1.8	30
New Jersey	27.0	44-T	65.6	41	11.8	28	19.6	30-T	31.8	41
New Mexico	**35.3**	20	**69.2**	20-T	12.5	21-T	22.9	13-T	31.1	44
New York	28.5	43	63.9	42	**12.2**	26	23.1	11-T	32.9	32-T
North Carolina	33.5	25-T	67.9	31	12.8	16-T	18.9	35	36.3	15
North Dakota	39.1	2	72.6	1	10.2	38-T	22.4	17-T	32.5	35
Ohio	**36.0**	16-T	69.7	17-T	12.8	16-T	21.7	21	36.1	17
Oklahoma	38.1	4	72.5	2-T	12.7	18-T	24.7	7	39.5 +/- 2.1	7
Oregon	**32.7 +/- 1.6**	31	**68.2 +/- 1.6**	28	**11.8 +/- 1.1**	29	18.4 +/- 1.3	37	33.7 +/- 1.7	27-T
Pennsylvania	33.5	25-T	66.3	39	**13.2**	14-T	20.1	27-T	37.2	10-T
Rhode Island	31.3	36	66.6	35	**12.0**	27	20.6	26	34.3	23
South Carolina	36.5	13	70.8	11	14.9	5	22.8	15	39.9	6
South Dakota	34.3 +/- 2.6	22	69.2 +/- 2.6	20-T	11.1 +/- 1.6	34	22.2 +/- 2.3	19-T	32.0 +/- 2.3	39-T
Tennessee	36.1	5	71.2	9	14.7	6	24.6	8-T	38.5	8
Texas	36.1	15	70.0	14	13.5	12	23.1	11-T	33.7	27-T
Utah	29.8	41	63.7 +/- 1.3	43	8.5 +/- 0.7	47	14.9 +/- 0.9	46	27.7 +/- 1.0	47
Vermont	**29.1 +/- 1.2**	42	**63.2**	44	10.1	40-T	16.4	44	33.9	26
Virginia	34.2	23	68.7	22-T	**14.1**	8	19.4	32	36.0	18-T
Washington	31.0	37	66.1	40	10.0	42	16.8	43	31.7	42
West Virginia	37.4**	7	72.5	2-T	16.9	1	28.5	1	43.8	1
Wisconsin	**36.6**	11-T	70.3	13	**11.2**	33	21.5	22-T	32.4	36
Wyoming	**32.6**	32-T	**68.7 +/- 1.9**	22-T	**10.2 +/- 1.0**	38-T	21.5 +/- 1.6	22-T	32.0 +/- 1.7	39-T

SOURCE: TFAH analysis of BRFSS data[207]

NOTE: For rankings, 1 = Highest Rate, and 51 = Lowest Rate; T = Tie. Red and * indicate state rates that significantly increased between 2024 and 2025. Green and ** indicate state rates that significantly decreased between 2024 and 2025; **Bold** indicates state rates that significantly increased between 2020 and 2025. Hypertension data is collected bi-annually; this data is from 2025. Data for California, Mississippi, and Nevada were not available for 2025.

TABLE 2: Adult Obesity Rates by Race/Ethnicity, 2023–2025

	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	44.2	6	15.5	14	49.2	1	35.4	30	36.1	11
Alaska	38.5	23-T	22.4	1	42.7	17	38.8	10	32.9	22
Arizona	50.8	4	18.9	4	34.3	36	39.7	6	28.2	39
Arkansas	41.9	15	13.9	20-T	46.2 +/- 3.3	4	38.7	11	37.1	4
California	--	--	--	--	--	--	--	--	--	--
Colorado	30.8	40	11.2	42	29.3	41	31.7	40	23.6	43
Connecticut	29.7	41	11.6	40	41.3	22	36.3	25	28.7	37-T
Delaware	--	--	15.6 +/- 6.4	13	44.9	7	33.1	36	34.9 +/- 1.5	13-T
DC	--	--	10.9 +/- 4.5	43	37.3 +/- 2.4	31	24.3 +/- 4.5	45	14.3 +/- 1.4	45
Florida	36.4	33	12.8	31	40.1	25	28.5	44	29.1	36
Georgia	37.0	31	12.3	34	43.0	15	37.7	15-T	32.6	23-T
Hawaii	33.7	37	18.0 +/- 1.4	5	34.0	37	34.3 +/- 3.1	32	20.3 +/- 1.4	44
Idaho	43.7	9	13.2	27-T	--	--	37.5	18-T	31.2 +/- 1.1	30
Illinois	35.2	34	12.9	30	42.8	16	37.9	13	34.0	17
Indiana	37.1	30	12.0	37	45.2	6	40.4	3	37.6	2
Iowa	53.7	1	13.3	26	41.8	19	39.2	7-T	37 +/- 0.8	5-T
Kansas	41.2	17	16.1	9	43.2	14	40.9	2	36.3 +/- 0.8	9
Kentucky	--	--	--	--	--	--	--	--	--	--
Louisiana	36.7	32	13.9	20-T	46.6	3	38.9	9	34.6	16
Maine	37.9	27-T	13.2	27-T	29.9	40	31.4	41	33.3 +/- 0.7	19
Maryland	37.4	29	12.4	33	40.9	23	37.6 +/- 2.5	17	30.7 +/- 0.8	31
Massachusetts	40.3	19	12.2	35	34.7	35	37.0	22	26.4	41-T
Michigan	43.0	12	16.7	8	44.0	11	37.2	21	34.9	13-T
Minnesota	43.9	8	20.6	3	35.2	34	34.0	33	33.1	20
Mississippi	--	--	--	--	--	--	--	--	--	--
Missouri	40.4	18	15.7	12	43.8	12	36.8	23	34.8 +/- 1.0	15
Montana	42.9	13	14.0	18-T	--	--	29.6	43	29.7	33
Nebraska	43.3	10	15.9	10	40.3	24	37.5	18-T	37.0 +/- 0.9	5-T
Nevada	--	--	--	--	--	--	--	--	--	--
New Hampshire	--	--	12.1	36	31.3	38	35.7	27	32.4	25
New Jersey	31.1	39	13.6	24	37.6	28	33.7	35	26.4	41-T
New Mexico	41.3	16	11.7	39	42.0	18	39.8	5	28.7 +/- 1.9	37-T
New York	34.6	36	14.0	18-T	36.0	32-T	33.8	34	28.2	40
North Carolina	35.0	35	12.7	32	46.0	5	36.0	26	31.5	29
North Dakota	49.9 +/- 5.7	5	17.5	6	30.1 +/- 6.8	39	40.0	4	36.6	8
Ohio	38.1	25	15.1	17	41.5	20-T	37.3	20	36.2	10
Oklahoma	38.9	22	13.2	27-T	44.7	8	41.0	1	37.2 +/- 1.1	3
Oregon	37.9 +/- 9.4	27-T	17.0 +/- 4.9	7	38.0	27	39.2 +/- 3.1	7-T	33.0	21
Pennsylvania	--	--	--	--	--	--	--	--	--	--
Rhode Island	39.9	20-T	15.3	15	36.0	32-T	37.7	15-T	30.0 +/- 1.2	32
South Carolina	29.2	42	11.9	38	47.5	2	32.8	37	32.1	27
South Dakota	42.8	14	21.3	2	20.3	43	37.8	14	35.9 +/- 1.9	12
Tennessee	--	--	--	--	--	--	--	--	--	--
Texas	39.9	20-T	13.5	25	43.7	13	38.4	12	33.5	18
Utah	38.5	23-T	13.7	22-T	37.4	30	35.5	28-T	29.3 +/- 0.7	34
Vermont	32.0	38	11.5	41	23.6	42	29.9	42	29.2 +/- 0.9	35
Virginia	38.0	26	15.2	16	44.4	9	32.2	39	32.6	23-T
Washington	44.1	7	13.7	22-T	37.5	29	36.7	24	31.6	28
West Virginia	51.6 +/- 13.7	3	--	--	41.5 +/- 6.7	20-T	35.5	28-T	40.5 +/- 1.1	1
Wisconsin	53.1	2	15.8	11	44.1	10	35.2	31	36.9	7
Wyoming	43.2 +/- 10.8	11	--	--	38.2 +/- 16.2	26	32.7 +/- 4.2	38	32.3 +/- 1.1	26

SOURCE: TFAH analysis of BRFSS data[208]

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; 2023–2025 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, 2025

	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	36.2	11	43.1	1	32.5	1	44.0	1	43.1	10-T	33.8 +/- 3.1	7
Alaska	32.0 +/- 2.5	33	34.3 +/- 2.9	27	21.1	14-T	34.9	27	38.0 +/- 3.2	31-T	29.5 +/- 3.0	30-T
Arizona	32.7 +/- 3.1	29-T	31.8 +/- 3.1	32	20.5	19-T	34.7	29	37.2	33-T	29.3 +/- 3.0	32
Arkansas	35.6 +/- 2.6	12-T	37.9	10	20.9 +/- 5.8	16-T	38.8 +/- 3.7	15	45.2	6	31.9 +/- 2.4	18
California	--	--	--	--	--	--	--	--	--	--	--	--
Colorado	25.3	47	26.0	47	13.2	46	25.2	47	31.0	47	25.6	46
Connecticut	29.9	40-T	30.9	34	18.3	34	32.8	36	35.4	39-T	27.0	38
Delaware	34.2 +/- 3.2	19	38.4 +/- 3.0	8	20.0	23	40.4	9	42.0 +/- 3.7	17-T	32.2 +/- 2.9	16
DC	20.1 +/- 3.3	48	27.8 +/- 3.2	44	10.9 +/- 6.9	48	21.7 +/- 3.4	48	32.1 +/- 5.0	45	26.8 +/- 4.2	39
Florida	29.9	40-T	30.0	37	13.0	47	31.7	40-T	37.2	33-T	26.6	42
Georgia	32.7	29-T	39.1	5-T	19.3	29	39.2	14	41.0	20-T	33.2	10-T
Hawaii	28.2 +/- 2.1	43	24.4 +/- 1.9	48	19.9	24	32.7	37	28.1 +/- 2.5	48	19.8 +/- 1.9	48
Idaho	36.7	8-T	28.0	43	24.6 +/- 5.8	5	35.4	26	35.4	39-T	29.5	30-T
Illinois	32.8	28	34.5	25	20.2	22	34.0	33-T	40.1	24	31.6	19-T
Indiana	37.5	4	37.4	15	20.5	19-T	41.8	6	43.8	7	33.0	13
Iowa	37.8 +/- 1.7	3	35.9 +/- 1.8	21	20.5	19-T	37.6	19	45.3 +/- 2.2	4-T	34.9 +/- 2.0	2
Kansas	35.6	12-T	39.2	4	21.6	11	42.2	5	42.1 +/- 2.4	16	33.9	6
Kentucky	37.9	2	39.8	2	22.9	9	43.1	3	45.3	4-T	33.2	10-T
Louisiana	33.3 +/- 2.4	23-T	37.8 +/- 2.5	11	18.8	32	37.7	18	42.0	17-T	33.6 +/- 2.7	8
Maine	32.6	32	33.3 +/- 1.8	29	18.4	33	34.8	28	38.2	30	30.7 +/- 1.7	25-T
Maryland	30.7 +/- 1.8	36-T	35.5 +/- 1.7	23	19.7	26	35.9	23	38.0 +/- 2.1	31-T	29.1 +/- 1.8	33-T
Massachusetts	27.7	44	26.4	46	14.3	43	28.0	45	31.7	46	26.4	44
Michigan	33.0	26-T	37.2	16	19.8	25	35.6	24	42.4	13-T	32.9	14
Minnesota	33.0	26-T	33.1	30	19.0	30	34.5	30	38.5	28	31.2	21-T
Mississippi	--	--	--	--	--	--	--	--	--	--	--	--
Missouri	35.2	16	38.1	9	21.1	14-T	40.1	10	43.1	10-T	32.0	17
Montana	30.0	39	30.5	36	14.0	45	28.7	44	38.3	29	30.6 +/- 2.3	27
Nebraska	37.1	6-T	34.7	24	17.9	36	37.3	20	43.3	9	35.3	1
Nevada	--	--	--	--	--	--	--	--	--	--	--	--
New Hampshire	33.0	22	29.7 +/- 2.8	38	15.4	42	32.6	38	37.1	35	28.3 +/- 2.1	37
New Jersey	26.0	46	27.7	45	19.4 +/- 5.5	27-T	26.9	46	32.5	44	23.4	47
New Mexico	34.0	21	37.1	17	28.2 +/- 7.9	2	41.5	8	39.4	26	26.5	43
New York	28.0	45	29.6	39	17.2	37	28.9	43	34.2	43	26.3	45
North Carolina	30.0 +/- 3.0	38	36.8	19	14.1 +/- 5.2	44	36.0	22	40.6	22	31.2	21-T
North Dakota	40.0 +/- 2.0	1	37.6	12-T	23.9 +/- 5.3	6-T	43.9 +/- 3.4	2	46.3 +/- 3.0	2-T	33.4	9-T
Ohio	34.0	17	37.6	12-T	21.3	13	39.5	12	39.5	25	34.1 +/- 2.2	5
Oklahoma	37.0	6-T	39.1	5-T	27.5	3	41.7	7	42.4 +/- 3.2	13-T	33.4	9-T
Oregon	32.0	34	33.6	28	21.5 +/- 5.3	12	35.5 +/- 3.2	25	35.3 +/- 2.8	42	30.7 +/- 2.7	25-T
Pennsylvania	35.0	14-T	31.5	33	20.9 +/- 6.9	16-T	34.1	32	41.6	19	29.6	29
Rhode Island	33.0	23-T	29.2 +/- 2.3	40	18.9 +/- 5.8	31	32.9	35	36.5 +/- 3.0	36-T	28.8	36
South Carolina	34.0	20	39.0	7	15.7	40-T	39.8	11	46.3	2-T	31.0	24
South Dakota	34.0 +/- 3.0	18	34.4 +/- 4.0	26	16.8 +/- 6.8	38	34.4	31	42.2	15	34.5 +/- 3.9	4
Tennessee	36.3	10	39.5	3	25.8	4	42.9	4	43.5	8	29.8	28
Texas	35.4	14-T	36.9	18	23.6	8	39.4	13	41.0	20-T	31.1	23
Utah	30.7	36-T	28.7	42	16.3	39	32.0	39	36.5	36-T	26.7 +/- 2.0	40-T
Vermont	29.0	42	29.1	41	15.7	40-T	29.1	42	36.3	38	26.7	40-T
Virginia	32.7	29-T	35.7	22	18.3	35	36.1	21	40.4	23	31.6	19-T
Washington	31.3	35	30.7	35	20.9	16-T	31.7	40-T	35.4	39-T	29.1	33-T
West Virginia	37.3	5	37.6 +/- 2.5	14	23.9 +/- 6.3	6-T	37.8	17	46.5 +/- 3.1	1	32.6 +/- 2.5	15
Wisconsin	36.7	8-T	36.4 +/- 1.9	20	19.4	27-T	38.5	16	42.9 +/- 2.2	12	34.7 +/- 1.7	3
Wyoming	33.1 +/- 2.5	25	32.1 +/- 2.8	31	22.2 +/- 6.8	10	34.0 +/- 3.8	33-T	38.7 +/- 3.3	27	28.9 +/- 2.2	35

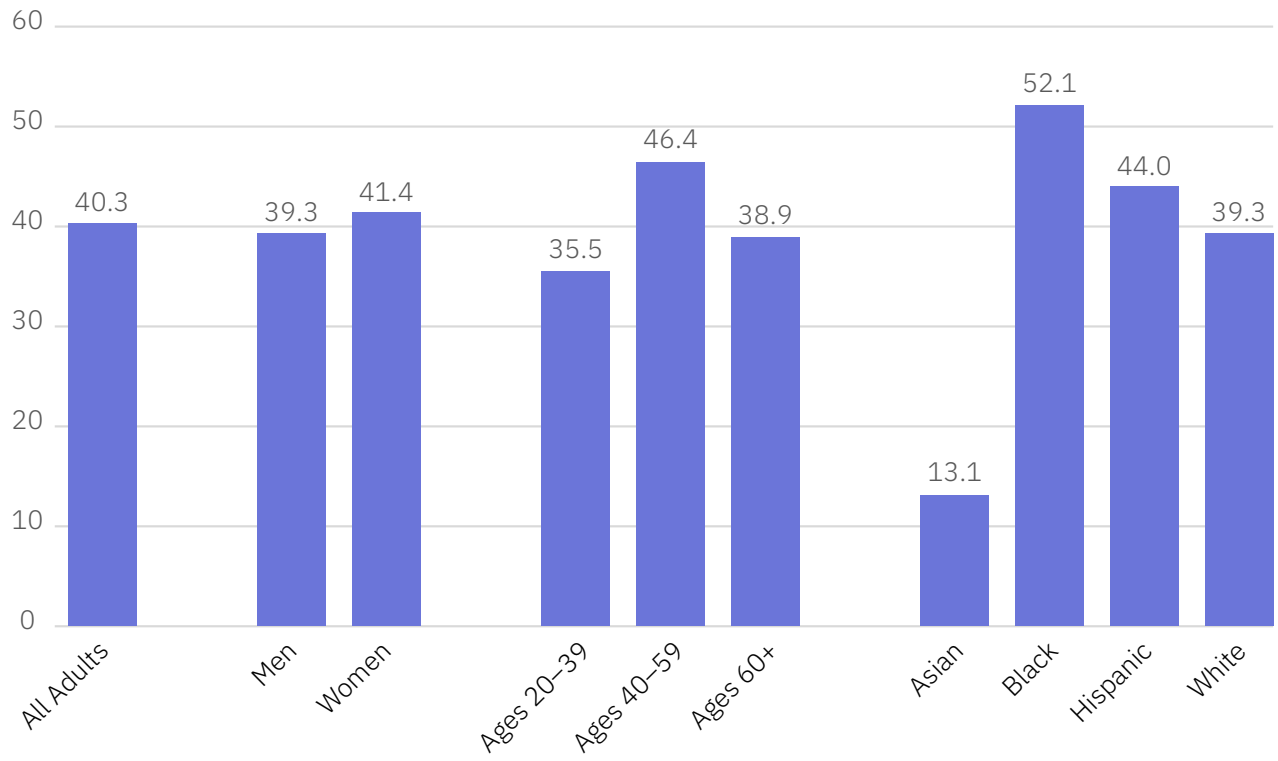
Source: TFAH analysis of BRFSS data[209]

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

II. DEMOGRAPHIC TRENDS

Obesity rates differ across demographic groups, including by sex, age, race/ethnicity, education, income, and geography. *(See Figure 4.)* While obesity rates depend on many factors, economic and community context shape Americans' daily lives and available choices around healthy food, physical activity, education, jobs, stress, financial security, and other factors that systematically affect people's weight and health.[210] The Appendix, on page 138, includes state-level indicators that track some of these factors, including community conditions (e.g., poverty rates), the built environment (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 4: Percent of Adults with Obesity, Overall, and by Select Demographics, August 2021–August 2023



Source: NHANES[1]

SEX

Obesity rates are similar for men and women ages 20 and older in the United States.

- According to age-adjusted 2021–2023 NHANES data, 39.3 percent of men and 41.4 percent of women had obesity, a non-statistically significant difference.[212]

AGE

Middle-aged 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).[213]

RACE/ETHNICITY

Racial/ethnic disparities in obesity rates are significant.

- In 2021–2023, Black Americans had the highest age-adjusted rate of obesity (52.1 percent) for adults ages 20 and older, followed by Hispanic (44.0 percent), white (39.3 percent), and Asian (13.1 percent) adults.[214]
- More than half—56.0 percent—of Black women had obesity. That is the highest sex and race/ethnicity combination included in NHANES—and a 15.6-percentage point difference compared with white women (40.4 percent).[215]
- Asian adults overall had much lower rates of obesity than any other race/ethnicity reported in NHANES. Other studies have shown variations in obesity rates among different ethnicities and national origins within the U.S. Asian population. For example, the 2024 National Health Interview Survey found that Native Hawaiian and other Pacific Islander adults ages 18 and older had self-reported obesity rates of 42.4 percent, while the overall obesity rate for Asian adults (not including Native Hawaiian and other Pacific Islanders) was 12.5 percent. For reference, white adults had a 33.0 percent obesity rate.[216]
- 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. These risks include a higher risk for type 2 diabetes and other metabolic diseases at lower BMIs.[217] Because a high BMI is a factor in determining whether to test for diabetes, fewer Asian individuals may be tested and diagnosed by healthcare providers.[218] 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.[219]
- It is also important to note that many national surveys, including NHANES, do not report data on health measures for American Indian and Alaska Native (AI/AN) people. The surveys that do exist do not gather or present findings by Tribal Nations. Available survey data show a high obesity prevalence among AI/AN adults. The 2024 National Health Interview Survey, which is based on self-reports, finds that 40.9 percent of AI/AN adults had obesity, which was slightly lower than Black adults in that survey (42.3 percent) and substantially higher than white adults (33.0 percent).[220] These national estimates may also mask substantial variations across Tribal Nations, regions, and communities. Such variations are often difficult to assess because many national surveys do not collect or report AI/AN health data at the Tribal Nation or community level. 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.

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).[221]

INCOME

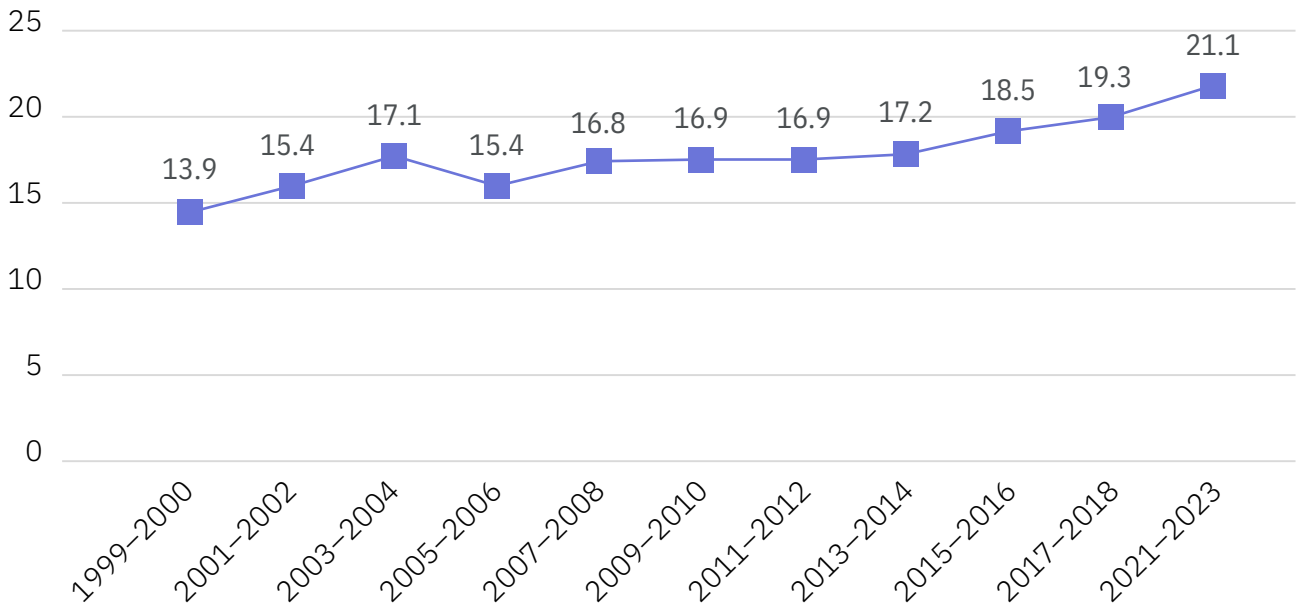
Adults in highest-income households have lower obesity rates.

- According to 2017–March 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.[222] FPL varies by household size and is updated each year. For example, in 2026, FPL was $15,960 for an individual and $33,000 for a family of four in the 48 contiguous states and DC.[223] 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 show 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).[224]

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 2017–2018 survey findings of 19.3 percent.[225] Obesity rates have been rising among children over the long term, too: between the 1999–2000 NHANES survey and the August 2021–August 2023 survey, obesity rates for children ages 2 to 19 increased approximately 52 percent.[226] *(See Figure 5.)* 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 5: Percent of Youth with Obesity, 1999–2023



Source: NHANES[2]

I. NATIONAL YOUTH OBESITY RATES

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. The 2021–2023 NHANES data released for youth include overall rates and rates by age, sex, and age *and* race/ethnicity.[228] For data by race/ethnicity overall and household income, data from the 2017–March 2020 NHANES survey are presented. Report authors note that the recent surveys were impacted by the COVID-19 pandemic which could explain some of the different demographics reported: "Due to COVID-19, [NHANES] had design changes and smaller sample sizes for certain race/Hispanic origin groups."[229]

AGE

The prevalence of obesity increases with age.

- In 2021–2023, 14.9 percent of youth ages 2 to 5, 22.1 percent of youth ages 6 to 11, and 22.9 percent of youth ages 12 to 19 had obesity.[230] Between the 1976–1980 and the 2021–2023 NHANES surveys, the percentage of youth ages 12 to 19 with obesity more than quadrupled.[231]

SEX

Boys had slightly higher rates of obesity compared with girls.

- In 2021–2023, 23.0 percent of boys had obesity, and 19.1 percent of girls had obesity.[232]

RACE/ETHNICITY AND SEX

Obesity prevalence among youth varied substantially by race/ethnicity.

- In 2021–2023, Black girls (29.9 percent) and Hispanic boys (29.8 percent) had high estimated obesity rates. 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.[233] The same 2021-2023 survey found Black boys had an obesity rate that almost doubled between the 2017–2018 and 2021–2023 surveys; however, the authors cautioned that the magnitude of the increase appears implausible and that small sample sizes may have contributed to unmeasured sampling variation.[234]

RACE/ETHNICITY

Hispanic and Black youth had higher rates of obesity than their Asian and white peers.

- Obesity prevalence for Hispanic youth was 26.2 percent, Black youth was 24.8 percent, white youth was 16.6 percent and Asian youth was 9.0 percent in 2017–March 2020.[235]

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.[236]

DATA SOURCES FOR CHILDHOOD OBESITY MEASURES

A. **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 recently released data are from the August 2021–August 2023 NHANES survey and include overall rates, rates by age and sex, and rates by race/ethnicity and sex.[237]

B. The **WIC Participant and Program Characteristics Report** is a biennial report based on data for WIC participants with active certifications in April of the reporting year, including women, infants, and children under age 5.[238] 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.[239]

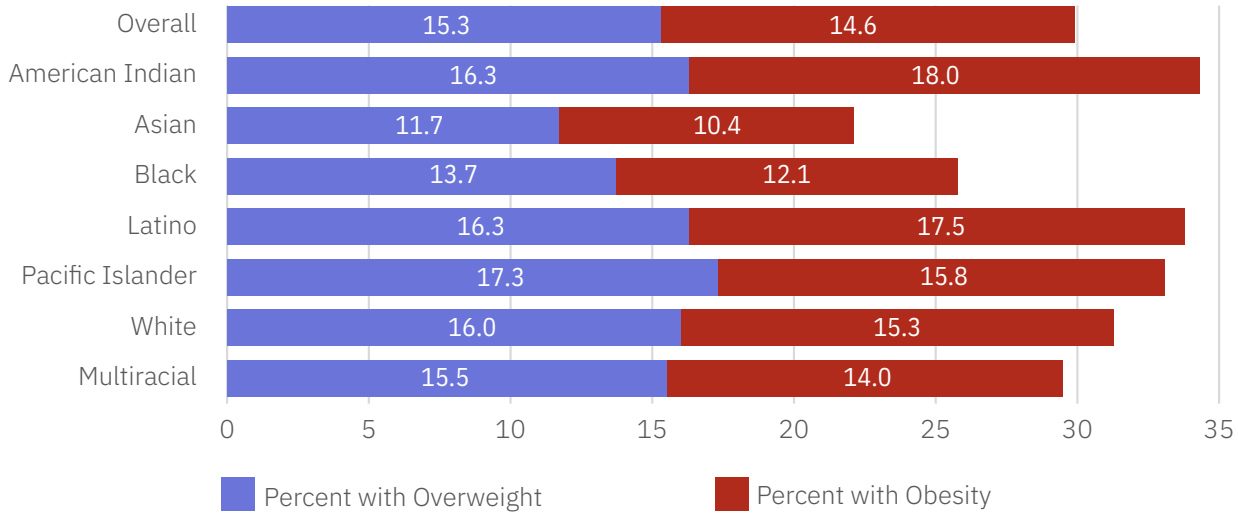
C. The **National Survey of Children's Health** surveys parents of children about aspects of their children's health, including height and weight for children ages 6 to 17. An advantage of this survey is that it includes state-level data. A disadvantage is that height and weight data are parent-reported, not directly measured.[240] The most recent data are from the 2022–2023 survey. This is the second year that the survey has used the expanded age range for reporting weight status of children ages 6 to 17 (from ages 10 to 17 in previous years).[241,242,243]

D. The **Youth Risk Behavior Survey (YRBS)** measures health behaviors, including eating habits and physical activity behaviors, as well as a BMI category (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.[244] 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.[245]

II. YOUNG WIC PARTICIPANTS, AGES 2 TO 4

In 2020, 14.6 percent of children ages 2 to 4 in the WIC program had obesity, and 15.3 percent had overweight.[246] 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, and whole grains *(see page 88 for more on the WIC program)*.[247,248] American Indian and Hispanic children were the most likely to have overweight or obesity compared with other races/ethnicities.[249] *(See Figure 6 for program participant data by race/ethnicity as well as the chart on page 55 for state-level data.)* *Note:* As of August 2026, the most recent available data are from 2020 since the 2024 report has not been released and the 2022 report did not include obesity data due to data collection issues related to the COVID-19 pandemic.

FIGURE 6: Percent of Children Ages 2–4 in the WIC Program Who Have Overweight or Obesity, by Race/Ethnicity, 2020



Source: USDA Food and Nutrition Service[248]

NOTE: Height and weight data are not included in the 2022 WIC Participant and Program Characteristics Report due to collection disruptions during the COVID-19 pandemic.

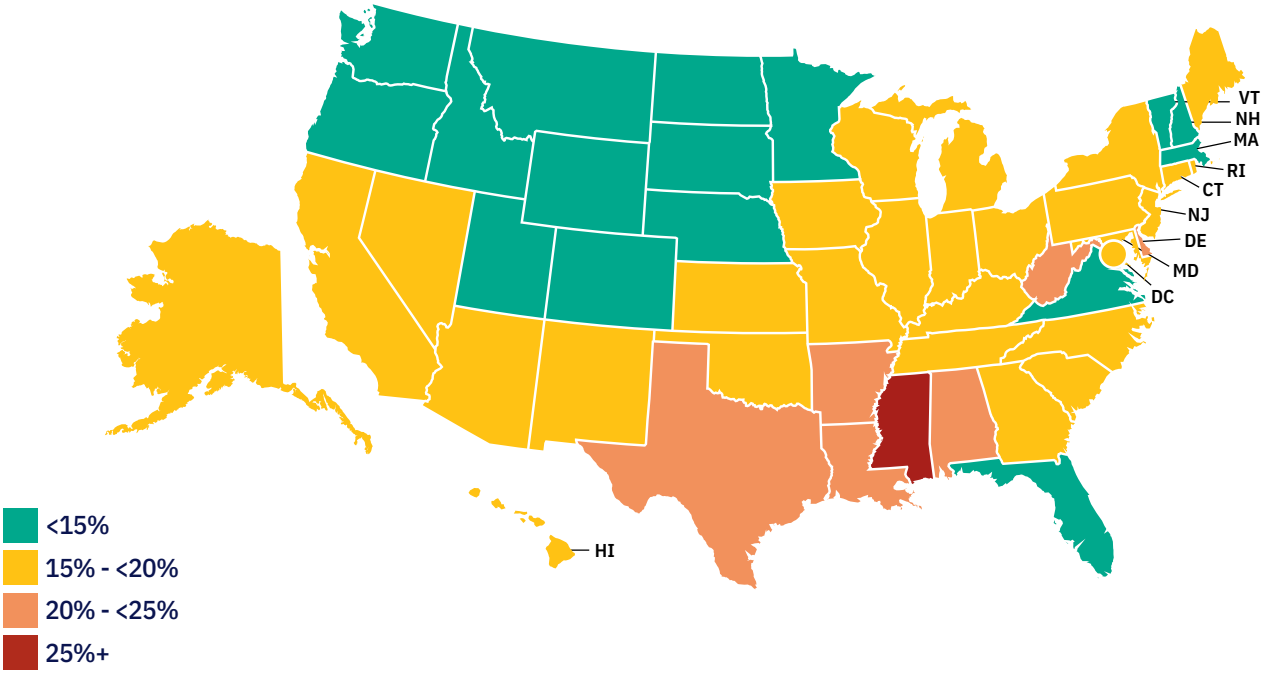
III. OBESITY RATES IN CHILDREN AND TEENAGERS, AGES 6 TO 17

The 2022–2023 National Survey of Children's Health reported that, nationwide, 17.0 percent of children ages 6 to 17 had obesity and another 15.2 percent were overweight.[251]

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 percent for Asian children, 23.5 percent 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.
- 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 55 for more state data.)*[252]

MAP 3: Percent of Youth Ages 6–17 With Obesity, by State, 2022–2023



Source: National Survey of Children's Health[253]

IV. HIGH SCHOOL OBESITY RATES

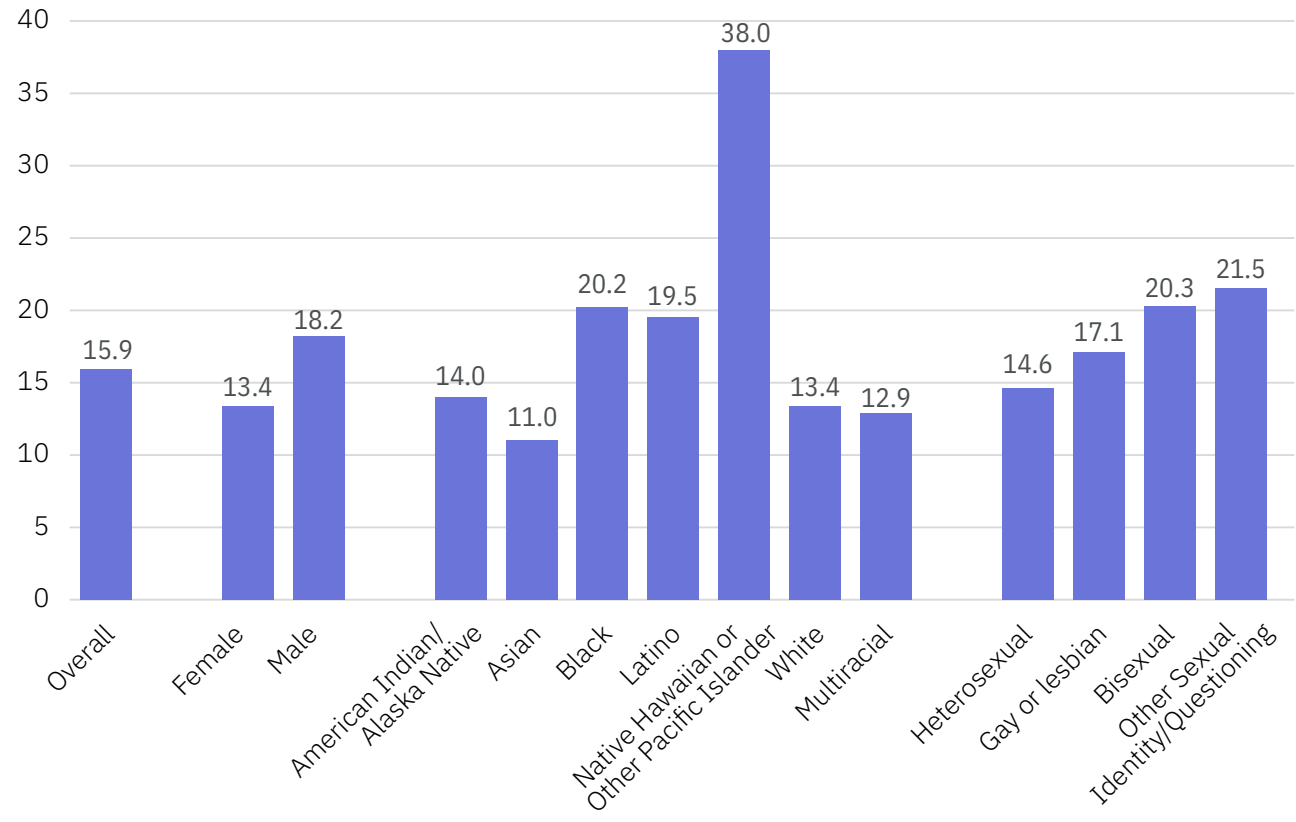
According to 2023 YRBS data, 15.9 percent of high school students (grades 9 to 12) nationwide had obesity and 14.7 percent were overweight.[254,255] In recent years, obesity levels have been fairly level among high schoolers (15.9 percent in 2023, 16.3 percent in 2021, and 15.5 percent in 2019), although there has been a long-term increase. In 1999, the obesity rate among high school students was 10.6 percent.[256]

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 for states with data.
- 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 percent) 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 (13.4 percent) students.[257] *(See Figure 7.)*

See page 55 for state-by-state data on obesity, overweight, and physical activity levels among high school students.

FIGURE 7: Percent of High School Students with Obesity by Select Demographics, 2023



Source: Youth Risk Behavior Survey[257]

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 Participant and Program Characteristics*[259] *National Survey of Children's Health*[260] *Youth Risk Behavior Survey*[261]

For rankings, 1 = Highest Rate, and 51 = Lowest Rate.

SECTION III

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) Food Supply Standards and Labels, (C) Nutrition Assistance and Education Programs, (D) Community Policies and Programs, and (E) Healthcare Coverage and Programs.

A) Economics of What We Eat and Drink

Food availability, pricing, and advertising are key components of the food environment that shape broader consumption patterns. This subsection provides information on fiscal and tax policies that promote healthy eating, including beverage taxes, the Healthy Food Financing Initiative, and the New Markets Tax Credit, as well as policies related to food and beverage marketing, which also play a major role in consumer choices.

I. FISCAL AND TAX POLICIES THAT PROMOTE HEALTHY EATING

For many Americans, the cost of food is a major factor in purchasing decisions, and the higher price of nutritious options can often be a barrier to healthy eating.[262,263,264,265] Steady increases in the cost of food and other consumer goods have made affordability a key issue for many Americans. Prices for all goods (or overall inflation) rose by 3.4 percent between July 2025 and July 2026, placing significant strain on Americans' budgets,[266] with half of Americans reporting they are more stressed financially in April 2026 than they were a year ago.[267] Between 2024 and 2025, average at-home food prices rose by 2.3 percent.[268] Economic policies—such as financial incentives that improve access to healthy foods or disincentives like taxes aimed at reducing consumption of less nutritious options—can influence behaviors and support improved health outcomes. They also have the potential to contribute to state and local budgets as states contend with less federal funding.

BEVERAGE TAXES

Sugary beverages are the top source of added sugars in the U.S. diet, and excessive consumption is associated with a range of chronic health conditions, including obesity, heart disease, gout, and type 2 diabetes.[269,270] Excise taxes on sugary beverages—typically 1–2 cents per ounce—can be an effective strategy to reduce consumption[271,272,273,274,275,276] and there is evidence these taxes may reduce BMI among certain adults and youth.[277,278] In many instances, revenue generated from these taxes is reinvested in public health initiatives focused on obesity, nutrition, and chronic disease, further enhancing the policy's impact on nutrition and public health.[279,280,281]

In 2024, the World Health Organization (WHO) released a policy brief on the link between sugary beverage consumption and childhood obesity, identifying taxation as a cost-effective approach to reduce consumption and support healthier food environments.[282] In addition, WHO released a global assessment report on sugary beverage taxes in January 2026 to provide guidance on sugary beverage tax considerations to advance public health.[283] The report found that policies vary in design, coverage, and effectiveness and that most countries have not fully adopted or optimized these policies, highlighting the need for more comprehensive, better-designed, and higher-rate taxes.[284] Another recent report, from Health Affairs in July 2025, provided recommendations for strengthening sugary beverage excise taxes, including: (1) Coordination between neighboring jurisdictions/localities to reduce cross-border shopping, (2) Tying sugary beverage taxes to sugar content through a tiered rate or tax per gram of sugar, (3) Taxing a broader range of sweet, ultra-processed foods to prevent product substitutions, and (4) Using a portion of tax revenues to help pay for local public health programs to increase public approval of the tax.[285]

As of March 2026, at least 83 national and 17 sub-national sugary beverage taxes have been implemented worldwide.[286] In the United States, eight U.S. cities and the Navajo Nation have excise taxes on sugary beverages, with the most recent one in Santa Cruz, California, taking effect in May 2025.[287] Shortly after the Santa Cruz sugar drink tax went into effect, the California Grocers Association and other industry groups challenged the law on the grounds that it violated a 2018 state-level law preventing local jurisdictions from imposing any new taxes on groceries, which include sugary drinks. In June 2026, the court ruled in favor of the City of Santa Cruz, upholding its sugary drink tax, and declared California's preemption law unconstitutional.[288] State-level sugary drink preemption laws have been implemented in at least three other states, including Arizona, Michigan, and Washington.[289,290,291,292]

Several states have considered sugary beverage taxes in the 2025–2026 legislative sessions. In Maryland, a sugary drink tax bill was introduced in 2025,[293] with revenue used to fund healthy school meals for all and a childcare scholarship fund.[294] In January 2026, the Massachusetts Senate's Revenue Committee considered a sugary drink tax of 1–2 cents per ounce, based on the amount of sugar in the beverage, with revenue dedicated to communities most impacted by health inequities and diet-related health conditions. Washington state legislators considered a statewide 3-cent-per-ounce sugary beverage tax in 2026, which would support food security and nutrition assistance programs for certain low-income populations and communities of color.[296] In Connecticut, House legislators introduced a bill to impose a 2-cent-per-fluid-ounce tax on sugary beverages, which would be used to help fund a universal free school meals program in the state.[297]

HEALTHY FOOD FINANCING INITIATIVE

Established by the 2014 Farm Bill and reauthorized in 2018, the Healthy Food Financing Initiative (HFFI) works to expand access to fresh, healthy, and affordable food in under-resourced communities.[298,299] By doing so, it helps to reduce food insecurity and support the development of a more resilient food system for underserved communities.[300,301]

Through HFFI, food retailers receive financial and technical assistance to offset higher costs and overcome barriers to entry often present in these communities.[302] The initiative operates as a public-private partnership, funded by USDA and administered by the Reinvestment Fund, an independent community development financial institution.[303,304]

During the 2024–2025 funding cycle, USDA and the Reinvestment Fund awarded $16.5 million in funding and technical assistance to 62 projects through the HFFI Food Access and Retail Expansion Fund (FARE Fund), funded through the American Rescue Plan Act.[305,306] The FARE Fund is 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.[307,308] At least $5.25 million is available for the 2026 FARE Fund planning and implementation grants cycle, along with a minimum of $1 million for technical assistance to support eligible food retail and post-harvest supply-chain projects nationwide.[309]

HFFI funds efforts such as:

- In response to a local food desert report, Delta Magic—a nonprofit dedicated to economic development and revitalization of its community in Helena, Arkansas—is developing Big River Grocery, a community-owned full-service grocery store. The store will expand access to healthy foods and support neighborhood economic growth. HFFI funds will support architectural design, construction, and staffing.[310]
- The nonprofit Bristol Bay Regional Seafood Development Association is using HFFI funds to develop supply-chain infrastructure for a food hub to distribute staple foods to Native communities in Alaska, Washington, Oregon, and Idaho. Funds will support business planning to assess feasibility and the design of the project. These efforts aim to strengthen food access and supply-chain capacity in underserved communities.[311]

Despite these investments, a July 2026 study evaluating longitudinal changes in the food environment found that there has been no substantial progress in reducing food deserts (areas lacking grocery store access) over two decades, while at the same time food swamps (areas with many fast-food and other restaurants, but few grocery stores) have increased.[312] These findings suggest that additional interventions or investments are needed to expand healthy food access.

The U.S. House of Representatives passed the Farm, Food, and National Security Act of 2026 (H.R. 7567), also known as the 2026 Farm Bill, which would reauthorize HFFI by increasing funding by $10 million to $135 million.[313] The same funding increase has also been included in the Senate discussion draft of the Agricultural Act of 2026, released in June 2026.[314]

NEW MARKETS TAX CREDIT

Created under the Community Renewal Tax Relief Act of 2000, the New Markets Tax Credit (NMTC) program is designed to stimulate private investment in economically distressed communities, including communities experiencing high unemployment or low average incomes and rural communities.[315] The credits are awarded on a competitive basis by the U.S. Treasury's Community Development Financial Institutions (CDFI) Fund. The NMTC was made permanent, with $5 billion in annual allocation authority, as part of the One Big Beautiful Bill Act (P.L. 119-21), the 2025 budget reconciliation bill.[316]

NMTC-supported projects are intended to create jobs and enhance quality of life by expanding access to healthcare services, increasing availability of local and regional healthy foods, providing spaces for physical activity, and fostering broader economic opportunities.[317] In March 2025, President Trump issued an executive order reducing the staff of the CDFI Fund to the minimum presence and function required by law.[318] In December 2025, the U.S. Treasury Department announced reforms on the NMTC awards that clarified allowable uses, reinforced compliance with federal anti-discrimination laws, and increased oversight of the use of funds to ensure alignment with applicable law.[319]

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

- ***Mascoma Community Development*** is using NMTC funds to support the redevelopment of Bennington High School in Vermont into a mixed-use development, including the relocation and expansion of fitness and wellness services through the Berkshire Family YMCA. The project will grow YMCA health, wellness, and after-school programs, increasing opportunities for physical activity for residents of all ages.[320]
- ***The Central Texas Food Bank*** in Waco, Texas, is using NMTC funds to expand fresh food capacity by 4.5 million meals, a 15 percent increase, and deliver 2.7 million pounds of nutritious food to rural households, allowing them to reach thousands of low-income, food-insecure individuals each year. The funds will help to strengthen partnerships with rural distribution networks throughout the area.[321]
- ***Nourish Up Foundation***, a nonprofit that provides food services to food-insecure residents in Mecklenburg County, North Carolina, is using NMTC financing to support the $30.7 million redevelopment of a former retail warehouse into a 90,000-square-foot "Hunger Hub." The funds will help significantly expand capacity, supporting up to 200,000 people annually with groceries and 2,500 Meals on Wheels daily, a fivefold increase.[322]

For the 2024–2025 allocation round, the U.S. Department of the Treasury's CDFI Fund awarded $10 billion in NMTC allocation authority to 142 community development entities, with an increased focus on investments in rural and non-metro communities.[323,324] Since its inception, NMTC has invested $81 billion in economically distressed communities.[325] CDFI Fund reports that the NMTC has generated $8 of private investment for every $1 of federal funding.[326]

USDA LOCAL FOOD PROGRAMS

USDA administers several programs through its Agricultural Marketing Service that support local food research, infrastructure, and markets. Created by the 2018 Farm Bill, the Local Agriculture Market Program (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.[327] The goals of LAMP are to support local economies, promote business development for value-added agricultural production and local and regional food system infrastructure, strengthen capacity, and support economic opportunities for producers and food businesses.[328] LAMP programs include the Farmers Market Promotion Program, Local Food Promotion Program, Regional Food System Partnerships Program, and Value-Added Producer Grants Program.[329] USDA announced the availability of $32.4 million in funding for LAMP programs in FY 2026, including $27.68 million through the Farmers Market Promotion Program and Local Food Promotion Program and $4.71 million through Regional Food System Partnerships.[330] The Farmers Market Promotion Program supports producer-to-consumer markets such as farmers markets, roadside stands, agritourism activities, community-supported agriculture programs, or online sales, while the Local Food Promotion Program funds local and regional food businesses that serve as intermediaries in producer-to-consumer marketing, such as shared-use kitchens, food hubs, and food incubators.[331] The Regional Food System Partnerships program supports public-private partnerships between local and regional producers, processors, intermediaries, and institutional markets or food-service operations.[332]

Other local food programs, including the Local Food Purchase Assistance program (LFPA) and Local Food for Schools program (LFS) were terminated in 2025.[333] LFPA provides funds for government purchases of local and regional foods that support local and regional producers,[334] while LFS provides funds for food-assistance purchases of domestic local foods for distribution to schools and childcare.[335] The Regional Food Business Centers program, which provides technical assistance, capacity-building awards, and service coordination to strengthen regional food economies,[336] was also terminated in July 2025.[337] However, funding will be honored for the more than 450 existing grantees.[338]

II. FOOD AND BEVERAGE MARKETING

Food and beverage industry actions play a central role in shaping the food supply, and they influence consumer purchasing habits, dietary preferences, and eating behaviors.[339] Private-sector decisions—such as which products are produced and distributed, how they are packaged, the ingredients used, and how they are marketed—directly affect the broader food environment. In addition, retail strategies related to product placement, stocking, and pricing influence consumer behavior and purchasing choices.[340]

Marketing is one of the industry's most powerful tools for influencing and driving consumption. Companies spend billions of dollars each year on advertising in the United States, with those expenditures mostly promoting less nutritious options, such as fast food, sugary beverages, candy, and ultra-processed foods.[341,342,343,344,345] These messages are delivered through multiple channels, including television advertising, product packaging, and digital platforms, with digital media increasingly taking over traditional advertising.[346,347,348] Research shows that marketing across television, packaging, and digital media is associated with children's and adolescents' food preferences, purchase requests, and consumption patterns.[349,350,351,352,353]

The shift to digital marketing platforms has raised concerns about the scale and nature of online food marketing directed at children and adolescents. Surveys indicate that half of Americans have encountered food and nutrition content on social media, with nearly 65 percent reporting at least some level of trust in that content; however, overall trust is trending slightly downward from previous years.[354] As with traditional advertising, digital campaigns largely promote less nutritious products.[355]

Industry increasingly targets consumers through interconnected advertising and online shopping environments that blur the line between advertising and purchasing.[356] Social media platforms provide

targeted content to users to increase brand awareness, drive website traffic, and ultimately boost sales.[357] An estimated 36 percent of American consumers will shop on social media by 2030.[358] Advertisers are also expanding into connected TV and interactive QR-code advertising, creating seamless pathways from media to immediate purchase behaviors among consumers.[359] Food and beverage companies are leveraging platform algorithms, using artificial intelligence to drive advertising, and tracking user-engagement metrics, including likes, shares, comments, and follower activity, to expand branded content reach online.[360,361,362] Repeated exposure to this content can increase consumer brand familiarity and influence purchasing preferences over time, often without the user recognizing it as advertising.[363]

A related concern is the rapid growth of social media influencer marketing, with spending estimated at nearly $33 billion in 2025 and potentially higher in 2026.[364] In this approach, branded products are embedded within influencer-generated, visually engaging, and highly targeted content.[365,366,367] Examples include personalized advertising, appealing food imagery, and viral food trends.[368] A recent study found that 75 percent of children ages 6–8 and 36 percent of children ages 3–5 encountered branded food content while viewing online videos, including embedded content, thumbnails, and ads, with the 6–8-year-olds having greater exposure than the younger children.[369] Candy, sugary beverages, fast food, and salty or sweet snack products made up nearly 75 percent of branded food exposures.[370] Research has found that influencer promotion of unhealthy snacks leads to immediate increases in children's consumption of those foods, while promotion of healthier options has no measurable effect.[371,372]

Like younger children, adolescents are also exposed to marketing of unhealthy, high-calorie foods through social media influencers and other platform-specific marketing techniques.[373] Research indicates that teens exposed to unhealthy food and beverage advertising demonstrate an increased desire and intent to consume those products.[374,375,376]

Another notable trend is the targeted marketing of products such as candy, sugary beverages, and fast food to specific racial/ethnic populations. For example, multiple studies have shown that Black and Hispanic youth and adults are disproportionately exposed to more food and beverage advertisements than their white counterparts.[377,378] A recent cross-sectional study of adolescent exposure to food and alcohol TV advertising found that, in 2022, Black teens saw disproportionately more food-related advertisements than their white peers.[379] Another recent study, on Hispanic audiences' exposure to food, beverage, and alcohol advertising on Spanish-language television in the United States, found that Hispanic children and adolescents on average were exposed to more than 300 food-related advertisements annually on Spanish-language television, while adults saw more than 1,100.[380] Approximately 40 percent of those ads promoted fast-food restaurants and nearly three-quarters of ads—excluding those from restaurants—featured unhealthy foods.[381] This exposure was on top of any ads seen on English-language television.

Targeted advertising is also evident in the promotion of "toddler milk" to Hispanic audiences.[382] These products, which are similar to infant formula but contain added sugars, are not recommended by the American Academy of Pediatrics.[383] Toddler milks are often marketed alongside infant formula, which can create confusion and lead to its use for infants, despite not meeting infants' unique nutritional needs.[384,385] Studies have found that Hispanic parents in the United States were more likely than non-Hispanic parents to purchase toddler milk,[386] illustrating how advertising can influence purchasing decisions and product use.

One emerging trend relates to wellness claims. Nutrition and marketing analyses suggest that food companies increasingly market processed foods using wellness-oriented claims, such as "high protein," "natural," "no sugar," and "plant-based," particularly as consumers are increasingly seeking health-oriented products.[387,388,389] Studies and expert analyses indicate these claims can create "health halo" effects in which consumers perceive products as healthier than their full nutritional profile would justify.[390,391,392]

Because commercial speech is often protected under the First Amendment,[393] most restrictions on food marketing rely on voluntary, self-regulatory approaches focused on reducing youth exposure to unhealthy food and beverages. For example, the Children's Food and Beverage Advertising Initiative (CFBAI) is a voluntary pledge program in which 21 major food, beverage, and fast-food companies have agreed not to advertise certain unhealthful products directly to children under age 13 on U.S. television and other platforms and to avoid advertising in elementary and middle schools.[394] Although strengthened CFBAI commitments have reduced children's exposure to unhealthy food marketing over time,[395] public health experts note persistent gaps, including exclusions for on-package marketing, in-store displays, sponsorships, and brand marketing.[396] In addition, these voluntary standards do not apply to youth over age 12, despite evidence that adolescents remain highly susceptible to marketing influences.[397,398]

The Childhood Diabetes Reduction Act (H.R.6294/S. 5026) was introduced in the U.S. House of Representatives in November 2025 and in the U.S. Senate in July 2026.[399,400] The bill bars the marketing to children of sugary beverages, foods or beverages containing non-sugar sweeteners, ultra-processed foods, and foods high in nutrients of concern (e.g., added sugars, sodium, and saturated fats).[401] Examples of child-directed marketing include the use of cartoon imagery, fantasy-based themes, children's music, athletes, celebrities, social media influencers, animated content, or free gifts, toys, contests, or interactive games.[402] The Senate bill was reported favorably from committee in July 2026.[403]

Additional legislation, such as the Kids Online Safety Act and the Children and Teens' Online Privacy Protection Act 2.0, is aimed at reducing children's and teens' exposure to harmful digital marketing broadly.[404,405] In June, the U.S. House of Representatives passed the bipartisan Kids Internet and Digital Safety Act, which included the Children and Teens' Online Privacy Protection Act 2.0 and would apply to unhealthy food and beverage marketing, although it is not specific to food marketing.[406]

B) Food Supply Standards and Labels

Standards and regulations are important tools in improving the safety and nutritional quality of the food supply. Labels educate and empower individuals to make healthier choices for themselves and their families, while encouraging industry reformulation. At the federal level, the Human Foods Program of the Food and Drug Administration (FDA) has the mission to protect and promote health and wellness by reducing chronic disease through diet, ensuring food chemicals are safe, and preventing foodborne illness.[407] This subsection covers information on policies and programs to address ultra-processed foods, food additives and synthetic dyes, reductions in sodium and added sugars in the U.S. food supply, and nutrition labeling, including packaged foods and menu labeling.

I. FOOD SUPPLY STANDARDS

ULTRA-PROCESSED FOODS

Ultra-processed foods were initially defined as part of the NOVA food classification system, which grouped foods and beverages by level of physical, biological, and chemical processes for research purposes.[408] Examples of foods meeting this ultra-processed foods definition include packaged breads, cookies, sweetened breakfast cereals, margarines, sauces and spreads, carbonated drinks, hot dogs, hamburgers, and pizzas.[409]

A growing body of research has associated higher intake of ultra-processed foods with adverse health outcomes, including obesity, overweight, and abdominal obesity; type 2 diabetes; cardiovascular disease; cancer and breast cancer risk; depression and anxiety; Parkinson's disease and dementia; impaired male reproductive health; and overall mortality.[410,411,412,413,414,415,416,417,418,419,420,421]

Research has also begun to identify the mechanisms through which intake of ultra-processed foods harms human health and which types of ultra-processed foods or processing methods are most harmful. For example, while refined breads; sauces, spreads, and condiments; artificially and sugar-sweetened beverages; animal-based products; and ready-to-eat mixed dishes are associated with increased type 2 diabetes risk, cereals, dark and whole grain breads, packaged sweet and savory snacks, fruit-based products, and yogurt and dairy-based desserts are associated with reduced risk.[422] Similarly, a 2024 systematic review and meta-analysis found that consumption of processed meats and artificially and sugar-sweetened beverages is associated with elevated cardiovascular risk, while whole-grain breads, cold cereals, yogurts, and savory snacks are associated with lower risk.[423]

This presents a critical public health challenge. During August 2021–August 2023, ultra-processed foods accounted for 55 percent of calories consumed by people ages 1 and older, including 62 percent among youth ages 1–18 and 53 percent among adults ages 19 and older.[424] 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 people.[425,426] Reducing intake of ultra-processed foods and minimizing their adverse health impacts has been a priority at both the federal and state levels. As policymakers consider new policies, they also need to ensure there are sufficient alternative food options for everyone that are available, affordable, safe, and healthy.

At the federal level, the *Make Our Children Healthy Again Assessment*, released in May 2025, highlights high intake of ultra-processed foods as a pressing health problem.[427] The report suggests that the food system, nutrition research and marketing, the *Dietary Guidelines for Americans*, and several federal programs are areas that could be improved in relation to ultra-processed foods.[428] The subsequent *Make Our Children Healthy Again Strategy*, released in September 2025, provides general recommendations related to ultra-processed foods, including supporting more nutrition and metabolic research, issuing the 2025 *Dietary Guidelines for Americans* and a related educational campaign focused on reducing artificial food dyes, creating additional reviews of chemical additives in foods, and determining a federal definition of "ultra-processed food."[429]

In July 2025, FDA and USDA issued a joint request to gather information and data to help establish a federal definition of ultra-processed foods.[430] Comments were accepted through September 2025. The request for information specifically asked for input on the existing classification systems, policies, ingredients or use of specific ingredients, processing methods, terminology, and associations with adverse health outcomes related to the definition of ultra-processed foods.[431] A uniform definition of "ultra-processed foods" is intended to allow for consistency in research and policy across federal agencies.[432] As of August 2026, the definition has not been finalized.

To advance research on the harms of ultra-processed foods and other priority areas, FDA and the National Institutes of Health (NIH) announced a joint Nutrition Regulatory Science Program in May 2025. The program is focused on accelerating a comprehensive nutrition research agenda to inform food and nutrition policies and improve Americans' diets.[433] FDA and NIH intend to design a research agenda with topics including how and why ultra-processed foods affect health outcomes, the role of food additives on metabolic health, and the impact of maternal and infant diets.[434]

The 2025–2030 *Dietary Guidelines for Americans*, released in January 2026, addresses ultra-processed foods with the recommendation to "avoid highly processed packaged, prepared, ready-to-eat, or other foods that are salty or sweet," and "instead, prioritize nutrient-dense foods and home-prepared meals." The *Guidelines* also recommend that Americans "limit foods and beverages that include artificial flavors, petroleum-based dyes, artificial preservatives, and low-calorie non-nutritive sweeteners."[435]

FOOD ADDITIVES AND DYES

Food additives are substances added to foods to improve safety, shelf life, nutrition, taste, smell, texture, or appearance. Most minimally processed and unprocessed foods do not contain additives.[436] Research has tentatively connected certain food additives to a range of adverse health outcomes, including mental health disorders, attention deficit hyperactivity disorder, cardiovascular disease, metabolic syndrome,[437] poor gut health,[438] and autoimmune and metabolic conditions.[439] Removing certain food dyes and other additives has been the subject of recent federal and state action.

Removing petroleum-based food dyes from the food supply has been a priority for FDA over the past two years. In January 2025, FDA revoked authorization of the use of Red No. 3 due to concerns about cancer risk, with the restriction taking effect for foods in January 2027 and for drugs in January 2028.[440] In April 2025, HHS and FDA announced an initiative to phase out petroleum-based dyes from the food supply through voluntary food and beverage industry actions.[441] As of August 2026, more than 25 pledges had been completed or were underway.[442] FDA has also stated its intention to publish draft guidance in 2026 on when fruit- and vegetable-derived juices qualify as color additives under FDA regulations.[443]

To confirm the safety of other food additives already on the market, FDA launched a new post-market food additive review process in May 2025 and updated its list of additives under review.[444] Between February and May 2026, FDA launched reassessments of butylated hydroxyanisole, butylated hydroxytoluene, and azodicarbonamide by issuing requests for information on the use and safety of these chemicals.[445,446,447] As of August 2026, there are 29 additives under review of information, scientific assessment, risk management review, or risk management action.[448]

In August 2026, FDA issued a proposed rule to update the "generally recognized as safe" (GRAS) process by implementing a mandatory GRAS notification program. Comments are accepted until December 2026.[449] The Federal Food, Drug, and Cosmetic Act requires that food additives be subject to premarket review and approval by FDA, unless the substance is GRAS, meaning qualified experts recognize the substance has "adequately shown to be safe under the conditions of its intended use".[450] The proposed rule is intended to close the "GRAS loophole," which allows companies to self-certify that products are GRAS without FDA notification or approval.[451,452] Congress is also considering several GRAS reform proposals, some of which would preempt state-level action on the issue.[453]

State policymakers have also taken action related to ultra-processed foods and food additives. As of April 2026, at least 17 states have proposed or passed bills addressing ultra-processed foods and food additives, mostly in schools.[454] Many state bills ban foods with the "standard 11" food dyes and additives, including potassium bromate, propylparaben, titanium dioxide, brominated vegetable oil, Yellow dye 5, Yellow dye 6, Blue dye 1, Blue dye 2, Green dye 3, Red dye 3, and Red dye 40.[455] West Virginia's law, enacted in March 2025, prohibits the use of seven specific food dyes in school meals, effective as of August 2025, with a restriction on sales of products containing these dyes, along with two additional preservatives, anywhere in the state, effective as of January 2028.[456] The law is subject to ongoing litigation.[457]

Other states, such as Massachusetts, seek to target ultra-processed foods more broadly based on the NOVA definition (that is, foods that have little intact whole food and consist primarily of processed culinary ingredients, industrial food derivatives, and additives).[458] Some state bills, including Pennsylvania, also include nutrition-based criteria.[459] California's law, enacted in October 2025, prohibits schools from serving "restricted school foods" or "ultra-processed foods of concern" using a phased-in approach through 2035.[460]

SODIUM REDUCTION EFFORTS

Although some sodium is essential for hydration,[461] most American adults consume too much sodium.[462] Excess sodium intake causes high blood pressure and increases cardiovascular disease risk.[463] *The Dietary Guidelines for Americans*, 2025–2030 recommend avoiding highly processed foods high in sodium and limiting sodium intake for individuals ages 14 years and older to less than 2,300 milligrams per day, with lower limits for children.[464]

FDA has taken steps to reduce sodium in the food supply through voluntary targets for industry. In 2021, FDA announced Phase I targets, which were intended to reduce average sodium intake to 3,000 milligrams per day.[465] A preliminary evaluation of changes in sodium in the food supply between 2010 and 2022 found that 62 percent of packaged food categories decreased in sodium, while 25 percent increased.[466] Among restaurant food categories, 35 percent decreased in sodium, while 49 percent increased.[467] The most recent NHANES survey, from 2021–2023, found an average sodium intake in the United States of 3,113 mg per day, which is lower than the 2017–2018 survey finding of 3,389 mg per day.[468,469] FDA intends to release a final evaluation of the Phase I targets in 2026.[470]

In August 2024, FDA issued Phase II voluntary sodium-reduction targets through draft guidance for industry.[471] Phase II provides three-year targets for sodium reduction across 163 food categories, intended to reduce overall sodium intake to about 2,750 milligrams per day.[472] FDA accepted comments on the Phase II voluntary sodium targets until January 2025. As of August 2026, the draft Phase II targets had not been finalized.[473]

ADDED SUGARS REDUCTION EFFORTS

The 2025–2030 *Dietary Guidelines* recommended that children younger than 11 consume no added sugars and that adolescents and adults limit added sugars to no more than 10 grams per meal.[474] Building on this recommendation, FDA has announced its intent to create an added sugar-reduction strategy in 2026. The strategy will focus on reformulation to reduce added sugar in processed and prepared foods, proposing a "low added sugar" claim, exploring targeted consumer education and investigating ingredient labeling and menu labeling requirements. FDA also intends to assess the use of low- or no-calorie and non-nutritive sweeteners, which are often used as added sugar replacements.[475]

II. NUTRITION LABELS

PACKAGED FOOD LABELS

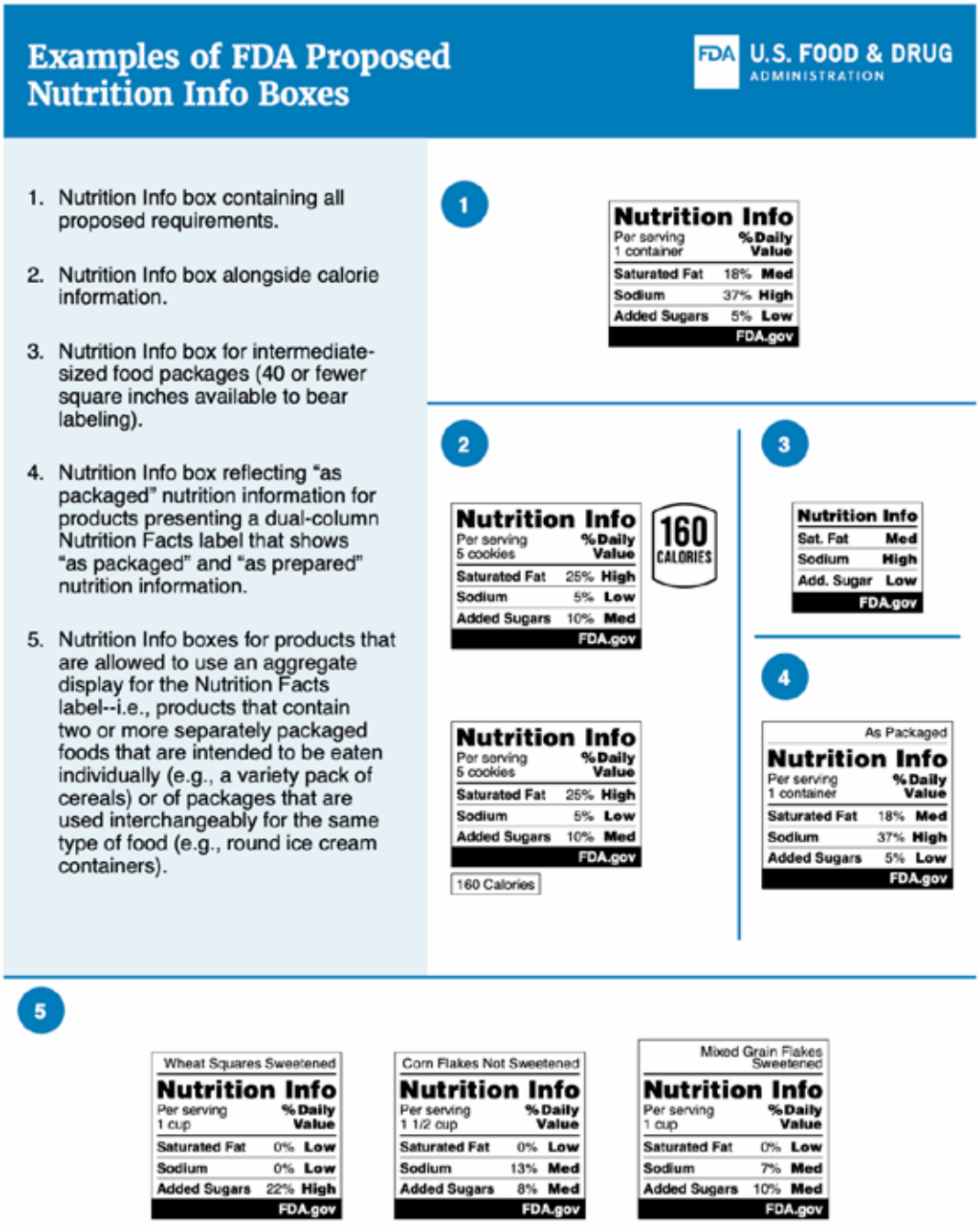
To help consumers make informed decisions, FDA requires that most packaged foods bear a Nutrition Facts label on the back or side of the package.[476] The label requirements were revised in 2016, with the updated requirements taking effect in January 2020 for most foods and January 2021 for smaller manufacturers.[477] The updates were intended to make the label easier to read and to align it with updated nutrition science, including the addition of added sugars.[478]

In January 2025, FDA issued a proposed rule to require a Nutrition Info box on the front of most packaged foods, and comments closed in July 2025. The Nutrition Info box would be a mandatory, interpretive front-of-package (FOP) label and provide the amount per serving of saturated fat, sodium, and added sugars, along with nutrients that consumers should limit. The percent daily value for each nutrient would be described as "low," "medium," or "high."[479] Research has shown that consumers are more likely to notice a FOP label than the Nutrition Facts label.[480] In addition to helping consumers make healthier choices, FOP labels can incentivize industry to reformulate to improve the healthfulness of their products.[481]

Research has found that the most effective FOP label systems are (1) mandatory, (2) interpretive (i.e., help people understand what the label information means), (3) focus on nutrients to limit, and (4) align with other nutrition and public health policies, such as the Nutrition Facts label and food label claims.[482,483]

A 2026 randomized controlled trial with 14,000 participants compared FDA's proposed FOP label with other label designs. The study found that all FOP label designs improved consumer understanding compared with no label.[484] Two label designs—including a label similar to FDA's proposal but without "% DV" and with "High" highlighted, and a multi-label scheme with separate labels for each nutrient contained in a high amount—were more effective than FDA's proposal in helping consumers identify the least-healthy nutrient profiles, with separate labels for each nutrient contained in a high amount being the most effective in reducing the selection of products high in unhealthful nutrients.[485] FDA could consider whether revisions to the proposed FOP label are needed to align with the 2025–2030 *Dietary Guidelines for Americans* and emerging evidence on label design. However, as of August 2026, FDA had not finalized its proposed rule or updated its FOP label proposal.

Examples of FDA Proposed Nutrition Info Boxes



Source: FDA[486]

FDA issued a final rule on the allowable use of the "Healthy" claim on food labels, effective April 28, 2025. The compliance date is February 2028. The final rule updates the criteria for when food companies are allowed to use the term "Healthy" on food labels for the first time in three decades.[487,488,489] To meet the updated criteria, a product must contain a certain amount of food from at least one food group or subgroup recommended by the *Dietary Guidelines* (e.g., fruit, vegetables, grains, fat-free and low-fat dairy, protein foods) and meet limits for added sugars, saturated fat, and sodium, which vary by food category.[490] 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.[491, 492] FDA has also been exploring the development of a new "Healthy" symbol to indicate to consumers that a product meets the "Healthy" criteria.[493] However, as of August 2026, a proposed symbol had not been announced. In 2026, FDA stated it plans to assess whether changes to the "Healthy" criteria are needed to align with the 2025–2030 *Dietary Guidelines for Americans*.[494]

MENU LABELS

Chain restaurants and other food establishments with 20 or more locations nationwide are required to provide calorie information at the point of purchase and make additional nutrition information available upon request.[495] Calorie labeling is also required for vending machine operators with 20 or more machines.[496] Third-party delivery services (e.g., Uber Eats, DoorDash)—which have proliferated in recent years—often do not include calorie counts on their platforms.[497] In December 2023, FDA updated its menu labeling guidance to encourage—but not require—calorie labeling on the third-party platforms.[498]

In addition, several states and cities require sodium menu labeling for chain restaurants, mandating that menu items high in sodium display a symbol (e.g., a saltshaker). New York City was the first locality, in 2015, to require a warning statement along with the symbol,[499] and Philadelphia enacted a similar requirement in 2018.[500] Other states and localities required sodium menu labeling as part of broader menu labeling laws, but they were preempted for chain restaurants when the national requirements were enacted.[501]

In October 2025, the New York City Health Department implemented the first-in-the-nation added sugars warning label for restaurants, modeled after the sodium menu labeling requirement. The rule requires that chain restaurants post an icon that looks like a spoonful of sugar next to any menu item that contains 50 grams or more of added sugars, equivalent to the daily limit for a person consuming a 2,000-calorie diet.[502] Other jurisdictions have also considered but not enacted similar requirements.[503]

Menu labeling allows consumers to make more informed choices when they eat out. About one-third of Americans' calories come from food prepared away from home, more than half of which comes from fast food.[504] 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.[505,506] A 2025 international evidence review found that menu labeling leads to about a 2 percent reduction in calories.[507] While small, this amount could be meaningful if sustained long-term.[508] In the United States, a national microsimulation study found that over five years, a national menu calorie-labeling law could prevent nearly 14,700 cardiovascular disease cases and over 21,500 type 2 diabetes cases, while saving the healthcare system $260 million.[509]

C) Nutrition Assistance and Education Programs

An estimated 14 percent of U.S. households were food insecure at some point in 2024, meaning they lacked access at all times to enough food for an active, healthy lifestyle for all family members.[510] Certain population groups are more likely to experience food insecurity, including people with low incomes, households with children, single-parent households, people living in urban and rural areas, and Black and Hispanic households.[511] Food insecurity is associated with an increased risk of obesity,[512] abdominal obesity in older adults,[513] and other chronic conditions in both children[514] and working-age adults.[515]

USDA's 16 nutrition assistance programs help reduce hunger, improve food security, expand access to nutritious foods, and support nutrition education. Programs including the Supplemental Nutrition Assistance Program (SNAP), the school nutrition programs, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the emergency food assistance programs serve one in four Americans each year.[516] Some programs provide nutritious foods directly to participants, while others provide funds to purchase groceries.

As of June 2026, USDA's Food and Nutrition Service became the Food and Nutrition Administration, with nutrition program operations reorganized around hubs in Atlanta, Georgia; Dallas, Texas; Denver, Colorado; Indianapolis, Indiana; Kansas City, Missouri; Los Angeles, California; New York, New York; and Raleigh, North Carolina.[517] Many nutrition and public health organizations expressed concern that the relocation would reduce efficiency and coordination, and lead to loss of expertise, as staff may leave the agency rather than relocate.[518,519]

Many of the federal nutrition programs have also experienced disinvestment in recent years. Federal spending on USDA nutrition assistance programs (except for Summer Electronic Benefits Transfer for Children, or "Summer EBT") totaled $142 billion in FY 2024, 18 percent lower than in FY 2023, adjusted for inflation.[520] Federal spending on SNAP is expected to decline substantially under the One Big Beautiful Bill Act (OBBBA), signed into law in July 2025. OBBBA is expected to cut $187 billion from SNAP and reduce program participation by 2.4 million people per month over the 2025–2034 period.[521, 522] Changes in SNAP enrollment will have carry-over effects on programs such as the school meal programs, since children in SNAP are automatically certified for free school meals and SNAP enrollment is one of the primary determinants of a school's eligibility to enroll in the Community Eligibility Provision for no-cost school meals for all students. [523, 524]

This subsection covers information on federal food and nutrition assistance programs, including SNAP and GusNIP, child nutrition programs, other programs in childcare and educational settings (Smart Snacks, K–12 local school wellness policies, Head Start), WIC, emergency food assistance programs, and local food programs.

I. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

The Supplemental Nutrition Assistance Program is the nation's largest food assistance program. In FY 2025, 42 million people participated in the program, at a total cost of $102 billion.[525] SNAP participants received an average of $188 in food assistance per month.[526] Two in three SNAP participants are children, older adults, or persons with a disability.[527] SNAP plays a critical role in reducing food insecurity and poverty among program participants.[528]

USDA research has estimated that each additional $1 invested in SNAP during a slowing economy produces a return on investment of more than $1.50.[529] Longitudinal research has also found 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.[530] Specifically, the study found that every SNAP dollar invested in children provides a $62 return over their lifetimes.[531]

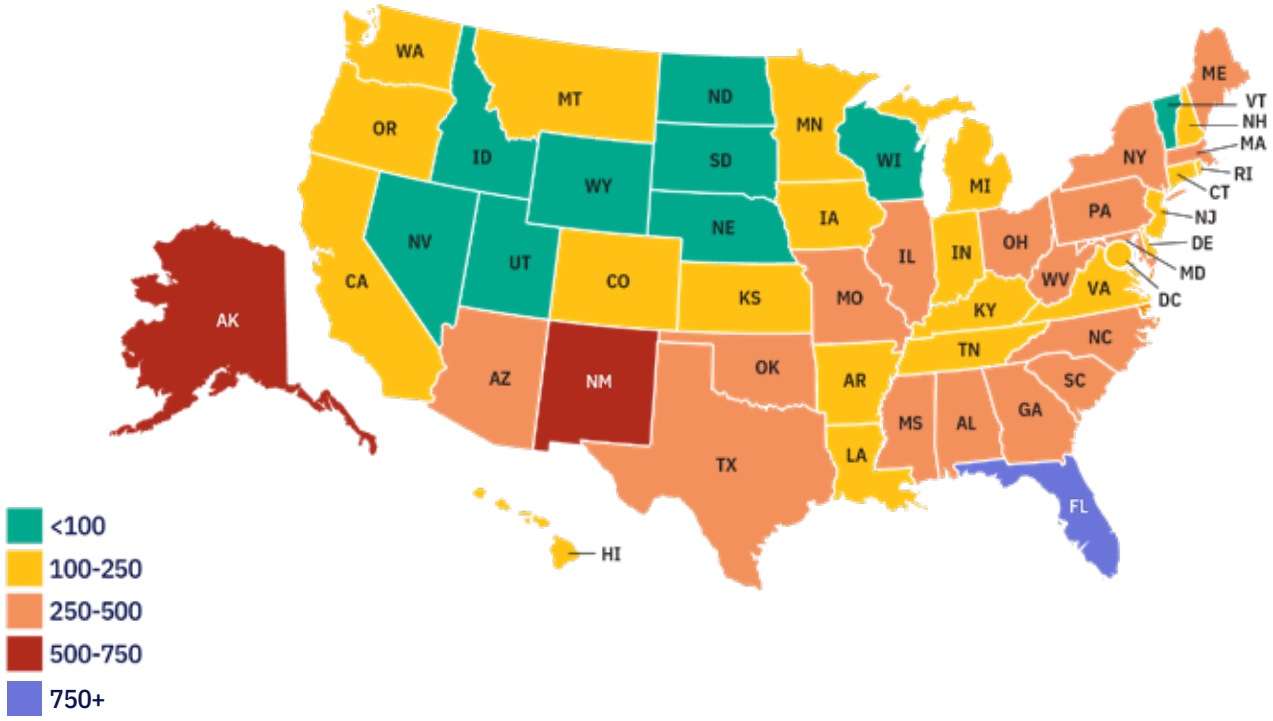
FUNDING, ELIGIBILITY, AND BENEFIT AMOUNTS

SNAP is administered by USDA's Food and Nutrition Administration, with state agencies responsible for program administration, program integrity, eligibility verification, and monthly benefit allotments.[532] OBBBA reduced SNAP eligibility by expanding work requirements from age 54 to age 64. Under OBBBA, SNAP participants ages 18–64 must meet work requirements in order to receive continued benefits for longer than a three-month period, unless they meet specific criteria to be exempt from the work requirements.[533]

In FY 2025, 93 percent of federal SNAP spending went toward grocery benefit costs.[534] Since the program's inception, the federal government has covered 100 percent of grocery benefits and 50 percent of program administration costs; the other 50 percent of administrative costs were covered by the states.[535] However, OBBBA is shifting more costs to states: in FY 2027, states will have to cover 75 percent of the administrative costs and, beginning in FY 2028, a portion of the SNAP grocery benefit costs, which will vary depending on the state's payment error rate.[536] (Note: SNAP payment error rate is a measure of the accuracy of each state's eligibility and benefit determinations, including both overpayments and underpayments, and is not a fraud assessment rate.) As a result of the new cost-sharing requirements, states' costs are expected to increase substantially, with a median increase of 202 percent, compared with FY 2024 state SNAP spending.[537] States with large populations and higher poverty rates are likely to be hit hardest, including Florida (nearly 770 percent), Alaska (nearly 650 percent), and New Mexico (nearly 540 percent).[538] Since states must balance their budgets every year, advocates and researchers believe states may respond to these cost increases by shifting funding away from other priorities, raising new revenue, enacting policies that reduce SNAP enrollment in order to reduce costs, or ending their SNAP program.[539]

Nationwide, SNAP participation is estimated to have declined by more than 5 million people—about 12 percent of participants—between July 2025 and May 2026, including about 1.5 million children.[540,541] Participation declined across all states except Alaska, which had a small increase, and Georgia, which had no data available.[542] In Arizona, SNAP participation declined by about half.[541] The loss of SNAP eligibility also makes it more difficult for children to qualify for other food assistance programs, such as WIC and school meals.[544]

MAP 4: Estimate of the Percentage Increase in States' SNAP Budgets Due to OBBBA



Source: Georgetown Center on Poverty and Inequality[545]

SNAP grocery benefit amounts are based on the Thrifty Food Plan, which provides the amounts, types, and costs of nutrient-dense foods and beverages for a healthy diet that can be purchased on a limited budget.[546] The FY 2025 SNAP benefit provides an average of $6.26 per day.[547] OBBBA required that future Thrifty Food Plan updates not increase in cost, except for annual inflation adjustments.[548]

RETAILER PARTICIPATION AND BENEFIT REDEMPTION

In May 2026, USDA issued a final rule updating the retailer stocking requirements for SNAP. The rule requires that all SNAP retailers, except for specialty stores, stock a minimum of seven varieties of "staple foods" in each of four food categories (dairy, fruits and vegetables, grains, and protein) and offer at least one perishable food item in three of the four food categories. The rule also reclassified butter, jerky, cheese dip, snack bars, and fruit spreads so they no longer count toward the staple food stocking requirements.[549]

The SNAP Online pilot program, which allowed online ordering and payment for SNAP purchases, was first authorized in the 2014 Farm Bill and implemented in six states in 2019–2020.[550] The program is now available in all 50 states and Washington, DC.[551] To protect against fraud, USDA is modernizing the program by transitioning its electronic benefits transfer (EBT) card system to a chip card technology. As of July 2026, EBT chip cards had been issued in seven states (Alabama, California, Massachusetts, Maryland, Michigan, New Jersey, and Oklahoma) and implementation is in progress in four additional states (Arkansas, New York, Oregon, and Virginia).[552]

ELIGIBLE FOODS AND FOOD RESTRICTION WAIVERS

SNAP benefits may be used to buy any grocery item with the exception of hot prepared foods, vitamins, medicine, supplements, live animals, nonfood items such as toiletries and hygiene items, and alcohol or tobacco.[553] 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.[554] Bipartisan legislation has been introduced in both chambers of Congress to allow SNAP dollars to be used to purchase hot foods.[555,556]

With the stated goals of strengthening integrity and restoring nutrition within SNAP, USDA approved its first ever "Food Restriction Waivers" in 2025. As of August 2026, 23 states had received approval for food restriction waivers, with implementation dates from January 2026 through February 2028, although a court in June 2026 prohibited implementation of the waivers in five states.[557] *(See sidebar on page 76 for more on the status of Food Restriction Waivers.)*

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.[558] 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.[559]

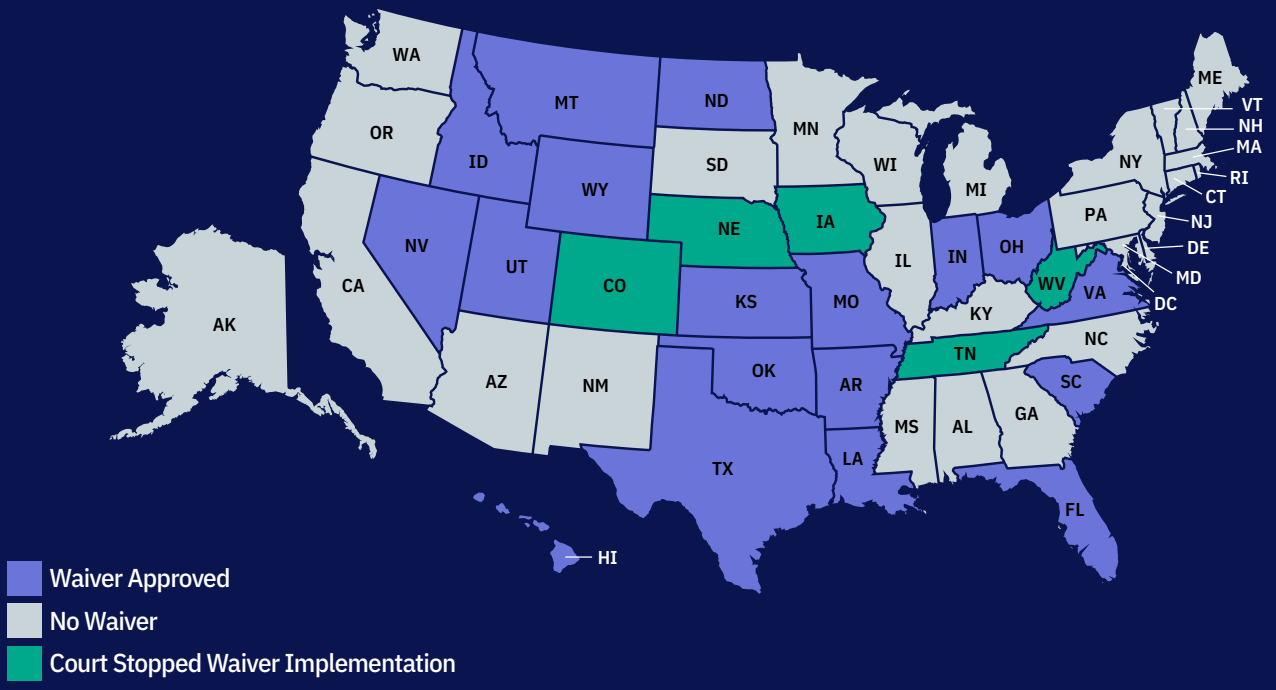
There is limited research on the effects of this new waiver, and the studies conducted so far show mixed evidence.[560] For example, a 2024 randomized controlled study found that participants who had restrictions on using program funds for particular foods (i.e., sugar-sweetened beverages, sweet baked 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 food items even less. The overall nutritional quality of participants' diets and food security measures, however, ended up being the same across all groups.[561] However, an August 2026 working paper on the early impacts of SNAP sugary drink purchase restrictions, from 10 states during the first half of 2026, found that SNAP participant purchases of restricted beverages declined 12 percent compared with states without purchase restrictions. SNAP participants partially substituted non-restricted sugary drinks in the states that prohibited SNAP purchases of only certain types of sugary drinks.[562]

SNAP FOOD RESTRICTION WAIVERS

Note: On March 11, 2026, a group of SNAP beneficiaries filed a challenge to the approvals of SNAP food restriction waivers for Colorado, Iowa, Nebraska, Tennessee, and West Virginia. The lawsuit was brought forth by the National Center for Law and Economic Justice and asks the court to postpone the implementation dates for the waivers in those five states and prohibit enforcement of the waivers that have already gone into effect.[563] In June 2026, the court ruled that implementation of the waivers in those states may not proceed,[564] stating that USDA did not have the authority to approve the waivers, which amend the definition of food that can be sold using SNAP dollars that was established by Congress, and failed to abide by a procedural requirement.[565,566]

In 2025, USDA began approving "Food Restriction Waivers," which allow states to restrict purchases of certain food items that a state considers non-nutritious. As of August 2026, 23 states have received approval for SNAP food restriction waivers.[567] Of the 23 states that have received approval for their waivers, 15 waivers have begun or will begin implementation in 2026; five states had their waivers vacated by court in June 2026; and three states (Nevada, Kansas, and Wyoming) are planning to begin implementation in 2027 or 2028.[568] One state (Mississippi) has a waiver approval pending, and many other states have taken steps in 2026 to pursue a waiver.[569,570]

MAP 5: States with SNAP Food Restriction Waivers



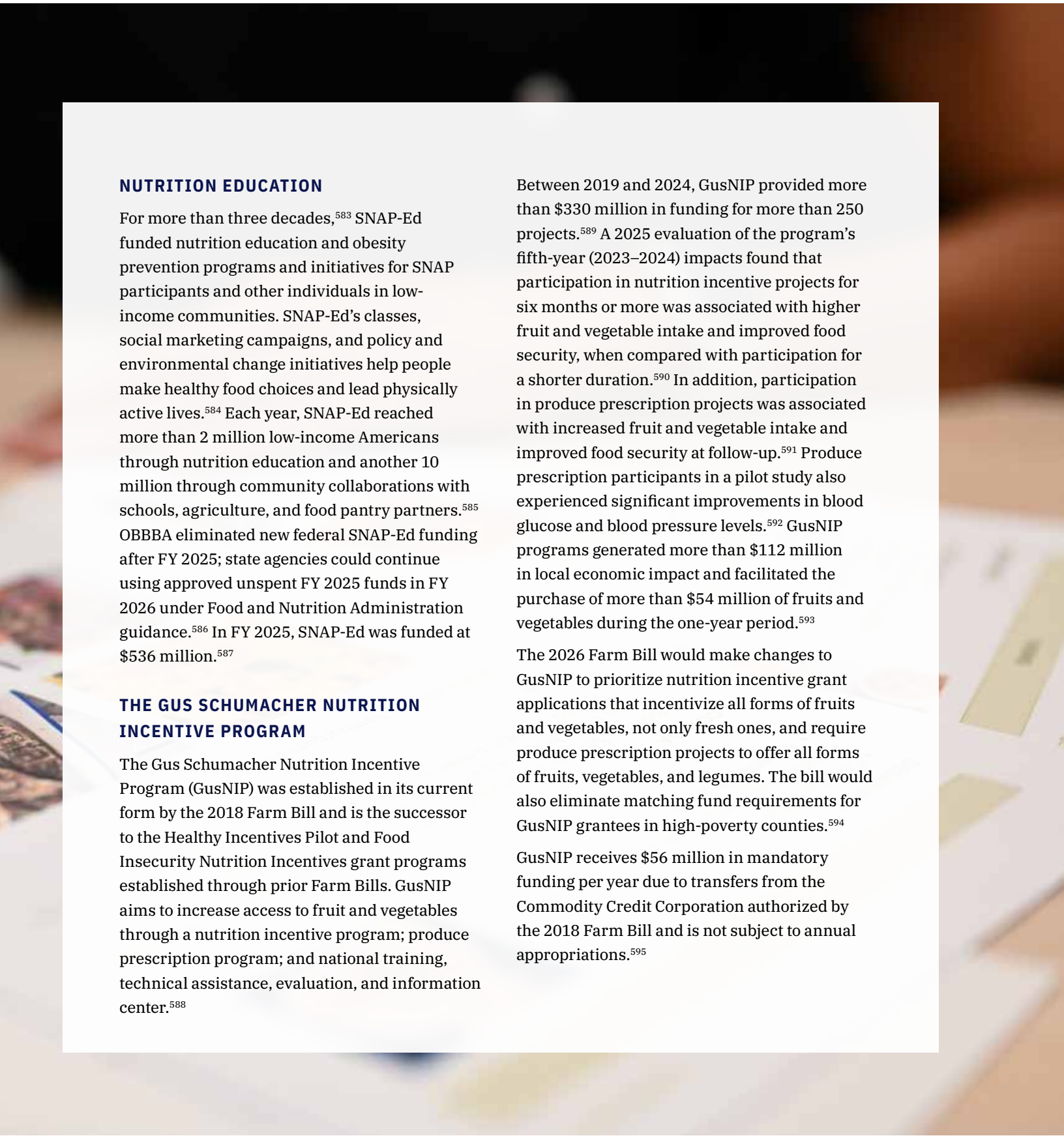
Source: USDA[571]

While USDA has encouraged states to pursue waivers that restrict the purchase of non-nutritious items like soda and candy, the department has not provided guidance for states to define the restricted food categories.[572] As a result, states' SNAP food restriction waivers vary widely, as each state government is tasked with creating a definition of "soda" and "candy." In some states, the restricted food categories include additional ultra-processed foods, such as energy drinks and juices.[573] Notably, one state's waiver restricts all taxable foods, including potentially healthier alternatives, such as fruit, nut, and honey granola bars, while allowing the purchases of other non-taxable ultra-processed foods, such as cakes, cookies and certain candies.[574, 575, 576]

As this patchwork of restrictions develops, retailers have been left to figure out much of the implementation, often without clear guidance. Retailers in many states must figure out the requirements and restrictions in each jurisdiction in which they operate.[577] For many retailers, this means new responsibilities and costs, such as staff training, administrative requirements, technology updates, and increased labor costs to comply with stocking requirements and labeling.[578] Since food retailers are not legally required to participate in the SNAP program, the new requirements and potential penalties raise concerns about retailers' willingness to participate in the program as they take on new administrative demands and compliance requirements.

In addition to the waiver implementation requirements, retailers will also be required to comply with the new Staple Food Stocking Standards beginning November 4, 2026, which outline the food varieties that SNAP-authorized retailers must have available on a continuous basis. Recent changes to the Staple Food Stocking Standards increased the minimum number of staple food varieties SNAP-authorized retailers must carry and updated the definitions for accessory foods that count as staple foods to include nutritious snacks and other ingredients important for food preparation.[579] These added administrative costs, new compliance regulations, and potential penalties related to the restrictions could lead to retailers dropping the program altogether.[580] For individuals and communities with limited supermarket access or transportation or mobility challenges—such as older adults and rural communities—the possibility that smaller retailers could leave raises concerns about food access and food security.[581]

While these waivers evolve and become enforceable, evaluations of such waivers are beginning to take shape, although little information is publicly available about each state's specific plan. USDA requires evaluations to include participant surveys assessing purchases, consumption, awareness, and shopping behavior, with the state responsible for identifying data sources, health, and other non-health outcomes the state will track and evaluate. A review of these evaluation plans notes that there is also substantial variation among them, and many lack sufficient specificity to make clear which outcomes each state is expected to report.[582] Experts familiar with several states' evaluations note that some states plan to focus their evaluations on tracking purchasing behaviors and participants' experience at checkout but have missed outcomes that capture the impact of the waivers on the larger food environment (e.g., retailer availability) and other systemic impacts of the policy (e.g., food security).



NUTRITION EDUCATION

For more than three decades,[583] SNAP-Ed funded nutrition education 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.[584] Each year, SNAP-Ed reached more than 2 million low-income Americans through nutrition education and another 10 million through community collaborations with schools, agriculture, and food pantry partners.[585] OBBBA eliminated new federal SNAP-Ed funding after FY 2025; state agencies could continue using approved unspent FY 2025 funds in FY 2026 under Food and Nutrition Administration guidance.[586] In FY 2025, SNAP-Ed was funded at $536 million.[587]

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 Incentives grant programs established through prior Farm Bills. GusNIP aims to increase access to fruit and vegetables through a nutrition incentive program; produce prescription program; and national training, technical assistance, evaluation, and information center.[588]

Between 2019 and 2024, GusNIP provided more than $330 million in funding for more than 250 projects.[589] A 2025 evaluation of the program's fifth-year (2023–2024) 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.[590] In addition, participation in produce prescription projects was associated with increased fruit and vegetable intake and improved food security at follow-up.[591] Produce prescription participants in a pilot study also experienced significant improvements in blood glucose and blood pressure levels.[592] GusNIP programs generated more than $112 million in local economic impact and facilitated the purchase of more than $54 million of fruits and vegetables during the one-year period.[593]

The 2026 Farm Bill would make changes to GusNIP to prioritize nutrition incentive grant applications that incentivize all forms of fruits and vegetables, not only fresh ones, and require produce prescription projects to offer all forms of fruits, vegetables, and legumes. The bill would also eliminate matching fund requirements for GusNIP grantees in high-poverty counties.[594]

GusNIP receives $56 million in mandatory funding per year due to transfers from the Commodity Credit Corporation authorized by the 2018 Farm Bill and is not subject to annual appropriations.[595]

II. YOUTH NUTRITION PROGRAMS

USDA CHILD NUTRITION PROGRAMS

USDA's child nutrition programs provide nutritious meals and snacks through a series of programs.[596] The child nutrition programs are federally funded and administered by the Food and Nutrition Administration (formerly the Food and Nutrition Service) and state agencies. They meet children and eligible adults where they are and operate in schools, childcare centers and family childcare homes, after-school programs, community centers, adult daycare centers, and other locations. Major programs are described in the table on the next page.

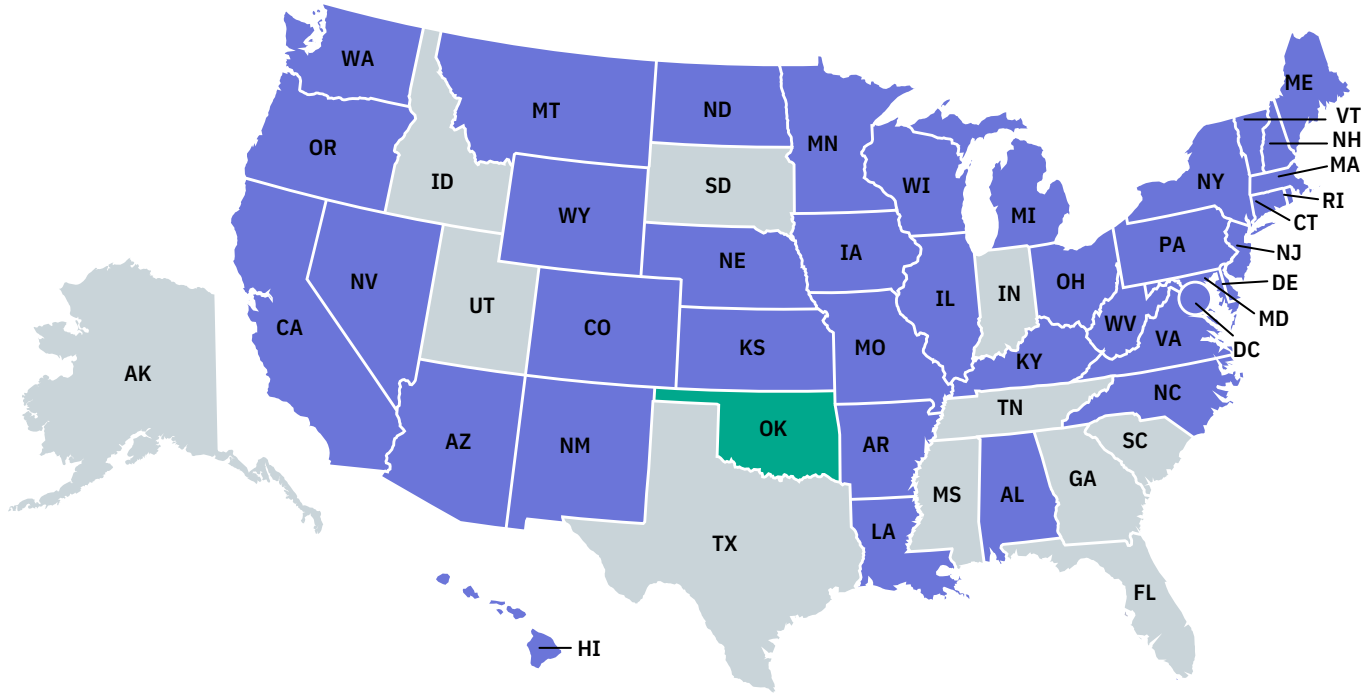
TABLE 5: Major USDA Child Nutrition Programs

NATIONAL SCHOOL LUNCH PROGRAM (NSLP)	■ NSLP is the largest child nutrition program and the second-largest nutrition assistance program overall, providing nutritious lunches to America's school-age children since 1946.[597] NSLP serves 30 million children per school day.[598] Nearly three in four participants receive nutritious meals at no or low cost.[599]
SCHOOL BREAKFAST PROGRAM (SBP)	■ SBP serves nutritious breakfasts to school-age children at low or no cost. SBP fed an average of 15.7 million children per school day in FY 2025,[600] about half as many as NSLP. Innovative service models, such as breakfast after the bell, can help increase SBP participation and improve diet quality and classroom behavior, particularly among students from racial and ethnic minority backgrounds and students eligible for free or reduced-price meals.[601]
SPECIAL MILK PROGRAM (SMP)	■ SMP provides milk to children in schools and childcare programs who do not participate in other federal nutrition programs, including children in half-day pre-kindergarten and kindergarten programs.[602]
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)	■ CACFP provides reimbursement for nutritious meals and snacks for children in childcare centers, family childcare homes, after-school programs, and emergency shelters, and older adults and adults with a disability in adult daycare centers.[603] In FY 2025, CACFP served 4.8 million individuals on a typical day.[604]
SUMMER FOOD SERVICE PROGRAM (SFSP)	■ SFSP provides free healthy meals to children in low-income communities during the summer months.[605] In FY 2025, SFSP served an average of 2.8 million youth on a typical July day.[606]
SEAMLESS SUMMER OPTION (SSO)	■ SSO is an alternative to SFSP and allows certain school districts participating in the school meal programs during the school year to continue to meet NSLP and SBP criteria and be reimbursed at those programs' free rates during the summer. Reimbursement is less than for SFSP, but paperwork is reduced.[607]
SUMMER ELECTRONIC BENEFITS TRANSFER (SUMMER EBT)	■ Summer EBT provides a $120 summer grocery benefit for each eligible school-age child in participating states.[608]
FRESH FRUIT AND VEGETABLE PROGRAM (FFVP)	■ FFVP provides free fresh fruit and vegetable snacks and nutrition education to students at eligible elementary schools.[609]

Several programs support access to nutritious foods during the summer months.[610] Depending on students' geographic location, they may have access to one or more programs:

- ***The Summer Food Service Program (SFSP)*** provides free nutritious meals and snacks to school-age children when school is not in session for extended periods.[611] These meals are typically provided at a central site, such as a school or community center, and accompanied by an enrichment activity.[612] However, in certain rural communities, school-age children have access to to-go meals.[613]
- ***The Summer Seamless Option (SSO)*** allows schools in which a majority of students receive free meals during the school year to continue to serve meals that meet NSLP and SBP criteria and be reimbursed at those programs' free rates during the summer. Reimbursement rates are lower than for SFSP and the nutrition criteria are stricter, but streamlined state agency approval processes can reduce local administrative expenses.[614]
- ***The Summer EBT Program*** provides families of children eligible for free or reduced-price school meals with $120 in benefits per school-age child to buy groceries during the summer months.[615] Summer EBT began as a pilot program more than a decade ago and was established as a permanent program beginning in summer 2024.[616] Evaluation of the Summer EBT pilot program showed that it helped reduce food insecurity and improve diet quality.[617] States opt in to participate in the program and pay a portion of the program's administrative fees. During summer 2026, 39 states, the District of Columbia, five U.S. territories, and five tribal nations were participating or planned to participate in the program *(See Map 6)*.[618] Iowa participated for the first time in 2026.[619] States decide annually whether to participate in the program.

MAP 6: States Participating in Summer EBT Program, 2026



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 Summer EBT in 2026.

Source: USDA[620]

In April 2024, USDA finalized a rule updating the school and CACFP nutrition standards to provide menu-planning flexibilities, make changes to program operations, strengthen limits on sodium, and add new limits on added sugars.[621] Several of the key provisions are still being phased in. Product-specific standards for added sugars in breakfast cereals, yogurt, and flavored milk took effect in school year 2025–2026, while an overall weekly limit on added sugars takes effect at the beginning of the 2027–2028 school year.[622]

In January 2026, Congress passed the Whole Milk for Healthy Kids Act (P.L. 119-69), which expanded the varieties of milk that may be offered through the NSLP from fat-free and 1 percent milk to also allow whole milk, 2 percent milk, lactose-free milk, and nondairy beverages that meet specified nutritional criteria.[623] The law also exempts saturated fat from milk from counting toward weekly saturated fat limits in the NSLP.[624] In May 2026, USDA issued a final rule, partially implementing and expanding on the requirements in the Whole Milk for Healthy Kids Act.[625] The rule allows whole and 2 percent milk options to be served in federal child nutrition programs for children and adults ages 2 and older, citing the Whole Milk for Healthy Kids Act and the 2025–2030 *Dietary Guidelines'* treatment of milk and saturated fat.[626,627]

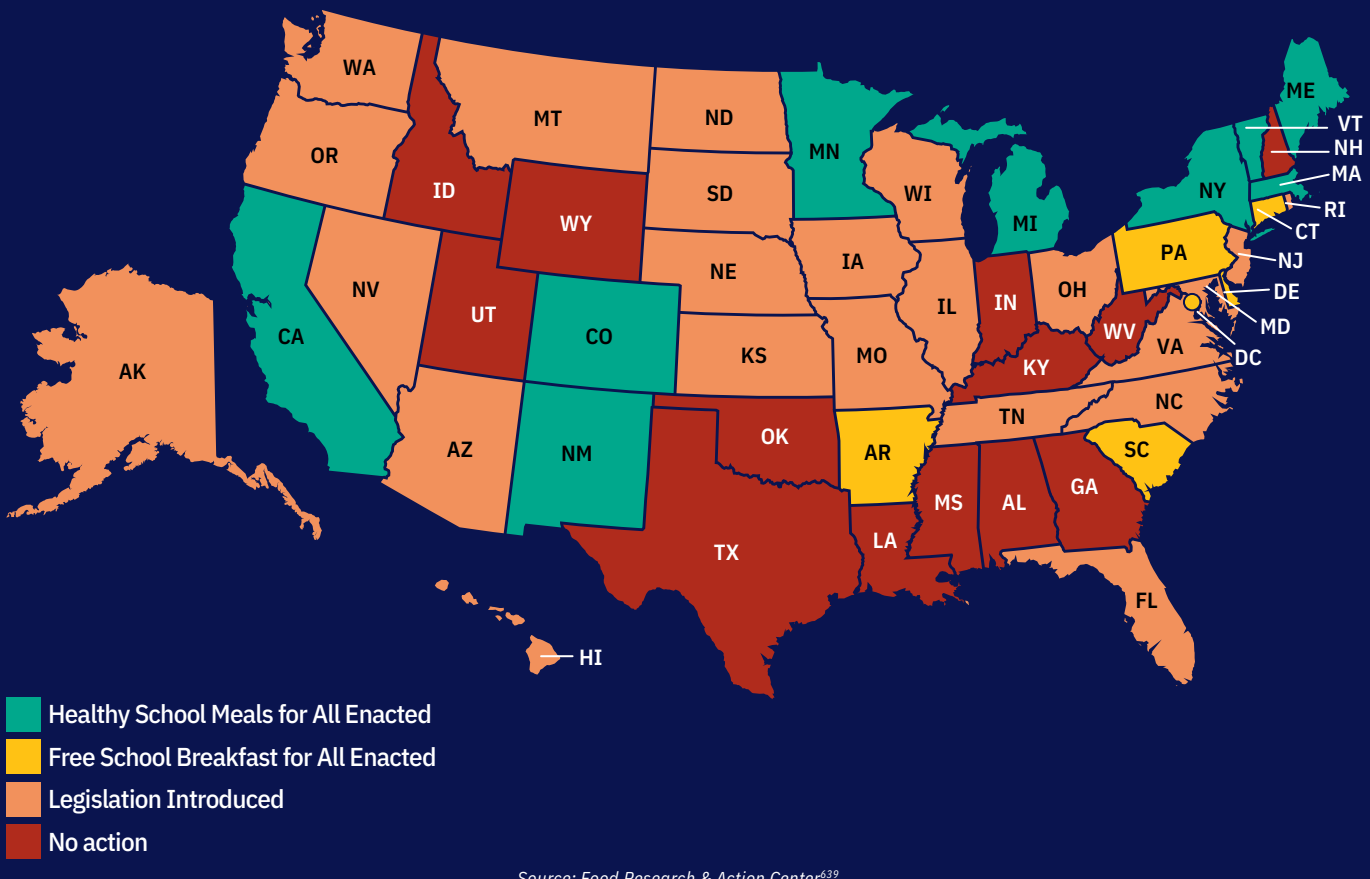
In August 2026, USDA and HHS announced an upcoming Harvest to Hallways Initiative to increase support for school meal programs. The announcement stated the initiative will include: a new education and outreach campaign to schools about the existing local food procurement options, $70 million for school cafeteria infrastructure grants, up to $25 million in additional Farm to School Grants for FY 2026, $30 million for research on improving school meal nutrition, and an optional Pledge for Healthier School Meals for schools.[628]

STATES' HEALTHY SCHOOL MEALS FOR ALL

During the COVID-19 pandemic, USDA issued temporary waivers that allowed school districts to offer healthy school meals for all students at no cost.[629] 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.[630] These states cover the difference between federal reimbursements and the cost of providing nutritious meals for all participating students. As of September 2026, nine states (California, Colorado, Maine, Massachusetts, Michigan, Minnesota, New Mexico, New York, and Vermont) had Healthy School Meals for All policies, while five additional states (Arkansas, Connecticut, Delaware, Pennsylvania, and South Carolina) and the District of Columbia had School Breakfast For All policies.[631] In addition, more than 20 states have introduced Healthy School Meals for All legislation.[632] Research has associated Healthy School Meals for All policies with benefits, including improved diet quality, increased food security, reduced stigma, and, in some studies, improved attendance, behavior, or academic outcomes.[633,634,635]

In addition, the Community Eligibility Provision (CEP) allows certain schools and districts with a high percentage of students qualifying for free meals to offer free meals to all students, reducing paperwork, increasing school meal program participation, and removing stigma.[636] In the 2025–2026 school year, about 27.6 million children attended schools that participated in CEP.[637] However, one in four schools that are eligible for CEP have not implemented it.[638] CEP can expand school meal participation while reducing administrative burdens; schools must cover with nonfederal funds any costs above federal reimbursements.

MAP 7: States with Healthy School Meals for All Programs, Sept. 2026



Source: Food Research & Action Center[639]

OTHER YOUTH NUTRITION PROGRAMS

Smart Snacks in Schools

Foods sold in schools during the school day, outside of the school meal programs, must meet the Smart Snacks in Schools federal nutrition standards.[640] These "competitive foods" are sold à la carte in the cafeteria, in vending machines, and at school stores. The standards do not apply to snacks sold more than 30 minutes after school ends, 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.[641] 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.[642] The Smart Snacks requirements were updated in 2024 to exempt bean dips (e.g., hummus) from the total fat standard.[643]

Farm to School

The Patrick Leahy Farm to School Program provides funding to incorporate local foods into NSLP, SBP, SFSP, CACFP, and other child nutrition programs.[644] Program funds have been used for activities, equipment, trainings, menu-item creation and testing, supply-chain strengthening, school gardens, and agricultural field trips.[645] In March 2025, USDA canceled $10 million in Farm to School grants for FY 2025.[646] In FY 2026, USDA re-launched the program with revised grant criteria[647] and provided nearly $20 million in funding for 68 projects in 37 states.[648,649] Since the Farm to School Grant program was launched in 2013, more than $115 million in funding has been awarded to support more than 1,250 projects nationwide.[650]

K–12 Local School Wellness Programs

Each school district that participates in NSLP or SBP is required to develop and implement a district-level local school wellness policy.[651] The wellness policy is a written document that guides the school district's efforts to promote students' health, well-being, and ability to learn.

The wellness policy must:

- Establish nutrition education, nutrition promotion, and physical activity goals, reviewing and considering evidence-based standards;
- Include nutrition guidelines for all foods and beverages sold to students on campus that are consistent with federal requirements, as well as foods and beverages provided to students (e.g., in classroom parties);
- Limit food marketing to products that meet the Smart Snacks in Schools nutrition standards; and
- Describe opportunities for public involvement, public updates, policy leadership, and evaluation plans.[652]

School districts are required to assess their local wellness policies every three years.[653] The review must consider compliance with the policy, comparison with model policies, and progress in attaining policy goals.[654]

School districts must permit the school community and the general public to participate in the wellness policy review and update process.[655]

Head Start

Head Start programs support early learning and development, health, and family well-being among children ages 0–5 from low-income families.[656] Head Start preschool (for children ages 3–5) and Early Head Start (for infants, toddlers up to age 3, and pregnant people) programs provide child development services in center-based, home-based, or family childcare settings.[657] The Office of Head Start, within the Administration for Children and Families at HHS, manages the federal program and provides oversight to local Head Start agencies.[658]

Head Start programs must provide high-quality and developmentally, culturally, and linguistically appropriate nutrition services. All Head Start grant recipients are required to participate in CACFP[659] and to implement snack and mealtimes 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.[660] Head Start programs can also support participant cross-enrollment in other nutrition programs, such as SNAP and WIC.[661]

Compared with nonparticipants, those enrolled in Head Start are more likely to have healthy eating patterns,[662] although studies are mixed regarding the impact of Head Start participation on BMI.[663,664,665] CACFP participation has also been shown to increase consumption of milk and vegetables and may reduce overweight and underweight among low-income children.[666,667]

Head Start was funded at $12.4 billion in FY 2026.[668]

III. SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN

WIC provides healthy foods, nutrition education, breastfeeding support, and healthcare referrals to income-eligible pregnant, postpartum, and breastfeeding women and infants and children up to age 5 who are at nutritional risk.[669] The program is funded by the federal government and administered by USDA, along with state and local agencies.[670]

In FY 2025, WIC served 6.9 million individuals.[671] The average monthly WIC food benefit cost was about $65 per person.[672] In 2023, WIC reached 56 percent of eligible individuals, with the highest participation for infants and postpartum individuals.[673] WIC participation also varies by state, from 41 percent of eligible individuals participating in Louisiana to a high of 80 percent of those eligible participating in Vermont.[674] Barriers and enablers to WIC participation include program logistics, program operations and functioning, food choice and availability, technology, knowledge and awareness of WIC, perceptions of the program, and relationships with WIC staff.[675] A 2025 study of more than 188,000 WIC participants in Southern California found that participants who redeemed a higher proportion of their benefits on the most popular food categories (e.g., fruits and vegetables, eggs, infant formula, and whole milk) were more likely to stay in WIC; participants who had lower redemption for popular categories had higher program discontinuation.[676]

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.[677,678] An economic analysis of prenatal participation in California's WIC program found that every $1 invested in WIC services saves about $2.48 in medical, educational, and productivity costs.[679]

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 base monthly fruit and vegetable cash-value benefit to $24 for children, $43 for pregnant and postpartum participants, and $47 for breastfeeding participants, with the amounts adjusted annually for inflation. In FY 2026, the inflation-adjusted monthly amounts are $26, $48, and $52, respectively. Other changes included reducing juice amounts for all participants and allowing an increased CVV to be substituted for juice; reducing the maximum milk allowance; requiring 75 percent of cereals to meet whole-grain requirements; and adding canned fish to food packages for children.[680,681] Most of the food-package changes were required to be implemented by April 20, 2026; the minimum vitamin D requirement for yogurt has a later implementation deadline of April 19, 2030.[682] An evaluation of the CVV, which increased temporarily 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, reduced food insecurity, and increased fruit and vegetable intake among individuals with the lowest initial intakes.[683]

While WIC was fully funded at $8.2 billion in FY 2026,[684] program funding continues to be at risk. The FY 2027 President's Budget Request included a significant cut to the CVV, bringing it down to $10 per month for children and $13 per month for pregnant, postpartum, and breastfeeding participants.[685] The FY 2027 House Agriculture Appropriations bill included a $200 million reduction for the program, including a 10 percent cut to the fruit and vegetable CVV.[686]

WIC also promotes breastfeeding through peer-counseling programs, provision of breastfeeding and pumping supplies, an enhanced food package, and longer program eligibility for breastfeeding participants compared with non-breastfeeding postpartum participants.[687] In FY 2025, 44 percent of WIC infants were breastfed (17 percent fully breastfed and 27 percent partially breastfed).[688] WIC participants' breastfeeding rates have increased more than 50 percent since FY 2010.[689] For infants who are not fully breastfed, WIC food packages include infant formula.[690] More than half of all infant formula consumed in the United States is by infants in WIC.[691]

During the COVID-19 pandemic, waivers allowed eligible individuals to receive WIC benefits without an in-person appointment, saving applicants lost work time, childcare, and transportation time and expenses. Without congressional action, remote WIC certification is slated to end on September 30, 2026, or until USDA ends its evaluation efforts. Bipartisan, bicameral legislation (The MODERN WIC Act/21st Century WIC Act) would permanently allow remote certification of WIC eligibility, with 90 days for nutritional risk evaluation, and mail or remote benefits issuance.[692,693]

USDA has also taken steps to increase access to online shopping for WIC participants. In February 2023, the Food and Nutrition Service (now Food and Nutrition Administration) issued a proposed rule to modernize WIC by allowing WIC benefits to be used to purchase groceries online, without the presence of a cashier.[694] 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 in person.[695] As of August 2026, the proposed rule has not yet been finalized. The Center for Nutrition and Health Impact is also supporting state agencies in implementing WIC online shopping with authorized vendors.[696] As of August 2026, 29 WIC agencies had online shopping projects.[697]

IV. EMERGENCY FOOD ASSISTANCE

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—support people in need and American farmers.[698] Each program serves a different population through unique mechanisms.

TEFAP provides people in need with emergency food assistance at no cost. Through TEFAP, USDA purchases domestically produced USDA Foods that are distributed to state agencies and then local agencies, usually food banks. These entities then distribute the foods to individuals through food pantries or soup kitchens.[699] 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, as these individuals are presumed to be low income.[700] About 50 million Americans received assistance from a food bank in 2023.[701]

In FY 2026, $471.5 million in funding was available for TEFAP, including $465.2 million for food purchases and $6.3 million for ordering and transportation costs.[702] There was also $94.3 million for state agency administrative costs, and state agencies could also use any unspent funds from FY 2025 during FY 2026.[703] In addition, $358 million in surplus foods acquired in FY 2025 is being made available to states through TEFAP in FY 2026, under the statutory authority of the Commodity Credit Corporation.[704]

D) Community Policies and Programs

Federal, state, and local policies and programs play an important role in helping communities promote healthy eating and physical activity. These initiatives influence factors such as food affordability and access; the availability and safety of opportunities for physical activity and active transportation; and delivery of nutrition education and support programs. This subsection highlights policies and initiatives that shape a community's built environment (including community design, transportation, and land use, housing, and Safe Routes to School), as well as CDC-led state and community initiatives related to nutrition, physical activity, obesity prevention, healthy schools, health equity, and preventive health.

In 2025, the Trump Administration announced executive orders and additional actions that eliminated long-standing programs and substantially reduced or delayed CDC funding and staffing levels. These changes continued into FY 2026, affecting programs that support state and local efforts related to nutrition, obesity reduction, physical activity promotion, and chronic disease prevention.[705,706,707] The FY 2027 President's Budget Request would eliminate the Division of Nutrition, Physical Activity, and Obesity (DNPAO) as a distinct CDC budget line and reorganize or eliminate many chronic disease prevention activities—previously housed in CDC's National Center for Chronic Disease Prevention and Health Promotion—under the proposed Administration for a Healthy America, creating uncertainty about the future structure, funding, and continuity of federal obesity-prevention programs.[708,709]

I. BUILDING HEALTHY COMMUNITIES

Obesity rates differ across a number of demographic measures, including age, education, race/ethnicity, income, and geography. While obesity rates depend on many factors, economic and community context shape Americans' daily lives and available choices around healthy food, physical activity, education, jobs, stress, financial security, etc., which systematically affect people's weight and health.[710] See Appendix on page 138 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).

Physical activity can help to reduce the risk of chronic disease; improve overall health and well-being; and help to manage weight.[711,712] A community's built environment—the human-made spaces where people live, work, play, and gather—influences physical activity and supports healthy weight outcomes in communities.[713,714,715,716,717,718,719] In the United States, built environment features often prioritize cars (e.g., wide, multi-lane roadways) and are impractical and unsafe for active modes of transport such as walking or bicycling. A combination of interventions to create or modify built environments can make it easier and safer to accommodate a variety of transportation modes.[720,721] However, longstanding underinvestment in many communities, particularly low-income communities, rural communities, and communities of color, has created systemic barriers that contribute to poorer health outcomes and deepen disparities in health and opportunity.[722,723,724,725]

COMMUNITY DESIGN, TRANSPORTATION, AND LAND USE

Health considerations should play a central role in community design, transportation, and land-use decisions. Policymakers can help support active lifestyles and help reduce obesity risk through a range of strategies, including:

- Expanding safe, affordable, and accessible options for active transportation and public transit to reduce reliance on cars and encourage routine physical activity;[726,727]
- Implementing Complete Streets policies, which are designed to make streets and transportation networks safer and more accessible for people of all ages and abilities, whether traveling by car, foot, bicycle, wheelchair, or other mobility device. These policies can include building and maintaining sidewalks, trails, and protected bike lanes, as well as adding safety features such as streetlights, speed bumps, traffic signals, crosswalks, roundabouts, and shade trees;[728]
- Committing to a Safe Approach, such as Vision Zero, consisting of a set of policies and programs dedicated to eliminating traffic fatalities and severe injuries and supporting safe mobility for all;[729,730]
- Supporting land-use and zoning policies that encourage walkable neighborhoods with a variety of housing options, nearby frequent destinations (e.g., grocery stores, parks, schools, local businesses), and strong public transportation connections;[731]
- Developing and maintaining parks, playgrounds, and other green spaces that encourage physical activity, improve air quality, and strengthen social connectedness within communities;[732,733]
- Investing in high-quality, accessible public transportation infrastructure, which is associated with increased physical activity because people often walk or bike to and from public transit stops;[734] and
- Implementing Safe Routes to School policies and initiatives that support infrastructure improvements that enable students to safely walk or bike to school, helping foster lifelong active transportation habits.[735,736]

Community design, transportation, and land-use policies and programs can play an important role in expanding access to and opportunity for physical activity, which is associated with numerous immediate and long-term health outcomes. However, the literature suggests that some populations such as low-income communities, rural communities, and communities of color often have less physical activity infrastructure, such as parks and green spaces, recreation centers, and physical activity programs, limiting opportunities for physical activity and overall well-being.[737,738,739,740,741,742] In addition, the ability of residents to safely walk, roll, and connect to public transportation is heavily shaped by community design and land-use decisions.[743] A 2025 study of Boston, Massachusetts found that pedestrians in predominantly Black and Latino neighborhoods are approximately four times more likely than pedestrians from predominantly white neighborhoods to be struck by vehicles.[744] This disparity exceeds what would be expected based on crash location alone by nearly 1.5 times.[745] These findings

suggest that broader structural and environmental inequities in investment in safe transportation options and community design policies contribute to their elevated risk.[746]

One example of a program that can reshape everyday transportation options and address the community design features that can limit physical activity is the Safe Streets and Roads for All (SS4A) grant program. The program, established through the Infrastructure Investment and Jobs Act (P.L. 117-58) with up to $5 billion in funding over five years (2022–2026), was created to reduce roadway injuries and deaths, including among pedestrians and bicyclists.[747] Although the program's stated purpose is to improve transportation safety, its benefits extend to increased physical activity and improved health. Communities perceived to be more walkable and safer from vehicles are associated with increased physical activity and reduced obesity levels.[748] In March 2025, the U.S. Department of Transportation (DOT) revised transportation grant criteria to deprioritize projects that remove driving lanes, resulting in the cancelation of funding for several ongoing projects designed to support safe active transportation.[749,750,751,752]

In FY 2025, DOT awarded nearly $1 billion in funding to 521 projects through Safe Streets and Roads for All.[753] Some of these projects may be used to improve pedestrian and bicyclist safety. As one example, Phoenix, Arizona, was awarded $24 million to improve safety at high-risk intersections and corridors, including testing protected bike lanes.[754]

RECENT CHANGES TO FEDERAL TRANSPORTATION FUNDING

Every five years, Congress reauthorizes surface transportation legislation and funding. The most recent legislative proposal, the BUILD America 250 Act, which was introduced in the U.S. House of Representatives in May 2026 and approved by the House Transportation and Infrastructure Committee later that month, would authorize a maximum of more than $580 billion toward highway development and infrastructure updates, as well as active and multimodal transportation projects that are shown to increase routine physical activity and reduce obesity prevalence.[755] However, $106 billion of that proposal would be subject to annual appropriations instead of the Highway Trust Fund guaranteed contract authority, a decrease in total guaranteed funding relative to the Infrastructure Investment and Jobs Act (IIJA).[756,757]

This legislation, if passed, as well as changes in administration policy, could have a significant impact on the ability of state and local governments to prioritize active mobility, including:

- While contract authority for transit is increased over IIJA levels, guaranteed funding for transit and rail would decrease by 45 percent. Guaranteed highway funding would increase from $351 billion to $376 billion.[758,759]
- The bill removes authorization for a number of programs to support active mobility, including Reconnecting Communities, Neighborhood Access and Equity, Healthy Streets, and Active Transportation Infrastructure Investment, all of which were included in IIJA.[760]
- The bill alters the Surface Transportation Block Grant (STBG). Some active and multimodal transportation programs will become eligible for STBG funding that could not receive it previously.[761,762] If the legislation passes, some states may then use STBG funding for programs that support safe, healthy, and accessible physical activity.
- The Transportation Alternatives Set-Aside, which under current law equals 10 percent of the amount that would otherwise be apportioned for the STBG program, would increase to $1.66 billion under the bill due to underlying increases in STBG funding and an inflation provision. The Transportation Alternatives Set-Aside is the largest source of dedicated federal funding for active mobility. However, the bill would also provide states additional flexibility to transfer Transportation Alternatives funds to highway programs.[764]

Significantly, the administration has continued to delay delivery of appropriated funding to approved transportation projects, with total frozen funding above $2.8 billion as of March 2026.[765] Delays and interruptions in funding make it difficult for state and local agencies to engage in the long-term planning and execution necessary to operate successful transitions toward more active modes of transportation.

SAFE ROUTES TO SCHOOL

Walking, rolling, or biking to and from school provides children and adolescents with an easy and effective way to incorporate physical activity into their daily lives. However, active transportation to school has declined significantly over the past half-century due to factors such as car-oriented community design, concerns about safety due to traffic and crime, and changing social norms.[766,767,768]

The Safe Routes to School (SRTS) program, established in 2005 and funded through DOT, encourages active travel to school by supporting state and local safety initiatives that range from public awareness campaigns to infrastructure improvements such as crosswalks, sidewalks, and bike lanes.[769,770] Research suggests that SRTS programs are cost-effective, can improve child health outcomes through physical activity, and can substantially increase active transportation to and from school.[771,772,773] Policies and programs related to infrastructure development for convenient transportation, active travel promotion, and shift of transport mode—such as SRTS—can also increase physical activity for all of society,[774] providing broad public health benefits.

IIJA strengthened SRTS by formally codifying it and expanding it to include high schools, while also allowing additional funding streams—including the Highway Safety Improvement Program and the Transportation Alternatives Program—to support SRTS projects.[775]

II. CDC STATE AND COMMUNITY INITIATIVES

CDC leads and funds a variety of state and community initiatives related to nutrition, physical activity, obesity prevention, healthy schools, health equity, and preventive health. The subsection covers critical programs at CDC, including the State Physical Activity and Nutrition Program (SPAN); High Obesity Program; Racial and Ethnic Approaches to Community Health (REACH) program; Healthy Tribes program; Family Healthy Weight Programs (FHWPs); Childhood Obesity Research Demonstration Projects; School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students (or "Healthy Schools program"); Preventive Health and Health Services (PHHS) block grant program; National Diabetes Prevention Program; Physical Activity Guidelines; Active People, Healthy Nation initiative; and more.

STATE PHYSICAL ACTIVITY AND NUTRITION PROGRAM

CDC's DNPAO administers SPAN, which supports state, territorial, and tribal initiatives aimed at improving nutrition and increasing opportunities for physical activity.[776] SPAN-funded efforts focus on a range of strategies, including:

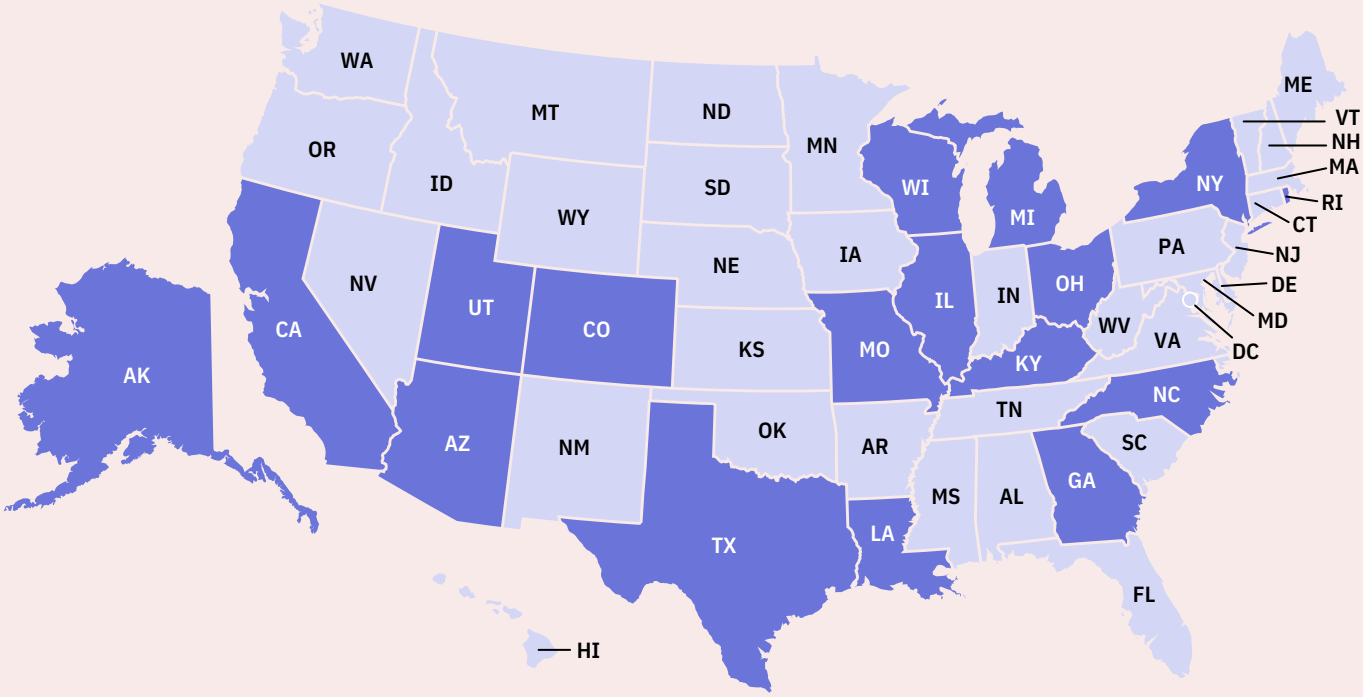
- Making physical activity safe and accessible for everyone;
- Expanding access to healthy foods through food-service and nutrition guidelines;
- Increasing the availability of fruit and vegetable incentive vouchers and produce prescription programs;
- Supporting continuity of care for breastfeeding support; and
- Strengthening obesity prevention initiatives in early care and education settings.[777]

During the past five-year period, 2018–2023, SPAN grants positively affected tens of millions of people across 16 states. Reported outcomes included:

- Reaching more than 8 million people through enhanced food-service guidelines and nutrition standards in organizations and institutions;
- Expanding opportunities for physical activity for approximately 19 million people; and
- Providing more than 1.7 million people with access to continuity of care for breastfeeding support.[778]

Under the current five-year SPAN cycle, which began in 2023, DNPAO is funding 17 states, with expected annual awards of $888,000 per recipient.[779] SPAN is among the DNPAO programs proposed for elimination in the FY 2027 President's Budget Request,[780] and the House of Representatives' FY 2027 budget proposal.[781]

MAP 8: States with SPAN Programs in FY 2025



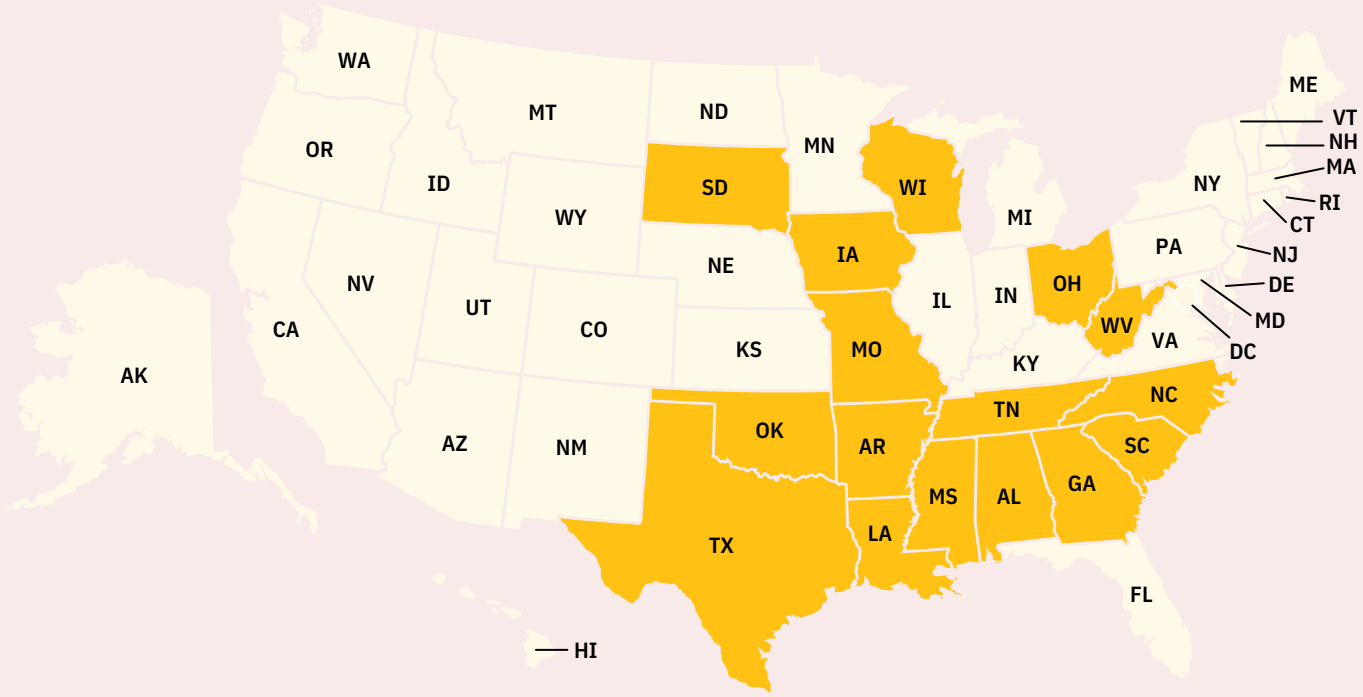
Source: CDC[782]

HIGH OBESITY PROGRAM

The High Obesity Program (HOP) provides funding to land-grant universities that partner with local communities through community extension service cooperative agreements to address obesity and other chronic diseases.[783] The program primarily operates in rural counties where adult obesity rates exceed 40 percent and focuses on community-based strategies designed to improve access to healthy foods, increase opportunities for physical activity, and reduce high obesity rates.[784] These strategies include adopting food-service guidelines, expanding fruit and vegetable prescription programs, supporting community design efforts that encourage physical activity, implementing FHWPs, and strengthening interventions in early childcare and education (ECE) settings.[785]

Like the SPAN program, the current five-year HOP funding cycle began on September 30, 2023, with expected funding awarded to 16 land-grant universities, at an average annual award of $712,000.[786] HOP is also among the DNPAO programs proposed for elimination in the FY 2027 President's Budget Request,[787] although the House of Representatives' FY 2027 proposal included flat funding for the program at $16.5 million.[788]

MAP 9: States with HOP Programs in FY 2025



Source: CDC[783]

TABLE 6: CDC's Obesity-Related Funding Opportunities

NAME	GRANT NUMBER	GOAL
STATE PHYSICAL ACTIVITY AND NUTRITION (SPAN)[794,795]	23-0012	Improve nutrition and physical activity at the state and local level
HIGH OBESITY PROGRAM (HOP)[796,797]	23-0013	Increase access to healthy foods and safe places for physical activity in high-obesity areas.
RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH)[798,799]	23-0014	Improve health, prevent chronic disease, and reduce health disparities among populations with the highest risk, or burden, of chronic disease.
SCHOOL-BASED INTERVENTIONS TO PROMOTE EQUITY AND IMPROVE HEALTH, ACADEMIC ACHIEVEMENT, AND WELL-BEING OF STUDENTS (HEALTHY SCHOOLS)[800,801]	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 help reduce disparities
PREVENTIVE HEALTH AND HEALTH SERVICES (PHHS) BLOCK GRANT[802,803,804]	24-2400	Provide each state with flexible support to address its most important health needs and challenges

Examples of HOP activities include:

- The **University of Georgia**'s HOP initiative is assessing county-level food environments and community design while partnering with local organizations to improve access to healthy foods and activity-friendly infrastructure.[790]
- The **Louisiana State University Agricultural Center** is expanding efforts to improve access to healthy foods and safe opportunities for physical activity through training, technical assistance, and policy support. Key activities include helping food pantries adopt nutrition standards; supporting nutrition incentives and voucher programs at local food retailers and farmers' markets; establishing a regional food policy council; and assisting parishes with Complete Streets and joint use agreement implementation.[791]
- The **University of Missouri**'s HOP initiative is expanding programs that promote nutrition, food security, Complete Streets, and Farm to ECE strategies. The program also supports healthy food procurement through county coalitions; enhances fruit and vegetable voucher and produce prescription programs; trains schools on healthy school concessions; trains ECE providers on nutrition and physical activity; and connects transportation and public health agencies on Complete Streets, Vision Zero, and SRTS efforts.[792]

	EXPECTED LENGTH	ANTICIPATED NUMBER OF GRANTS	ANNUAL ESTIMATED FUNDING PER RECIPIENT	TOTAL ANTICIPATED FUNDING
	5 years beginning in 2023	17 states	$888,000	Up to $75.5 million over 5 years (2023–2028)
	5 years beginning in 2023	16 land-grant universities in states with eligible counties	$499,000–$888,000	Up to $57 million over 5 years (2023–2028)
	5 years beginning in 2023	41 state and local health departments, tribes, universities, and community-based organizations	$500,000–$1.5 million	Up to $228 million over 5 years (2023–2028)
	5 years beginning in 2023	20, including 16 state agencies, 3 universities, and 1 Tribal Nation	N/A	Up to $31.5 million over 5 years (2023–2028)
	Annual	61, including 50 states, DC, 2 American Indian tribes, 5 U.S. territories, and 3 freely associated states	N/A	Up to $168 million in FY 2025

**Note: The duration, number, size, annual funds, and total funding for these funding opportunities are based on projected information from the most recent Notice of Funding Opportunities and project websites. Program funding is the maximum allowable and dependent on availability of funds.*

- **South Dakota State University**'s HOP initiative is strengthening school and community wellness coalitions to support obesity prevention among children, adolescents, and families. The program also promotes healthy food-service guidelines; coordinates statewide nutrition incentives and produce prescription efforts; supports counties in developing Active People, Healthy Nation action plans; and improves community design for physical activity through strategies such as SRTS, signage, and shared use.[793]

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

The REACH program, administered by DNPAO, is designed to improve health, prevent chronic disease, and reduce health disparities in communities disproportionately affected by chronic disease. REACH provides funding to community-based organizations, universities, local health departments, tribal organizations, and municipalities to develop and implement evidence-based strategies and culturally tailored resources that address the underlying drivers of chronic disease, including obesity.[805]

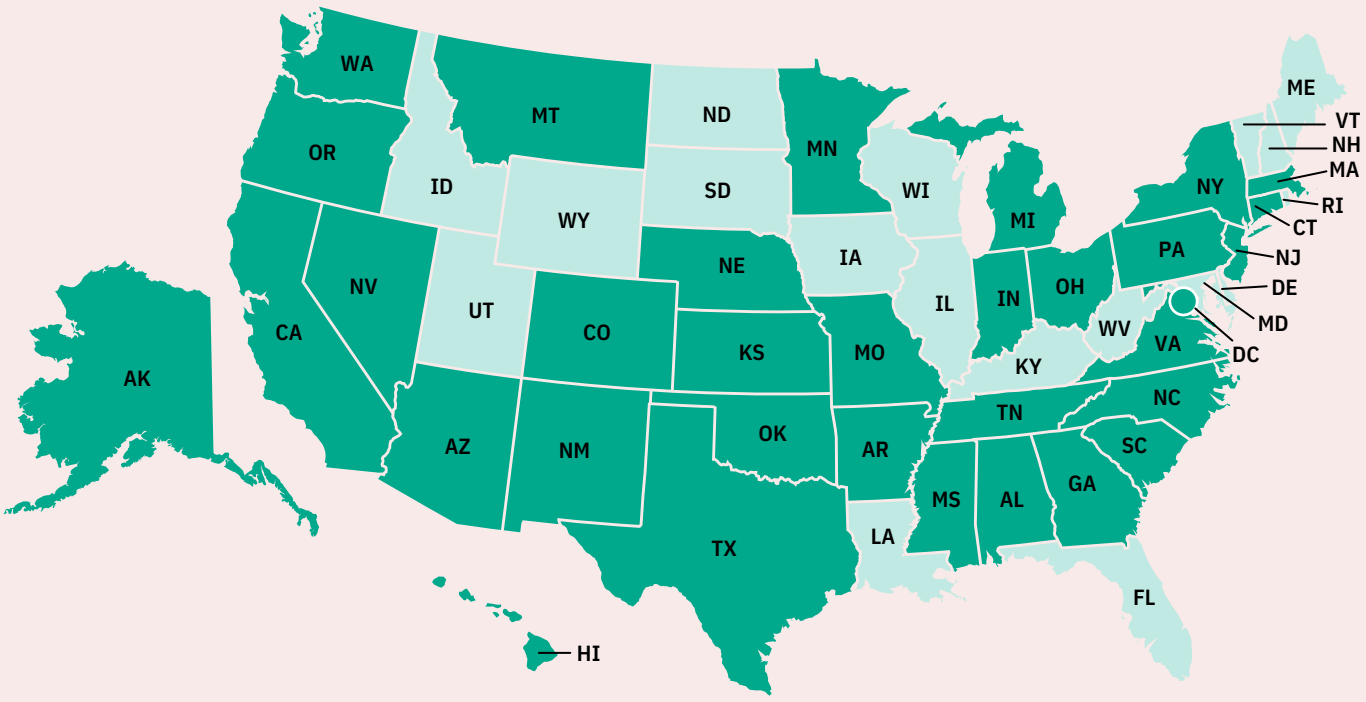
The program has positively impacted millions of lives since its launch in 1999 by improving access to healthy foods, FHWPs, safe spaces for physical activity, breastfeeding support, and stronger connections between community resources and clinical care.

In previous funding cycles, REACH recipients have reported the following outcomes:

- More than 2.3 million people gained greater access to healthier foods.
- More than 8.6 million people gained improved access to places to be physically active.
- More than 1 million more people live or work in communities with updated healthy nutrition standards.
- Nearly 1.3 million people received community support to initiate and continue breastfeeding.
- More than 41,000 patients were referred from clinical settings to community health programs.
- More than 1 million employees worked in environments with strengthened smoke-free and tobacco-free policies.[806,807]

The current five-year REACH funding cycle (2023–2028) includes grants to 50 state and local health departments, tribal organizations, universities, and community-based organizations across 32 states and the District of Columbia.[808] Total funding for the five-year period was expected to be $228 million.[809] In February 2026, the Trump Administration issued grant cancellation notifications for a range of CDC programs totaling more than $600 million, including REACH program funding in Minneapolis, Minnesota.[810,811] The administration stated the grants did not align with current priorities.[812] A court order temporarily blocked the cuts while legal challenges proceed.[813] The President's Budget Request for FY 2027 and the U.S. House of Representatives' FY 2027 budget proposal would also eliminate funding for the REACH program.[814,815]

MAP 10: States with REACH Programs in FY 2025



States with REACH Programs

Source: CDC[816]

Some examples of REACH-funded initiatives include:

- The **University of Hawaii** is promoting nutrition standards across community settings, including government agencies, senior centers, hospitals, after-school programs, and ECE centers. The program also expands produce voucher and prescription initiatives and supports efforts to reduce tobacco use in workplaces, schools, and youth-focused environments.[817]
- The **Corewell Health Equity and Community Partnerships in Wayne County, Michigan**, is working with Corewell Health East to expand healthy food-service guidelines and the Prescribe Life produce prescription program to improve access to healthy foods and beverages. The initiative also plans to partner with local parks and recreation departments on community design strategies to improve access to physical activity and conduct needs assessments to strengthen breastfeeding continuity of care strategies.[818]
- The **Southern Nevada Health District** is working with faith-based food pantries and regional food banks to strengthen food-service guidelines, as well as with the Southern Nevada Food Council to expand the Double Up Food Bucks incentive program. The initiative also supports Safe Routes to Parks, expanded bike-share access in communities, and smoke-free policies in workplaces, multiunit housing, and higher education settings.[819]

HEALTHY TRIBES PROGRAM

Administered by DNPAO, the CDC Healthy Tribes Program partners with AI/AN communities to deliver strategies in three program areas that support health and wellness. The program areas support community-driven chronic disease prevention, cultural wellness practices, and stronger tribal public health infrastructure. The program is rooted in AI/AN cultural traditions and ways of life.[820]

GHWIC, one of three funded efforts of the Healthy Tribes program, is designed to support culturally grounded and effective public health strategies that promote health and prevent chronic disease in AI/AN communities.[821] Its long-term goal is to reduce illness, disability, and premature death associated with chronic conditions such as prediabetes, diabetes, and obesity.[822] GHWIC is in its third funding cycle (2024–2029), which awarded 29 grants to tribes, tribal organizations, and Urban Indian Organizations, totaling an estimated $103.5 million over the five-year grant cycle.[823,824] Through both direct and indirect funding, GHWIC-supported activities reach more than 115 federally recognized tribes and urban Indian organizations.[825] Programs supported through GHWIC include culturally tailored initiatives focused on nutrition, physical activity, breastfeeding support, and chronic disease prevention.[826]

GHWIC was funded at $27 million in FY 2026.[827] While GHWIC is proposed for elimination in the President's Budget Request for FY 2027, the U.S. House of Representatives' FY 2027 budget proposal would increase funding to $30 million.[828,829]

Tribal Practices for Wellness in Indian Country (TPWIC), another CDC Healthy Tribes Program initiative, supports traditional and cultural practices and teachings that build resilience and connections to community, family, and culture to reduce risk factors for chronic disease, promote holistic health and well-being in AI/AN communities.[830] TPWIC provides a total of $5.1 million per year to 22 tribes and 13 urban Indian organizations.[831]

A third Healthy Tribes Program initiative, Tribal Epidemiology Centers Public Health Infrastructure (TECPHI), builds tribal public health capacity and infrastructure to deliver essential public health services.[832] TECPHI is a five-year cooperative agreement, operating from 2022–2026. It provides about $6.8 million in annual funds to 12 tribal epidemiology centers and one network coordinating center.[833]

FAMILY HEALTHY WEIGHT PROGRAMS

FHWPs are intensive, family-based lifestyle treatment programs designed for children and adolescents ages 2–18 years with overweight or obesity.[834] These programs focus on nutrition, physical activity, and behavior change strategies and counseling, and include at least 26 contact hours delivered over 2–12 months in clinical, community, or public health settings by trained staff.[835,836] Also referred to as intensive health behavior and lifestyle treatment programs or pediatric weight management interventions, FHWPs are recommended by national organizations, including the American Academy of Pediatrics,[837] the U.S. Preventive Services Task Force, and the American Psychological Association as effective approaches for treating childhood obesity.[838]

CDC-recognized FHWPs are research-tested childhood obesity treatment programs ready for immediate implementation in healthcare or community settings with standardized curricula and ready-to-use implementation materials.[839] To earn CDC recognition, programs must be supported by peer-reviewed evidence demonstrating measurable improvement in youth weight outcomes, include family-centered behavioral interventions, provide nutrition and physical activity counseling, meet the recommended clinical hours and duration, and be ready for immediate use.[840]

Research shows that FHWPs can improve or stabilize children's weight and BMI while improving nutrition habits, physical activity, and metabolic markers (e.g., blood pressure and lipids), while also increasing self-esteem and quality of life.[841,842] Many programs also positively impact parents and caregivers by reducing stress, improving self-efficacy, and supporting healthier family behaviors.[843,844] Evidence suggests FHWPs can be cost-effective and may help reduce disparities when accessible to families facing higher barriers to care.[845]

Despite their effectiveness, many families still face barriers to access, including limited insurance coverage, lack of program availability, insufficient referrals, stigma, and limited community resources.[846] Expanding sustainable access requires consideration of local community needs, healthcare infrastructure, staffing, and state policies related to chronic disease prevention and treatment.[847] DNPAO supports implementation of FHWPs in more than 60 communities through HOP and REACH programs.[848]

CHILDHOOD OBESITY RESEARCH DEMONSTRATION PROJECTS

CDC's Childhood Obesity Research Demonstration (CORD) projects supported research on evidence-based strategies to prevent and treat childhood obesity.[849,850] The first CORD project took place in communities in Texas, Massachusetts, and California in 2011–2015.[851] CORD 2.0 researched healthcare interventions to improve obesity screening and counseling, including FHWPs, in 2016–2018.[852]

Building on earlier CORD initiatives, CORD 3.0 funded five research teams through the Healthy Kids Act of 2018, from 2019–2024.[853] The initiative focused on adapting, testing, and packaging effective FHWPs for lower-income families to ensure they are practical, sustainable, and scalable across healthcare, communities, and public health settings.[854,855] For example, Massachusetts General Hospital collaborated with the American Academy of Pediatrics' Institute for Healthy Childhood Weight to develop and test implementation of the Healthy Weight Clinic program at community-based health centers in Mississippi and Massachusetts.[856]

In 2026, a final review of CORD 3.0 was published in the journal Childhood Obesity. The paper highlighted how CORD's research demonstrations fueled dissemination efforts by showing that programs made adaptable and acceptable to communities, organizations, and families can be implemented effectively. FHWPs are the foundational behavioral intervention for children with overweight or obesity to build skills and behavior-change strategies.[857]

HEALTHY SCHOOLS PROGRAM

CDC's Division of Adolescent and School Health supports efforts to prevent chronic disease among children and adolescents through cooperative agreements.[858] Research demonstrates that comprehensive, school-wide health initiatives can promote healthy behaviors, increase nutrition knowledge, and improve academic outcomes, particularly among students in communities with the greatest needs.[859,860,861,862,863]

The Division's Healthy Schools cooperative agreement provides funding to state education and health agencies, universities, and a tribal nation to implement policies and programs, using the Whole School, Whole Community, Whole Child framework, that help students in communities with the greatest needs increase physical activity, improve nutrition, and better manage chronic health conditions such as obesity.[864] The 2023–2028 five-year Healthy Schools cooperative agreements are funding 16 states, one Tribal Nation, and three universities, with total funding of up to $31.5 million.[865,866]

An example of how Healthy Schools funding is used is West Virginia's WV Healthy Schools in Action initiative, which supports healthier school environments by helping schools implement CDC's Whole School, Whole Community, Whole Child framework, which is designed to bolster student health and academic achievement; improve nutrition and physical activity practices; and strengthen student and staff health and well-being initiatives to improve health outcomes and behaviors.[867]

The other major cooperative agreement, the National Initiative to Advance Health Equity in K–12 Education by Preventing Chronic Disease and Promoting Healthy Behaviors, funds six organizations to provide technical assistance and training to school personnel. These initiatives focus on areas such as emotional well-being, school health services, healthy out-of-school programming, and professional development and technical assistance for school personnel serving communities with the greatest needs.[868] For example, one organization, the National Association of School Nurses, supports CDC-funded state education agencies, districts, schools, and school nurses to improve student and staff well-being through evidence-based policies, practices, and programs that improve delivery of school health services.[869] Funding for the current five-year cycle (2022–2027) was expected to be $7.5 million total according to the 2021 grants notice.[870]

The President's Budget Request for FY 2027 and the U.S. House of Representatives' FY 2027 budget bill propose eliminating all funding for school health.[871,872] In FY 2026, Congress dedicated $19.4 million to school health programs.[873]

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

The PHHS block grant provides flexible funding to states, territories, and tribes to address public health priorities aligned with Healthy People 2030 objectives that might otherwise be unfunded or underfunded.[874] PHHS block grants support all 50 states, the District of Columbia, two tribes, five U.S. territories, and three freely associated states.[875] In FY 2025, states were awarded $168 million in PHHS funding, including over $12 million dedicated to nutrition and weight status initiatives.[876]

Examples of PHHS-funded programs include:

- The **Maryland Department of Health** funded local health departments to implement obesity screening programs in oral healthcare settings and support community-based overweight, obesity, and diabetes prevention strategies for adults and children.[877]
- The **Kansas Department of Health and Environment** used PHHS funding to create the Governor's Council on Wellness, which advises Kansas leaders on strategies to improve health through physical activity, healthy eating, and tobacco prevention, with goals aligned to Healthy Kansas 2030. Its work includes coordinating statewide health-promotion efforts; building public- and private-sector support; and recognizing communities and organizations advancing wellness initiatives.[878,879]
- The **North Carolina Department of Health and Human Services** uses funds to support the Healthy Communities Program, with one strategy focused on increasing the number of new community venues or small food stores providing access to healthy foods, particularly in socially vulnerable areas.[880]

For FY 2026, Congress appropriated funding for PHHS at $160 million.[881] The President's Budget Request for FY 2027 proposes to eliminate the program.[882]

NATIONAL DIABETES PREVENTION PROGRAM

Efforts to prevent obesity and diabetes are closely connected, as obesity is a major risk factor for developing type 2 diabetes.[883] The National Diabetes Prevention Program (National DPP) is a nationwide initiative that brings together public and private partners, including community-based organizations, healthcare provider and payer organizations, employers, faith-based organizations, and government agencies to help prevent or delay the onset of type 2 diabetes.[884] An estimated 115 million American adults have prediabetes, and 8 in 10 adults with prediabetes are unaware of their condition.[885]

A central component of the National DPP is its evidence-based lifestyle change program, which uses a CDC-approved curriculum and provides participants with support from trained lifestyle coaches, as well as one year of group support delivered through in-person, virtual, or hybrid formats.[886,887] Clinical trial evidence has shown that participation in the DPP reduces the risk of developing type 2 diabetes and helps improve weight, physical activity, and fruit and vegetable consumption among participants.[888,889,890] A 2026 study evaluating the impacts on Medicare enrollees who participated in an early DPP trial, which began more than 20 years ago and featured ongoing booster programming, found that those who participated in the DPP were less likely to have multiple chronic conditions compared with those who received a placebo.[891]

In 2018, CMS launched an initiative to cover the National DPP lifestyle-change program for Medicare enrollees at risk of developing diabetes. A recent evaluation found that Medicare DPP has expanded to 414 sites nationwide and has led to meaningful health improvements among participants, including sustained weight loss averaging nearly 5 percent of body weight for about half of participants.[893] However, the program's overall reach remains limited, with fewer than 10,000 participants despite millions being eligible.[894] Still, strong outcomes among enrolled beneficiaries suggest that expanding supplier access, increasing prediabetes awareness, and improving provider referrals could significantly strengthen the program's long-term public health impact.[895]

In FY 2026, Congress provided $37.3 million for the National DPP, the same as FY 2025.[896] While the administration's FY 2027 budget would eliminate the National DPP, the House of Representatives proposed to increase FY 2027 funding for the program to $39.3 million.[897,898]

PHYSICAL ACTIVITY GUIDELINES

Regular physical activity is associated with a wide range of health benefits, including reduced risk of obesity, type 2 diabetes, cardiovascular disease, certain cancers, infectious diseases, anxiety, and depression, while also supporting brain health (including reduced risk of dementia) and stronger bones and muscles.[899,900,901,902] The 2018 *Physical Activity Guidelines for Americans, Second Edition*, provides evidence-based recommendations on the amount and types of physical activity across the lifespan needed to improve health and reduce chronic disease risk.[903]

Key recommendations from the 2018 *Physical Activity Guidelines* for Americans include:

- **Children ages 3 to 5:** Be physically active throughout the day.
- **Youth ages 6 to 17:** Participate in at least 60 minutes of moderate-to-vigorous physical activity daily. This should include vigorous activity occurring at least three days per week, muscle-strengthening activities at least three days per week, and bone-strengthening activities at least three days per week.[904]
- **Adults:** Engage in at least 150 minutes (2.5 hours) of moderate-intensity aerobic activity, or 75 minutes (1.25 hours) of vigorous-intensity aerobic activity per week, or an equivalent combination, along with muscle-strengthening activities two or more days each week.[905]
- **Older adults:** Follow adult recommendations as physically able and incorporate balance training in addition to aerobic and muscle-strengthening activities.[906]

Only about one in four (26 percent) of American adults meet both aerobic and muscle-strengthening physical activity recommendations during their leisure time.[907] In addition, 25 percent of adults engage in no leisure-time physical activity.[908] Research indicates that participation in leisure-time physical activity is lower among people of color and individuals with lower incomes compared with white adults and those with higher incomes.[909,910] Disparities in access to parks, green space, and safe infrastructure for walking and biking can create significant barriers to physical activity in certain communities, including low-income communities and communities of color.[911,912]

Unlike the *Dietary Guidelines for Americans*, which federal law requires to be updated every five years, there is no statutory requirement for regular updates to the *Physical Activity Guidelines for Americans*.[913] Bipartisan legislation has been introduced in both chambers of Congress aimed at requiring the *Physical Activity Guidelines* to be updated by 2029 and every 10 years thereafter.[914,915]

PRESIDENTIAL PHYSICAL FITNESS TEST

In July 2025, President Trump signed an Executive Order reestablishing the Presidential Fitness Test to "address the threat to the vitality and longevity of our country that is posed by America's declining health and physical fitness."[916] The Executive Order also named the HHS secretary to administer the test.[917] In July 2026, the U.S. House of Representatives' Education and Workforce Committee passed H.R. 9723, the Fit Future Act, out of committee. The legislation would codify the restoration of the Presidential Fitness Test.[918]

Experts have raised concerns about physical assessments for youth that focus on performance and competition as they can create demoralizing and negative associations. Instead, experts suggest creating physical education lessons that are fun and positive for participants, focusing on personal improvement and health outcomes, and weaving physical activity throughout the school day.[919]

The President's Council first promoted a "Youth Fitness Test" in 1966.[920] In 2013 the test was discontinued and transitioned to the noncompetitive Presidential Youth Fitness Program in its place.[921]

ACTIVE PEOPLE, HEALTHY NATION

The CDC-led initiative Active People, Healthy Nation℠ is a nationwide effort aimed at helping 27 million Americans become more physically active by 2027.[922] If adults were more physically active, even for as little as 10 minutes per day, 110,000 premature deaths per year could be prevented.[923] It is estimated that inactivity costs our healthcare system $192 billion per year.[924] Active People, Healthy Nation℠ brings together national, state, and local partners to support population-level increases in physical activity.[925] Its goals include:

- Move 15 million adults with no daily activity to some daily moderate-intensity physical activity; and
- Help 10 million adults and 2 million young people progress from some physical activity to meeting the aerobic physical activity guideline.[926]

To advance these goals, Active People, Healthy Nation promotes evidence-based strategies designed to improve access to physical activity opportunities for all:

A. Community design that supports physical activity;
B. Access to places for physical activity;
C. School and youth physical activity programs;
D. Community-wide physical activity campaigns;
E. Social supports that encourage active lifestyles;
F. Individual supports; and
G. Prompts that encourage people to be physically active.[927]

OTHER CDC PROGRAMS

Several additional CDC programs also support initiatives aimed at preventing obesity and promoting healthy living:

- **Advancing Health Equity for Priority Populations with or at Risk for Diabetes:** This program supports efforts to reduce the risk for type 2 diabetes among adults with prediabetes and improve diabetes self-management, quality of care, and early detection of complications among people living with diabetes.[928] The initiative also funds evidence-based, family-centered childhood obesity interventions as a strategy to reduce type 2 diabetes risk.[929] Beginning in FY 2023, the program was anticipated to provide approximately $411 million over five years to 77 grantees.[930,931]
- **Hospitals Promoting Breastfeeding:** Funded at an anticipated $9.75 million for FY 2026, this initiative supports efforts to strengthen lactation services and reduce disparities in breastfeeding rates.[932] The President's Budget Request for FY 2027 proposes to eliminate the program.[933]
- **National Early Child Care Collaboratives:** With approximately $5 million in anticipated funding for FY 2026, this initiative supports the implementation of obesity-prevention strategies for young children in early care and education settings.[934] The President's Budget Request for FY 2027 also proposes to eliminate this program.[935]

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 approximately 70 million Americans, about 91 percent of whom are ages 65 and older.[936] Medicaid, the public health insurance program for low-income Americans, provides coverage to 67 million individuals, as of April 2026.[937] These public insurance programs cover a large portion of the medical costs of obesity and its related chronic diseases in the United States. Republican staff of the Joint Economic Committee projected that combined Medicare and Medicaid spending on obesity and obesity-related diseases would total $4.1 trillion over 2024–2033.[938]

MEDICARE

About half of all Medicare beneficiaries are enrolled in traditional Medicare.[939] Traditional Medicare provides the following obesity-related benefits:

- Obesity screening and behavioral therapy for those with a BMI of 30 or more;[940]
- Medical nutrition therapy services, such as an initial nutrition assessment and nutritional therapy services, for beneficiaries with diabetes;[941] 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.[942]

Traditional Medicare covers obesity behavioral therapy only when delivered in a primary care setting, creating a barrier to treatment as many providers offering these services do not practice in those settings. Medicare only

covers medical nutrition therapy services provided by registered dietitians for people with diabetes or kidney disease, excluding many individuals with obesity even though dietitians often have the greatest training and expertise in this area.[943] The bipartisan Treat and Reduce Obesity Act of 2025 would address these provider-related policy barriers, as well as increase access to obesity medications. The bill allows coverage for intensive behavioral therapy for obesity that is provided by other types of physicians, nurse practitioners, physician assistants, and registered dietitians.[944] Another bipartisan bill, the Medical Nutrition Therapy Act of 2025, extends coverage of nutrition counseling provided by a registered dietitian to individuals with obesity- and other diet-related conditions currently not covered.[945]

Medicare has historically been prohibited by federal law from covering medications used exclusively for obesity treatment.[946, 947] Coverage is allowed for obesity medications that have other medical indications, such as diabetes and certain cardiovascular diseases.[948, 949]

From July 2026 through December 2027, CMS is running the "Medicare GLP-1 Bridge short-term demonstration," a pilot program that will provide eligible Medicare Part D beneficiaries with access to certain glucagon-like peptide-1 (GLP-1) drugs.[950] To qualify for the Medicare GLP-1 Bridge, the enrollee must meet certain BMI levels and other medical indications.[951] Individuals with existing GLP-1 prescriptions covered through Medicare or who have certain health conditions, including type 2 diabetes, are not eligible.[952]

MEDICAID

Medicaid provides health coverage for low-income adults, children, pregnant women, older adults, and people with disabilities. It is jointly funded by states and the federal government, resulting in geographic variation in both Medicaid eligibility requirements and coverage.[953] Medicaid participants are more likely to have obesity than individuals with private insurance.[954, 955]

For children and adolescents enrolled in Medicaid, the Early and Periodic Screening, Diagnostic, and Treatment benefit covers all medically necessary obesity-related services.[956] For adults, states have the option to provide coverage for obesity treatment, and most state Medicaid programs cover at least one obesity-related service, such as bariatric surgery or intensive behavioral therapy.[957] Coverage for nutritional counseling and anti-obesity medications remains more limited and varies substantially across states. As of January 2026, 13 state Medicaid programs covered GLP-1s for obesity treatment under fee-for-service.[958] Even when state coverage exists for obesity-related services, many include limitations and restrictions based on patient demographics or other requirements that impede access.[959]

Under Section 4106 of the Affordable Care Act, Medicaid offers a higher federal match for states that cover all preventive services rated Grade "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) without cost-sharing.[960] Obesity-related treatments include:

- Providing or referring children and adolescents 6 years and older with a high BMI (≥95th percentile for age and sex) to intensive behavioral interventions (Grade B);[961]
- Offering or referring adults with a BMI of 30 or higher to intensive, multicomponent behavioral interventions (Grade B);[962]
- Screening for prediabetes and type 2 diabetes in adults aged 35 to 70 who are overweight or have obesity, and referrals for preventive interventions for patients with prediabetes (Grade B);[963] and
- Offering behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain during pregnancy (Grade B).[964]

State Medicaid managed care organizations can provide services that address health-related social needs, including nutrition, through Medicaid in lieu of services (ILOS). ILOS are permitted when they are medically appropriate and cost-effective compared with standard care. One 2025 study analyzed publicly available Medicaid managed care contracting materials from 39 states and the District of Columbia, and found that only 10 states (25 percent) have authorized ILOS to address nutrition.[965]

Section 1115 of the Social Security Act gives the secretary of HHS authority to approve experimental, pilot, or demonstration projects that are deemed useful in promoting the objectives of the Medicaid program.[966] These demonstration waivers have offered states an avenue to test new approaches, including many nutrition-based and food is medicine (FIM) interventions. Currently, 16 states have approved or pending Section 1115 demonstrations that provide coverage for nutrition-related services. *(See more on 1115 demonstrations in the Food is Medicine section on page 117.)*[967]

OBBBA made substantial changes to Medicaid that are estimated to reduce federal Medicaid spending by more than $900 billion over 10 years and increase the number of people without health insurance by 7.5 million in 2034.[968,969,970] This will significantly impact patients and their ability to access care such as obesity-related services. Key provisions include stricter work requirements for people enrolled in Medicaid expansion, as well as requiring state redeterminations every six months.[971]

RURAL HEALTH TRANSFORMATION: STATE EFFORTS FOR IMPROVING NUTRITION AND PHYSICAL ACTIVITY

The Rural Health Transformation (RHT) program, authorized by the OBBBA, is a $50 billion federal investment over five years, with $10 billion available each fiscal year from FY 2026 through FY 2030, to strengthen rural healthcare systems, improve access to care, and support better health outcomes in rural communities.[972] The program, managed by the Office of Rural Health Transformation within CMS, requires that states focus their efforts on five strategic areas: (1) preventive health, (2) increased coordination across the healthcare system, (3) workforce development and retention, (4) innovative care models, and (5) innovative technology to increase access to care.[973] States were encouraged to develop initiatives and policies aligned with the Make America Healthy Again objectives developed by CMS.[974,975] To meet the objectives, states could choose to advance nutrition and physical activity efforts by promoting evidence-based interventions and promoting technology-driven solutions for the prevention and management of chronic diseases.[976]

In December 2025, CMS announced the awards for the first year of the program. Funding for each subsequent year will depend on CMS's performance evaluation of the state and the state's progress in implementing its RHT program efforts.[977,978] A few examples of states' proposed actions to advance access to healthy foods and encourage increased physical activity are listed below.

ARKANSAS'S HEALTHY EATING, ACTIVE RECREATION, AND TRANSFORMATION

The Healthy Eating, Active Recreation, and Transformation (HEART) initiative focuses on improving access to preventive care by building a coordinated, community-driven approach to nutrition, physical activity, and chronic disease management in rural Arkansas.[979] One of the initiative's components focuses on improving the food environment by promoting a buy local produce initiative, introducing healthy vending machines, and integrating FIM strategies, such as medically tailored meals for chronic disease management, into communities.[980] Efforts to increase physical activity include expanding access to spaces that promote physical activity, including fitness trails, modular fitness equipment, and recreation activities.[981] The state also hopes to address the gaps in nutrition education by embedding nutrition and fitness education in medical, nursing, pharmacy, and continuing medical education programs.[982] Because Arkansas's initiatives are still being planned, they are assessing the state's existing food system capacity; building partnerships with local partners, such as farmers and retailers; and identifying strategies to establish accreditation for its new nutrition education curriculum.[983,984,985]

MARYLAND'S EMPOWER RURAL MARYLANDERS TO EAT FOR HEALTH

Maryland's nutrition efforts, part of the RHT program, aim to expand state efforts already underway to expand capacity and demand for healthy fresh foods. The state has already invested in FIM efforts, having launched a medically tailored meals program as part of its participation in CMS's Achieving Healthcare Efficiency through Accountable Design (AHEAD) model.[986] To expand its statewide FIM strategy, the state will invest RHT Program funds to scale up engagement with the state's rural healthcare and agriculture systems.[987] Empower Rural Marylanders to Eat for Health Initiative includes efforts to increase the capacity of small farms to reliably supply local markets through investments in cold-storage infrastructure such as freezers, refrigerators, and lockers.[988] The state will also expand the NourishMD program to provide grants for small retailers and mobile markets to purchase the necessary tools to ensure they are able to stock fresh proteins, produce, and dairy.[989,990] Lastly, the Eat for Health initiative will both work to expand healthy food supply by increasing access to groceries and mobile markets and increase demand for healthy food by providing nutrition education to empower residents to make healthy choices.[991] As of June 2026, the state has released its Notice of Funding Opportunity and plans to announce awards later in 2026.[992]

GROWING CARDIOMETABOLIC HEALTH STANDARDS OF CARE IN RURAL INDIANA

Indiana's RHT program nutrition efforts focus on leveraging existing FIM frameworks and infrastructure in the state.[993,994] The state has invested in formalizing its FIM efforts by establishing the FIM director position in charge of statewide efforts to connect food and nutrition support within the healthcare system, as well as partnership-building across communities.[995] One piece of Indiana's RHT state plan is focused on reducing obesity, diabetes, and cardiovascular disease in rural communities.[996] For the initial stages of this work, the state will conduct a feasibility study to assess the logistics and supports needed to implement a rural FIM program.[997] The state also plans to invest in provider nutrition education by establishing a Cardiometabolic Center of Excellence in each rural health region, with the goal of reaching rural health professionals and training them in Lifestyle Medicine.[998]

To ensure sustainability, the state plans to integrate nutrition education in medical school curricula, as well as provide certifications for clinicians to lead preventive care initiatives.[999] While Indiana is still in the early stages of the work, the state is currently reviewing grantee applications and will award funding in September 2026.[1000]

NORTH CAROLINA'S RURAL ORGANIZATIONS ORCHESTRATING TRANSFORMATION FOR SUSTAINABILITY HUB

Building off its successful Healthy Opportunities Pilots' investments to address food insecurity, North Carolina's RHT program focuses on leveraging existing networks to establish North Carolina Rural Organizations Orchestrating Transformation for Sustainability (ROOTS) Hubs to increase access to healthy foods.[1001,1002] Through the ROOTS hubs, the Healthy Foods and Healthy Families programs will establish partnerships with the social service ecosystem (e.g., community-based organizations, food pantries, clinics) to deliver nutrition supports, like healthy food boxes, medically tailored meals, and nutrition education.[1003] The state is also looking to increase food access by investing in the food ecosystem infrastructure to support farmers, community food banks, and mobile food markets.[1004] Additionally, the state plans to build a stronger connection between clinical care and nutrition education by working with community health workers to deliver nutrition education and strengthen linkages to primary and behavioral healthcare.[1005] As of June 2026, North Carolina's Department of Health and Human Services has awarded funds for the ROOTS Hub's Lead Organizations.[1006]

NORTH DAKOTA'S EAT WELL NORTH DAKOTA AND NORTH DAKOTA MOVES TOGETHER INITIATIVES

North Dakota is working to implement the Eat Well North Dakota and North Dakota Moves Together initiatives. These programs focus on expanding evidence-based nutrition, physical activity, and behavioral health strategies.[1007] North Dakota Moves Together will focus on launching a statewide public education campaign to encourage residents to engage in physical activity. To support these efforts, the state plans to host events such as Walk with a Doc, offer free passes to state parks, and establish shared use agreements with more school gyms and enhanced playgrounds to make physical activity more visible and accessible to residents.[1008] The state also plans to bring technology into its initiative by integrating wearable and biometric tools to track health outcomes and link individuals to care providers as needed.[1009] The Eat Well North Dakota initiative will center much of its efforts on increasing nutrition education in different settings (e.g., schools, grocery retailers, childcare facilities, etc.) to engage rural residents to make healthier food choices. It will also work on increasing access to nutritious foods by establishing cooperative purchasing agreements and addressing barriers that limit access to healthier foods.[1010] As of August 2026, the state has released its funding opportunity announcements and is currently reviewing grantee applications, although a funding date has not yet been announced.[1011]

II. OBESITY MEDICATIONS

GLP-1 receptor agonists (e.g., semaglutide, liraglutide, tirzepatide) are a class of medications used to treat several chronic diseases, including FDA-approved indications for type 2 diabetes, obesity, heart disease, and obstructive sleep apnea for adults.[1012,1013,1014,1015,1016] In 2022, FDA approved GLP-1 medication for the treatment of obesity among adolescents ages 12–17 years.[1017]

These medications mimic a naturally occurring hormone that regulates blood sugar and appetite, stimulating insulin release when blood glucose levels are elevated, slowing digestion, and increasing feelings of fullness. GLP-1 medications were first developed as self-injections, but some are now available in oral pill formulation.[1018]

GLP-1 medications have been shown to be highly effective. A review of 64 randomized clinical trials found that GLP-1 medications caused weight loss across diverse populations, including different ages, races, and starting BMI.[1019]

The use of GLP-1 agonists has increased rapidly in recent years. According to KFF's 2025 Health Tracking Poll, nearly one in five (18 percent) adults say they have taken a GLP-1 medication either to lose weight or to treat a chronic condition, a 6 percentage-point increase from the previous year's tracking poll (12 percent).[1020,1021] Among adults who have taken a GLP-1 medication, 84 percent have been diagnosed with at least one of the conditions these drugs are prescribed to treat, including 77 percent diagnosed with obesity or being overweight in the past five years, 49 percent ever being diagnosed with diabetes, and 21 percent ever being diagnosed with heart disease.[1022] GLP-1 use has also risen rapidly in adolescents, though overall rates of use remain low.[1023,1024]

Despite their demonstrated effectiveness, affordability and insurance coverage remain significant barriers to accessing GLP-1 medications for obesity or weight management. Some commonly prescribed FDA-approved GLP-1 medications cost more than $1,000 per month without insurance coverage.[1025] Coverage also varies considerably across insurance types, and many employer-sponsored health plans restrict or exclude coverage when these medications are prescribed for obesity treatment.[1026]

Public insurance coverage remains limited as well. 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 January 2026, only 13 state Medicaid programs cover GLP-1s for obesity treatment.[1027]

Medicare has historically been prohibited by federal law from covering medications used exclusively for obesity treatment;[1028] however, beginning in July 2026, CMS launched the Medicare GLP-1 Bridge, a temporary demonstration program intended to expand access to GLP-1 medications for weight loss through December 2027. Eligible Medicare beneficiaries enrolled in Part D prescription drug coverage can obtain certain GLP-1 medications for weight management through the Medicare GLP-1 Bridge for a $50 copay per monthly supply. *(See the Medicare section on page 110 for additional information on the Medicare GLP-1 Bridge.)*[1029] The state of the obesity-drug-coverage landscape will continue to evolve as the Medicare GLP-1 Bridge is piloted.

The rapid growth of GLP-1 medication usage has also had significant implications for healthcare spending. Medicaid spending on GLP-1 medications increased from approximately $1 billion in 2019 to almost $9 billion in 2024, while the number of GLP-1 prescriptions increased from roughly 1 million to more than 8 million.[1030]

To promote optimal health and to reduce the risk of possible side effects of GLP-1 medications like loss of muscle mass and bone density, it is crucial to pair GLP-1 medications with wraparound services and supports for comprehensive obesity treatment for patients. In fact, services like nutrition and behavioral therapy can help reduce the risk of certain side effects, support nutritional

changes in the long term, and promote weight-reduction maintenance after an initial period of weight loss.[1031] 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.[1032] There are also concerns with the use of GLP-1 medications that have not been approved by the FDA, or compounded drugs. Compounded drugs may be appropriate if a patient's medical needs cannot be met by an FDA-approved drug or during shortages. However, the FDA emphasizes that compounded medications are not FDA approved, and there are serious concerns about quality, safety, and efficacy of mass-produced compounded GLP-1 drugs.[1033]

III. HEALTHCARE AND HOSPITAL PROGRAMS

U.S. healthcare spending was projected to reach $5.7 trillion in 2025, and healthcare spending continues to outpace overall economic expansion, with a projected increase in healthcare's share of the nation's gross domestic product from 18.0 percent in 2024 to 18.4 percent in 2025.[1034] Hospitals and the healthcare sector have a key role to play in preventing and reducing obesity. Potential strategies include comprehensive healthcare provider training and education, FIM programs, patient education and health promotion, sponsoring community benefit programs, and breastfeeding promotion.

MEDICAL EDUCATION, TRAINING, AND BEST PRACTICES

Many health professionals lack adequate training in nutrition and obesity care, limiting their ability to effectively treat patients.[1035, 1036, 1037, 1038] Evidence shows that healthcare providers with stronger training in these areas feel more comfortable referring their patients to appropriate interventions, such as registered dietitians and nutritionists. [1039]

Comprehensive obesity education includes training about the complex, multifactorial causes of the disease and strategies for providing care without 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. [1040] Importantly, medical school training and continuing education should address the full range of effective treatments for obesity.

Despite this need, nutrition and obesity education remain limited in medical training. As of 2024, 75 percent of U.S. medical schools required no clinical nutrition coursework. [1041] This gap has been a standing concern of educators, obesity medicine experts, and policymakers for several years. [1042 1043, 1044, 1045] In March 2026, HHS and the U.S. Department of Education secured voluntary commitments from 53 medical schools, out of about 200 total schools in the United States, to implement at least 40 hours of nutrition education or a 40-hour competency equivalent.[1046, 1047, 1048] To support schools, HHS has developed 71 core nutrition competencies and pledged $5 million to support medical schools in developing coursework, clinical training opportunities, and research initiatives focused on sound nutrition science. [1049]

There are ongoing quality-improvement initiatives around clinical management of obesity, including CDC's provider education on best practices, clinical guidelines from the American Academy of Pediatrics for treating childhood and adolescent obesity, and NIH research on improving health outcomes for pediatric patients with obesity.[1050,1051,1052,1053]

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 healthy on-site dining options and using pricing and point-of-purchase strategies to promote healthier choices;
- Implementing healthy food procurement policies, such as contracting and bulk-purchasing strategies that support the availability of nutritious 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 for physical activity expenses; and
- Designating a private space where employees can breastfeed or express milk.[1054,1055,1056]

HHS's Food Service Guidelines for Federal Facilities can also provide nutrition standards and best operational practices that can inform hospital and healthcare food service.[1057]

Many healthcare systems have also taken steps to improve the nutritional quality of the foods they provide. Through voluntary initiatives, approximately 700 hospitals, or about 10 percent of all hospitals nationwide, have set standards for nutrition, food labeling, food marketing, and food preparation.[1058] For example, through the Good Food, Healthy Hospitals initiative in Pennsylvania, 68 hospitals across 31 counties have agreed to incorporate purchasing, positioning, pricing, and promotion strategies for healthier choices in patient meals, cafeteria and catering services, and vending.[1059] Another example is Health Care Without Harm, which works with hospitals to implement successful strategies for food system improvement through nutrition and sustainability goals.[1060]

FOOD IS MEDICINE

In recent years, FIM has evolved from a set of pilots into a broader framework that integrates food-based services, interventions, and programs within the healthcare sector to prevent, treat, or manage chronic disease among populations at high risk of poor outcomes. Many FIM interventions rely on registered dietitian nutritionists and medical nutrition therapy to assess patients, tailor interventions, support long-term dietary behavior change, and build on a wider range of food and nutrition programs and additional population-level healthy food policies and programs.[1061]

FIM interventions include:

- **Medically tailored meals (MTMs)**, which provide fully prepared, home-delivered meals designed to meet the nutritional needs of individuals with specific medical conditions and functional limitations.
- **Medically tailored groceries**, which offer preselected healthy foods, often chosen by a registered dietitian, and distributed through home delivery or pickup at food banks or healthcare facilities.
- **Produce prescription programs**, which enable healthcare providers to prescribe fruits and vegetables that patients can access through participating retailers or community organizations.
- **Nutrition education and culinary medicine programs**, including employer wellness programs that incorporate nutrition education and incentives for healthier eating, as well as teaching kitchens that build skills for sustained dietary behavior change.[1062]

Research has shown that FIM interventions can lead to better nutrition and health outcomes among patients. An evaluation of produce prescription programs in 12 states found that, after six months, participation was associated with increased fruit and vegetable intake, reduced food insecurity, improved blood pressure among adults with high blood pressure, improved blood glucose control, and reduced BMI among adults with overweight and obesity.[1063] Recent research has also examined the impact and cost-effectiveness of bringing these interventions to scale. A *JAMA Network Open* study modeled cost savings and found that nationwide MTM implementation for individuals with diet-related conditions and limitations in activities of daily living could prevent approximately 1.6 million hospitalizations and generate $13.6 billion in healthcare savings in a single year.[1064] Another cost-effectiveness analysis indicates potential savings across all states except Alabama (where MTMs were cost-neutral), with savings reaching up to $6,300 per patient annually.[1065] While the evidence base for FIM interventions continues to grow, additional long-term and large-scale evaluations are needed to better understand sustainability, implementation challenges, and population-level impacts.

As the field has matured, efforts have shifted to maximizing effectiveness and standardizing interventions to support scaling and equity of access across the United States. In 2024, the American Heart Association also announced the Health Care by Food research initiative through which it pledged $7.8 million to 19 research projects nationwide. The initiative's goal is to "examine the efficacy of strategic approaches for providing healthy food as part of patient care to help treat, manage and prevent chronic health conditions in ways that alleviate health inequities."[1066] Also in 2024, the Food Is Medicine Coalition launched a national accreditation program to ensure the fidelity of MTM interventions regardless of program location, size, or number of clients.[1067,1068] In 2026, the Food Is Medicine Coalition also worked in partnership with the Center for Health Law and Policy Innovation to develop the Medically Tailored Meal Sustainability Blueprint, a framework that outlines a pathway to sustainable funding streams and standards for MTM interventions.[1069]

At the state level, FIM interventions for people with chronic disease are being tested through Medicaid Section 1115 demonstration waivers.[1070] According to KFF, 12 states (Arkansas, Colorado, Delaware, Hawaii, Illinois, Massachusetts, New Jersey, New Mexico, New York, North Carolina, Oregon, and Washington) have approved Section 1115 demonstrations that provide coverage for nutrition-related services.[1071] In these demonstrations, states are covering FIM services such as MTM, medically tailored groceries, produce prescriptions, nutrition counseling, and food insecurity screening and referral systems.[1072] However, as of 2025, CMS is no longer approving certain new Section 1115 waivers or renewals, including nonmedical services like nutrition supports.[1073]

At the federal level, HHS has announced several new federal funding opportunities for FIM programs in 2026:

- **CMS's Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence (MAHA ELEVATE) Model**, which is a Medicare pilot program to test the effectiveness of whole-person functional or lifestyle medicine interventions, which include nutrition or physical activity as part of the design. The program is expected to fund up to 30 three-year cooperative agreements for a total of $100 million starting in fall 2026.[1074]
- **The Health Resources and Service Administration's Maternal Produce Prescription Program**, which supports community-based programs that provide produce prescription and nutrition education for maternal populations with food insecurity or health-related risk factors.[1075]

- **The Indian Health Service's Produce Prescription Pilot Program Phase II**, which supports tribes, tribal organizations, and urban Indian organizations in running produce prescription programs with the goal of increasing access to nutritious and community-relevant foods and promoting whole-person health and well-being. The program is expected to fund 18 five-year programs for a total of $3.5 million starting in 2026.[1076,1077]

COMMUNITY BENEFIT PROGRAMS

To qualify as federal tax-exempt entities, nonprofit hospitals—which constitute 58 percent of community hospitals in the United States[1078] — must "demonstrate that it operates to promote the health of a class of persons that is broad enough to benefit the broader community."[1079] Nonprofit hospitals are required to report on these benefits to the IRS. These benefits include financial assistance and subsidized care, as well as community health improvement activities, such as health promotion and prevention programs and health education.[1080]

Federal law also requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and to adopt an implementation strategy to address identified priorities. CHNAs must incorporate input from community stakeholders, including public health experts and community-based organizations, and must be made publicly available.[1081]

Increasingly, hospitals are using CHNAs and community benefit investments to address upstream drivers of obesity and chronic disease, particularly social and economic factors such as food insecurity. These efforts include screening patients for food insecurity, partnering with local food assistance organizations, and implementing programs that improve access to healthy foods and nutrition resources.[1082]

Some examples of CHNA initiatives include:

- **UChicago Medicine Ingalls Memorial** identified obesity as a significant health condition in the community in its 2024–2025 CHNA cycle. In response, the hospital will address chronic diseases by including strategies that also tackle obesity.[1083]
- The 2025 **Baystate Franklin Medical Center** CHNA identified food security as a health priority, citing the impact of poor nutrition on health and the increasing levels of food insecurity in the region.[1084]
- **MedStar Georgetown University Hospital**'s 2024 CHNA compares trends in select indicators since MedStar Health's first CHNA in 2012, identifying obesity as a key area to address in Prince George's County, St. Mary's County, Montgomery County, Baltimore County, and Washington, DC.[1085]

BREASTFEEDING PROGRAMS

Breastfeeding is associated with important health benefits for both the mother and the child, including improved postpartum weight regulation and a reduced risk of childhood obesity.[1086,1087,1088,1089] The American Academy of Pediatrics, the *Dietary Guidelines for Americans, 2025–2030*, and the World Health Organization recommend exclusive breastfeeding for about six months, with continued breastfeeding alongside complementary foods for two years or longer.[1090,1091,1092]

Breastfeeding initiation in the United States is high, with 86 percent of infants born in 2022 ever receiving breast milk. However, sustained and exclusive breastfeeding remain lower: 28 percent were exclusively breastfed through 6 months, and 41 percent were breastfed at 1 year.[1093] Disparities in breastfeeding initiation exist by race, ethnicity, and state. Despite breastfeeding rates being generally higher among infants of Asian and White mothers and lower among infants of AI/AN and Black mothers, this was not true in all states. The magnitude of disparities in breastfeeding initiation also varied from state to state.[1094] Common barriers to breastfeeding include a lack of in-hospital support, lack of workplace accommodation, and broader social and cultural norms. These barriers are more likely to affect low-wage workers.[1095]

To help reduce these barriers, the Baby-Friendly Hospital Initiative is a global program to recognize and assist hospitals in supporting and promoting breastfeeding. The 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. About one in five infants in the United States is born at one of 441 facilities designated as "baby-friendly" by WHO and UNICEF.[1096]

In parallel, federal workplace protections have been strengthened through implementation of the Providing Urgent Maternal Protections for Nursing Mothers Act, which requires most employers to provide reasonable break time and a private, non-bathroom space for milk expression for up to one year postpartum.[1097] Recent WIC program enhancements have also expanded breastfeeding support through state performance incentives. In FY 2026, WIC awarded a total of $2 million to 15 state agencies with the highest breastfeeding rates or the greatest improvement in breastfeeding rates of fully breastfed infants during FY 2025.[1098]

Recommendations

While some contributors to obesity risk include non-modifiable factors such as genetics, many of the core root causes of obesity can be addressed through policy.

Physical activity and diet are the most commonly known drivers of obesity. But duration of breastfeeding,[1099] socioeconomic status and other demographic factors,[1100,1101] psychosocial stress,[1102] and environmental exposures[1103] are some of the many modifiable risk factors for obesity. Policy action can be taken to address root causes to ensure physical activity and healthy nutrition are accessible, affordable, and easy choices to make.

Not all communities experience equivalent prevalence of obesity and related cardiometabolic conditions, due to patterns of historical and ongoing discrimination, exclusion, and underinvestment.[1104,1105] Policymakers and program implementers should co-develop programs and policies with communities that bear a disproportionate burden of obesity and ensure solutions center better health and well-being for all groups, reflect community needs and desires, and build toward more equitable health outcomes.

Within this context, TFAH offers the following policy recommendations for federal, state, or local governments and other sectors across seven areas to reduce obesity prevalence:

- **A.** Support public health infrastructure for the planning, implementation, and evaluation of strategies to reduce obesity and improve health.
- **B.** Reduce or remove structural barriers to healthy nutrition and physical activity.
- **C.** Allocate resources and amend policies to improve nutritional quality and reduce nutrition insecurity.
- **D.** Alter pricing systems to improve nutritional quality, affordability, and accessibility.
- **E.** Support public health education for nutrition and limit marketing that encourages overconsumption of unhealthy foods.
- **F.** Support programs that increase access to safe, routine, and equitable physical activity.
- **G.** Expand access to prevention, screening, and treatment for obesity and related chronic diseases within the healthcare system.

A) Support Public Health Infrastructure for the Planning, Implementation, and Evaluation of Strategies to Reduce Obesity and Improve Health

Foundational public health infrastructure and stable and sufficient workforces are the bedrock to successful efforts to reduce obesity and improve health. Federal, state, tribal, territorial, and local public health agencies research and track community health trends and coordinate obesity prevention efforts across domains and diverse partnerships to reach communities where they are while addressing root causes of disease. In addition, public health capacity helps with the evaluation and continuous improvement of obesity-prevention programs. See TFAH's 2026 *Underfunded and Under Strain: The State of America's Public Health System* report for more detailed recommendations addressing core public health capabilities and capacities.[1106]

RECOMMENDATIONS FOR FEDERAL, STATE, AND LOCAL GOVERNMENTS:

- **Congress and HHS should increase capacity to prevent obesity and related chronic diseases.** Congress and the U.S. Department of Health and Human Services (HHS) should retain the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (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 2027 for CDC's Division of Nutrition, Physical Activity and Obesity (DNPAO) 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 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 Racial and Ethnic Approaches to Community Health (REACH) and Good Health and Wellness in Indian Country (GHWIC) programs have strong track records of supporting locally driven, culturally appropriate strategies that improve healthy behaviors and address chronic disease risk factors in funded communities. REACH and GHWIC provide communities with resources, technical assistance, and evidence-based policy models so that each grantee can create unique chronic disease prevention programs that are tailored for the local, urban, rural or tribal context. TFAH recommends at least $74.5 million for REACH and Healthy Tribes in FY 2027 to expand these effective approaches to additional communities.

- **The administration should prioritize the preservation of key public health functions and capacities that focus on obesity prevention, nutrition security, physical activity, and obesity 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 DNPAO provide national guidance, training, grants, technical assistance, and data tools on which millions of health professionals rely. The public health backbone provided by these federal programs amplifies the effectiveness of state and local chronic disease prevention efforts by coordinating activities, evaluating program data, and disseminating best practices.
- **Grants should prioritize resources to areas of high unmet need.** Federal agencies that support obesity and chronic disease prevention efforts should structure grants to prioritize communities that bear disproportionate burdens of chronic disease due to historical under-resourcing.
- **Federal grantmaking practices should prioritize transparent guidelines and consistent and predictable delivery of grant funding.** Community-based organizations may need technical assistance or flexibility to meet the procedural requirements of federal grants, such as upfront financial barriers and limited operating budgets. 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. Grantmaking agencies should never pause, delay, or withhold funds unexpectedly or arbitrarily. Disruptions in grant funding can impair essential community programs and derail innovative research.
- **Support a robust state, tribal, territorial, and local public health infrastructure as a coordinator and convener of efforts to address obesity and chronic disease.** Congress, state, and local governments should support the public health workforce with consistent, predictable, and sufficient funding levels. State and local governments should empower public health to function as an interdepartmental coordinator to help address nonmedical drivers, such as access to housing, employment and income, transportation access, air quality, recreation, education, and others that impact obesity. Likewise, stable public health infrastructure supports the development of strong partnerships with community-based organizations that implement many obesity-reduction strategies and helps public health agencies build trust and share power with the communities they serve.

B) Reduce or Remove Structural Barriers to Healthy Nutrition and Physical Activity

Environmental and systemic factors, such as where people live, work, play, and build communities, have a significant impact on health outcomes. While individual people can take actions to increase physical activity or improve their nutrition, there are larger social, economic, and environmental barriers that policymakers and communities should address, such as modifying community design so it is easier and safer for people to walk and bike, ensuring affordable and healthy foods are available in a variety of settings, and creating opportunities for economic well-being that lead to better health outcomes.[1109]

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT:

- **Congress should address root causes of health disparities such as economic factors that contribute to obesity.** Poverty and economic insecurity are associated with obesity and other chronic diseases and can shape access to healthy food, safe physical activity, healthcare access, healthcare coverage, and other health-promoting resources.[1110] Multifaceted approaches, including providing a living wage, expanding child tax credits and earned-income tax credits, and offering access to safe, healthy, and affordable housing can reduce poverty and improve population health.[1111,1112,1113] For further discussion of TFAH's policy recommendations on health and economic benefits resulting from tax and housing policy, see the report ***Promoting Health and Cost Control in States.***[1114]
- **Congress and DOT should continue to fund active transportation in all communities, with a focus on those with the greatest need.** Congress should instruct the U.S. Department of Transportation (DOT) to develop strong guidance to support Complete Streets plans, development, and implementation as communities apply for new transportation grants. Congress should modify transportation program authorizations so that local matching requirements for active transportation projects are 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 under-resourced 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 School, 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.

RECOMMENDATIONS FOR STATE AND LOCAL GOVERNMENTS:

- **States and local governments should evaluate 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. Research suggests that minimum wage increases are associated with reduced all-cause mortality among populations.[1115,1116,1117] The living wage accounts for geographic location and the cost of basic necessities, such as the minimum food, childcare, health insurance, housing, and transportation necessary to maintain self-sufficiency.[1118] States can establish living-wage laws and adopt wage standards that exceed federal requirements, including stronger protections for domestic service workers and tipped workers.
- **Create or strengthen a child tax credit.** Child tax credits significantly reduce prevalence of child poverty.[1119] Expanded child tax credits are also associated with a reduction in average BMI and cholesterol among low-income children.[1120] A number of states have enacted child tax credit programs of their own, expanding on the federal child tax credit.[1121] States should implement new or strengthen existing policies. Seventeen states and the District of Columbia have enacted a child tax credit, including Oklahoma, Maine, and Idaho.[1122]
- **Increase earned-income tax credit match rates and implement refundable EITC.** Research suggests that those living in states with the most generous refundable state tax credits have experienced significant declines in food insecurity.[1123] A refundable earned-income tax credit (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.
- **Community design should encourage healthy and affordable 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 high prevalence of nutrition insecurity and meet certain requirements for the amount of affordable healthy food they provide.
- **States and large cities should implement active mobility improvement projects.** States should use flexible DOT funding sources and technical support to implement Complete Streets and Vision Zero transportation plans that prioritize safe active transportation and reduce automobile dependency.
- **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.

C) Allocate Resources and Amend Policies to Improve Nutritional Quality and Reduce Nutrition Insecurity

Individuals who are food and nutrition 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 for millions of people. In FY 2025, the Supplemental Nutrition Assistance Program (SNAP) helped 42.4 million people; however, participation fell to 38.7 million people in FY 2026.[1124] The average monthly benefit was $188 in FY 2025 and $189 in FY 2026.[1125] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provided healthy foods and nutrition services to 6.9 million participants.[1126] Critically, by supporting food security, SNAP can help people eat healthier and is linked to reduced healthcare costs.[1127] However, new work requirements and cost shifts mean millions more people are facing administrative hurdles to accessing SNAP benefits, which puts at risk long-term efforts to reduce chronic diseases.[1128]

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT:

- **Congress should reverse enacted cuts to SNAP, eliminate work requirements, and not shift the cost burden for the SNAP program onto states.** 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.[1129]
- **Congress and USDA should ensure states have sufficient resources to monitor and evaluate the impact of changes to SNAP policy and incentivize SNAP modernization.** As states adopt purchase-restriction waiver programs, the U.S. Department of Agriculture (USDA) should allocate sufficient resources for the standardized monitoring, evaluation, and analysis of waiver progress as well as impact on key metrics of purchase behavior, nutrition security, obesity prevalence, and program enrollment. Resources should also be allocated to modernize program implementation.
- **Congress should increase healthy food benefits in SNAP.** Congress should reinstate and increase investments in nutrition education programs. Congress should expand GusNIP to be a national benefit that supports nutrition projects and that increases fruit and vegetable purchases among SNAP beneficiaries. In lieu of expanding GusNIP, Congress should decrease the cost share so that communities with limited resources can participate.
- **Congress should ensure full funding and increased access to the WIC program.** WIC has proved effective at reducing obesity and promoting good health in children.[1130,1131] Congress should ensure sufficient funding to fully fund WIC and uphold the decades-long, bipartisan commitment to providing benefits to all families eligible for the program without waiting lists. In addition, Congress should protect the increase in the overall value of the WIC benefit. Additionally, Congress should expand access to WIC for children up to age 6 and postpartum women up to two years postpartum, extend certification periods, partner more closely with Head Start to enhance child retention, and allow WIC benefits to be remotely loaded onto benefit cards. These policies will make

WIC more flexible and allow more families to access WIC's effective interventions by reducing duplicative paperwork requirements for both participants and service providers.

- **Congress should allocate the resources schools need to provide healthy school meals to all children.** The adoption of the Healthy, Hunger-Free Kids Act of 2010 has had a significant positive impact on obesity prevalence among low-income children since its adoption.[1132] Increasing access to Community Eligibility Provision (CEP) or passing the Universal School Meals Program Act would further advance these goals. Providing free meals to children regardless of income will help eliminate school meal debt and lunch-shaming, reduce program financial loss,[1133] and control administrative costs. Congress should also increase funding for outreach to ensure the enrollment of eligible children and families for school meals and a summer feeding program.[1134]
- **Congress and USDA should further build on increasing access to healthy school meals by providing resources to improve school meal nutritional quality.** Additional funding could help states and localities acquire the equipment and staff needed to provide meals with minimally processed foods and maximum nutritional benefit.[1135] Congress needs to invest significant resources, including increasing reimbursement rates and funding for school kitchen equipment grants, farm to school, School Breakfast Program, Team Nutrition, and the Institute for Child Nutrition to help school districts incentivize local food procurement and improve nutritional quality of meals. USDA should recommit to best practices it has honed over decades to provide technical assistance and training.
- **Federal agencies should continue to improve school nutrition standards.** USDA should ensure school meals align with science-based recommendations to reduce added sugars, sodium, saturated fat, and, when applicable and feasible, processed foods. USDA should also reinstate its nonpunitive performance-based incentives that reward schools for innovative approaches to improving nutritional quality and accessibility of school meals, 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 CEP enrollment and should expand funding and eligibility.** Participating schools report that CEP, which enables schools in high-poverty areas to serve meals to all students at no charge, improves children's access to healthy meals, cuts paperwork for parents and schools, and makes school meal programs more efficient.[1136] Congress should appropriate additional funding to increase meal reimbursements to further incentivize schools to implement CEP.[1137] During the 2024–2025 school year, 54,234 schools—with 27.2 million students—participated in CEP.[1138] CEP enables free 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. Limitations in current reimbursement structures prevent some eligible schools from participating in CEP. Increased funding and reimbursement rates would maximize enrollment and expand access to healthy school meals in areas experiencing high rates of poverty.
- **Congress should expand access to the Child and Adult Care Food Program.** Low-income preschoolers attending childcare centers participating in the Child and Adult Care Food Program (CACFP) are moderately less likely to have overweight, obesity, or underweight than similar children attending nonparticipating centers.[1139] 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.** Breastfeeding is associated with multiple positive health outcomes, including reduced risk of childhood obesity.[1140] 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.[1141] 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.[1142, 1143]

RECOMMENDATIONS FOR STATE AND LOCAL GOVERNMENTS:

- **States and localities should support access to healthy school and out-of-school meals.** 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.
- **States and localities should continue strengthening school nutrition standards** by working to align them with nutrition standards based on the preponderance of strong scientific evidence. Improving the nutritional quality of school meals has been associated with a significant decrease in risk of obesity and improved health outcomes for low-income children.[1144]

D) Alter Pricing Systems to Improve Nutritional Quality, Affordability, and Accessibility

There is a substantive and growing body of evidence showing that increasing the price of unhealthy items like sugary drinks through excise taxes reduces consumption (similar to pricing strategies that helped decrease smoking rates).[1145,1146,1147,1148,1149,1150] Governments may also choose to use this revenue to fund programs and services that improve population health. [1151, 1152] Policies in several communities show clear evidence that this approach works to reduce the consumption of sugary drinks. [1153, 1154] Likewise, policies can also support nutrition security and consumption of healthier foods by making those options more cost-effective and accessible.

RECOMMENDATIONS FOR THE FEDERAL, STATE, AND LOCAL GOVERNMENTS:

- **Lawmakers should discourage overconsumption of added sugars through taxation policy.** Sugary beverage taxes have been shown to meaningfully decrease purchases of beverages high in added sugars.[1155] 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 added sugars consumption is making the tax amount proportional to the amount of sugar in drinks, thereby incentivizing companies to reformulate and reduce the sugar content in their products.
- **Federal agencies should promote healthy food options through procurement policies.** Government agencies can improve health outcomes by prioritizing nutrition in food-purchasing contracts and guidelines.[1156] Federal, state, local, school, and other institutional food-service facilities should improve the nutritional quality of the food they provide by uniformly implementing the *Food Service Guidelines for Federal Facilities*.[1157]

E) Support Public Health Education for Nutrition and Limit Marketing that Encourages Overconsumption of Unhealthy Foods

Nutrition labeling and packaging are among the most important and visible ways public health can communicate with consumers about the nutritional quality of the food they choose. By improving nutrition labeling, policymakers can help communities make healthier dietary choices.

Additionally, from infancy through adulthood, Americans are exposed to effective advertising via television, radio, digital, and retail ads encouraging the consumption of fast food, sugary drinks, and calorie-dense, low-nutrient food products. While these messages reach virtually all populations, children of color are disproportionately exposed to food and beverage marketing.[1158,1159]

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT:

- **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 shown to help consumers make better choices by putting simplified, essential nutrition information on the front of packaged food products.[1160,1161] Labeling regulations should be updated to improve accuracy and legibility for all food types. The agency should also establish clear and consistent labeling requirements for "toddler milks," many of which have misleading labels.[1162,1163] FDA should 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.
- **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 television advertising subsidies for unhealthy foods and beverages would prevent approximately 17,000 cases of obesity over a decade.[1164] The Federal Trade Commission, FDA, and USDA should support interagency strategies to study and develop policy to reduce childhood exposure to online marketing for unhealthy foods.

RECOMMENDATIONS FOR STATE AND LOCAL GOVERNMENTS:

- **Communities should reduce unhealthy food marketing to children at the local level.** Exposure to marketing is a significant factor driving consumption of unhealthy foods. Local officials should incorporate 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.[1165]

F) Support Programs that Increase Access to Safe, Routine, and Equitable Physical Activity

Beyond efforts to design activity-friendly physical spaces, policymakers can support physical activity through guidelines, public education, and school-based programs. In particular, physical activity in childhood has lasting benefits for health and well-being. Physical activity in school-based programs also can increase physical activity outside of school and into adulthood.[1166,1167]

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT:

- **Congress should fund programs that support physical education and healthier schools.** Given the positive relationship between increased physical activity and improved mental health,[1168] 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[1169] 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. The Every Kid Outdoors program should be expanded to children beyond fourth grade.

- **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.[1170,1171] The first two editions of the guidelines were released in 2008 and 2018, with a midcourse report released in 2023.[1172]

RECOMMENDATIONS FOR STATE AND 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 use the Every Student Succeeds Act Title I and/or IV funding for physical education and other physical activity opportunities.[1173]
- **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.

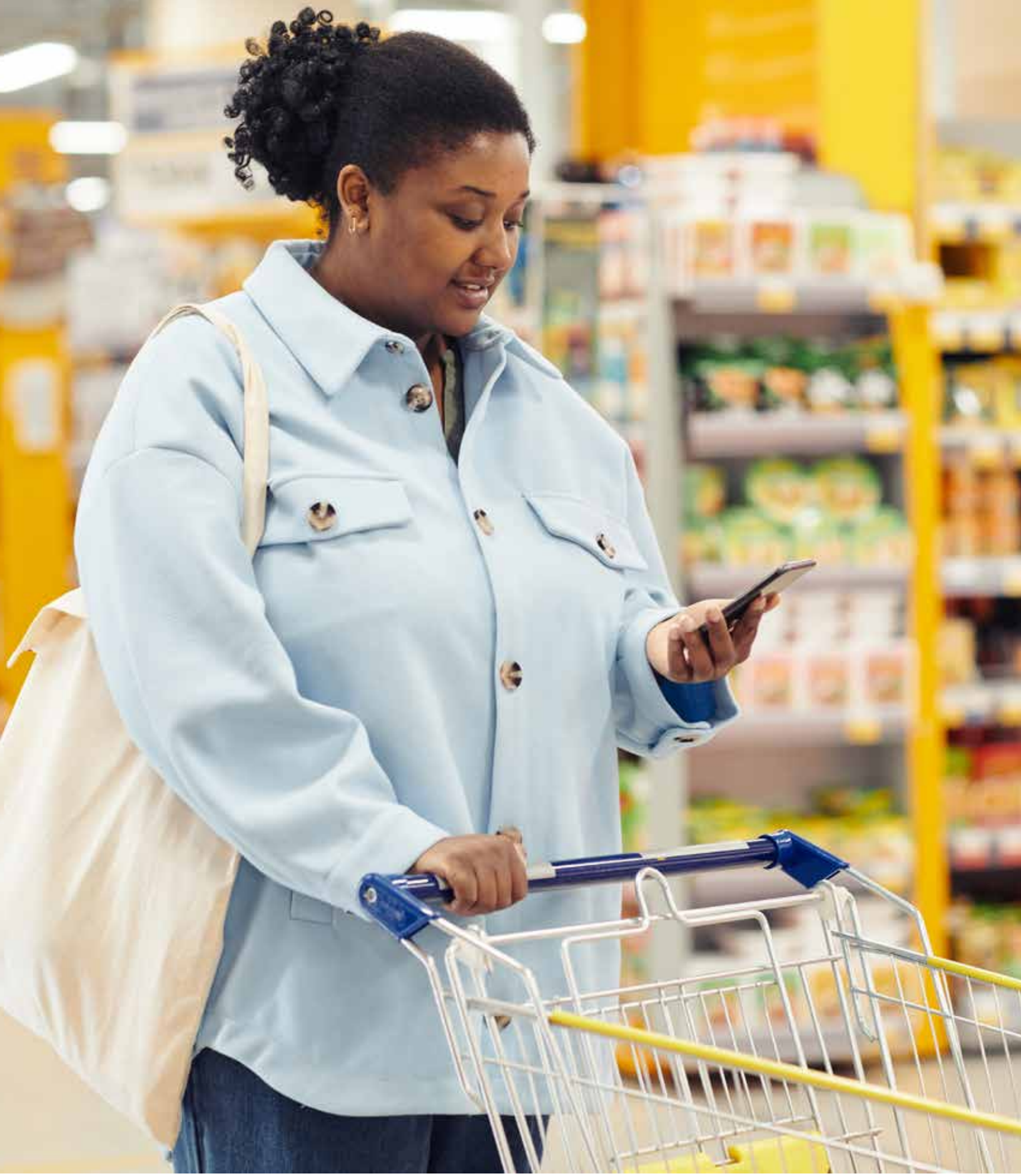
G) Expand Access to Prevention, Screening, and Treatment for Obesity and Related Chronic Diseases Within the Healthcare System

Health insurance and access to care are important for obesity prevention and treatment, as well as to overall health. Payers, healthcare providers, facilities, and community health organizations have important roles in preventing and treating obesity. The expansion of treatment options must be accompanied by supportive health and nutrition services and efforts to address health-related social needs.

RECOMMENDATIONS FOR THE FEDERAL, STATE, AND LOCAL GOVERNMENTS:

- **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, eliminate barriers to coverage such as work requirements, and maintain existing federal matching rates.
- **HHS and other federal agencies should protect and strengthen coverage of USPSTF-recommended obesity-prevention services.** Any A or B grade preventive services recommended 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.[1174] 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 restart the Childhood Obesity Research Demonstration to inform how to translate USPSTF recommendations into lifestyle and clinical interventions.
- **All stakeholders in the healthcare system should expand opportunities for public health and healthcare coordination.** HHS, payers, healthcare facilities, public health agencies, and Congress should expand the capacity of healthcare providers and payers, social service providers, and public health officials to use data to inform population health interventions.
- **Medicare, Medicaid, and other payers should expand coverage of weight management, preventive care, food is medicine interventions, treatment, and other obesity-related services.**[1175] Medicaid should reimburse providers for evidence-based comprehensive pediatric and adult weight management programs and services, such as Family-Based Behavioral Treatment programs and Integrated Chronic Care Models.[1176] State Medicaid programs should also expand coverage of obesity-related services, such as obesity medications, bariatric surgery, produce prescriptions, and obesity and nutritional counseling provided by professionals like registered dietitians.

- **The Centers for Medicare & Medicaid Services, healthcare systems, and payers should prioritize strategies to address health-related social needs.** The Centers for Medicare & Medicaid Services should reinstate its health-related social needs guidance from 2023[1177] and 2024.[1178] In addition, the agency should continue to roll out pilots that address nutrition and physical activity, such as the ELEVATE model, and build on cost-effective 1115 waiver demonstrations that have addressed social needs.[1179] States, insurers, and healthcare facilities should continue efforts to manage these underlying nonmedical 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 in low-resourced areas to provide culturally and linguistically appropriate health education and to connect residents with relevant safety-net and social-support resources.
- **Build and support the capacity of community-based partners through Medicaid.** State Medicaid agencies should seek 1115 waivers or state plan amendments that would allow state Medicaid 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., FIM and produce 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

The appendix covers 27 indicators spanning state-level conditions, policies, and performance measures across five themes: (1) community conditions; (2) nutrition assistance programs; (3) youth nutrition access and standards; (4) built environment and active transportation; and (5) healthcare coverage and programs. 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

	Overall Poverty (2022–2024)	Child Poverty (2022–2024)	Educational Attainment (2024)	Health Insurance Coverage (2024)	Household Food Insecurity (2022–2024)	Child Food Insecurity (2024)	Food-Insecure Population Above SNAP Eligibility Threshold (2024)	Average Cost per Meal (2024)
	What percentage of people live below the federal poverty level?[1]	What percentage of children live below the federal poverty level?[2]	What percentage of adults age 25 or older have a bachelor's degree or higher?[3]	What percentage of people ages 0–64 are uninsured?[4]	What percentage of households experience low or very low food security?[5]	What percentage of children under age 18 are food insecure?[6]	What percentage of food-insecure people in the state have incomes above the SNAP eligibility threshold?[7]	What is the average cost per meal in the state?[8]
Alabama	16%	22%	30%	10%	12%	24%	55%	$3.58
Alaska	9%	14%	33%	13%	13%	20%	47%	$4.30
Arizona	10%	13%	35%	13%	13%	21%	45%	$3.44
Arkansas	13%	18%	27%	11%	19%*	27%	44%	$3.32
California	10%	14%	38%	7%	13%	20%	41%	$3.79
Colorado	8%	9%	48%	9%	11%*	18%	51%	$3.80
Connecticut	9%	15%	43%	7%	12%	19%	49%	$3.98
Delaware	8%	13%	36%	9%	11%*	21%	51%	$3.69
DC	11%	16%	66%	5%	10%*	22%	41%	$4.53
Florida	12%	15%	36%	14%	13%	21%	43%	$3.83
Georgia	13%	20%	36%	14%	15%	22%	64%	$3.68
Hawaii	9%	15%	38%	4%	11%*	22%	53%	$4.51
Idaho	8%	6%	33%	11%	13%	18%	64%	$3.79
Illinois	12%	15%	39%	8%	13%	18%	52%	$3.70
Indiana	9%	12%	31%	9%	14%	21%	61%	$3.32
Iowa	8%	13%	32%	7%	11%*	18%	53%	$3.52
Kansas	7%	7%	36%	10%	13%	21%	62%	$3.48
Kentucky	16%	22%	28%	8%	19%*	25%	34%	$3.28
Louisiana	20%	32%	28%	9%	18%*	26%	35%	$3.49
Maine	7%	11%	37%	7%	13%	21%	46%	$3.92
Maryland	7%	8%	45%	7%	12%*	20%	50%	$3.83
Massachusetts	9%	9%	48%	3%	12%*	17%	49%	$4.06
Michigan	11%	19%	33%	6%	15%	20%	40%	$3.48
Minnesota	7%	9%	40%	6%	10%*	16%	43%	$3.85
Mississippi	18%	25%	27%	12%	17%*	26%	20%	$3.45
Missouri	9%	14%	34%	9%	13%	21%	62%	$3.58

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	Overall Poverty (2022–2024)	Child Poverty (2022–2024)	Educational Attainment (2024)	Health Insurance Coverage (2024)	Household Food Insecurity (2022–2024)	Child Food Insecurity (2024)	Food-Insecure Population Above SNAP Eligibility Threshold (2024)	Average Cost per Meal (2024)
	What percentage of people live below the federal poverty level?[1]	What percentage of children live below the federal poverty level?[2]	What percentage of adults age 25 or older have a bachelor's degree or higher?[3]	What percentage of people ages 0–64 are uninsured?[4]	What percentage of households experience low or very low food security?[5]	What percentage of children under age 18 are food insecure?[6]	What percentage of food-insecure people in the state have incomes above the SNAP eligibility threshold?[7]	What is the average cost per meal in the state?[8]
Montana	8%	8%	36%	11%	12%	18%	46%	$3.58
Nebraska	7%	8%	35%	9%	13%	16%	53%	$3.44
Nevada	12%	13%	29%	14%	15%	22%	43%	$3.59
New Hampshire	6%	6%	42%	6%	9%*	16%	58%	$3.84
New Jersey	10%	15%	45%	9%	10%*	16%	53%	$3.91
New Mexico	14%	18%	32%	13%	15%	24%	31%	$3.44
New York	11%	13%	41%	6%	14%	21%	38%	$3.93
North Carolina	14%	19%	37%	10%	12%	22%	16%	$3.68
North Dakota	8%	11%	34%	7%	9%*	17%	45%	$3.56
Ohio	10%	16%	32%	8%	14%	21%	60%	$3.53
Oklahoma	12%	14%	29%	14%	17%*	27%	59%	$3.46
Oregon	9%	10%	38%	6%	13%	19%	45%	$3.92
Pennsylvania	10%	11%	36%	7%	11%*	19%	44%	$3.74
Rhode Island	11%	14%	39%	6%	11%*	18%	48%	$3.92
South Carolina	11%	16%	33%	11%	14%	21%	57%	$3.58
South Dakota	9%	14%	34%	10%	10%*	19%	62%	$3.62
Tennessee	9%	10%	32%	12%	13%	22%	58%	$3.70
Texas	11%	17%	35%	19%	18%*	26%	47%	$3.17
Utah	8%	5%	39%	9%	12%*	19%	69%	$3.50
Vermont	7%	10%	45%	6%	9%*	17%	53%	$4.12
Virginia	8%	11%	43%	8%	12%	16%	45%	$3.78
Washington	10%	11%	41%	8%	11%*	20%	51%	$3.94
West Virginia	13%	15%	24%	7%	14%	24%	38%	$3.31
Wisconsin	9%	12%	35%	7%	12%	20%	44%	$3.61
Wyoming	8%	8%	32%	12%	16%	20%	62%	$3.65
United States	**11%**	**14%**	**37%**	**10%**	**13%**	**20%**	**38%**	**$3.70**

Sources and notes

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6. Feeding America. "Food Insecurity among the Child Population in the United States." https://map.feedingamerica.org/. Accessed July 31, 2026.
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NUTRITION ASSISTANCE PROGRAMS

	SNAP Participation Rates (2022)	SNAP Participation Change Post-OBBBA (2026)		Estimated SNAP Administrative Cost Increase (2027)	SNAP Food Restriction Waivers (2026)	WIC Participation (2023)	WIC Breastfeeding Performance Measurements (2024)
	What percentage of eligible people participate in SNAP?[1]	What was the numerical reduction in SNAP participation between July 2025 and January 2026?[2]	What was the percentage change in SNAP participation between July 2025 and January 2026?[3]	How much will the state's estimated share of SNAP of administrative costs rise (in millions) after the federal share falls from 50 to 25 percent in FY 2027?[4]	Has USDA approved the state's request to restrict the purchase of specified foods or beverages with SNAP benefits?[5]	What percentage of eligible people participate in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?*[6]	What percentage of infants participating in WIC were fully or partially breastfed?[7]
Alabama	90%	36,912	-5%	$104		51%	18%
Alaska	73%	2,471	-4%	$18		50%	52%
Arizona	77%	372,724	-42%	$106		60%	37%
Arkansas	59%	11,944	-5%	$68	✓a	46%	21%
California	81%	257,937	-5%	$661		72%	50%
Colorado	100%	18,233	-3%	$142	✓b	54%	45%
Connecticut	98%	25,257	-7%	$120		48%	46%
Delaware	91%	7,456	-6%	$33		62%	42%
DC	100%	N/A	N/A	$56		59%	49%
Florida	81%	278,720	-10%	$205	✓a	53%	46%
Georgia	92%	460,583	-24%	$190		48%	36%
Hawaii	81%	4,421	-3%	$49	✓a	57%	55%
Idaho	73%	7,332	-6%	$14	✓a	45%	53%
Illinois	100%	155,111	-8%	$260		44%	40%
Indiana	89%	44,776	-8%	$142	✓a	58%	39%
Iowa	98%	16,422	-6%	$41	✓b	54%	36%
Kansas	79%	13,284	-7%	$44	✓a	51%	39%
Kentucky	75%	22,509	-4%	$161		62%	31%
Louisiana	99%	89,366	-11%	$134	✓a	41%	24%
Maine	94%	8,375	-5%	$21		55%	47%
Maryland	85%	19,330	-3%	$164		61%	49%
Massachusetts	100%	102,210	-9%	$138		69%	46%
Michigan	100%	109,352	-7%	$296		63%	31%
Minnesota	93%	15,758	-3%	$131		66%	48%
Mississippi	74%	29,764	-8%	$44		46%	20%
Missouri	92%	38,903	-6%	$94	✓a	43%	31%

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   a) Waiver approved b) Waiver was approved but a June 2026 court case ordered the approval of the waiver be vacated and that the waiver's implementation may not proceed.
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   ***Note:** These values capture eligibility and participation across all WIC participant categories (infants, children, and women).
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	SNAP Participation Rates (2022)	SNAP Participation Change Post-OBBBA (2026)		Estimated SNAP Administrative Cost Increase (2027)	SNAP Food Restriction Waivers (2026)	WIC Participation (2023)	WIC Breastfeeding Performance Measurements (2024)
	What percentage of eligible people participate in SNAP?[1]	What was the numerical reduction in SNAP participation between July 2025 and January 2026?[2]	What was the percentage change in SNAP participation between July 2025 and January 2026?[3]	How much will the state's estimated share of SNAP of administrative costs rise (in millions) after the federal share falls from 50 to 25 percent in FY 2027?[4]	Has USDA approved the state's request to restrict the purchase of specified foods or beverages with SNAP benefits?[5]	What percentage of eligible people participate in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?*[6]	What percentage of infants participating in WIC were fully or partially breastfed?[7]
Montana	75%	5,734	-7%	$22	✓a	43%	42%
Nebraska	93%	13,205	-9%	$37	✓b	60%	41%
Nevada	98%	54,979	-11%	$59	✓a	48%	38%
New Hampshire	82%	765	-1%	$17		50%	43%
New Jersey	91%	29,920	-4%	$289		58%	52%
New Mexico	100%	14,656	-3%	$47		44%	42%
New York	91%	127,445	-4%	$746		62%	56%
North Carolina	95%	142,045	-11%	$219		62%	39%
North Dakota	81%	4,321	-8%	$19	✓a	52%	37%
Ohio	99%	82,393	-6%	$219	✓a	46%	19%
Oklahoma	98%	77,652	-11%	$87	✓a	54%	25%
Oregon	100%	42,113	-5%	$237		63%	46%
Pennsylvania	100%	145,186	-7%	$339		44%	27%
Rhode Island	100%	11,161	-8%	$39		61%	36%
South Carolina	76%	50,053	-9%	$54	✓a	44%	30%
South Dakota	84%	3,949	-5%	$15		58%	38%
Tennessee	84%	85,488	-12%	$192	✓b	47%	38%
Texas	74%	248,655	-7%	$285	✓a	57%	59%
Utah	76%	17,002	-10%	$39	✓a	45%	50%
Vermont	99%	2,580	-4%	$19		80%	55%
Virginia	83%	100,913	-12%	$8	✓a	47%	33%
Washington	100%	25,801	-3%	$190		55%	53%
West Virginia	98%	15,390	-6%	$32	✓b	59%	23%
Wisconsin	100%	19,418	-3%	$128		56%	35%
Wyoming	63%	1,819	-7%	$14	✓a	43%	37%
United States	**88%**	**N/A**	**N/A**	**N/A**	**18 States**	**56%**	**42%**

Sources and notes

1. Cunnyngham, Karen. "Reaching Those in Need: Estimates of State SNAP Participation Rates in 2022." Produced by Mathematica for USDA Food and Nutrition Service. February 2025. Accessed July 23, 2026.
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YOUTH NUTRITION ACCESS AND STANDARDS

	Obesity Prevention in Early Care and Education (2024)	Summer EBT (2026)	Community Eligibility Provision (2024–2025)	Healthy School Meals for All (2026)	Child and Adult Care Food Program Participation (2025)	National School Lunch Program Participation (2025)
	How well do state licensing regulations for childcare centers incorporate high-impact obesity-prevention standards, on a scale of 0 to 100?*[1]	Did the state participate in the Summer EBT program in 2026?*[2]	What percentage of eligible districts have adopted the community eligibility provision?*[3]	Has the state enacted or introduced legislation to provide Healthy School Meals for All or Free School Breakfast for All?[4]	What is the average daily attendance for the CACFP in 2025?[5]	What was the average daily participation in the National School Lunch Program in 2025?*[6]
Alabama	57	✓	85%		63,914	527,604
Alaska	68		97%	✓c	5,521	42,505
Arizona	55	✓	71%	✓c	54,606	591,849
Arkansas	75	✓	32%	✓b	60,901	307,503
California	68	✓	71%	✓a	713,384	3,287,642
Colorado	76	✓	89%	✓a	32,580	456,697
Connecticut	68	✓	57%	✓b	23,239	292,121
Delaware	81	✓	86%	✓b	51,700	96,570
DC	74	✓	84%	✓b	24,622	51,242
Florida	71		72%	✓c	296,899	1,799,255
Georgia	71		78%		141,245	1,154,653
Hawaii	67	✓	93%	✓c	8,186	88,872
Idaho	32		37%		7,717	130,015
Illinois	80	✓	60%	✓c	127,802	948,415
Indiana	50		43%		73,755	724,219
Iowa	66	✓	14%	✓c	33,644	359,502
Kansas	45	✓	30%	✓c	38,396	312,515
Kentucky	64	✓	97%		69,821	495,303
Louisiana	73	✓	88%		85,354	503,882
Maine	61	✓	31%	✓a	8,931	116,709
Maryland	73	✓	66%	✓c	76,372	465,939
Massachusetts	44	✓	97%	✓a	73,786	627,121
Michigan	75	✓	78%	✓a	62,260	923,752
Minnesota	65	✓	33%	✓a	80,700	660,928
Mississippi	69		35%		48,885	309,731
Missouri	51	✓	38%	✓c	189,102	521,118
Montana	64	✓	41%	✓c	11,234	75,367
Nebraska	38	✓	24%	✓c	30,882	237,009
Nevada	67	✓	81%	✓c	18,524	225,465

Sources and notes

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   ***Note:** Participation data are nine-month averages; summer months (June-August) are excluded.

	Obesity Prevention in Early Care and Education (2024)	Summer EBT (2026)	Community Eligibility Provision (2024–2025)	Healthy School Meals for All (2026)	Child and Adult Care Food Program Participation (2025)	National School Lunch Program Participation (2025)
	How well do state licensing regulations for childcare centers incorporate high-impact obesity-prevention standards, on a scale of 0 to 100?*[1]	Did the state participate in the Summer EBT program in 2026?*[2]	What percentage of eligible districts have adopted the community eligibility provision?*[3]	Has the state enacted or introduced legislation to provide Healthy School Meals for All or Free School Breakfast for All?[4]	What is the average daily attendance for the CACFP in 2025?[5]	What was the average daily participation in the National School Lunch Program in 2025?*[6]
New Hampshire	70	✓	7%		5,695	75,318
New Jersey	79	✓	28%	✓c	104,269	734,695
New Mexico	72	✓	99%	✓a	38,584	208,017
New York	74	✓	99%	✓a	266,921	1,759,463
North Carolina	76	✓	81%	✓c	119,526	841,146
North Dakota	49	✓	80%	✓c	13,470	92,641
Ohio	50	✓	61%	✓c	95,752	988,005
Oklahoma	72		55%		61,488	397,826
Oregon	71	✓	93%	✓c	30,613	300,224
Pennsylvania	48	✓	67%	✓b	121,817	989,160
Rhode Island	76	✓	77%	✓c	8,498	75,020
South Carolina	64		94%	✓b	42,571	505,083
South Dakota	38		52%	✓c	9,676	99,022
Tennessee	83		82%	✓c	76,290	647,060
Texas	81		63%		1,053,694	3,395,635
Utah	70		67%		30,291	321,498
Vermont	72	✓	98%	✓a	5,815	54,255
Virginia	68	✓	93%	✓c	90,844	742,113
Washington	81	✓	77%	✓c	53,743	552,916
West Virginia	80	✓	100%		23,762	166,188
Wisconsin	69	✓	36%	✓c	41,001	478,548
Wyoming	41	✓	39%		5,279	42,731
United States	**N/A**	**38 States and DC**	**64%**	**9 states passed Healthy School Meals for All policies; 5 states and DC passed Free School Breakfast for All policies; 23 states introduced Healthy School Meals for All legislation**	**4,831,699**	**29,986,667**

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BUILT ENVIRONMENT AND ACTIVE TRANSPORTATION

	Neighborhood Sidewalks and Parks (2023–2024)		Complete Streets Policy Strength (2026)	Walking, Biking, and Safe Routes to School Criteria (2026)
	What percentage of children live in neighborhoods with sidewalks or walking paths?[1]	What percentage of children live in neighborhoods with parks or playgrounds?[2]	What is the strength of the state's Complete Streets policy, on a scale of 0 to 20?*[3]	Do the state's school-siting guidelines include criteria that encourage or require consideration of walking, biking, or Safe Routes to School?[3]
Alabama	52%	55%	0	
Alaska	66%	68%	0	✓
Arizona	87%	81%	0	✓
Arkansas	52%	57%	0	
California	90%	85%	20	✓
Colorado	92%	90%	18	✓
Connecticut	71%	84%	16	✓
Delaware	75%	70%	11	✓
DC	98%	94%	11	
Florida	76%	73%	8	✓
Georgia	62%	62%	13	
Hawaii	83%	87%	11	✓
Idaho	76%	71%	0	
Illinois	88%	89%	3	
Indiana	72%	66%	11	
Iowa	83%	79%	15	
Kansas	77%	77%	0	
Kentucky	62%	59%	13	✓
Louisiana	56%	54%	15	
Maine	60%	71%	12	✓
Maryland	81%	83%	11	✓
Massachusetts	85%	85%	19	✓
Michigan	71%	77%	14	
Minnesota	79%	87%	16	✓
Mississippi	45%	48%	5	
Missouri	70%	69%	2	

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

	Neighborhood Sidewalks and Parks (2023–2024)		Complete Streets Policy Strength (2026)	Walking, Biking, and Safe Routes to School Criteria (2026)
	What percentage of children live in neighborhoods with sidewalks or walking paths?[1]	What percentage of children live in neighborhoods with parks or playgrounds?[2]	What is the strength of the state's Complete Streets policy, on a scale of 0 to 20?*[3]	Do the state's school-siting guidelines include criteria that encourage or require consideration of walking, biking, or Safe Routes to School?[3]
Montana	72%	74%	0	
Nebraska	89%	83%	0	
Nevada	93%	79%	16	
New Hampshire	60%	73%	0	
New Jersey	88%	90%	13	✓
New Mexico	79%	74%	1	
New York	81%	88%	13	✓
North Carolina	58%	59%	11	
North Dakota	83%	85%	0	✓
Ohio	76%	79%	0	✓
Oklahoma	55%	62%	0	✓
Oregon	81%	82%	6	
Pennsylvania	73%	78%	9	✓
Rhode Island	76%	81%	11	✓
South Carolina	55%	54%	10	
South Dakota	82%	80%	0	
Tennessee	54%	57%	13	
Texas	77%	75%	5	
Utah	94%	90%	6	✓
Vermont	64%	71%	8	✓
Virginia	72%	74%	12	✓
Washington	81%	79%	16	
West Virginia	49%	54%	14	✓
Wisconsin	73%	81%	7	
Wyoming	82%	77%	0	✓
United States	**76%**	**76%**	**N/A**	**N/A**

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HEALTHCARE COVERAGE AND PROGRAMS

	Potential State GDP Impact of Locally Sourced Food Is Medicine Programs (2026)	Medicaid Coverage of GLP-1 Medications for Obesity Treatment (2026)
	What is the modeled potential increase in state GDP from scaling locally sourced Food Is Medicine programs (in millions)?*[1]	Which states' Medicaid fee-for-service programs covered GLP-1 medications for obesity treatment?[2]
Alabama	$827	
Alaska	$83	
Arizona	$962	
Arkansas	$560	
California	$5,028	
Colorado	$591	
Connecticut	$282	
Delaware	$108	✓
DC	N/A	
Florida	$2,952	
Georgia	$1,644	
Hawaii	$126	
Idaho	$293	
Illinois	$1,365	
Indiana	$1,079	
Iowa	$429	
Kansas	$408	✓
Kentucky	$918	
Louisiana	$879	
Maine	$213	
Maryland	$562	
Massachusetts	$526	✓
Michigan	$2,000	✓
Minnesota	$686	✓
Mississippi	$515	✓
Missouri	$932	✓

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	Potential State GDP Impact of Locally Sourced Food Is Medicine Programs (2026)	Medicaid Coverage of GLP-1 Medications for Obesity Treatment (2026)
	What is the modeled potential increase in state GDP from scaling locally sourced Food Is Medicine programs (in millions)?*[1]	Which states' Medicaid fee-for-service programs covered GLP-1 medications for obesity treatment?[2]
Montana	$160	
Nebraska	$198	
Nevada	$418	
New Hampshire	$150	
New Jersey	$602	
New Mexico	$314	
New York	$2,744	
North Carolina	$1,620	✓
North Dakota	$96	
Ohio	$2,309	
Oklahoma	$653	
Oregon	$772	
Pennsylvania	$1,626	
Rhode Island	$107	✓
South Carolina	$661	
South Dakota	$94	
Tennessee	$1,241	✓
Texas	$3,862	
Utah	$307	✓
Vermont	$85	
Virginia	$1,182	✓
Washington	$1,088	
West Virginia	$408	
Wisconsin	$843	✓
Wyoming	$82	
United States	**N/A**	**13 States**

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