ECONOMIST ENTERPRISE

Urgency without action: US state responses to obesity

Key findings from the United States Obesity Response Index

Supported by Lilly A MEDICINE COMPANY

Why action on obesity is needed

Almost half of all US adults—around 117m people—are living with obesity; without adequate policy intervention, this proportion is projected to rise to two-thirds by 2050.[1,2,3] People living with obesity lose 2.4 years of life: in the US, adults living with obesity will collectively lose 280m years.[4,5]

Defining obesity

Obesity, defined as the presence of excessive fat that can harm health, is a complex, relapsing chronic disease shaped by genetic, social, psychological and environmental factors.[6]

Obesity hits communities of colour the hardest, driven by longstanding barriers to accessing healthy food, spaces for physical activity, quality healthcare and culturally sensitive support. Non-Hispanic Black Americans are 30% more likely to be living with obesity than non-Hispanic white Americans.[7,8] Geographic divides add another layer of inequality: nearly two-fifths of people living in rural areas are living with obesity, compared with fewer than a third in urban areas.[9]

The US spends around US$173bn on obesity-related medical care annually.[10] But the economic cost of obesity extends beyond hospital bills: more than US$1trn each year is lost to reduced productivity, absenteeism and missed workdays.[11]

States are increasingly exploring how to take evidence-based and comprehensive action to address obesity. Economist Enterprise's United States Obesity Response Index, supported by Lilly, assesses obesity prevention and management policy in all 50 US states. Graded on their obesity response measures, 14 states achieve a passing score (a score of 60 and above).

The United States Obesity Response Index identifies where policy intervention is needed across the US and in each state. This summary showcases key findings from the Index and highlights states that are leading the way in their obesity policy response to enable others to learn and improve. The case for action is clear: without bold intervention, states will miss the opportunity to inspire and support the realisation of healthier, more equitable futures for millions of people in the US.

The full US Index report, which will delve into more state-level detail, will be published in September 2025.

Measuring state-level action: the United States Obesity Response Index

The United States Obesity Response Index assesses US state efforts to prevent and manage obesity. The index utilises 23 indicators across three pillars to assess: the obesity policy landscape and the availability and affordability of holistic obesity management; access to affordable, nutritious food at home and in schools; and access to opportunities for physical activity for all ages. It highlights where policy intervention is most needed and where states can learn from each other.

Key findings

There are plenty of examples of good obesity policy, but their existence is uneven within and across states. Overall, US states lack holistic action targeting obesity prevention and management. On average, states score just 54 out of 100. Equated to academic grades this means that only 14 states would achieve a passing grade of 60 or above. This highlights a substantial gap in state-level obesity response efforts, leaving millions of people without the tools and support to maintain a healthy weight.

Figure 1: The United States Obesity Response Index framework

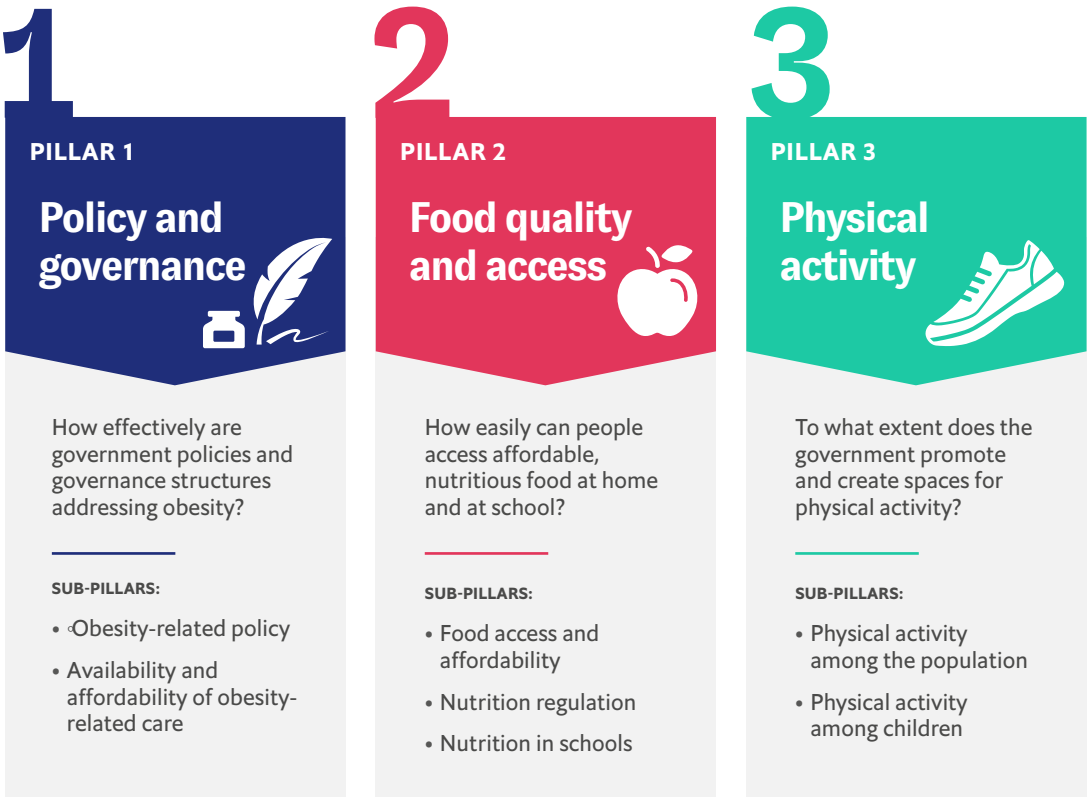


Figure 2: Index rankings

Scores 0-100 where 100 = strongest obesity response

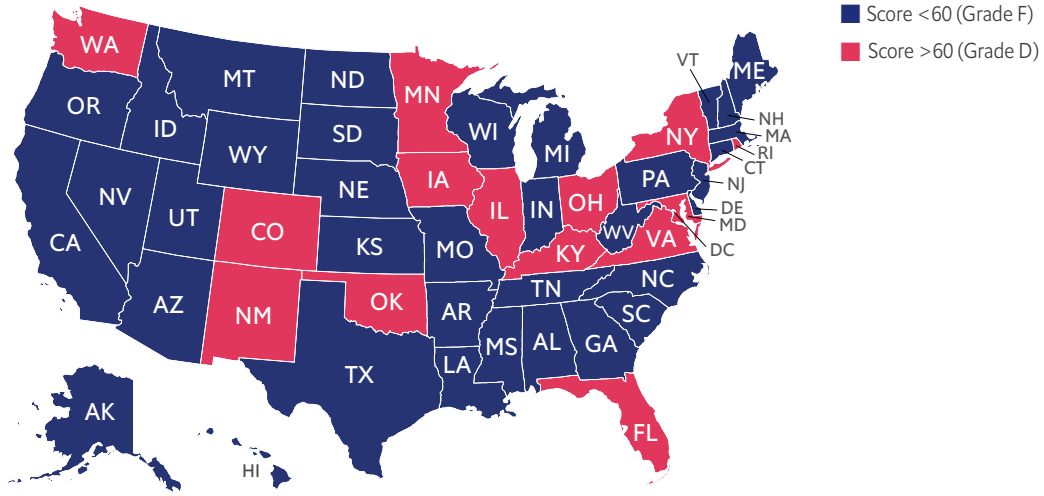
OVERALL		
Rank	State	Score
1	Minnesota	69.2
2	Kentucky	66.5
3	Colorado	65.5
4	Iowa	64.4
5	Florida	64.1
6	Illinois	63.7
7	Virginia	63.2
8	Ohio	63
9	Rhode Island	62.5
10	Maryland	61.6
11	New Mexico	60.6
11	New York	60.6
13	Oklahoma	60.4
14	Washington	60
15	Nevada	59.3
16	Indiana	59.2
17	Wisconsin	58.7
18	North Carolina	58.5
19	California	58.1
20	Texas	57.8
21	Maine	56.8
22	Mississippi	55.4
23	Hawaii	54.8
23	Louisiana	54.8
25	Vermont	54.4
	Average	**54.2**
26	Arkansas	54.1
26	Connecticut	54.1
26	West Virginia	54.1
29	Tennessee	53.9
30	Pennsylvania	53.1
31	Oregon	52.9
32	Idaho	52.1
33	Michigan	51
34	Utah	50.5
35	Nebraska	50.3
36	Wyoming	49
37	Delaware	48.9
37	Missouri	48.9
39	Massachusetts	48.5
40	Alaska	48.1
40	New Jersey	48.1
42	South Dakota	47.1
43	North Dakota	45.3
44	Montana	45.1
45	Alabama	43.7
45	New Hampshire	43.7
47	South Carolina	40.3
48	Georgia	39.8
49	Arizona	38.8
50	Kansas	38.1

PILLAR 1: Policy and governance		
Rank	State	Score
1	Oklahoma	67.7
2	New Mexico	63.8
3	Nebraska	60
4	Florida	58.8
4	Idaho	58.8
4	Mississippi	58.8
7	Minnesota	56.3
8	Nevada	55
8	West Virginia	55
10	Louisiana	52.5
11	Iowa	50
11	Kentucky	50
11	Ohio	50
14	California	46.3
14	Rhode Island	46.3
16	Colorado	45.6
17	Wyoming	43.8
18	Michigan	42.1
19	Hawaii	41.5
20	Montana	41.3
21	Missouri	40
	Average	**39.5**
22	Pennsylvania	38.8
23	New York	37.5
23	Texas	37.5
25	Maryland	36.3
26	Oregon	35.4
27	South Dakota	35
27	Tennessee	35
27	Utah	35
27	Virginia	35
27	Washington	35
32	Wisconsin	34.6
33	Maine	33.1
34	Alaska	32.5
34	Illinois	32.5
36	Delaware	31.3
37	Indiana	30
37	Massachusetts	30
37	North Carolina	30
40	Connecticut	28.8
40	New Hampshire	28.8
40	New Jersey	28.8
40	Vermont	28.8
44	Alabama	28.3
45	Kansas	25
45	North Dakota	25
47	Arkansas	23.8
47	South Carolina	23.8
49	Arizona	20
50	Georgia	17.5

PILLAR 2: Food quality and access		
Rank	State	Score
1	Iowa	89.7
2	Minnesota	88.2
3	Illinois	86
4	North Carolina	84.3
5	Maryland	84
6	Kentucky	82
6	Texas	82
8	Arkansas	81.2
9	New York	79.2
10	Maine	79
11	Wisconsin	78.8
12	Indiana	78.7
13	Colorado	78.3
13	Florida	78.3
15	Rhode Island	75.6
16	Vermont	75.2
17	Washington	73.5
18	Connecticut	68.8
19	Tennessee	68.2
20	Ohio	68
21	North Dakota	66.9
22	Virginia	66.8
	Average	**61.6**
23	Massachusetts	58.5
24	Hawaii	58
25	New Mexico	57.5
25	Pennsylvania	57.5
27	Michigan	56
28	South Carolina	54.8
29	California	54.6
30	Louisiana	51.2
30	Oregon	51.2
32	West Virginia	50.8
33	Alaska	50.3
34	Nevada	50.2
35	Arizona	49.9
35	New Jersey	49.9
37	Georgia	49.7
38	South Dakota	46.2
39	Alabama	45.8
40	Missouri	45.7
41	Delaware	45.6
41	Oklahoma	45.6
43	Utah	45.4
44	Idaho	45.1
45	Nebraska	44.8
46	Kansas	44.2
47	Mississippi	43
48	Wyoming	42.3
49	New Hampshire	39.3
50	Montana	34

PILLAR 3: Physical activity		
Rank	State	Score
1	Virginia	87.7
2	California	73.5
3	Illinois	72.8
3	Nevada	72.8
5	Colorado	72.5
6	Oregon	72
7	Washington	71.5
8	Utah	71.3
9	Ohio	71
10	Delaware	69.8
11	Indiana	69
12	Oklahoma	67.8
13	Kentucky	67.5
14	New Jersey	65.7
14	Rhode Island	65.7
16	Connecticut	64.9
16	Hawaii	64.9
16	New York	64.9
19	Maryland	64.7
20	Mississippi	64.5
21	Minnesota	63.2
21	Pennsylvania	63.2
23	New Hampshire	62.9
24	Wisconsin	62.7
	Average	**61.6**
25	Alaska	61.4
26	North Carolina	61.2
27	Missouri	60.9
27	Wyoming	60.9
29	Louisiana	60.7
29	New Mexico	60.7
31	Montana	60.2
32	South Dakota	59.9
33	Vermont	59.2
34	Tennessee	58.7
35	Maine	58.4
36	Arkansas	57.4
37	Massachusetts	57.1
38	Alabama	56.9
39	West Virginia	56.4
40	Florida	55.3
41	Michigan	54.8
42	Texas	53.8
43	Iowa	53.3
44	Idaho	52.6
45	Georgia	52.1
46	Arizona	46.5
47	Nebraska	46.3
48	Kansas	45
49	North Dakota	44
50	South Carolina	42.3

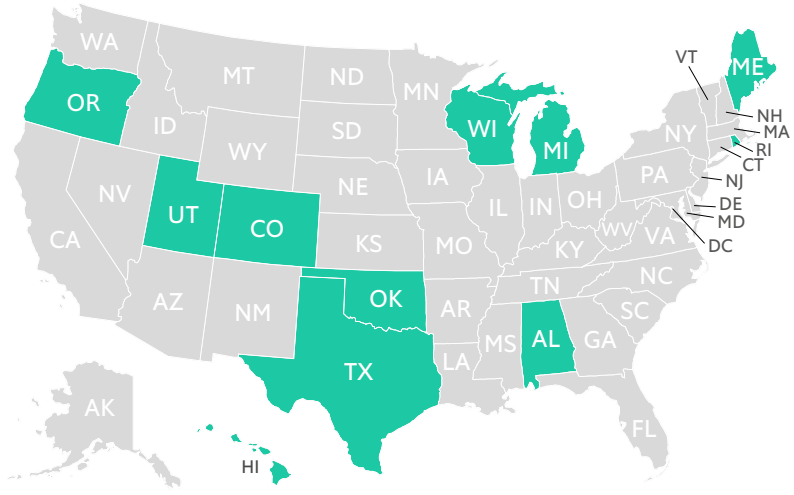
Figure 3: Grading the response to obesity
Index scores by state, equated to academic grades



Source: Economist Enterprise

Most states lack dedicated obesity strategies to guide comprehensive, evidence-based action to preventing and managing the disease. States score an average of just 25 out of 100 on the "Obesity-related policy" sub-pillar of the index. Only 20 states identify obesity as a priority in broader health policies, and just 11 have an active obesity plan or strategy. Twelve states that previously prioritised obesity in health strategies no longer do—which is curious given the clear and enduring need for action. Without clear policy direction, states struggle to strategically prioritise, fund and implement evidence-based interventions and stay accountable when it comes to tracking progress.

Figure 4: Planning for obesity response
States with an active obesity plan or strategy in place



Source: Economist Enterprise

Even among the states with obesity strategies, few are comprehensive and contain defined actions and goals. Only five states—Alabama, Hawaii, Oklahoma, Oregon and Rhode Island—include specific interventions and evaluation metrics for prevention in their obesity plans, and just two—Hawaii and Oklahoma—do the same for obesity management. Additionally, only four states (Colorado, Hawaii, Oklahoma and Oregon) have set either short- or long-term obesity-reduction targets, and none have set both. Without clear goals, concrete actions and measurable outcomes, states risk misallocating resources and, owing to not being able to monitor progress, correct course.

Spotlight on state action: Oklahoma

Oklahoma leads the way on the "Obesity-related policy/strategy/plan" indicator of the index, scoring 90 out of 100. Its comprehensive obesity plan includes clear actions focused on both obesity prevention and management, short-term targets for reducing obesity prevalence, a focus on vulnerable groups, and measures to combat stigma and discrimination—all developed through multi-stakeholder input.

States do not engage people living with obesity when shaping the policies that affect them. This is a missed opportunity to create policy that reflects the range of experiences of people living with obesity.

Obesity-related stigma is largely overlooked. Over half of US states do not recognise obesity as a chronic disease, reinforcing harmful stereotypes and impeding access to holistic treatment. Colorado, Oklahoma and Oregon are the only states that acknowledge stigma in their obesity plans, and only Oklahoma includes actions to address it. Just two states—Michigan and Washington—provide legal protections against weight-based discrimination. This lack of recognition and protection can fuel prejudice, exacerbate mental health challenges, and affect access to jobs, education and healthcare, deepening the inequalities faced by people living with obesity.

Spotlight on state action: Michigan

Michigan stands out for the enshrined protections against weight-based discrimination included in its 1976 Elliott-Larsen Civil Rights Act. This law prohibits unfair treatment based on a person's weight in hiring practices, housing, education and other areas.[12]

Few states offer comprehensive obesity care coverage through Medicaid, limiting access for vulnerable populations. Effective obesity management requires holistic, evidence-based care. Yet, Medicaid—a key source of health insurance for low-income individuals, particularly among racial and ethnic minority communities—often fails to deliver comprehensive coverage. Only 12 states provide full Medicaid coverage for obesity care that includes the main types of treatment (nutrition counselling, behavioural therapy, medications and bariatric surgery). Although nearly all states cover behavioural therapy and surgery, only two in three cover nutrition counselling and just two in five cover medications. By broadening coverage, states can address persistent health inequalities and strengthen their efforts to reduce obesity-related disparities among low-income and minority communities.

Figure 5: The primary forms of obesity care

Nutrition counselling

Nutrition counselling is a collaborative process in which a registered dietitian or nutritionist works with individuals to create tailored nutrition plans that support healthy weight management and improve overall wellbeing. It includes assessing eating habits, setting goals and providing ongoing support to facilitate lasting lifestyle changes.

Source: National Council on Aging

Behavioural therapy

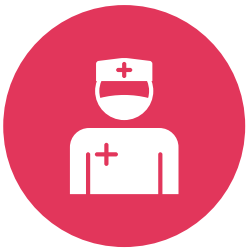
Behavioural therapy for obesity supports individuals in changing their eating and exercise habits through guided support, with the goal of achieving weight loss and sustaining long-term lifestyle changes.

Source: Johns Hopkins Medicine

Obesity medications

Obesity medications are prescription drugs that aid individuals in weight loss and management through various mechanisms, such as appetite suppression, enhancing feelings of fullness, reducing fat absorption and increasing energy expenditure.

Source: National Institute of Diabetes and Digestive and Kidney Diseases



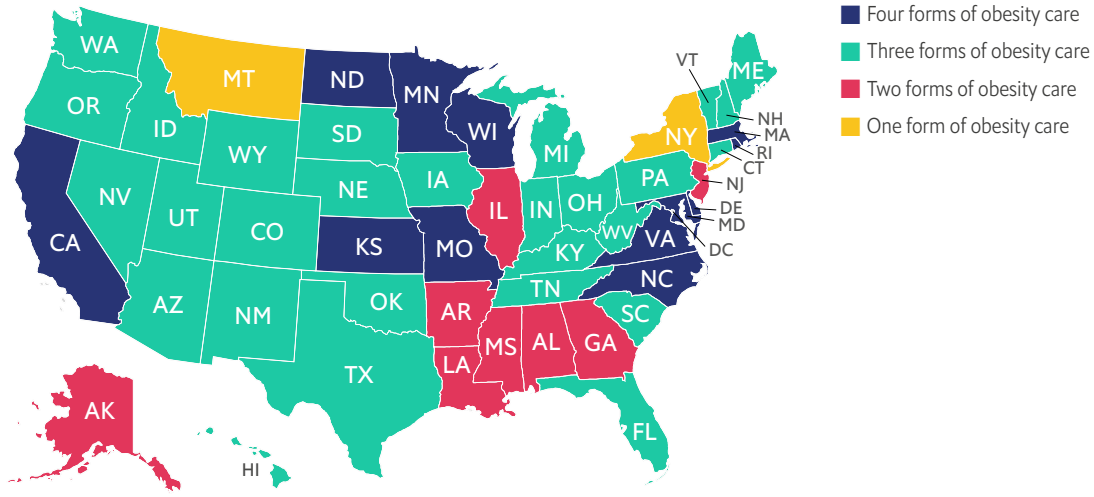
Bariatric surgery

Bariatric surgery (also known as weight-loss or metabolic surgery) encompasses a range of procedures that help individuals with obesity to lose weight by altering the digestive system—typically by limiting food intake, reducing nutrient absorption, or modifying hormonal signals related to hunger and satiety. Common procedures include gastric sleeve, gastric bypass and adjustable gastric band.

Source: National Institute of Diabetes and Digestive and Kidney Diseases

States are missing opportunities to utilise existing incentives for weight loss and medical care in their approach to obesity. Healthy Behaviour Incentive Programmes (HBIPs), implemented through Medicaid, can be powerful tools to encourage weight loss and healthier lifestyles by offering rewards such as fitness classes, food vouchers or lower insurance premiums. Currently, only 16 states leverage HBIPs to specifically target weight loss. Minnesota stands out as the only state that implements a HBIP that targets weight loss and also offers full Medicaid coverage for all four types of obesity care. This highlights the potential for states to move beyond siloed strategies and explore a more integrated approach to address obesity—one that aligns incentives like HBIPs with access to care.

Figure 6: Lacking coverage
Obesity care coverage through Medicaid by state



Source: STOP Obesity Alliance and Obesity Action Coalition

Spotlight on state action: Montana

Montana's Healthy Weight Incentive programme provides up to US$200 in direct payments to Medicaid participants who partake in a Healthy Behaviour Incentive Programme for at least four months, engage in regular physical activity and can demonstrate a 10% reduction in their BMI.[13]

Spotlight on state action: Washington

In an effort to address food insecurity and support healthier choices, Washington's Department of Health implemented the Fruit and Vegetable Prescription (FV Rx) programme. Through it, community healthcare centres prescribe food vouchers, redeemable at participating stores, for fruits and vegetables to patients facing food insecurity.[16]

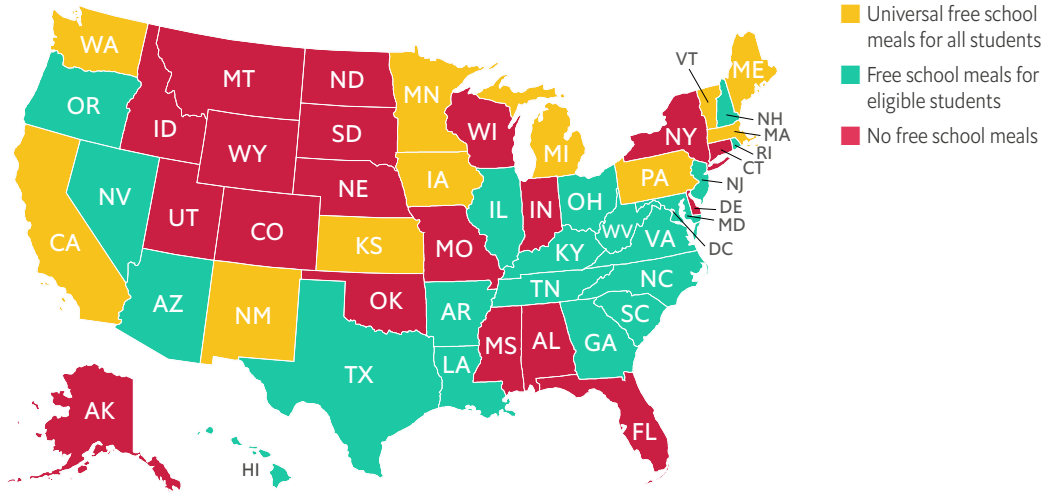
Programmes like the Supplemental Nutrition Assistance Program (SNAP) present a ready-made opportunity to address food insecurity and support healthier diets, yet most states are not managing to enroll all eligible residents in SNAP. Food insecurity—inadequate access to enough nutritious food to lead an active, healthy life—saw one in seven US households struggling to put enough food on the table in 2023.[14,15] Hunger and obesity often coexist—a paradox driven by limited access to healthy, affordable food. SNAP provides food aid to low-income individuals to address food access issues. Six states have achieved full SNAP enrollment among eligible residents (Illinois, Massachusetts, New Mexico, Oregon, Pennsylvania and Rhode Island). Others, like Wyoming, reach fewer than half. This uneven participation represents a missed opportunity to harness a pre-existing scheme that could support millions of people to maintain a nutritious diet—especially among those already facing systemic disadvantages.

States have an opportunity to reduce child hunger and improve nutrition by expanding access to free or reduced-price meals for all school students. Food insecurity starts early: one in five American children are affected.[17] Yet, only 11 states currently provide free or reduced-price school meals to all students. In 20 states, eligibility depends on family income, which can unintentionally create stigma that can deter students from getting the food they need. Expanding universal school meals could remove this barrier by reducing shame to ensure that every child gets the nutrition they need to grow and learn, all while helping to prevent obesity.

Spotlight on state action: Massachusetts

Massachusetts provides free school meals to all students, ensuring that every child has access to nutritious food during the school day. A 2023 survey of parents with school-age children in Massachusetts found that more than two in five said their child would be less likely to eat a school meal if it were not free for all children, highlighting the importance of universal access in facilitating healthy eating for all students.[18]

Figure 7: Minding the meal gap
Provision of free school meals by state



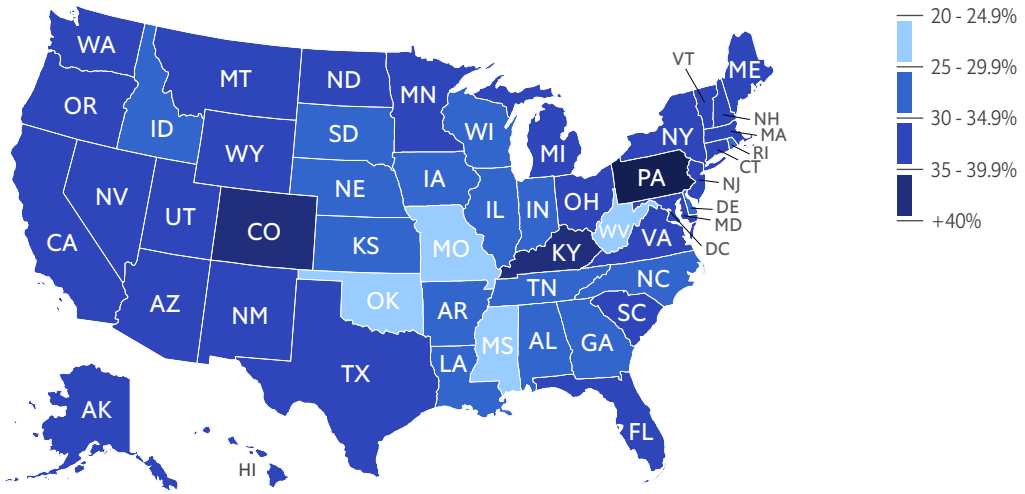
Source: Economist Enterprise

States could expand current physical activity in schools to better support children's health and development. The Centers for Disease Control and Prevention (CDC) recommends that children get at least 60 minutes of exercise per day to stay healthy. Although nearly all states mandate physical activity in schools—the exceptions are Arizona and Kansas—only Virginia meets the 60-minute standard. By fully harnessing the role of schools—which already have the space and equipment to support daily physical activity—states would have a powerful opportunity to instill lifelong healthy habits and help to level the playing field for children who lack safe or affordable opportunities to be active outside of school.

Across the country, states are taking steps to promote active forms of travel, but unequal access to safe spaces for exercise continues to limit physical activity. Forty states are investing in walking and cycling infrastructure and launching public campaigns to encourage active living. Although these efforts aim to create environments that support and facilitate healthier living, millions of people in the US still struggle to stay active. Fewer than half of American adults meet the CDC's recommendation of 150 minutes of moderate-intensity exercise each week.[19] A major barrier is access: about one in five Americans lack nearby safe or convenient places to exercise, such as public parks or recreational facilities.[20] Access varies widely by state: 96% of residents in New Jersey and Rhode Island live near exercise-friendly spaces, compared with fewer than 60% in Mississippi and West Virginia—the states with the highest rates of adult obesity.[21] By closing these gaps, states can ensure that efforts to increase physical activity reach the people who currently lack access.

Figure 8: Running behind

Percentage of adults who met the federal physical activity guidelines in the past 30 days (%, 2023)



Source: Centers for Disease Control and Prevention, 2023 Behavioral Risk Factor Surveillance System

Conclusion: from awareness to action

Obesity is not just a health issue; it is a structural, social and economic crisis that demands coordinated, comprehensive and equitable responses. The data are clear: states have an opportunity to act. From unaddressed stigma and inadequate Medicaid coverage to inconsistent physical education policies and widespread food insecurity, the systems meant to protect and promote health are leaving millions behind—particularly communities of colour and low-income families. Now is the time for states to use the Index to see where they need to take action, share best practices, and prioritise a holistic response to obesity to benefit individuals and the state.

To address the issue effectively, states must recognise obesity as a public health priority, demanding structural reform through a whole-of-society approach. Millions already living with obesity need integrated treatment plans that are embedded within broader strategies for managing chronic diseases (as recommended by the World Health Organisation—WHO), with guaranteed coverage and equitable access.[22] Managing and preventing obesity in the short- and long-term means reshaping our environments to support healthy eating and regular physical activity—from schools and food policy to urban planning.

Obesity is a chronic, relapsing disease, but with inclusive policies to co-ordinate a whole-of-society approach, it can be prevented and managed. The question is not whether action is needed, but how quickly states can make it happen.

Acknowledgements

Economist Enterprise would like to thank the following experts—consulted during the development of the Index framework—for their time and valuable input:

- **Louis J Aronne,** Sanford I Weill professor of metabolic research, Weill-Cornell Medical College
- **Rachel Nugent,** affiliate associate professor, Department of Global Health, University of Washington
- **Dr David Sarwer,** director for Obesity Research and Education, Temple University

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Economist Enterprise bears sole responsibility for the content of this report. The findings and views expressed do not necessarily reflect the views of the sponsor.

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