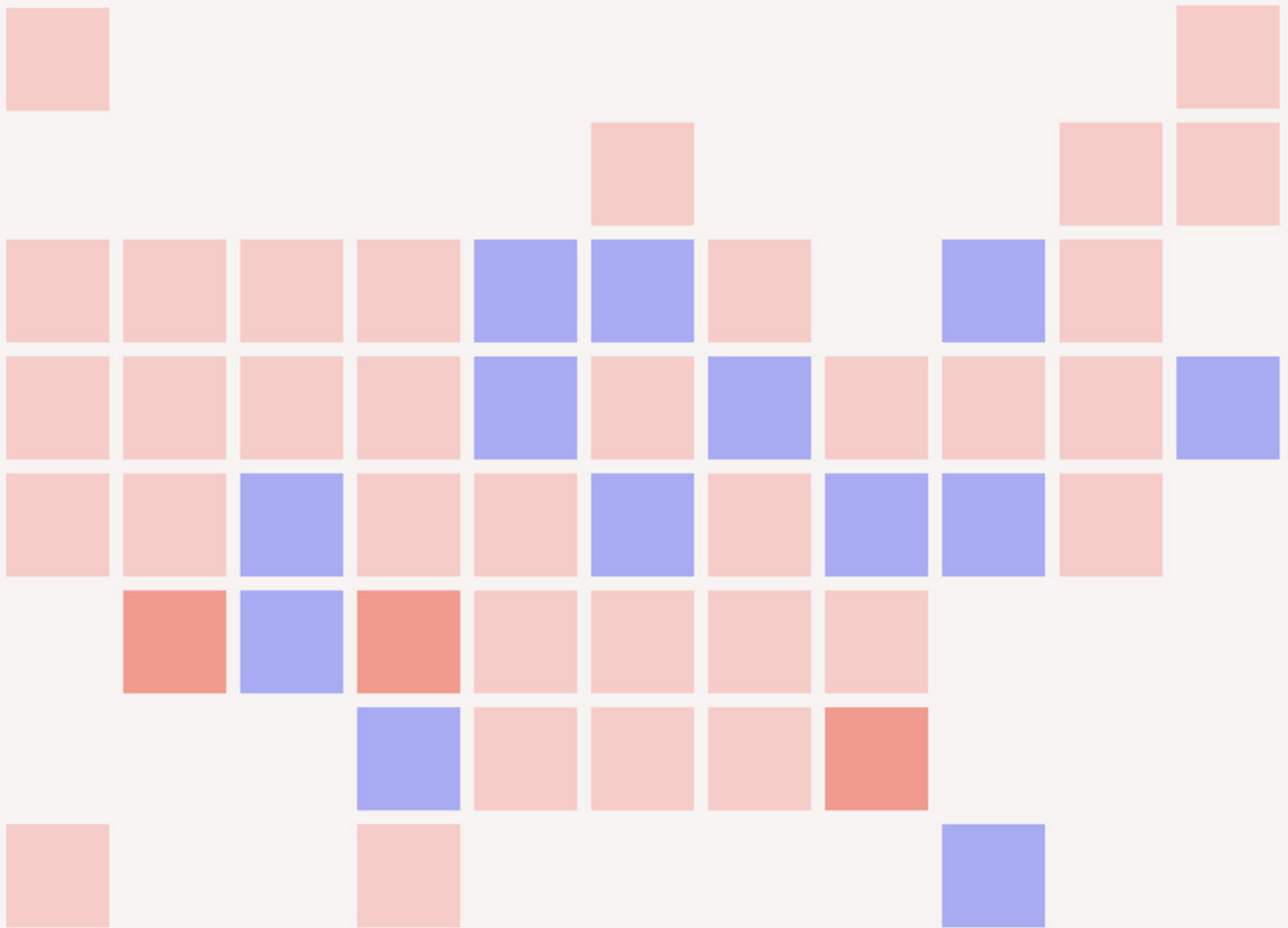


Urgency without action: US state responses to obesity

Findings from the United States Obesity
Response Index



Supported by



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About the report

Urgency without action: US state responses to obesity is an Economist Enterprise report, supported by Eli Lilly and Company. It is based on the findings of the United States Obesity Response Index, which assesses obesity prevention and management policy in all 50 US states. The Index identifies where policy intervention is needed across the US and in each state. This report showcases findings from the Index and highlights states that are leading the way in their obesity policy response.

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Support provided to the framework's development does not imply endorsement (in part or in full) of the project approach or findings.

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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 or the experts we consulted.

Executive summary

Obesity is now one of the most pressing public health challenges facing the United States. Almost half of all US adults—around 117m people—are living with obesity.^{1,2} Without adequate policy intervention, this is projected to rise to two-thirds by 2050.³ But this is not the full picture: one in five American children is living with obesity, with many likely to carry it into adulthood, increasing the risk of lifelong health complications.⁴

The consequences of these trends are far-reaching. Obesity raises the risk of developing other chronic diseases including heart disease, type 2 diabetes and some cancers.⁵ Complications related to excess weight

contribute to the deaths of approximately 500,000 Americans every year.⁶ And the impacts go far beyond individual health. Obesity affects economic productivity and increases demand on healthcare systems. The US spends around US\$173bn on obesity-related medical care annually and loses more than US\$1trn each year to reduced obesity-related productivity and missed workdays.^{7,8}

Once seen as the result of lifestyle choices, obesity is now understood to be a complex, relapsing and treatable chronic disease shaped by an interconnected web of genetic, psychological, social and environmental factors.⁹ Because of its multifaceted nature, there are no quick fixes. Yet, many efforts to address obesity still focus too heavily on individual behaviours like diet and exercise. This narrow view places the burden of change on individuals while ignoring the environments in which people live, work and grow.

Most states are yet to adopt comprehensive strategies that address both individual support needs and the physiologic and structural drivers of the disease through a whole-of-society approach. Addressing obesity effectively means following the science. It requires bold, coordinated policies that expand access to evidence-based care, invest in long-term systems and promote health equity—all of which make healthier lives possible for everyone.

What is the United States Obesity Response Index?

Economist Enterprise's United States Obesity Response Index, supported by Eli Lilly and Company, assesses US state efforts to prevent and manage obesity. It uses 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.

This report examines how US states are responding to the obesity challenge, using a set of indicators to assess the extent to which they embrace comprehensive, system-wide strategies. It highlights areas of progress and critical gaps where further action is urgently needed.

The Index data show that:

There are many examples of effective obesity policy, but they are unevenly distributed 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, only 14 states would achieve a passing mark of 60 or above. This highlights a significant gap in state-level obesity response efforts, leaving millions of people without the tools and support to maintain a healthy weight.

Most states lack dedicated obesity strategies to guide comprehensive, evidence-based action to prevent and manage 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 troubling given the clear and enduring need for action. Among the states with obesity strategies, only five include specific interventions and evaluation metrics for prevention, and just two do the same for management. Additionally, only four states have set either short- or long-term obesity-reduction targets, and none have set both. Without clear policy direction, concrete goals and measurable outcomes, states struggle to strategically prioritise, fund and implement evidence-based interventions and stay accountable when tracking progress.

Obesity-related stigma is largely overlooked.

More than half of US states do not recognise obesity as a chronic disease, reinforcing harmful stereotypes and impeding access to holistic treatment. Only Colorado, Oklahoma and Oregon 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, worsen mental health challenges, and affect access to jobs, education and healthcare, deepening the inequalities faced by people living with obesity.

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.

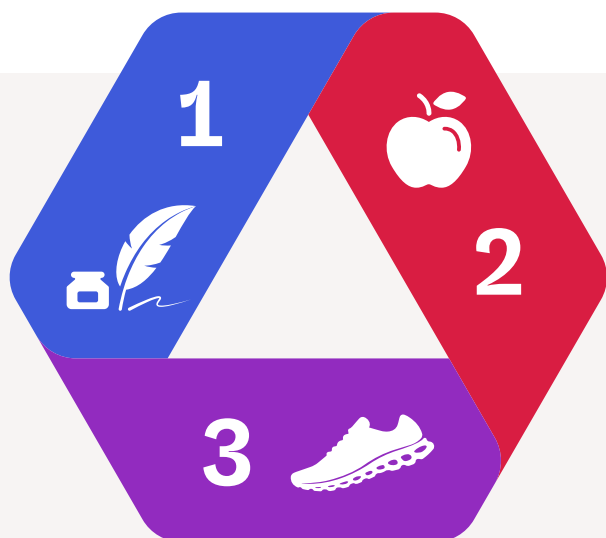
Programmes like the Supplemental Nutrition Assistance Program (SNAP) present an opportunity to address food insecurity and support healthier diets, yet most states are not managing to enroll all eligible residents in SNAP. Hunger and obesity often coexist—a paradox driven by limited access to healthy, 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), whereas others, like Wyoming, reach fewer than half. This uneven participation represents a missed opportunity to harness an existing scheme that could help millions maintain a nutritious diet, especially those facing systemic disadvantages.

States can 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.¹⁰ 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 create stigma that deters students from getting the food they need. Expanding universal school meals could remove this barrier by reducing shame, ensuring that every child gets the nutrition they need to grow and learn, while helping to prevent obesity.

States could expand current physical activity in schools to better support children's health and development. The US Department of Health and Human Services recommends that children get at least 60 minutes of exercise per day to stay healthy.¹¹ 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 often have the space and equipment to support daily physical activity (though resources vary among them)—states could have a powerful opportunity to instill lifelong healthy habits and help level the playing field for children who lack safe or affordable opportunities to be active outside of school.

Across the country, states are promoting active forms of travel, but unequal access to safe exercise spaces limits 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 healthier living, millions in the US still struggle to stay active. Only a quarter of US adults meet the Department of Health and Human Services' recommendation of 150 minutes of moderate intensity or 75 minutes of vigorous exercise per week, combined with muscle-strengthening activities on two or more days.¹² A major barrier is access: about one in five people in the US lack nearby safe or convenient places to exercise, such as public parks or recreational facilities.¹³ By closing these gaps, states can ensure that efforts to increase physical activity reach the people who currently lack access.

Figure 1: Closing the gap—where the US should focus to build a holistic response to obesity

**PILLAR 1****Policy and governance****Employs a comprehensive, strategic approach to obesity policy**

Recognises obesity as a chronic disease and implements policy to address the structural, social and economic conditions that contribute to obesogenic environments, leading to better health outcomes, less discrimination and improved care for people living with obesity

States lack comprehensive obesity plans and strategies

- Twenty states identify obesity as a priority in broader health policies, but only 11 have an active obesity plan or strategy
- Among the states with obesity strategies, only five set clear actions, targets and evaluation metrics for prevention, and just two do the same for management
- No state involved people living with obesity in developing its obesity strategy

States are not doing enough to address weight-related stigma and discrimination

- Half of US states do not formally define obesity as a chronic disease, reinforcing harmful stereotypes
- Only two states (Michigan and Washington) prohibit weight-based discrimination

Medicaid coverage for obesity-related care varies significantly from state to state

- Only 12 states cover the four main forms of obesity care (nutrition counselling, intensive behavioural therapy, obesity medications, and metabolic and bariatric surgery) within Medicaid

PILLAR 2**Food quality and access****Ensures equitable access to nutritious food for all residents**

Enacts policies to ensure fair access to nutritious food, encourage healthy dietary habits and promote nutrition education among young people

States are not fully harnessing essential food programmes like the Supplemental Nutrition Assistance Program (SNAP), and federal budget cuts may reduce eligibility and participation

- Only six states have achieved full SNAP enrolment among eligible residents

Not all states are using fiscal policy to encourage healthier food choices

- Seventeen states apply the standard sales tax to unhealthy foods and drinks while exempting essential groceries
- Two states impose a direct excise tax on unhealthy drinks, and three states impose a higher sales tax on unhealthy items than on other groceries

Schools have an opportunity to provide all students with vital nutrition

- Eleven states provide free or reduced-price school meals to all students, while 20 others maintain an income-based eligibility model

PILLAR 3**Physical activity****Ensures physical activity is equitable and accessible for all**

Implements policies that encourage daily physical activity and ensure safer and more equitable access to exercise

States are taking steps to promote physical activity, but access to exercise-friendly spaces varies greatly across states

- Thirty-five states lack comprehensive physical activity plans to promote active transport and reduce car dependency
- About one in five Americans lack nearby safe or convenient places for physical activity

States do not mandate sufficient physical activity in schools

- Only Virginia requires 60 minutes of daily physical activity in schools, as recommended by the US Department of Health and Human Services

The state of weight: where obesity policy is today

Understanding how the US is addressing obesity can be complex: from policy to healthcare to nutrition and physical activity programmes, state governments take different approaches to managing the systems key to tackling the issue.

At the core of understanding strengths and weaknesses across the country is an assessment of the extent to which states embrace a holistic approach to addressing obesity. The Index revolves around a central question: what does a holistic approach to preventing and managing obesity look like?

The Index framework recognises the role played by structural factors: from the healthcare system to the education sector, obesity prevention and management is inter-sectoral. To identify areas for targeted intervention, the Index evaluates all 50 states across three pillars: policy and governance, food quality and access, and physical activity. Within these pillars, it includes a set of indicators to assess whether states have developed systems, policies and programmes in line with a holistic approach.

The Index shows that while there are examples of effective obesity policy in the US, their presence is uneven across states. Overall, 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 mark of 60 or above. This highlights a significant gap in state-level obesity response efforts, leaving millions without the tools and support to maintain a healthy weight.

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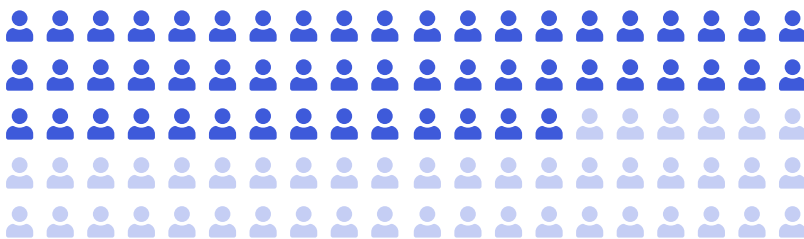


Figure 2: A holistic approach to preventing and managing obesity

The United States Obesity Response Index framework

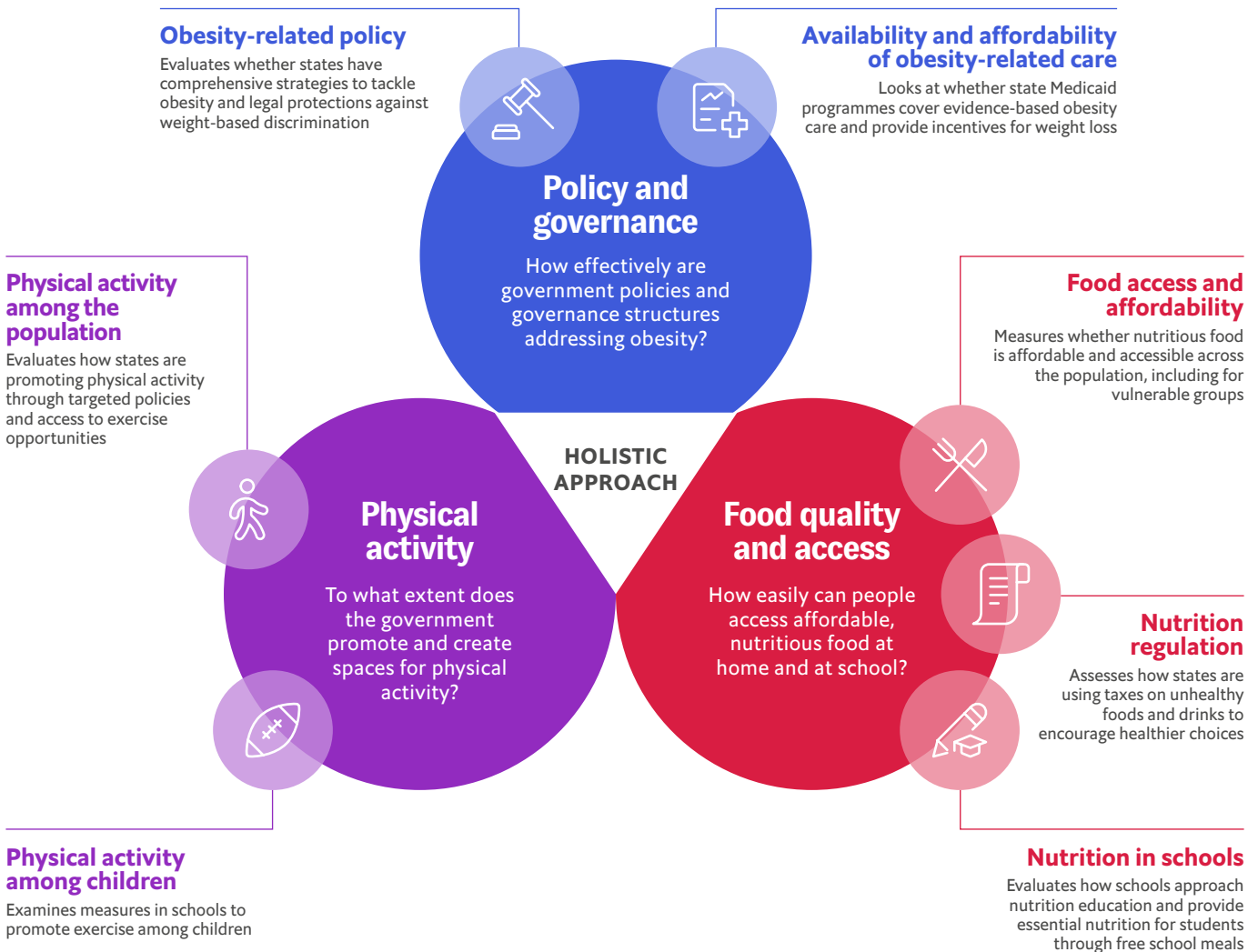


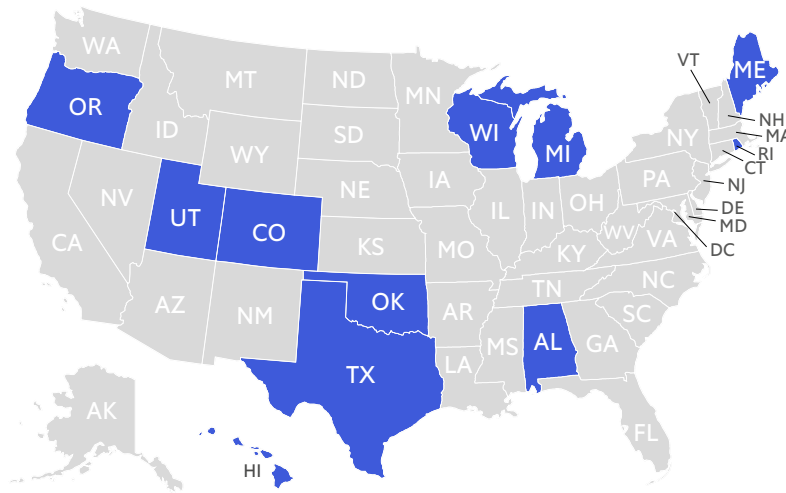
Figure 3: Index rankings

Scores 0-100 where 100 = strongest obesity response

OVERALL			PILLAR 1: Policy and governance			PILLAR 2: Food quality and access			PILLAR 3: Physical activity		
Rank	State	Score	Rank	State	Score	Rank	State	Score	Rank	State	Score
1	Minnesota	69.2	1	Oklahoma	67.7	1	Iowa	89.7	1	Virginia	87.7
2	Kentucky	66.5	2	New Mexico	63.8	2	Minnesota	88.2	2	California	73.5
3	Colorado	65.5	3	Nebraska	60	3	Illinois	86	3	Illinois	72.8
4	Iowa	64.4	4	Florida	58.8	4	North Carolina	84.3	3	Nevada	72.8
5	Florida	64.1	4	Idaho	58.8	5	Maryland	84	5	Colorado	72.5
6	Illinois	63.7	4	Mississippi	58.8	6	Kentucky	82	6	Oregon	72
7	Virginia	63.2	7	Minnesota	56.3	6	Texas	82	7	Washington	71.5
8	Ohio	63	8	Nevada	55	8	Arkansas	81.2	8	Utah	71.3
9	Rhode Island	62.5	8	West Virginia	55	9	New York	79.2	9	Ohio	71
10	Maryland	61.6	10	Louisiana	52.5	10	Maine	79	10	Delaware	69.8
11	New Mexico	60.6	11	Iowa	50	11	Wisconsin	78.8	11	Indiana	69
11	New York	60.6	11	Kentucky	50	12	Indiana	78.7	12	Oklahoma	67.8
13	Oklahoma	60.4	11	Ohio	50	13	Colorado	78.3	13	Kentucky	67.5
14	Washington	60	14	California	46.3	13	Florida	78.3	14	New Jersey	65.7
15	Nevada	59.3	14	Rhode Island	46.3	15	Rhode Island	75.6	14	Rhode Island	65.7
16	Indiana	59.2	16	Colorado	45.6	16	Vermont	75.2	16	Connecticut	64.9
17	Wisconsin	58.7	17	Wyoming	43.8	17	Washington	73.5	16	Hawaii	64.9
18	North Carolina	58.5	18	Michigan	42.1	18	Connecticut	68.8	16	New York	64.9
19	California	58.1	19	Hawaii	41.5	19	Tennessee	68.2	19	Maryland	64.7
20	Texas	57.8	20	Montana	41.3	20	Ohio	68	20	Mississippi	64.5
21	Maine	56.8	21	Missouri	40	21	North Dakota	66.9	21	Minnesota	63.2
22	Mississippi	55.4		Average	39.5	22	Virginia	66.8	21	Pennsylvania	63.2
23	Hawaii	54.8	22	Pennsylvania	38.8		Average	61.6	23	New Hampshire	62.9
23	Louisiana	54.8	23	New York	37.5	23	Massachusetts	58.5	24	Wisconsin	62.7
25	Vermont	54.4	23	Texas	37.5	24	Hawaii	58		Average	61.6
	Average	54.2	25	Maryland	36.3	25	New Mexico	57.5	25	Alaska	61.4
26	Arkansas	54.1	26	Oregon	35.4	25	Pennsylvania	57.5	26	North Carolina	61.2
26	Connecticut	54.1	27	South Dakota	35	27	Michigan	56	27	Missouri	60.9
26	West Virginia	54.1	27	Tennessee	35	27	Michigan	56	27	Wyoming	60.9
29	Tennessee	53.9	27	Utah	35	28	South Carolina	54.8	29	Louisiana	60.7
30	Pennsylvania	53.1	27	Virginia	35	29	California	54.6	29	Louisiana	60.7
31	Oregon	52.9	27	Washington	35	30	Louisiana	51.2	29	New Mexico	60.7
32	Idaho	52.1	32	Wisconsin	34.6	30	Oregon	51.2	31	Montana	60.2
33	Michigan	51	33	Maine	33.1	32	West Virginia	50.8	32	South Dakota	59.9
34	Utah	50.5	34	Alaska	32.5	33	Alaska	50.3	33	Vermont	59.2
35	Nebraska	50.3	34	Illinois	32.5	34	Nevada	50.2	34	Tennessee	58.7
36	Wyoming	49	36	Delaware	31.3	35	Arizona	49.9	35	Maine	58.4
37	Delaware	48.9	37	Indiana	30	35	New Jersey	49.9	36	Arkansas	57.4
37	Missouri	48.9	37	Massachusetts	30	37	Georgia	49.7	37	Massachusetts	57.1
39	Massachusetts	48.5	37	North Carolina	30	38	South Dakota	46.2	38	Alabama	56.9
40	Alaska	48.1	40	Connecticut	28.8	39	Alabama	45.8	39	West Virginia	56.4
40	New Jersey	48.1	40	New Hampshire	28.8	40	Missouri	45.7	40	Florida	55.3
42	South Dakota	47.1	40	New Jersey	28.8	41	Delaware	45.6	41	Michigan	54.8
43	North Dakota	45.3	40	New Jersey	28.8	41	Oklahoma	45.6	42	Texas	53.8
44	Montana	45.1	40	Vermont	28.8	43	Utah	45.4	43	Iowa	53.3
45	Alabama	43.7	44	Alabama	28.3	44	Idaho	45.1	44	Idaho	52.6
45	New Hampshire	43.7	45	Kansas	25	45	Nebraska	44.8	45	Georgia	52.1
47	South Carolina	40.3	45	North Dakota	25	46	Kansas	44.2	46	Arizona	46.5
48	Georgia	39.8	47	Arkansas	23.8	47	Mississippi	43	47	Nebraska	46.3
49	Arizona	38.8	47	South Carolina	23.8	48	Wyoming	42.3	48	Kansas	45
50	Kansas	38.1	49	Arizona	20	49	New Hampshire	39.3	49	North Dakota	44
			50	Georgia	17.5	50	Montana	34	50	South Carolina	42.3

Figure 5: Planning for obesity response

States with an active obesity plan or strategy in place



Source: Economist Enterprise

The Index shows that states with active plans prioritise prevention over a combined approach of prevention and management. All 11 include prevention measures, and only eight include measures focused on managing obesity. Looking more closely, few states are translating these priorities into actionable steps. Just five states (Alabama, Hawaii, Oklahoma, Oregon and Rhode Island) have set clear actions, targets and evaluation metrics for prevention, and just two (Hawaii and Colorado) have done the same for management. This imbalance highlights a critical gap: without an integrated focus on both prevention and management, states risk falling short in reducing rising obesity rates and adequately supporting the millions of Americans already living with obesity.

When it comes to setting time-bound obesity reduction targets—essential benchmarks for evaluating the impact of interventions, identifying gaps, ensuring accountability and directing resources where they are needed most—only four states (Colorado, Hawaii, Oklahoma and Oregon) have set either short-

or long-term goals, and none have set both. Without targets, states risk misallocating resources and losing the ability to monitor progress. As obesity rates are projected to rise in every state over the next decade, targets will be essential to maintain accountability and correct course over time.¹⁴

Effective strategies must also be informed by real-world perspectives. Robust stakeholder engagement across government sectors, organisations representing people living with obesity and patients themselves is key to designing plans that are practical, inclusive and grounded in lived experience. However, only seven of the 11 states with active strategies have consulted governmental, industry or expert stakeholders from at least three sectors, fostering more well-rounded policies through a collaborative approach. Importantly, no state has engaged people living with obesity in the development of the policies that directly affect them. This is a missed opportunity to ensure that plans address the complex factors contributing to obesity and reflect real-world challenges.

Leading the way on obesity policy: Oklahoma

An example of strong policy action comes from Oklahoma, which outpaces other states on the “Obesity-related policy/strategy/plan” indicator in the Index, scoring 90 out of 100. In 2022 the Oklahoma State Department of Health published *Health for a Lifetime: State of Oklahoma Obesity Prevention Plan*, a five-year plan to address obesity and its risk factors.¹⁵ When the plan was drafted, Oklahoma had the ninth highest obesity rate in the country, with more than one in three residents living with obesity. Obesity-related medical costs exceeded US\$1.7bn a year.¹⁶

The plan stands out for its comprehensiveness and clarity of action. It addresses both prevention and management, including commitments to expand access to care for all Oklahomans, improve nutrition, and adapt infrastructure to support safe biking and walking. The plan also sets short-term targets to reduce obesity prevalence by 2026, prioritises support for vulnerable groups, and is unique as the only state strategy to specify actions to address stigma and discrimination. Crucially, Oklahoma consulted 200 stakeholders across sectors through surveys and listening sessions during the plan’s development, incorporating diverse perspectives and expert input to shape a plan rooted in local needs and cross-sectoral collaboration.¹⁷

Even the best laid plans to prevent and manage obesity are likely to fall short without dedicated funding. The Index highlights that just two states—Colorado and Texas—have a specified budget to implement their plans. Colorado’s *Chronic Disease State Plan 2022-2030* includes a section on obesity with recommended interventions to address it.¹⁸ To fund this work, among other initiatives to improve physical activity and nutrition, Colorado’s Department

of Public Health and Environment received a US\$4.4m grant from the Centers for Disease Control and Prevention (CDC).¹⁹ In Texas, plans related to obesity like the 2023 *Obesity Prevention Priority Strategies* are funded through chronic disease grants from the Department of State Health Services.^{20,21} Without consistent and earmarked funding across more states, most plans risk remaining aspirational rather than operational.

Addressing stigma will help states reduce discrimination and work towards equity

Obesity does not affect all Americans equally. Longstanding barriers to accessing healthy food, spaces for physical activity, quality healthcare and culturally sensitive support mean that obesity hits communities of colour hardest. Non-Hispanic Black or African American adults in the US are 30% more likely to be living with obesity than non-Hispanic white adults.²² 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.²³

Effectively tackling obesity involves more than just setting prevalence reduction measures and targets—it also concerns culture and inclusion. Yet, state policies often fail to reflect these realities. The Index finds that only nine state obesity strategies focus on vulnerable and minority groups. Among these states, just seven have well-defined and actionable measures to meet their specific needs. By embedding equity into obesity strategies, states have an opportunity to invest in and support the communities most affected by the disease.

Taking an inclusive approach: Alabama

The Alabama *Physical Activity and Nutrition Plan 2023-2033* recognises that “obesity and chronic diseases do not affect all Alabamians equally” and that “marginalized populations tend to have poorer health outcomes and decreased access to physical activity opportunities and healthy foods and beverages”.²⁴ It discusses that low-income individuals, adults with disabilities and people of colour face higher rates of obesity and often have fewer health resources available to them.

To narrow the divide, the plan outlines actionable goals to increase physical activity and healthy eating among individuals facing health disparities.²⁵ For example, Alabama has one of the lowest rates of access to exercise facilities in the country, with just over six in ten residents having safe access.²⁶ Recognising that lack of access can worsen health outcomes, one of the plan’s objectives is to “adopt and/or implement equitable policies for all to create systems and environments that provide safe, inclusive, and affordable opportunities to improve fitness and participate in sports to increase physical activity and reduce sedentary behavior.”²⁷ By focusing on inclusivity, Alabama is ensuring that interventions are tailored to those most vulnerable.

Alongside inequalities, weight-related stigma remains a powerful and often overlooked barrier to progress. It can isolate people and fuel shame, discourage individuals from seeking care, and reduce access to jobs and career advancement, worsening the physical, emotional and economic impact of obesity. Yet the Index shows that most states overlook stigma in their obesity policies. Although the CDC recognises obesity as a disease at the federal level, only half of US states formally define obesity as a chronic disease—a gap that can reinforce harmful stereotypes.²⁸

Colorado, Oklahoma and Oregon are the only states that acknowledge stigma in their obesity plans, and only Oklahoma includes specific actions to address it. Legal protections against weight-based discrimination are also rare. Only two states, Michigan and Washington, have enacted laws prohibiting such discrimination. Without efforts to tackle stigma directly, its effects will continue to undermine public health goals.

Tackling discrimination and promoting fairness: 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 religion, race, colour, national origin, age, sex, height, weight, familial status or marital status in hiring practices, housing, education and other areas.²⁹

To be effective, state efforts to tackle obesity must consider the social and cultural dimensions of the disease. This means embedding equity into every stage of policy design, confronting stigma, and ensuring that the people most affected by obesity are supported and protected.

Closing the Medicaid coverage gap will lessen health inequalities and improve outcomes

As states look to address obesity, there are a range of effective, evidence-based treatment options—from medications and surgeries to forms of therapy that help tackle the psychological elements of obesity prevention and management. These tools offer hope for better outcomes, but only if people can access them.

Today, there are four main types of obesity care: nutrition counselling, intensive behavioural therapy, obesity medications, and metabolic and bariatric surgery.³⁰ For some individuals with obesity, more individualised

interventions like nutrition counselling and behavioural therapy can support prevention and management. For others, a combination of nutrition, exercise, surgery and medications can be transformative.

Figure 6: 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

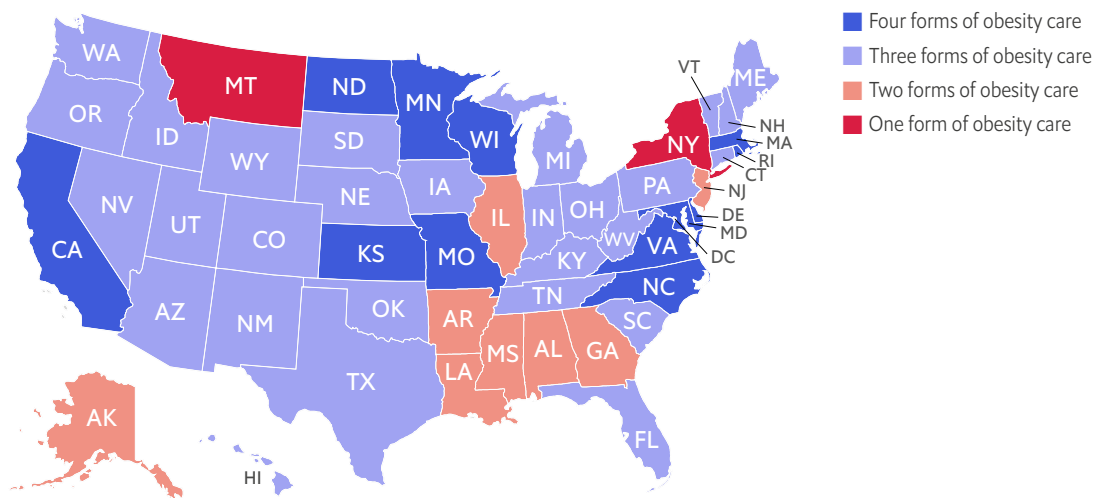
In the US, access to obesity care depends on whether people have adequate health insurance. Tens of millions of Americans rely on Medicaid, which provides low- or no-cost healthcare to low-income families, people with disabilities and pregnant individuals. However, coverage for obesity-related care varies significantly from state to state, reinforcing inequalities in who can access the full range of support. Minority populations already experience higher levels of obesity, and this disparity is compounded by existing inequalities in wealth and insurance coverage—meaning that those most at risk of developing obesity are often among the least able to access effective management interventions.

Although nearly all states cover behavioural therapy and surgery, only two in three cover nutrition counselling and just two in five cover medications. Twelve states cover all four forms of obesity care within Medicaid, while two states—Montana and New York—each offer

only one type of treatment, revealing disparities in access to care across the country. Bridging these gaps is essential to ensure equitable and effective obesity care is available to everyone who needs it.

At the federal level, there was an effort under the government of the former president, Joe Biden, to expand care: the Biden administration introduced a proposal requiring states to cover obesity-related medications under Medicare and Medicaid.^{31,32} However, the Trump administration declined to advance the proposal, pausing what could have been a major step in improving access for millions of Americans living with obesity, enhancing health outcomes and reducing health inequalities for underserved communities.³³ Since then, the passage of the Trump administration’s Big Beautiful Bill in July 2025 is set to significantly affect Medicaid enrollment and eligibility, presenting new challenges for states, with fewer people supported through Medicaid.^{34,35}

Figure 7: Lacking coverage
Obesity care coverage through Medicaid by state



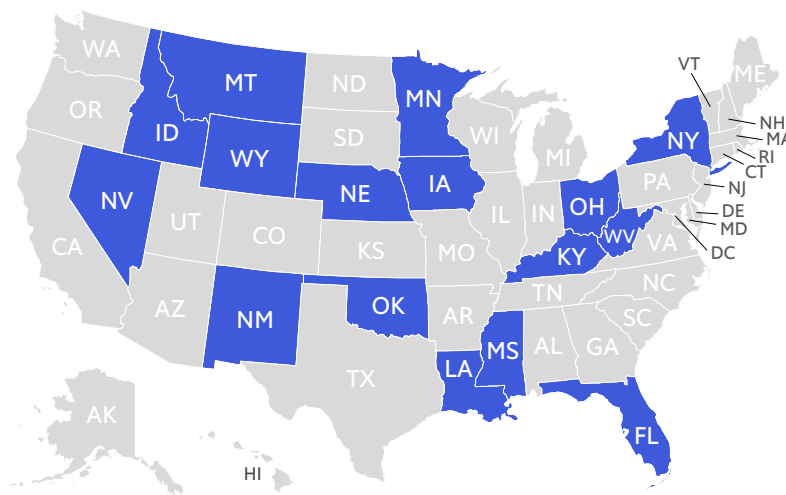
Source: STOP Obesity Alliance and Obesity Action Coalition

Some states are trying to encourage healthier behaviours through Healthy Behavior Incentive Programs (HBIP) under Medicaid. These programmes reward individuals for actions like quitting smoking and reducing unhealthy food and drink consumption with incentives including cash benefits and insurance premium waivers.³⁶ Currently, 16 states offer some type of

HBIP targeting weight loss, but Minnesota is the only state to offer these incentives and provide comprehensive Medicaid coverage of obesity care. This highlights the potential for states to move beyond isolated strategies and explore a more integrated approach to addressing obesity—one that aligns behavioural incentives with access to care.

Figure 8: Incentivising healthy behaviours

States offering an HBIP to encourage weight loss



Source: Economist Enterprise

An integrated approach through Medicaid: Minnesota

Minnesota stands out for its integrated approach to addressing obesity through Medicaid, combining behavioural incentives with comprehensive medical care coverage. In a state where one in five residents is enrolled in Medicaid and one in three adults lives with obesity, Minnesota has aligned incentives and access uniquely.^{37,38,39}

What distinguishes Minnesota is its dual strategy: it is the only state that provides full Medicaid coverage for all four types of obesity care and implements a weight loss-targeting HBIP through Medicaid. To encourage healthy behaviours, the HBIP offers a US\$75 gift card to participants who complete three sessions of free health coaching on wellness topics like weight management, nutrition, physical activity, sleep, stress and back health.⁴⁰

A fork in the road: addressing hunger and promoting healthier habits

Eliminating inequalities in access to healthy food is central for obesity prevention and management

Across the US, hunger and obesity often coexist—a contradiction that reveals a deeper issue that states have yet to adequately address, particularly in communities facing economic hardship. Although basic access to food is vital, access to healthy, nutritious food shapes long-term health, particularly in preventing and managing obesity in both children and adults. The US Department of Agriculture (USDA) defines food security as having “access by all people at all times to enough food for an active, healthy life”.⁴¹ Unfortunately, for millions of Americans, food security remains out of reach—one in seven households across the country experienced food insecurity in 2023.⁴²

Not all communities are impacted equally. Nearly one in four Black and Hispanic households experienced food insecurity in 2023, compared with 10% of white households.⁴³ This lack of access to enough food that meets dietary needs increases the risk of nutrition-related chronic diseases and can lead to poorer health outcomes.

States are attempting to tackle the hunger-obesity paradox but food access remains uneven

To fill the hunger gap and support Americans who cannot afford a healthy diet, each state runs its own Supplemental Nutrition

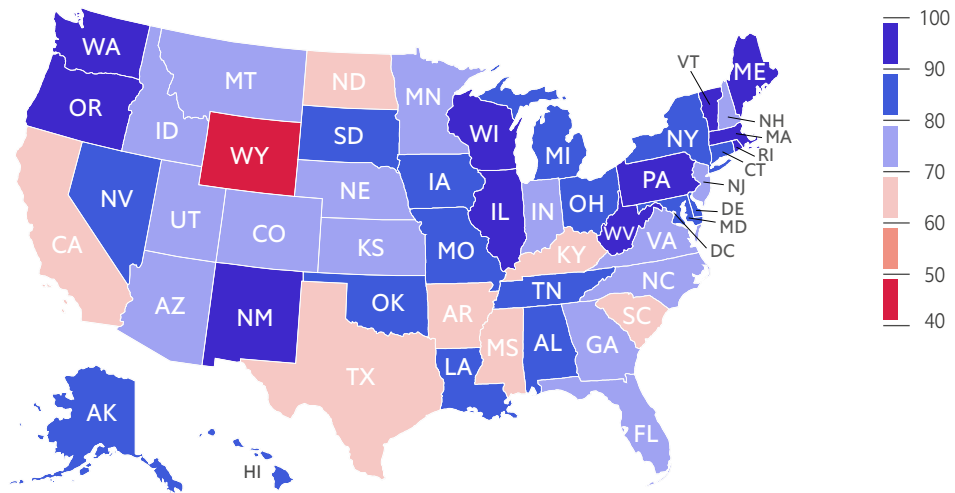
Assistance Program (SNAP), providing financial assistance to “help low-income people buy the food they need for good health”.⁴⁴ Although federally funded, states set their own eligibility requirements. Six states have achieved 100% SNAP participation (Massachusetts, Illinois, New Mexico, Oregon, Pennsylvania and Rhode Island), while in other states, stricter requirements and limited public awareness lead to lower enrollment rates.⁴⁵ Wyoming’s 49% is the lowest rate, and means more than half of eligible people are not receiving the benefits they are entitled to.⁴⁶ This uneven participation is a missed opportunity to use an existing scheme that could support millions of people in maintaining a nutritious diet—especially those already facing systemic disadvantages.

The amount of SNAP benefits given to each eligible household also varies by state. States like Hawaii offer higher benefits due to high food prices, but the average monthly benefit nationally is just US\$200 per person when adjusted for regional food price differences. Although SNAP is designed to supplement rather than fully cover a household’s food budget, it remains a vital support for over 41.7m enrolled Americans who might otherwise struggle to provide nutritious meals for their families.⁴⁷

The passage of the Big Beautiful Bill in July 2025 poses new challenges to how SNAP is operated and funded. The law is expected to

Figure 9: A SNAPshot of inequity

Percentage of individuals eligible for SNAP who participate in the programme (% , 2020)



Source: United States Department of Agriculture

reduce federal SNAP spending by US\$187bn over the next decade and expands work requirements for able-bodied adults to remain eligible.^{48,49} The Congressional Budget Office estimates that around 3.2m people could lose access to SNAP as a result.⁵⁰ In cash-strapped states like Louisiana, West Virginia and New Mexico, which suffer some of America’s highest obesity and food insecurity rates, such changes could have severe consequences—particularly for children and adolescents—and undermine progress in improving food security and addressing the obesity crisis.^{51,52}

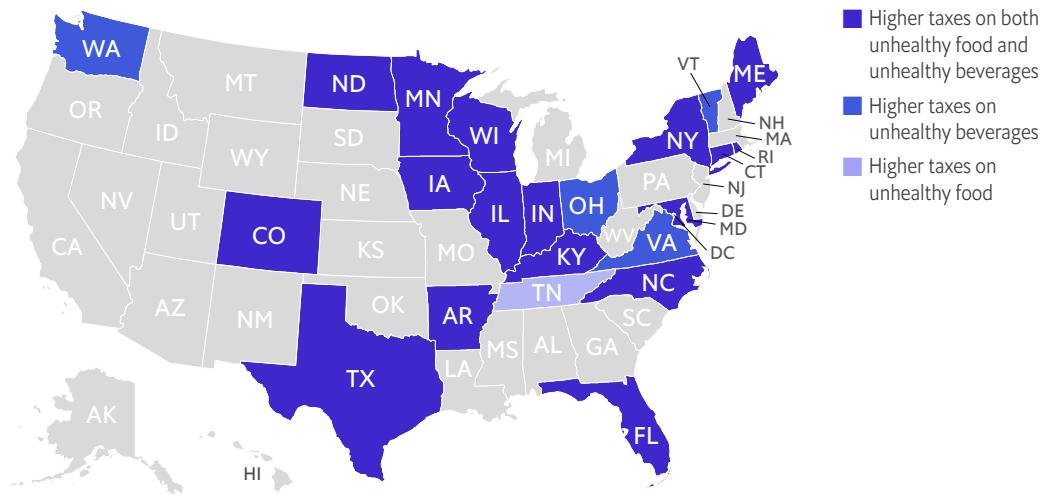
Several states are using tax policy to curb sugar consumption and drive healthier choices

Fiscal policy can play a powerful role in shaping food environments. In guidelines published in 2022, the World Health Organisation (WHO) recommends taxing sugar-sweetened beverages (SSBs) to discourage their consumption, describing SSB taxes as “a win-win-win strategy: a win for public health (and averted healthcare costs), a win for government revenue, and a win for health equity”.⁵³ In 2024 the WHO issued further guidance on using taxes and incentives to address unhealthy foods.⁵⁴

The Index highlights that several US states have taken steps in this direction. Seventeen states apply the standard sales tax to unhealthy foods and beverages while exempting essential groceries. Two states have imposed a direct excise tax on unhealthy foods or beverages: Arkansas, which taxes the sale of soft drink syrup or powders and bottled drinks, and Virginia, which taxes carbonated soft drinks. Three other states—Illinois, North Carolina and Tennessee—have imposed a higher sales tax on unhealthy foods or beverages than on other grocery items.

In states without a statewide tax, some cities have taken action. In 2017 Philadelphia introduced a 1.5 cent per ounce tax on SSBs served or bought in the city.⁵⁵ The effects on consumption were clear: reduced SSB consumption among adults, a 35% drop in SSB sales and less stocking of SSBs in stores.⁵⁶ In 2018 California banned the enactment of new SSB taxes within the state, but cities like Berkeley, Albany, Oakland and San Francisco had already enacted local-level taxes as a public health measure.⁵⁷ In 2025 Santa Cruz’s city council defied California’s ban on SSB taxes by imposing a two cents per fluid ounce tax on soda in the city.⁵⁸ The primary supporter of the measure, city councilwoman and vice-mayor

Figure 10: Taming the sugar rush
Type of unhealthy food and beverage taxes by state



Source: Economist Enterprise

Shebreh Kalantari-Johnson, argued that this tax was essential in addressing health disparities.⁵⁹

Schools are serving up nutrition for healthier bodies and sharper minds

Schools play a vital role in teaching healthy behaviours from a young age—whether in the classroom, playground or lunchroom. The habits that children develop often continue into adulthood, influencing long-term health outcomes.

Encouragingly, the Index shows that 44 states require public schools to provide nutrition education. To support educators, the USDA publishes teaching materials such as “Serving Up MyPlate: A Yummy Curriculum”, which informs classroom teaching and adapts the curriculum to each grade in an informative and engaging way.⁶⁰ However, what students learn and how much they learn vary greatly between states, leaving gaps in some students’ understanding of food and health. Most students receive fewer than eight hours of nutrition education per year, according to CDC research—far below the 40 to 50 hours considered effective for behaviour change.⁶¹ This gap is a missed opportunity to

promote nutrition literacy and build healthier futures for the next generation.

Teaching children about nutrition is one thing, ensuring that they have access to nutritious school meals is another. For the one in five American children living with food insecurity, school meals provide essential daily nutrition they might not otherwise receive, supporting their health, wellbeing and ability to learn.⁶² Since the National School Lunch Act was signed in 1946, children from families meeting income-based criteria have been eligible for free or low-cost school lunches through the National School Lunch Program, with some schools also offering breakfast.^{63,64} Today, 20 states continue to follow this income-based eligibility model, mandating free or reduced-price school meals for students who qualify. Although this approach reflects longstanding federal policy, it can create bureaucratic hurdles and stigma that deter students from getting the food they need. To address this—and amid recent economic pressures like the covid-19 pandemic and rising household costs—11 states have gone further, mandating free school meals to all students, regardless of income.

Expanding free school meals to all to bridge the hunger gap: Massachusetts

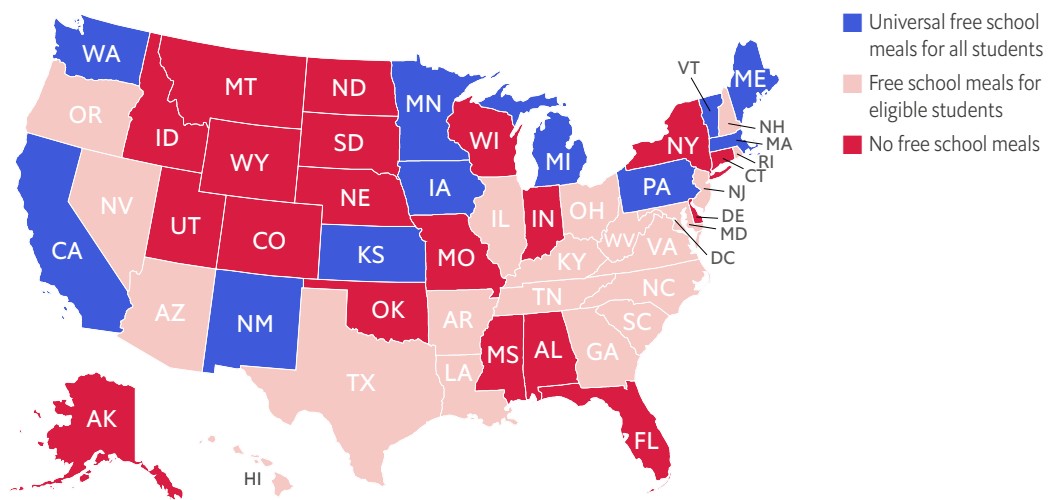
In 2023, Massachusetts made free school breakfasts and lunches available to all students, ensuring that every child has access to nutritious food during the school day.⁶⁵ The state follows the National School Lunch Program Nutrition Standards, which mandate that school lunches include fruits, vegetables, grains, meats/meat alternatives and fluid milk to ensure that meals sustain students throughout the day.^{66,67}

A 2023 survey of parents with school-age children in Massachusetts found that more than two in five said that their child would be less likely to eat a school meal if meals were not free for all children, highlighting the importance of universal access in facilitating healthy eating for all students by reducing stigma and bureaucratic hurdles to uptake.⁶⁸ Evidence indicates that universal free school meal programmes have a positive impact on BMI, diet quality, food security and academic performance.⁶⁹

Expanding universal school meals across the country could be transformative. It would reduce stigma and ensure that every child receives the nutrition that they need to grow and learn, while also helping to prevent obesity. Despite budget constraints, universal school meals are a long-term investment that improves attendance, academic performance and student wellbeing by making sure that all children start and end the day nourished.

Even when meals are available, the quality matters. The USDA provides nutritional guidelines for school meals, emphasising the need for a balanced mix of fruits, vegetables and whole grains, and limits on sugar and salt.⁷⁰ All states except Montana either follow these federal nutrition standards or have enacted their own. However, the quality of state guidelines can vary, and some public health experts argue that existing federal standards should be stricter to ensure that school meals better support long-term health.⁷¹

Figure 11: Minding the meal gap
Provision of free school meals by state



Source: Economist Enterprise

Putting change in motion: bridging the physical activity gap

States are taking steps to promote daily physical activity through targeted policy interventions

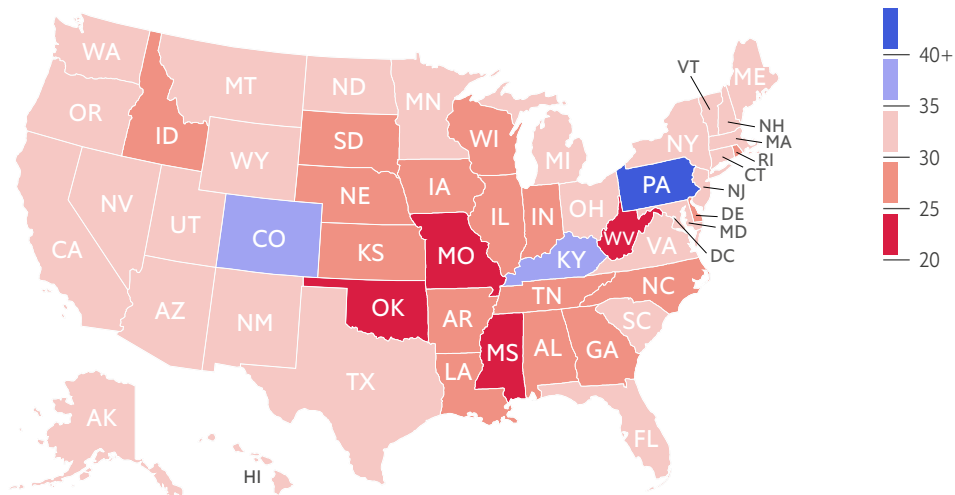
One of the most effective ways to maintain a healthy weight and live a longer, healthier life is through daily physical activity. Regular activity improves cognitive function, cardiometabolic health and mental health, and reduces the risk of developing conditions like heart disease, stroke, diabetes, obesity and dementia.^{72,73} But most Americans are struggling to stay active

in the vast, car-centric US.⁷⁴ As of 2023, fewer than one in three adults meet federal physical activity guidelines of at least 150 minutes of moderate physical activity or 75 minutes of vigorous physical activity per week, combined with muscle-strengthening exercises on two or more days.^{75,76}

Recognising the urgency of the issue, states across the country are increasingly promoting physical activity. The Index highlights that 47 states now have physical activity plans,

Figure 12: 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

and 40 are investing in walking and cycling infrastructure or launching public campaigns to encourage active living and healthier lifestyles. But progress is uneven. Only 15 states have comprehensive physical activity plans that aim to both promote active travel *and* reduce car dependency. Without addressing an overreliance on cars, efforts to encourage movement may fall short.

One major barrier to physical activity is access: about one in five Americans lack nearby safe or convenient places for physical activity, such as public parks or recreational facilities.⁷⁷ However, access rates vary greatly from state

to state. In Rhode Island and New Jersey, 96% of residents live near exercise-friendly spaces, compared with fewer than 60% of people in Mississippi and West Virginia—the states with the highest rates of adult obesity.^{78,79} By closing these gaps, states can ensure that efforts to increase physical activity reach the people who currently lack access.

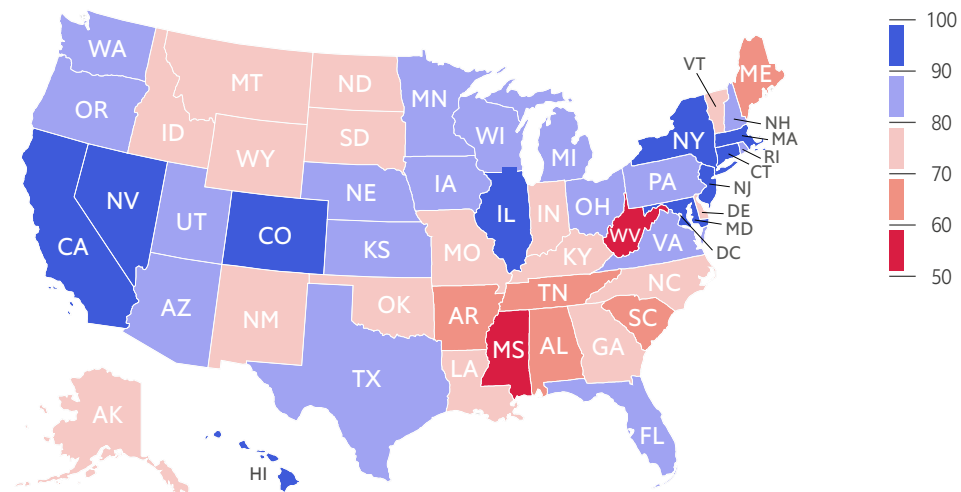
States have an opportunity to harness schools as a vital arena to get students moving

In the absence of uniform access to physical activity opportunities, schools can play a vital role in ensuring that children and adolescents remain active, even during long learning days. For children aged 6-17, the US Department of Health and Human Services recommends 60 minutes of physical activity per day, including aerobic activity and muscle and bone strengthening activities.⁸⁰ Although nearly all states mandate physical activity in schools—except Arizona and Kansas—only Virginia meets this 60-minute standard. By fully harnessing the role of schools, which often have the space and equipment to support daily physical activity (though resources vary), states could instill lifelong healthy habits and help to ensure more equitable access for children who lack safe or affordable opportunities to be active outside of school.

Paving the way to health through movement: Kansas

Kansas, where just over a quarter of adults met the federal recommendation for weekly physical activity in 2023, launched its *Active Transportation Plan* to promote safe and healthy modes of transport.⁸¹ The plan highlights the need to build safe infrastructure, reduce speed limits in populated areas and ensure accessible, walkable pathways in underserved communities to increase foot traffic. By focusing on both equity and safety, the plan aims to foster more active lifestyles statewide.⁸²

Figure 13: Access granted (to some)
Percentage of adults with adequate access to locations for physical activity (2025)



Source: University of Wisconsin Population Health Institute

Conclusion: from awareness to action

Obesity is a public health crisis that continues unabated. It is also a structural, social and economic crisis that calls for coordinated, comprehensive and fair solutions. Data from the US Obesity Response Index are clear: states have an opportunity to act. Yet, from persistent stigma and patchy Medicaid coverage to widespread food insecurity and inconsistent access to physical activity and evidence-based medical treatments, the systems designed to promote health are leaving millions behind—particularly the most vulnerable.

To make meaningful progress, states must recognise obesity as a critical public health issue and pursue structural reform through a whole-of-society approach. The millions already living with obesity need disease management pathways that

are embedded within broader chronic disease management frameworks, as recommended by the WHO and The Obesity Association (a division of the American Diabetes Association).^{83,84} These pathways must be backed by equitable access to recommended treatments, ensuring that support is not dependent on geography or income.

Managing and preventing obesity—both in the short- and long-term—requires reshaping the environments that influence and constrict everyday choices. This means rethinking how we design our schools, structure our food systems, plan our communities, and ensure access to comprehensive and evidence-based obesity management. It involves ensuring that government policies actively dismantle rather than reinforce existing barriers to health, that healthy food is affordable and accessible, and that physical activity is built into daily life.

Obesity is a chronic, relapsing disease. But with inclusive policies and coordinated, cross-sector action, it can be prevented and managed effectively. The question that we face now is not whether to act—but how quickly states can deliver meaningful change.

To make meaningful progress, states must recognise obesity as a critical public health issue and pursue structural reform through a whole-of-society approach.

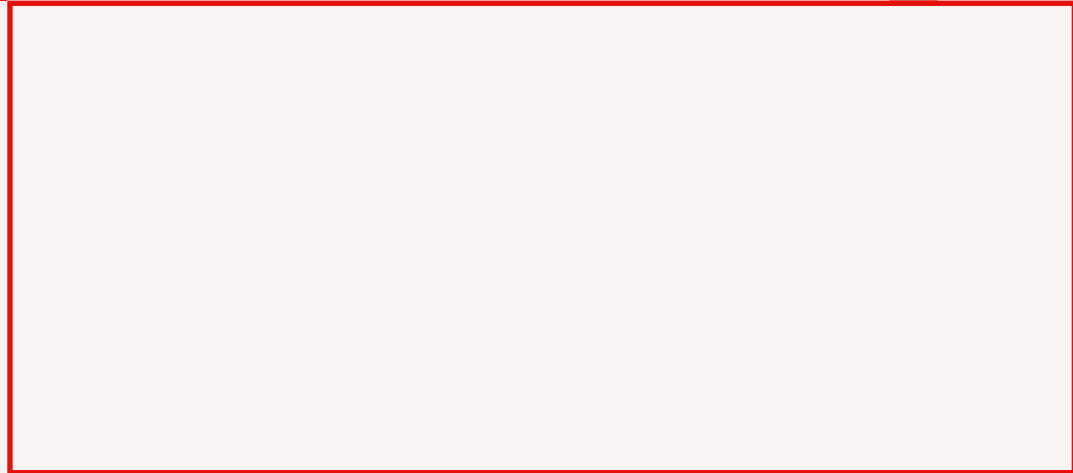
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