NGA Center for BEST PRACTICES

Issue Brief

Health Policy Studies Division
Contact: Michael P. Fierro, 202/624-5380 or
mfierro@nga.org
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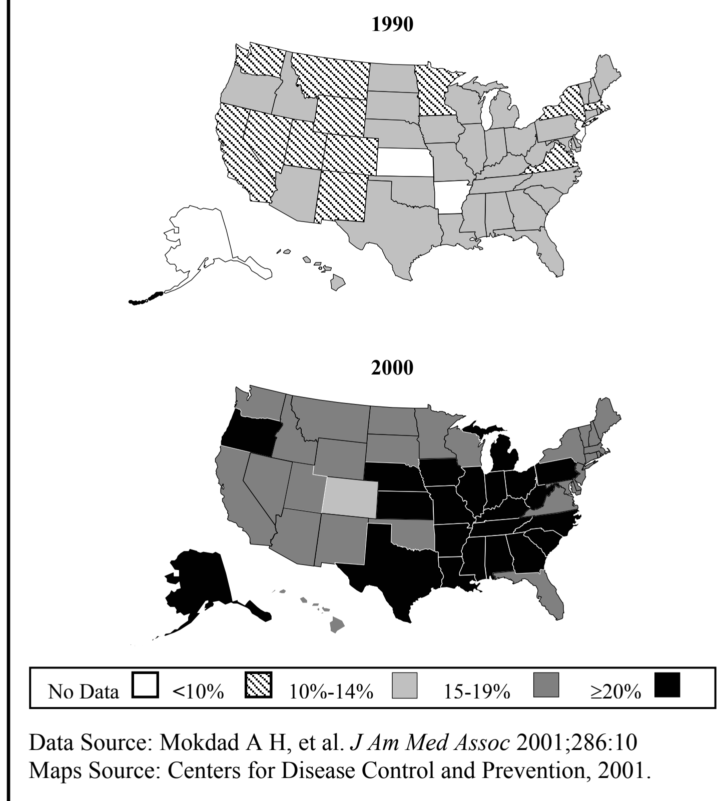
The Obesity Epidemic – How States Can Trim the "Fat"*

Summary

Obesity[1,2] is not just a matter of personal health – it's a costly and deadly public health concern that affects economic productivity, state budgets[3], and personal and family well being. As seen in Figure 1, U.S. adult obesity rates have risen drastically in the last decade, from 12 percent to 20 percent. Thirteen percent of children and adolescents are now overweight or obese, which represents more than a doubling in the last 30 years. Minority groups and those with less education and lower income are much more likely to be overweight and obese.[4] Nearly 30 percent of African-American adults and 23 percent of Hispanic adults are obese. One in five Hispanic and African-American children are overweight. There has been a ten-fold increase in the number of children with adult-onset diabetes in the last five years. The results of this ongoing problem are additional absence from work and school, lost productivity, and higher healthcare costs. At-risk and overweight children increasingly suffer from depression, anxiety, social angst, diabetes and other health problems, and are more likely to grow up to be obese adults.

States are paying heavily for obesity and its care – currently, four million obese children are Medicaid beneficiaries and an unknown number of adult Medicaid beneficiaries are obese.[5] There is much work to be done to significantly improve health and the associated healthcare costs. Fortunately, states are leading the way in addressing this problem. Much of the death, disease, and disability associated with obesity can be prevented through state actions to increase physical activity, promote better diet, and improve prevention and treatment available through healthcare systems. This issue brief focuses on programs and policies that states can implement to address obesity and its causes.

Figure 1: Adult Obesity Rates by State, 1990 and 2000



Data Source: Mokdad A H, et al. *J Am Med Assoc* 2001;286:10
Maps Source: Centers for Disease Control and Prevention, 2001.

This document is available at: http://www.asu.edu/educ/epsl/CERU/Articles/CERU-0206-200-OWI.pdf

Tools

- Implementing food and physical activity policies/standards in schools and public worksites
- Implementing Healthy community design and smart growth strategies
- Raising public and policymaker awareness
- Increasing access and availability of obesity treatment
- Targeting high-risk population groups
- Taxing junk foods and soda

Recommendations

Ten actions states can take immediately:

1. Educate people on the health benefits of healthy eating and being physically active.
2. Strengthen school physical education requirements to meet national recommendations for physical activity for children and encourgage shared community use of PE facilities outside school hours.
3. Convene stakeholders, including trade groups from the food and fitness industries, and engage the state health department to develop a comprehensive statewide nutrition and physical activity plan to address obesity and chronic diseases.
4. Consider regulating access to junk foods and soft drinks in schools and other government facilities; and increase availability of healthier foods, such as non-fat/low-fat milk, fruits and vegetables, and 100% fruit juice.
5. Evaluate options to provide health insurance coverage for obesity prevention and therapies for state employees, retirees, Medicaid recipients, and SCHIP beneficiaries.
6. Assess the economic impact of obesity on current state resources, Medicaid, employee and retiree systems, and SCHIP; and use the utilization data and behavioral data from the Behavioral Risk Factor Surveillance System to make strategic prevention and treatment purchasing decisions.
7. Collaborate with community-based organizations, voluntary organizations, state medical associations, and public health groups to implement services targeting lower income, racial minorities, and other groups at high risk for obesity.
8. Partner with state and local growth management agencies and with the private sector to encourage smart growth and healthy community design.
9. Use executive authority to issue executive orders and proclamations that promote good nutrition and physical activity, such as making stairwells in public buildings available.
10. Challenge policymakers, cabinet members, healthcare providers, voluntary organization and the food and fitness industries to mobilize efforts in response to the obesity epidemic.

A Closer Look at Obesity

Obesity Defined

For adults, **overweight** is defined as a body mass index (BMI) of 25 to 29.9 (approximately 10 to 15 pounds overweight) and **obese** equals a BMI of greater than or equal to 30 (approximately 30 pounds overweight). For children, obesity is calculated based on growth charts, physical development, gender, and age; and therefore, child measures do not have the same cut-points for BMI as adults.[6] To avoid stigma, the terms *at-risk* and *overweight* are used when referring to children and youth.

The Causes of Obesity

Behavioral and environmental factors — namely poor nutrition and physical inactivity — are the leading causes of obesity and represent the best opportunities for prevention and treatment. While genetics play an important role in obesity, hereditary factors are not responsible for this epidemic.

Poor nutrition is on the rise in the United States:

- The typical American diet is high in calories and fat and low in nutrients.
- Fast food is widely available, and its consumption and portion sizes continue to increase.
- Fewer meals eaten at home, even though homemade meals generally are the healthiest.
- Most Americans are eating fewer fruits and vegetables, and whole grains that are needed for maintaining good health.
- Vending machines selling soft drinks, high-fat snacks, and sweet snacks are common in schools and workplaces — Consumption of soft drinks in the U.S. increased from 27 gallons per year in 1972 to 44 gallons per year in 1992.
- Milk, juices, water, and healthy snacks are far less accessible than their unhealthy counterparts.

Physical inactivity contributes to being overweight and obese by reducing the energy expenditure of the body, which allows the body to store the excess calories as fat. Societal changes that have reduced opportunities for physical activity include:

- Fewer children walk to school today than did so 30 years ago.
- Adults spend more time in sedentary activities, such as watching television, working on the computer or commuting to and from work.
- Children are watching 12 to 14 hours of television a week and spending seven hours playing video games.[7]
- Schools have reduced the frequency and intensity of physical education classes for children.[8]
- Families increasingly are living in communities designed for car use, unsuitable and often unsafe for activities such as walking, biking, and running. These communities lack sidewalks, green space for recreation, and commuting, transportation alternatives to the passenger car, adequate street lighting, and minimal or no mixed-use buildings.

Economic Costs of Obesity

Obesity has a staggering effect on state Medicaid budgets, as well as the economy.[9] Put simply, the costs of obesity now exceed those of tobacco use.[10] Obese people generally have higher healthcare costs, face greater health risks, and are more likely to experience a disability. Recent research on the rising prevalence of overweight and obesity in the United States underscores the link between obesity and increased health risks.[11,12,13] In addition, the association between obesity and increased morbidity and mortality translates into substantially increased medical and disability costs.[14,15] Together obesity, poor nutrition and/or physical inactivity:

- Result in total health related costs for obesity of $117 billion annually, including $61 billion in direct costs (treatment of related disease), plus $56 billion in indirect costs (lost productivity due to disability, morbidity and mortality).[16]
- Contribute to the $33 billion in annual spending on "quick-fix" weight loss solutions by 65 million Americans.[17]
- Comprise approximately 10 percent of Medicaid expenditures (Indiana Medicaid).[18]
- Raise an individual's healthcare costs by 36 percent and medication costs by 77 percent compared to the general population.[19]

Human Costs of Obesity

Among the United States population, poor diet and physical inactivity are major preventable causes of death, second only to tobacco use.[1] These problems are linked to 300,000 deaths each year, making them nearly as lethal as HIV/AIDS, alcohol, drug abuse, motor vehicle accidents, murders, suicides, and fires **combined**. The number of overweight or obese adolescents and children has more than doubled in the last 30 years.

Overweight and obese individuals face an increased risk of:[3]

- cardiovascular disease
- diabetes
- cancer(s)
- musculoskeletal conditions
- hypertension
- high blood cholesterol
- angina
- congestive heart failure
- stroke
- gallstones
- gout
- osteoarthritis
- sleep apnea
- respiratory problems
- pregnancy complications and poor reproductive health
- bladder problems
- psychological disorders

State Activities for Obesity

Many states are pursuing innovative strategies to combat the ill effects of overweight and obese conditions. Governors are instituting new efforts to promote better health and diet, and implementing program and policy strategies that support healthy eating, physical activity, and weight reduction. Several states are also examining new tax strategies to raise funds for obesity prevention measures.

Using the Bully Pulpit

Governors can use their executive power to fight obesity and promote good nutrition and physical activity through executive orders, proclamations, Blue Ribbon Commissions, and also by actively supporting their Councils on Physical Fitness, Food Policy Councils, and 5 a Day Coalitions. Governors can also assemble Cabinet officials, agency directors, and state representatives to begin planning and coordinating a state strategy to prevent and control obesity.

- **California** has made two proclamations regarding nutrition. The first declared Kids Cooking Week and the second proclaimed March as Nutrition Awareness Month. Various nutrition

promotion activities are scheduled around these dates throughout the state, including events held by the Departments of Health Services and Education.

- **New Hampshire** issued a proclamation on July 12 as Team Nutrition Day to coincide with the University of New Hampshire's Team Nutrition Summer Institute (in 2000).
- The **Michigan** Governor's Council on Physical Fitness, Health and Sports is the largest of the state councils on fitness. The Council recognizes exemplary physical activity achievement for students and teachers with an annual awards event; it also, has created the Exemplary Physical Education Curriculum, began the ACES initiative (All Children Exercising Simultaneously), in which over 300,000 children participated last year, and supports regional fitness councils.

Incorporate Healthy Community Design

It is recommended that policymakers partner with communities to assist and target children, families, older adults and communities. The **Missouri** Department of Health & Senior Services Physical Activity Program worked with the Saint Louis University Prevention Research Center to plan and construct 13 walking trails in the Bootheel and Ozark communities. Forty-two percent of the community residents used the walking trails established by the program, and 60 percent reported an increase in their physical activity after the trails were constructed.

In 2001, **Texas** passed House Bill 2203[20] which established the Safe Routes to School Program. The program aims to make it safe for kids to walk or bike to school, increase their physical activity, and decrease traffic congestion around schools. Under the legislation, Safe Routes can increase safety by constructing new or repairing existing sidewalks, and creating new crosswalks, bike lanes, and multi-use trails.

Stakeholders to Bring to the Table:

- Public Health Officials
- School Health Administrators
- Aging/Elderly Officials
- Health Promotion Managers
- Chronic Disease Directors
- Transportation Officials
- School/State Education Officials
- Parks and Recreation
- City and State Planners
- Economic Development Officials
- Medical Pprofessionals
- Epidemiologists
- Environmental Officials
- Colleges and Universities
- Voluntary Organizations
- Health Plans and Insurers
- State Employee Benefits Administrators
- Legislators
- City, Town and County Elected Officials
- Developers
- Business Leaders

Utilize School and Community-based Approaches

Experts suggest using schools, worksites, and community-based organizations to encourage healthy eating, physical activity and to prevent obesity.

In March 2002, to help combat childhood obesity, **Texas** reinstated a rule requiring elementary school students to take a minimum of 135 minutes of physical education every week. This rule reversed a 1995 law that categorized physical education as an elective course, along with classes such as music and art.

The **California** Children's 5 a Day – Power Play! Campaign uses a multi-channel, community-based approach to encourage children ages 9-11 and their families to be physically active and eat at least five servings of fruits and vegetables every day as part of a low-fat, high-fiber diet. The *Power Play! Campaign* uses lead agencies in 11 regions that oversee coalition development and implementation of the *Power Play! Campaign* in schools, community youth organizations, farmers' markets, supermarkets, food services/restaurants, and the media.

Provide Coverage for Obesity Treatment

The health care system provides a significant opportunity to assist overweight and obese persons, given that most Americans visit a doctor or hospital at least once a year. Kaiser Permanente[21] (KP) provides a variety of programs and policies to combat obesity. KP focuses on achieving healthy lifestyle changes, as opposed to losing weight or attaining an "ideal weight." They have launched a National Weight Management Initiative and also utilizes prevention, screening, management of high-risk patients with a secondary chronic disease, and management of those with severe obesity. KP's National Weight Management Initiative pilots innovative programs, disseminates best practices to providers across regions, develops evidence-based treatment protocols for members of all ages across the weight spectrum, partners with community groups and schools, and partners with state agencies.

For children and adolescents, KP offers counseling about physical activity, works with schools to develop school-based interventions, provides growth charts to children's parents, and coordinates with community groups to devise exercise programs. For adults, KP encourages being physically active through step programs (using pedometers to record number of steps walked per day), exercise plans, and identification and management of at-risk, overweight and obese patients by providing comprehensive weight management programs to adult members, that may or may not include medication. For members who are morbidly obese or have other chronic conditions such as diabetes or heart disease, very low calorie diets or bariatric surgery may be considered.

Conduct Public Education Campaigns

While it is most effective when part of a comprehensive effort, media can disseminate health messages and display healthy behaviors aimed at changing dietary habits and exercise patterns. **Maine** was the first state to establish the U.S. Department of Agriculture's *Eat Smart, Play Hard* media campaign. The campaign was implemented as part of the larger Healthy Maine Campaign. *Eat Smart, Play Hard* provided:

- a statewide promotional campaign to encourage children to eat healthy foods and get plenty of exercise.
- mini-grants for schools to develop or expand opportunities for K-8 students to participate in regular physical activity.
- training and funding are providing training to create and support a healthy nutrition and physical activity environment in Maine schools.
- PE assessment tools to physical education instructors statewide.

Michigan conducts a statewide obesity prevention initiative through its Department of Community Health. The initiative includes and distributes information about healthy eating, physical activity, maintaining and achieving a healthy weight, healthy snacking, and various cookbooks and recipes. The initiative has an extensive website devoted to obesity prevention.[22]

Target High Risk Populations

North Carolina works with the National Cancer Institute to deliver the 5 a Day program. North Carolina's 5 a Day is a public/private partnership administered through a statewide coalition that promotes eating five or more servings of fruits and vegetables every day for better health. As part of that effort, they established a four-year, $2.4 million research and demonstration program using black churches to encourage rural African Americans to eat more fruits and vegetables. The Black Churches United for Better Health project uses the church as the primary communication channel and intervention site. Each

intervention church established a Nutrition Action Team to plan and implement church activities and used lay health advisers to support church members in increasing their fruit and vegetable consumption. The project concluded in 1997 and evaluations found the intervention to be highly successful in increasing fruit and vegetable consumption in the rural African American population. Based on these results, a training module for delivering nutrition intervention in partnership with Black churches has been developed and is being tested and revised in collaboration with two local health departments.

Finance Obesity Prevention Initiatives

Relatively few states levy fees on soft drinks and snack foods, and such taxes are not always tied to efforts to combat obesity. However more and more states are considering such taxes to provide funding for statewide obesity, nutrition, and physical activity programs. Currently, states with existing taxes on soft drinks or snacks are: [23,24]

- **Arkansas**, which collects $.02 per can of soft drinks, raises an estimated $40 million per year to fund the 27 percent state match portion of their Medicaid program.
- **California**, which currently collects 7.25 percent sales tax on soft drinks.
- **Tennessee**, which earmarks 21 percent of the revenues from soft drink tax for cleaning up highway litter.
- and **West Virginia**, which collected soft drink tax revenue to fund state medical, dental, and nursing schools.

In the 2002 legislative session, several bills were introduced to implement taxes specifically to fund obesity prevention and control programs. As this brief goes to press, tax provisions in SB 1520 were removed and HB 553 was not passed by the legislature. Other legislative actions include:

- **California** Senate Bill 1520, which extends nutritional standards in SB19 (see below) to middle and high schools; phases out the sale of carbonated beverages in public schools.
- **Vermont** House Bill 648, which - establishes a cardiovascular health coalition and is charged with developing a state cardiovascular health plan; also it and proposes to levy a sales tax on soft drinks to fund the coalition and other programs promoting health.
- **Kentucky** House Bill 553, - seeks to replace junk foods in school vending machines with healthier alternatives, such as animal crackers, pretzels and baked potato chips

In 2001, **California** passed SB 19[25] which raises nutritional standards for foods sold in elementary schools (only water, milk, fruit drinks with at least 50 percent juice, and certain sports drinks - and --no carbonated beverages-- could be sold in California schools); also it, increases the state's reimbursement rate of free and reduced priced meals in schools to offset the need to accept soft drink contracts, subject to future budet acts, offers schools a pilot program to implement the standards, and gives schools planning grants to implement the changes.

Conclusion

States are at the forefront of battling the human and economic costs of obesity and overweight. Governors have committed significant resources to address the epidemic and are using innovative solutions such as taxes, executive councils, coalitions, media, community programs, and federal resources. However, states are facing a tremendous burden in the immediate future to further reduce disability, lowered quality of life, and economic costs associated with the obesity epidemic. Ten things states can do immediately are:

1. Educate people on the health benefits of healthy eating and being physically active.
2. Strengthen school physical education requirements to meet national recommendations for physical activity for children and encourgage shared community use of PE facilities outside school hours.
3. Convene stakeholders, including trade groups from the food and fitness industries, and engage the state health department to develop a comprehensive statewide nutrition and physical activity plan to address obesity and chronic diseases.
4. Consider regulating access to junk foods and soft drinks in schools and other government facilities; and increase availability of healthier foods, such as non-fat/low-fat milk, fruits and vegetables, and 100% fruit juice.
5. Evaluate options to provide health insurance coverage for obesity prevention and therapies for state employees, retirees, Medicaid recipients, and SCHIP beneficiaries.
6. Assess the economic impact of obesity on current state resources, Medicaid, employee and retiree systems, and SCHIP; and use the utilization data and behavioral data from the Behavioral Risk Factor Surveillance System to make strategic prevention and treatment purchasing decisions.
7. Collaborate with community-based organizations, voluntary organizations, state medical associations, and public health groups to implement services targeting lower income, racial minorities, and other groups at high risk for obesity.
8. Partner with state and local growth management agencies and with the private sector to encourage smart growth and healthy community design.
9. Use executive authority to issue executive orders and proclamations that promote good nutrition and physical activity, such as making stairwells in public buildings available.
10. Challenge policymakers, cabinet members, healthcare providers, voluntary organization and the food and fitness industries to mobilize efforts in response to the obesity epidemic.

Additional Resources

California 5 a Day Program: http://www.ca5aday.com/

CDC, Nutrition and Physical Activity information: http://www.cdc.gov/nccdphp/dnpa/

North Carolina Black Churches 5 a Day Program:
http://www.communityhealth.dhhs.state.nc.us/hlthprom/fiveaday.htm

The Surgeon General's Call to Action: to Prevent Overweight and Obesity, 2001.
http://www.cdc.gov/nccdphp/dnpa/pdf/CalltoAction.pdf

USDA Dietary Guidelines for Americans: http://www.nalusda.gov/fnic/dga/index.html

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[1] Individuals with a BMI of 25 to 29.9 are considered overweight, while individuals with a BMI of 30 or more are considered obese. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity, 2001. http://www.cdc.gov/nccdphp/dnpa/obesity/basics.htm

[2] The term "obese" is no longer applied to children and adolescents. Instead, the terms "at risk of overweight" and "overweight" parallel the adult classifications of "overweight" and "obese", respectively.

[3] Center on an Aging Society, Georgetown University. Analysis of 1997 Medical Expenditure Panel Survey, 2002.

[4] Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Institutes of Health, Bethesda, Maryland, 2001.

[5] Center on an Aging Society, Georgetown University. Analysis of 1997 Medical Expenditure Panel Survey, 2002

[6] http://www.cdc.gov/nccdphp/dnpa/bmi/00binaries/bmi-checkbook.pdf

[7] Strauss. RS, Pollack, HA. Epidemic Increase in Childhood Overweight, 1986-1998. JAMA;(286):2845-2848, 2001.

[8] Center on an Aging Society, Georgetown University. Analysis of 1997 Medical Expenditure Panel Survey, 2002.

[9] http://www.kaiserpermanente.org/newsroom/releases/030898.html

[10] Sturm, R. The Effect of Obesity, Smoking, and Drinking on Medical Problems and Costs. Health Affairs 21(2):245-253, 2002.

[11] Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Institutes of Health, Bethesda, Maryland, 2001.

[12] Health implications of obesity. National Institutes of Health Consensus Development Conference Statement. Ann Intern Med. 1985;103:1073-1077 as cited in Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Institutes of Health, Bethesda, Maryland, 2001.

[13] Pi-Sunyer FX. Medical hazards of obesity. Ann Intern Med. 1993;119:655-660 as cited in Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Institutes of Health, Bethesda, Maryland, 2001.

[14] Wolf AM, Colditz GA. Social and economic effects of body weight in the United States. Am J Clin Nutr. 1996;63:466S-469S.

[15] Seidell JC. The impact of obesity on health status: some implications for health care costs. Int J Obes Relat Metab Disord. 1995;19 (Suppl 6):S13-S16 as cited in Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Institutes of Health, Bethesda, Maryland, 2001.

[16] U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. 2001.

[17] Opening Statement of Chairman Ron Wyden, Subcommittee on Regulation, Business Opportunities, and Energy, May 7, 1990. *News from Congressman Ron Wyden.* 1990: 1-2.

[18] Report to the Indiana General Assembly Pursuant to House Concurrent Resolution No. 48: Assessing the Impact of Obesity on Members of the Indiana Medicaid Program, December 15, 2000.

[19] Sturm, R. The Effect of Obesity, Smoking, and Drinking on Medical Problems and Costs. Health Affairs 21(2):245-253, 2002.

[20] Texas State Legislature, H.B. No. 2203. http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=77&SESS=R&CHAMBER=H&BILLTYPE=B&BILLSUFFIX=02203&VERSION=1&TYPE=B

[21] Information regarding Kaiser Permanente's Weight Management initiatives were provided by Trina Histon, PhD, Kaiser Permanente Care Management Institute.

[22] http://www.michigan.gov/mdch/1,1607,7-132-2940_2955-7968--,00.html

[23] Nestle, M, Jacobson, M. Halting the Obesity Epidemic: A Public Health Policy Approach. Public Health Reports, January/February 2000, Volume 115.

[24] http://www.arksoftdrink.org/issues.html

[25] http://www.publichealthadvocacy.org/legislation/legislation_pdfs/SB_19_Escutia_2001.pdf

Table 1: Trends of Adult Obesity (Percent), United States

Region/State	1991	1995	1998	1999	2000
U.S. Average	*12.0*	*15.3*	*17.9*	*18.9*	*19.8*
Alabama	13.2	18.3	20.7	21.8	23.5
Alaska	13.1	19.2	20.7	19.2	20.5
Arizona	11.0	12.8	12.7	11.6	18.8
Arkansas	12.7	17.3	19.2	21.9	22.6
California	10.0	14.4	16.8	19.6	19.2
Colorado	8.4	10.0	14.0	14.3	13.8
Connecticut	10.9	11.9	14.7	14.5	16.9
Delaware	14.9	16.2	16.6	17.1	16.2
District of Columbia	15.2	n/a	19.9	17.9	21.2
Florida	10.1	16.5	17.4	17.9	18.1
Georgia	9.2	12.6	18.7	20.7	20.9
Hawaii	10.4	10.4	15.3	15.3	15.1
Idaho	11.7	13.8	16.0	19.5	18.4
Illinois	12.7	16.4	17.9	20.2	20.9
Indiana	14.8	19.6	19.5	19.4	21.3
Iowa	14.4	17.2	19.3	20.9	20.8
Kansas	n/a	15.8	17.3	18.5	20.1
Kentucky	12.7	16.6	19.9	21.1	22.3
Louisiana	15.7	17.4	21.3	21.5	22.8
Maine	12.1	13.7	17.0	18.9	19.7
Maryland	11.2	15.8	19.8	17.6	19.5
Massachusetts	8.8	11.1	13.8	14.3	16.4
Michigan	15.2	17.7	20.7	22.1	21.8
Minnesota	10.6	15.0	15.7	15.0	16.8
Mississippi	15.7	18.6	22.0	22.8	24.3
Missouri	12.0	18.0	19.8	20.8	21.6
Montana	9.5	12.6	14.7	14.7	15.2
Nebraska	12.5	15.7	17.5	20.2	20.6
Nevada	n/a	13.3	13.4	15.3	17.2
New Hampshire	10.4	14.7	14.7	13.8	17.1
New Jersey	9.7	14.2	15.2	16.8	17.6
New Mexico	7.8	12.7	14.7	17.3	18.8
New York	12.8	13.3	15.9	16.9	17.2
North Carolina	13.0	16.5	19.0	21.0	21.3
North Dakota	12.9	15.6	18.7	21.2	19.8
Ohio	14.9	17.2	19.5	19.8	21.0
Oklahoma	11.9	13.0	18.7	20.2	19.0
Oregon	11.2	14.7	17.8	19.6	21.0
Pennsylvania	14.4	16.1	19.0	19.9	20.7
Rhode Island	9.1	12.9	16.2	16.1	16.8
South Carolina	13.8	16.1	20.2	20.2	21.5
South Dakota	12.8	13.6	15.4	19.0	19.2
Tennessee	12.1	18.0	18.5	20.1	22.7
Texas	12.7	15.0	19.9	21.1	22.7
Utah	9.7	12.6	15.3	16.3	18.5
Vermont	10.0	14.2	14.4	17.2	17.7
Virginia	10.1	15.2	18.2	18.6	17.5
Washington	9.9	13.5	17.6	17.7	18.5
West Virginia	15.2	17.8	22.9	23.9	22.8
Wisconsin	12.7	15.3	17.9	19.3	19.4
Wyoming	n/a	13.9	14.5	16.4	17.6

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, 2001.
Data were not available for U.S. Territories.