OLIVER WYMAN

ANALYSIS OF THE IMPACTS OF THE ACA'S TAX ON HEALTH INSURANCE IN 2018 AND BEYOND

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REPORT QUALIFICATIONS/ASSUMPTIONS & LIMITING CONDITIONS

Oliver Wyman was commissioned by UnitedHealth Group to analyze the impact of the ACA's tax on health insurance premiums. The primary audience for this report includes health insurers that are responsible for paying the tax on health insurance premiums and other interested parties.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

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While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events, and are subject to economic and statistical variations from expected values.

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1. Executive Summary

Section 9010 of the Patient Protection and Affordable Care Act (Pub L. 111-148) and the Health Care and Education Reconciliation Act (Pub L. 111-152), collectively "the ACA," imposes fees on insurance companies that offer fully-insured health insurance coverage. The fees, which are treated as taxes under the Internal Revenue Code, are assessed on earned health insurance premiums, with certain exclusions.

In December 2015, Congress passed H.R. 2029, the Consolidated Appropriations Act, which created a one-year moratorium on collecting the insurer taxes for 2017. The $13.9 billion that would have been due in 2017 will not be collected and, as a result of the moratorium policyholders are projected to save approximately 3% of premiums. However, under current law the moratorium will lapse in 2018 and the tax on health insurance will be reinstated for 2018 at a higher annual level ($14.3 billion), resulting in higher fully insured premiums for the 2018 plan year and all future years.

The taxes on health insurance are non-deductible for federal tax purposes for health insurers. Therefore, for each dollar assessed and paid in taxes, more than a dollar in additional premium must be collected (e.g. $1.54 for every $1.00 in taxes, assuming a 35% federal corporate income tax rate)[1] yielding a total premium impact in 2018 of as much as $22.0 billion. In total, the amount assessed and collected is projected to be $267 billion over the next ten years (2018 to 2027).

This report provides an analysis of the impact of the tax on health insurer premiums beginning in 2018. In addition, we provide the allocation of these taxes across each state and by line of business and also describe the potential effect that the taxes and increased premiums will have on enrollment.

In summary, we estimate that the tax on health insurance will increase premiums by 2.6% in 2018, and between 2.5% and 2.7% in subsequent years when the amounts collected in taxes is mandated to increase at the same level as premium trend. In 2018, this amount equates to $158 per individual in the non-group market, $185 per single contract and $500 per family contract in the small group market, $188 per single contract and $540 per family contract in the large group market, $245 per Medicare Advantage member (including Special Needs Plans and Employer Group Waiver Plans), and $181 per Medicaid managed care enrollee. Over the next ten years, this amount equates to $2,276 per individual in the non-group market, $2,282 per single contract and $6,190 per family contract in the small group market, $2,326 per single contract and $6,675 per family contract in the large group market, $3,030 per Medicare Advantage member, and $2,370 per Medicaid managed care enrollee.

The taxes apply to all fully-insured coverage, including the on-exchange and off-exchange individual market, large and small group markets, and any insured public programs including Medicare Advantage, Medicare Part D, and Medicaid Managed Care. The increased cost of health insurance leads to many negative outcomes, including:

[1] $1.00 = $1.54 x (1.00 - .035)

- Increasing costs facing the Medicare Advantage and Medicare Part D programs that could result in increased cost-sharing and premiums for Medicare Advantage and Medicare Part D enrollees.
- Increasing the tax burden on small employers that are fully-insured, unlike self-insured public and private employers that are not required to pay the tax on health insurance.
- Increasing costs for States and State taxpayers to pay the tax costs for Medicaid Managed Care enrollees.
- Increasing the cost of fully-insured health care coverage will result in individuals and groups delaying purchase of health insurance and increasing the number of uninsured individuals.
- A potential exacerbation of concerns related to "adverse selection" in the individual and small group markets as younger, healthier individuals forego coverage leading to a less stable risk pool and higher premiums.

The opinions and conclusions expressed herein reflect technical assessments and analyses, and do not reflect statements or views with respect to public policy.

2. Data

The health insurance taxes discussed in this report are allocated to each insurer based on their applicable net premiums for health insurance, but during the year prior to the year the taxes are due. The 2018 taxes will be allocated based on 2017 net premiums. The portion of the tax to be paid by each insurer will be based on the proportion of each insurer's premiums to total premiums for all covered entities (referred to here as the "denominator"). In order to determine the applicable tax to be paid by each insurer relative to their premiums, we need to calculate the total premiums for entities that will be charged the taxes.

There are three main components in developing the net premiums to be used as the denominator in our analysis. The first component is an estimation of current health insurance premiums that would be eligible to be assessed the insurer taxes. The next component is the expected increase in per capita costs due to such factors as the underlying health care trend, benefit changes either required by the ACA or resulting from the general course of business, and changes in the demographics of the insured population. The final component is the expected change in enrollment counts.

Base premiums

Insurance companies are required to file annual financial statements with the applicable state regulatory agencies. Most of these data are publicly available and represent the experience for insurers during the preceding calendar year. We accumulated all of the available financial statement data for their 2016 experience. There are some states that do not require public disclosure of financial statements for certain plans (e.g., Medicaid managed care plans). Therefore, we relied on data from the IRS for companies that did not appear in the accumulated financial statement data. Table 1 below shows the total health insurance premiums from the five sources of data we used.

Table 1
Aggregate Health Premiums for 2016 by Source

Source of Premium Data	Health Insurance Premiums (000s)
Health Insurance Financial Statements (Orange Blanks)	$ 636,085,918
Life, Accident and Health Financial Statements (Blue Blanks)	178,465,725
Property and Casualty Financial Statements (Green Blanks)	4,552,997
California Data (Knox-Keene)	153,746,952
IRS Form 8963 Database	22,993,720
Total Gross Premiums	**$ 995,845,313**

Additionally, our data is collected at the state and coverage type level using information from the National Association of Insurance Commissioners' (NAIC) supplemental exhibits, which include the Accident and Health Policy Experience Exhibit and the Supplemental Health Care Exhibits (SHCE). The SHCE were required beginning in 2012 and are used to calculate the medical loss ratios for individual, small group and large group plans.

We accumulated the data by identifying all companies that had health insurance premiums during 2016 and pulled the earned premiums by line of business for every state and US territory from the supplemental exhibits. Where the supplemental exhibits are not completed, we used the direct written premiums by state from Schedule T of the NAIC Financial Statement to allocate experience for all lines of business by state.

The insurer taxes are allocated based on net premium subject to certain exclusions. Using the accident and health supplemental exhibits from insurers' financial statements, we estimated the amount of the exclusions for the health products that are not subject to the insurer taxes. These exclusions include amounts for hospital indemnity type plans, critical illness, long- and short-term disability, Medicare supplement and long-term care.

Section 9010(c)(2)(C) of the ACA provides for an insurer tax exclusion for all companies that meet four criteria. First, they must be incorporated as a non-profit corporation under state law; second, no part of net earnings may inure to any private shareholder or individual; third, no substantial part of the entity's activities may be engaging in lobbying or political campaigns; and fourth, more than 80 percent of gross revenues must be received from government programs that target low-income, elderly or disabled participants under Titles XVIII, XIX and XXI of the Social Security Act. We have removed all companies that satisfy these requirements from our analysis.

In comparing the NAIC data and the IRS data that were reported for 2015, we found that the IRS data reported premiums for certain companies that we were unable to locate from our sources. In these cases, we relied on the data from the IRS. Note that we relied on IRS data from 2015 as data for 2016 is not available.

Further, for each company, all premiums up to $25 million are excluded from the insurer tax calculations, and premiums from $25 million to $50 million are reduced by one-half. Finally, premiums for tax-exempt companies are further reduced by one-half. Our analysis compiles information for each company, thus we modeled the exclusions on a company-by-company basis. Table 2 shows the calculation of the premiums based on 2016 data reflecting exclusions.

Table 2
Excluded Premiums and Denominator Based on 2016 Premiums

Premium by Tiers	Premium Excluded (000s)
Total Gross Premium	$ 995,845,313
Premium for Lines of Business Not Subject to Insurer Fee	114,298,437
Net Premium	**$ 881,546,875**
Excluded under Section 9010 (c)(2)(C)	59,630,588
Net Premiums After Exclusion	**$ 821,916,287**
$0 to $25 million	8,823,415
$25 to $50 million	3,940,482
Net Premiums After Tiers	**$ 809,152,390**
Premium for Tax Exempt	63,212,094
Total Net Premiums (Denominator)	**$ 745,940,296**

Our modeling assumes that the tiered exclusions of premium up to $50 million will be based on consolidated groups. Companies are assigned to a group based on the group assignments in the IRS data.

The IRS rules describe the applicability of the exclusion for tax exempt organizations.[2] Per the regulations, the exclusion for tax exempt companies is applied at the member level, thus if the member of a consolidated group is tax exempt, it will benefit from the 50% exemption, even if the consolidated group is not entirely tax exempt.

We used the supplemental exhibits from the financial statements to identify the net premiums by line of business, splitting premium into individual, small group, large group, FEHBP, Medicare Advantage and Part D, and Medicaid. In total, this method generated net premiums of $822 billion in 2016 that are subject to the tax. We further reduced applicable premium base to $746 billion after allowable exclusions. Table 3 shows the results of our analysis split by line of business and tax status.

Table 3
Denominator Premiums by Line of Business for 2016

Line of Business	Applicable Premiums (000s)	Excluded Premium (000s)	Net Premiums (Denominator) (000s)
Individual	$ 81,419,621	$ 7,013,485	$ 74,406,137
Small Group	78,414,406	7,473,323	70,941,083
Large Group	242,913,154	33,382,163	209,530,991
FEHBP	11,873,336	1,359,297	10,514,039
Medicare Advantage	193,235,253	17,192,768	176,042,485
Medicaid	198,152,502	9,214,768	188,937,734
Medicare PDP	15,908,014	340,187	15,567,828
	$ 821,916,287	**$ 75,975,991**	**$ 745,940,296**

Table 3 shows the base premiums for 2016, but because of the moratorium on taxes for 2017, no taxes will be paid based on 2016 data. Therefore we project the premiums to 2017 and later to determine the estimated premiums that will be considered in the calculation of the insurer taxes for 2018 and subsequent years. Below we describe the assumptions used in our projections.

Per capita costs

The projection of the premium rates required us to estimate changes to the cost to provide health care between 2016 and 2017, and later. We compiled data from public sources that estimate the changes in the per capita costs by line of business. Below we list the basis of these assumptions:

- Individual – For 2017, premium rate increases are based on the October 24, 2016 Research Brief published by the Office of the Assistant Secretary for Planning and Evaluation

[2] https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

(ASPE).[3] For 2018, the premium rate increase is based on a report prepared by Oliver Wyman and assumes that the payments to health plans related to the cost sharing reductions (CSR) will continue to be paid.[4] For 2019 and later years, premium rate increases are based on the average medical cost trends from the Oliver Wyman Carrier Trend Survey.[5]

- Large, Small Group and FEHBP – Based on data from the National Health Expenditures.[6]
- Medicare Advantage – Based on data from the National Health Expenditures.[7]
- Medicare Part D – Based on the Express Scripts Annual Trend Report for 2016.[8]
- Medicaid – Based on data from the National Health Expenditures.[9]

Enrollment estimates

The next step in establishing the premiums in 2018 and later years is to estimate the changes in enrollment by line of business. Again, our assumptions for enrollment come from public sources, as described below:

- Individual – For 2017, based on a study from McKinsey & Company. No change in enrollment for years 2018 and later.[10]
- Large, Small Group and FEHBP – Based on data from the National Health Expenditures.[11]
- For Medicare Advantage and Medicaid, the data from the National Health Expenditures includes both changes in the per capita costs and the enrollment.
- Medicare PDPs - Based on actual changes in enrollment from July 2016 to July 2017, with similar enrollment increased assumed from 2017 to 2018.

Table 4 shows the assumptions to project the 2016 premium experience to 2017.

[3] https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf

[4] http://health.oliverwyman.com/content/oliver-wyman/hls/en/transform-care/2017/06/analysis_market_unc.html

[5] http://www.oliverwyman.com/our-expertise/insights/2017/mar/carrier-trend-report---july-2016.html

[6] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/

[7] Ibid.

[8] http://lab.express-scripts.com/lab/drug-trend-report

[9] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/

[10] http://healthcare.mckinsey.com/individual-market-enrollment-dropped-10-12-year-over-year-end-first-quarter-2017

[11] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/

Table 4
Projection Assumptions for 2016 to 2017

Line of Business	Premium Rate Increases	Enrollment
Individual	22.0%	-11.0%
Small Group	6.5%	0.0%
Large Group	6.5%	0.0%
FEHBP	6.5%	0.0%
Medicare Advantage	5.9%	0.0%
Medicaid	3.7%	0.0%
Medicare PDP	4.7%	1.8%

As mentioned previously, employer groups are more likely to self-insure their medical coverage if the moratorium ends and the taxes are once again collected. This affects all those that pay the insurer taxes since the self-insured groups are excluded from the insurer taxes, while the dollar amount of taxes that are to be collected from the market would generally remain the same. Therefore, if more employers self-insure, additional costs would need to be shouldered by the remaining fully insured health plans. To reflect the possibility of an acceleration of employers moving to self-insurance, we prepared a range of estimates. The low estimate of the insurer taxes reflects the current split between insured and self-insured plans and the high estimate reflects a continuation of the historical move to self-insurance.

We used data from the Medical Expenditure Panel Survey (MEPS) to project the increased use of self-insurance for employers. Specifically, the percent of employers offering a self-insured plan increased from 37.2% in 2014 to 39.0% in 2015 after several years of no change in the percentage of employers with self-insurance. For this analysis, in developing our high estimate we have assumed that this recent experience continues and the percent of employers self-insuring increases at 1.8% per year.[12]

Tables 5 and 6 show the projections of premiums by line of business based on the two scenarios described above.

[12] https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

Table 5
Projected Premiums for 2017 – Based on Current Information

Line of Business	2016 Premiums (000s)	Cost Trend (2016-2017)	Membership Trend (2016-2017)	2017 Premiums (000s)	Exclusions (000s)	Net Premiums (Denominator) (000s)
Individual	$ 81,419,621	1.220	0.890	$ 88,405,425	$ 7,516,562	$ 80,888,863
Small Group	78,414,406	1.065	1.000	83,483,648	7,894,545	75,589,103
Large Group	242,913,154	1.065	1.000	258,616,717	35,367,776	223,248,942
Government	11,873,336	1.065	1.000	12,640,909	1,433,573	11,207,336
Medicare Advantage	193,235,253	1.059	1.000	204,653,959	18,067,090	186,586,869
Medicaid	198,152,502	1.037	1.000	205,510,951	9,445,540	196,065,410
Medicare PDP	15,908,014	1.047	1.018	16,949,882	353,285	16,596,597
	$ 821,916,287			**$ 870,261,491**	**$ 80,078,371**	**$ 790,183,120**

Table 6

Projected Premiums for 2017 – Based on Increased Self-Insurance

Line of Business	2016 Premiums (000s)	Cost Trend (2016-2017)	Membership Trend (2016-2017)	2017 Premiums (000s)	Exclusions (000s)	Net Premiums (Denominator) (000s)
Individual	$ 81,419,621	1.220	0.890	$ 88,405,425	$ 7,523,965	$ 80,881,459
Small Group	78,414,406	1.065	0.982	81,980,943	7,765,184	74,215,759
Large Group	242,913,154	1.065	0.982	253,961,617	34,768,680	219,192,937
Government	11,873,336	1.065	1.000	12,640,909	1,434,083	11,206,826
Medicare Advantage	193,235,253	1.059	1.000	204,653,959	18,071,152	186,582,806
Medicaid	198,152,502	1.037	1.000	205,510,951	9,446,756	196,064,195
Medicare PDP	15,908,014	1.047	1.018	16,949,882	353,650	16,596,232
	$ 821,916,287			**$ 864,103,684**	**$ 79,363,470**	**$ 784,740,214**

3. Results

Using the assumptions described above, we projected the net premiums forward to each year from 2017 to 2026. Next, we calculated the ratio of the insurer taxes to the projected applicable premiums. Finally, we grossed up the ratio to reflect the non-deductibility of the taxes by assuming a 35% overall federal tax rate, reflecting the federal statutory rate for corporate income tax. This implies that for each dollar paid in taxes, an additional $1.54 in premium must be collected.

As discussed above, for the base premiums and the group insured membership we applied different assumptions to reflect alternate scenarios. Therefore, our results are represented by a range. The low end of the range of the premium increase reflects the current makeup of the group market. The high end of the range reflects lower aggregate premiums over which the taxes can be spread and a decrease in insured group lives due to a trend among employers to self-insure.

Table 7
Estimated Increase in Health Insurance Premiums Due to Section 9010 Taxes

Year	Low	High
2018	2.6%	2.6%
2019	2.6%	2.6%
2020	2.6%	2.6%
2021	2.5%	2.6%
2022	2.5%	2.7%
2023	2.5%	2.7%
2024	2.5%	2.7%
2025	2.5%	2.7%
2026	2.5%	2.7%
2027	2.5%	2.7%

Table 7 represents the increase in average premium rates by year that will be needed to fund the payments that insurers will be required to make to support the taxes imposed on them.

Per Capita Increase in Premium

Using the amounts in Table 7, we applied these increases on a per capita basis to the premiums in each market. Table 8 shows the projected per capita premium increase for the next ten years by line of business.

Table 8
Estimated Increase in Per Capita Premiums Due to Section 9010 Taxes

Year	Individual	Small Group		Large Group		FEHBP		Medicare Advantage	Medicaid	Medicare PDP
		Single	Family	Single	Family	Single	Family			
2018	$ 158	$ 185	$ 500	$ 188	$ 540	$ 190	$ 535	$ 245	$ 181	$ 21
2019	171	194	526	198	567	199	562	256	191	22
2020	184	202	548	206	591	208	585	268	202	24
2021	198	211	573	215	618	217	612	281	214	25
2022	214	221	600	225	647	228	641	294	226	26
2023	231	232	628	236	677	238	671	309	240	27
2024	249	242	657	247	709	249	703	323	254	28
2025	269	254	688	258	741	261	735	337	270	30
2026	290	265	719	270	775	273	769	351	287	31
2027	312	277	752	282	811	285	804	366	305	32
Total	**$ 2,276**	**$ 2,282**	**$ 6,190**	**$ 2,326**	**$ 6,675**	**$ 2,349**	**$ 6,617**	**$ 3,030**	**$ 2,370**	**$ 266**

4. State Specific Results

Using the financial statement data, we were able to split the premium data further into state specific data. Therefore, we have calculated for each state and line of business, the additional premium that will be paid in 2018 in aggregate, and per capita. The detailed data are shown in the tables below.

Additional Premium to Be Paid as a Result of Section 9010 Taxes in 2018 ($ 000s)

State	Individual	Small Group	Large Group	FEHBP	Medicare Advantage	Medicaid	Medicare PDP	Total
AK	$ 6,766	$ 4,245	$ 17,165	$ 0	$ 156	$ 0	$ 186	$ 28,519
AL	34,412	33,529	72,724	259	50,026	0	4,011	194,961
AR	48,660	13,062	30,793	1,224	19,270	0	2,871	115,880
AZ	33,863	19,163	70,046	15,310	87,288	18,897	5,391	249,958
CA	316,444	271,207	1,123,066	63	670,834	1,287,493	24,212	3,693,319
CO	30,351	30,185	76,103	777	48,136	1,865	4,154	191,571
CT	25,318	28,416	64,395	0	351,452	0	4,906	474,486
DC	3,415	14,921	106,339	2,644	2,616	24,729	1,061	155,725
DE	5,990	5,712	14,553	1	2,438	0	754	29,448
FL	268,250	110,473	346,611	10,553	564,821	388,815	46,251	1,735,772
GA	79,305	42,676	146,252	3,725	135,712	113,391	7,469	528,530
HI	4,325	16,881	64,802	12,843	22,023	20,300	2,154	143,329
IA	23,340	21,176	48,821	1,006	6,801	85,708	3,924	190,776
ID	12,438	8,122	26,644	0	6,777	0	1,090	55,069
IL	76,256	86,976	298,668	9,692	156,408	181,148	21,502	830,650
IN	27,186	27,828	63,865	85	38,522	93,011	8,658	259,155
KS	22,848	19,146	51,004	841	6,794	86,563	2,201	189,396
KY	20,287	17,270	53,722	149	212,120	149,798	6,121	459,468
LA	42,080	29,814	72,894	5,709	48,789	157,387	3,726	360,397
MA	10,759	27,223	120,959	13,723	34,233	29,364	11,993	248,253
MD	34,316	36,741	143,514	5,024	15,148	95,836	4,676	335,255
ME	6,308	6,961	31,618	0	6,908	0	867	52,662
MI	42,592	50,001	160,869	4,521	108,601	199,883	10,422	576,889
MN	28,019	28,072	88,745	52,079	6,175	70,758	2,471	276,319
MO	50,869	35,513	94,244	0	125,158	41,684	7,141	354,609
MS	17,619	11,560	29,676	3,088	4,384	68,815	2,711	137,853
MT	9,556	6,123	11,592	0	4,637	0	566	32,474
NC	115,256	40,214	103,524	0	96,728	0	10,056	365,777
ND	7,707	8,769	22,416	3,268	48	8,445	824	51,479
NE	19,675	10,460	38,372	608	7,823	15,811	2,568	95,316
NH	10,488	8,429	22,345	0	3,820	7,825	857	53,763
NJ	57,134	78,557	195,997	743	126,864	265,863	7,905	733,063
NM	6,434	6,945	23,281	125	29,180	127,386	2,145	195,496
NV	18,385	11,869	49,008	725	31,453	44,318	1,166	156,924
NY	48,784	227,895	409,376	15,895	224,023	143,413	25,698	1,095,085
OH	49,186	99,580	135,366	21,242	141,597	396,174	25,335	868,480
OK	24,973	25,449	64,528	20	22,004	0	4,300	141,274
OR	20,689	16,989	72,015	9,608	44,798	13,448	2,066	179,613
PA	84,215	97,228	276,229	49,660	203,788	216,279	10,476	937,876
RI	4,614	9,700	22,743	343	24,810	14,687	1,669	78,566
SC	38,227	18,696	52,452	449	45,582	81,141	3,826	240,371
SD	7,792	7,026	15,534	3,761	99	0	787	34,999
TN	48,957	40,188	72,408	618	138,917	179,462	4,191	484,742
TX	179,941	150,876	331,102	32,891	304,968	430,465	27,328	1,457,572
UT	12,106	12,450	44,425	478	27,018	10,857	1,161	108,496
VA	57,335	51,922	177,533	2,357	24,928	50,413	5,468	369,957
VT	5,196	6,685	5,977	0	2,320	0	776	20,955
WA	33,527	38,500	134,121	1,309	89,198	121,071	4,835	422,561
WI	38,034	41,049	130,443	8,020	569,964	34,144	122,791	944,445
WV	8,181	7,821	21,886	0	2,953	39,206	1,844	81,890
WY	6,114	3,199	5,953	258	446	0	547	16,517

Additional Premium per Capita as a Result of Section 9010 Taxes in 2018

State	Individual	Small Group Single	Small Group Family	Large Group Single	Large Group Family	FEHBP Single	FEHBP Family	Medicare Advantage	Medicaid	Medicare PDP
AK	$ 370	$ 252	$ 606	$ 228	$ 633	$ 231	$ 642	$ 258	$ 305	$ 21
AL	149	175	489	178	461	180	467	241	133	19
AR	128	154	393	156	454	158	461	242	170	19
AZ	162	168	455	172	499	174	506	243	226	19
CA	146	172	467	188	560	190	568	262	144	23
CO	167	183	500	188	512	190	519	236	183	23
CT	179	205	586	200	582	203	590	254	241	20
DC	126	207	581	196	547	199	555	257	286	19
DE	176	216	551	197	563	200	570	244	192	19
FL	159	188	500	185	511	188	518	202	143	24
GA	159	189	469	179	521	181	528	244	129	20
HI	128	170	471	171	477	173	484	231	175	16
IA	164	166	443	179	511	181	518	238	177	21
ID	154	162	400	160	473	162	480	241	184	24
IL	148	198	542	197	552	200	560	251	144	20
IN	158	187	476	194	553	197	561	246	169	21
KS	142	171	467	172	503	175	510	247	193	21
KY	138	161	437	190	537	193	544	242	191	21
LA	191	183	478	183	512	186	519	276	157	19
MA	164	211	625	204	569	207	577	262	281	20
MD	138	182	506	195	554	197	561	282	227	19
ME	162	186	493	190	531	192	538	239	192	19
MI	152	184	497	180	501	183	508	244	163	20
MN	145	185	522	187	526	190	533	235	242	21
MO	162	175	460	177	498	180	505	246	209	21
MS	143	172	448	175	485	177	492	254	172	20
MT	164	177	430	189	482	191	489	238	230	21
NC	197	184	470	180	521	182	528	242	169	21
ND	163	166	458	177	496	180	503	240	269	21
NE	176	183	480	179	518	181	526	247	186	21
NH	157	208	577	204	582	206	590	247	234	19
NJ	178	209	556	207	615	210	623	258	268	21
NM	127	190	496	184	507	186	513	236	187	18
NV	148	173	453	174	519	177	526	271	120	22
NY	217	202	564	203	559	205	567	258	287	22
OH	162	172	466	191	513	193	520	241	221	20
OK	163	174	454	181	523	184	530	244	154	20
OR	145	177	468	183	525	186	532	240	191	22
PA	142	186	513	189	525	192	532	245	252	22
RI	150	212	574	198	527	200	535	249	298	20
SC	154	181	470	188	515	191	523	245	155	20
SD	163	174	466	188	525	191	533	241	177	21
TN	161	176	442	171	514	173	521	238	166	19
TX	141	180	492	184	545	187	553	277	170	20
UT	146	163	463	178	513	180	520	240	158	24
VA	154	181	495	174	533	177	541	246	201	20
VT	228	196	503	199	535	201	543	236	203	20
WA	143	169	449	190	560	192	568	243	161	22
WI	182	192	552	189	553	191	560	237	175	23
WV	179	196	503	198	560	200	568	241	204	22
WY	230	195	525	188	524	190	531	249	197	21

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