ISSUE BRIEF

ASSESSING PREMIUMS, DEDUCTIBLES, AND PLAN COMPETITION IN HEALTHCARE.GOV'S INDIVIDUAL MARKET

MARCH 2017

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

ISSUE BRIEF

ASSESSING PREMIUMS, DEDUCTIBLES, AND PLAN COMPETITION IN HEALTHCARE.GOV'S INDIVIDUAL MARKET

By almost any standard, health coverage costs for working families are too high and rising unsustainably. Despite the Affordable Care Act's (ACA) intrusive efforts to regulate health insurance, premiums and deductibles for workers both in and outside the ACA's health exchanges have continued to rise nearly four times faster than wages.[1] Recent reports show that, even with substantial financial assistance and new marketplace protections, many ACA exchange enrollees are devoting 25 percent or more of their incomes to health costs while one in five individuals with qualified health plans still cannot afford their out-of-pocket medical bills.[2, 3]

CAHC examined plan offerings—including number of plans offered and premiums available—on HealthCare.gov, the federal exchange used in the 39 states that do not operate their own health exchanges. CAHC analyzed the premiums before application of any tax credits for the second lowest cost silver plan—the benchmark plans used to calculate subsidies—for a 27-year-old, by state in each year from 2014 to 2017.

We also analyzed average national premiums for a 40-year-old and average national deductibles for Silver plans on HealthCare.gov for these years. Silver plans are the most popular exchange plans, and individuals aged 35 to 54 represent the largest age cohort enrolled in exchange plans.[4] We believe displaying information for average deductibles and premiums facing 40-year-olds enrolling in Silver plans provides a general picture of a typical enrollee's coverage. CAHC did not examine premiums or deductibles available on the state-based exchanges, nor did we look at national average premiums for other age cohorts.

Over the 2014-2017 window, we found significant average growth in premiums and cost sharing and a general reduction issuer in between choices. CAHC's previous research shows a major reason for this trend is that risk pools are seriously unbalanced, with older and sicker enrollees. Our findings show that the individual market is currently struggling and rapidly deteriorating. We speculate that in many markets, these pools are in or headed towards a death spiral, but could be saved by intervention to reduce risk and relief from the crushing mandates, restrictions, and rules imposed by current law.

In the final section, we outline a series of proposals designed to stabilize individual insurance markets and reduce pressures on cost growth.

1 Meyer, A. (2016, March 24). Health insurance premiums rising faster than wages. Fox News. Retrieved from: http://www.foxnews.com/poltics/2016/03/24/health-insurance-premiums-rising-faster-than-wages.html
2 Andrews, M. (2016, January 15). Study: Some marketplace customers spend 25% of income on health expenses. Kaiser Health News. Retrieved from: http://khn.org/news/study-some-marketplace-customers-spend-25-percent-of-income-on-health-expenses/
3 Hamel, L. et al. (2016, July 5). The burden of medical debt: Results from the Kaiser Family Foundation/New York Times medical bills survey. Kaiser Family Foundation. Retrieved from: http://kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/
4 Council for Affordable Health Coverage/Avalere. (2016, June 7). Exchange enrollment: An opportunity for reform. Retrieved from: http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief _ExchangeEnrollment_061616.pdf

FINDINGS

- ACA Exchange Market Premiums:[5] For 2017, average premiums for the second-lowest cost Silver plans increase by 25 percent for the 39 states using HealthCare.gov as their marketplace.[6] In several local markets, premiums are going up by much more. For example, in Arizona premiums increased by an average 116 percent in 2017.[7]

- Across all 39 states using HealthCare.gov, premiums increased on average by 38.6 percent overall from 2014 to 2017.

- Nationwide, premiums for the second-lowest cost Silver plans on HealthCare.gov states increased, on average, by 9.6 percent annually since the ACA's marketplaces came on line in 2014.

- Premium growth is also accelerating. Between 2014 and 2015, premiums increased just 2.7 percent, but increased by 8.0 percent for 2016 and by nearly 25 percent for 2017. More recent premium increases have reflected better information available to insurers on the risk of plan enrollees and the actual risk of the population – which has been older and sicker than predicted.

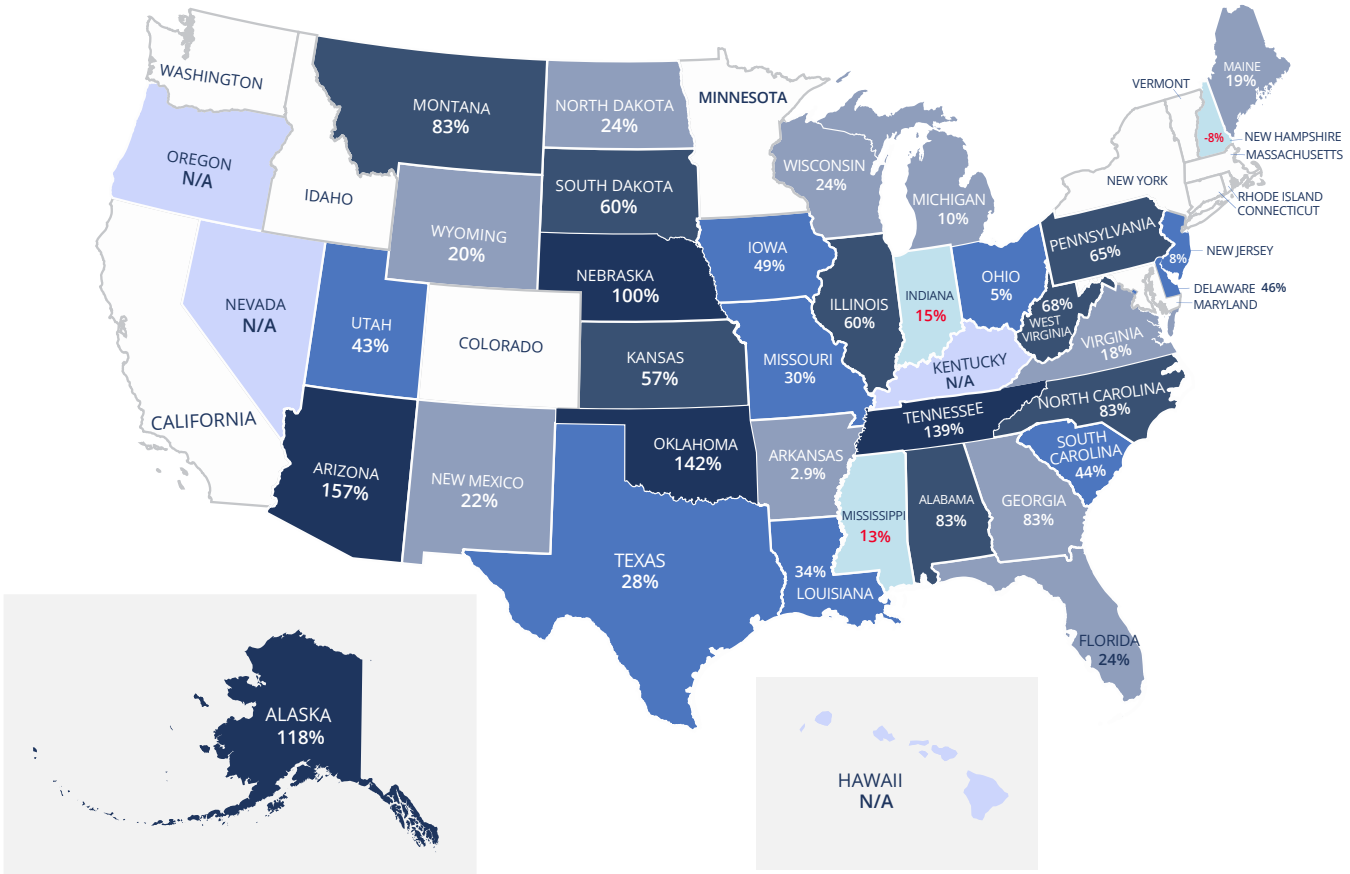
- While these numbers reflect national averages, we see significant variation across the country, with average increases from 2014-2017 varying from a high of 157.32 percent to a decrease of 15.19 percent. Only three states did not experience overall premium growth from 2014 to 2017, while five states saw more than 100 percent premium increases over this period. Most states had premium increases between 20 and 50 percent.

- In 2017, average annual national premiums for Silver plan for a 40-year-old without a tax subsidy was $4,929. This is more than a $1,000 increase since 2014.[8]

5 Unless otherwise noted, data on premium increases come from the following sources: Avery, K. et al. (2015, October 30). Health plan choice and premiums in the 2016 health insurance marketplace. U.S. Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace
6 U.S. Department of Health and Human Services. (2016, October 24). Health plan choice and premiums in the 2017 health insurance marketplace. Retrieved from: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace
7 CBS New York/Associated Press. (2016, October 25). Arizona Obamacare plan to jump by 116 percent when premiums go up next year. CBS New York/Associated Press. Retrieved from: http://newyork.cbslocal.com/2016/10/25/arizona-obamacare-premiums/
8 U.S. Department of Health and Human Services. Data.HealthCare.gov via HealthPocket InfoStat.

PERCENTAGE CHANGE IN OVERALL PREMIUMS FOR SECOND-LOWEST COST SILVER PLANS

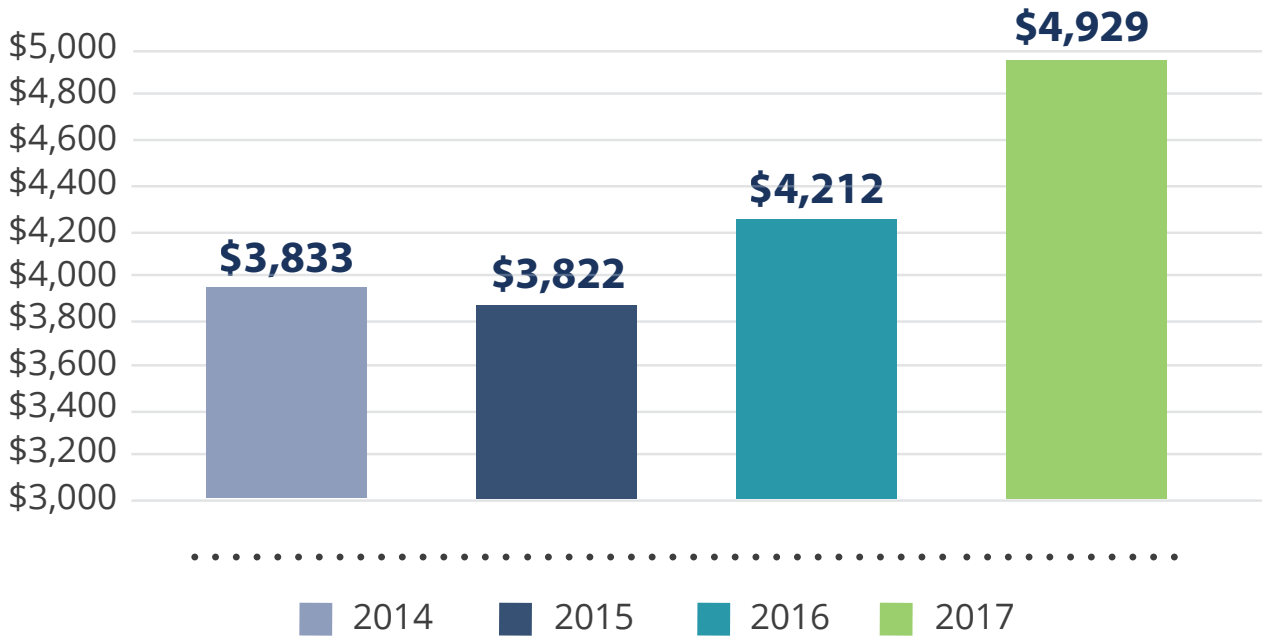
27 YEAR-OLD (BEFORE TAX CREDITS) IN HEALTHCARE.GOV STATES, 2014-2017



N/A means the state adopted the federal exchange during the 2014 to 2017 period and is not valid in the comparisons.

Source: Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace." Department of Health and Huiman Services, 24, October 2016, CAHC Calculations

AVERAGE NATIONAL PREMIUMS FOR INDIVIDUAL EXCHANGE COVERAGE FOR A 40 YEAR-OLD INDIVIDUAL*



*Silver plans are the most popular exchange plan. Premiums are national averages for a 40-year-old non-smoker, which represents the largest enrolled age group on the individual market exchanges. There is wide variation throughout the country in premiums, however.[9]

See Appendix A for a breakdown by state of premium changes.

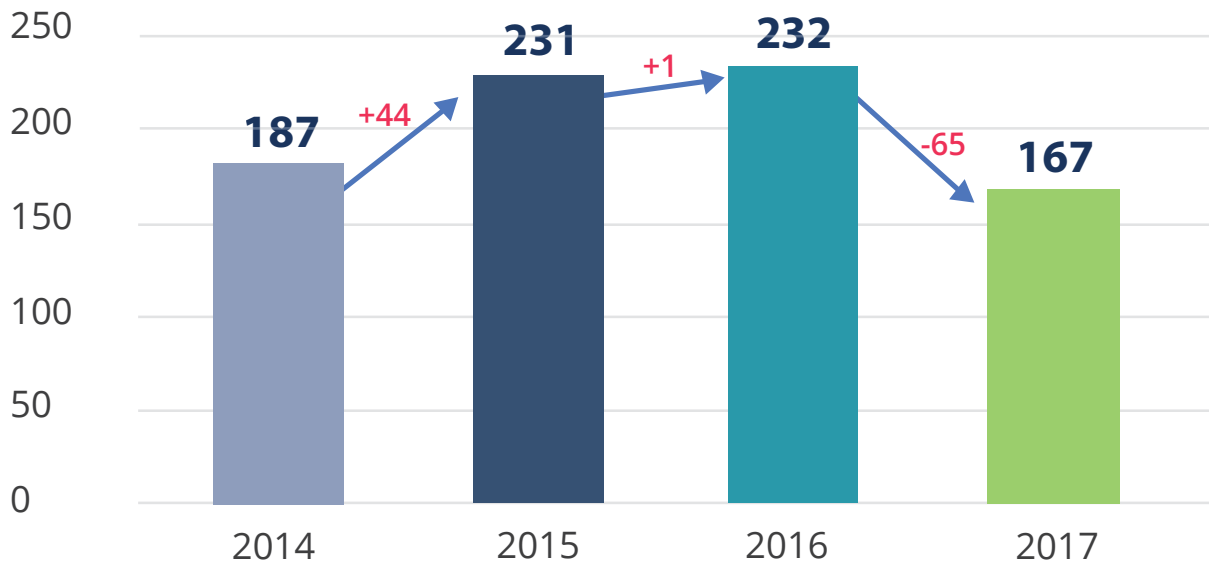
9 Source for Chart Data: U.S. Department of Health and Human Services. Data.HealthCare.gov via HealthPocket InfoStat.

PUBLIC EXCHANGE COMPETITION AND CHOICE

Over the 2014-2017 window, plan choice and competition have declined. Insurers' losses in the individual ACA exchange markets eclipsed gains by $5.2 billion in 2015, more than twice the 2014 deficit of $2.2 billion.[10] While some larger companies may be able to sustain such losses for a short time, this trend is not sustainable over the long-term, and does not bode well for the future viability of the exchange markets.

This is evident in the withdrawal of 83 issuers in markets across the country. As a result, approximately 21 percent of consumers had only one health issuer to "choose" from in 2017.[11]

NUMBER OF MARKETPLACE ISSUERS, 2014-2017



Source: "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace." Department of Health and Human Services, 24 Oct 2016.

- In 2016, there were **182 counties in HealthCare.gov states** with only one insurer participating on the exchanges. In 2017, there are **687 counties**.[12]
- Some large insurers have indicated they will not participate in the exchanges for 2018, absent some form of new stabilization policy.

See Appendix B for a state-by-state analysis of the number of participating issuers.

10 Blase, B. (2016, November 21). A taxpayer bailout of Obamacare issuers just got a lot more expensive. Forbes. Retrieved from: http://www.forbes.com/sites/theapothecary/2016/11/21/a-taxpayer-bailout-of-obamacare-insurers-just-got-a-lot-more-expensive/#7981d1387495
11 U.S. Department of Health and Human Services. (2016, October 24). Health plan choice and premiums in the 2017 health insurance marketplace. Retrieved from: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace
12 Cliff, S. (2016, August 24). Big insurers have quit Obamacare. That means more shoppers only get one choice. Vox. Retrieved from: http://www.vox.com/a/obamacare-competition-2017

COST SHARING FOR INDIVIDUAL PLANS ON PUBLIC EXCHANGES

Increasing cost sharing for enrollees is one of the few tools left to hold down premiums while still meeting the numerous coverage requirements imposed by the ACA. Not only have premiums increased substantially over the past four years, but deductibles, co-payments, and coinsurance are also rising by double-digits. Unfortunately, the ACA has made it more difficult to utilize tax-preferred mechanisms such as Health Savings Accounts (HSAs) to help cover high cost sharing. Most exchange plans are not coupled with HSAs, including standardized plans being offered this year, even when their deductibles are higher than those in HSA-compatible plans.

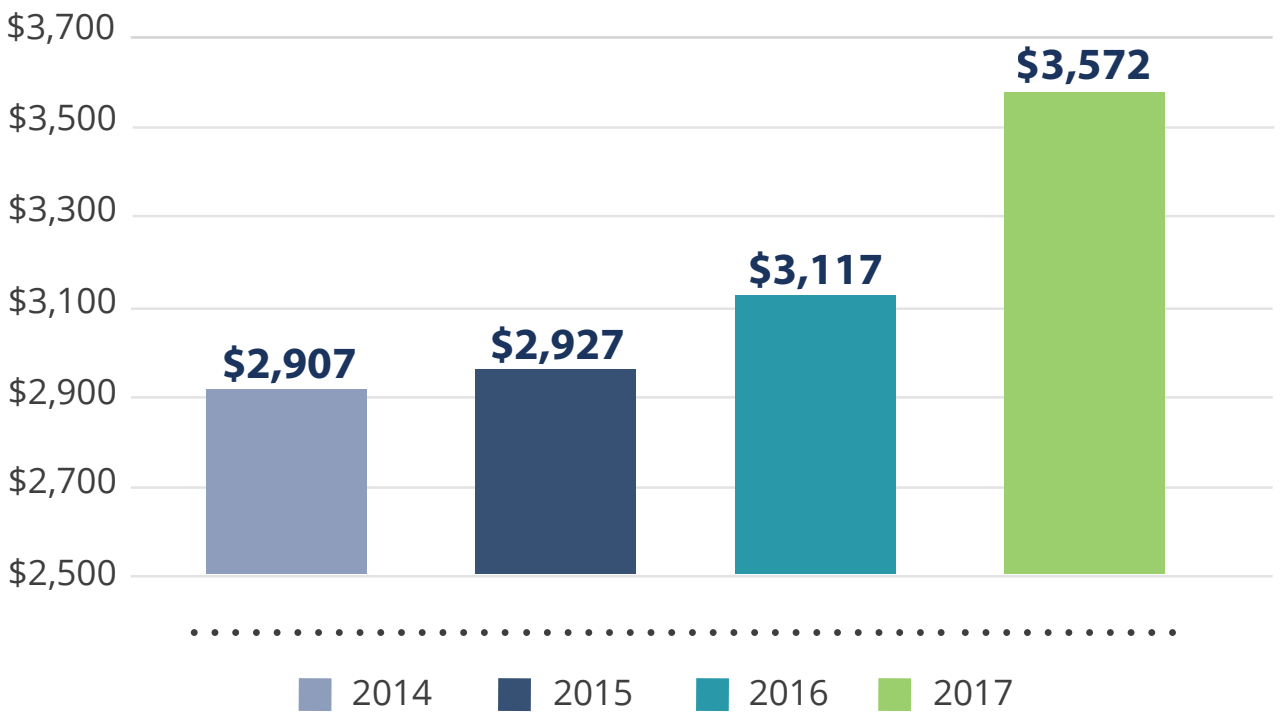
The Internal Revenue Service sets upper and lower out-of-pocket limits on HSA-compatible plans. Any health plan that has out-of-pocket limits outside this range cannot be coupled with an HSA. These requirements are not aligned with other ACA plan requirements, however, so the number of plans eligible for HSAs is dwindling.

For example, out-of-pocket limits for standard individual Bronze and Silver plans for 2017 are $7,150, which is $600 above the $6,550 upper maximum out-of-pocket limit for HSA qualification.[13, 14] For 2017, average annual out-of-pocket maximums for Bronze plans were $6,940 with average deductibles of $6,092.[15] Because of the misalignment in thresholds, individuals enrolled in these polices do not have access to tax-preferred mechanisms that can help cover these high out-of-pocket costs.

- Silver plan deductibles are increasing by 15 percent on average for 2017.[16]
- Families enrolled in these plans will have average deductibles of nearly $7,500 while families enrolled in Bronze plans will face average deductibles of an eye-popping $12,393.[17] This means that Bronze level deductibles equal nearly a quarter of a typical family's income.[18]
- In 2017, average national deductibles for individual Silver plans were $3,572 – up more than $600 since 2014.[19]

13 HealthCare.gov. (Accessed on 2016, January 8). Out-of-pocket maximum/limit. U.S. Department of Health and Human Services. Retrieved from: https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/
14 Miller, S. (2016, May 2). IRS sets 2017 HSA contribution limits: Health savings account annual limit for individuals rises by $50. Retrieved from: https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/irs-sets-2017-hsa-contribution-limits.aspx
15 InfoStat. (2016, October 26). Aging consumers without subsidies hit hardest by 2017 Obamacare premiums and deductibles. HealthPocket. Retrieved from: https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.WHRZrvkrI2x
16, 17, 18 Mangan, D. Obamacare deductibles are on the rise for 2017, along with monthly premiums. (2016, 26 October). CNBC. Retrieved from: http://www.cnbc.com/2016/10/26/obamacare-deductibles-are-on-the-rise-for-2017-along-with-monthly-premiums.html
19 U.S. Department of Health and Human Services. Data.HealthCare.gov via HealthPocket InfoStat.

AVERAGE NATIONAL DEDUCTIBLES FOR SILVER EXCHANGE PLANS*



* Silver plans are the most popular exchange plan.[20]

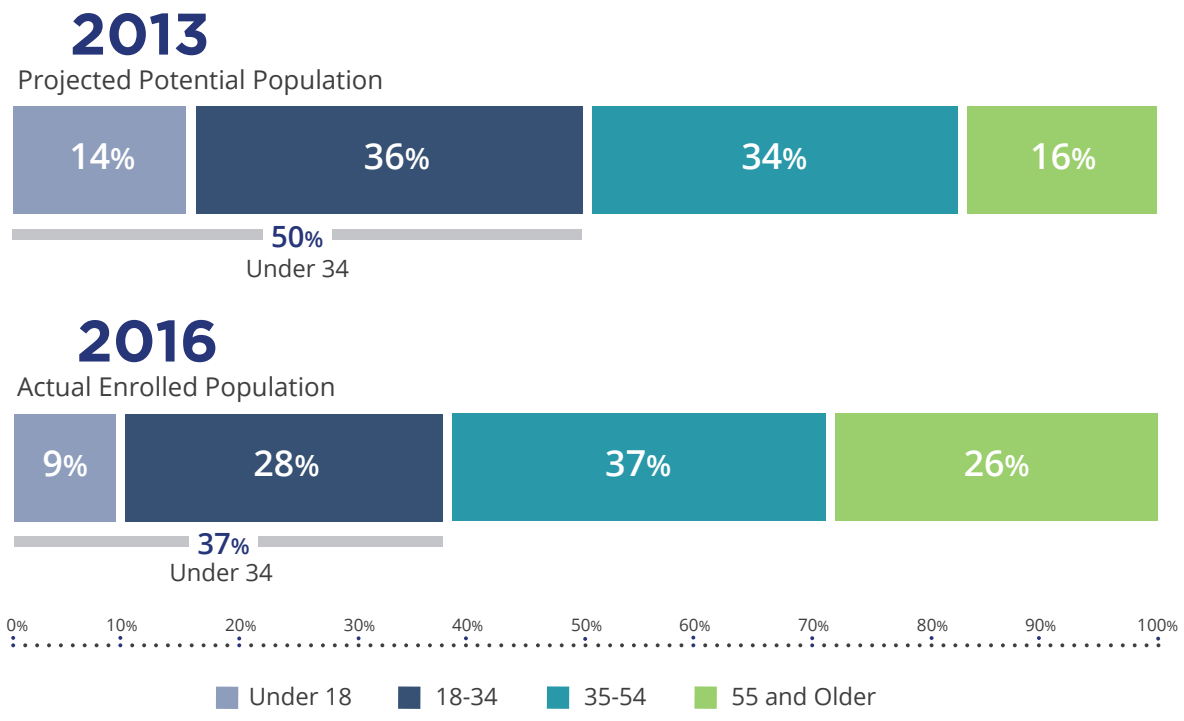
20 Source for Chart Data: U.S. Department of Health and Human Services. Data.HealthCare.gov via HealthPocket InfoStat.

PUBLIC EXCHANGE MARKET RISK POOLS

Rising premiums and deductibles and the exit of insurers from the exchange marketplaces are all related directly to unbalanced and deteriorating risk pools. Younger, healthier consumers have lower enrollment rates than expected in exchange plans. The resulting smaller, older, and sicker risk pools have caused premiums to skyrocket, further dissuading younger, healthier consumers from enrolling, creating a vicious cycle that is leading us rapidly toward a so-called "death spiral in several markets."

- Total ACA insurance exchange enrollment continues to lag original projections. Average total enrollment in 2016 was roughly 10.5 million, or about half of the 21 million originally estimated by the Congressional Budget Office (CBO) for that year at the time of enactment.[21, 22]

- Roughly half of the enrollees were originally projected to be under age 35, but only 37 percent of 2016 enrollees are in that age bracket.[23] **Even if numbers met projections, however, it might not be enough to keep markets healthy.** The exchanges need around an additional 35 percent of younger enrollees to keep markets healthy.[24, 25]



Source: CAHC Exchange Enrollment, An Opportunity for Reform, June 2016

21 Congressional Budget Office. (2010, March 20). Cost Estimate for H.R. 4872, the Reconciliation Act of 2010. Retrieved from: http://cbo.gov/sites/default/files/amendreconprop.pdf
22 First Half of 2016 Effectuated Enrollment Snapshot." Centers for Medicare and Medicaid Services, 19 Oct 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html
23, 24 Council for Affordable Health Coverage/Avalere. (2016, June 7). Exchange enrollment: An opportunity for reform. Retrieved from: http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief _ExchangeEnrollment_061616.pdf
25 Herman, B. (2016, May 14). What, me buy insurance? How slow uptake by 'young invincibles' is driving the ACA's exchange rates higher.

SOLUTIONS TO STABILIZE MARKETS AND IMPROVE MARKETS

Put simply, the current insurance marketplace is in peril, and consumers face significant uncertainty and insecurity in their coverage. Immediate action must be taken to stabilize markets and improve them in future years.

One of the most effective ways to lower premiums is by broadening and improving the risk pool. Only about half of those eligible have enrolled in ACA exchange plans, reflecting a lack of consumer enthusiasm for the plans found there.[26] Greater participation rates particularly by younger, healthier enrollees – would lower average costs for everyone by spreading risk across a larger population.

Preserving and improving the integrity of the risk pool while incentivizing targeted outreach efforts to better attract greater participation in marketplaces is essential to long-term market stability, insurer participation, and consumer options.

CAHC calls on Congress and the Administration to enact the following reforms to stabilize markets, cultivate healthy risk pools, empower consumers, reduce regulatory burdens, enable state flexibility, and support the employer market.

1. **Provide immediate, new risk pool stabilization funding to the states.** While there are many policies that can help improve risk pools, there is a strong need in both the short- and long-term to provide funding to states that will help mitigate risk posed by the highest cost enrollees. By helping stabilize and improve risk, premiums and subsequent premium tax credits will be lowered. CAHC calls on Congress to provide $20 billion in annual funding. We estimate such funding will lower premiums by 20 to 24 percent, reversing the 2017 average Silver plan premium increase.[27]

2. **Cultivate healthy risk pools.** Younger, healthier consumers have lower enrollment rates than expected because they often find exchange plans to be too expensive compared to the benefits they provide. The resulting older, sicker risk pool has caused premiums to skyrocket. Congress and the Administration should enact policies to reverse this trend, including:

   - Strong continuous coverage incentives that include penalties and rewards.
   - Reliable, fair enrollment policies that prevent gaming of the system.
   - Expanded age rating bands to lower premiums for younger enrollees.
   - Subsidy structures that ensures adequate access to coverage, particularly for younger consumers.
   - Incentives for healthy behavior and wellness programs.

26 Council for Affordable Health Coverage/Avalere. (2016, June 7). Exchange enrollment: An opportunity for reform. Retrieved from: http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief _ExchangeEnrollment_061616.pdf
27 Council for Affordable Health Coverage analysis of leaked ACA Repeal and Replace draft bill dated February 10, 2017.

3 **Give consumers more choices.** The ACA's rules and regulations have both dramatically increased cost-sharing requirements and hampered the use of consumer-driven health products, including HSAs, which consumers rely on to manage out-of-pocket costs and have been shown to reduce costs. These mechanisms are also likely to lower unnecessary health care utilization without negatively impacting quality or access.[28] In fact, premiums for HSA-compatible plans are typically some of the lowest among the various coverage options.[29] Despite these positive attributes, consumer-driven health products use has been hampered by restrictions. Policies should be reversed that discourage the use of consumer-driven health products, including:

- Allowing individuals to use tax credits for HSA contributions.
- Creating marketplace standards to encourage HSA usage.
- Provide for more flexibility in plan design for HSA-compatible plans.

4 **Allow consumers to use subsidies off-exchange.** The ACA requires consumers to use their premium subsidies on the public exchanges. The law further mandates the types of products available for purchase that are laden with requirements, which drive up costs. Consumers should be free to use their subsidies off-exchanges and for products they want and need, including for account-based plans and programs. Innovative private-sector tools to enable transparent markets that foster informed decision-making should be more widely available for the evaluation of plan and provider choices.

Enacting these reforms will help meet diverse consumer needs while also putting the health system on a more sustainable path.

28 Cardon, J. & Showalter, M. (2007, March). Insurance choice and tax-preferred health savings accounts. Journal of Health Economics. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0167629606001226
29 Kaiser Family Foundation, 2016 Employer Health Benefits Survey, September 14, 2016. Retrieved from: http://kff.org/report-section/ehbs-2016- section-eight-high-deductible-health-plans-with-savings-option/

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

ABOUT US

The Council for Affordable Health Coverage (CAHC) is a broad-based organization with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a range of interests, including organizations representing consumers, physicians, small businesses, large employers, manufacturers and retailers, franchises, insurers, brokers and agents. We are concerned that health coverage and care has become less affordable and accessible over the last decade—a trend that has continued despite the passage of major reform legislation.

APPENDIX A

AVERAGE MONTHLY PREMIUMS FOR SECOND-LOWEST COST SILVER PLANS FOR A 27-YEAR-OLD (BEFORE TAX CREDITS), 2014-2017 IN HEALTHCARE.GOV STATES

2014-2015 Source: https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace
Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform.

Note: The numbers in this table represent premiums before the application of advance premium tax credits. State and HealthCare.gov average premiums are weighted by the number of Marketplace plan selections in each county, except for Hawaii, in which all counties were weighted equally. Numbers presented here may differ from those in CMS's "2016 Marketplace Affordability Snapshot." The CMS snapshot analyzes percent changes in the second-lowest cost silver plan from 2015 to 2016, ranked by full premium price. This brief identifies the second-lowest cost silver plan in each county based on the portion of the premium that covers essential health benefits (EHB). See the "Methodology and Limitations" section for details.

2016-2017 Source: https://aspe.hhs.gov/health-plan-choice-and-premiums-2017-health-insurance-marketplace
For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files.
Note: The numbers in this table represent premiums before the application of advance premium tax credits. State and HealthCare.gov average premiums are weighted by the number of Marketplace plan selections in each county, except for Kentucky, in which all counties were weighted equally. The 2016 and 2017 averages use 2016 plan selections in 38 states. This analysis identifies the second-lowest cost silver plan in each county based on the portion of the premium that covers essential health benefits (EHB); however, premiums reported in this table are for the full premium amount, not just the premium amount that covers EHB. See the "Methodology and Limitations" section for details.

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AVERAGE MONTHLY PREMIUMS FOR SECOND-LOWEST COST SILVER PLANS FOR A 27-YEAR-OLD (BEFORE TAX CREDITS), 2014-2017 IN HEALTHCARE.GOV STATES

STATE	AVERAGE SECOND-LOWEST COST SILVER PREMIUM (BEFORE TAX CREDITS) FOR A 27-YEAR-OLD				
	2014	2015	2016	2017	% CHANGE IN OVERALL PREMIUMS, 2014-2017
HEALTHCARE.GOV STATES AVERAGE	$218	$224	$242	$302	38.53%
ALASKA	$349	$449	$590	$760	117.7%
ALABAMA	$210	$216	$244	$384	82.86%
ARKANSAS	$241	$235	$244	$248	2.90%
ARIZONA	$164	$161	$196	$422	157.32%
DELAWARE	$237	$247	$292	$347	46.41%
FLORIDA	$218	$235	$238	$270	23.85%
GEORGIA	$236	$228	$237	$273	15.68%
HAWAII	N/A	N/A	$213	$288	N/A
IOWA	$207	$217	$246	$308	48.79%
ILLINOIS	$186	$192	$208	$298	60.22%
INDIANA	$270	$268	$235	$229	-15.19%
KANSAS	$196	$187	$217	$308	57.14%
KENTUCKY	N/A	N/A	N/A	$259	N/A
LOUISIANA	$252	$267	$290	$340	34.92%
MAINE	$266	$263	$275	$317	19.17%
MICHIGAN	$207	$209	$213	$228	10.14%
MISSOURI	$235	$233	$257	$305	29.79%
MISSISSIPPI	$313	$255	$230	$273	-12.78%
MONTANA	$208	$196	$264	$381	83.17%
NORTH CAROLINA	$244	$259	$319	$446	82.79%
NORTH DAKOTA	$233	$248	$270	$288	23.16%
NEBRASKA	$205	$243	$272	$411	100.49%
NEW HAMPSHIRE	$237	$205	$215	$219	-7.59%
NEW JERSEY	$265	$259	$272	$286	7.92%
NEW MEXICO	$183	$163	$174	$224	22.40%
NEVADA	N/A	$217	$234	$249	N/A
OHIO	$216	$218	$222	$226	4.63%
OKLAHOMA	$175	$185	$251	$424	149.29%
OREGON	N/A	$183	$225	$287	N/A
PENNSYLVANIA	$198	$193	$213	$327	65.15%
SOUTH CAROLINA	$222	$223	$247	$319	43.69%
SOUTH DAKOTA	$234	$216	$270	$374	59.83%
TENNESSEE	$161	$191	$236	$385	139.13%
TEXAS	$204	$211	$221	$261	27.94%
UTAH	$206	$212	$245	$294	42.72%
VIRGINIA	$223	$230	$239	$264	18.39%
WISCONSIN	$246	$251	$262	$304	23.58%
WEST VIRGINIA	$230	$248	$294	$386	67.83%
WYOMING	$344	$359	$380	$413	20.06%

APPENDIX
B

NUMBER OF MARKETPLACE ISSUERS BY STATE, 2014-2017 IN HEALTHCARE.GOV STATES

2014-2015 Source: https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace
Plan and premium information is from the plan landscape files for states using the HealthCare.gov platform.

Note: An issuer is counted as "new" in 2016 if it did not offer an individual market health plan in a given state's Marketplace in 2015 based on its HIOS issuer ID number, and "exiting" if it was active in a given state's Marketplace in 2015 but not in 2016.

* Hawaii is not included in the net change in the number of issuers from 2015 to 2016, the sum of new issuers in 2016, and the sum issuers exiting in 2016.

2016-2017 Source: https://aspe.hhs.gov/health-plan-choice-and-premiums-2017-health-insurance-marketplace
For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files.
Note: An issuer is counted as "new" in 2017 if it did not offer an individual market health plan in a given state's Marketplace in 2016 based on its HIOS issuer ID number, and "exiting" if it was active in a given state's Marketplace in 2016 but not in 2017.

APPENDIX B

NUMBER OF MARKETPLACE ISSUERS BY STATE, 2014-2017 IN HEALTHCARE.GOV STATES

STATE	NUMBER OF ISSUERS IN STATE				NET CHANGE IN OVERALL NUMBER OF ISSUERS IN STATE, 2014-2017
	2014	2015	2016	2017	
HEALTHCARE.GOV STATES TOTAL	187	231	232	167	-20
ALASKA	2	2	2	1	-1
ALABAMA	2	3	3	1	-1
ARKANSAS	3	4	5	4	1
ARIZONA	10	12	8	2	-8
DELAWARE	3	3	3	3	0
FLORIDA	11	12	10	7	-4
GEORGIA	5	8	9	5	0
HAWAII	N/A	N/A	2	2	N/A
IOWA	4	3	4	5	1
ILLINOIS	8	9	9	5	-3
INDIANA	4	8	8	4	0
KANSAS	4	5	4	3	-1
KENTUCKY	N/A	N/A	N/A	3	3
LOUISIANA	5	5	5	4	-1
MAINE	2	3	2	3	1
MICHIGAN	12	15	14	10	-2
MISSOURI	4	7	7	4	0
MISSISSIPPI	2	3	3	2	0
MONTANA	3	3	3	3	0
NORTH CAROLINA	2	3	3	3	0
NORTH DAKOTA	3	3	3	3	0
NEBRASKA	4	2	4	2	-2
NEW HAMPSHIRE	1	4	4	4	3
NEW JERSEY	4	6	6	3	-1
NEW MEXICO	4	5	4	4	0
NEVADA	N/A	4	4	4	N/A
OHIO	12	15	16	11	-1
OKLAHOMA	6	3	2	1	-5
OREGON	N/A	10	9	6	N/A
PENNSYLVANIA	14	14	13	8	-6
SOUTH CAROLINA	4	4	4	1	-3
SOUTH DAKOTA	3	3	2	2	-1
TENNESSEE	4	3	4	3	-1
TEXAS	12	14	19	10	-2
UTAH	6	6	4	3	-3
VIRGINIA	8	9	11	11	3
WISCONSIN	13	15	16	15	2
WEST VIRGINIA	1	1	2	2	1
WYOMING	2	2	1	1	-1

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