



What does the ACA excise tax on high-cost plans actually tax?

Prepared for:
National Education Association

Prepared by:
Robert H. Dobson, FSA, MAAA

Stuart D. Rachlin, FSA, MAAA

3000 Bayport Drive
Suite 1050
Tampa, FL 33607 USA

Tel +1 813 282 9262
Fax +1 813 282 8276

milliman.com

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EXECUTIVE SUMMARY

Milliman was retained by the National Education Association (NEA) to assess two components of the excise tax on high-cost employer-sponsored health plans that is part of the Patient Protection and Affordable Care Act (ACA). The first component was the degree to which the excise tax on high-cost plans taxes the level of a health plan's benefits versus the degree to which it taxes a plan based on factors exogenous to the plan's benefits. The second component was the degree to which that tax's age and gender adjustment appropriately corrects for the impact of age and gender on health insurance premiums.

The analyses demonstrate that there are several quantifiable elements of premium determination, including plan members' geographical location, the industry in which they work, their age and gender, and the number of people in the health insurance group in which they participate, that can increase premiums in addition to the level of benefits. See Summary One below for a sample of these results.

Depending on the combination of these premium-driving factors other than benefit level, premiums for a given employer can be expected to exceed the threshold for incurring the tax even for a plan without especially rich benefits. As a result, although the excise tax is often referred to as a tax on overgenerous health benefits, it is likely to be a tax based on factors other than benefit level and beyond the control of health plan members. In our analysis, this was the case for our baseline plan (using the plan design of the Blue Cross and Blue Shield standard benefit option under the Federal Employees Health Benefits Program), the platinum plan, and the gold plan (the latter two using the benefits of plans offered on an exchange). The opposite is also true: There are also many areas of the country where the combined effect of premium-driving factors will make it unlikely that the threshold could be exceeded, no matter how rich the benefit plan. Unexpected consequences of the tax, therefore, include imposing a tax on moderate-benefit plans based primarily on geography, age, and gender, while failing to impose a tax on rich-benefit plans for the exact same reasons.

Although the statute attempted to correct for the impact on premiums of age and gender, we find that it does not always do so. For that reason, age and gender remain on the list of factors that can drive an employer to face a tax. We find that the age and gender adjustment accurately reflects the age and gender characteristics of employers, but does so only for employers generally in areas with average healthcare costs and average network discounts. For example, using all of the assumptions described in this paper, our analysis shows 30 metropolitan statistical areas (MSAs) around the country where the benefits of the Blue Cross and Blue Shield standard benefit option under the Federal Employees Health Benefits Program (FEHBP) are estimated to generate an excise tax for a standard employer population based on the national labor force. In these same areas, the age and gender adjustment may prove to be inadequate, for reasons discussed below, increasing the tax for employers whose employees are older or higher-cost male/female profiles.¹ In many of these areas, a less rich gold plan is also estimated to generate a tax and inadequate age and gender adjustment.

¹ In general, women are more expensive to insure until age 60, when men become, in general, more expensive to insure.

Summary Two and Summary Three below show samples of the results for six of the areas in our chosen 30 markets.

There are two important considerations to note about these analyses.

- First, we have only identified some areas where the combined geographical area and average provider discount cause the threshold to be exceeded, which is just due to the location of the employer. There are also many areas where the combined effect of these two factors is to make it unlikely that the threshold could be exceeded based on location of the employer, no matter how rich the benefit plan. Looking at those areas is beyond the scope of this paper.
- Second, there are other combinations of elements of premium determination that may also result in the threshold being exceeded even for the baseline benefit plan. The examples we show should be considered illustrative, not exhaustive.

Please see the full report that follows for a detailed description of our results and some important considerations and caveats concerning our work. The opinions expressed in this paper are those of the authors and not necessarily those of the NEA or other Milliman consultants.

Summary One: Relative impact on premiums of isolated premium-driving factors

Our analyses demonstrate that several quantifiable elements of premium determination, including plan members' geographical location, the industry in which they work, their age and gender, and the number of people in the health insurance group in which they participate, can increase premiums in addition to benefit levels. Depending on how these premium-driving factors combine, premiums for a given employer can be expected to exceed the threshold for incurring the excise tax even for a plan without especially rich benefits. As a result, although the excise tax is often referred to as a tax on overgenerous health benefits, it is likely to be a tax based on factors other than benefit richness and beyond the control of health plan members.

Here, we determined a premium for a baseline plan (self-only coverage for the benefits of the 2014 Blue Cross and Blue Shield standard option under the FEHBP, with costs projected forward to 2018) and then changed one cost-driving factor at a time, keeping all other factors as they were in the baseline. The result shows the impact on the baseline cost of the factor we isolated. Summary Two and Summary Three show how some of these premium-driving factors interact with each other.

Isolated Premium-Driving Factor	Relative Impact on Premiums of the Isolated Premium-Driving Factor	Baseline Annual Premium of \$9,189 Priced to Account for Isolated Factor	Increase That Is Due to Isolated Factor
Geographical area (example: Trenton, New Jersey)	69.3%	\$15,556	\$6,367
Industry factor (assumption of mining industry)	20.0%	\$11,027	\$1,838
Provider discounts (assumption of low provider discounts)	15.7%	\$10,629	\$1,440
Group size (assumption of small group with an expense factor of 20% plus 4% adverse selection risk)	10.5%	\$10,154	\$965
Expense factor (assumption of high expenses 20%)	6.3%	\$9,763	\$574
Benefit level (assumption of typical platinum plan)	6.2%	\$9,757	\$569

Summary Two: Impact on premiums of geographical healthcare cost differences and area-specific provider discounts

When we hold benefit packages constant, geographical cost differences, combined with area-specific provider discounts, lead to much higher premiums and substantial taxable costs in many parts of the country. Here, we show the results for self-only coverage for three baseline plans in six illustrative areas, projected forward to 2018.

	Annual Premium for Baseline Plan	Baseline Priced for San Francisco, California	Baseline Priced for Anchorage, Alaska	Baseline Priced for Atlantic City, New Jersey	Baseline Priced for Charleston, South Carolina	Baseline Priced for Bloomington, Illinois	Baseline Priced for Huntington, West Virginia
Benefits of a Typical Platinum-Level Plan	\$9,757 (0% increase, \$0 taxable)	\$16,689 (71.05% increase, \$6,489 taxable)	\$15,588 (59.76% increase, \$5,388 taxable)	\$14,192 (45.45% Increase, \$3,992 taxable)	\$13,745 (40.87% Increase, \$3,545 taxable)	\$11,370 (16.53% Increase, \$1,170 taxable)	\$10,831 (11.01% Increase, \$631 taxable)
Benefits of the 2014 Blue Cross and Blue Shield Standard Option Under the FEHBP	\$9,189 (0% increase, \$0 taxable)	\$15,959 (73.68% Increase, \$5,759 taxable)	\$14,848 (61.58% Increase, \$4,648 taxable)	\$13,355 (45.34% increase, \$3,155 taxable)	\$13,053 (42.05% increase, \$2,853 taxable)	\$10,786 (17.38% increase, \$586 taxable)	\$10,215 (11.17% increase, \$15 taxable)
Benefits of a Typical Gold- Level Plan	\$8,459 (0% increase, \$0 taxable)	\$14,995 (77.27% increase, \$4,795 taxable)	\$13,964 (65.08% increase, \$3,764 taxable)	\$12,583 (48.75% increase, \$2,383 taxable)	\$12,115 (43.22% increase, \$1,915 taxable)	\$9,969 (17.85% increase, \$0 taxable)	\$9,435 (11.54% increase, \$0 taxable)

Summary Three: Estimated taxable amounts that are due to the inadequacy of the age and gender adjustment

The excise tax's age and gender adjustment fails to compensate for the impact on premiums of age and sex in many areas of the country. Here, we show the estimated adjustment using national-level census data for all public- and private-sector education employees and the amount in six illustrative areas that would be taxed because of the inadequacy of the adjustment. As a baseline, we use the benefits of the 2014 Blue Cross and Blue Shield standard option under the FEHBP, with costs projected forward to 2018, and the age and gender of the national labor force.

	San Francisco, California	Anchorage, Alaska	Charleston, South Carolina	Atlantic City, New Jersey	Bloomington, Illinois	Huntington, West Virginia
Estimated adjustment	\$1,253	\$1,253	\$1,253	\$1,253	\$1,253	\$1,253
Needed adjustment, given geographical costs and area-specific provider discounts	\$2,223	\$2,032	\$1,756	\$1,722	\$1,491	\$1,335
Taxable portion of cost of coverage that is due to adjustment inadequacy	\$969	\$779	\$503	\$469	\$237	\$82

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was enacted into law in March 2010. One of the provisions of the ACA is an excise tax on high-cost employer-sponsored health plans. The law provides for this tax to take effect in 2018. The tax is based on the aggregate cost of employer-sponsored coverage. The largest element of this is the premium for insured plans or premium equivalent for self-insured plans.² In this paper, we explore the elements that go into premium determination for employer-sponsored health insurance in order to evaluate what the excise tax is actually taxing. We also illustrate the variability that results from each element, which in turn sheds light on the unintended consequences that will result from taxing based on premium levels. We do this by addressing the elements commonly included in a manual rating approach, described later, and evaluating the variability of each item using the Milliman Health Cost Guidelines™ (the Guidelines). The Guidelines are a nationally recognized reference tool that is used for manual rating, among other things such as benchmarking and pricing new products. Our approach is different from other studies on the same topic in that it uses an accepted reference tool to evaluate the variability in factors driving the premium. The rationale behind this approach is discussed below as well.

² Inclusion of other elements of the cost of coverage for excise tax purposes, such as health spending accounts or employer-provided medical clinics, would not necessarily alleviate the tax burden determined by analyzing the taxable portion of premiums. It is beyond the scope of this paper to analyze how those other components would affect the amount of the excise tax on high-cost plans.

OVERVIEW OF ACA EXCISE TAX ON HIGH-COST PLANS

The basis of the tax is defined in Internal Revenue Code Section 4980I (the code). The tax is 40% of the amount of employer-sponsored health coverage (the largest part of which is premium or premium equivalent for employers that are self-insured) that exceeds a threshold amount specified in the code. In this paper, we will use the word “insurer” to include both health insurance companies and self-insured employers and the word “premium” to mean premiums or premium equivalents. For 2018, these threshold amounts are \$10,200 for self-only coverage and \$27,500 for other than self-only, subject to a health cost adjustment based on cost increases in the Federal Employees Health Benefits Program (FEHBP) between 2010 and 2018. The premium includes both the portion paid by the employer and any employee contribution. The inherent difficulty with using premium as the basis of the tax is that the premium paid for an employer-sponsored health plan is subject to many variables. In partial recognition of this fact, the code provides for an adjustment for the age and gender composition of an employer's workforce as well as exception amounts for certain retiree groups and certain plans for employees working in specified high-risk occupations or employed in specified industries.

PREMIUM DETERMINATION FOR EMPLOYER-SPONSORED HEALTH INSURANCE

EXPERIENCE RATING VS. MANUAL RATING

Some background on premium development is necessary in order to appreciate the relevance of our analysis. There are many elements that go into determining the premium for employer-sponsored health insurance. These elements affect rates for all types of employer-sponsored health coverage, whether experience-rated, manually rated, subject to adjusted community rating, or self-insured. In most cases, an underwriter determining a premium rate to charge will base the premium, at least in part, on the claims experience recently generated by the particular employer. Actuaries set up manual rating approaches to be applied by underwriters when there is no experience available or when the experience is not considered fully credible. These manual rating approaches are intended to represent the best estimate of the actual cost that will be generated by the employer. An experience rating formula is used to produce an estimate of future costs based on the prior experience of the employer, adjusted for known changes, such as benefit levels, and anticipated cost and utilization trends. For employers below a certain size threshold (typically 500 or 1,000 employees), this adjusted experience will be blended with a manual rate. This manual rate would be based on the insurer's overall book of business for the line of business being rated. For employers where no prior experience is available, only the manual rate will be reflected. As a result of the ACA, only adjusted community rating will be permitted in the small group market for employers up to 100 employees (50 employees in 2015), which can be considered a form of manual rating.

COMMON ELEMENTS OF MANUAL RATING

As mentioned, the manual rate is typically based on an insurer's overall book of business. It would start with a base rate that applies to a certain rating period and benefit package. This base rate would already reflect the insurer's provider reimbursement levels, or discounts, and its level of utilization management, sometimes called medical management. The following adjustment factors would then be applied to determine that manual rate for a given employer-sponsored health plan: trend factor; product or plan type (sometimes called network adjustment factor); benefit adjustment factor; age/gender factor; geographical area factor; industry factor; and a factor to reflect administrative expenses, taxes, licenses and fees, and risk or profit margin (hereinafter referred to as "expense factor").

All of these factors are intended to represent the insurer's best estimate of the future experience of the particular employer-sponsored health plan based on characteristics that have been shown to affect future experience.

COST DRIVERS NOT TYPICALLY REFLECTED IN MANUAL RATING

There are other factors that are thought to affect claims, but that are not typically reflected in manual rating. Lifestyle and socioeconomic status are examples. While the ACA permits tobacco usage to be reflected in premium development for individual and small-employer medical coverage (which individual states may prohibit), it is not often used by insurers for pricing large-employer

medical coverage. Income level and genetics are also not typically reflected for various reasons. Savings from coordination of benefits is sometimes considered and built into manual rates. Finally, random events such as catastrophic claims³ can obviously affect the claims experience of employer-sponsored health plans. The base rates in the manual rating system would generally be assumed to include the effect of all of these drivers on claims. Experience rating systems often include a provision to spread the risk of catastrophic claims over the insurer's entire book of business.

HEALTH COST GUIDELINES

The Health Cost Guidelines are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing the Guidelines, including published and unpublished data. In most instances, cost assumptions are based on our evaluation of several data sources and are not specifically attributable to a single source.

Milliman has more health insurance actuaries (270) that are members of the Society of Actuaries than any other consulting firm in the United States. Milliman's health actuarial database is built on 50 million commercial member-years of data, and its MedInsight® data warehouse software package is used by more than 180 clients for the compilation and analysis of healthcare data for more than 70 million members. Our clients include most of the leading health insurers, Blue Cross plans, and health maintenance organizations (HMOs), as well as providers, employers and sponsors, government policymakers, pharmaceutical companies, and foundations.

When using the Guidelines, the information is adjusted to reflect the appropriate trend, medical management, discounts, benefit level (including in- and out-of-network benefits, if both are covered), geographical area, and age/gender demographics input by the user. A load to reflect administrative expenses, taxes, licenses and fees, and risk or profit margin is added at the end.

³ Catastrophic claims are usually defined as claims exceeding some dollar threshold, such as \$100,000, and can result from a myriad of different events or conditions.

ANALYSIS

VARIABILITY OF MANUAL RATING FACTORS TAKEN ONE AT A TIME

We start with an analysis of manual rating factors taken one at a time in isolation. We do this to demonstrate the relative importance of each element, especially in relation to benefit level. However, the key is how the factors work together to produce unintended consequences. We explore these interrelationships in our second and third analyses.

Our first analysis is intended to show the level of variability of each of the major factors reflected in determining a premium rate for an employer-sponsored health benefits plan. To the extent that each of these elements can cause the premium rate to exceed the excise tax threshold, the excise tax can be thought of as potentially taxing that item. Note that some manual rating factors are no longer allowed for small employers under ACA (e.g., gender and industry). Other factors may be limited by state regulation. Any such limitations do not affect the conclusions of our overall analyses, though they would affect the variability for the particular item in question. For example, industry is not an allowed rating factor under ACA, so the 1.20 value shown in Figure 1 would not apply to small employers rated under ACA rules.

The table in Figure 1 shows the results of our first analysis. For each factor, we show the ratio of the premium produced by the factor in question divided by the premium for the baseline plan, holding all other baseline assumptions constant. In other words, we determine the impact of each premium-driving factor on the baseline premium used in our study. For example, the premium for the benchmark plan would cost \$6,367 more if priced for Trenton, New Jersey. The plan would cost \$1,440 more if priced based on lower provider discounts. Looked at from another perspective, these ratios mean, for example, that changing from the baseline plan to a richer, platinum plan, taken by itself, would increase premium by 6.2%, but the effect of having a plan in Trenton, New Jersey, would be to increase the premium by 69.3%, and having provider discounts at the low end of our assumed range would increase premiums by 15.7%, which are much greater impacts than benefit richness.

At the opposite end of the spectrum, if low relative factors apply to a given employer, there may be no tax generated even with the richest benefits available. The study of that effect is beyond the scope of this paper. Our factors are based on the Guidelines and our experience gained from working in the industry. Actual factors used by insurers may have more or less variance.

Note that our analysis only considers the effect of taxing based on elements used in premium determination. For this reason we examine high relative factors. Low relative factors would produce premiums lower than our baseline and generally, all else equal, not result in a tax.

FIGURE 1: VARIABILITY OF MANUAL RATING FACTORS TAKEN ONE AT A TIME

Factor and Explanation	Ratio to Baseline	Impact on 2018 Baseline Self-Only Premium of \$9,189	Increase That Is Due to Premium-Driving Factor
Geographical area (example: Trenton, New Jersey)	1.693	\$15,556	\$6,367
Industry factor (assumption of mining industry)	1.200	\$11,027	\$1,838
Provider discounts (assumption of low provider discounts)	1.157	\$10,629	\$1,440
Group size (assumption of small group with an expense factor of 20% plus 4% adverse selection risk)	1.105	\$10,154	\$965
Expense factor (assumption of high expenses 20%)	1.063	\$9,763	\$574
Benefit richness (assumption of typical platinum plan)	1.062	\$9,757	\$569
Age and gender (after application of the age and gender adjustment but without application of other factors that interact with age and gender to affect premium costs)	1.000	\$9,189	\$0

The ratio for age and gender deserves a special note. Because we show it after the age and gender adjustment provided for in the code, it appears that it has no effect. This is only true when this element is taken by itself. As we will show in the next section of this report, when combined with a higher-cost geographical area and/or lower provider discounts, age and gender can lead to a higher tax.

The 2014 Guidelines were used to develop a baseline manual rate or premium for calendar year 2018, the first year of the excise tax. The medical cost trends shown in the table in Figure 2 were assumed in projecting the 2014 Guidelines to 2018.

FIGURE 2: PROJECTED MEDICAL COST TRENDS

Category	Average Annual Utilization Trend (2014-2018)	Average Annual Charge Trend (2014-2018)
Inpatient Facility	0.0%	4.9%
Outpatient Facility	1.6%	5.7%
Professional	1.2%	4.5%
Radiology	1.2%	4.5%
Pathology/Lab	1.2%	4.5%
Other Medical	1.2%	4.5%
Generic Drugs	3.3%	1.2%
Brand Drugs	-3.7%	9.4%

For our baseline manual rate, the following key assumptions were made:

- Large employer plan with employees spread over the United States to achieve a 1.0 geographical area factor.
- Loosely managed care or minimal medical and utilization management.
- Estimated mid-level provider discounts from billed charges.
- Blue Cross and Blue Shield standard benefit option under the FEHBP plan. We have used the 2014 benefits for the Blue Cross and Blue Shield Service Benefit Plan standard option as found on opm.gov.⁴
- National workforce: We used 2013 annual average labor force statistics from the U.S. Bureau of Labor Statistics Current Population Survey (CPS), Table 3, Employment Status of the Civilian Noninstitutional Population by Age, Sex, and Race, which is found at <http://www.bls.gov/cps/cpsaat03.htm>. We used the total labor force, not just those currently employed.
- For simplicity, we did not include dependents, but developed a premium per employee based only on employee costs. While the absolute value of the factors studied could vary for family coverage, the drivers of premium level are the same.
- A load of 15% of premium is included to reflect administrative expenses, taxes, licenses and fees, and risk or profit margin. This is based on the ACA maximum allowance for large group business (generally over 100 employees) under the minimum medical loss ratio regulations.

Our baseline per employee per year premium for 2018 is \$9,189. This compares to the ACA excise tax threshold of \$10,200 for 2018 for self-only coverage, assuming that the health cost adjustment percentage provided for in the code is not activated. This means that, given the assumptions used in our analysis, an employer with the assumed level of costs would not incur the excise tax. Premiums would have to be some 11% higher for the tax to be triggered. This could result from richer benefits or any of the other elements that go into premium determination.

We then varied one element at a time of the manual rating process to illustrate the effect of that element on the ultimate premium rate. In each case, we held all other elements of the rating process equal to the baseline assumption. The factors are discussed below in alphabetical order.

Age and gender. Age and gender, if unadjusted, can generate more variability than any other element. The age and gender adjustment provided in the code appropriately addresses this, if applied in the manner we have assumed for the baseline plan. However, the adjustment will not be adequate to correct for age and gender when other elements lead to above-average costs, such as high-cost areas or plans with low provider discounts. The impact of those combinations is examined in Figure 6 below. For the purposes of Figure 1, we show this element as 1.000, or no impact after the adjustment.

⁴ This is not to say that the premium we determined has anything to do with the premiums for the FEHBP. We used only the benefits of the identified plan, not the demographics or experience. We use this as our baseline benefit plan to study the effect of other elements of premium determination.

Benefit level. The level of benefits is also a factor driving cost in premium rate development. While there is an infinite array of possible benefits, for this analysis we tested two alternative benefit packages currently available on the Small Business Health Options Program (SHOP) exchange in the Commonwealth of Virginia, namely a platinum plan and a gold plan.⁵ We chose Virginia because we considered the benefits offered under the gold and platinum plan to be fairly typical of other states. While we used the benefits from the Virginia SHOP, our baseline plan is large group, so the premium produced is not representative of the premium that would be offered on the SHOP exchange. The platinum plan produces a ratio to the baseline of 1.062, while the gold plan produces a ratio of 0.921. Note that benefit level could also be thought of to include product design, such as HMO vs. preferred provider organization (PPO), and the level of utilization management included. Because our baseline assumed a PPO plan design and loosely managed care, these elements do not affect our results. The gold plan would have a lower premium than our baseline, all other things held equal. This is not surprising and simply means that the baseline plan is richer than the gold plan, but not as rich as the platinum plan. Further, while the platinum plan generates a premium higher than our baseline, it is not high enough to exceed the excise tax threshold, again with all other elements of premium determination held equal. See Figure 5, though, for the effect of combining the platinum plan with higher-than-average costs resulting from geographical area and/or provider discounts. A final point to note about benefit level is that it can be affected by state-mandated benefits. State-mandated benefits are beyond the scope of our study.

Expense factor. Expense charges include administrative expenses, taxes, licenses and fees, commissions, and profit or risk margin. In our experience, they can vary from 20% at the high end (limited by small employer minimum loss ratio requirements) to a low of 6% for the largest fully insured national employer groups (or even lower for large employers that are self-insured). They are considered as part of group size below as well as separately here. Overall, this element of the rating process produces a ratio of 1.063 from the highest charge to the baseline assumption.

Geographical area. Clearly, the cost of healthcare is not equal across the country. In fact, the greatest level of variability comes from geographical area given that the code allows an age and gender adjustment. The highest-cost area as reflected in the Guidelines is Trenton, N.J. All else equal, the premium rates paid by an employer in Trenton based on our analysis would be 1.69 times the premium rates paid by an employer with the baseline assumptions. Geographical area is complicated by the interrelationship between the Guidelines area factors, which are based on billed charges, and provider discounts. This relationship is explored further in a later section of this report where we look at a total of 30 different markets including Trenton.

Group size. For group size, we considered two elements. The first is the expense factor as described previously. Second, we also considered adverse selection loadings that are typically reflected in small group premium rates. While such loads vary considerably in practice, we used 4% as a typical load. This includes the expected effects of more restrictive rating and underwriting requirements under the ACA. Overall, these two elements produce a ratio of 1.105 to the baseline. Note that not all of the elements used in manual rating are allowed in the small group market and others that are allowed are restricted.

⁵ Platinum plans are expected to insure 90% of health costs while the patient remains responsible for 10%. Gold plans are expected to insure 80%. These are based on ACA actuarial value, a discussion of which is beyond the scope of this paper.

Industry/occupation. Not all insurers use industry factors in their rating processes and industry factors are not allowed in the small group market. Further, in our experience, the factors used are not very consistent from insurer to insurer. However, it is not uncommon to see factors as low as 0.9 for industries with below-average claims morbidity or as high as 1.2 for industries with claims morbidity that is higher than average. This produces a ratio of 1.200 from the highest-rated to the baseline. While the industries that are assumed to be high-cost will vary by insurer, examples we have seen include industries as diverse as mining and beauty and barber shops. As noted earlier, the code provides an exception amount for certain plans for employees working in specified high-risk occupations or specified industries. This exception will at least partially mitigate the variability of this element, but only for the specified employees.

Provider discounts. The level of provider discounts relative to their normal billed charges is another significant variable. This can also be affected by the breadth or narrowness of the provider network (narrow networks would be expected to generate greater discounts) and the level of provider competition in a particular geographical area. As noted above, our baseline assumes mid-level discounts as seen nationally. In our experience, high discounts would generate costs a bit more than 15% below the baseline and low discounts would generate costs slightly more than 15% above the baseline. Thus the ratio for provider discounts comes to 1.157 from the highest-cost (lowest provider discounts) to the baseline discounts.

VARIABILITY OF COMBINED AREA AND PROVIDER DISCOUNT FACTORS

For our analysis of the variability of combined factors, we looked at the combination of geographical area and provider discounts. We identified metropolitan statistical areas (MSAs) and non-MSA areas (rural) where the combined effect of geographical area and average provider discounts cause the expected premium, all other elements held constant, to exceed the excise tax threshold. We have chosen a variety of market sizes to illustrate that the impact of area is not limited to large geographical areas. There are other areas that could have been chosen. The size of the markets chosen varies from Kokomo, Indiana, with some 70,000, to the New York City metropolitan area with over 12 million. In total, the 30 markets represent almost 36 million individuals under age 65. Note that the geographical area factor by itself is less than 1.0 for some of these areas, but the combination of that below-average area factor and below-average provider discounts causes the premium to exceed the threshold.

In areas where the combined effect of geographical area and average provider discounts cause the expected premium, all other elements held constant, to exceed the excise tax threshold, two things happen. First, the threshold is exceeded even for the baseline plan benefits without any increased benefit level. Second, if an age/gender adjustment is generated, it will be inadequate because the adjustment is defined as a dollar amount rather than a percentage adjustment or ratio.

Our analysis used geographical area factors by MSA from the 2014 Health Cost Guidelines discussed earlier. The factors adjust for both utilization and cost by area. The provider discounts by MSA used were the averages from the 2013 version of a Milliman proprietary database.

There are two important things to note about this analysis. First, we have only identified some areas where the combined geographical area and average provider discount cause the threshold to be

exceeded, which is just due to the location of the employer. There are also many areas where the combined effect of these two factors is to make it unlikely that the threshold could be exceeded based on location of the employer, no matter how rich the benefit plan. Looking at those areas is beyond the scope of this paper. Second, there are other combinations of elements of premium determination that would also result in the threshold being exceeded even for the baseline benefit plan. The examples we show should be considered illustrative, not exhaustive. In all, we have shown results for a total of 30 markets in 16 states. Appendix C shows the population under age 65 for the 30 markets chosen.

Figures 3 to 5 show the amount of premium that would exceed the threshold and thereby be taxable for each MSA and non-MSA area studied based on all of the assumptions described in this report. We have analyzed three different benefit plans. Figure 3 shows the results for the baseline plan, while Figure 4 shows the results for the gold plan and Figure 5 the results for the platinum plan. The impact for the baseline plan varies from a minimal \$15 in Huntington, West Virginia, to a more substantial \$5,759 in San Francisco, California. This is the amount by which the annual threshold is exceeded given all of the assumptions in our analysis. The tax would be 40% of that amount. For the less rich gold plan, many of the areas would not incur the tax, while for the platinum plan the tax for each area would be greater than that for the baseline plan.

FIGURE 3: IMPACT OF GEOGRAPHICAL AREA AND PROVIDER DISCOUNTS (BASELINE PLAN)

Selected MSAs	Primary State	Annual Premium	Threshold	Taxable Portion
Baseline ⁶	National	\$ 9,189	\$ 10,200	\$ -
Anchorage, Alaska	Alaska	\$ 14,848	\$ 10,200	\$ 4,648
Modesto, Calif.	Calif.	\$ 12,863	\$ 10,200	\$ 2,663
Oakland-Hayward-Berkeley, Calif.	Calif.	\$ 13,815	\$ 10,200	\$ 3,615
San Diego-Carlsbad, Calif.	Calif.	\$ 12,332	\$ 10,200	\$ 2,132
San Francisco-Redwood City, Calif.	Calif.	\$ 15,959	\$ 10,200	\$ 5,759
San Jose-Sunnyvale-Santa Clara, Calif.	Calif.	\$ 12,811	\$ 10,200	\$ 2,611
Pocatello, Idaho	Idaho	\$ 10,869	\$ 10,200	\$ 669
Bloomington, Ill.	Ill.	\$ 10,786	\$ 10,200	\$ 586
Indianapolis-Carmel-Anderson, Ind.	Ind.	\$ 10,737	\$ 10,200	\$ 537
Kokomo, Ind.	Ind.	\$ 11,144	\$ 10,200	\$ 944
Muncie, Ind.	Ind.	\$ 10,589	\$ 10,200	\$ 389
Duluth, Minn.-Wis.	Minn.	\$ 10,432	\$ 10,200	\$ 232
Minneapolis-St. Paul, Minn.-Wis.	Minn.	\$ 10,564	\$ 10,200	\$ 364
Omaha-Council Bluffs, Neb.-Iowa	Neb.	\$ 11,036	\$ 10,200	\$ 836
Atlantic City-Hammonton, N.J.	N.J.	\$ 13,355	\$ 10,200	\$ 3,155
Trenton, N.J.	N.J.	\$ 11,662	\$ 10,200	\$ 1,462
New York-Jersey City, N.Y.-N.J.	N.Y.	\$ 11,385	\$ 10,200	\$ 1,185
Dayton, Ohio	Ohio	\$ 10,479	\$ 10,200	\$ 279
Eugene, Ore.	Ore.	\$ 10,615	\$ 10,200	\$ 415
Medford, Ore.	Ore.	\$ 11,387	\$ 10,200	\$ 1,187
Salem, Ore.	Ore.	\$ 10,830	\$ 10,200	\$ 630
Philadelphia, Pa.	Pa.	\$ 12,721	\$ 10,200	\$ 2,521
Charleston-North Charleston, S.C.	S.C.	\$ 13,053	\$ 10,200	\$ 2,853
Kennewick-Richland, Wash.	Wash.	\$ 10,627	\$ 10,200	\$ 427
Non-MSA Area, Wash.	Wash.	\$ 10,957	\$ 10,200	\$ 757
Tacoma-Lakewood, Wash.	Wash.	\$ 12,145	\$ 10,200	\$ 1,945
Milwaukee-Waukesha-West Allis, Wis.	Wis.	\$ 12,491	\$ 10,200	\$ 2,291
Non-MSA Area, Wis.	Wis.	\$ 10,829	\$ 10,200	\$ 629
Wausau, Wis.	Wis.	\$ 11,601	\$ 10,200	\$ 1,401
Huntington-Ashland, W.V.-Ky.-Ohio	W.V.	\$ 10,215	\$ 10,200	\$ 15

⁶ The baseline plan used in figure 3 has the benefit level of the Blue Cross and Blue Shield standard benefit option under the FEHBP.

FIGURE 4: IMPACT OF GEOGRAPHICAL AREA AND PROVIDER DISCOUNTS (GOLD PLAN)

Selected MSAs	Primary State	Annual Premium	Threshold	Taxable Portion
Baseline with Gold Plan Benefits	National	\$ 8,459	\$ 10,200	\$ -
Anchorage, Alaska	Alaska	\$ 13,964	\$ 10,200	\$ 3,764
Modesto, Calif.	Calif.	\$ 12,086	\$ 10,200	\$ 1,886
Oakland-Hayward-Berkeley, Calif.	Calif.	\$ 12,925	\$ 10,200	\$ 2,725
San Diego-Carlsbad, Calif.	Calif.	\$ 11,527	\$ 10,200	\$ 1,327
San Francisco-Redwood City, Calif.	Calif.	\$ 14,995	\$ 10,200	\$ 4,795
San Jose-Sunnyvale-Santa Clara, Calif.	Calif.	\$ 11,964	\$ 10,200	\$ 1,764
Pocatello, Idaho	Idaho	\$ 10,063	\$ 10,200	\$ -
Bloomington, Ill.	Ill.	\$ 9,969	\$ 10,200	\$ -
Indianapolis-Carmel-Anderson, Ind.	Ind.	\$ 9,904	\$ 10,200	\$ -
Kokomo, Ind.	Ind.	\$ 10,320	\$ 10,200	\$ 120
Muncie, Ind.	Ind.	\$ 9,844	\$ 10,200	\$ -
Duluth, Minn.-Wis.	Minn.	\$ 9,696	\$ 10,200	\$ -
Minneapolis-St. Paul, Minn.-Wis.	Minn.	\$ 9,804	\$ 10,200	\$ -
Omaha-Council Bluffs, Neb.-Iowa	Neb.	\$ 10,231	\$ 10,200	\$ 31
Atlantic City-Hammonton, N.J.	N.J.	\$ 12,583	\$ 10,200	\$ 2,383
Trenton, N.J.	N.J.	\$ 10,832	\$ 10,200	\$ 632
New York-Jersey City, N.Y.-N.J.	N.Y.	\$ 10,632	\$ 10,200	\$ 432
Dayton, Ohio	Ohio	\$ 9,705	\$ 10,200	\$ -
Eugene, Ore.	Ore.	\$ 9,871	\$ 10,200	\$ -
Medford, Ore.	Ore.	\$ 10,616	\$ 10,200	\$ 416
Salem, Ore.	Ore.	\$ 10,067	\$ 10,200	\$ -
Philadelphia, Pa.	Pa.	\$ 11,917	\$ 10,200	\$ 1,717
Charleston-North Charleston, S.C.	S.C.	\$ 12,115	\$ 10,200	\$ 1,915
Kennewick-Richland, Wash.	Wash.	\$ 9,804	\$ 10,200	\$ -
Non-MSA Area, Wash.	Wash.	\$ 10,184	\$ 10,200	\$ -
Tacoma-Lakewood, Wash.	Wash.	\$ 11,349	\$ 10,200	\$ 1,149
Milwaukee-Waukesha-West Allis, Wis.	Wis.	\$ 11,651	\$ 10,200	\$ 1,451
Non-MSA Area, Wis.	Wis.	\$ 10,050	\$ 10,200	\$ -
Wausau, Wis.	Wis.	\$ 10,849	\$ 10,200	\$ 649
Huntington-Ashland, W.V.-Ky.-Ohio	W.V.	\$ 9,435	\$ 10,200	\$ -

FIGURE 5: IMPACT OF GEOGRAPHICAL AREA AND PROVIDER DISCOUNTS (PLATINUM PLAN)				
Selected MSAs	Primary State	Annual Premium	Threshold	Taxable Portion
Baseline with Platinum Plan Benefits	National	\$ 9,757	\$ 10,200	\$ -
Anchorage, Alaska	Alaska	\$ 15,588	\$ 10,200	\$ 5,388
Modesto, Calif.	Calif.	\$ 13,491	\$ 10,200	\$ 3,291
Oakland-Hayward-Berkeley, Calif.	Calif.	\$ 14,447	\$ 10,200	\$ 4,247
San Diego-Carlsbad, Calif.	Calif.	\$ 12,964	\$ 10,200	\$ 2,764
San Francisco-Redwood City, Calif.	Calif.	\$ 16,689	\$ 10,200	\$ 6,489
San Jose-Sunnyvale-Santa Clara, Calif.	Calif.	\$ 13,439	\$ 10,200	\$ 3,239
Pocatello, Idaho	Idaho	\$ 11,399	\$ 10,200	\$ 1,199
Bloomington, Ill.	Ill.	\$ 11,370	\$ 10,200	\$ 1,170
Indianapolis-Carmel-Anderson, Ind.	Ind.	\$ 11,337	\$ 10,200	\$ 1,137
Kokomo, Ind.	Ind.	\$ 11,733	\$ 10,200	\$ 1,533
Muncie, Ind.	Ind.	\$ 11,228	\$ 10,200	\$ 1,028
Duluth, Minn.-Wis.	Minn.	\$ 11,079	\$ 10,200	\$ 879
Minneapolis-St. Paul, Minn.-Wis.	Minn.	\$ 11,200	\$ 10,200	\$ 1,000
Omaha-Council Bluffs, Neb.-Iowa	Neb.	\$ 11,664	\$ 10,200	\$ 1,464
Atlantic City-Hammonton, N.J.	N.J.	\$ 14,192	\$ 10,200	\$ 3,992
Trenton, N.J.	N.J.	\$ 12,418	\$ 10,200	\$ 2,218
New York-Jersey City, N.Y.-N.J.	N.Y.	\$ 12,153	\$ 10,200	\$ 1,953
Dayton, Ohio	Ohio	\$ 11,064	\$ 10,200	\$ 864
Eugene, Ore.	Ore.	\$ 11,186	\$ 10,200	\$ 986
Medford, Ore.	Ore.	\$ 11,976	\$ 10,200	\$ 1,776
Salem, Ore.	Ore.	\$ 11,364	\$ 10,200	\$ 1,164
Philadelphia, Pa.	Pa.	\$ 13,494	\$ 10,200	\$ 3,294
Charleston-North Charleston, S.C.	S.C.	\$ 13,745	\$ 10,200	\$ 3,545
Kennewick-Richland, Wash.	Wash.	\$ 11,125	\$ 10,200	\$ 925
Non-MSA Area, Wash.	Wash.	\$ 11,485	\$ 10,200	\$ 1,285
Tacoma-Lakewood, Wash.	Wash.	\$ 12,788	\$ 10,200	\$ 2,588
Milwaukee-Waukesha-West Allis, Wis.	Wis.	\$ 13,206	\$ 10,200	\$ 3,006
Non-MSA Area, Wis.	Wis.	\$ 11,416	\$ 10,200	\$ 1,216
Wausau, Wis.	Wis.	\$ 12,308	\$ 10,200	\$ 2,108
Huntington-Ashland, W.V.-Ky.-Ohio	W.V.	\$ 10,831	\$ 10,200	\$ 631

Figure 6 shows the amount by which the age/gender adjustment will be inadequate and the additional amount that will be taxable based on the age/gender adjustment for an employer whose employees have the age and gender characteristics of the national education workforce. See Appendix A for a further discussion of the age/gender adjustment. While Huntington, West Virginia, only exceeded the excise tax threshold by \$15 in Figure 3, we see in Figure 6 that the age/gender

adjustment would be inadequate by \$82. In San Francisco, California, the age/gender adjustment would be inadequate by \$969.

FIGURE 6: AGE/GENDER ADJUSTMENT WITH IMPACT OF AREA AND PROVIDER DISCOUNTS				
Selected MSAs	Primary State	Age gender Adjustment	Needed Adjustment	Taxable Portion
Baseline ⁷	National	\$ 1,253	\$ 1,253	\$ -
Anchorage, Alaska	Alaska	\$ 1,253	\$ 2,032	\$ 779
Modesto, Calif.	Calif.	\$ 1,253	\$ 1,695	\$ 442
Oakland-Hayward-Berkeley, Calif.	Calif.	\$ 1,253	\$ 1,827	\$ 574
San Diego-Carlsbad, Calif.	Calif.	\$ 1,253	\$ 1,666	\$ 413
San Francisco-Redwood City, Calif.	Calif.	\$ 1,253	\$ 2,223	\$ 969
San Jose-Sunnyvale-Santa Clara, Calif.	Calif.	\$ 1,253	\$ 1,747	\$ 494
Pocatello, Idaho	Idaho	\$ 1,253	\$ 1,459	\$ 206
Bloomington, Ill.	Ill.	\$ 1,253	\$ 1,491	\$ 237
Indianapolis-Carmel-Anderson, Ind.	Ind.	\$ 1,253	\$ 1,465	\$ 212
Kokomo, Ind.	Ind.	\$ 1,253	\$ 1,502	\$ 249
Muncie, Ind.	Ind.	\$ 1,253	\$ 1,398	\$ 145
Duluth, Minn.-Wis.	Minn.	\$ 1,253	\$ 1,433	\$ 180
Minneapolis-St. Paul, Minn.-Wis.	Minn.	\$ 1,253	\$ 1,461	\$ 208
Omaha-Council Bluffs, Neb.-Iowa	Neb.	\$ 1,253	\$ 1,520	\$ 267
Atlantic City-Hammonton, N.J.	N.J.	\$ 1,253	\$ 1,722	\$ 469
Trenton, N.J.	N.J.	\$ 1,253	\$ 1,574	\$ 321
New York-Jersey City, N.Y.-N.J.	N.Y.	\$ 1,253	\$ 1,545	\$ 292
Dayton, Ohio	Ohio	\$ 1,253	\$ 1,366	\$ 113
Eugene, Ore.	Ore.	\$ 1,253	\$ 1,448	\$ 195
Medford, Ore.	Ore.	\$ 1,253	\$ 1,551	\$ 298
Salem, Ore.	Ore.	\$ 1,253	\$ 1,454	\$ 201
Philadelphia, Pa.	Pa.	\$ 1,253	\$ 1,666	\$ 413
Charleston-North Charleston, S.C.	S.C.	\$ 1,253	\$ 1,756	\$ 503
Kennewick-Richland, Wash.	Wash.	\$ 1,253	\$ 1,414	\$ 161
Non-MSA Area, Wash.	Wash.	\$ 1,253	\$ 1,470	\$ 217
Tacoma-Lakewood, Wash.	Wash.	\$ 1,253	\$ 1,605	\$ 352
Milwaukee-Waukesha-West Allis, Wis.	Wis.	\$ 1,253	\$ 1,763	\$ 510
Non-MSA Area, Wis.	Wis.	\$ 1,253	\$ 1,488	\$ 235
Wausau, Wis.	Wis.	\$ 1,253	\$ 1,651	\$ 398
Huntington-Ashland, W.V.-Ky.-Ohio	W.V.	\$ 1,253	\$ 1,335	\$ 82

⁷ The baseline plan used in Figure 6 has the benefit level of the Blue Cross and Blue Shield standard benefit option under the FEHBP plan.

CAVEATS

The work for this report was performed by Milliman as requested by the National Education Association (NEA). However, the opinions expressed in this paper are those of the authors and not necessarily those of the NEA or other Milliman consultants.

In order to provide the information requested by the NEA, we have used the Milliman Health Cost Guidelines. Differences between the Guidelines and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The results of our analysis are based on our understanding of the excise tax statute. As of this writing, no regulations have been issued related to the statute. To the extent that regulations are promulgated, our work may be subject to change. Milliman is not a law firm. Nothing in this paper should be construed as legal advice. In the event a legal interpretation is required, we recommend review by your legal counsel.

The services provided for this project were performed under the Consulting Services Agreement between Milliman and the NEA effective June 2, 2014.

This work product was prepared for the NEA to assist in the understanding of the factors that drive premium rates for employer-sponsored health insurance plans subject to the ACA excise tax. It may not be appropriate to use for other purposes. Milliman does not intend to benefit and assumes no duty of liability to other parties who receive this work product. Any third-party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs. Any release of this report to a third party shall be in its entirety.

The authors are consulting actuaries for Milliman, are members of the American Academy of Actuaries, and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

APPENDIX A: AGE AND GENDER ADJUSTMENT

There are several issues that we would expect to be clarified by regulation before the implementation of the excise tax. The following is a list of issues we identified in our work and includes the assumptions we made.

- Premium cost: There may be a specific methodology defined in regulations. For our purposes, we have used our standard pricing models adjusted for typical provider discounts and utilization management on a national basis. Our pricing model assumes that an employer's premium and the premium for the national workforce population reflect the best estimate of actuarial risk by age and gender.
- Blue Cross Blue Shield standard benefit option under the Federal Employees Health Benefits Program: We have used the 2014 benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option as found on opm.gov.
- National workforce: We used 2013 annual average labor force statistics from the Current Population Survey (CPS), Employment Status of the Civilian Noninstitutional Population by Age, Sex, and Race, Table 3, as prepared by the U.S. Bureau of Labor Statistics, found here: <http://www.bls.gov/cps/cpsaat03.htm>. We used the total labor force, not just those currently employed.
- Adjustment for employees with coverage other than self-only coverage: We determined the age/gender adjustment in aggregate for all employees based on self-only coverage. We used this adjustment for employees with self-only coverage and applied a 2.70 multiplier (the ratio of \$27,500 to \$10,200) for employees with coverage other than self-only.
- Cost trends: We used long-term health cost trends to trend to 2018 as shown previously in this report.

We find that the adjustment accurately reflects the age and gender characteristics of the employer versus the national labor force and does so equally well in all age and gender combinations, but does so only for employers with average costs. Note that this conclusion is based on the approach taken and the assumptions used in our analysis, which may not be supported by future regulations. Further, this is true only when a full detailed census is available for both the employer and the national labor force. When shortcuts are used such as average age and percentage female versus male, approximations are introduced that can produce adjustments that overcompensate or undercompensate. These discrepancies will vary by the difference between the actual detailed census and the approximations used.

Based on our current interpretation of Section 4980I, the age/gender adjustment is defined as a dollar amount. This is consistent with the fact that the thresholds are expressed as dollar amounts. This approach disadvantages employers with higher-than-average costs, such as those located in high-cost areas, relative to those with lower-than-average costs, such as those located in lower-cost areas. That is, the age/gender adjustment for employers with higher-than-average costs will understate the age and gender impact while the age/gender adjustment will overstate the age and gender impact for employers with lower-than-average costs.

APPENDIX B: BACKGROUND

As noted earlier, the ACA excise tax is scheduled to take effect in 2018. The delay in effective date for the excise tax relative to other provisions of the ACA and other elements of the excise tax were discussed in “The President’s Proposals,” released by the White House on February 22, 2010. This document may be found at: <http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>. Page 8 of this document includes the following concerning the excise tax on high-cost plans:

Part of the reason for high and rising insurance costs is that insurers have little incentive to lower their premiums. The Senate bill includes a tax on high-cost health insurance plans. CBO has estimated that this policy will reduce premiums as well as contribute to long-run deficit reduction. The President’s Proposal changes the effective date of the Senate policy from 2013 to 2018 to provide additional transition time for high-cost plans to become more efficient.

Later in the same paragraph, “The President’s Proposal” states:

To ensure that the tax affects firms equitably, the President’s Proposal reforms it by including an adjustment for firms whose health costs are higher due to the age or gender of their workers...

The U.S. Congressional Budget Office (CBO) position is described on page 8 of a November 30, 2009, letter from Douglas W. Elmendorf, director, to Senator Evan Bayh:

However, CBO and [the Joint Committee on Taxation (JCT)] estimate that most people would avoid the cost of the excise tax by enrolling in plans that had lower premiums; those reductions would result from choosing plans that either pay a smaller share of covered health care costs (which would reduce premiums directly as well as indirectly by leading to less use of covered medical services), manage benefits more tightly, or cover fewer services.

APPENDIX C: TOTAL POPULATION UNDER AGE 65 BY MSA		
Selected MSAs	Primary State	Population in MSA
Anchorage, Alaska	Alaska	354,180
Modesto, Calif.	Calif.	462,871
Oakland-Hayward-Berkeley, Calif.	Calif.	2,260,994
San Diego-Carlsbad, Calif.	Calif.	2,740,554
San Francisco-Redwood City, Calif.	Calif.	1,307,584
San Jose-Sunnyvale-Santa Clara, Calif.	Calif.	1,639,440
Pocatello, Idaho	Idaho	75,485
Bloomington, Ill.	Ill.	166,984
Indianapolis-Carmel-Anderson, Ind.	Ind.	1,675,846
Kokomo, Ind.	Ind.	70,340
Muncie, Ind.	Ind.	99,810
Duluth, Minn.-Wis.	Minn.	237,390
Minneapolis-St. Paul, Minn.-Wis.	Minn.	2,994,618
Omaha-Council Bluffs, Neb.-Iowa	Neb.	769,090
Atlantic City-Hammonton, N.J.	N.J.	235,315
Trenton, N.J.	N.J.	332,138
New York-Jersey City, N.Y.-N.J.	N.Y.	12,090,964
Dayton, Ohio	Ohio	684,882
Eugene, Ore.	Ore.	299,106
Medford, Ore.	Ore.	166,149
Salem, Ore.	Ore.	340,438
Philadelphia, Pa.	Pa.	1,841,032
Charleston-North Charleston, S.C.	S.C.	586,896
Kennewick-Richland, Wash.	Wash.	225,793
Non-MSA Area, Wash.	Wash.	585,519
Tacoma-Lakewood, Wash.	Wash.	701,506
Milwaukee-Waukesha-West Allis, Wis.	Wis.	1,365,409
Non-MSA Area, Wis.	Wis.	1,258,620
Wausau, Wis.	Wis.	108,379
Huntington-Ashland, W.V.-Ky.-Ohio	W.V.	304,338
Total		35,981,670

Note: MSAs are defined by the federal government Office of Management and Budget (OMB) and are current as of February 2013.

All MSAs are defined by county, but some states have independent cities that may be listed separately. Metropolitan Division definitions were used in the 11 areas in which they exist instead of the larger MSA areas.

Population is based on U.S. Census.

Population is compiled by five-digit ZIP Code, not by county. Because ZIP Code boundaries do not conform to county boundaries, population differences with other sources will occur.