Analysis of the Potential Health Impacts of Reducing Ozone Levels in the Ozone Transport Region Using BenMAP – 2021 Edition

Includes data through 2020

Ozone Transport Commission
OTC Modeling Committee
July 2021

Executive Summary

In 2015, the 8-hour ozone National Ambient Air Quality Standard (NAAQS) was lowered to 70 ppb. This was the high end of the range recommended by the Clean Air Scientific Advisory Committee (CASAC) originally and in the rule proposal by Administrator McCarthy. The lower end of the range proposed by EPA was 65 ppb. Additionally, recent research has shown health effects from ozone occur at even lower levels. Given that health effects could be caused at levels closer to what is considered background we decided to also look at 40 ppb which close to a level considered to be United States Background (USB). As a result, three levels of ozone were investigated in this analysis: 70 ppb, 65 ppb, and 40 ppb.

Each year that air quality does not meet the NAAQS the health of the individuals exposed to the poor air quality are impacted. The Ozone Transport Commission (OTC) began examining the potential health impacts of these levels of exposure starting in 2011 and as of this writing 2020 is the most recent year for which data is available. As a result, the analysis will focus on each ozone season for which data has been processed, 2011-2020, with the intention of adding new information annually.

Several states in the Ozone Transport Region (OTR) exceed the NAAQS set by the Environmental Protection Agency (EPA), which were set to a level to adequately protect the public health. This implies that individuals in the OTR would receive a health benefit if the entire OTR were to meet the NAAQS. Additionally, even more monitors have ozone values above the other thresholds discussed.

This paper looks at the benefits that would have occurred each year from 2011-2020, using monitored data had the entire OTR met ozone levels of 70 ppb, 65 ppb, and 40 ppb as estimated using health benefit and economic functions that came from peer reviewed sources employed by EPA in many studies processed with BenMAP. 2020 data should be particularly noted since it covers periods when emission reductions due to the COVID-19 health emergency occurred.

It was estimated that approximately 600 – 2,400 individuals would have not died prematurely each year between 2011-2019 had the OTR attained a level that met the 70 ppb Ozone NAAQS with even more individuals that would not have died if ozone levels were even lower. In, 2020 about 80 individuals would not have died prematurely had the OTR attained a level that met the 70 ppb Ozone NAAQS, though given the emission reductions were due to the impact of the COVID-19 health emergency, this small co-benefit does not outweigh the great loss of life experienced by many in the OTR.

As a point comparison in 2014 about 2,600 people died of homicide in the OTR and all of Virginia, 1,500 of HIV/AIDS, and 1,300 of Hepatitis C, which places deaths from ozone exposure among other notable health issues.

Additionally, it was estimated that there would have been economic benefit to the OTR in the range of $5-19 billion in all health impacts from reducing ozone to 70 ppb in more typical years.

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Introduction

In 2015, the 8-hour ozone National Ambient Air Quality Standard (NAAQS) was lowered to 70 ppb.[1] This was the high end of the range recommended by the Clean Air Scientific Advisory Committee (CASAC) originally and in the rule proposal by Administrator McCarthy. The lower end of the range proposed by the Environmental Protection Agency (EPA) was 65 ppb. Additionally, recent research has shown health effects from ozone occur at even lower levels.[2] Given that health effects could be caused at levels closer to what is considered background we decided to also look at 40 ppb which is close to a level considered to be United States Background (USB). As a result, three levels of ozone were investigated in this analysis: 70 ppb, 65 ppb, and 40 ppb.

Each year that air quality does not meet the NAAQS the health of the individuals exposed to the poor air quality are impacted. The Ozone Transport Committee (OTC) began examining the potential health impacts of these levels of exposure starting in 2011 and as of writing 2020 is the most recent year for which data is available. As a result, the analysis will focus on each ozone season for which data has been processed, 2011-2020, with the intention of adding new information annually.

Several states in the Ozone Transport Region (OTR) had monitored design values that were above the NAAQS set by EPA. Given that the primary NAAQS are set to a level to adequately protect the public health, this implies that the population of the OTR would receive a health benefit if the entire OTR were to meet the NAAQS. This paper looks at the benefits that would have occurred each year from 2011-2020 had the entire OTR met ozone levels of 70 ppb, 65 ppb, and 40 ppb as estimated by the Environmental Benefits Mapping and Analysis Program (BenMAP) Community Edition (CE) program.[3]

Methods

Overview of the Health Impact Functions

BenMAP CE v1.4.1.14 was employed to process the health impact functions. These functions are developed to calculate the change in health incidence for a given population due to a change in air quality. The health impact functions typically consist of four variables: change in air quality, population, baseline incidence rate, and effect estimates that are drawn from epidemiological literature. The health impact functions used in the analysis were all functions provided in the downloadable version of BenMAP CE. The typical health impact function (Δy) is log-linear as follows:

$$\Delta y = y_0(e^{\beta\Delta q}-1)pop$$

where y_0 is the baseline incidence rate, β is the effect estimate, Δq is the change in air quality, and pop is the population.

Change in Air Quality - Rollback

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[1] US EPA, "2015 National Ambient Air Quality Standards for Ozone."
[2] Di et al., "Air Pollution and Mortality in the Medicare Population."
[3] US EPA, "Environmental Benefits Mapping and Analysis Program – Community Edition: User's Manual."

Monitored ozone data were obtained throughout the entire OTR and the states that border the region (Ohio, West Virginia, and the remainder of Virginia) for 2011-2020 from the Air Quality System (AQS) monitor network and the data was originally compiled by staff at the Maine Department of Environmental Protection. The Voronoi Neighborhood Averaging (VNA) inverse distance interpolation squared technique was used to interpolate to grid cells between monitors to the OTC 2011 based modeling platform CMAQ grid[4]. The bordering states were included so that the VNA would not result in inappropriate values along the western and southern borders of the OTR. Monitored ozone data was not available from Canada, so VNA may create unexpected results along the northern border, but exceedances are less common in that region so the monitors would not be rolled back anyway.

To avoid high levels recorded at mountain top monitors leading to unrealistic estimates of reductions in rural areas, several monitors (Cadillac Mountain: 230090102, Mt Washington: 330074001, Whiteface Mountain: 360310002, and Shenandoah Big Meadows: 511130003) were removed from the data.

Annual ozone season data was imported, but in many cases monitors only are operated during a shorter time period when conditions are conducive to ozone formation as defined in federal regulations (see Table 1). Furthermore, BenMAP requires that certain thresholds be met for the data at a particular monitor to be considered acceptable. The default time spans for data to be considered are too stringent since several monitors with 4th high 8-hour ozone values above 70 ppb would be excluded so the time span of May 1 – September 30 was used, with a requirement for 50% valid days.

Since exceedances do occur outside of the May to September window, but within the ozone monitoring season in Table 1 there are a few instances when an exceeding monitor will not be rolled back because though there are four or more exceedances during the full ozone season, but fewer than four exceedances between May 1 and September 30. The default start and end hours were also used.

4th high 8-hour ozone data for each year can be seen in Figure 1 though Figure 10. Data for the 27 monitors in the OTR based on that had 4th high 8-hour ozone data that exceeded in either 2019 or 2020 can be seen in Table 2 and the 4th high 8-hour ozone data for each monitor that exceeded in 2019 or 2020 is in Figure 11. It should be noted that only eight monitors exceeded 70 ppb in 2020.

Data for the 37 monitors in the OTR based on that had design values that exceeded in either 2017-19 or 2018-20 can be seen in Table 3 and the design value data for each monitor that exceeded in 2017-19 or 2018-20 is in Figure 12. The lower ozone levels in 2020 resulted in the number of monitors with 2018 to 2020 design values decreasing to 19.

Table 1: Ozone monitoring season requirements (40 CFR 58 Appendix D (4)(i))

State	Start Date	End Date	State	Start Date	End Date
Connecticut	March 1	September 30	New Jersey	March 1	October 31
Delaware	March 1	October 31	New York	March 1	October 31
District of Columbia	March 1	October 31	Pennsylvania	March 1	October 31
Maine	April 1	September 30	Rhode Island	March 1	September 30
Maryland	March 1	October 31	Vermont	April 1	September 30
Massachusetts	March 1	September 30	Virginia	March 1	October 31
New Hampshire	March 1	September 30			

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[4] Ozone Transport Commission, *Technical Support Document for the 2011 Ozone Transport Commission/Mid-Atlantic Northeastern Visibility Union Modeling Platform - 2nd Revision*.

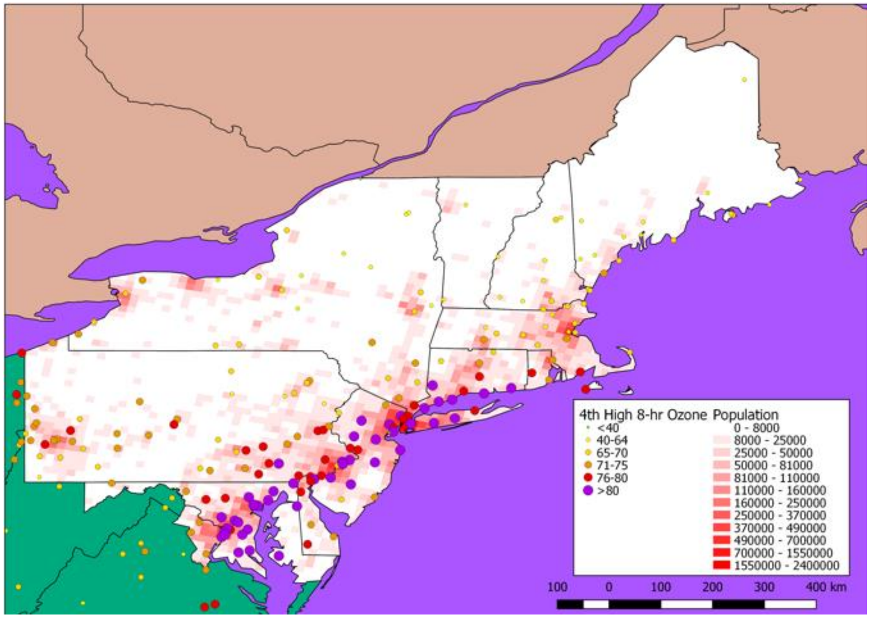

Figure 1: 4th high monitored 8-hour ozone (ppb) values and population for 2011

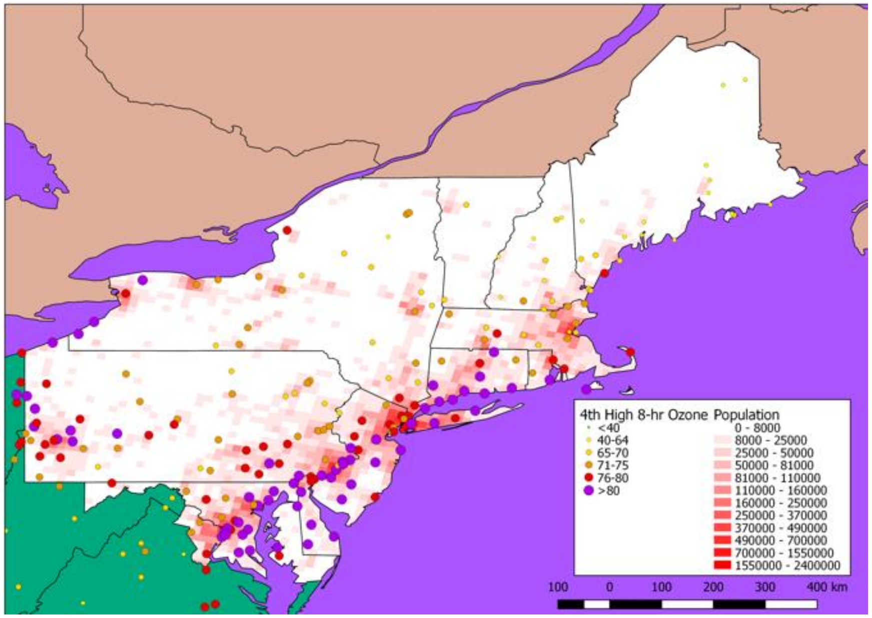

Figure 2: 4th high monitored 8-hour ozone (ppb) values and population for 2012

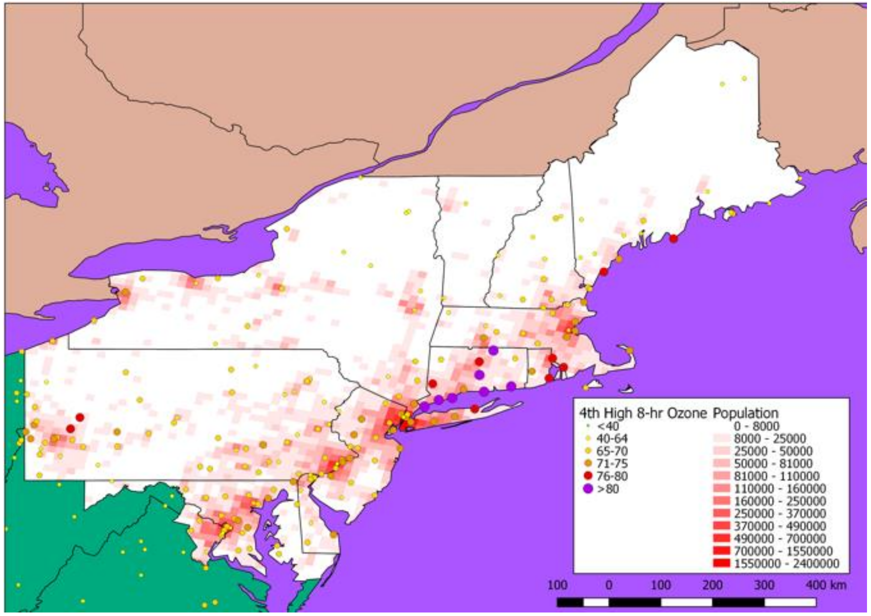

Figure 3: 4th high monitored 8-hour ozone (ppb) values and population for 2013

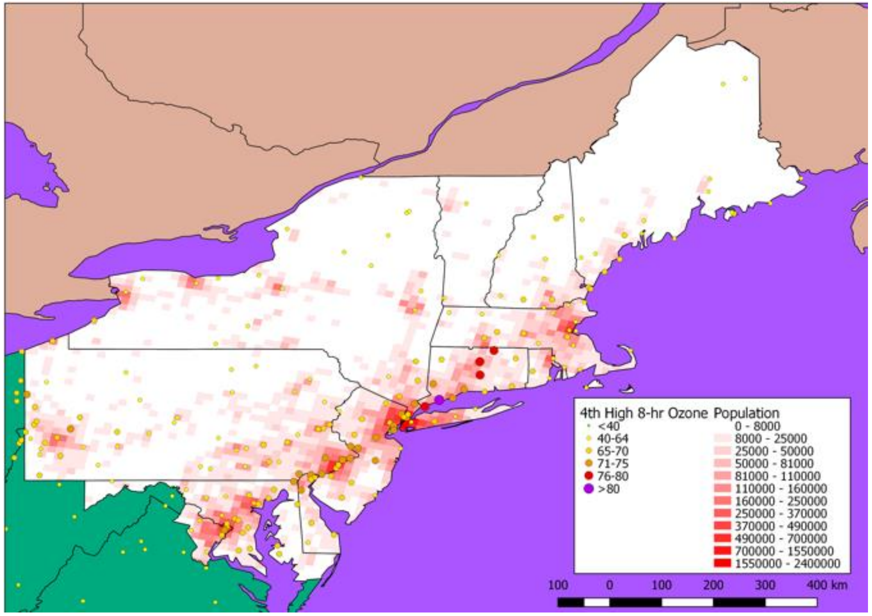

Figure 4: 4th high monitored 8-hour ozone (ppb) values and population for 2014

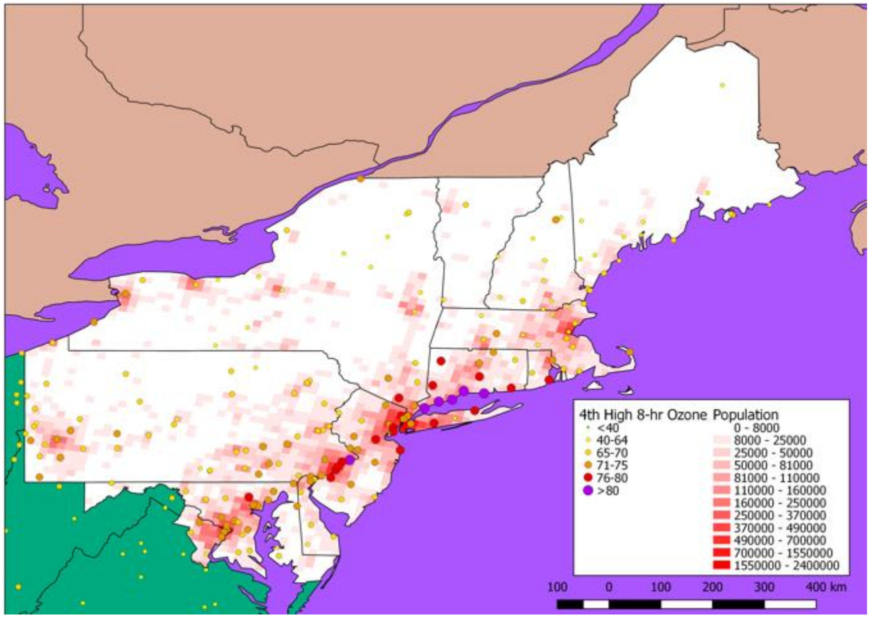

Figure 5: 4th high monitored 8-hour ozone (ppb) values and population for 2015

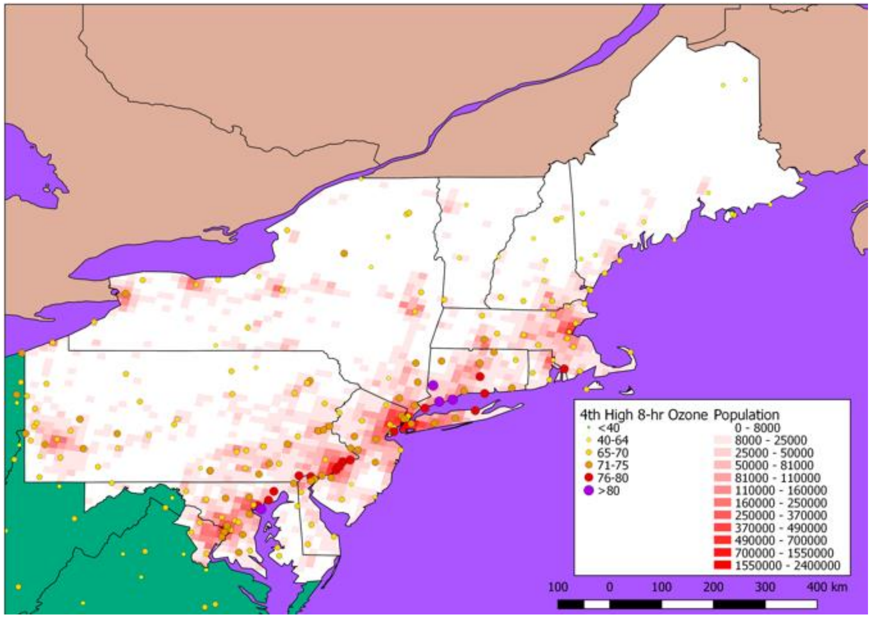

Figure 6: 4th high monitored 8-hour ozone (ppb) values and population for 2016

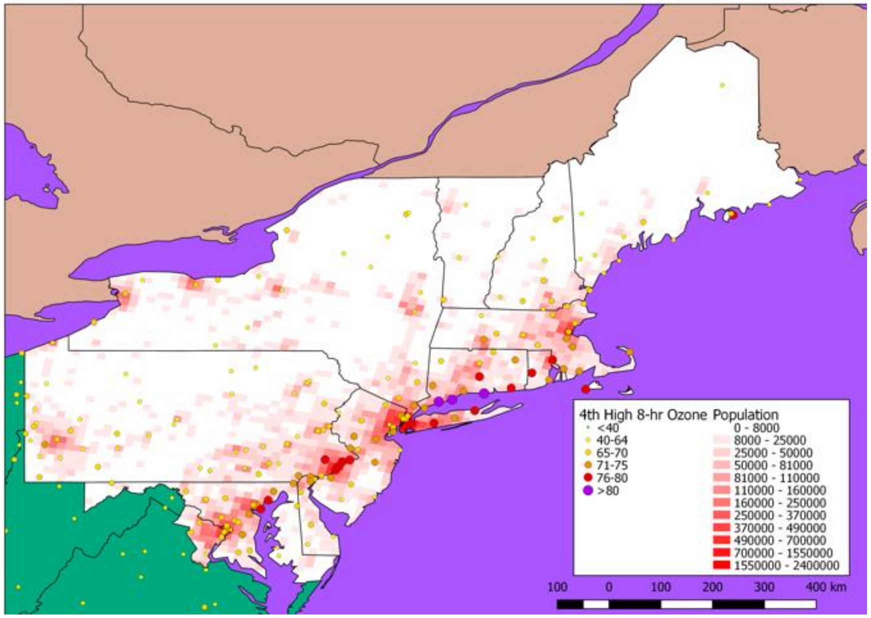

Figure 7: 4th high monitored 8-hour ozone (ppb) values and population for 2017

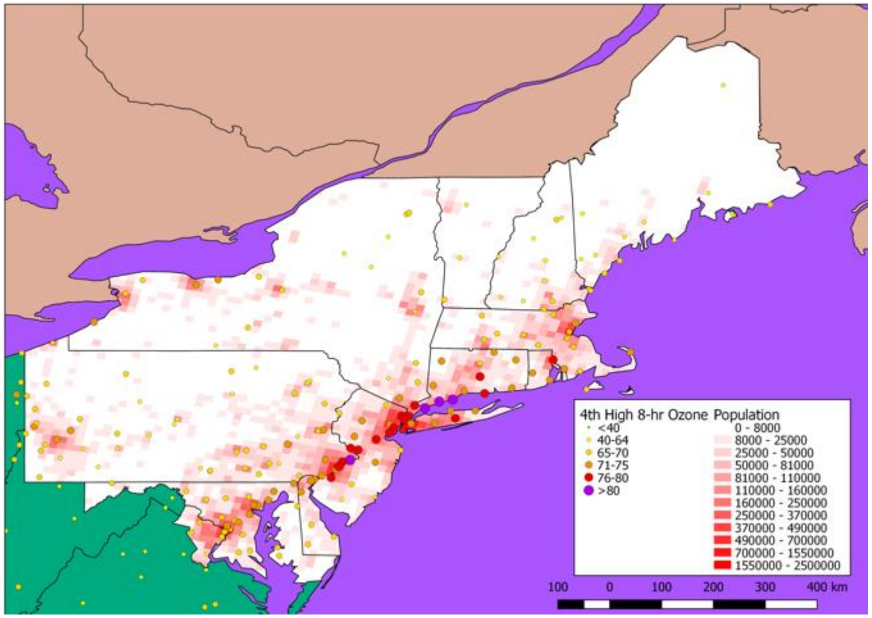

Figure 8: 4th high monitored 8-hour ozone (ppb) values and population for 2018

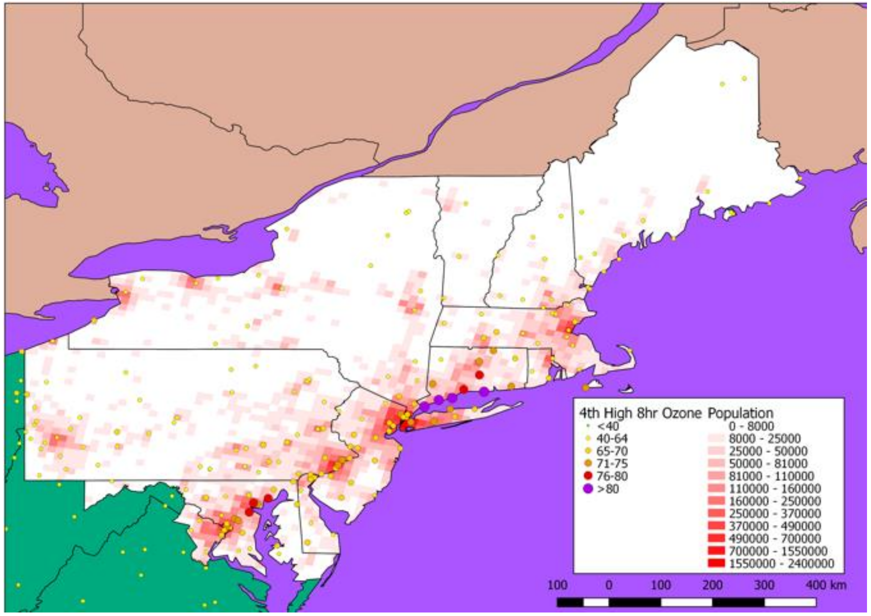

Figure 9: 4th high monitored 8-hour ozone (ppb) values and population for 2019

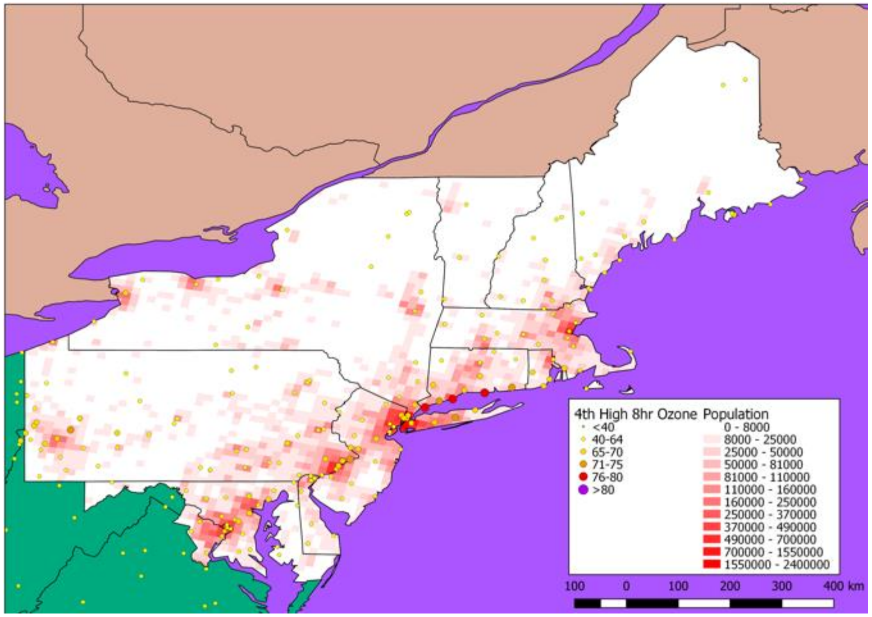

Figure 10: 4th high monitored 8-hour ozone (ppb) values and population for 2020

Table 2: 4th highest 8-hour ozone concentrations from 2011 – 2020 (ordered by 2019 Concentrations)

	State	Site Name	AQS Code	4th Highest 8-hr Ozone Concentrations (ppb)									
				2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1	CT	Greenwich	90010017	81	88	82	78	84	79	74	86	84	77
2	CT	Madison-comb.	90099002	92	90	85	69	81	80	86	77	84	80
3	CT	Stratford	90013007	87	90	90	74	86	83	81	83	82	76
4	CT	Westport	90019003	87	89	86	81	87	81	81	84	81	73
5	CT	New Haven-B	90090027	80	81	75	72	81	75	75	72	78	68
6	MD	Edgewood	240251001	98	86	72	67	74	77	76	74	77	67
7	CT	Middletown-comb.	90079007	80	81	82	80	78	80	79	77	76	69
8	MD	Furley E.S.Rec Center	245100054	82	71	63	60	72	67	69	74	76	
9	MD	Glen Burnie	240031003						74	73	75	76	66
10	CT	Groton Fort Griswold	90110124	82	87	85	65	77	75	78	74	75	71
11	MD	Beltsville	240339991	84	84	72	69	67	70	70	73	75	65
12	MD	Essex	240053001	85	83	67	68	72	78	71	71	74	62
13	CT	Stafford	90131001	68	83	81	77	72	72	70	71	73	63
14	NY	Flax Pond	361030044								74	73	
15	CT	Danbury	90011123	83	84	76	74	79	81	72	75	72	67
16	CT	East Hartford	90031003	74	77	77	77	75	72	70	67	72	64
17	NY	Babylon	361030002	89	83	72	66	78	73	77	74	72	69
18	PA	NEW	421010048				68	78	76	76	76	72	67
19	DC	McMillan	110010043	85	87	66	68	72	72	71	73	71	63
20	MA	Martha's Vineyard	250070001	78	82	65	59		66	76	68	71	60
21	MD	HU-Beltsville	240330030	83	79	68	65	72	70	69	70	71	64
22	NJ	Leonia	340030006	82	76	74	73	76	73	74	79	71	66
23	NY	NYC-Queens	360810124	84	82	71	63	73	71	79	73	71	68
24	PA	NEA	421010024	89	85	68	72	79	80	76	79	71	70
25	NY	Suffolk County-comb.	361030009	82	79	74	62	63	73	71	76	68	73
26	PA	Bristol	420170012	81	82	73	71	82	80	79	84	67	71
27	PA	Harrison Township-comb.	420031008	80	85	76	71	74	67	66	72	61	71

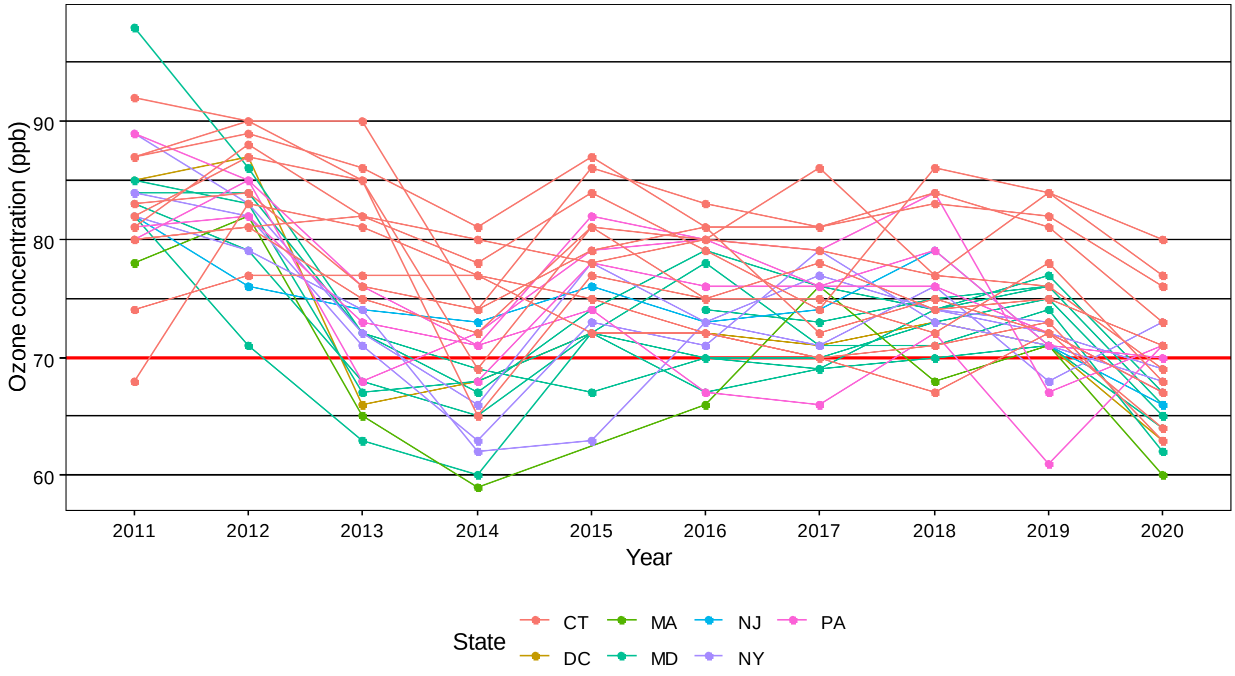

Figure 11: 4th highest 8-hour ozone concentrations (ppb) from 2011 – 2020 for monitors with 2019 or 2020 concentration > 70ppb

Table 3: Design values from 2011 – 2020 (ordered by 2017-19 concentrations)

	State	Site Name	AQS Code	Design Values (ppb)							
				2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20
1	CT	Madison-combined	90099002	89	81	78	76	82	81	82	80
2	CT	Stratford	90013007	89	84	83	81	83	82	82	80
3	CT	Westport	90019003	87	85	84	83	83	82	82	79
4	CT	Greenwich	90010017	83	82	81	80	79	79	81	82
5	CT	Middletown-comb.	90079007	81	81	80	79	79	78	77	74
6	PA	Bristol	420170012	78	75	75	77	80	81	76	74
7	CT	Groton Fort Griswold	90110124	84	79	75	72	76	75	75	73
8	CT	New Haven-B	90090027	78	76	76	76	77	74	75	72
9	MD	Edgewood	240251001	85	75	71	72	75	75	75	72
10	PA	NEA	421010024	80	75	73	77	78	78	75	73
11	MD	GLEN BURNIE	240031003						74	74	72
12	NJ	Leonia	340030006	77	74	74	74	74	75	74	72
13	NY	Babylon	361030002	81	73	72	72	76	74	74	71
14	NY	NYC-Queens	360810124	79	72	69	69	74	74	74	70
15	PA	NEW	421010048				74	76	76	74	71
16	CT	Danbury	90011123	81	78	76	78	77	76	73	71
17	MD	Furley E.S.Rec Center	245100054	72	64		66	69	70	73	
18	NJ	Camden-Spruce St	340070002		73	70	74	77	75	73	69
19	NJ	Rutgers U	340230011	79	74	72	74	75	75	73	70
20	NY	White Plains	361192004	75	75	73	74	73	75	73	71
21	RI	E Providence	440071010	76	73	70	66	70	73	73	69
22	MD	Beltsville	240339991	80	75	69	68	69	71	72	71
23	MD	Essex	240053001	78	72	69	72	73	73	72	69
24	MD	Fair Hill	240150003	82	77	73	74	74	74	72	68
25	NJ	Clarksboro	340150002	84	76	73	73	74	74	72	69
26	NJ	Colliers Mills	340290006	80	75	72	72	73	73	72	68
27	NJ	Wash Crossing	340219991	76	73	71	73	73	74	72	70
28	NY	Riverhead	361030004	80	75	72	72	76	75	72	70
29	CT	Abington	90159991	71	70	68	68	70	71	71	66
30	CT	Stafford	90131001	77	80	76	73	71	71	71	69
31	DC	McMillan	110010043	79	73	68	70	71	72	71	69
32	MA	Martha's Vineyard	250070001	75	68				70	71	66
33	NY	NYBG-Bronx-comb.	360050133	74	71	70	70	70	72	71	71
34	NY	NYC-CCNY	360610135	72	67	66	69	70	72	71	70
35	NY	Suffolk Count-comb.	361030009	78	71			69	73	71	72
36	PA	Norristown	420910013	74	72	71	70	72	72	71	68
37	RI	W Greenwich	440030002	74	70	70	69	72	73	71	67

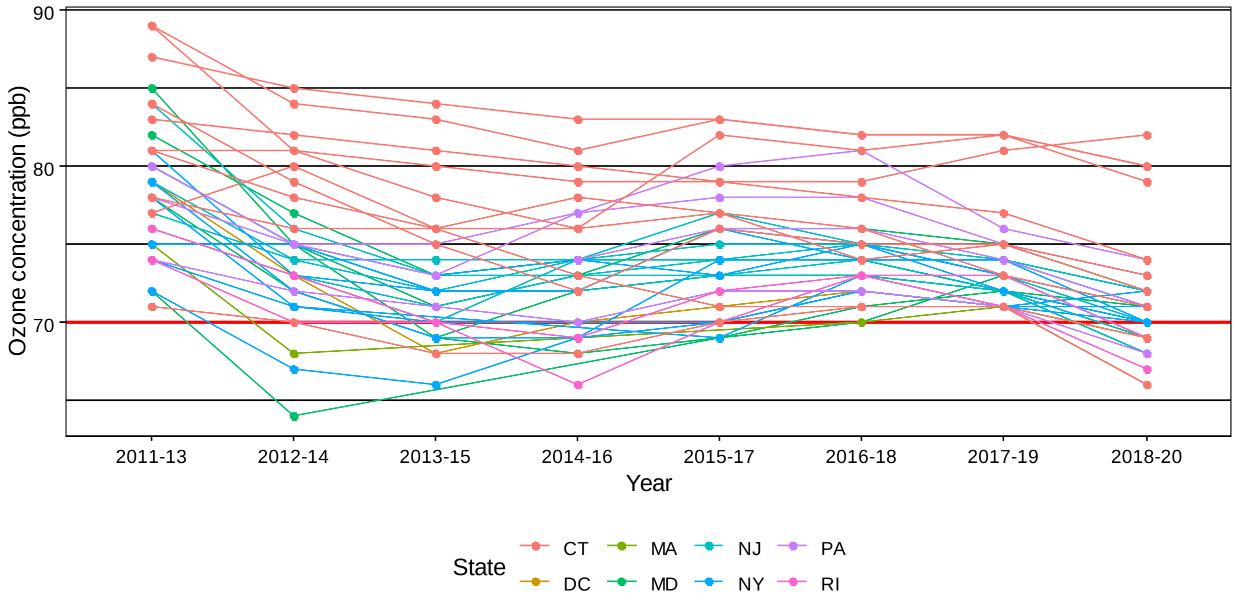

Figure 12: Ozone DV concentrations (ppb) from 2011-13 – 2018-20 for monitors with 2017-20 or 2018-20 DV > 70ppb

After importing each year's monitored ozone data, BenMAP CE was employed to conduct an analysis termed "roll back." In this approach a mathematical technique is used to reduce the ozone values at the monitors so that each meets a threshold, in these cases a 4th highest daily maximum 8-hour ozone average concentration of 70 ppb, 65 ppb, or 40 ppb. Technically to demonstrate compliance with the 8-hour ozone NAAQS, the average of 3 years of the 4th highest daily maximum 8-hour ozone averages is calculated and referred to as a design value (DV). This is necessary since BenMAP CE only accepts one year's air quality data in an analysis. After the "roll back" is complete, the monitor data was then interpolated geographically using an inverse distance weighting technique.

There are three techniques for rolling back the monitored values to the standard: percentage reduction, incremental, and peak shaving that need to be applied to the inter-day and intra-day rollback. The peak shaving technique was employed for the inter-day rollback so values meeting the standard would not have reductions applied, which would result in more conservative results. The percentage technique was employed for the intra-day rollback since it best reflected the implementation of measures that would affect each hour of the day equally.

In conducting the analysis, including a background rate was necessary to prevent monitors from being lowered below what would occur absent anthropogenic emissions. There are a variety of estimates for background, and even several values considered background (e.g., United States Background (USB) and North American Background (NAB)). For this aspect of the modeling a value of 30 ppb was used which is associated with lower levels of NAB found in the Eastern United States in the summertime as was presented in Figure 3-9 of EPA's Integrated Scientific Assessment for the 2015 Ozone NAAQS.[5] Peak shaving was used as the inter-day rollback method and percentage reduction was used as the intra-day rollback method. In both cases 30 ppb was used for the background level.

One potential flaw with the rollback approach is that only monitors that have 4th highest values above 70 ppb were rolled back to the standard. However, in a case where controls are put on to achieve such a monitored level, downwind areas would also have reduced ozone concentrations even though their monitors are already below the standard. As a result, the health effects benefits downwind, in New England in particular, are lower than what would be experienced in a real world scenario.

Population

US population data were based on estimates of population in the corresponding year projected from 2010 block-level US Census data. The geographic extent of population was limited to the population that lives in the 12 full states in the OTR, the District of Columbia and the nine cities/counties in Virginia that are considered part of the OTR. However, not all health incidences are evaluated against the entire population of the OTR, some are evaluated only against sub populations based on age. The total population used for each year and various age cohorts as well as the health endpoint group associated with the age cohort is in **Error! Not a valid bookmark self-reference.**. A similar breakdown by state is available upon request.

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[5] Lin Zhang et al., "Improved Estimate of the Policy-Relevant Background Ozone in the United States Using the GEOS-Chem Global Model with 1/2° × 2/3° Horizontal Resolution over North America"; US EPA, *Integrated Science Assessment for Ozone and Related Photochemical Oxidants*.

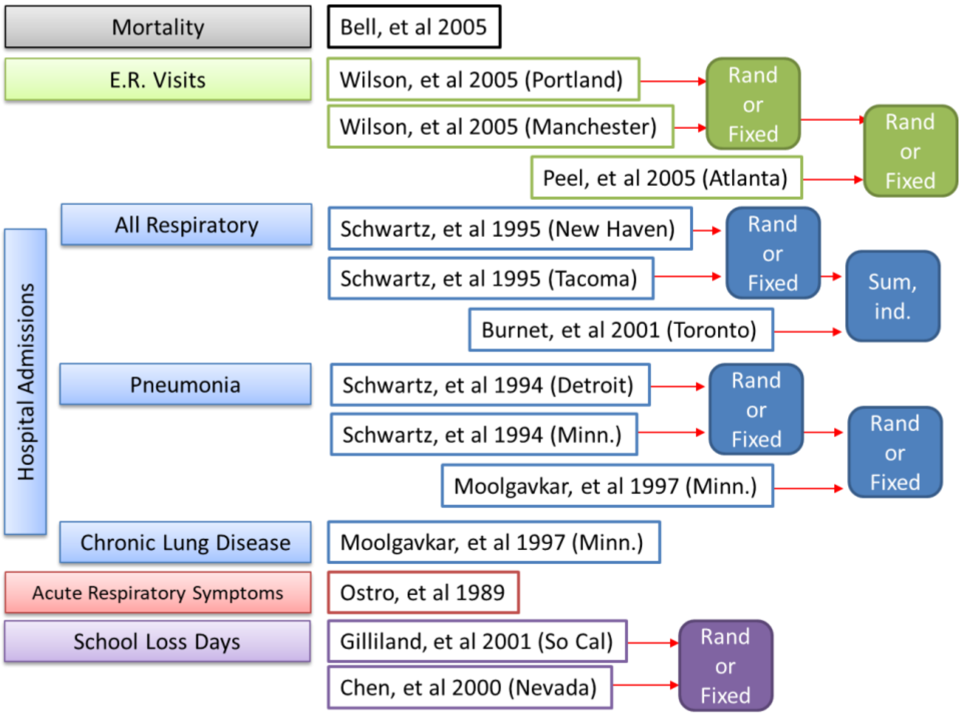
Table 4: Population for each age cohort by year analyzed (millions people)

	Ages	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Mortality											
Mortality, All Causes	*All*	65.8	66.1	66.4	66.6	66.9	67.3	67.7	68.1	68.4	68.8
Emergency Room Visits											
Asthma	*All*	65.8	66.1	66.4	66.6	66.9	67.3	67.7	68.1	68.4	68.8
Hospital Admissions											
All Respiratory	*0-1*	5.3	5.5	5.6	5.8	5.9	6.1	6.2	6.4	6.6	6.7
Chronic Lung Disease	*65+*	9.1	9.5	9.7	10.0	10.3	10.5	10.8	11.1	11.4	11.8
Pneumonia	*65+*	9.1	9.5	9.7	10.0	10.3	10.5	10.8	11.1	11.4	11.8
Acute Respiratory Symptoms											
Minor Restricted Activity Days	*18-64*	42.0	42.0	42.1	42.2	42.2	42.3	42.4	42.4	42.4	42.4
School Loss Days											
School Loss Days, All Causes	*5-17*	10.8	10.7	10.7	10.6	10.5	10.5	10.4	10.4	10.4	10.4

Selection of Health Impact Functions

There is evidence of a relationship between long-term exposure to concentrations of ozone and premature respiratory mortality, which is one of a few studies that detect an increase in mortality from long-term ozone exposure.[6] However there remain questions as to whether long-term mortality has the same direct relationship to ozone exposure as short-term mortality does since this is a newer finding in the literature, so this paper will only examine short-term mortality. Additionally, several functions representing morbidity, including acute respiratory symptoms, respiratory hospital admissions, respiratory emergency room visits, and school loss days, were used, which are functions typically used in EPA studies. The process to aggregate the results of the health studies is in Figure 13.

Figure 13: Aggregation of health effects studies



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[6] Jerrett et al., "Long-Term Ozone Exposure and Mortality."

Baseline Incidence Rates

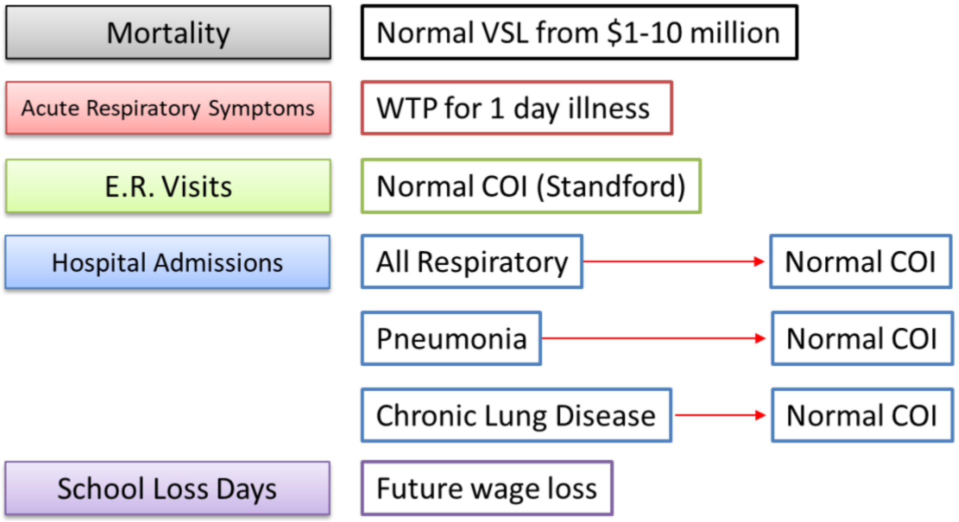
Baseline incidence rates that are part of EPA's dataset were used in this analysis. Incidence rate data sets are not available for every year so selections of which year to use are largely made based on the proximity of the year the incidence data set is for to the year of the monitored data being evaluated. Projections of mortality incidence rates were available in five-year increments and 2015, which coincided with one of the years analyzed, was determined to be the most appropriate data set to use with the mortality health impact functions. Only one incidence data set was available for the other health endpoints so the incidence estimates for 2014 were used for the other health endpoints excepting school loss days where 2000 was the only data set available and acute respiratory systems which has a slightly different form than the other functions, so baseline incidence rates are not included in the equation.

Economic Analysis

In order to quantify the impact of the health benefits the reduced incidence is multiplied by a valuation estimated through one of several techniques. In the case of mortality, the Value of Statistical Life (VSL) based upon a normal distribution was used. The VSL uses differences in salaries and the inherent risk of a job to infer the rate at which life is valued. A Willingness to Pay (WTP) estimate was used to monetize acute respiratory symptoms. WTP relies on survey data to determine how much people value not having an adverse health effect. Cost of Illness (COI) estimates were used to value emergency room visits and hospital admissions. COI totals up the amount spent on medicine, hospital visits, etc. due to an adverse heath effect. Since the VSL is based on hedonic economic analysis it best characterizes the complete value of the effect, with the WTP estimates characterizing less of the true cost, and COI capturing the least of the true cost. The process undertaken to aggregate the economic results are in Figure 14.

Additionally, income effects were adjusted to the year analyzed and all valuations are in 2010 U.S. Dollars, inflated using the Consumer Price Index (CPI) and Employer Costs for Employee Compensation (ECEC).

Figure 14: Aggregation of economic evaluations



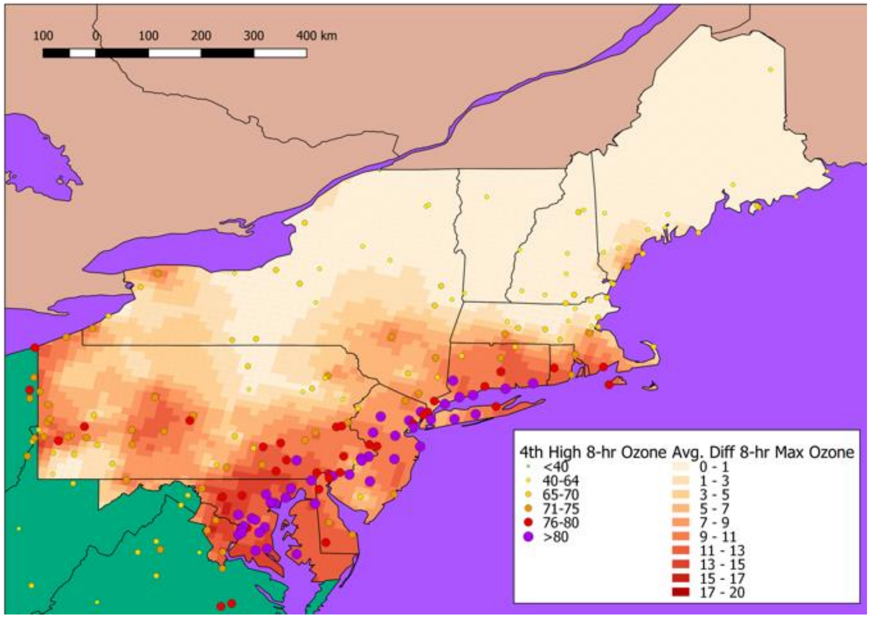


Figure 15: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2011 data

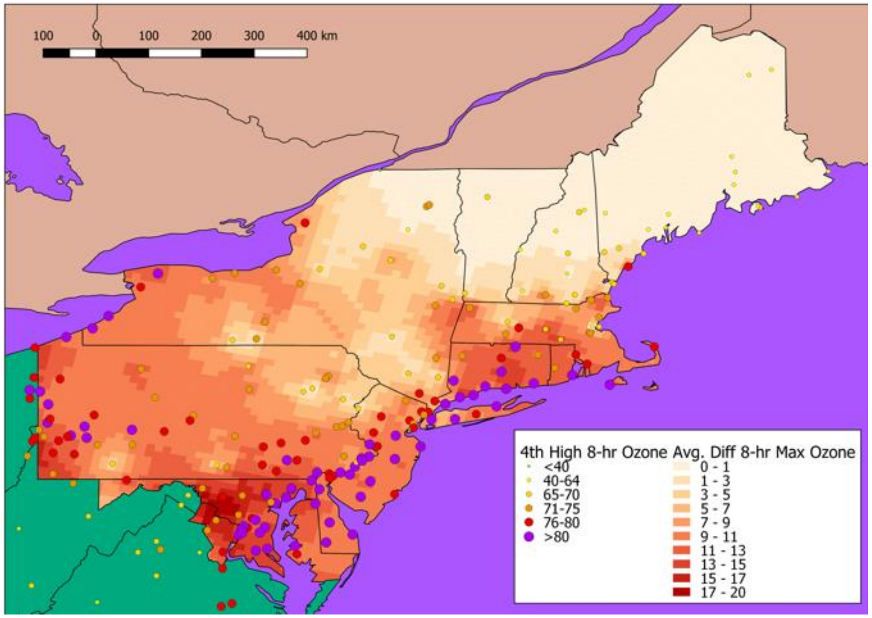


Figure 16: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2012 data

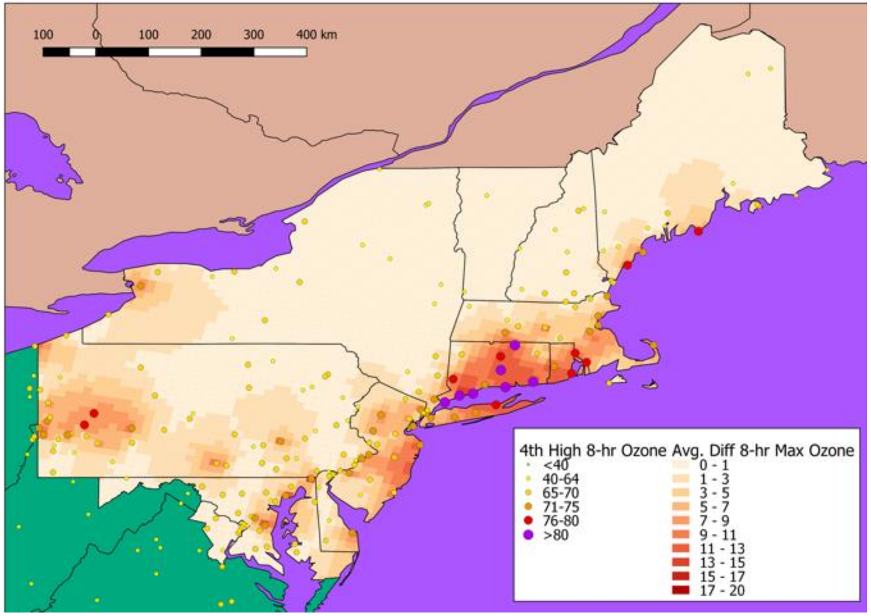


Figure 17: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2013 data

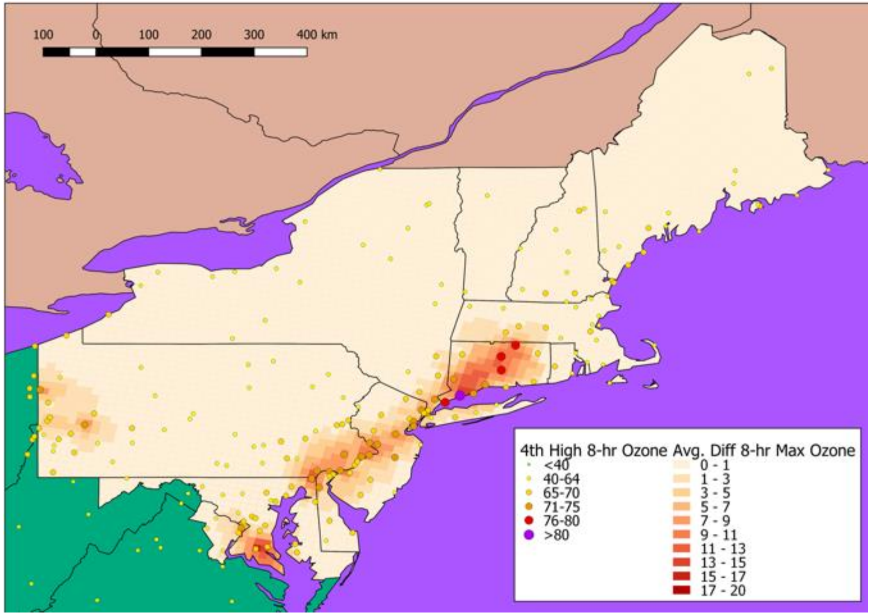


Figure 18: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2014 data

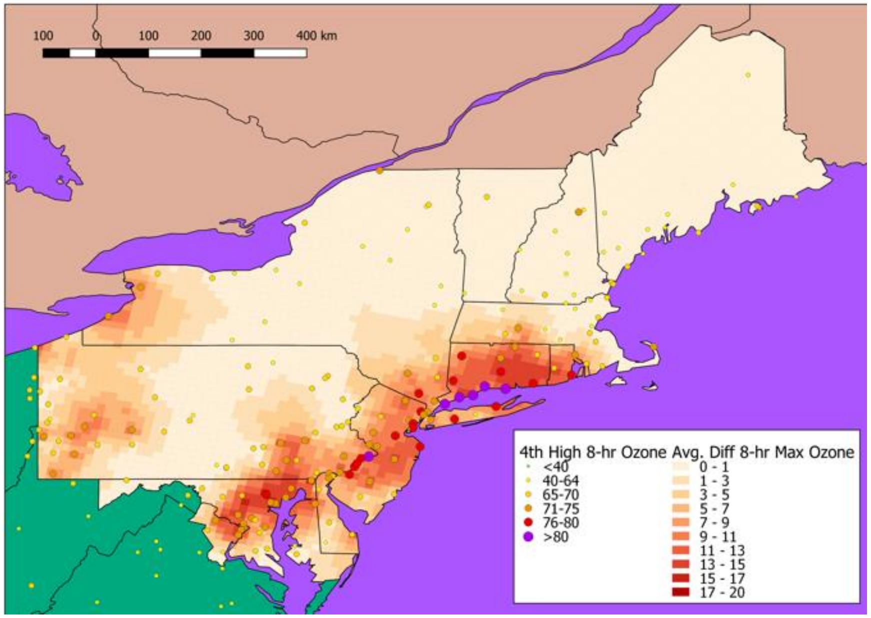


Figure 19: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2015 data

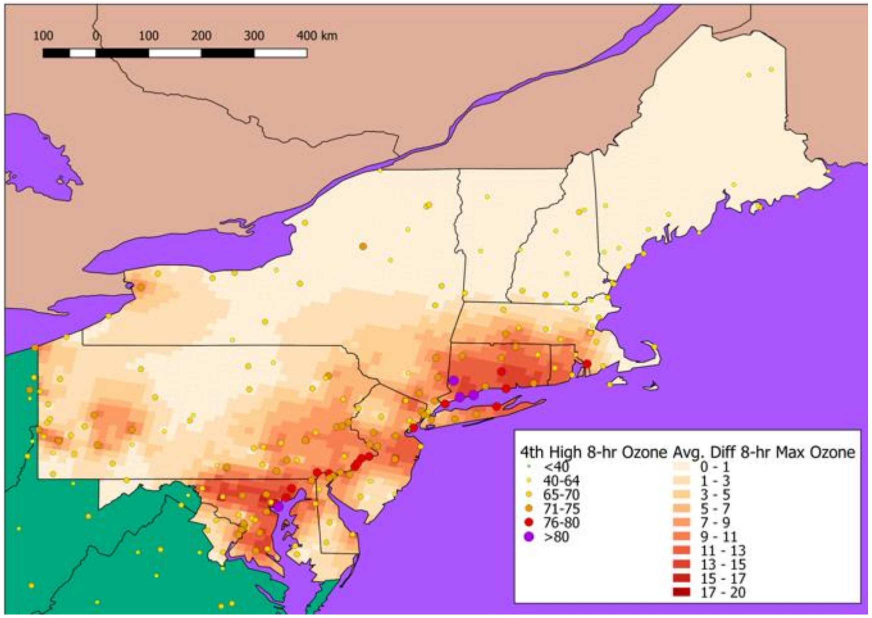


Figure 20: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2016 data

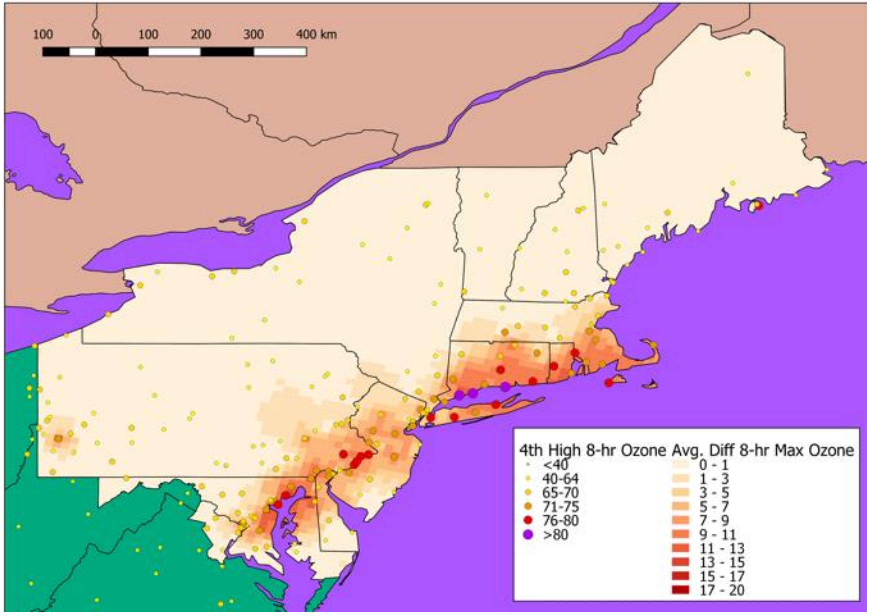


Figure 21: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2017 data

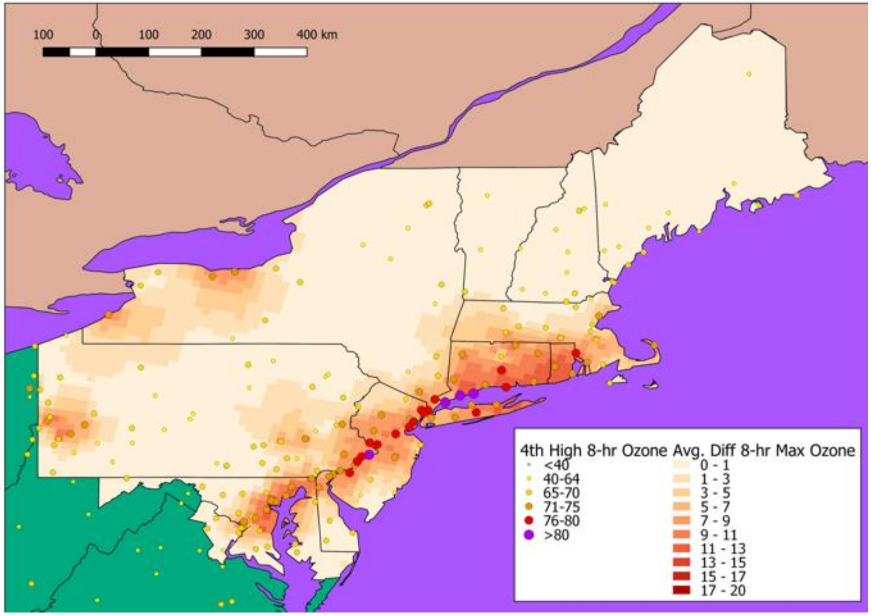


Figure 22: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2018 data

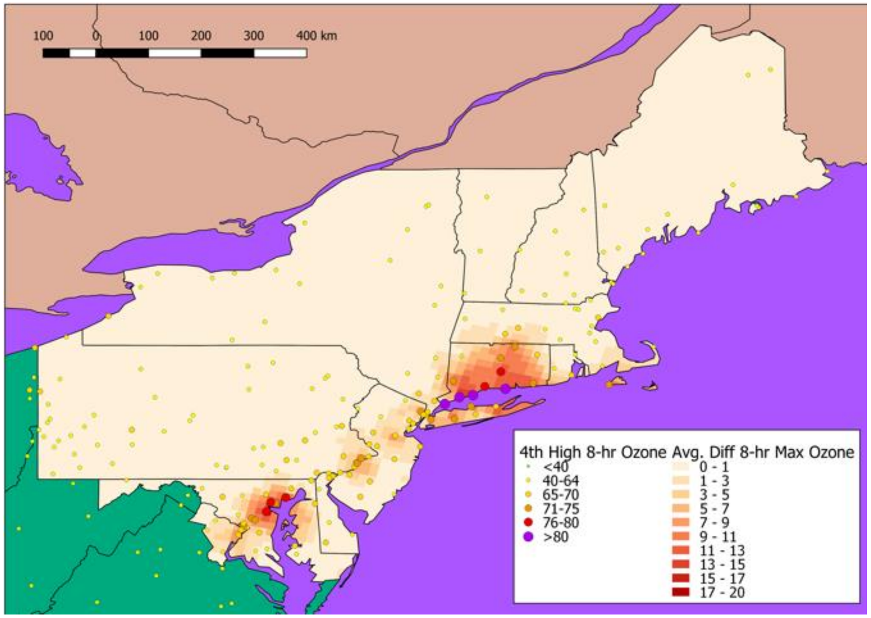


Figure 23: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2019 data

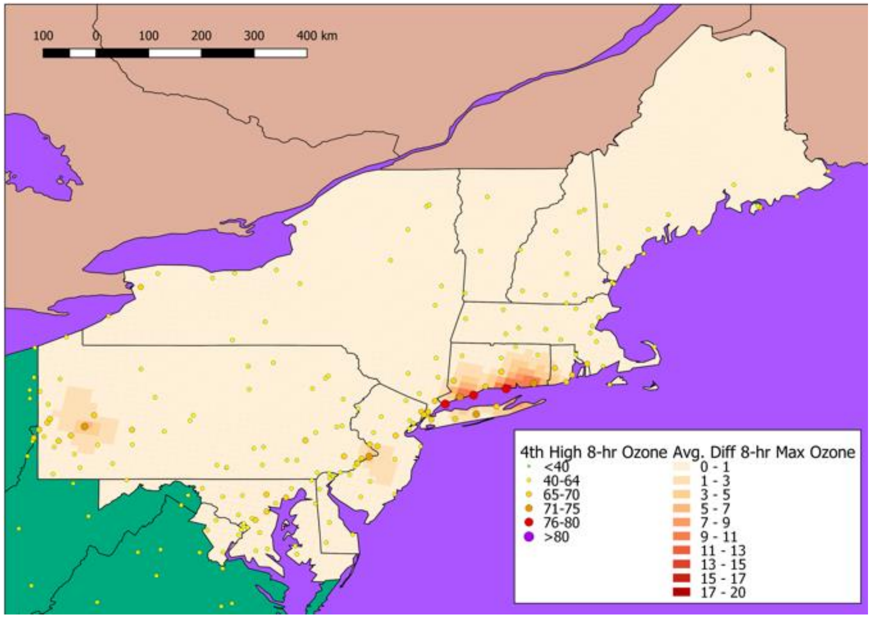


Figure 24: Change in avg. 8-hour max. ozone after roll back to 70ppb using 2020 data

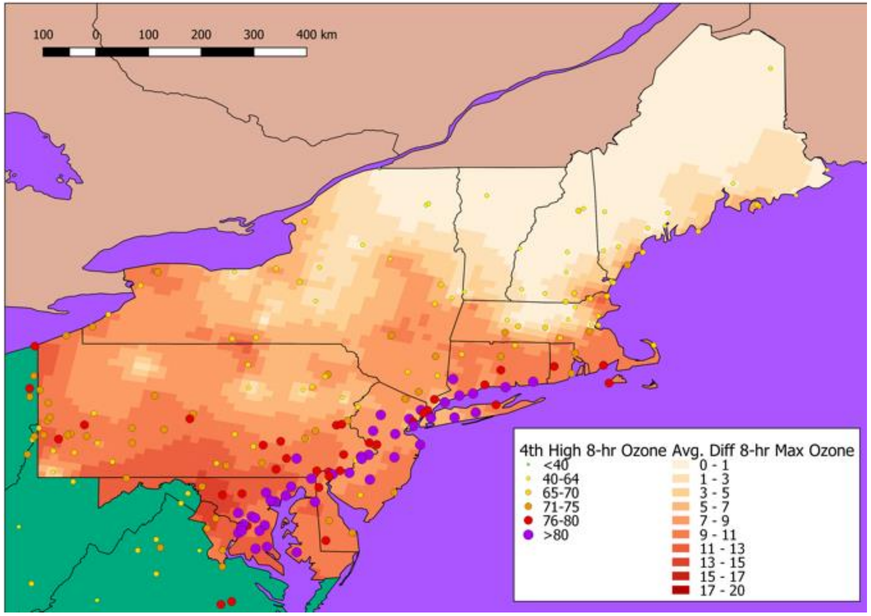


Figure 25: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2011 data

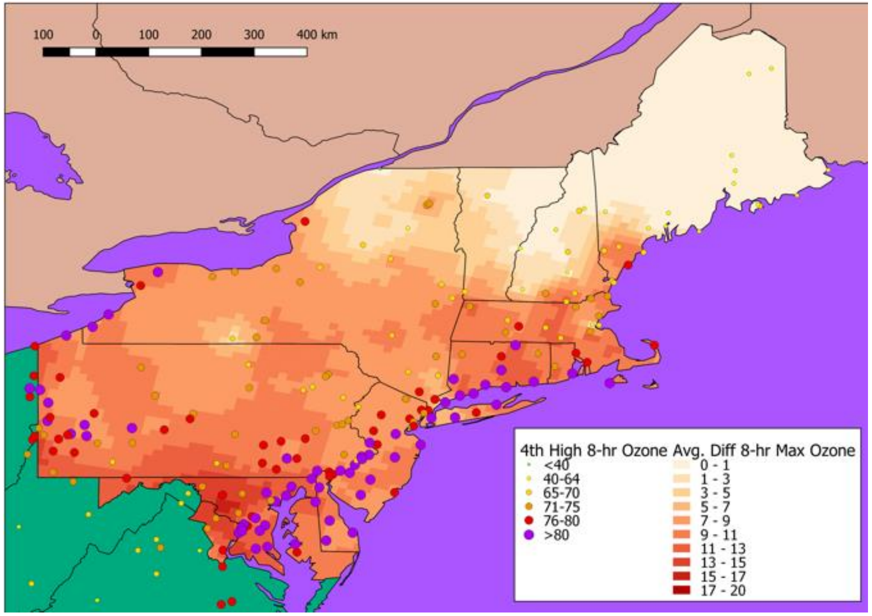


Figure 26: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2012 data

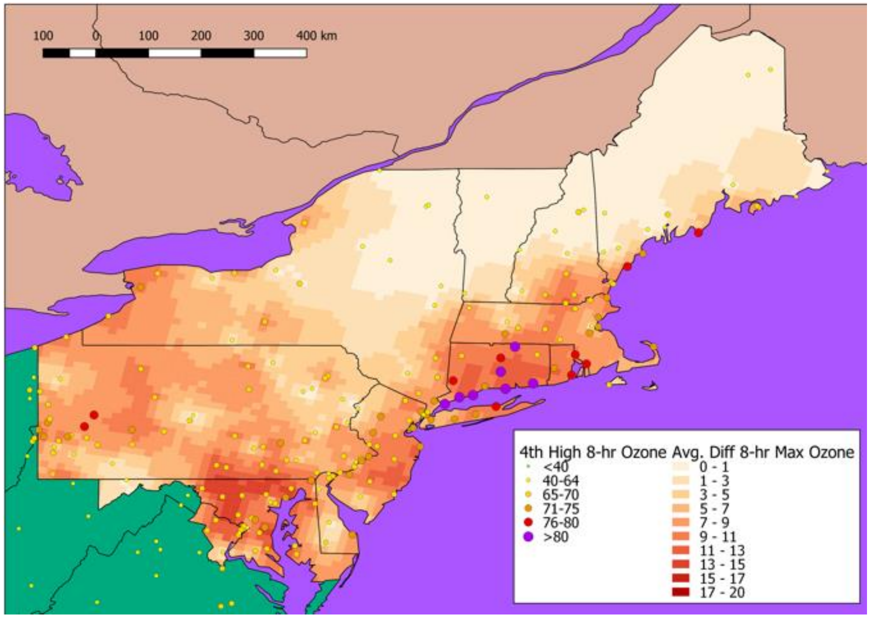


Figure 27: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2013 data

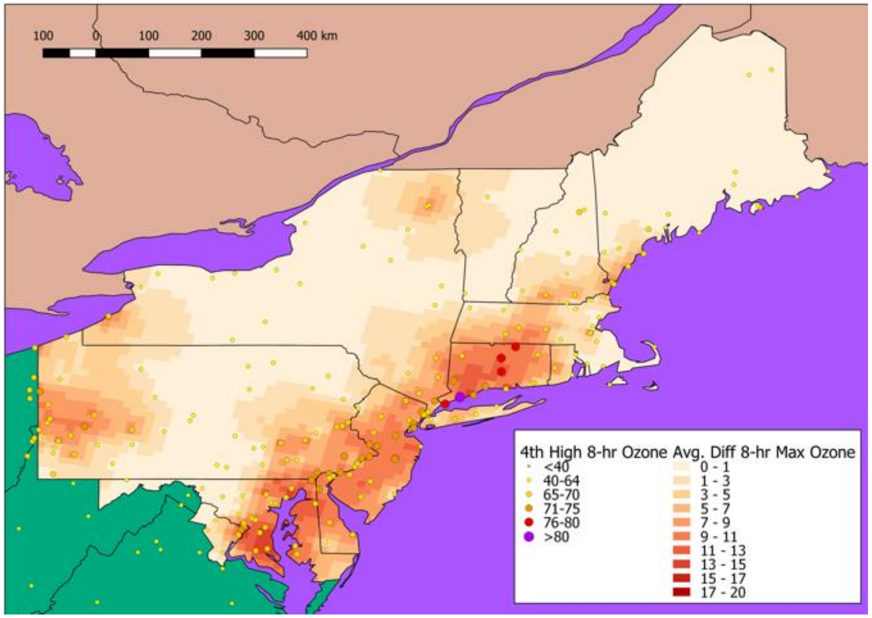


Figure 28: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2014 data

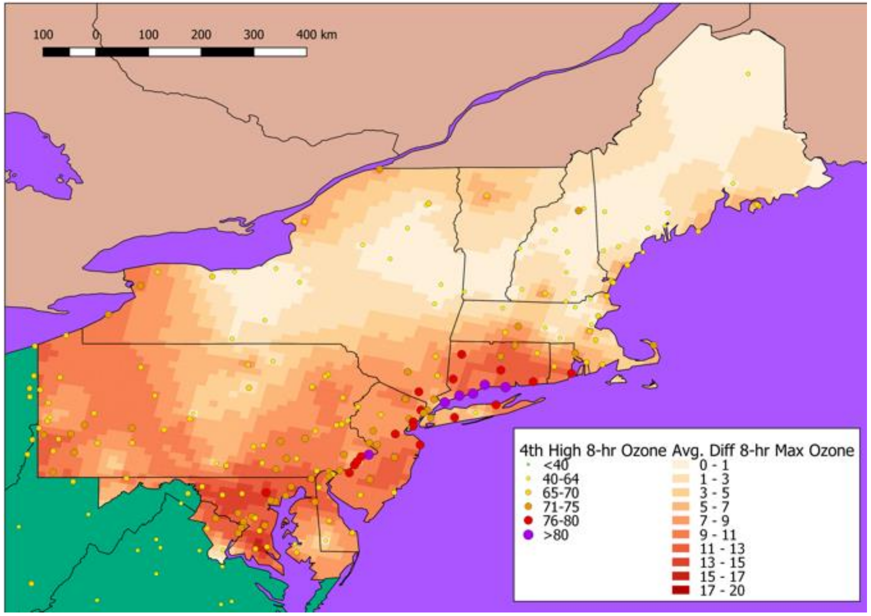


Figure 29: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2015 data

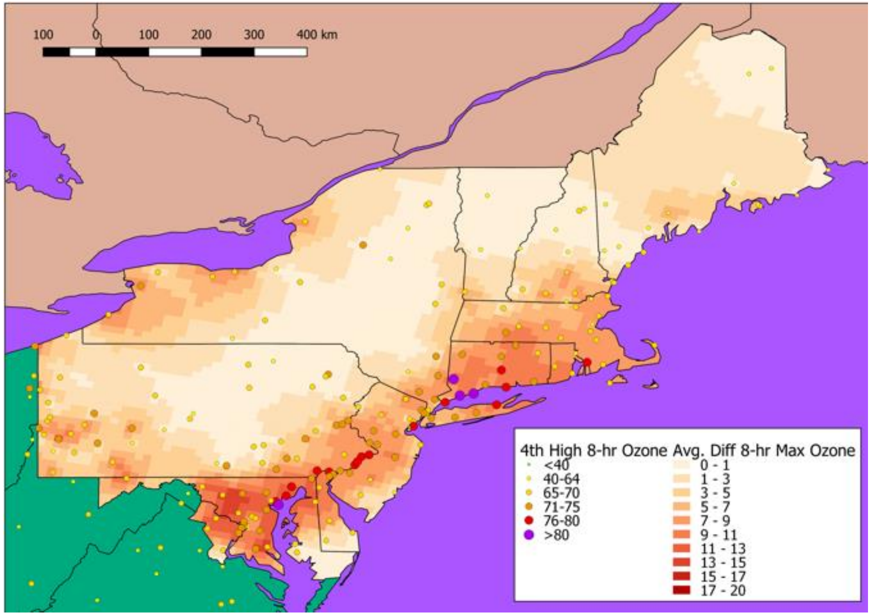


Figure 30: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2016 data

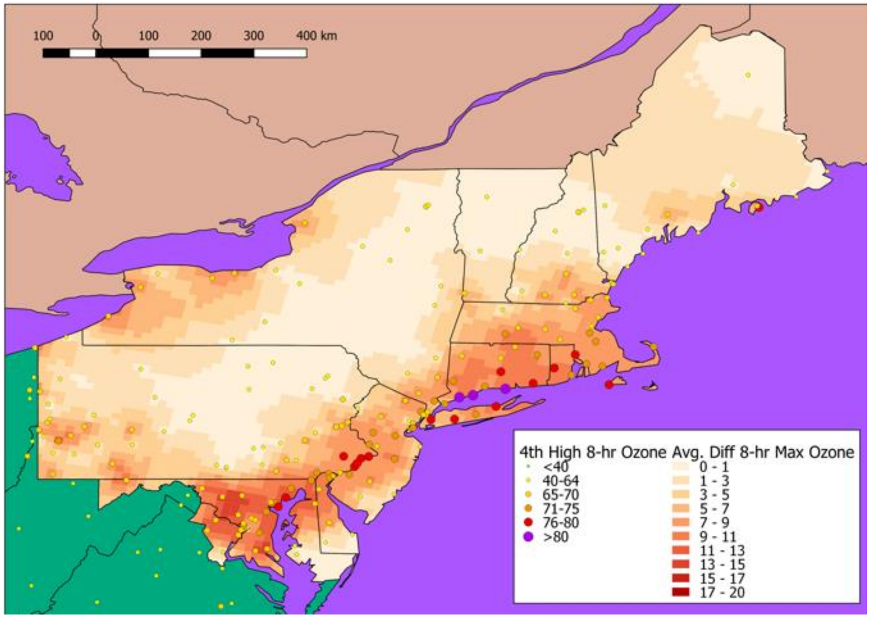


Figure 31: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2017 data

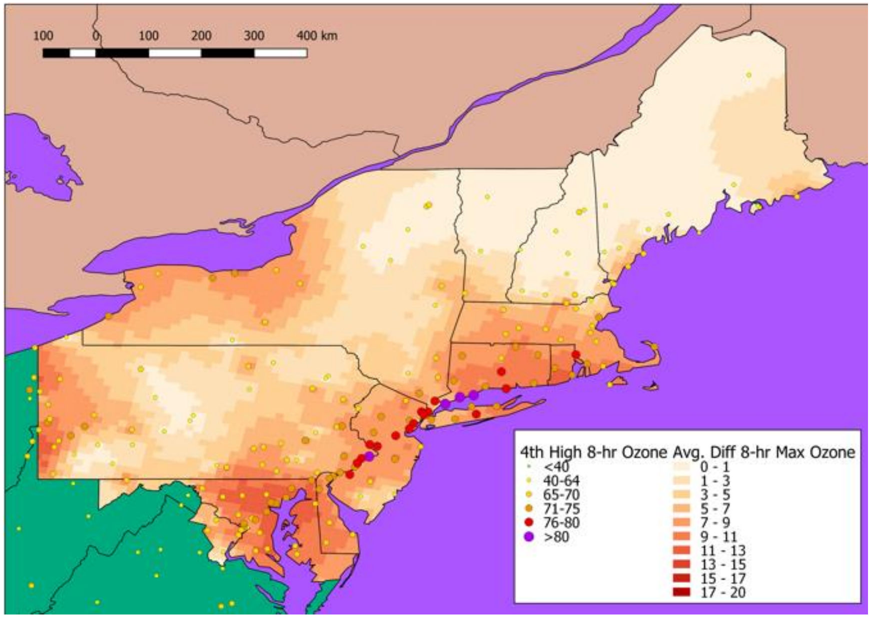


Figure 32: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2018 data

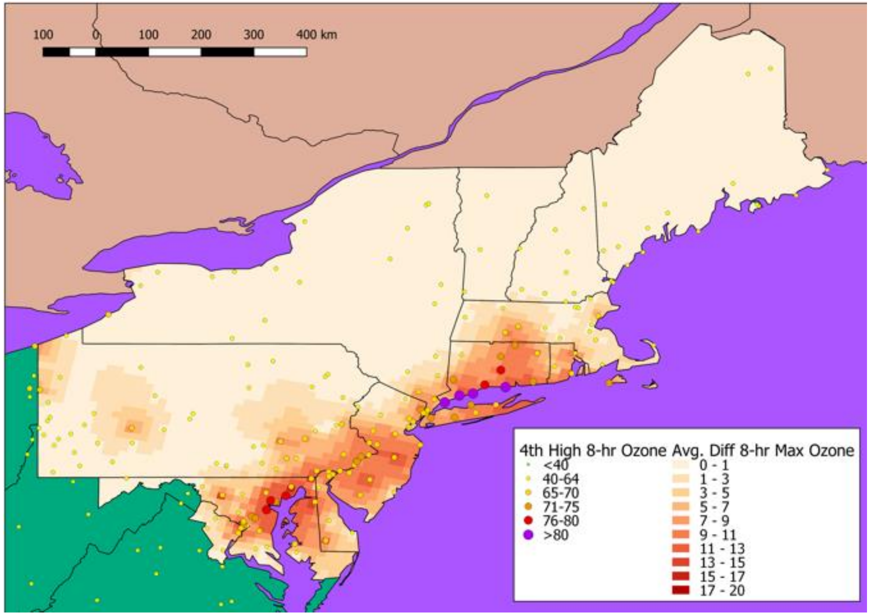


Figure 33: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2019 data

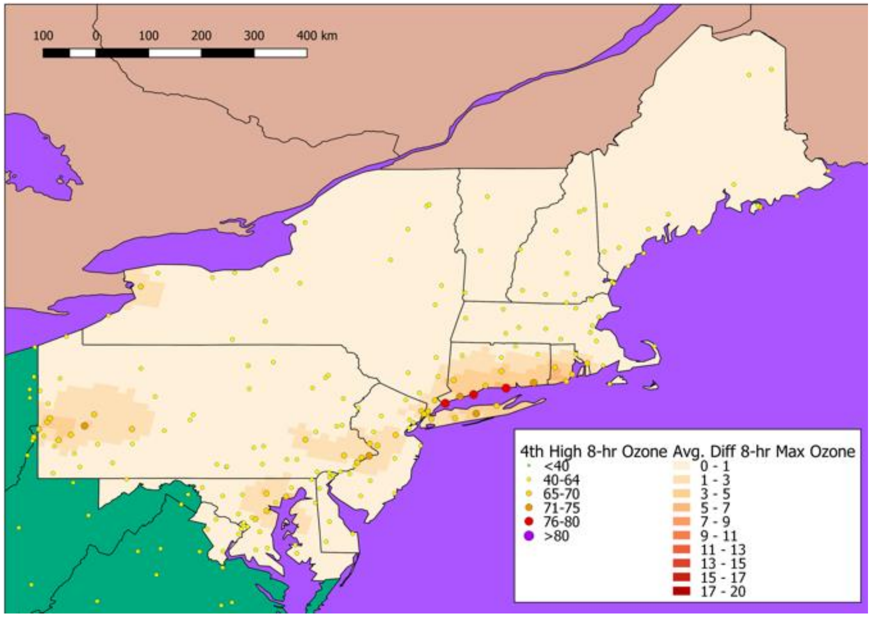
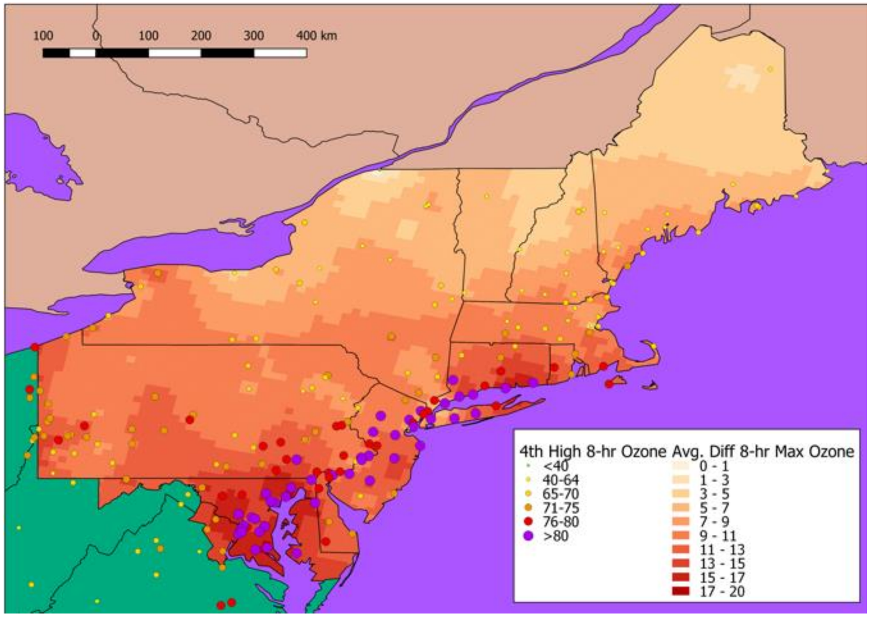


Figure 34: Change in avg. 8-hour max. ozone after roll back to 65ppb using 2020 data



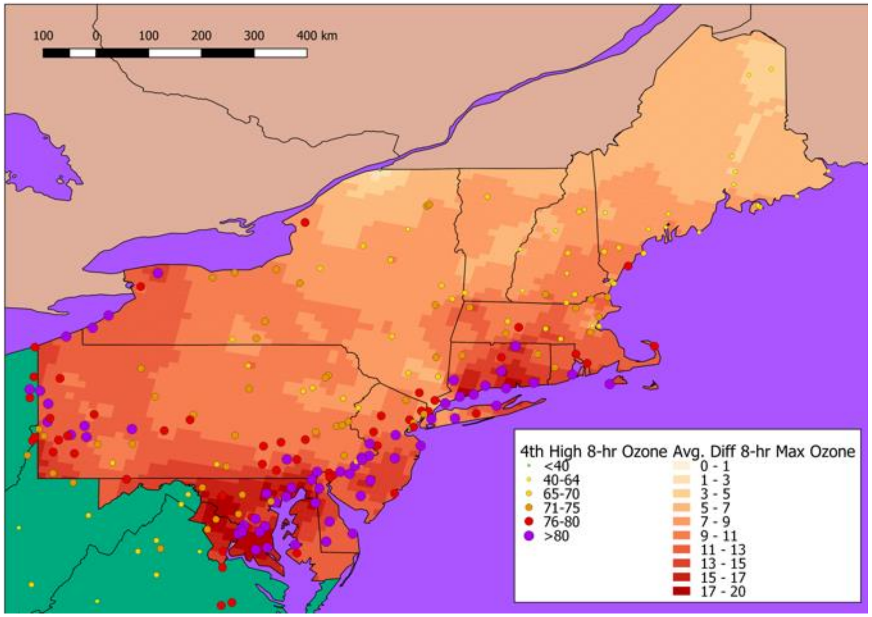
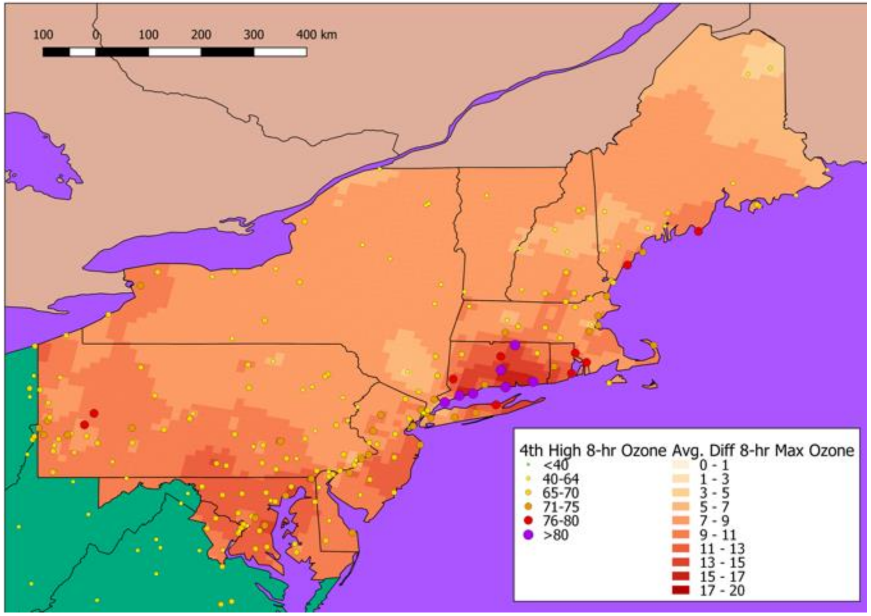


Figure 35: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2011 data

Figure 36: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2012 data



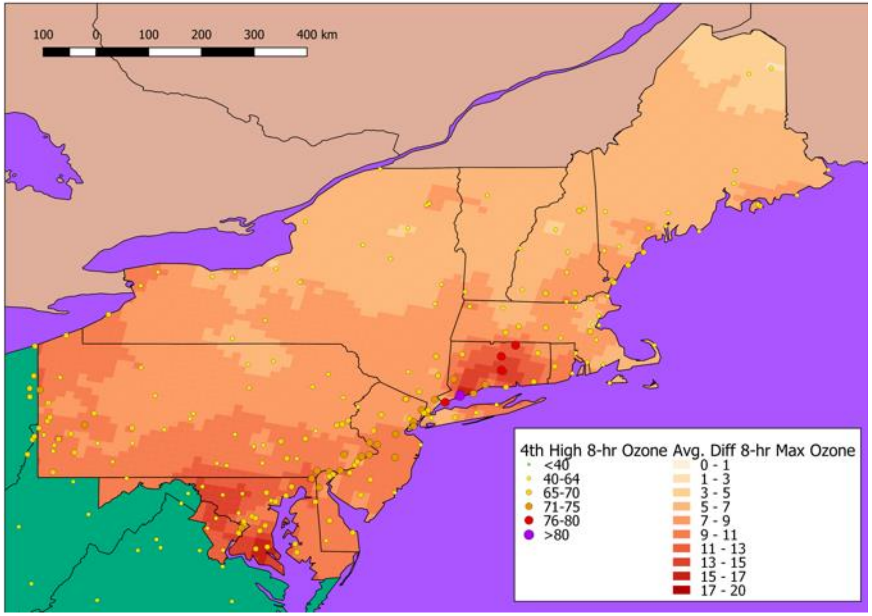


Figure 37: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2013 data

Figure 38: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2014 data

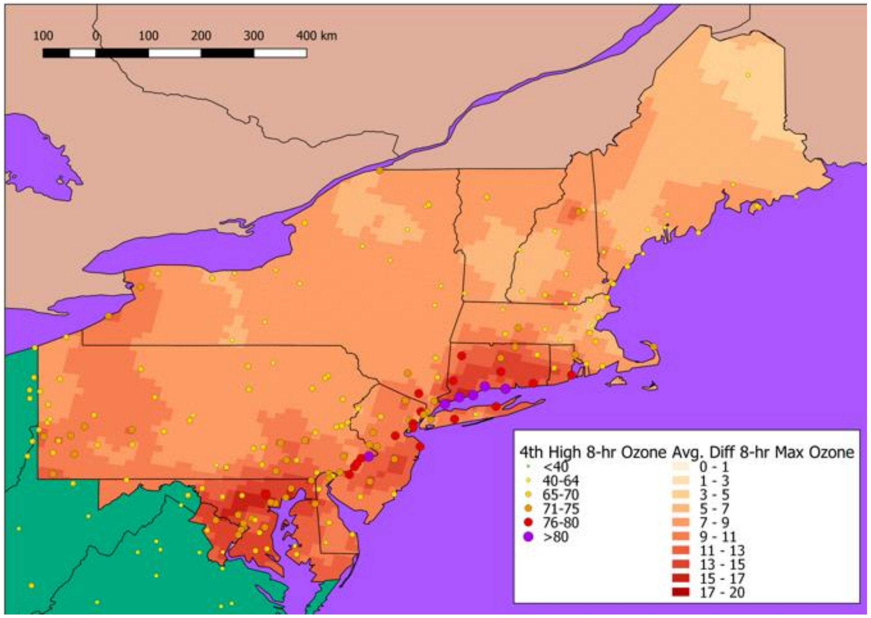


Figure 39: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2015 data

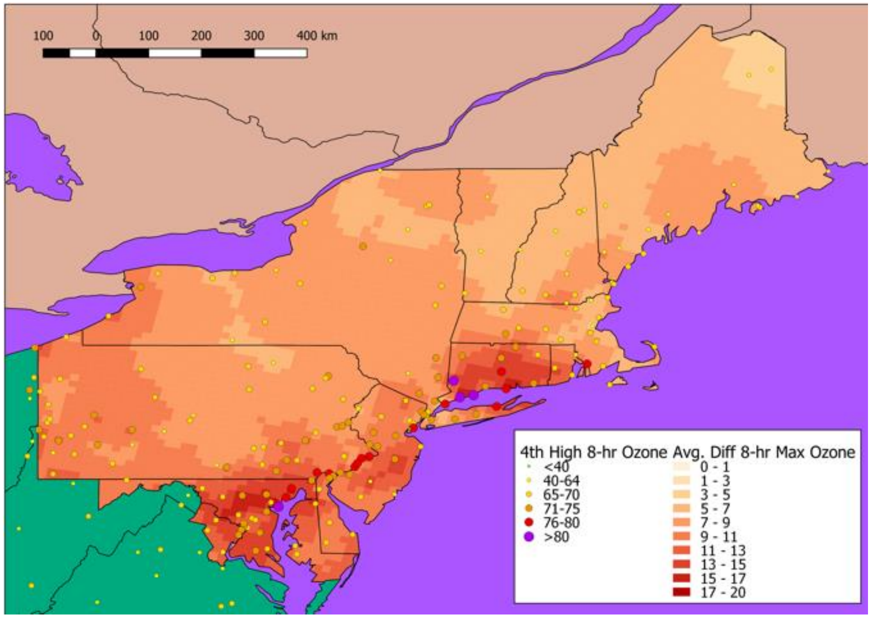


Figure 40: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2016 data

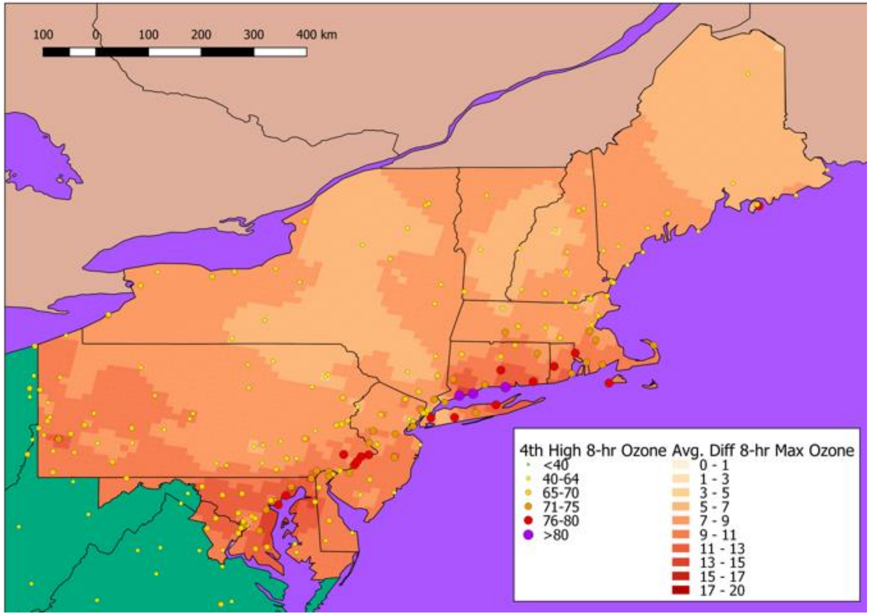


Figure 41: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2017 data

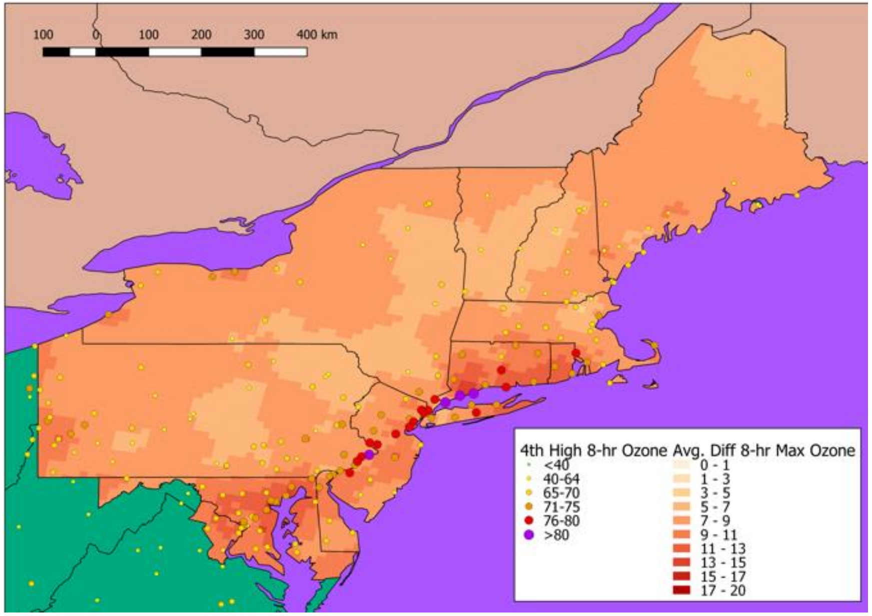


Figure 42: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2018 data

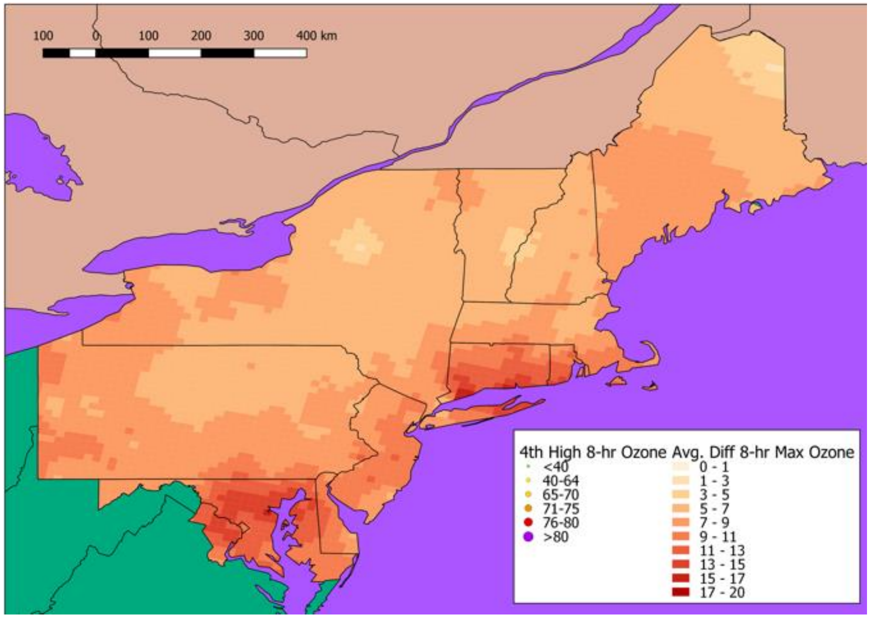


Figure 43: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2019 data

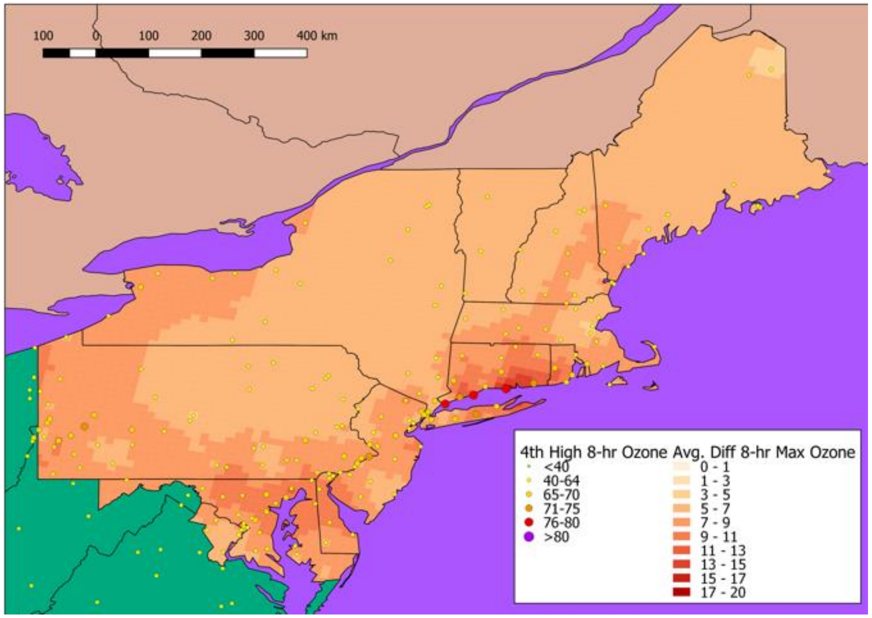


Figure 44: Change in avg. 8-hour max. ozone after roll back to 40ppb using 2020 data

Results

Monitor Rollback

Overview maps of the changes in average 8-hour maximum ozone concentrations in the OTR after being rolled back to 70 ppb (Figure 15 through Figure 24), to 65 ppb (Figure 25 through Figure 34), and to 40 ppb (Figure 35 through Figure 44).

The majority of the reductions in ozone levels in 70 ppb rollbacks occurred in the I-95 corridor between Washington, DC and New York City, NY, with smaller reductions extending north to Boston, MA. In years with higher ozone overall, the reductions in and along the corridor were of higher magnitude.

Reductions were most widespread in 2012 (Figure 16) when they extended throughout Central Pennsylvania, New York, Massachusetts, and southern Northern New England. Reductions in 2011 (Figure 15) were also widespread, though did not extend to North Central New York, Southern Vermont, or Southern New Hampshire. The least reductions were seen in 2020 (Figure 24), which was expected due to the sharp decrease in emissions throughout the year due to the Covid-19 health emergency. The reductions in 2019 (Figure 23) were also minimal and confined strictly to the coastal corridor between Washington, DC and Southern Massachusetts, but not to the same extent as 2020.

The Pittsburgh area also saw reductions in the 70 ppb rollback scenarios except in 2014 (Figure 18), 2019 (Figure 23), and 2020 (Figure 24). Isolated areas in Western New York and Central Pennsylvania also saw reductions in 2013 (Figure 17), 2015 (Figure 19), and 2016 (Figure 20).

In the 65 ppb scenarios for 2013 (Figure 27) through 2018 (Figure 33), the results resembled those in the 70ppb scenario for 2011 and 2012. In 2011 (Figure 25) and 2012 (Figure 26) rolling back monitors to 65 ppb did not increase the geography that saw reductions much from the 70 ppb rollback scenario, with one exception is that in many of the 65 ppb scenarios Northern New York and Northern New England did begin to see reductions in ozone levels. Though there were not many differences for the 70 ppb rollback between the 2018 (Figure 22) and 2017 (Figure 21) the 2018 rollback for 65 ppb (Figure 32) saw more reductions than the 2017 rollback (Figure 31). The 65 ppb rollback for 2019 (Figure 33), like the rollback to 70 ppb was very limited in terms of reductions, but in this case some reductions were seen in Western Pennsylvania. The rollback in 2020 (Figure 34) showed even less in the way of ozone reductions than in all of the 70 ppb rollback scenarios, save 2020, which again was expected given the low ozone levels throughout the OTR.

The entire OTR saw massive reductions in ozone levels in the 40 ppb rollback scenarios including many rural areas in the OTR, with the least reductions occurring in Northern New York and Northern New England and the greatest reductions again along the I-95 corridor. In this case, the 2020 scenario (Figure 44) since the reductions in emissions due to the Covid-19 health emergency were not enough to achieve background ozone levels.

Health Impact

After processing the health impact functions, prior to 2020 we estimated that had the entire OTR had 4th highest monitor results at or under 70 ppb it is expected that there would have been anywhere from 600 to 2,400 fewer short-term mortalities due to ozone exposure in a given year (Table 5). Of these years 2012 saw the highest magnitude in excess mortality, which was expected given the widespread ozone higher ozone levels that year. In 2020, due to reduced transportation and economic activity as the result of the Covid-19 health emergency, emissions and thus ozone levels were far lower than typical, resulted in only 88 mortalities being estimated to have occurred due to ozone exceedances. To see how reduced mortality changed in the OTR for each analysis year see Figure **45**.

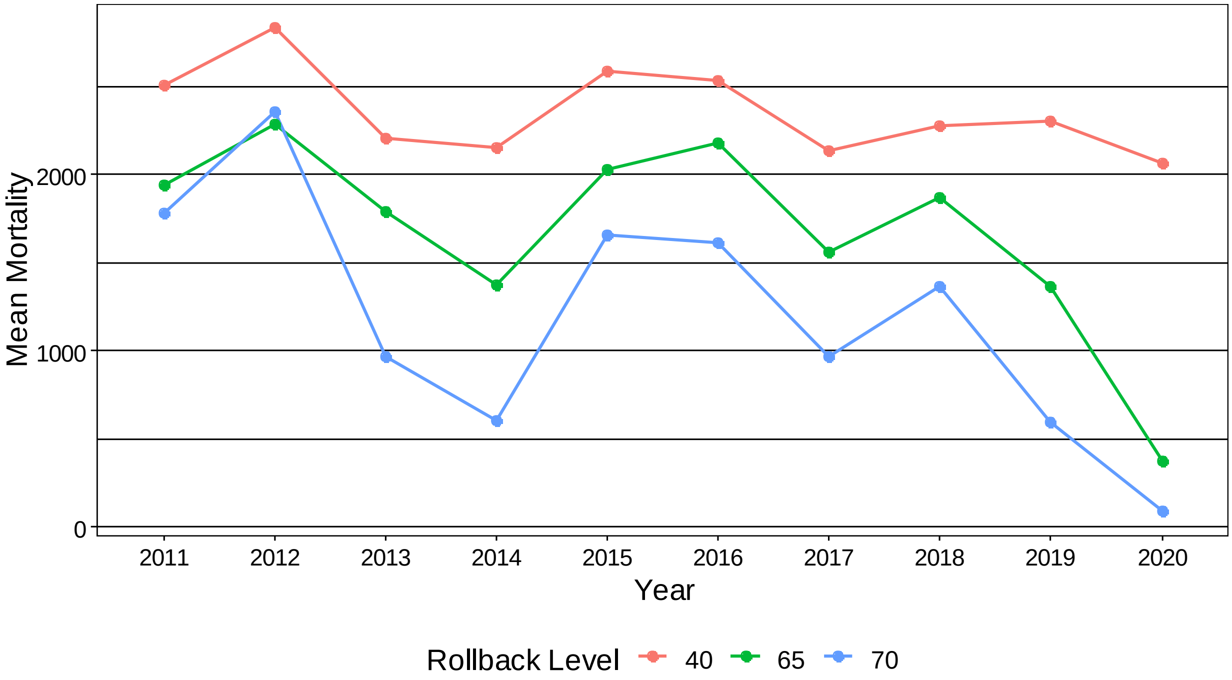


Figure 45**: Change in mean mortality (number of deaths) reduced by meeting the ozone NAAQS for each analysis year in the OTR**

To put these numbers into perspective in 2014 the 33rd highest cause of mortality was homicide in the OTR+VA, which lead to 2,599 deaths, and the 47th highest cause of mortality was rheumatic heart conditions, which lead to 617 deaths (Table 7). Other causes of mortality that fall into this range are oral cancer (1,763), HIV/AIDs (1,547), alcohol (1,492), and skin disease (995).

First looking at 2012 through 2019, with one exception, more mortality was modeled to have been prevented from achieving a level of 65 ppb. The largest increases in magnitude (nearly doubling) of decreased mortalities were in the years (e.g., 2013, 2015, 2017) with the lowest decreases in mortality in the 70 ppb scenario. Years (e.g., 2011, 2015, 2016, and 2018) with higher magnitudes of decreased mortality in the 70 ppb scenario did not see the same doubling of benefits in reduced mortality from achieving a 65 ppb level. In this case the increase in the magnitude of reduced mortality was more in the range of a 30% to 50% increase. This would be expected since there is greater geography in 2013, 2015, and 2017 that would not have emissions reduced by the BenMap algorithm in the 70 ppb scenario since they were attaining the standard, but they would have been reduced somewhat in the 70 ppb scenario in 2011, 2015, and 2016. The one anomaly is that avoided mortalities increased between the 70 ppb and 65 ppb scenarios in 2012.

2020 again provided a different story. Ozone levels were so low, that even the 65 ppb rollback scenario did not point towards many excess exceedances (only 331 were estimated). While it was over double the number of deaths attributed to being over the level 70 ppb, that magnitude of excess deaths from ozone far dwarfed 2014, the cleanest year on record in the recent past.

In all of the 40 ppb scenarios there is an increase in the modeled avoided mortality from the 65 ppb scenario for the same year, and like the comparison between 65 and 70, the increase depended somewhat on the level of the expanded geography being impacted by the algorithm in addition to the lowering of the ozone levels. In the 40 ppb rollback scenario, the excess deaths from being above background maintained consistent, pointing to the fact that despite the emission reductions that resulted from the Covid-19 health emergency, ozone levels were still well above background.

Emergency room visits for asthma related conditions were estimated not to be significantly different than 0.

The same pattern of results occurred for the other health endpoints as mortality with the magnitude being of hospital admissions all respiratory symptoms being about double the mortality incidence and for pneumonia being about half of the mortality incidence. Acute respiratory symptoms were roughly 2000 times the mortality incidence, and school loss days were roughly 500 times.

State level graphs showing the mean mortality for each year from 2011-2020 for having met 70 ppb, 65 ppb, and 40 ppb are in Figure 46, Figure 47, and Figure 48, respectively.

Looking specifically at the 70 ppb scenario, you can see in 2013 and 2014 that states in the far southern OTR (Virginia, Maryland, Delaware) and the far northern OTR (Massachusetts, Rhode Island) did not have the same level of mortalities as in other years as would be expected. New York and Pennsylvania saw marked increases in 2012, which also would be expected given the impact ozone had in the central portions of those states in that year. Those two states also saw drops in 2013, 2014, and 2017, though not to nearly zero due to ozone levels still being high near Philadelphia and New York City. Connecticut saw consistently moderate reduced mortalities in all of the scenarios, which would be expected since the state had consistently higher ozone levels, even in 2013, 2014, and 2019. 2018 appeared to be an average year across the board. Even though 2019 was quite low in terms of reduced mortality throughout the OTR, especially in New York and New Jersey, the same reductions that were observed in the southern OTR in 2013 and 2014 were not observed. In 2020, the mortality associated with exceeding the 2015 Ozone NAAQS was almost exclusively centered in the New York City and Philadelphia metropolitan areas, and even the number of deaths in those areas was lower than typical.

A full listing of state level breakdowns is available upon request.

Economic Impact

Following analysis of the health impacts, economic impacts were estimated using the previously discussed techniques. The value of the mortalities outweighs the other economic impacts considerably, though one should consider that some economic benefits such as reduced personal suffering may not have been monetized for morbidity due to the data, such as cost of illness estimates, used in developing the cost estimates. Again emergency room visits for asthma related conditions were found to be not significantly different from zero, as were hospital admissions due to all respiratory conditions and minor restricted activity days. Total economic benefits for the OTR, excluding emergency room visits and minor restricted activity days, are found for each year from 2011-2020 for having met 70 ppb, 65 ppb, and 40 ppb in Figure 49, Figure 50, and Figure 51, respectively. Since the differences in mortality estimates do not vary as much from year to year in the 40 ppb rollback, the economic value calculation is more impacted by inflation than the change in mortality. A full break down of the economic impacts is in Table 6 and state level breakdowns are available upon request.

Summary

Reductions in ozone levels are still necessary to meet the 70 ppb NAAQS. Every year that the OTR is not in attainment of the ozone NAAQS, as this analysis shows, residents of the OTR die prematurely and face a decreased quality of life due to the health effects of ozone. These health effects come with an economic price tag as well. Lowering the NAAQS at a future date, and then meeting a lower NAAQS would bring even more health benefits than simply meeting the current 70 ppb NAAQS as well.

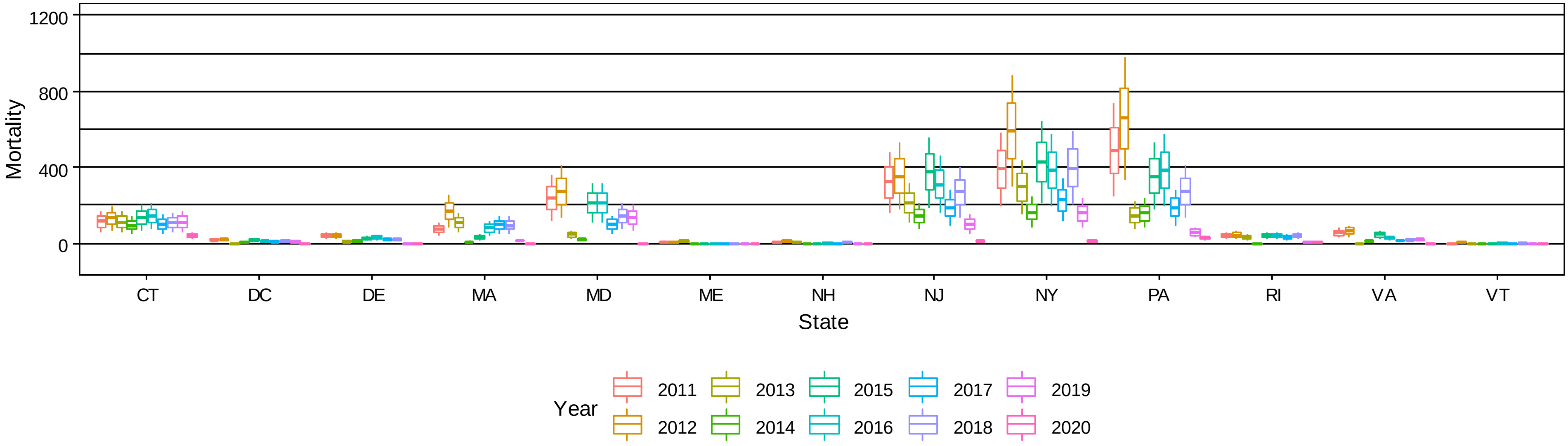


Figure 46: Estimated state mortalities (number of deaths) that could have been avoided by meeting a 70 ppb threshold from 2011-2020

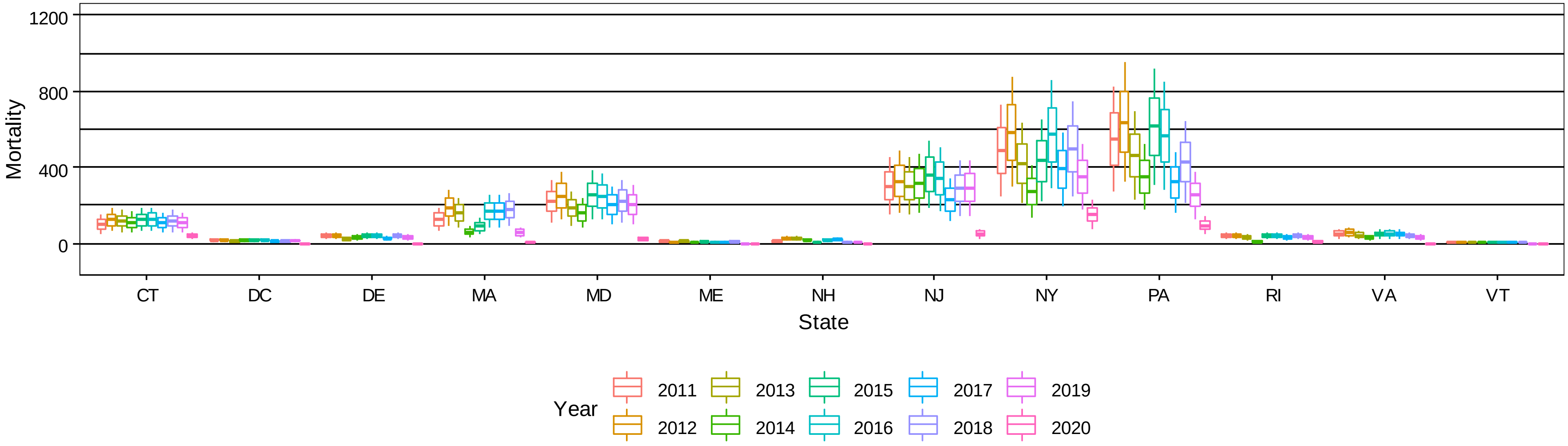


Figure 47: Estimated state mortalities (number of deaths) that could have been avoided by meeting a 65 ppb threshold from 2011-2020

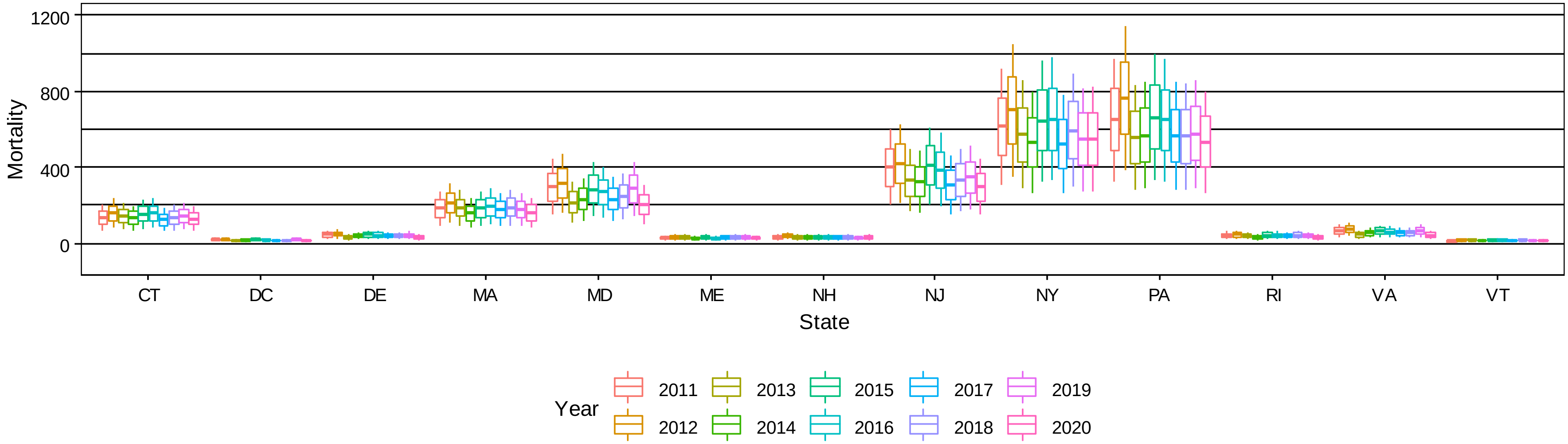


Figure 48: Estimated state mortalities (number of deaths) that could have been avoided by meeting a 40 ppb threshold from 2011-2020

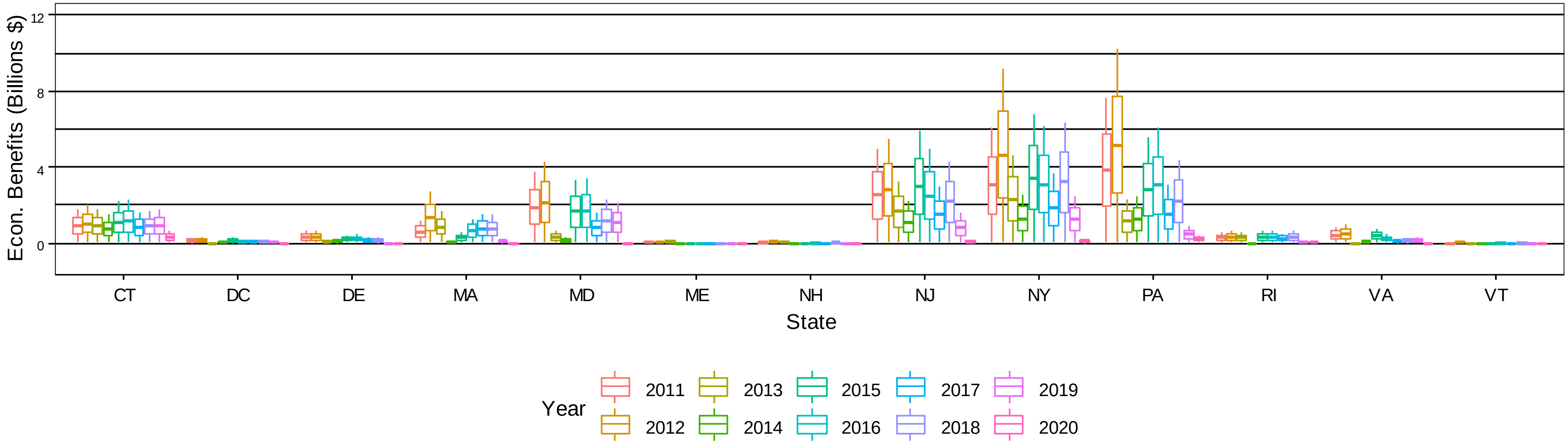


Figure 49: Estimated state level economic benefits (billions of 2010$) that could have occurred by meeting a 70 threshold NAAQS from 2011-2020

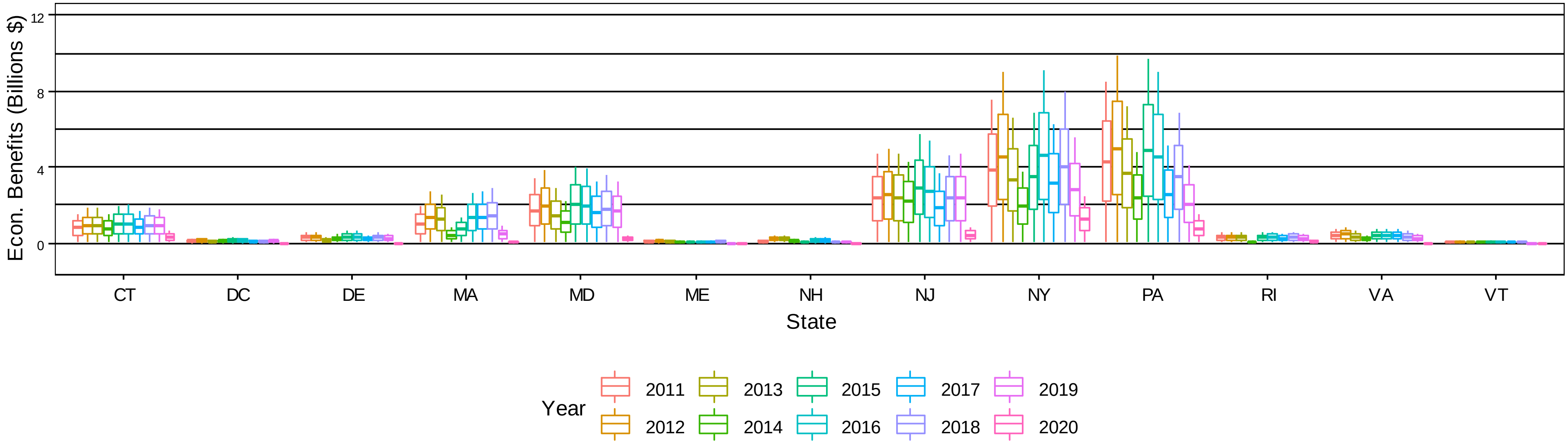


Figure 50: Estimated state level economic benefits (billions of 2010$) that could have occurred by meeting a 65 ppb threshold from 2011-2020

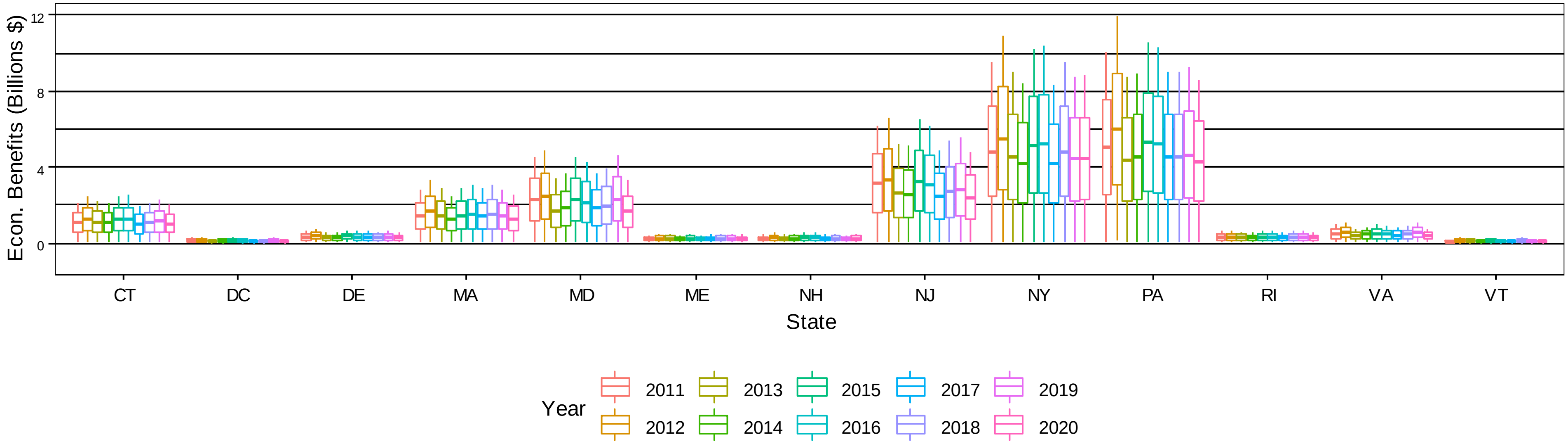


Figure 51: Estimated state level economic benefits (billions of 2010$) that could have occurred by meeting a 40 ppb threshold from 2011-2020

Table 5: Estimated ozone-related health impacts following monitor rollback to 40, 65, and 70 ppb for 2011-2020 in the OTR

	2011			2012			2013			2014			2015			2016			2017			2018			2019			2020		
	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70
Mortality																														
All Causes[7]																														
Mean	2,512	1,941	1,782	2,833	2,288	2,355	2,204	1,790	963	2,152	1,370	606	2,584	2,030	1,656	2,535	2,180	1,617	2,136	1,559	967	2,279	1,866	1,363	2,303	1,365	597	2,063	371	88
-2σ	1,264	975	896	1,426	1,150	1,184	1,107	899	483	1,081	688	304	1,299	1,020	832	1,275	1,095	812	1,073	783	485	1,146	937	684	1,156	685	299	1,036	186	44
2σ	3,760	2,907	2,668	4,240	3,425	3,525	3,301	2,682	1,442	3,224	2,052	908	3,869	3,040	2,480	3,796	3,265	2,422	3,199	2,335	1,449	3,412	2,795	2,041	3,449	2,045	895	3,091	556	132
E.R. Visits																														
Asthma[8]																														
Mean	2,789	2,149	2,112	3,028	2,472	2,599	2,323	1,937	1,052	2,281	1,581	817	2,700	2,166	1,934	2,611	2,313	1,743	2,151	1,708	1,065	2,303	1,937	1,589	2,324	1,628	684	2,031	436	76
-2σ	-551	-429	-420	-597	-492	-516	-464	-389	-212	-456	-317	-165	-536	-432	-385	-519	-462	-349	-430	-342	-215	-458	-387	-317	-465	-326	-138	-407	-61	-11
2σ	6,129	4,727	4,643	6,653	5,436	5,713	5,110	4,264	2,315	5,018	3,479	1,799	5,936	4,764	4,252	5,740	5,088	3,836	4,731	3,759	2,344	5,064	4,262	3,495	5,112	3,583	1,505	4,469	933	163
Hospital Admissions																														
All Respiratory[9]																														
Mean	5,003	3,873	3,630	5,592	4,535	4,677	4,383	3,614	1,972	4,317	2,809	1,300	5,182	4,070	3,403	5,118	4,392	3,309	4,326	3,270	2,048	4,646	3,844	2,858	4,753	2,943	1,273	4,249	803	180
-2σ	1,082	847	795	1,192	940	936	858	765	413	857	586	317	1,048	830	746	1,034	874	693	833	685	425	885	776	632	901	650	257	774	183	29
2σ	8,924	6,900	6,465	9,993	8,130	8,419	7,909	6,464	3,531	7,778	5,032	2,283	9,317	7,310	6,061	9,201	7,911	5,925	7,819	5,855	3,672	8,406	6,912	5,084	8,604	5,237	2,288	7,725	1,424	331
Chronic Lung (- Asthma)[10]																														
Mean	1,464	1,132	1,043	1,660	1,345	1,376	1,320	1,076	589	1,297	821	358	1,559	1,213	985	1,543	1,318	988	1,322	971	612	1,418	1,164	834	1,458	863	378	1,316	228	58
-2σ	461	351	325	525	420	431	409	332	180	402	253	109	488	377	307	482	409	306	410	299	188	442	361	258	451	266	115	405	69	18
2σ	2,467	1,912	1,761	2,795	2,270	2,321	2,230	1,820	998	2,192	1,390	607	2,631	2,050	1,664	2,605	2,227	1,669	2,234	1,642	1,035	2,395	1,966	1,409	2,465	1,460	641	2,227	388	99
Pneumonia[11]																														
Mean	1,481	1,140	1,042	1,679	1,358	1,387	1,328	1,078	581	1,299	810	353	1,558	1,202	967	1,539	1,309	970	1,313	961	594	1,408	1,152	816	1,437	834	369	1,296	224	57
-2σ	646	494	452	733	589	603	575	465	250	562	349	152	677	520	419	668	567	419	568	414	256	611	498	353	621	360	158	559	96	24
2σ	2,317	1,787	1,631	2,624	2,126	2,171	2,080	1,691	913	2,037	1,271	555	2,439	1,884	1,515	2,409	2,052	1,520	2,057	1,507	933	2,206	1,805	1,280	2,253	1,308	580	2,033	352	90
Acute Resp. Symptoms																														
Minor Restricted Activity Days (thousands)[12]																														
Mean	5027	3854	3657	5499	4453	4616	4225	3487	1864	4120	2696	1253	4855	3796	3262	4693	4074	3058	3890	3003	1851	4106	3413	2592	4134	2616	1165	3586	675	140
-2σ	2282	1737	1652	2500	2012	2090	1904	1567	835	1856	1211	560	2197	1712	1473	2122	1837	1377	1753	1350	830	1856	1538	1169	1862	1177	520	1611	301	62
2σ	7773	5970	5661	8498	6893	7142	6546	5407	2893	6384	4182	1945	7513	5880	5052	7264	6311	4739	6027	4656	2871	6356	5287	4016	6406	4056	1810	5561	1050	217
School Loss Days																														
All Causes (thousands)[13]																														
Mean	1499	1123	1068	1632	1290	1341	1208	1001	527	1170	763	351	1369	1072	918	1316	1140	860	1083	833	511	1142	947	715	1148	727	320	993	183	38
-2σ	521	454	432	568	522	542	489	405	213	473	308	142	553	434	371	532	461	348	438	337	207	462	383	289	464	294	130	402	74	15
2σ	2477	1792	1704	2697	2059	2139	1928	1597	840	1867	1217	559	2184	1711	1464	2100	1819	1372	1727	1329	815	1822	1511	1141	1831	1160	511	1585	292	60

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[7] Bell, Dominici, and Samet, "A Meta-Analysis of Time-Series Studies of Ozone and Mortality With Comparison to the National Morbidity, Mortality, and Air Pollution Study."

[8] Wilson et al., "Air Pollution, Weather, and Respiratory Emergency Room Visits in Two Northern New England Cities: An Ecological Time-Series Study"; Peel et al., "Ambient Air Pollution and Respiratory Emergency Department Visits."

[9] Burnett et al., "Association between Ozone and Hospitalization for Acute Respiratory Diseases in Children Less than 2 Years of Age"; Schwartz, "Short Term Fluctuations in Air Pollution and Hospital Admissions of the Elderly for Respiratory Disease."

[10] Moolgavkar, Luebeck, and Anderson, "Air Pollution and Hospital Admissions for Respiratory Causes in Minneapolis-St. Paul and Birmingham."

[11] Ibid.; Schwartz, "Air Pollution and Hospital Admissions for the Elderly in Detroit, Michigan."; Schwartz, "PM10 Ozone, and Hospital Admissions for the Elderly in Minneapolis-St. Paul, Minnesota."

[12] Ostro and Rothschild, "Air Pollution and Acute Respiratory Morbidity: An Observational Study of Multiple Pollutants."

[13] Chen et al., "Elementary School Absenteeism and Air Pollution"; Gilliland et al., "The Effects of Ambient Air Pollution on School Absenteeism Due to Respiratory Illnesses."

Table 6: Estimated ozone-related economic impacts (millions 2010$) following monitor rollback to 70, 65, and 40 ppb for 2011-2020 in the OTR

	2011			2012			2013			2014			2015			2016			2017			2018			2019			2020		
	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70	40	65	70
Mortality																														
All Causes																														
Mean	$19,641	$15,177	$13,932	$22,277	$17,698	$18,517	$17,393	$14,126	$7,596	$17,099	$9,525	$4,809	$20,660	$16,228	$13,241	$20,319	$17,473	$12,958	$17,214	$12,562	$7,791	$18,455	$15,112	$11,034	$18,648	$11,056	$4,838	$16,708	$3,005	$714
-2σ	$298	$224	$207	$341	$263	$2789	$257	$206	$109	$251	$138	$68	$310	$240	$196	$304	$258	$190	$254	$183	$112	$275	$223	$163	$273	$161	$68	$243	$42	$10
2σ	$38,984	$30,130	$27,658	$44,212	$35,132	$36,755	$34,530	$28,046	$15,083	$33,930	$18,912	$9,549	$41,010	$32,217	$26,286	$40,334	$34,689	$25,726	$34,174	$24,942	$15,470	$36,634	$30,002	$21,905	$37,022	$21,951	$9,608	$33,173	$5,969	$1,418
Emergency Room Visits																														
Asthma																														
Mean	$1.1	$0.8	$0.8	$1.2	$0.9	$1.0	$0.9	$0.8	$0.4	$0.9	$0.6	$0.3	$1.0	$0.8	$0.8	$1.0	$0.9	$0.7	$0.8	$0.7	$0.4	$0.9	$0.8	$0.6	$0.9	$0.6	$0.3	$0.8	$0.2	$0.0
-2σ	-$0.2	-$0.2	-$0.2	-$0.2	-$0.2	-$0.2	-$0.2	-$0.2	-$0.1	-$0.2	-$0.1	-$0.1	-$0.2	-$0.2	-$0.1	-$0.2	-$0.2	-$0.1	-$0.2	-$0.1	-$0.1	-$0.2	-$0.2	-$0.1	-$0.2	-$0.1	-$0.1	-$0.2	$0.0	$0.0
2σ	$2.4	$1.8	$1.8	$2.6	$2.1	$2.2	$2.0	$1.7	$0.9	$1.9	$1.4	$0.7	$2.3	$1.8	$1.7	$2.2	$2.0	$1.5	$1.8	$1.5	$0.9	$2.0	$1.7	$1.4	$2.0	$1.4	$0.6	$1.7	$0.4	$0.1
Hospital Admissions																														
All Respiratory																														
Mean	$153.2	$118.9	$111.3	$171.5	$138.0	$143.5	$136.0	$111.9	$60.6	$133.8	$86.1	$39.1	$160.9	$126.2	$104.2	$159.2	$136.4	$101.8	$135.6	$100.6	$63.4	$145.2	$119.4	$88.2	$150.4	$91.4	$39.8	$64.8	$12.2	$2.7
-2σ	-$14.7	-$12.0	-$9.8	-$16.8	-$13.9	-$14.0	-$15.5	-$12.7	-$6.7	-$14.6	-$8.8	-$3.3	-$16.4	-$13.4	-$9.4	-$16.6	-$15.3	-$11.1	-$15.5	-$10.5	-$7.2	-$16.4	-$13.4	-$7.7	-$29.6	-$16.9	-$7.8	$12.2	$2.9	$0.5
2σ	$321.2	$249.7	$232.3	$359.7	$290.0	$301.1	$287.5	$236.5	$127.9	$282.2	$181.0	$81.5	$338.2	$265.9	$217.9	$335.0	$288.1	$214.7	$286.7	$211.7	$134.0	$306.7	$252.2	$184.0	$330.4	$199.7	$87.3	$117.4	$21.6	$5.0
Chronic Lung (-Asthma)																														
Mean	$33.3	$25.8	$23.8	$37.8	$30.1	$31.3	$30.0	$24.5	$13.4	$29.5	$18.7	$8.2	$35.5	$27.6	$22.5	$35.1	$30.0	$22.5	$30.1	$22.1	$13.9	$32.3	$26.5	$19.0	$33.2	$19.7	$8.6	$30.0	$5.2	$1.3
-2σ	$10.5	$8.0	$7.4	$12.0	$9.4	$9.8	$9.3	$7.6	$4.1	$9.1	$5.8	$2.5	$11.1	$8.6	$7.0	$11.0	$9.3	$7.0	$9.3	$6.8	$4.3	$10.1	$8.2	$5.9	$10.3	$6.1	$2.6	$9.2	$1.6	$0.4
2σ	$56.2	$43.5	$40.1	$63.6	$50.8	$52.9	$50.8	$41.4	$22.7	$49.9	$31.7	$13.8	$59.9	$46.7	$37.9	$59.3	$50.7	$38.0	$50.8	$37.4	$23.6	$54.5	$44.8	$32.1	$56.1	$33.3	$14.6	$50.7	$8.8	$2.3
Pneumonia																														
Mean	$40.4	$31.1	$28.4	$45.7	$36.4	$37.8	$36.2	$29.4	$15.9	$35.4	$22.1	$9.6	$42.5	$32.8	$26.4	$41.9	$35.7	$26.4	$35.8	$26.2	$16.2	$38.4	$31.4	$22.3	$39.2	$22.8	$10.1	$35.3	$6.1	$1.6
-2σ	$17.6	$13.5	$12.3	$20.0	$15.8	$16.4	$15.7	$12.7	$6.8	$15.3	$9.5	$4.1	$18.5	$14.2	$11.4	$18.2	$15.5	$11.4	$15.5	$11.3	$7.0	$16.7	$13.6	$9.6	$16.9	$9.8	$4.3	$15.2	$2.6	$0.7
2σ	$63.1	$48.7	$44.5	$71.5	$57.0	$59.2	$56.7	$46.1	$24.9	$55.5	$34.7	$15.1	$66.5	$51.3	$41.3	$65.7	$55.9	$41.4	$56.1	$41.1	$25.4	$60.1	$49.2	$34.9	$61.4	$35.7	$15.8	$55.4	$9.6	$2.5
Acute Resp. Symptoms																														
Minor Restricted Activity Days																														
Mean	$160.2	$122.8	$116.6	$175.6	$140.0	$147.4	$135.1	$111.5	$59.6	$132.1	$82.3	$40.2	$156.0	$122.0	$104.9	$151.0	$131.1	$98.4	$125.4	$96.8	$59.7	$132.6	$110.2	$83.7	$133.5	$84.5	$37.6	$470.7	$88.6	$18.3
-2σ	-$50.7	-$39.1	-$37.0	-$55.5	-$44.5	-$46.7	-$43.0	-$35.6	-$19.1	-$42.0	-$26.2	-$12.9	-$49.5	-$38.8	-$33.3	-$47.9	-$41.7	-$31.3	-$39.9	-$30.9	-$19.1	-$42.1	-$35.1	-$26.6	-$42.5	-$26.9	-$12.1	$204.3	$38.1	$7.9
2σ	$371.1	$284.8	$270.1	$406.7	$324.5	$341.6	$313.3	$258.7	$138.3	$306.2	$190.8	$93.2	$361.5	$282.8	$243.0	$349.8	$303.8	$228.1	$290.7	$224.5	$138.4	$307.3	$255.5	$194.1	$309.5	$195.9	$87.3	$737.1	$139.1	$28.8
School Loss Days																														
All Causes																														
Mean	$143.9	$107.8	$102.5	$156.7	$121.9	$128.7	$116.0	$96.1	$50.6	$112.3	$73.2	$33.6	$131.4	$102.9	$88.1	$126.3	$109.4	$82.5	$103.9	$80.0	$49.0	$109.6	$90.9	$68.6	$110.2	$69.8	$30.7	$95.3	$17.6	$3.6
-2σ	$50.2	$43.8	$41.6	$54.6	$49.5	$52.3	$47.1	$39.0	$20.5	$45.6	$29.7	$13.7	$53.4	$41.8	$35.8	$51.3	$44.4	$33.5	$42.2	$32.5	$19.9	$44.5	$36.9	$27.9	$44.8	$28.3	$12.5	$38.7	$7.1	$1.5
2σ	$237.6	$171.7	$163.4	$258.7	$194.3	$205.1	$184.9	$153.1	$80.6	$179.0	$116.7	$53.6	$209.4	$164.0	$140.4	$201.3	$174.3	$131.5	$165.6	$127.4	$78.2	$174.7	$144.8	$109.4	$175.6	$111.2	$49.0	$151.9	$28.0	$5.8

Table 7: Top causes of death according to 2014 CDC data for the OTR and all of Virginia

Health Endpoint	Rank	Mortalities	Health Endpoint	Rank	Mortalities
Coronary Heart Disease	1	91,148	Homicide	33	2,599
Lung Cancers	2	34,976	Stomach Cancer	34	2,592
Stroke	3	27,908	Diarrheal diseases	35	2,442
Lung Disease	4	27,039	Oral Cancer	36	1,763
Diabetes Mellitus	5	16,138	HIV/AIDS	37	1,547
Hypertension	6	15,474	Alcohol	38	1,492
Alzheimer’s	7	15,175	Congenital Anomalies	39	1,440
Influenza & Pneumonia	8	13,774	Hepatitis C	40	1,266
Colon-Rectum Cancers	9	12,017	Low Birth Weight	41	1,077
Kidney Disease	10	11,559	Skin Disease	42	995
Blood Poisoning	11	10,816	Multiple Sclerosis	43	798
Breast Cancer	12	9,842	Asthma	44	728
Pancreas Cancer	13	9,823	Cervical Cancer	45	722
Poisoning	14	9,748	Anemia	46	652
Endocrine Disorders	15	9,176	Rheumatic/Heart	47	617
Lymphomas	16	7,882	Malnutrition	48	404
Suicide	17	7,779	Drug Use	49	293
Inflammatory/Heart	18	7,233	Peptic Ulcer Disease	50	273
Falls	19	6,799	Birth Trauma	51	218
Liver Disease	20	6,632	Rheumatoid Arthritis	52	208
Prostate Cancer	21	6,522	Fires	53	135
Parkinson's Disease	22	5,811	Drownings	54	68
Liver Cancer	23	5,304	Diphtheria	55	-
Road Traffic Accidents	24	5,197	Measles	55	-
Leukemia	25	5,173	Osteoarthritis	55	-
Other Injuries	26	4,753	Meningitis	55	-
Bladder Cancer	27	4,010	Oral conditions	55	-
Other Neoplasms	28	3,698	Pertussis	55	-
Esophagus Cancer	29	3,608	Tetanus	55	-
Ovary Cancer	30	3,319	Prostatic Hypertrophy	55	-
Skin Cancers	31	2,720	War	55	-
Uterine Cancer	32	2,609	Appendicitis	55	-