White Paper

The Cost of the 340B Program to States

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Abstract

The 340B Drug Pricing Program is not free, as established in previous research. For employer-sponsored health plans, which in aggregate cover more than 150 million Americans, 340B discounts displace manufacturer rebates on the same drug, raising costs for employers and workers.

However, 340B utilization — defined here as the percentage of drug sales or prescriptions involving products purchased at 340B discount pricing — can vary by geography due to factors such as the geographical concentration and distribution of 340B covered entities, the extent of their contract pharmacy networks, and the degree of Medicaid expansion in a state. Using a national sample of pharmacy claims and drug sales data from 2023, the authors studied 340B utilization in each state and modeled its costs for employer-sponsored health insurance plans. Modeled under the status-quo patient definition, 340B utilization was found to vary by an order of magnitude, from 4% to 43%, across states. That translated into cost increases for employer-sponsored plans from $13 to $152 per covered beneficiary depending on the state, totaling $6.6B over the entire United States for 2023. Separately estimated, 340B increased healthcare costs for state and local governments by $1.0B, with the cost per covered beneficiary being about 10% greater due to higher government plan spending.

Furthermore, this study looked at the potential effect of state contract pharmacy legislation, where states have proposed or implemented prohibitions on manufacturers' contract pharmacy policies. These state bills would restore a potentially unlimited number of contract pharmacies per cover entity, further raising 340B utilization. We estimated the additional cost of these bills to be $1.9B for all employer-sponsored plans, and $273M for state and local government plans, measured separately.

These findings suggest that employers and workers are being asked to pay substantial 340B program costs, which has policy implications.

Introduction

The 340B program results in price arbitrage[1] when 340B drugs are dispensed to patients with commercial health insurance plans. They also displace manufacturers' commercial rebates, raising drug spending for these plans and patients. More than 150 million Americans have commercial health insurance,[2] often provided by their employers, unions, and state and local governments.

A natural follow-up question to ask is: Is utilization of 340B uniform across the nation? Furthermore, some states have introduced legislation to restore unlimited contract pharmacies. This study seeks to estimate the size and cost of 340B for each state, and to estimate the additional cost of expanded 340B utilization from state contract pharmacy legislation.

A statistical model[3] was created combining multiple data sources, including participation data for 340B hospitals and clinics, pharmacy and medical claims, and drug purchasing data.

The history of the 340B program

The 340B program was created by the Veterans Health Care Act of 1992. The goal of the program was to help 340B hospitals and clinics to stretch scarce federal resources to low-income and uninsured patients. The program requires drug manufacturers to provide discounted pricing on qualifying drugs to participating 340B hospitals and clinics.

The program has grown rapidly since its inception. This growth has been driven by a number of factors, including but not limited to: hospital consolidation; legislative changes such as the Affordable Care Act; the introduction and expansion of contract pharmacies; and judicial decisions that could impact how the program is implemented, such as the Genesis Healthcare case.[4] The 2023 estimate of total sales in the 340B program is more than $120B at wholesale acquisition cost (WAC)[5] and more than $60B at discounted prices.[6]

340B eligibility

The legislation that created the 340B program notably did not include a definition of 340B patient eligibility.[7] In 1996, The Health Resources and Services Administration (HRSA) released guidance known as the "patient definition" to clarify eligibility.[8] It was understood that only medications prescribed or administered during care episodes at the 340B hospital or clinic could be 340B-eligible. However, with the introduction and expansion of contract pharmacies, and more recently, the Genesis Healthcare case,[9] 340B eligibility has expanded while still being subject to potentially varying interpretations by different stakeholders in the system.

To reflect this reality, 340B eligibility is modeled in two ways in this study: the first is based on a claim-level interpretation of the 1996 patient definition, and the second is based on the "expanded definition" following the Genesis case. The former represents a conservative view on 340B eligibility as-is, while the latter gives a forward-looking view on the size and reach of 340B covered entities.

Manufacturers' contract pharmacy policies and state contract pharmacy bills

The original 1992 340B legislation did not contain any provision regarding contract pharmacies, with the intent that hospitals and clinics would stock and offer discounted drugs onsite. In 1996, HRSA issued guidance allowing covered entities without onsite pharmacies to contract with one off-site pharmacy. Later guidance eliminated the limitation of one contract pharmacy and the total number of contract pharmacies increased sharply.[10] In conducting this study, IQVIA was able to identify about 40,000 contract pharmacies nationally in 2023 using Office of Pharmacy Affairs (OPAIS) records.

Starting in 2020, manufacturers implemented policies to require contract pharmacy data submission and limit the number of contract pharmacies allowed for each coverered entity in the 340B program.[11]

And in response to manufacturer restrictions, several states have introduced or passed bills prohibiting the use of contract pharmacy restrictions.[12] If these bills are widely adopted, they could accelerate 340B growth by allowing covered entities to utilize contract pharmacies more extensively, expanding 340B drug utilization.

Data and methods

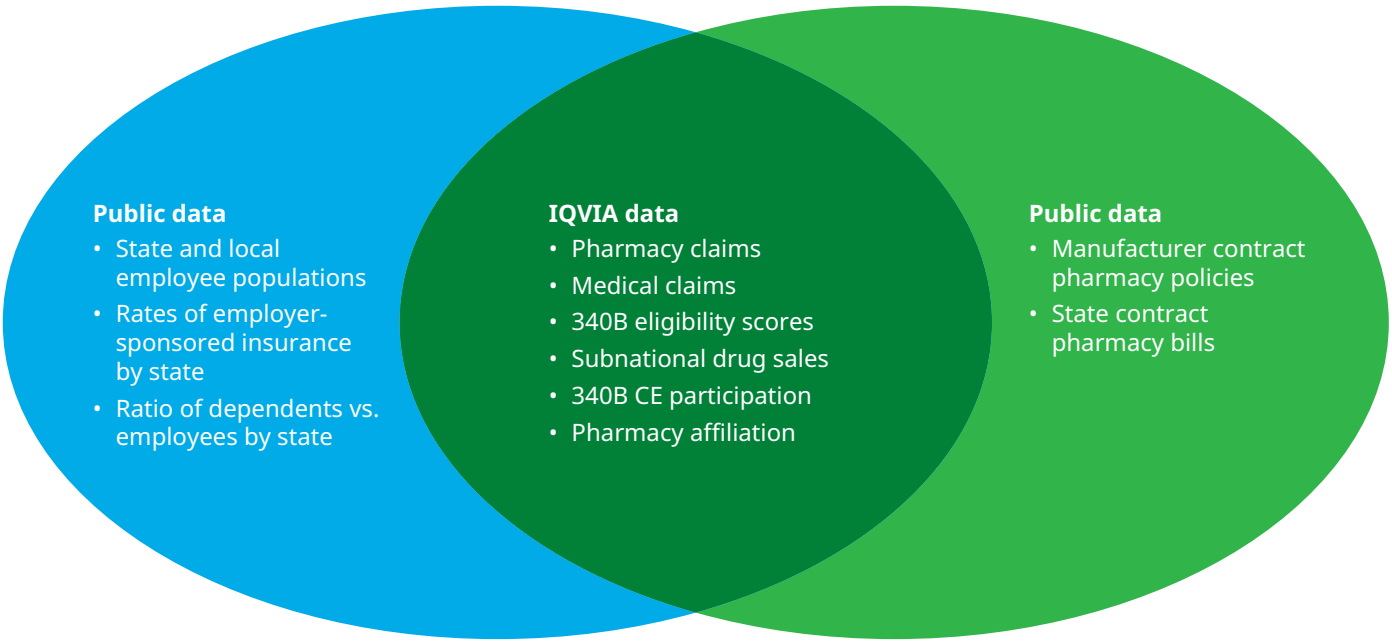
Data

A number of public and IQVIA proprietary data sources were used in this study, including drug sales, pharmacy and medical claims, healthcare providers (HCP) affiliation data, and covered entity and contract pharmacy participation data.

Additionally, IQVIA summarized textual data from state contract pharmacy legislation and manufacturers' contract pharmacy policy letters.

A list of data sources used is summarized in Figure 1.

Figure 1: Summary of public and IQVIA data used in the study. CE: covered entity.



340B utilization by state

340B utilization was estimated in two ways: 340B eligibility scores and subnational drug sales data. A claims-level estimate, called "340B eligibility scores" based on the 1996 patient definition was created using previously reported methods.[13] In addition, 340B utilization was estimated using subnational sales data as the percentage of sales at list price purchased through the 340B program.

The 340B eligibility score is based on claims data. IQVIA used a combination of claims data, IQVIA's HCP affiliation data, and OPAIS 340B covered entity and contract pharmacy reports data to determine the percentage of 340B eligibility of each claim. 340B eligibility was aggregated to the state contract pharmacy level to account for a consistent measure of eligibility.

Subnational drug sales capture both 340B and non-340B sales to hospitals, clinics, and pharmacies. The 340B sales figures were aggregated to the state level using their bill-to locations. Averages of the two methods were used as 340B utilization by state. See Figure 2 for an illustration of state-level 340B utilization.

Additional methodology[14] was used to estimate a separate set of 340B utilization by state under the expanded 340B patient definition following the Genesis case. For this method, patients of a 340B covered entity would have all of their pharmacy claims, within a period of up to two-years after the initial encounter at the 340B covered entity, converted to 340B no matter who the prescribing HCP was or where they worked at the time of prescription.

For the rest of this white paper, "Patient Definition" and "Expanded Eligibility" are used to denote the two methods, respectively.

Costs to plans

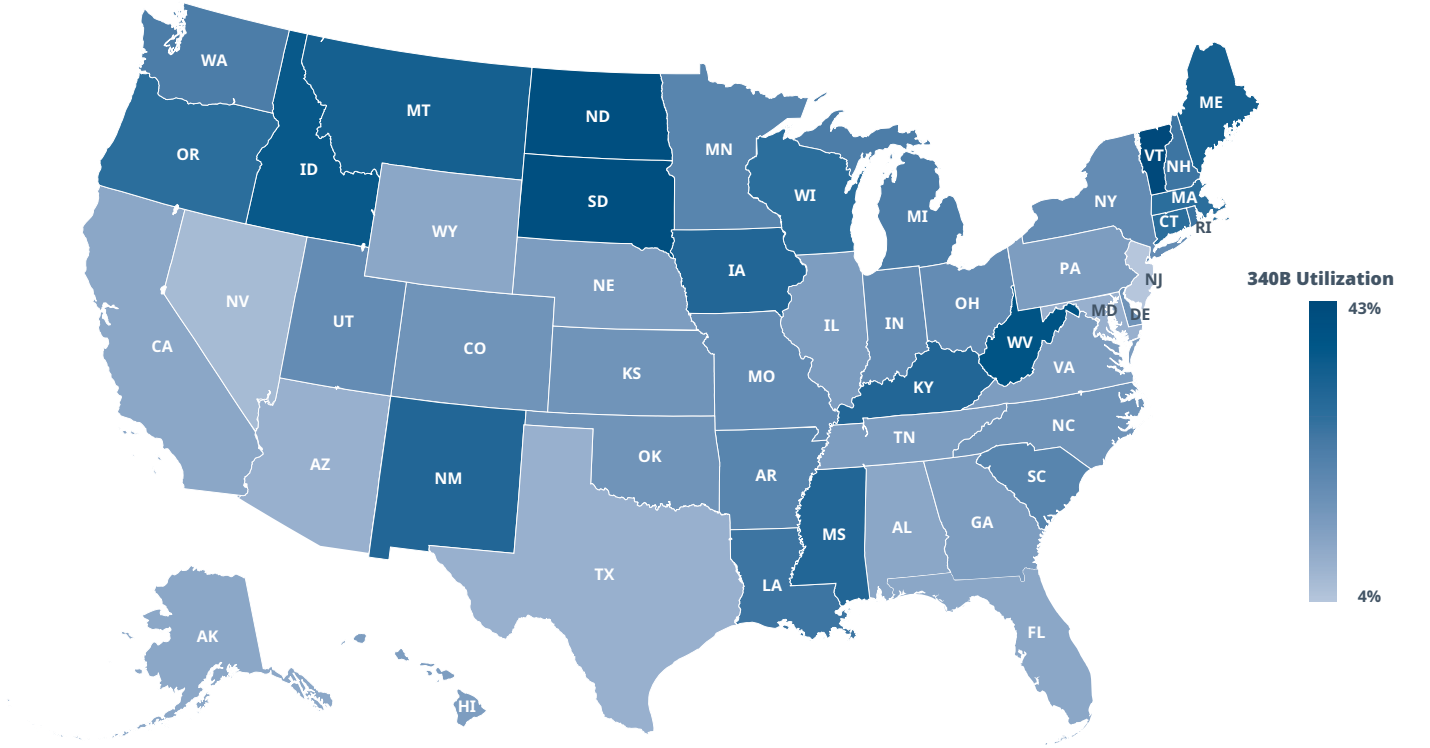
The study used two sources on healthcare spending. Generally, government plans have higher premiums and spending. While premiums for non-government plans were not publicly available, premium data for state and local government plans-only was sourced from the Medical Expenditure Panel Survey (MEPS) 2023.[15] And for all employer-sponsored plans, the study used premium data as estimated in a recent study.[16]

Numbers of beneficiaries covered under employer-sponsored plans by state were sourced from Kaiser Family Foundation (KFF) estimates based on the 2023 American Community Survey.[2] The data excluded beneficiaries under multiple coverages such as Medicare, Medicaid, or Veterans Affairs.

Numbers of beneficiaries covered under state and local government plans were estimated by state using a combination of: 1) the number of state and local Full-Time Equivalents (FTEs)[17] and 2) dependent/worker ratios by state.[2]

340B utilization was used to estimate lost rebates using a previously reported methodology,[3] aggregated at the state level.

Figure 2: 340B utilization varies by state



Additional cost of state contract pharmacy bills

This analysis focused on self-administered products subject to manufacturers' contract pharmacy restriction policies. We employed two methods to estimate the impact of state contract pharmacy bills on 340B eligibility.

1. **Eligibility score method:** This method combined current 340B utilization in subnational drug sales data and claim-level 340B eligibility to estimate potential 340B expansion for individual products at the state level.
2. **Historical trend method:** This approach used historical 340B volume trends to predict 340B volumes in scenarios without contract pharmacy policies.

The two methods were combined to generate robust product-state 340B expansion estimates, which were input into our financial model to calculate rebate loss per worker, scaled by the number of covered beneficiaries to determine incremental costs above status quo 340B expenses.

Limitations

Several limitations apply to this study.

For states with a significant percentage of their population living close to state borders, or a significant percentage of the population regularly commuting across state lines, 340B utilization might not be accurately attributed to states.

For mail-order contract pharmacies and central-warehouse/central-fill contract pharmacies, their contribution to 340B utilization was allocated to the state of their registered addresses. To the extent they shipped 340B drugs across state lines, the 340B utilization and cost of state contract pharmacy bills might not be attributed accurately by state.

It was assumed that all plans sponsored by commercial employers have the same average premiums, total healthcare spend, drug spend, and rebates. This was done to ensure the only independent variables were 340B utilization and size of covered beneficiaries. For state and local government plans, a separate set of cost estimates was used. Government plans often have better coverage (hence higher premiums)[18] and more dependents per employee. Federal employees and the military were excluded from the study.

To estimate the costs of state contract pharmacy bills, individual products under manufacturers' contract pharmacy policies were assumed to continue their pre-bill growth in sales.

Physician-administered drugs can be 340B when they are administered for outpatient care at 340B covered entities and separately payable. However, drug cost estimates for health plans might underestimate spending on physician-administered drugs since they are generally covered under medical benefits mixed with procedures and other services, while self-administered drugs are separately covered under pharmacy benefits.

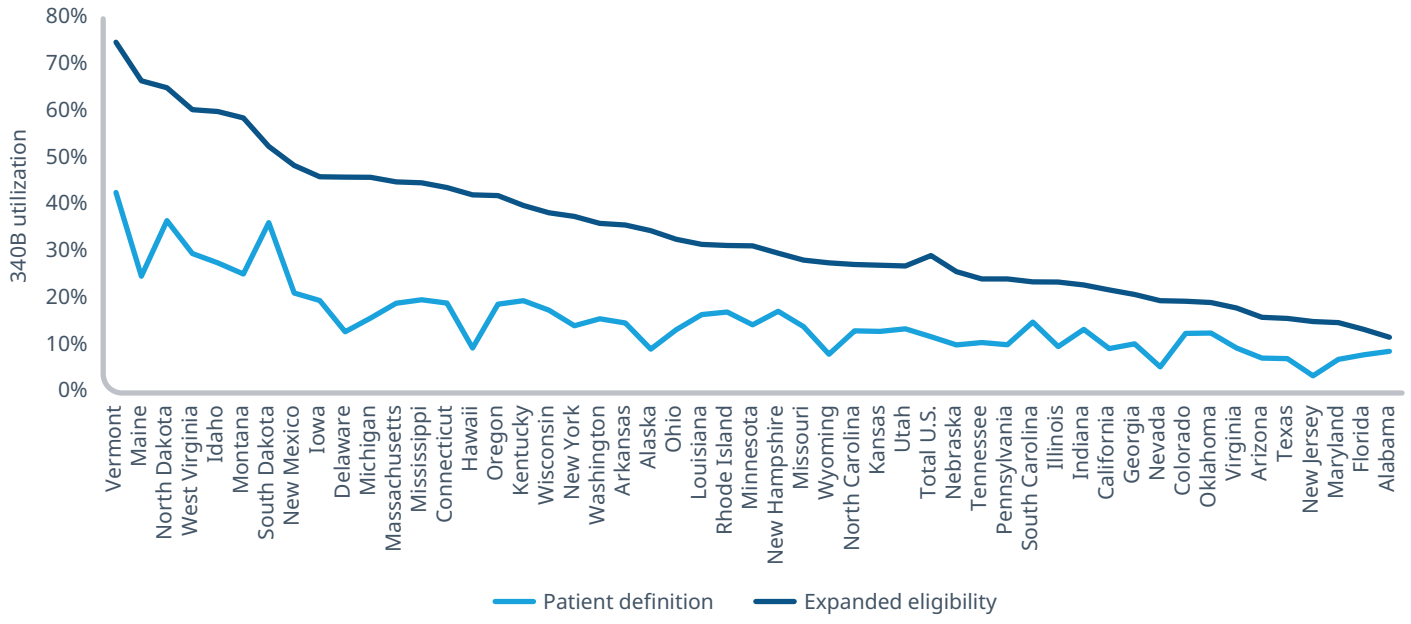
Findings

Cost to all employer-sponsored plans

Nationally, 12% of drug utilization was 340B-eligible under the Patient Definition method and 29% under the Expanded Eligibility method. This represented $43 per beneficiary under the Patient Definition and increased to $96 per beneficiary under Expanded Eligibility.

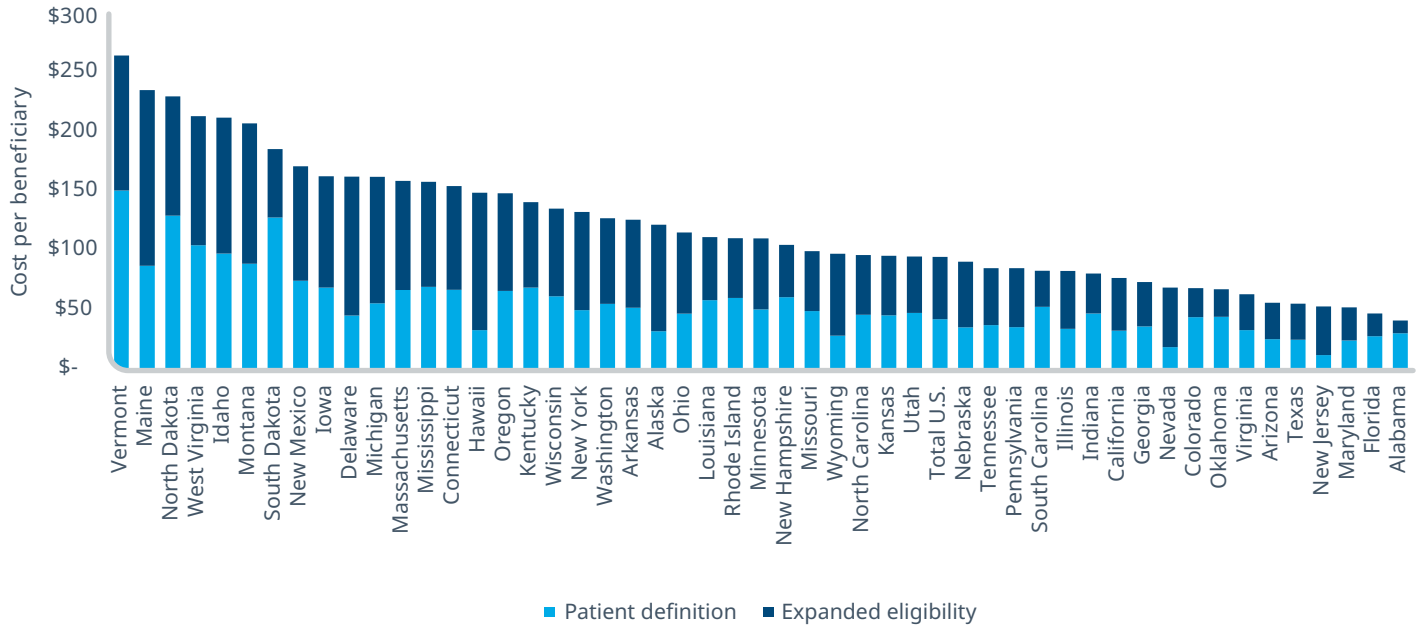
Some rural states had 340B utilization as high as 43% under the Patient Definition and 75% under Expanded Eligibility, which represented $152 per beneficiary under the Patient Definition and up to $265 under Expanded Eligibility. A complete set of state-level estimates for 340B utilization and per beneficiary cost under both methods are summarized in Figures 3 and 4, respectively.

Figure 3: 340B utilization by state, ranked in descending order of 340B cost per beneficiary



Source: Data shown is based on the authors' calculations. IQVIA 2025.

Figure 4: 340B cost per beneficiary by state, ranked in descending order of cost



Source: Data shown is based on the authors' calculations. IQVIA 2025.

Cost to state and local government plans

We also used state-level 340B eligibility to calculate the cost of 340B to state and local governments, but assumed higher premiums and higher drug spending for these plans as estimated from the MEPS 2023 data. This resulted in a slightly higher cost of 340B in terms of lost rebates, ranging from $14 to $160 per covered beneficiary under the Patient Definition and $45 to $281 under Expanded Eligibility.

By state, total costs ranged from $2M to $89M under the Patient Definition, and $7M to $215M for Expanded Eligibility. Figure 5 presents a visualization of 340B costs for state and local government plans.

Figure 5: 340B costs to state and local government plans by state, ranked in descending order of the number of covered beneficiaries

Source: Data shown is based on the authors' calculations. IQVIA 2025.

Additional cost of state contract pharmacy bills

Nationally, state contract pharmacy bills could add $1.8B to existing 340B drug costs. This represents a 27% increase in the total cost of the program from $6.6B to $8.4B.

The impact of contract pharmacy bills varied significantly by state, influenced by factors such as the concentration of 340B covered entities, provider-pharmacy market consolidation, 340B eligibility rates, and workforce size. For all employers, the estimated rebate loss per worker from state bills would rise from $9 to $21 under the Patient Definition and surge to $41 under Expanded Eligibility, a substantial increase. See Figure 6 for a visualization of cost per beneficiary by state.

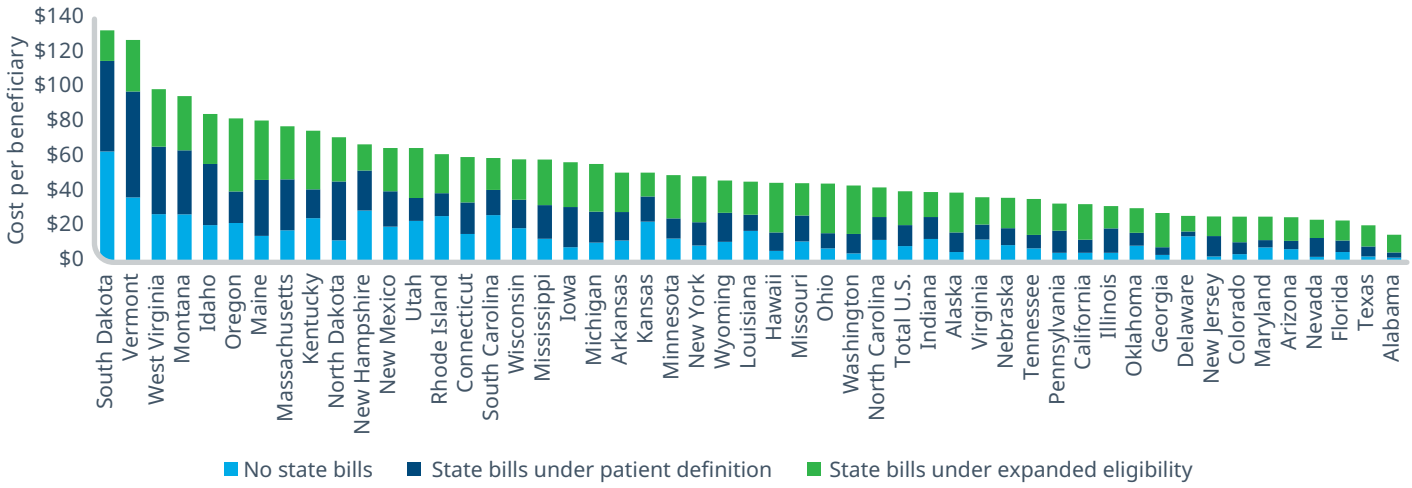
State and local governments face particularly acute cost increases, rising from $234M without contract pharmacy mandates to $506M under the Patient Definition with state bills and reaching $965M under Expanded Eligibility. See Figure 7 for a summary of estimates by bill status.

We predicted states that have already enacted contract pharmacy bills would experience cost increases. Eight states that passed contract pharmacy bills (AR, KS. LA. MD, MN, MS, MO, and WV; see Figure 9 for a timeline) face an increase from $223M to $425M (a 91% increase) under Patient Definition, potentially escalating to $735M under Expanded Eligibility.

For the four states with pending contract pharmacy legislation (DE, KY, MA, and RI), if the bill were to go into effect, state and local governments could see costs rise from $137M to $281M (106% increase) under the Patient Definition, or $472M under Expanded Eligibility. Fifteen states with introduced bills (AZ, CT, FL, ID, IL, IA, MI, NE, NY, OH, OK, OR, SC, UT, and VA) might experience a jump from $592M to $1.3B (113% increase) or $2.4B under Expanded Eligibility. See Figure 8 for a complete summary of the incremental costs of 340B by legislation status.

See Appendix Tables for the complete set of cost estimates by state.

Figure 6: Cost of 340B per beneficiary under contract pharmacy bill by state



Source: Data shown is based on the authors' calculations. IQVIA 2025

Figure 7: Total cost of state contract pharmacy bills at a national level

	KEY METRICS	NO STATE BILLS	STATE BILLS + PATIENT DEFINITION	STATE BILLS + EXPANDED ELIGIBILITY
Size of 340B	340B expansion factor vs trend	1	**2.2**	4.2
	340B utilization	5%	**10%**	20%
Financial impact of 340B	Cost per beneficiary	$9	**$21**	$41
	Cost of 340B for employer-sponsored plans	$1,516M	**$3,305M**	$6,309M
	Cost of 340B for state and local government plans	$234M	**$506M**	$965M

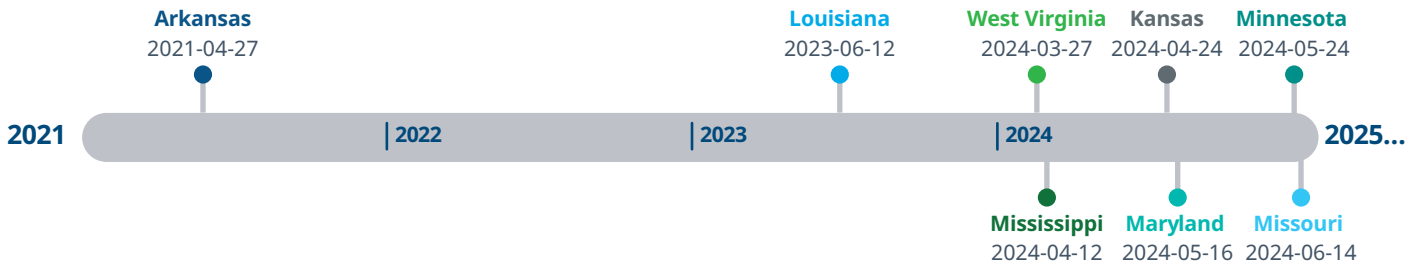
Source: Data shown is based on the authors' calculations. IQVIA 2025

Figure 8: Incremental cost of 340B by state legislation status

STATE STATUS	# OF STATES	NO STATE BILLS	STATE BILLS + PATIENT DEFINITION	STATE BILLS + EXPANDED ELIGIBILITY
Bill passed	8	$223M	$425M (+91%)	$735M
Bill cleared a legislative chamber	4 (27)	$137M	$281M (+106%)	$472M
Bill introduced	15	$592M	$1,261M (+113%)	$2,413M
No bill	23	$565M	$1,337M (+137%)	$2,689M
Grand total	**50**	**$1,516M**	**$3,305M (+118%)**	**$6,309M**

Source: Data shown is based on the authors' calculations. IQVIA 2025

Figure 9: Timeline for the eight states that passed contract pharmacy bills



Discussion

We previously estimated the cost of the 340B program to self-insured employers and their workers due to the loss of manufacturer rebates,[3] but it was unknown how these costs varied across states for employer-sponsored plans and state and local government plans. Using a national sample of drug sales and claims, the current study found that the cost of the 340B program per beneficiary varies by an order of magnitude across geographies, from a low of $13 per beneficiary in more urbanized states to a high of over $152 per beneficiary in rural states. Studies have found that increases in healthcare costs harm wages and employment.[19]

Although identifying the cause of this variation was not within the scope of the current study, it is likely due to factors such as the mix of urban versus rural populations, the number and density of 340B hospitals and clinics, and variation in adoption of Medicaid expansion as part of the Affordable Care Act.

Notably, there is no limit on the number of affiliated 340B locations for a single 340B hospital; some of the associated offsite locations may be in different states than their 340B parent hospital.[20] See Figure 1 in the Appendix for a graph comparing the number of Covered Entity locations (normalized by population) and 340B utilization by state.

These findings suggest that in some states, employers and workers are being asked to pay a disproportionate share of the cost of the 340B program. However, because of a lack of transparency regarding how the program raises costs, employers and workers are likely oblivious to its impact. A handful of states have implemented reporting requirements for the 340B program.[21,22]

The mechanism modeled by the current study was how the 340B program increases drug costs by displacing manufacturer rebates. However, other studies have reported how the program could raise the cost of healthcare services in general via hospital consolidation,

driven by the incentive of 340B revenue, such as: 1) the acquisition of community practices and rising prices from to hospital markups,[23] 2) local patients and employers paying higher costs from such markups,[24] and 3) patients getting into more medical debt.[23] If so, our estimates of the cost of the 340B program to states are conservative.

Future empirical studies can further this research by testing factors contributing to state variation in 340B utilization as shown in this study, and testing for causal relationships between high 340B utilization, hospital consolidation, and markups.

Meanwhile, federal legislation is needed to constructively address the unintended consequences of 340B. Currently state and local taxpayers are inadvertently responsible for unintended 340B costs to state and local government plans. Even ignoring the cost argument, the patchwork of state 340B laws complicates compliance for all 340B stakeholders, undermining the original intent of assistance to low-income and uninsured patients. Furthermore, federal reporting requirements for 340B covered entities are necessary to cultivate trust between all stakeholders and ensure the integrity of the program.

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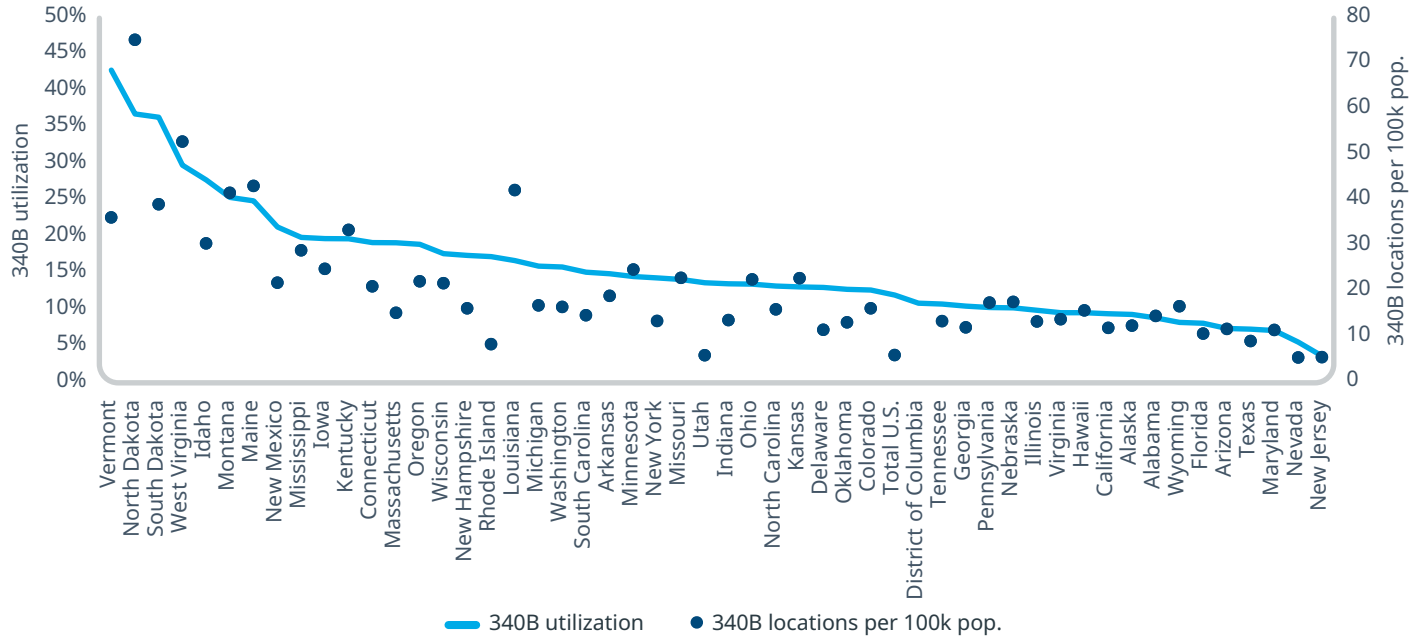
Appendix

Appendix figure 1: 340B utilization and number of 340B locations per 100k population by state



Appendix table 1: State level 340B utilization, cost per beneficiary, and total cost under the patient definition. (CP = Contract Pharmacy)

			PER BENEFICIARY				TOTAL COST			
STATE	STATE	340B UTILIZATION	LOST REBATE: ALL EMPLOYER	LOST REBATE: STATE AND LOCAL GOVERNMENTS	CP BILL: ALL EMPLOYER	CP BILL: STATE AND LOCAL GOVERNMENTS	LOST REBATE: ALL EMPLOYER	LOST REBATE: STATE AND LOCAL GOVERNMENTS	CP BILL: ALL EMPLOYER	CP BILL: STATE AND LOCAL GOVERNMENTS
Alabama	AL	9%	$31	$33	$3	$3	$69,823,686	$12,354,243	$6,465,753	$1,144,017
Alaska	AK	9%	$33	$35	$11	$12	$10,463,277	$2,366,270	$3,554,954	$803,953
Arizona	AZ	7%	$26	$28	$5	$5	$84,395,691	$10,675,447	$15,323,102	$1,938,262
Arkansas	AR	15%	$53	$56	$16	$17	$62,653,923	$12,231,084	$19,416,336	$3,790,391
California	CA	9%	$34	$35	$8	$8	$586,203,036	$89,003,479	$132,439,149	$20,108,298
Colorado	CO	13%	$45	$48	$7	$7	$131,863,886	$19,639,688	$20,042,138	$2,985,058
Connecticut	CT	19%	$68	$72	$18	$19	$121,302,602	$17,353,633	$32,477,551	$4,646,260
Delaware	DE	13%	$46	$49	$3	$3	$22,313,073	$3,290,302	$1,349,375	$198,980
Florida	FL	8%	$29	$31	$7	$7	$245,816,719	$35,058,227	$56,231,096	$8,019,644
Georgia	GA	11%	$37	$39	$5	$5	$186,734,179	$27,289,637	$22,611,877	$3,304,537
Hawaii	HI	10%	$34	$36	$11	$11	$21,921,487	$3,342,083	$6,861,661	$1,046,108
Idaho	ID	28%	$98	$104	$35	$37	$86,679,674	$12,687,795	$30,997,424	$4,537,269
Illinois	IL	10%	$35	$37	$14	$15	$223,778,035	$31,008,037	$89,631,185	$12,419,839
Indiana	IN	14%	$48	$51	$13	$13	$162,969,991	$22,352,767	$42,757,863	$5,864,617
Iowa	IA	20%	$70	$74	$23	$25	$113,646,899	$19,079,897	$37,670,044	$6,324,331
Kansas	KS	13%	$47	$49	$15	$15	$69,010,989	$13,451,789	$21,608,023	$4,211,888
Kentucky	KY	20%	$70	$74	$17	$18	$136,823,983	$22,854,309	$32,679,332	$5,458,572
Louisiana	LA	17%	$59	$63	$9	$10	$103,452,582	$21,095,402	$16,210,640	$3,305,572
Maine	ME	25%	$88	$93	$32	$34	$54,306,001	$8,736,466	$19,797,796	$3,184,966
Maryland	MD	7%	$25	$27	$4	$4	$79,242,889	$11,454,138	$13,154,636	$1,901,433
Massachusetts	MA	19%	$68	$72	$29	$31	$240,574,983	$33,125,138	$103,892,613	$14,305,133
Michigan	MI	16%	$57	$60	$18	$19	$272,352,492	$34,328,664	$85,692,887	$10,801,158
Minnesota	MN	15%	$51	$55	$12	$12	$157,909,602	$22,072,419	$35,600,107	$4,976,141
Mississippi	MS	20%	$70	$75	$19	$21	$82,833,492	$17,305,085	$22,807,510	$4,764,811
Missouri	MO	14%	$50	$53	$15	$16	$152,187,640	$21,875,041	$45,385,798	$6,523,632
Montana	MT	25%	$90	$95	$37	$39	$41,563,396	$7,360,077	$17,018,999	$3,013,737
Nebraska	NE	10%	$36	$38	$10	$10	$36,621,755	$6,805,508	$9,789,728	$1,819,248
Nevada	NV	6%	$20	$21	$11	$11	$28,032,574	$3,196,793	$15,357,739	$1,751,374
New Hampshire	NH	17%	$62	$65	$23	$24	$45,669,055	$5,716,718	$17,031,765	$2,131,986
New Jersey	NJ	4%	$13	$14	$12	$12	$62,635,135	$8,646,072	$56,577,031	$7,809,819
New Mexico	NM	21%	$76	$80	$20	$22	$54,510,340	$12,581,514	$14,655,749	$3,382,689
New York	NY	14%	$51	$54	$13	$14	$445,368,718	$81,901,229	$117,345,224	$21,579,239
North Carolina	NC	13%	$47	$50	$13	$14	$221,100,409	$35,753,048	$62,074,974	$10,037,835
North Dakota	ND	37%	$130	$138	$34	$36	$53,441,272	$9,503,537	$13,878,721	$2,468,073
Ohio	OH	14%	$48	$51	$9	$9	$275,518,168	$40,143,237	$50,705,458	$7,387,829
Oklahoma	OK	13%	$45	$48	$7	$8	$73,947,493	$13,661,751	$12,083,342	$2,232,390
Oregon	OR	19%	$67	$71	$18	$19	$130,603,406	$19,986,914	$35,403,543	$5,417,987
Pennsylvania	PA	10%	$36	$39	$13	$13	$226,891,625	$27,042,079	$78,848,280	$9,397,533
Rhode Island	RI	17%	$61	$65	$13	$14	$31,958,235	$3,955,707	$6,897,025	$853,696
South Carolina	SC	15%	$54	$57	$14	$15	$120,751,529	$19,723,996	$32,583,394	$5,322,291
South Dakota	SD	36%	$129	$136	$52	$55	$57,047,819	$9,099,013	$23,084,753	$3,681,972
Tennessee	TN	11%	$38	$40	$8	$8	$123,358,581	$18,094,583	$25,185,657	$3,694,303
Texas	TX	7%	$26	$28	$6	$6	$352,698,400	$57,473,004	$78,195,369	$12,742,113
Utah	UT	14%	$49	$51	$13	$14	$95,221,477	$13,046,951	$25,959,211	$3,556,850
Vermont	VT	43%	$152	$160	$61	$65	$43,907,105	$7,778,671	$17,661,209	$3,128,895
Virginia	VA	10%	$34	$36	$9	$9	$145,778,935	$22,104,059	$37,154,992	$5,633,709
Washington	WA	16%	$56	$59	$11	$12	$218,005,416	$30,972,124	$43,518,970	$6,182,759
West Virginia	WV	30%	$105	$112	$39	$41	$75,890,638	$14,460,940	$27,974,481	$5,330,529
Wisconsin	WI	18%	$63	$66	$16	$17	$192,460,122	$24,505,120	$50,361,322	$6,412,291
Wyoming	WY	8%	$29	$31	$17	$18	$8,139,777	$2,178,520	$4,658,363	$1,246,759
Total U.S.		**12%**	**$43**	**$46**	**$12**	**$16**	**$6,640,382,193**	**$1,019,722,208**	**$1,788,664,147**	**$272,780,773**

Appendix table 2: State level 340B utilization, cost per beneficiary, and total cost under the expanded eligibility. (CP = Contract Pharmacy)

			PER BENEFICIARY				TOTAL COST			
STATE	STATE	340B UTILIZATION	LOST REBATE: ALL EMPLOYER	LOST REBATE: STATE AND LOCAL GOVERNMENTS	CP BILL: ALL EMPLOYER	CP BILL: STATE AND LOCAL GOVERNMENTS	LOST REBATE: ALL EMPLOYER	LOST REBATE: STATE AND LOCAL GOVERNMENTS	CP BILL: ALL EMPLOYER	CP BILL: STATE AND LOCAL GOVERNMENTS
Alabama	AL	12%	$42	$45	$13	$14	$93,467,502	$16,537,658	$29,278,462	$5,180,380
Alaska	AK	35%	$123	$130	$34	$36	$38,700,490	$8,752,115	$10,784,890	$2,439,003
Arizona	AZ	16%	$57	$60	$18	$19	$182,861,799	$23,130,701	$58,929,392	$7,454,144
Arkansas	AR	36%	$127	$134	$39	$41	$150,353,800	$29,351,554	$46,250,520	$9,028,868
California	CA	22%	$78	$82	$28	$30	$1,361,876,676	$206,774,368	$490,548,925	$74,480,271
Colorado	CO	20%	$69	$73	$22	$23	$203,248,052	$30,271,581	$63,331,941	$9,432,602
Connecticut	CT	44%	$155	$164	$44	$47	$277,100,717	$39,642,217	$79,119,500	$11,318,889
Delaware	DE	46%	$163	$173	$12	$12	$78,692,467	$11,604,048	$5,627,851	$829,887
Florida	FL	14%	$48	$51	$18	$19	$409,182,898	$58,357,410	$154,006,445	$21,964,303
Georgia	GA	21%	$74	$79	$24	$26	$373,581,878	$54,595,864	$121,596,352	$17,770,289
Hawaii	HI	42%	$150	$158	$39	$42	$96,603,156	$14,727,822	$25,339,516	$3,863,185
Idaho	ID	60%	$213	$225	$64	$68	$187,451,934	$27,438,401	$56,412,993	$8,257,489
Illinois	IL	24%	$84	$89	$27	$28	$533,436,201	$73,916,145	$171,281,322	$23,733,775
Indiana	IN	23%	$82	$86	$27	$29	$276,726,707	$37,955,501	$91,310,774	$12,524,076
Iowa	IA	46%	$163	$173	$49	$52	$265,866,026	$44,635,590	$79,640,646	$13,370,671
Kansas	KS	27%	$97	$102	$28	$30	$143,348,434	$27,941,823	$41,847,235	$8,156,964
Kentucky	KY	40%	$142	$150	$50	$53	$277,726,106	$46,389,808	$98,784,225	$16,500,362
Louisiana	LA	32%	$112	$119	$28	$30	$195,985,195	$39,964,073	$49,432,773	$10,080,021
Maine	ME	67%	$236	$250	$66	$70	$145,239,086	$23,365,305	$40,868,219	$6,574,666
Maryland	MD	15%	$53	$56	$18	$19	$166,066,533	$24,004,034	$55,257,821	$7,987,224
Massachusetts	MA	45%	$160	$169	$60	$63	$565,757,390	$77,900,002	$212,078,494	$29,201,413
Michigan	MI	46%	$163	$173	$45	$48	$784,462,458	$98,877,554	$217,645,312	$27,433,099
Minnesota	MN	31%	$111	$118	$36	$39	$340,984,672	$47,662,438	$111,815,010	$15,629,371
Mississippi	MS	45%	$159	$168	$46	$48	$186,733,584	$39,011,281	$53,615,564	$11,201,048
Missouri	MO	28%	$100	$106	$34	$35	$305,070,342	$43,849,988	$101,873,612	$14,643,038
Montana	MT	59%	$208	$220	$68	$72	$96,174,087	$17,030,578	$31,469,247	$5,572,598
Nebraska	NE	26%	$92	$97	$27	$29	$92,349,034	$17,161,440	$27,442,230	$5,099,655
Nevada	NV	20%	$70	$74	$21	$23	$99,163,135	$11,308,415	$30,339,017	$3,459,816
New Hampshire	NH	30%	$106	$112	$38	$40	$78,199,633	$9,788,800	$28,133,119	$3,521,621
New Jersey	NJ	15%	$54	$57	$23	$24	$259,972,815	$35,886,307	$111,046,001	$15,328,644
New Mexico	NM	49%	$172	$182	$45	$48	$124,075,629	$28,637,856	$32,669,458	$7,540,427
New York	NY	38%	$133	$141	$40	$42	$1,168,781,422	$214,933,450	$348,651,591	$64,115,401
North Carolina	NC	27%	$97	$103	$30	$32	$457,488,355	$73,978,167	$142,616,704	$23,061,838
North Dakota	ND	65%	$231	$244	$59	$63	$94,637,958	$16,829,602	$24,333,780	$4,327,311
Ohio	OH	33%	$116	$123	$37	$39	$668,841,587	$97,450,803	$214,755,174	$31,290,016
Oklahoma	OK	19%	$68	$72	$22	$23	$111,620,437	$20,621,803	$35,324,697	$6,526,215
Oregon	OR	42%	$149	$158	$60	$64	$290,344,536	$44,432,924	$117,168,559	$17,930,910
Pennsylvania	PA	24%	$86	$91	$28	$30	$535,903,754	$63,871,692	$175,780,475	$20,950,397
Rhode Island	RI	32%	$111	$118	$36	$38	$58,226,010	$7,207,064	$18,593,967	$2,301,513
South Carolina	SC	24%	$84	$89	$33	$35	$188,997,848	$30,871,600	$74,034,089	$12,092,999
South Dakota	SD	53%	$186	$197	$70	$74	$82,565,168	$13,168,980	$30,878,839	$4,925,113
Tennessee	TN	24%	$86	$91	$28	$30	$278,628,751	$40,870,047	$91,991,519	$13,493,574
Texas	TX	16%	$56	$60	$18	$19	$763,685,316	$124,444,255	$242,675,693	$39,544,555
Utah	UT	27%	$96	$102	$42	$44	$188,364,500	$25,809,118	$82,331,938	$11,280,866
Vermont	VT	75%	$265	$281	$91	$96	$76,786,872	$13,603,716	$26,266,331	$4,653,396
Virginia	VA	18%	$64	$68	$24	$26	$275,477,623	$41,769,915	$104,544,470	$15,851,791
Washington	WA	36%	$128	$136	$39	$41	$497,640,873	$70,700,055	$151,713,747	$21,554,038
West Virginia	WV	61%	$214	$227	$72	$76	$154,038,022	$29,351,902	$51,840,552	$9,878,203
Wisconsin	WI	39%	$136	$144	$40	$42	$418,876,125	$53,333,697	$121,751,074	$15,502,041
Wyoming	WY	28%	$98	$104	$35	$37	$27,314,364	$7,310,385	$9,812,083	$2,626,095
Total U.S.		**29%**	**$96**	**$102**	**$32**	**$34**	**$14,728,677,959**	**$2,257,029,850**	**$4,792,842,149**	**$731,484,069**

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