



How Copay Coupons Could Raise Prescription Drug Costs By \$32 Billion Over the Next Decade

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I. Executive Summary

Much has been much written about the strategies that brand drug companies will use to combat the “generic wave” of medications becoming available. One answer can be found in the “copay coupon” marketing campaigns now flooding the marketplace. Much is at stake, as each one percentage point decrease in the generic drug dispensing rate raises the amount that employers, unions, state governments, and consumers spend on prescription drugs by \$3 billion annually.

From cereal to detergent, consumer brands often use coupon promotions instead of price reductions to lure consumers away from lower-priced competitors. Recently, however, drug companies have started using copay coupons to increase sales of brand name drugs among those with prescription drug coverage. The difference is that two-thirds of prescription drug costs are not paid by consumers but by the employers, unions, and government agencies (i.e., taxpayers) that provide coverage. As copay coupons reduce the use of generics and more affordable brands, overall prescription drug costs increase dramatically.

By definition, copay promotions target only those who already have prescription drug coverage (i.e., those who pay copays). These programs are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are banned in Medicare and Medicaid but are allowed in the commercial market (except in Massachusetts).

This report examines copay coupon marketing programs that encourage insured consumers to choose expensive brand drugs over generics and other, more affordable brands in the same therapeutic class. The potential costs of such programs are substantial:

- **Copay coupons will increase ten-year prescription drug costs by \$32 billion for employers, unions and other plans sponsors if current trends continue.**

If the use of copay coupons were to expand into programs that currently ban them, costs would rise even more:

- **If Medicare’s ban on copay coupons were not enforced, costs to the Part D program would increase by \$18 billion over the 2012–21 period.**
- **If Massachusetts were to repeal its law banning copay coupons, prescription drug costs for employers and other plan sponsors in that state would increase by \$750 million over the next decade.**

Drug companies profit from coupon marketing programs in several key ways:

- Copay coupons induce consumers to choose higher-cost brands (despite higher copays) over lower-cost competitors (despite lower copays). When consumers redeem copay coupons, the drug companies process them through a “shadow claims system” that prevents employers and other plan sponsors from knowing when enrollees have used them.
- Drug companies often require consumers to submit confidential, personal information in order to redeem copay coupons. Manufacturers have long sought (but found difficult to obtain) such sensitive patient data, which enables them to identify and directly target individual patients with “brand loyalty” marketing programs.

Impact of Copay Coupons on Employers

Copay coupons undermine employers’ ability to use different copay amounts to reduce drug costs. Employer costs rise dramatically when enrollees choose expensive brands over more affordable options. The economics of brand copay coupons are simple: each time a drug company can sell a \$150 product by helping cover a \$50 copay, it gains \$100 in revenue, which is paid by the employer that offers coverage.

As one analyst puts it, copay coupons “warp the system,” “steer prescriptions to higher-priced drugs that would ordinarily be written for generics,” and “lead to higher overall costs.”¹

Impact of Copay Coupons on Consumers

Coupons can also increase consumer costs in several ways:

- To help cover the \$4 billion spent annually on copay coupons, manufacturers can simply raise prices. Manufacturers reportedly earn a 4:1 to 6:1 return on investment (ROI) on copay coupon programs.
- Copay coupons create “brand loyalty” to the most expensive products in each therapeutic class of drugs, even among newly diagnosed patients.
- Copay coupons do little to help the poor and uninsured. By definition, copay coupons target those who already have prescription coverage (i.e., those who pay copays).

As Consumers Union has noted, coupon marketers “know what they are doing” when it comes to copay coupons and are “not Santa Claus.”²

¹ CLSA, “Drug Companies: Let’s Make a Deal,” January 19, 2011.

II. Discussion

How Formularies and Copay Incentives Encourage Competition and Reduce Costs

Formularies and copay incentives are important tools used by health plans and pharmacy benefit managers (PBMs) to encourage price competition and reduce drug costs. A plan develops its formulary, or list of covered drugs, based on safety, efficacy, and cost-effectiveness, and then typically covers about two-thirds of the cost of these drugs while enrollees have a copay that covers the remainder.

Health plans design copays so that enrollees have an incentive to choose clinically appropriate prescription drug options with the lowest net cost. Generics typically have the lowest copay and costly brands the highest. Studies show that properly structured copayment incentives encourage consumers to use generics and more affordable brands.^{3,4}

Formularies and copay incentives also provide a competitive structure for health plans and PBMs to negotiate price concessions from brand drug manufacturers. “Preferred” formulary status involves the plan assigning a brand drug a lower copayment than similar brand drugs in the same therapeutic class. Brand drug manufacturers must factor the ability to achieve preferred formulary status into their decisions on introductory prices, price increases, and price concessions in order to effectively compete against rival products.

How Copay Coupons Induce Patients and Prescribers to Ignore Formularies

The Federal Trade Commission (FTC) has recognized the importance of formularies and copay incentives, asserting that insurers “must be free to design plans that align to their and the enrollees’ interests” and that efforts that “make generic substitution and therapeutic interchange less common... increase[s] the costs of pharmaceuticals.”⁵ Manufacturer coupons interfere with plan design and make generic substitution and therapeutic interchange less common. As a result, enrollees choose more expensive brands and costs increase.

Brand drug manufacturers specifically target copay coupons at patients who have prescription drug benefits rather than uninsured or indigent populations. Usually, coupons are available for brand drugs that face competition from generics or preferred medications with lower copays on plan formularies. Coupons undermine formularies by narrowing copayment differentials between

² “Drug Coupon Use Soars, Prompting Safety and Spending Concerns,” *Bloomberg*, October 28, 2010.

³ Fairman, K., “The Future of Prescription Drug Cost Sharing: Real Progress or Dropped Opportunity,” *Journal of Managed Care Pharmacy*, January/February 2008.

⁴ Shang, B., et al., “Pharmacy Benefit Design and Prescription Drug Utilization,” The Urban Institute, Academy Health Abstract No. 190, 2008.

⁵ Federal Trade Commission, Letter to Rep. Patrick T. McHenry, U.S. House of Representatives, July 15, 2005.

brands and generics, reducing the use of generics, and compelling plan sponsors to cover the additional costs associated with greater use of costly brand drugs.

One major copay coupon covers all but \$4 of the consumer's copayment, making the consumer cost for a \$150 non-preferred prescription the same or less than generic alternatives. Though the consumer pays just \$4, the health plan will still pay two-thirds of the original price or approximately \$100. If the consumer had used a generic, the total cost to the consumer and plan would have been as low as \$4.

Copay Coupons Increase 260% in Two Years, \$4 Billion Spent Annually

The profitability of manufacturer copay coupons is evident in their increasing use and ROI. The number of copay coupon programs marketed to the American public has increased by more than 260% in the past two years.⁶ The number of programs listed on the consumer website www.internetdrugcoupons.com is now over 340.⁷ Brand drug makers now spend \$4 billion annually on copay coupon programs⁸ and vendors that administer such programs report that manufacturers earn a 4:1 to 6:1 ROI.^{9,10}

Copay Coupons Create Moral Hazard for Patients and Prescribers

Prescription drugs are not typical consumer products and copay coupons are not typical coupons. Manufacturers of consumer products ranging from cereal to detergent have used coupons for years as an effective marketing strategy to entice consumers to choose their brands over lower priced competitors. Unlike other products prescriptions are ordered by doctors, filled by pharmacists, taken by patients, and mostly paid for by the employers that offer health coverage. As such, "moral hazard" occurs when individuals use more expensive drugs simply because they have insurance.

Copay coupons encourage patients and prescribers to gravitate toward higher-cost brands that offer copay coupons in each therapeutic class.¹¹ One company that administers copay coupons

⁶ Cleveland Research, "How Co-pay Discount Cards Are Affecting Drug Spend," Presented at Pharmacy Benefits Academy, August 2011.

⁷ Visante analysis of www.internetdrugcoupons.com

⁸ Herper, M., "How Bargain Lipitor Could Raise Health Costs," *Forbes*, March 16, 2011.

⁹ "Facing Generic Competition Head On," TrialCard Rx Marketing Intelligence, www.trialcard.com/PDF/TRCC220_CS1_V3.pdf, accessed April 6, 2011.

¹⁰ "Coupons, Vouchers and 'Loyalty Cards' Connect Drugmakers with Patients Brand Marketing/Communications," *Pharmaceutical Commerce*, October 31, 2009.

¹¹ CLSA, op. cit.

freely admits that its goals are to help drug manufacturers increase “loyalty among patients and providers” to specific brands, “neutralize copay disadvantages,” and “help physicians set aside concerns over costs.”¹²

Why Copay Coupons Are Banned in Federal Programs

The Health and Human Services Office of Inspector General (OIG) has consistently advised that manufacturer coupons are banned in federal programs, including Medicare, based on the federal Anti-Kickback Statute.¹³ This statute prohibits the offer or payment of any “remuneration (including any kickback, bribe, or rebate), directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to purchase... any good... or item for which payment maybe made in whole or part under a Federal health care program.” Copay coupons meet the definition of bribes under the statute, since payments are made to induce the use of specific products.

The ban on copay coupons in federal programs serves a vital budgetary role because the Congressional Budget Office (CBO) estimates that Medicare pays an extra \$76 each time a beneficiary chooses a single-source brand over a generic competitor in key therapeutic classes.¹⁴ In the cholesterol-reducing class alone, where brand drug manufacturers are aggressively promoting coupons to the public, CBO estimates that Part D could save nearly \$2 billion annually from greater use of generics.¹⁵ Private-sector employers and other plan sponsors face similar cost implications when brands are used over generics, but are not similarly protected against coupon programs. Each one percentage point decrease in the generic drug dispensing rate raises the amount that employers, unions, state governments, and consumers spend on prescription drugs by \$3 billion annually.

If Medicare’s ban on copay coupons were not enforced, costs to the Part D program would increase by \$18 billion over the 2012–21 period.

¹² “Overcome Formulary Disadvantages and Increase Adherence to Your Brands,” eVoucherRx, Relay Health, www.relayhealth.com/solutions/where-i-work/pharmaceutical-manufacturer/brand-and-marketing-management-roles/evoucherrx.html accessed April 11, 2011.

¹³ 42 U.S.C §1320a-7b(b)

¹⁴ Congressional Budget Office, “Effects of Using Generic Drugs on Medicare’s Prescription Drug Spending,” September 2010.

¹⁵ Ibid.

How Copay Coupons Are Distributed

Copay coupons are typically distributed in three ways:

1. Copay coupons/cards are distributed to physicians' offices (or sometimes pharmacies) by pharmaceutical sales representatives. The coupons or cards are then provided to patients by their physician or pharmacist.
2. Copay coupons/cards may be distributed directly to consumers via drug manufacturer websites, advertisements, and direct mail.
3. Some programs do not require any "coupon/card distribution" whatsoever. Instead, an electronic transaction occurs automatically via an electronic "switch" company that acts as an intermediary between the pharmacy computer systems and the PBM, automatically reducing the patient's copay at the point of service in the pharmacy.

"Shadow Claims System" Makes Copay Coupons Invisible to Payers

Regardless of the distribution method, copay coupon programs are all invisible to the payer and PBM, because they all occur *after* the adjudication of the prescription. That is, the pharmacy sends the claim through the switch, to the PBM. The PBM adjudicates the claim and sends the necessary information back through the switch to the pharmacy, including the dollar amount to be paid by the payer plus the copay amount to collect from the patient. Then, after the PBM has sent this information, the coupon program reduces the copay due from the consumer. Thus, copay coupon programs act as a "shadow claims system" that facilitates consumers using more expensive drugs instead of less expensive drugs. Payers have no easy way to detect transactions taking place through this "shadow claims system."

Drug Manufacturers Harvest Patient Data Using Copay Coupons

Drug companies often require consumers to submit confidential, personal information in order to redeem copay coupons. Manufacturers have long sought (but found difficult to obtain) such sensitive patient data, which enables them to identify and directly target individual patients with "brand loyalty" marketing programs. Coupons enable companies to know "who redeemed the coupons, where the user found the coupons" and which "ads, marketing vehicles, and communication are working best."¹⁶

¹⁶ "Boost Sales With Coupons and Contests," *Entrepreneur*, April 25, 2005.

III. Methodology

Visante modeled the cost of copay coupons using a variety of data sources, including data published by industry sources and equity research analysts, commercial third party data, PBM industry trend reports, and national drug expenditures projected by the Centers for Medicare and Medicaid Services (CMS).

Modeling Baseline Prescription Drug Trends 2012–21

To derive baseline drug expenditures over a ten-year period, Visante began with CMS National Health Expenditure projections for outpatient prescription drug expenditures from 2011 to 2020. CMS segments outpatient prescription drug expenditures by payer, including private insurance, the area examined in this study.

CMS outpatient drug expenditure projections reflect net costs to payers, including plan sponsors and consumers. Manufacturer and pharmacy discounts are reflected in CMS figures. Outpatient prescription drug expenditures account for about 75% of the nation's drug bill and drug company coupon programs examined in this study apply to outpatient prescription drugs. Because CMS projections are based on 2009 data and coupon use has expanded rapidly only since that time, we assume that the current and future impact of copay coupons is not captured in these baseline expenditures.

CMS projections reflect assumptions concerning the impact of health reform, manufacturer price inflation, patent expirations, new drug introductions, follow-on biologics, and other factors. By using CMS data, our model incorporates these assumptions. CMS does not publish the detailed factors underlying its model, so we estimated the factor inputs necessary to estimate the impact of copay coupons and then applied these to baseline expenditures derived from the CMS data.

Growth in the number of prescriptions was estimated based on PBM industry projections for both Medicare and the commercial market. The share of these prescriptions that will be generics, non-specialty brands, and specialty pharmaceuticals was projected over the next ten years based on current trends in third party prescription data. In 2012, we project about 3 billion prescriptions for generics, 870 million for non-specialty brands, and 24 million for specialty pharmaceuticals.

We then estimated average cost per prescription for generic drugs, brand name drugs, and specialty pharmaceuticals over the next ten years based on current trends. Average costs are estimated net of rebates.¹⁷ We then estimated how these costs would change over ten years based on current trends in price inflation for generics, non-specialty brands, and specialty pharmaceuticals.

¹⁷ "Drug Prices Rise Despite Calls for Cuts," *The Wall Street Journal*, March 17, 2011.

Treatment of Specialty Pharmaceuticals

Based on our estimates for prescriptions and average costs, we estimated ten-year expenditures on specialty pharmaceuticals and subtracted these expenditures from our baseline. We exclude expenditures on specialty pharmaceuticals because copay offset programs on specialty products do not undermine generics and manufacturer price concessions to health plans in the same way that copay coupons on non-specialty brands do. First, generic alternatives are not generally available for specialty pharmaceuticals. Second, plans typically make more frequent use of administrative mechanisms, such as prior authorization and quantity limits, to achieve formulary compliance for specialty medications, so manufacturer rebates are not as dependent on copayment differentials as are rebates for non-specialty products.

Determining Underlying Prescription Costs to Plan Sponsors for Brands and Generics

Average copayments per prescription for generics, preferred brands, and non-preferred brands were then estimated. Future increases are projected to mirror the past three to four years, with first-tier copays flat and second- and third-tier copays increasing at approximately 4% per year.¹⁸

We then estimated the number and cost of prescriptions for non-specialty brands that were on preferred vs. non-preferred formulary tiers. We project that non-preferred brands are 21% more expensive than preferred brands based on our analysis of drug list prices and published estimates of manufacturer rebates. Our analysis of published data on average wholesale prices revealed that list prices for non-preferred brands with copay coupons were generally higher than brands without coupons.¹⁹ Published estimates indicate that preferred brands have rebates of approximately 14%.²⁰ Manufacturers do not typically provide rebates on non-preferred brands.

To estimate net costs to plan sponsors per prescription, we subtracted average copays from average prescription costs net of manufacturer rebates. Over the next ten years, we estimate that, on average, payer costs for generic prescriptions will increase from \$16 to \$17, preferred brand from \$118 to \$230, and non-preferred brands from \$124 to \$251.

¹⁸ Kaiser Family Foundation, HRET Employer Health Benefits Survey, 2010.

¹⁹ Visante analyzed published average wholesale prices in 2011 for top brands with copay cards and other competing brands in the same therapeutic categories.

²⁰ *Wall Street Journal*, op, cit.

Estimating the Impact of Copay Coupons on the Use of More Affordable Medications

Evidence published by drug coupon administrators suggests that copay coupons result in a substantial number of patients switching from either preferred brands or generics to couponed products. One such study conducted by Verispan found that patients using coupons who were new to a drug were significantly more likely to have switched to that drug from a different product than were patients who had not used coupons.²¹ Among the 70% of the patients in the study who were new to a brand drug and used a coupon, 55% had converted to the brand from a different drug. Thus, 39% of all coupon users had switched to the brand from a different product. Among all patients not using a coupon, only 14% had converted from a different drug. Thus, use of a copay coupon increased the number of patients switching from a different drug by 25 percentage points.

The Verispan study also showed that brand loyalty among physicians increased greatly with the introduction of the coupon program. Among prescribing physicians, 65% increased their prescriptions of the brand after the program started. Some 40% of physicians increased prescriptions for the brand by more than 50%. In addition, the manufacturer “saw a 10% increase in new prescribers and grew its product share among participating prescribers by 27%.”²²

Based on this evidence, we assume that 25% of coupon use results in a couponed drug being used instead of a preferred brand or generic that might have been used in the absence of the coupon.

Modeling How Copay Coupons Compete Against Generics

With many brand drugs losing patent protection, it is widely anticipated that the generic dispensing rates will increase to 80% over the next two to three years, and we believe that this trend will increasingly spur brand drug manufacturers to use copay coupons to compete against generics. The potential success of such a strategy is demonstrated in a published case study where more than 50% of copay coupon users continued on a brand medication for nearly a year after a generic equivalent had been introduced.²³ For those not using a coupon, the case study showed that the brand’s market share dropped to the low single digits after just six months.

Our analysis of more than 300 copay coupon programs revealed that the majority of such programs are designed to reduce a \$40–\$50 copayment to \$20–\$30, which removes the economic incentive established by the plan sponsor to encourage the patient to use a preferred

²¹ McKesson, “Case Study: Loyalty Script,” accessed September 2011.

²² Ibid.

²³ “Facing Generic Competition Head On: To Combat Generic Intrusion, One Proactive Brand Team and TrialCard Collaborated to Create Outstanding Results.” www.trialcard.com/case.html

brand over a non-preferred brand. Copay coupon programs also reduce or eliminate the incentive to use generics. For example, one major program reduces the brand copay to just \$4. Our model assumes that coupon programs take market share from preferred brands and generics in ratios of approximately 4 to 1 (i.e., four preferred brand conversions for every one generic conversion).

Expected Growth in the Use of Copay Coupons

Visante next projected growth trends for copay coupons based on reports published by industry analysts. According to Cleveland Research, the number of drugs with coupons has increased 260% in just two years, from 86 in July 2009 to 310 in July 2011.²⁴ In early 2010, The Amundsen Group estimated spending by pharmaceutical manufacturers on coupon programs at approximately \$3 billion.²⁵ In March 2011, Amundsen increased their estimate to \$3–6 billion.²⁶ Based on Visante’s analysis of drug coupon programs listed on internetdrugcoupons.com, this rapid growth has continued in 2011. As of April 2011, 275 different prescription drugs were listed on the website. By the end of September, just six months later, more than 340 were listed.

Analysts estimate that some 100 million to 125 million prescriptions are currently associated with copay coupons.²⁷ This amounts to 13% of branded prescriptions.²⁸ Visante conservatively assumes approximately 100 million prescriptions were associated with coupons in 2010, amounting to 11% of brand prescriptions.

Based on current trends, Visante projects that the number of prescriptions associated with copay coupons will increase approximately 15% per year, rising from 100 million in 2010 to 500 million in 2021. These projections equate to approximately 20% of non-specialty brand prescriptions in 2014, 30% in 2017, and 50% in 2021.

Projecting the Ten-Year Cost of Copay Coupons for Commercial Sector Plan Sponsors

To project the ten-year cost of copay coupons for commercial sector plan sponsors, Visante combined our estimates of the growth and impact of coupon programs in order to derive a new baseline for ten-year prescription drug expenditures with coupons. We then subtracted the original baseline expenditures that assume no coupon use in order to determine the expected cost of coupon programs. We assume that coupons are not used in Medicare and Medicaid, so their

²⁴ Cleveland Research, op.cit.

²⁵ Tenaglia M., and C. Meister, “First Do No Harm. Designing and Deploying Company Copay Offset Programs without Devaluing the Brand.” *Pharmaceutical Executive*, Vol. 30, No. 1, January 2010.

²⁶ The Amundsen Group, “Improving Patient Adherence through Lower Co-Pays,” Presentation to CBI’s 2nd Annual Risk-Sharing and Innovative Contracting Models for Bio/Pharmaceuticals, Philadelphia, March 24–25, 2011.

²⁷ “Copay Cards Could Be Win-Win if All Sides Work Together,” *Drug Benefit News*, July 22, 2011.

²⁸ Ibid.

use is constrained to those with commercial insurance coverage. Based on drug expenditure patterns for those with and without insurance, we assume the insured account for 95% of coupon use and the uninsured account for 5% of coupon use.

Based on this methodology, copay coupons issued by brand drug manufacturers could increase prescription drug costs by \$32 billion over the next ten years for employers, unions, and other private health insurance plan sponsors if current trends continue.

Projecting the Potential Additional Costs if Copay Coupons Were Used in Medicare

Because manufacturer coupons are banned in federal programs, Visante assumes that copy coupons are not used by Medicare beneficiaries. To model the potential costs if copay coupons were allowed in Medicare Part D, we assume that non-specialty brand prescriptions in Medicare Part D would have the same percentage of coupon use as in commercial insurance. Based on this, we estimate that in the absence of a ban, 70 million prescription coupons would be used in Medicare in 2012, increasing to 270 million in 2021.

Based on this methodology, if the federal ban on coupons were not in place, then copay coupons issued by brand drug manufacturers would potentially increase Medicare's prescription drug costs by nearly \$18 billion over the 2012–21 period.

Projecting the Cost of Copay Coupons by State

We used third party prescription data to break down our national estimate of the cost copay coupons on a state-by-state basis.²⁹ Prescription drug expenditures in Massachusetts were excluded, as copay coupons are banned by law in that state. These state-by-state estimates should be considered as illustrative because different market conditions and trends in individual states may not be fully captured. The state-by-state breakdown is presented in Table 1.

If Massachusetts were to repeal its law banning copay coupons, Visante estimates that prescription drug costs for employers and other plan sponsors in that state would increase by \$750 million over the next decade.

²⁹ Data from Wolters Kluwer Pharma Solutions Source® Pharmaceutical Audit Suite (PHAST), Jan–Dec 2009. Published in Novartis Pharmacy Benefit Report 2010–11, Retail Data Tables.

Table 1: Projected Ten-Year Cost of Copay Coupons to Commercial Sector Plan Sponsors by State

| State | Increase in Prescription Expenditures Due to Copay Coupons, 2012–21 |
|-----------------------------|--|
| Alabama | \$607,673,857 |
| Alaska | \$62,409,292 |
| Arizona | \$590,854,258 |
| Arkansas | \$307,639,232 |
| California | \$2,453,919,806 |
| Colorado | \$409,745,954 |
| Connecticut | \$446,638,331 |
| Delaware | \$138,026,887 |
| District of Columbia | \$83,717,468 |
| Florida | \$2,051,999,952 |
| Georgia | \$973,882,668 |
| Hawaii | \$120,287,042 |
| Idaho | \$148,796,201 |
| Illinois | \$1,387,486,550 |
| Indiana | \$802,891,369 |
| Iowa | \$296,509,719 |
| Kansas | \$308,598,738 |
| Kentucky | \$598,861,471 |
| Louisiana | \$508,985,670 |
| Maine | \$140,421,312 |
| Maryland | \$708,864,850 |
| Massachusetts ³⁰ | \$0 ³¹ |
| Michigan | \$1,120,528,811 |
| Minnesota | \$570,764,284 |
| Mississippi | \$290,978,428 |
| Missouri | \$681,137,889 |
| Montana | \$95,918,632 |

³⁰ Massachusetts law bans the use of copay coupons.

³¹ Additional ten-year costs of approximately \$750 million in Massachusetts if its law banning copay coupons were repealed.

| <u>State</u> | <u>Increase in Prescription Expenditures Due to Copay Coupons, 2012–21</u> |
|---------------------|---|
| Nebraska | \$189,034,841 |
| Nevada | \$252,677,774 |
| New Hampshire | \$164,132,453 |
| New Jersey | \$1,043,487,351 |
| New Mexico | \$165,241,511 |
| New York | \$2,315,587,824 |
| North Carolina | \$1,120,306,101 |
| North Dakota | \$64,312,489 |
| Ohio | \$1,511,244,056 |
| Oklahoma | \$401,221,428 |
| Oregon | \$338,388,288 |
| Pennsylvania | \$1,756,295,193 |
| Rhode Island | \$140,276,890 |
| South Carolina | \$546,786,087 |
| South Dakota | \$64,476,302 |
| Tennessee | \$889,565,080 |
| Texas | \$2,560,330,059 |
| Utah | \$277,372,167 |
| Vermont | \$66,538,223 |
| Virginia | \$934,760,991 |
| Washington | \$637,713,432 |
| West Virginia | \$261,069,648 |
| Wisconsin | \$617,307,058 |
| Wyoming | <u>\$50,795,793</u> |
| U.S. Total | \$32,276,459,710 |

Source: Visante analysis, 2011.