



Free markets. Real solutions.

---

R STREET SHORTS NO. 80  
December 2019

---

## MEDICAL LICENSING REFORM CAN PROVIDE BETTER ACCESS TO PRIMARY CARE

Courtney M. Joslin

### INTRODUCTION

**A** 2016 study from the U.S. Dept. of Health and Human Services found that by 2025, 37 states will experience shortages of primary care physicians.<sup>1</sup> This is hardly good news, as primary care in the United States is already under strain. In fact, 44 million Americans currently live in areas with a shortage of primary care doctors, and the projected demand for primary care services in the United States will continue to outpace supply over the coming decades.<sup>2</sup> For this reason, recent years have seen a push to allow advanced medical professionals like physician assistants, nurse practitioners and pharmacists to perform expanded roles in primary care as a way to address the shortage.

As it stands, medical licensing in the United States overly restricts the ability of these advanced medical professionals to take on expanded roles in the primary care space. For this reason, fixing these limitations through scope-of-practice reform would greatly benefit both patients and practitioners.<sup>3</sup> For patients, greater access to primary care would

mean better health outcomes. For practitioners, expanded duties would take better advantage of their education and training, both of which are often underused due to licensing restrictions. It would also benefit primary care physicians who are currently overworked and experiencing burnout.<sup>4</sup> Accordingly, states should consider expanding the scope of practice for all advanced medical professionals.

Toward that end, the present study provides an overview of the primary care shortage and how expanded scope of practice can help to alleviate it. It then explores the ways in which physician assistants, nurse practitioners and pharmacists are currently restricted by state scope-of-practice regulations.

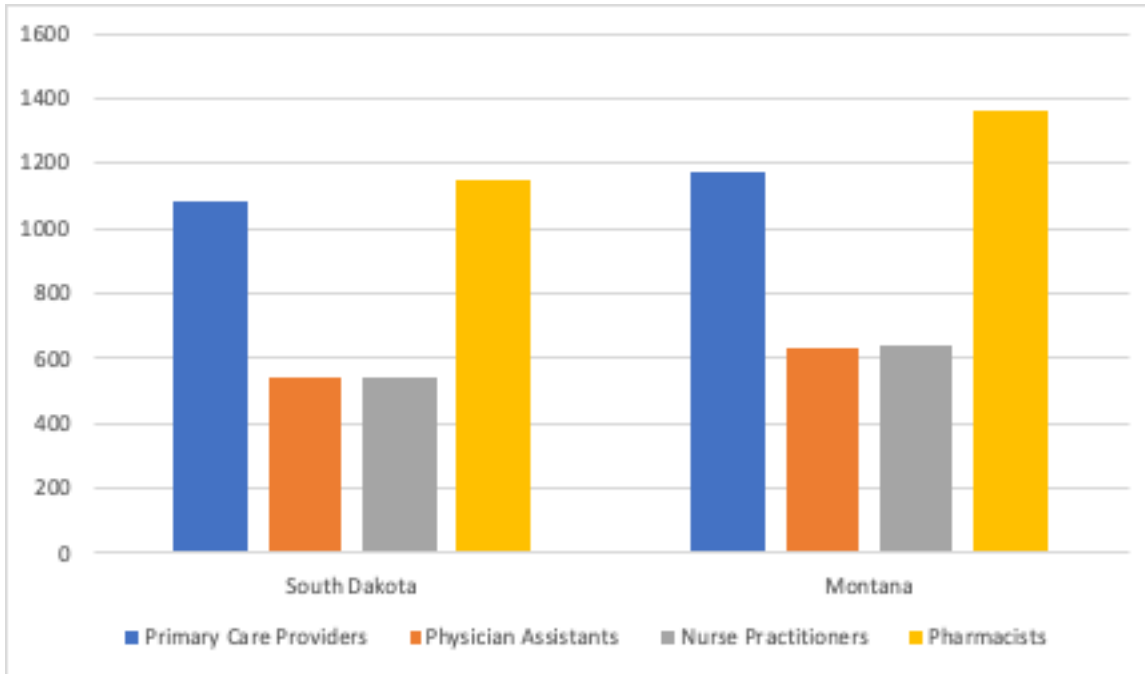
### THE PRIMARY CARE SHORTAGE

Current estimates from the Association of American Medical Colleges show that, by 2032, the United States could face a primary care provider deficit of anywhere from 21,100 to 55,200 practitioners.<sup>5</sup> The shortages differ in severity by region. For example, according to projections from the Department of Health and Human Services, southern states will all experience significant primary care shortages by 2025, while a select few northeastern states like Massachusetts, Maine and Vermont will see primary care supply meet or outweigh demand.<sup>6</sup> Even in these states, however, access is highly uneven depending on what part of the state one lives in.<sup>7</sup>

Overall, 37 states will need more primary care providers to match their respective levels of demand.<sup>8</sup> By 2032, these levels will range from Rhode Island's projected shortage of 10 practitioners to Florida's unmet need for 3,060.<sup>9</sup> This dearth is worrisome for future health outcomes in the United States, particularly as adequate supplies of primary care providers are associated with lower mortality, lower healthcare costs, longer life spans and overall better health.<sup>10</sup> In sum, states with better primary care provider-to-patient ratios have healthier populations.<sup>11</sup> Increasing access to primary care is therefore crucial to maintain and improve population health.

The growing chasm between supply and demand is due to several factors. First, the U.S. population is aging—including its doctors. Over the next decade, over 40 percent of the currently active physician workforce will be of retirement age.<sup>12</sup> Furthermore, the number of Americans aged 65 or older in 2032 will grow by 50 percent, as compared to 2017 levels.<sup>13</sup> Combined, these projections present a problem: older patients demand more primary care services than their younger counterparts, and the increase in primary care provider retirements means a growing gap between demand and supply.<sup>14</sup> And, while the most obvious solution to this shortage would seem to be encouraging new doctors to enter the primary care workforce at the same rate older ones are retiring out, this is simply not happening.

CHART I: PRACTITIONER TYPES IN SOUTH DAKOTA AND MONTANA



SOURCE: Compiled from Bureau of Labor Statistics data. <https://www.bls.gov/oes/current/oesrcst.htm>.

Since 2011, the percentage of graduates choosing primary care has been on a steady decline.<sup>15</sup> This is because physicians are choosing to go into specialty fields rather than primary care due to better pay, better working conditions and the emphasis placed on medical research positions during medical school.<sup>16</sup> Further, residency programs in the United States—which provide the postgraduate medical training required for a doctor to become board certified—have not kept up with the number of medical students applying. This bottleneck means that the doctor workforce is stymied due to program capacity, and recent medical graduates are unable to contribute their services.<sup>17</sup>

These workforce trends have had myriad negative consequences. To begin with, current physicians are simply overworked and burning out. Indeed, the 2019 Medscape “National Physician Burnout, Depression and Suicide Report” found that 44 percent of physicians reported burnout—up from 42 percent the previous year.<sup>18</sup> Bureaucratic tasks and long work hours were the top two reasons cited; of note, 20 percent of respondents also cited government regulation as a primary contributor.<sup>19</sup>

And, while burnout is a serious and increasing problem, the primary care shortage overall is systemic and thus requires multiple long-term solutions. One of the most promising avenues for this is medical licensing reform that would allow some current medical professionals to expand their scopes-

of-practice.<sup>20</sup> This would bolster the current primary care workforce even without the need to recruit and train new doctors.

### SCOPE-OF-PRACTICE REFORM

The scope-of-practice for a licensed worker is the legal bounds of what duties or services they can perform with their license. These bounds, however, can differ significantly by state for a single profession. In the case of medical professionals in many states, current scope-of-practice laws overly restrict their ability to perform work that they are qualified to do. Scope-of-practice reform, then, reduces or eliminates these disparities in licensing by allowing workers to undertake a broader scope of activities and tasks. Specifically, allowing physician assistants, nurse practitioners and pharmacists to work to the fullest extent of their expertise is a win-win for primary care providers and patients. These professionals already work with physicians in the primary care space and, with sensible scope-of-practice reform, can better contribute to the primary care workload. What’s more, the data show just how beneficial scope-of-practice reform could be in the primary care realm. For example, the Association of American Medical Colleges notes that, overall, the nurse practitioner and physician assistant workforces are “growing at about six times the rate of growth of demand for health care services.”<sup>21</sup>

Even at current levels, expanding scopes of practice for these professionals could contribute significantly to the available providers for patients. To illustrate this, Texas is projected to have a shortage of 1,760 primary care physicians by 2025.<sup>22</sup> Currently, Texas has 12,020 active nurse practitioners, 7,930 physician assistants and 21,250 pharmacists. If Texas allowed these professionals to take on more primary care duties, then the effects of this shortage would be substantially reduced.

Furthermore, in several states—particularly less populated ones, such as South Dakota and Montana—expanding pharmacist duties alone would more than double the supply of certain primary care services. State-level data, compiled in Appendix A, shows the potential primary care workforce amplification potential in each state if nurses, pharmacists, and physician’s assistants were given more primary care duties.

## CURRENT BARRIERS RELATED TO SCOPE-OF-PRACTICE

### Public Perception of Safety

Before scope-of-practice reform can take hold, it must first be established that expanding the duties of non-physician professionals is both safe and desirable. Fortunately, the available evidence suggests positive outcomes on this front, particularly with respect to primary care.

Both physician assistants and nurse practitioners who take on primary care duties provide the same, or sometimes better, quality of care than primary care physicians.<sup>23</sup> Examples of this abound and moreover, are aligned with work these practitioners are already doing. For example, in intensive care units (ICUs) where physicians are in short supply and quality of care is of vital importance, nurse practitioners are already helping to provide coverage.<sup>24</sup> And, research demonstrates that in these acute care scenarios, nurse practitioners provide the same quality care and achieve the same patient outcomes as physicians.<sup>25</sup> Likewise, pharmacists on primary care teams have been associated with improvements in patient adherence to complex medication regimens and with helping to alleviate physician burnout.<sup>26</sup>

Yet another benefit of scope-of-practice reform is its impact on care levels for low-income and geographically remote patients, who are often disproportionately affected by doctor shortages and lacking access.<sup>27</sup> For example, given that nurse practitioners accept lower payments and are more likely to work in rural areas, an expansion of their role would directly benefit these populations.<sup>28</sup> Similarly, physician assistants in rural areas are more likely to work in primary care than their urban counterparts and thus can help to provide the necessary coverage to ensure that people in remote areas have access to medical care.<sup>29</sup>

## Regulatory Barriers by Practitioner

Unfortunately, despite this potential, physician assistants, nurse practitioners and pharmacists are often inappropriately restricted in their practices. The following sections explore how each of these professions is restricted in many states, and how reform would translate to better primary care access.

**Physician assistants**—Physician assistants are advanced practitioners with extensive medical training and clinical experience, and who perform many duties that primary care doctors do, including physical exams, patient diagnosis and the prescribing of medications.<sup>30</sup> Despite these advanced skillsets, their scope of practice is limited in numerous ways. First, states mandate collaborative agreements between a physician and physician assistant that dictate how their working relationship functions. For example, physicians are limited to a certain number of physician assistants they can oversee. And, they also review and sign off on some physician assistant cases instead of simply allowing physician assistants to have full autonomy over relatively routine medical decisions.<sup>31</sup>

Many states have already instituted various reforms to scope of practice for physician assistants. For instance, many states now allow a physician and physician assistant to determine their work division and the physician assistant’s scope of practice at the practice level, instead of following strict state-level guidelines.<sup>32</sup> This allows for flexibility and discretion by the physician based on a physician assistant’s skill level. However, 13 states still do not allow this, including Alabama, Georgia, Mississippi and Virginia.<sup>33</sup>

It is important to note that all of these states are projected to have primary care shortages, and therefore could benefit from increasing the autonomy of physicians and their physician assistants to determine the appropriate scope of practice.<sup>34</sup> Doing so would also take more medical decisions out of the hands of state bureaucrats and place them in the hands of doctors.

**Nurse Practitioners**—As in the case of physician assistants, states do not always grant nurse practitioners the authority to practice to their full abilities. According to the American Association of Nurse Practitioners (AANP), full practice for nurse practitioners is the ability “to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances.”<sup>35</sup>

However, only 23 states currently allow nurse practitioners to practice to this extent.<sup>36</sup> In the remaining 27, practice authority is classified as either reduced or restricted. Under the full practice authority that is granted in some states, nurse practitioners are able to operate independently. But

in others, nurse practitioners' practice and prescription authority are overseen by physicians.<sup>37</sup> In fact, in about half of all states, a nurse practitioner is required to have a relationship with a physician in order to prescribe medication to their patients, despite their training to do so without such oversight.<sup>38</sup> And, since nurse practitioners are more likely to work in rural areas, accept uninsured and Medicaid patients, and accept lower payments than physicians,<sup>39</sup> they are particularly well positioned to alleviate primary care shortages in rural and low-income areas specifically.

**Pharmacists**—In recent years, pharmacists have experienced important scope-of-practice expansions in the states. And accordingly, their experiences can serve as a model for other practitioner expansions.

Pharmacists are increasingly recognized as an integral part of primary care. In recent years, their practices have expanded to administering vaccinations, providing screenings for common medical ailments like strep throat and urinary tract infections, and prescribing certain medications to patients.<sup>40</sup> Additionally, 11 states and Washington, D.C. now employ the “pharmacy-access” model for contraception, which allows pharmacists to prescribe hormonal birth control directly to patients without the necessity of a doctor’s visit.<sup>41</sup>

Furthermore, Oregon, which was the first state to implement this birth control reform, has since extended pharmacist’s prescriptive authority<sup>42</sup> to allow them to prescribe all non-controlled medications directly to patients, as long as a practitioner has previously made a relevant diagnosis.<sup>43</sup> This helps reduce the often-long wait times to see a practitioner just to renew a prescription. Oregon pharmacists can also directly prescribe some cold and cough medicines not available over the counter.<sup>44</sup>

In addition to this expanded prescribing authority, pharmacists are also increasingly playing a role nationwide in combating the opioid epidemic. Nearly every state now allows them to dispense naloxone, which counters the effects of an opioid overdose—even to patients without a prescription.<sup>45</sup> This has brought roughly a 34 percent reduction in fatal opioid overdoses in states where the practice is allowed.<sup>46</sup> And, although these various reforms are relatively new, their early successes provide a roadmap for legislators looking to improve primary care outcomes in their state.

## CONCLUSION

Future primary care demands dictate that the medical community and state regulators continue to find innovative ways to meet patient needs. As more physicians retire—and the already-strained physician workforce struggles to meet demand—other advanced providers in the primary care workforce can step into the void. As state-level provider data

shows, expanding the primary care duties of nurses, physician assistants and pharmacists could more than double the primary care workforce in some states. Expanding scopes of practice for these professions not only would take advantage of their advanced medical training, but it will benefit the current primary care physician workforce by reducing current workloads. Most importantly, patients will benefit from better access and health outcomes.

State scope-of-practice laws are restricting the ability of these advanced medical providers to offer services in the primary care space. Physician assistants, nurse practitioners and pharmacists are all integral to meeting primary care needs. Overall, as states look for solutions to primary care problems, legislators must work to ensure that scope-of-practice laws empower the medical community and serve patients to the highest possible level.

## ABOUT THE AUTHOR

**Courtney Joslin** is a resident fellow in the R Street Institute’s Commercial Freedom program, wherein she leads R Street’s birth control deregulation research initiative and works on occupational licensing issues.

## ENDNOTES

1. U.S. Dept. of Health and Human Services et al., “State-Level Projections of Supply and Demand for Primary Care Practitioners: 2013-2025,” November 2016, p. 10. <https://bhwh.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf>.
2. “Addressing the Nation’s Primary Care Shortage: Advanced Practice Clinicians and Innovative Care Delivery Models,” United Health Group, Nov. 12, 2018, p. 1. <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2018/UHG-Primary-Care-Report-2018.pdf>.
3. Scope-of-practice reform refers to expanding the types of services a licensed worker can legally perform in a state.
4. See, e.g., Rikinkumar S. Patel et al., “Factors Related to Physician Burnout and Its Consequences: A Review,” Behavioral Sciences 8:11 (November 2018). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6262585>.
5. “The Complexities of Physician Supply and Demand: Projections from 2017 to 2032,” The Association of American Medical Colleges, April 23, 2019. <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.
6. U.S. Dept. of Health and Human Services et al., pp. 11-12. <https://bhwh.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf>.
7. For example, see “Health Professions Data Series – Physicians 2014,” Massachusetts Dept. of Public Health, 2016, p. 7. This shows that many parts of western Massachusetts have no primary care physicians: <https://www.mass.gov/files/documents/2016/07/tf/massachusetts-health-professions-data-series-physicians-2014.pdf>.

8. Ibid.
9. Ibid.
10. Barbara Starfield et al., "Contribution of Primary Care to Health Systems and Health," *The Millbank Quarterly* 83:3 (September 2005), pp. 457-502. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145>.
11. Ibid.
12. "The Complexities of Physician Supply and Demand." <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.
13. Mark Mather et al., "Fact Sheet: Aging in the United States," Population Reference Bureau, July 15, 2019. <https://www.prb.org/aging-unitedstates-fact-sheet>.
14. Kate Rogers, "America's aging population is leading to a doctor shortage crisis," CNBC, Sept. 6, 2019. <https://www.cnbc.com/2019/09/06/americas-aging-population-is-leading-to-a-doctor-shortage-crisis.html>.
15. Victoria Knight, "American Medical Students Less Likely to Choose to Become Primary Care Doctors," Kaiser Health News, July 3, 2019. <https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors>.
16. Ibid. and; M. Linzer et al., "Working conditions in primary care: physician reactions and care quality," *Annals of Internal Medicine* 151:1 (July 7, 2009), pp. 28-36. <https://www.ncbi.nlm.nih.gov/pubmed/19581644>.
17. Kevin Dayaratna et al., "Reforming American Medical Licensure," *Harvard Journal of Law & Public Policy* 42:1 (2018), pp. 253-78. <http://www.harvard-jlpp.com/wp-content/uploads/sites/21/2019/02/Larkin-Final.pdf>.
18. Leslie Kane, "Medscape National Physician Burnout, Depression & Suicide Report 2019," Medscape, Jan. 16, 2019. <https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056>.
19. Ibid.
20. Encouraging medical students and international applicants to enter primary care is another avenue for improving primary care access.
21. "The Complexities of Physician Supply and Demand." <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.
22. See, e.g., U.S. Dept. of Health and Human Services et al. <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf>.
23. See, e.g., Peter Buerhaus, "Nurse practitioners: A solution to America's primary care crisis," American Enterprise Institute, Sept. 18, 2018. <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis>; Timothy Bates et al., "California's Physician Assistants: How Scope of Practice Laws Impact Care," California Health Care Foundation, September 2018. <https://www.chcf.org/wp-content/uploads/2018/09/PhysicianAssistantsScopePracticeLaws.pdf>.
24. J.S. Landsperger et al., "Outcomes of Nurse Practitioner-Delivered Critical Care: A Prospective Cohort Study" *Chest Journal* 149:5 (May 2016), pp. 1146-54. <https://www.ncbi.nlm.nih.gov/pubmed/26836900>
25. Ibid.
26. Kylee A. Funk et al., "Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life," *Journal of the American Board of Family Medicine* 32:4 (July 2019), pp. 462-73. <https://www.jabfm.org/content/32/4/462>.
27. Eric Larson et al., "How Could Nurse Practitioners and Physician Assistants Be Deployed to Provide Primary Care?", WWAMI Rural Health Research Center, March 2016. [http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC\\_PBI55\\_Larson.pdf](http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC_PBI55_Larson.pdf).
28. See, e.g., Buerhaus. <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis>.
29. The Rural Health Research and Policy Centers have noted that, in less restrictive states, nurse practitioners and physician assistants are particularly helpful in alleviating the doctor shortages in rural areas. See Larson et al. [http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC\\_PBI55\\_Larson.pdf](http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC_PBI55_Larson.pdf). See also, "PAs in Rural Locations Ready to Meet Primary Care Needs," American Academy of Physician Assistants, June 12, 2018. <https://www.aapa.org/news-central/2018/06/pas-rural-locations-ready-meet-primary-care-needs>.
30. "PA Scope of Practice," American Academy of Physician Assistants, 2017. [https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief\\_Scope-of-Practice\\_0117-1.pdf](https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Scope-of-Practice_0117-1.pdf).
31. Bates et al. <https://www.chcf.org/wp-content/uploads/2018/09/PhysicianAssistantsScopePracticeLaws.pdf>.
32. Ibid.
33. Ibid.
34. U.S. Department of Health and Human Services et al. <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf>.
35. "State Practice Environment," American Association of Nurse Practitioners. <https://www.aanp.org/advocacy/state/state-practice-environment>
36. Ibid.
37. "Nurse Practitioners Overview," Scope of Practice Policy, updated Dec. 20, 2018. <http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/#targetText=Nurse%20practitioners%20are%20advanced%20practice.to%20people%20of%20all%20ages>.
38. Most states allow nurse practitioners to prescribe drugs ranging from schedules II-V like physicians, but a handful still restrict nurse practitioners to only prescribing schedules III-V. See "Nurse Practitioner Prescriptive Authority," Nursing License Map. <https://nursinglicensemap.com/about-nurse-license-map/>
39. Buerhaus. <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis>.
40. Alex J. Adams and Kristalyn K. Weaver, "The Continuum of Pharmacist Prescriptive Authority," *Annals of Pharmacotherapy* 50:9 (Sept. 1, 2016), pp 778-84. <https://journals.sagepub.com/doi/10.1177/1060028016653608>.
41. Courtney Joslin and Steven Greenhut, "Birth control in the states: A review of efforts to expand access," *R Street Policy Study No. 159*, Nov. 21, 2018. <https://www.rstreet.org/2018/11/21/birth-control-in-the-states-a-review-of-efforts-to-expand-access>.
42. Cheryl A. Thompson, "New Oregon Law Lets Pharmacists Prescribe Formulary Drugs, Devices," American Society of Hospital Pharmacists. Aug. 25, 2017. <https://www.ashp.org/news/2017/08/25/new-oregon-law-lets-pharmacists-prescribe-formulary-drugs>.
43. "Oregon expands prescribing for pharmacists," American Pharmacists Association, June 15, 2017. <https://www.pharmacist.com/article/oregon-expands-prescribing-pharmacists>.
44. "Permanent Administrative Order," Chapter 855 Board of Pharmacy, Oct. 18, 2018. <https://www.oregon.gov/pharmacy/Imports/Rules/FormularyPermanentFiling.pdf>.
45. "As Naloxone Accessibility Increases, Pharmacist's Role Expands," Pharmacy Times, Oct. 25, 2016. <https://www.pharmacytimes.com/contributor/marilyn-bull-och-pharmd-bcps/2016/10/as-naloxone-accessibility-increases-pharmacists-role-expands>.
46. Rahi Abouk et al., "Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose," *JAMA Internal Medicine* 179:6 (May 6, 2019), pp. 805-11. <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2732118>.



**APPENDIX A: PRIMARY CARE PROVIDERS BY STATE**

	Primary Care Physicians	Physician Assistants	Nurse Practitioners	Pharmacists
Alabama	5,863	750	3,680	4,880
Alaska	1,054	520	440	420
Arizona	8,537	2,100	3,510	7,420
Arkansas	3,513	530	1,900	3,270
California	54,135	10,520	13,420	30,950
Colorado	7,220	3,190	2,920	5,180
Connecticut	6,990	2,300	2,340	3,100
District of Columbia	3,176	590	840	1,070
Delaware	1,564	500	760	1,060
Florida	27,396	6,040	10,590	20,790
Georgia	12,524	3,470	6,110	10,530
Hawaii	1,856	320	410	1,710
Idaho	1,617	730	750	1,410
Illinois	21,993	2,670	5,540	12,260
Indiana	8,110	1,550	4,780	5,600
Iowa	4,424	1,000	1,830	3,150
Kansas	4,113	1,040	2,270	2,990
Kentucky	5,481	1,070	3,160	5,010
Louisiana	6,328	1,060	2,820	4,520
Maine	2,477	720	1,240	1,250
Maryland	10,944	3,040	3,710	5,750
Massachusetts	15,784	3,720	6,200	7,970
Michigan	18,516	4,490	4,490	9,140
Minnesota	8,788	1,980	3,880	6,490
Mississippi	3,216	200	2,930	2,280
Missouri	9,410	1,070	4,390	6,180
Montana	1,174	630	640	1,360
Nebraska	2,882	1,190	1,070	2,550
Nevada	3,065	650	710	2,490
New Hampshire	2,002	710	1,140	1,140
New Jersey	14,384	2,810	5,900	9,280
New Mexico	2,936	680	980	1,480
New York	40,592	12,060	13,710	20,400
North Carolina	13,400	5,010	4,760	9,970
North Dakota	1,112	260	480	1,030
Ohio	19,591	4,430	7,510	12,500
Oklahoma	4,810	1,390	1,590	3,470
Oregon	5,987	1,530	2,030	4,360

Pennsylvania	24,302	6,650	7,280	14,610
Rhode Island	2,407	260	690	1,670
South Carolina	6,395	1,430	2,260	5,070
South Dakota	1,083	540	540	1,150
Tennessee	8,876	2,010	7,010	7,330
Texas	30,704	7,930	12,020	21,250
Utah	3,065	1,090	1,380	2,540
Vermont	1,128	290	520	640
Virginia	11,555	2,510	4,710	6,970
Washington	10,919	2,470	3,430	5,740
West Virginia	2,882	770	1,080	2,180
Wisconsin	8,498	2,020	3,030	5,390
Wyoming	628	220	290	590
<b>Totals</b>	<b>479,406</b>	<b>114,710</b>	<b>178,830</b>	<b>309,540</b>