To: Vermont Health Benefit Exchange Advisory Board
From: Bailit Health Purchasing (Amy Lischko, Beth Waldman, Peter Burns)
RE: Analysis of Basic Health Program Option
Date: November 28, 2011 (revised)

Summary

We have reviewed the potential implications of pursuing the Basic Health Plan option in Vermont and have identified a number of key policy considerations affecting consumers, providers, and the state. These considerations include: continuity of care, financial protection for consumers, cost shifting and access to providers, consumer preferences, safety net viability, risk selection, financial sustainability, and the state's transition towards a single payer system. State policymakers will want to consider these issues as they continue with the implementation of the Patient Protection and Affordable Care Act (PPACA). This memo presents a discussion of these issues given the information currently available from the Federal government. Additional information will be forthcoming which will help shape this decision and others in the months to come.

Introduction

The PPACA offers states the option to implement a Basic Health Program (BHP) to adults with incomes between 134 and 200 percent of the federal poverty level (FPL) and legally resident immigrants with incomes no greater than 133 percent FPL whose immigration status disqualifies them from federally-matched Medicaid. The Federal government will reimburse states 95 percent of what they would have spent on premium tax credits and cost-sharing reductions had such eligible individuals been enrolled in a qualified health plan through the state's Health Benefit Exchange (Exchange).

The BHP must include at least the essential benefits under PPACA and consumers may not be charged more in premiums than what they would have paid in the Exchange. In addition, cost sharing must be no greater than a platinum plan (90 percent actuarial value) for individuals with incomes less than 150 percent FPL or a gold plan (80 percent actuarial value) for individuals with incomes between 150 and 200 percent FPL.

States selecting to implement a BHP need to contract with a "managed care system" or a "system that offer(s) as many of the attributes of managed care as are feasible in its local health care market."[i] In addition, plans must report on selected performance measures and must also maintain medical loss ratios of 85 percent or higher. States may not be precluded from running their own managed care arrangement using a fee for service (FFS) payment system with primary care case managers. However, the plan must also include case coordination and case management, incentives for preventive services, maximize patient involvement in health care decision-making and provide incentives for appropriate utilization.[ii]

If states choose to implement a BHP, eligible individuals cannot receive tax credits through the state's Exchange. The Federal government will make a single payment to the state at the start of the fiscal year based on best available estimates and will make corrections (if the amount was too high or low) in the next year's payment.

Although the Federal government has not yet issued guidance on the detailed methodology that will be used to determine state reimbursement, Section 1331(d)(3) requires the Secretary of Health and Human Services (HHS) to determine the amount of transfer to the state on a per enrollee basis taking into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided, including the age and income of the enrollee, whether the enrollment is for self or for family, variance in health care spending based on geographic differences in average spending for health care, and the health status of the individual.

Because Vermont has already extended coverage through its Medicaid program to many of the adults who would be eligible for the BHP, and because it is simultaneously planning for its single-payer system, the decision about whether or not to implement the BHP option is understandably complex.

This memo presents a background assessment of Vermont's current programs and eligibility and projections for the population up to 200 percent FPL. Financing and cost estimates for the BHP is presented and a discussion of the policy issues to be considered, especially in light of Vermont's ultimate goal of a single-payer system, is provided.

This memo does not discuss the option of maintaining Medicaid coverage for Vermont's expansion populations except to document the increased costs (to the state) of doing so (and without regard to the potential financial implications to the State's Global Commitment Waiver). This memo discusses the following two choices:

1. Do not establish a BHP and instead move all eligible adults above 133 percent FPL to the Exchange for subsidized coverage under PPACA.
2. Transition VHAP, Catamount Health and Dr. Dynasaur coverage for adults between 134 --200 percent FPL to a new BHP and allow only those adults between 200 – 400 percent FPL to receive subsidies in the Exchange.

<u>Title XIX Savings Projections</u>

At this time, it is unclear whether the federal government will allow states to continue coverage for expanded populations under their waivers post 2013. So far, CMS has only approved waivers up until the implementation of PPACA's coverage expansions beginning in January 2014. If allowed, it would be certainly more costly for states (including Vermont) to continue with such Medicaid coverage than either 1) moving the

eligible population to the Exchange, or 2) enrolling them in a BHP. Vermont's State share of Medicaid coverage is a little more than 40 percent. Estimates of what the state will save in General Fund revenue by converting this population to either the Exchange or a BHP, taking into account the costs of the uninsured moving onto Medicaid coverage, are provided in Table 1 below. The net savings projected for 2014 are $5.3M for a full-fiscal year. Because the ACA is implemented in January, the projected savings will likely be one-half of what is noted below. It also will be important to balance these projected savings with any impact to the Global Commitment Waiver from these changes.

Table 1: State Fund Savings[1] from Moving Expansion Population out of Medicaid into Exchange or Basic Health Program

	SFY2014	SFY2015	SFY2016
SMAP nc	31.03%	20.63%	14.31%
SMAP cat	41.40%	40.80%	42.45%
State share nc	$11,371,974	$7,562,227	$5,242,753
State share cat	$9,434,685	$9,298,512	$9,674,555
Total State share	$20,806,659	$16,860,740	$14,917,308
State share of new Medicaid enrollees nc	($6,189,254)	($4,115,781)	($2,853,395)
State share of new Medicaid enrollees cat	($9,272,245)	($9,138,416)	($9,507,984)
Net State Savings (cost)	$5,345,160	$3,606,543	$2,555,929

Additional Assumptions:
16,652 = Stable convertible population (VHAP and CHAP >133 percent FPL)
8,094 = Number of uninsured who move onto Medicaid
nc = non-categorical
cat = categorical

Background Assessment

Vermont has implemented numerous reforms to its Medicaid program using waiver flexibility to increase access to and affordability of health insurance. The Dr. Dynasaur

[1] This analysis does not consider any potential cost to the State of moving individuals out of the Global Commitment Waiver.

program covers children to 300 percent FPL as well as pregnant women with household incomes under 200 percent FPL. The Vermont Health Access Plan (VHAP) provides coverage for uninsured adults with incomes under 150 percent FPL and adults with children under 185 percent FPL. Finally, Catamount Health Premium Assistance Program is available to Vermont residents less than300 percent FPL who have been uninsured for at least 12 months and do not have access to employer-sponsored health insurance. Table 2 summarizes public program eligibility pre and post implementation of the PPACA. Individuals at all income levels, except those eligible for Medicaid, are precluded from enrolling in the Exchange or the BHP if they have access to affordable employer coverage (defined as their share of premium costing 9.5 percent or less of household income). [2]

Table 2: Current Program Eligibility

Eligibility Group	Current Eligibility	PPACA Eligibility
Citizen adults no children	VHAP < 150% FPL Catamount Health < 300% FPL	<134% FPL - Medicaid 134-200%FPL - BHP or Exchange 200-400%FPL- Exchange
Citizen adults with children	VHAP < 185%FPL Catamount Health <300% FPL (for subsidized coverage)	<134%FPL - Medicaid 134-200% FPL- BHP or Exchange 200-400%FPL- Exchange
Pregnant Women	Dr. Dynasaur < 200%FPL	<134%FPL - Medicaid 134-200%FPL – BHP, Exchange or Medicaid 200-400%FPL - Exchange
Children	Dr Dynasaur < 300%FPL	<300%FPL – Dr. Dynasaur (over cap enroll in Exchange)

Table 3 provides information on benefits and cost sharing for the various subsidized programs available to people under 200 percent FPL.

Table 3: Premiums and Co-payments of Current Vermont Programs

Program	Beneficiary Premium	Beneficiary Cost sharing
VHAP	133-150%FPL - $33/month 150-185%FPL - $49/month	$1 & $2 pharmacy co-pays for beneficiaries > 100%; $25 ER co-pay
Dr. Dynasaur	Pregnant women 0-15/month	No copayments
Catamount	$60/month BCBS $119/month MVP	Office visits - $10 Rx- $10-$55

[2] The employer plan must also have an actuarial value of 60% or more.

		$500/$1000 deductible (individual/family) for in-network services

Table 4 presents estimates of the number of people who would be eligible for the BHP based on current enrollment in Vermont's programs and the most recent survey data on the uninsured. These projections assume that people currently enrolled in VHAP ESI and ESIA will not be eligible for either the BHP or the Exchange subsidies due to their access to ESI.

Table 4: Estimates of Adults Eligible for a Basic Health Program in Vermont

Income Range	Catamount	VHAP	Uninsured	Total
133%-150% FPL	203	3,422	1,563	5,188
150% - 200% FPL	6,200	3,073	4,285	13,558
Total	6,403	6,495	5,848	18,746

The analyses that follow make several assumptions about take-up rates of the eligible populations presented in Table 4. Specifically, the analysis assumes that 50% of the uninsured and that approximately 90% of those currently enrolled in Vermont's access programs will participate in a Basic Health Program if established. These estimates can, of course, be adjusted up or down.

Financing and Cost Estimates of the Basic Health Program in Vermont[3]

Using the provisions in the ACA for the BHP and data from Vermont regarding premiums and actuarial values, an estimate for financing available to the state from the federal government can be calculated.

ACA Provisions for the Basic Health Program

Table 5 displays the requirements by income of people receiving subsidies in the Exchange. For each income group there is a range of premiums. For people between 133-150 percent FPL the range is between 3 and 4 percent of income or premiums ranging from $37.02 -$54.89. For people between 150 and 200 percent FPL the range is between 4 and 6.3 percent of income or premiums ranging from $55.63 to $116.05. There is also an OOP maximum of $1983 for people under 200 percent FPL.

[3] Additional estimates are presented in Appendix 1

Table 5: ACA Provisions for Premiums, Actuarial Value and OOP Maximums

Income Range	Premium Range	Est Income	Est Premium % of income	[monthly] Income (1 Person)	[monthly] Participant Premium	AV	OOP Max
133-150%	3-4%	134%	3.00%	$1,234.14	**$37.02**	94%	$1,983
133-150%	3-4%	142.5%	3.50%	$1,312.43	**$45.93**	94%	$1,983
133-150%	3-4%	149.0%	4.00%	$1,372.29	**$54.89**	94%	$1,983
150-200%	4- 6.3%	151.0%	4.00%	$1,390.71	**$55.63**	87%	$1,983
150-200%	4-6.3%	175%	5.15%	$1,611.75	**$83.01**	87%	$1,983
150-200%	4-6.3%	200%	6.30%	$1,842.00	**$116.05**	87%	$1,983

Estimate Private Market Premiums

It is necessary to estimate the value of the second-lowest cost silver plan in the Exchange to determine how much the state would receive from the federal government for people enrolled in the BHP.

For the analysis that follows, Catamount per member per month costs for 2011 are used as the starting point for estimating individual market premiums ($420.81). Adjustments are made to these costs to account for out-of-pocket differences between Catamount and a silver plan in the Exchange and administrative costs. Given those adjustments, we estimate a monthly premium (in today's dollars) of $346.55.

Estimate Cost sharing subsidies

To calculate the amount of cost sharing subsidy people will receive in the Exchange, the average amount of cost sharing in a typical silver plan is first estimated. Here it is assumed that the current Catamount Health product has an actuarial value of 83 percent. The actuarial value is then adjusted to 94 and 87 percent respectively as per the ACA and the annual and monthly cost sharing subsidies are calculated to be approximately $101/month for people under 150 percent FPL and $71.54/month for people between 150-200 percent FPL.

Table 6 provides a summary of the estimated revenue per person that will be provided to Vermont to run the BHP.

Table 6: Premium and Cost Sharing Revenue

Point estimate Income %FPL	Participant Premium	Premium for Silver plan	Premium Subsidy	Cost Sharing Subsidy	Total Monthly Subsidy @100%	Total Monthly Subsidy @95%
134%	**$37.02**	$346.55	$309.52	$100.99	$410.52	**$389.99**
142.5%	**$45.93**	$346.55	$300.61	$100.99	$401.61	**$381.53**
149%	**$54.89**	$346.55	$291.66	$100.99	$392.65	**$373.02**
151%	**$55.63**	$346.55	$290.92	$71.54	$362.46	**$344.34**
175%	**$83.01**	$346.55	$263.54	$71.54	$335.08	**$318.33**
200%	**$116.05**	$346.55	$230.50	$71.54	$302.04	**$286.94**

Additional Assumptions:

- Catamount premiums are used as starting point for estimating average non-group silver premiums
- State mandated benefits are included in premiums
- Estimates are made using 2011 premiums
- Actuarial value of Catamount is estimated to be 83.3% based on actuarial evaluation
- Administration costs in the silver tier commercial plan = 15%

Costs of the Basic Health Program.

A state could choose to establish the BHP to look more like its public or commercial plans. A commercial BHP would potentially allow for a broader network and possibly less stigma for beneficiaries. However, it is important to note that Vermont has a single delivery system and unlike other states there is not a plan/network differential that must be considered. Lower provider reimbursement levels of a more public plan means savings to the state and can allow for seamlessness with the Medicaid and CHIP plans for beneficiaries.

The estimates provided in Table 7 were made assuming Basic Health provider rates would be equal to VHAP. Costs for operating a BHP with Medicare and commercial reimbursement levels are higher as shown in the analyses presented in the appendix. In addition, other assumptions were made regarding the health status of the population that will be insured and the administrative costs of running the program. The results in Table 7 assume the same health status as the current VHAP population with 10 percent administrative costs. Also assumed are the take-up rates mentioned earlier. That is,

90% of currently enrolled and 50% of uninsured will take up BHP. Several models were estimated varying these assumptions, which can be found at the end of this memo.

In 2011, PMPM claims are $339.63 per month and VHAP is estimated to have an actuarial value of 95%. Assuming that the BHP would require additional administrative costs compared to the current VHAP operations (with an administrative load of 6.9%) we assume 10 percent administrative costs here. With administrative costs of 10 percent a fully loaded premium of $377.37 is estimated. The projected cost of the BHP using the estimated revenue that will be provided by the Federal government in lieu of premium and cost sharing subsidies for Basic Health enrollees (Total PPACA Subsidy) and the estimate of the costs of the Basic Health Program (Basic Health Cost) are provided below. It is estimated that it will cost the state an additional $541,067 to run a BHP as described above.

This model also assumes that premiums and benefits are kept at VHAP levels. Policymakers could choose to increase beneficiary premiums to what people at the same income levels would be expected to pay in the Exchange. This would bring in significant additional revenue that could be used to increase provider rates above VHAP levels. Policymakers could also adjust benefits somewhat as VHAP is currently at 95 percent actuarial value and the Federal Basic Health Program requires that the value of the plan be at 90 percent for people with incomes between 134-150 percent FPL and 80 percent for people with incomes between 150-200 percent FPL.

Table 7a: Estimated Impact of Moving People Out of Exchange into Basic Health Program

Point estimate income %FPL	BasicHealth Cost (At VHAP level)	Total PPACA Subsidy	Premiums (at VHAP levels)	Cost (Savings) to State	Average (Gain)/ Loss	Total People	Estimated Impact
134%	**$377.37**	$389.99	$33	($45.62)			
142.5%	**$377.37**	$381.53	$33	($37.16)	**($37.16)**	**4,043**	**($1,802,854)**
149%	**$377.37**	$373.02	$33	($28.65)			
151%	**$377.37**	$344.34	$49	($15.97)			
175%	**$377.37**	$318.33	$49	$10.04	**$10.04**	**10,473**	**$1,261,787**
200%	**$377.37**	$286.94	$49	$41.43			
Total							**$541,067**

Policy Considerations

The following discussion presents some of the policy considerations associated with establishing a BHP in Vermont. These considerations include those important to consumers, providers, and the state. This is not a discussion of advantages and disadvantages of each option. That is, most of what might be perceived by some as an advantage to establishing a BHP can be addressed for enrollees in the Exchange as State policymakers see fit. For example, while it is true that a BHP would likely have more of the look and feel of a public program thus ensuring greater continuity of care for participants, it is not difficult to incorporate important "public program" features into the Exchange products for lower-income members. No matter which path Vermont policy makers take, the following policy questions should be considered in a thoughtful manner.

1) **Which option offers better continuity of care for low-income Vermonters?** If Vermont implements a BHP it could continue to streamline benefits for all people under 200 percent FPL and possibly ensure better continuity in coverage. The state could ensure that premiums and cost sharing remain at VHAP levels financed through state savings from moving people off of the waiver and onto a BHP. In addition, if the state builds off of a Medicaid look-alike product such as VHAP or Dr. Dynasaur, potentially more family members can enroll in the same plan. However, there is no reason why these advantages could not be incorporated into the Exchange as well.

2) **Which option offers greater financial protection for consumers**? The PPACA requires that individuals between 133-150 percent FPL contribute between 3-4 percent of income and those between 150-200 percent FPL 4-6.3 percent of income towards premiums. Under a BHP Vermont could potentially offer greater subsidies to individuals at these lower-income levels ensuring greater enrollment and affordability. Depending on what benefits are included in the federal definition of "essential benefits," the state may choose to maintain the subsidy levels it currently has in its programs for people under 200 percent FPL of between 2.4-2.9 percent of income with the savings it realizes from the elimination of the 40 percent state share of coverage for this population. Further reductions in premiums for low-income participants could also be incorporated into the Exchange, although the funds flow could be more complex and uncertain for participants.

The Federal government requires reconciliation at year's end that could endanger tax refunds to, or require payment to the IRS from, people receiving subsidies through the Exchange. This may deter some low-income individuals from enrolling in the Exchange. The BHP is not required to establish a reconciliation process.

3) Which option best assures access to providers? Because Vermont would receive 95% of the second-lowest-cost silver plan if it establishes a BHP, it is likely the state would need to pay a carrier (and the carrier would pay providers) less than what providers would receive from a private plan operating in the Exchange. In fact, cost estimates for the analysis presented here are based on VHAP premiums that incorporate Medicaid rates to providers. This could decrease choice of providers for people in the BHP and could continue the current cost shift. Because Vermont has been studying the cost-shifting issue since 2006, it is well aware of the impact such cost shifts have on private premiums. Because Vermont is moving towards a single-payer system and will strive to equalize payments to providers, this issue will likely be addressed in the coming years.

4) **What is the preference of beneficiaries?** A state-managed program could be perceived by beneficiaries as carrying a stigma compared to accessing private products in the Exchange. However, since Vermont has had expanded access to public products and is moving towards a single payer system, this issue is probably not an important one for consideration.

5) **Which option best promotes safety net viability?** The PPACA includes a provision that mandates full participation by safety-net health care providers in Exchange plans, requiring Exchange plans to contract with all safety net providers, such as federally-qualified health centers. Moreover, the PPACA ensures that beginning in 2014 health center reimbursement is no less than their Medicaid prospective payment system rate from private insurers offering insurance plans through the new Exchange. The health reform package aligns health center payment within private insurance plans with reimbursement under the Medicaid program to ensure that FQHCs do not lose revenue when they treat patients insured under the new Exchange-based plans.

Even with these provisions, there is no guarantee that eligible individuals insured by private plans will continue to seek care at safety-net providers. There are currently eight FQHCs in Vermont that serve low-income, medically-underserved individuals. Creating a BHP that encourages people to seek care at safety-net providers through tighter networks or lower cost sharing could help to ensure viability for the safety net as Vermont moves towards its single-payer system.

6) **What is the effect of each option on the Exchange?** Implementing a BHP would reduce the number of people purchasing insurance in the Exchange. As Vermont moves to its single-payer system, it would like to use the Exchange as a platform and encourage as many people as possible into the Exchange. If the state continues to operate an expanded Medicaid program, either through Medicaid or the BHP, fewer individuals will be purchasing via the Exchange. This may also present challenges for the financial viability of the Exchange because of Vermont's small market size, although as Vermont moves towards single-payer, this issue will be resolved. The projection for participation in the Exchange (excluding SHOP enrollment) beginning in 2014 is 31,025 people. If the

state decided to establish a BHP, enrollment in the Exchange would drop to 16,508. It is difficult to imagine a sustainable Exchange model with so few members enrolled.

7) **What is the impact of each option on risk selection?** Are people enrolled in VHAP between 133 and 200 percent FPL better or worse risk than those purchasing insurance through Catamount, those in the non-group market, and newly eligible uninsured between 200 and 400 percent FPL? It is unclear whether the Federal government will allow the Basic Health Program risk pool to be merged with the overall non-group pool. It is important to understand the differences in risk profiles if the Federal government does not allow the pools to be merged as it will impact the analyses and projections included here.

8) How does each option relate to plans for a Single Payer? Establishing a new program or augmenting existing programs comes with a cost. Vermont is establishing its single-payer system and focusing all its attention on this goal will be important. In addition, it is not clear how the Federal government will address reconciliation with states if their estimates for the Basic Health program are under or over actual costs, leaving some uncertainty regarding revenue funds flow.

Next Steps

Vermont may want to consider some additional information and analysis before it makes a final decision about whether to establish a BHP. First, information from the Federal government regarding the make-up of the essential benefit plan is important. In addition, the risk profile of some of the population who would be eligible for the BHP is unknown. The estimates here assume that the uninsured will present with similar risk profiles as those who are currently enrolled in public programs. While sensitivity analyses around such an assumption are easy to make, the uncertainty is something with which states may not be comfortable. In this regard, the Federal government has not ruled on whether the BHP's risk pool can be merged with the overall non-group risk pool. Guidance on this issue may provide additional information that could be useful to decision-makers.

In addition, before making any final decisions on whether or not to implement a BHP, policymakers should consider the financial impact of the movement of the VHAP and/or Catamount Health populations from the Global Commitment waiver.

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[i] ACA S1331(c)(2)(C)
[ii] ACA S1331(b)(2)(A)

Appendix 1: Alternative Estimates for Basic Health Program

Alternative 1: Instead of using Catamount premiums to estimate revenue generated by the second-lowest cost silver plan, premiums were increased to commercial rates (25% increase) and administrative costs were assumed to be 10% (advisory group recommendations)

Table 7: Estimated Annual Impact of Moving People Out of Exchange into Basic Health Program with Alternative Revenue Estimate, Premiums for Basic Health are at VHAP Levels and Basic Health pays VHAP Provider Rates

Point estimate income %FPL	Basic Health Cost (at Medicare Rates)	Total PPACA Subsidy	Premiums (at VHAP levels)	Cost (Savings) to State	Average (Gain)/ Loss	Total People	Estimated Impact
134%	**$399.56**	$496.28	$33	($129.72)			
142.5%	**$399.56**	$487.82	$33	($121.26)	**($121.26)**	**4,043**	**($5,883,050)**
149%	**$399.56**	$479.30	$33	($112.74)			
151%	**$399.56**	$443.62	$49	($93.06)			
175%	**$399.56**	$417.61	$49	($67.02)	**($67.02)**	**10,473**	**($8,422,805)**
200%	**$399.56**	$386.22	$49	($35.66)			
Total							**($14,305,855)**

Alternative 2: Using 1 above for revenue, provider rates in Basic Health Program are increased to Catamount level (original analysis at Medicaid levels, 30% increase)

Table 7: Estimated Annual Impact of Moving People Out of Exchange into Basic Health Program with Alternative Revenue Estimate, Premiums for Basic Health at VHAP Levels and Basic Health pays Catamount Provider Rates

Point estimate income %FPL	Basic Health Cost (at Catamount Rates)	Total PPACA Subsidy	Premiums (at VHAP levels)	Cost (Savings) to State	Average (Gain)/ Loss	Total People	Estimated Impact
134%	**$507.74**	$496.28	$33	($21.54)			
142.5%	**$507.74**	$487.82	$33	($13.08)	**($13.08)**	**4,043**	**($634,589)**
149%	**$507.74**	$479.30	$33	($4.56)			
151%	**$507.74**	$443.62	$49	$15.12			
175%	**$507.74**	$417.61	$49	$41.13	**$41.13**	**10,473**	**$5,169,054**
200%	**$507.74**	$386.22	$49	$72.52			
Total							**$4,534,465**

Alternative 3: Using 1 above for revenue, provider rates in Basic Health Program are increased to Commercial level (60% increase).

Table 7: Estimated Annual Impact of Moving People Out of Exchange into Basic Health Program with Alternative Revenue Estimate, Premiums for Basic Health at VHAP Levels and Basic Health pays Commercial Provider Rates

Point estimate income %FPL	Basic Health Cost (at Commercial Rates)	Total PPACA Subsidy	Premiums (at VHAP levels)	Cost (Savings) to State	Average (Gain)/ Loss	Total People	Estimated Impact
134%	**$624.92**	$496.28	$33	$95.64			
142.5%	**$624.92**	$487.82	$33	$104.10	**$104.10**	**4,043**	**$5,050,516**
149%	**$624.92**	$479.30	$33	$112.62			
151%	**$624.92**	$443.62	$49	$132.30			
175%	**$624.92**	$417.61	$49	$158.31	**$158.31**	**10,473**	**$19,895,767**
200%	**$624.92**	$386.22	$49	$189.70			
Total							**$24,946,283**