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Backgrounder
Executive Summary

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How Congress's Medicare Drug Provisions Would Reduce Seniors' Existing Private Coverage

Edmund F. Haislmaier

Millions of seniors stand to lose their private employer-based drug coverage or find that their existing drug coverage is significantly scaled back from what it is today. That is the likely result if provisions in major Medicare legislation recently approved by both houses of Congress (S. 1 and H.R. 1) to provide all Medicare beneficiaries with a new Medicare prescription drug benefit are approved in their current form.

A House–Senate conference committee is now attempting to reconcile the differences between the two massive bills. Rather than reconciling two profoundly flawed bills, however, the conferees should go back to the drawing board. They should use as a blueprint the 1999 majority recommendations of the National Bipartisan Commission on the Future of Medicare, which proposed that Medicare beneficiaries be given a choice between traditional Medicare as it exists today and new, private plans offering comprehensive, integrated benefits including full outpatient prescription drug coverage.

Replay of a Bad Policy. This is not the first time that Congress has tried to add a prescription drug benefit to Medicare as a universal entitlement. In 1988, Congress passed the Medicare Catastrophic Coverage Act, which included a Medicare prescription drug benefit. But strong opposition from senior citizens, the law's intended beneficiaries, forced Congress to repeal the legislation a year later. Among the chief opponents of the 1988 Catastrophic Act were retirees with prescription drug coverage provided as a retirement benefit by their former employers. They calculated that under the new Medicare prescription drug program, they would pay more in premiums and receive less generous coverage in return, relative to their existing employer-sponsored coverage.

Now, with the passage of S. 1 and H.R. 1, Congress and the Administration are perilously close to repeating that history. According to *The New York Times*, "The Congressional Budget Office estimates that 32 percent of retired workers with employer-sponsored drug coverage would lose it under the House bill. The comparable figure for the Senate bill is 37 percent." This implies that the CBO believes about 3.8 million to 4.4 million retirees

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could lose their employer-provided drug coverage outright.

What has not been closely examined is the effect the legislation would be likely to have on the rest of the approximately 12 million retirees with employer-sponsored drug coverage as well as the approximately 4.8 million additional retirees who have purchased Medicare supplemental insurance (Medigap) plans with prescription drug coverage. A close reading of both bills indicates that those retirees would also experience reductions in their current prescription drug coverage under the pending legislation.

The most likely scenario is that under either bill's provisions, almost all employers currently offering retiree drug coverage sooner or later would drop their coverage outright, scale back their plans' benefits to the new Medicare standard plan design, or replace it with wrap-around coverage that pays the initial deductible and cost-sharing for their retirees. The effects of such wrap-around coverage would be to:

- **Limit employers' liabilities** and shift much of the risk and cost for prescription drugs onto the taxpayer.
- **Give retirees with employer wrap-around plans up-front coverage.** In other words, they would get free drug coverage on the first $4,500 worth of drugs under the Senate bill or the first $2,000 worth of drugs under the House bill.
- **Force retirees with higher drug costs to pay a large share of the bill.** These retirees would be forced to pay entirely out-of-pocket for the next $3,700 worth of drugs under the Senate bill or the next $3,500 worth of drugs under the House bill.

Not surprisingly, retirees are beginning to be concerned about how the pending legislation would affect their existing employer-sponsored or individually purchased coverage. Absent a significant rewrite of the final bill in the conference committee, there is a growing likelihood that those concerns could translate into a full-scale retiree revolt following final passage of the legislation—as was the case with the Medicare Catastrophic Coverage Act in 1989.

Needed: Better Medicare Choices. To head off such a revolt, Congress should scrap the drug provisions in both the House and Senate bills and go back to the 1999 majority recommendations of the National Bipartisan Commission on the Future of Medicare to give Medicare beneficiaries a choice between traditional Medicare as it exists today and new, private plans offering comprehensive, integrated benefits including full outpatient prescription drug coverage.

Such an approach would forestall a brewing political backlash and—even more important—ensure that both today's retirees and tomorrow's retirees get the kind of quality, integrated, chronic care that they need and deserve. It would move Medicare away from its current model of fragmented care that is costly and results in sub-optimal health outcomes for senior citizens. The result would be a system that not only paid for prescription drugs, but also integrated them with other health care benefits to get the most value for seniors out of the ability of drugs to reduce other health care costs and improve the quality of their health outcomes and lives.

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REPLAY OF A BAD POLICY

This is not the first time that Congress has tried to add a prescription drug benefit to Medicare as a universal entitlement. In 1988, Congress passed the Medicare Catastrophic Coverage Act, which included a Medicare prescription drug benefit. But strong opposition from senior citizens, the law's intended beneficiaries, forced Congress to repeal the legislation a year later.

That popular opposition in 1988 and 1989 was fueled by the growing realization among a large number of retirees that they would actually be worse off under the Medicare legislation. Among the chief opponents of the 1988 Catastrophic Act were retirees with prescription drug coverage provided as a retirement benefit by their former employers. They calculated that under the new Medicare prescription drug program, they would both pay more in premiums and receive less generous coverage in return, relative to their existing employer-sponsored coverage.

This fierce retiree opposition was augmented by objections from the non-elderly to the fact that the Catastrophic Act would cause large employers to shift much of the costs for their retiree health benefits onto the taxpayers.

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THE NEW THREAT TO RETIREE COVERAGE

Now, with the passage of S. 1 and H.R. 1, Congress and the Administration are perilously close to repeating that history. According to *The New York Times*, "The Congressional Budget Office estimates that 32 percent of retired workers with employer-sponsored drug coverage would lose it under the House bill. The comparable figure for the Senate bill is 37 percent."[1] This implies that the CBO believes about 3.8 million to 4.4 million retirees could lose their employer-provided drug coverage outright.

What has not been closely examined is the effect the legislation would be likely to have on the rest of the approximately 12 million retirees with employer-sponsored drug coverage as well as the approximately 4.8 million additional retirees who have purchased Medicare supplemental insurance (Medigap) plans with prescription drug coverage. A close reading of both bills indicates that those retirees would also experience reductions in their current prescription drug coverage under the pending legislation.

The most likely scenario is that under either bill's provisions, almost all employers currently offering retiree drug coverage sooner or later would either drop their coverage outright, scale back their plans' benefits to the new Medicare standard plan design, or replace it with wrap-around coverage that pays the initial deductible and cost-sharing for their retirees. The effects of such wrap-around coverage would be to:

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IMPACT ON MEDIGAP PLANS

In addition, both bills would cause the approximately 4.8 million additional retirees who have purchased Medicare supplemental insurance (Medigap) plans with front-end prescription drug coverage to lose that coverage. The Senate bill would effectively abolish Medigap drug coverage. Although the House bill would let those who currently have Medigap policies with drug coverage keep them, it is not likely that the added benefit for the vast majority of those retirees would be worth the cost, since insurance payments for drugs do not count toward the beneficiary's out-of-pocket limit under either bill.

Thus, almost all retirees with employer prescription drug coverage most likely would see those benefits at least scaled back. While those with low drug costs would still have comprehensive coverage, those with higher drug costs could end up paying *more* out-of-pocket than they do now, even if their employers provided them with wrap-around coverage. For those without employer coverage, there would be no way to obtain private insurance to cover the costs of the deductible, cost-sharing, or coverage gap in the new Medicare Part D drug plan.

Not surprisingly, retirees are beginning to be concerned about how the pending legislation would affect their existing employer-sponsored or individually purchased coverage. Absent a significant rewrite of the final bill in the conference committee, there is a growing likelihood that those concerns could translate into a full-scale retiree revolt following final passage of the legislation—as was the case with the Medicare Catastrophic Coverage Act in 1989.

To head off such a revolt, Congress should scrap the drug provisions in both the House and Senate bills and go back to the 1999 majority recommendations of the National Bipartisan Commission on the Future of Medicare to provide Medicare beneficiaries with a choice between traditional Medicare as it exists today and new, private plans offering comprehensive, integrated benefits including full outpatient prescription drug coverage.

1. Robin Toner and Robert Pear, "House Committee Approves Drug Benefits for Medicare," *The New York Times*, June 18, 2003.

Such an approach would forestall a brewing political backlash and—even more important—ensure that both today's retirees and tomorrow's retirees get the kind of quality, integrated, chronic care that they need and deserve. It would move Medicare away from its current model of fragmented care that is costly and results in sub-optimal health outcomes for senior citizens. The result would be a system that not only paid for prescription drugs, but also integrated them with other health care benefits to get the most value for seniors out of the ability of drugs to reduce other health care costs and improve the quality of their health outcomes and lives.

THE CHALLENGE: DOING MEDICARE DRUG POLICY THE RIGHT WAY

Currently, insurance coverage for outpatient prescription drugs among Medicare enrollees ranges from no coverage at all to comprehensive coverage with very low out-of-pocket costs. Testifying in April before the House Ways and Means Committee, CBO Director Douglas Holtz-Eakin noted that

> Most Medicare beneficiaries now have coverage for prescription drugs at some point in the year, but the extent of that coverage varies widely. CBO's analysis of the Medicare Current Beneficiary Survey indicates that in 2000 (the most recent year for which data are available), 75 percent of the Medicare population—or roughly 30 million individuals—had some form of insurance coverage for the costs of prescription drugs for at least part of the year; 25 percent—or roughly 10 million beneficiaries—had no drug coverage. Beneficiaries who have coverage for their drug costs obtain it from a variety of sources. For example, nearly 30 percent of Medicare beneficiaries obtained coverage through employer-sponsored retiree benefits, and another 16 percent had coverage through the Medicaid program. About 12 percent of beneficiaries are estimated to have had drug coverage through individually purchased medigap policies, while the remainder obtained coverage through a Medicare+Choice plan or from another state or federal program.[2]

These disparities in drug coverage show why it has proven so difficult for Congress to design improvements in prescription drug coverage for Medicare beneficiaries.

To start with, almost half (46 percent) of all Medicare beneficiaries—those for whom Medicaid or an employer plan provides supplemental coverage to Medicare—actually have comprehensive drug coverage. A recent study by the benefits consulting firm Hewitt Associates estimates that 28,000 employers currently provide prescription drug coverage for their retirees at an estimated annual collective cost of $22.5 billion this year.[3] Those retirees stand to gain little or nothing from a new Medicare drug benefit and could very well end up worse off. However, their former employers stand to gain a lot from the pending legislation if they use it as a way to scale back coverage for their retirees and then shift much of the remaining costs of those benefits onto taxpayers.

Another 29 percent of Medicare beneficiaries have some drug coverage, either through an individually purchased Medigap plan, enrollment in a Medicare+Choice health maintenance organization (HMO), or through another state or federal program. However, their plans generally provide them only with limited "front-end" benefits, leaving them exposed to catastrophic drug costs. Whether they would gain or lose under a new Medicare drug benefit depends very much on the benefit design and the premiums charged. To the extent that the new program provided them with catastrophic coverage, it would be a plus. On the other hand, to the extent that the new program replaced or reduced their existing front-end drug coverage, it would be either neutral or negative for them.

Finally, the remaining 25 percent of Medicare beneficiaries have no drug coverage. Some of them have high drug expenditures, while others have

2. Douglas Holtz-Eakin, Director, Congressional Budget Office, *Prescription Drug Coverage and Medicare's Fiscal Challenges*, testimony before the Committee on Ways and Means, U.S. House of Representatives, April 9, 2003.
3. Milt Freudenheim, "Medicare Drug Benefits Would Aid Big Employers," *The New York Times*, July 3, 2003.

average or low drug expenditures. Logically, it is the subset of this group with high drug costs that most desires a new Medicare drug benefit. For the others, with average or below average drug expenditures, a new Medicare drug benefit would provide peace of mind but could also mean a total cost in premiums and out-of-pocket spending that ranged from somewhat less than to substantially more than they now pay when buying all of their drugs out-of-pocket.

Table 1 B 1668

Comparison of Coverage Under Standard Prescription Drug Plan for First Year (2006) in S.1 and H.R.1

	S. 1	H.R. 1
Deductible	$275	$250
Initial Cost–Sharing	50% up to initial coverage limit of $4,500 in total drug spending.	20% up to initial coverage limit of $2,000 in total drug spending.
Coverage Gap	Beneficiary pays 100% of the cost of the next $1,312.50 in drug spending.	Beneficiary pays 100% of the cost of the next $2,900 in drug spending.
Stop–Loss on Out–of–Pocket Spending	$3, 700 in beneficiary deductibles and co–pays (reached at $5,182.50 in total drug spending).	$3,500 in beneficiary deductibles and co–pays (reached at $4,900 in total drug spending).
Cost–Sharing Above Stop–Loss	Beneficiary pays 10% of each additional dollar of drug spending after reaching the $3,700 stop–loss.	No beneficiary cost–sharing above the $3,500 stop–loss.
Income–Related Stop–Loss Threshold	No provision.	Stop–loss threshold is higher for enrollees with incomes above $60,000 (individuals) and $120,000 (couples).

Note: In both bills, the deductible, initial coverage limit, and stop–loss are indexed for years after 2006.

Thus, the challenge facing Congress is to design reforms that provide outpatient prescription drug coverage for Medicare beneficiaries who currently lack coverage and that also improve the coverage of beneficiaries who currently have limited benefits without at the same time diminishing the benefits of those who currently have more comprehensive coverage.

The danger for Congress is that, in taking a one-size-fits-all approach, it runs the risk of creating as many or more losers as it does winners, and thus generating the kind of retiree opposition that it experienced with the 1988 Medicare Catastrophic legislation. Regrettably, that is the approach both the House and the Senate have again taken in the pending Medicare legislation.

KEY FEATURES OF THE HOUSE AND SENATE DRUG PROVISIONS

Standard Benefit Design

Both H.R. 1 and S. 1 would create a new Part D Medicare drug benefit, with a standard benefit design. Both bills also have provisions designed to induce private insurers to offer the new coverage, and both would subsidize the cost of coverage for enrollees. Table 1 shows how the coverage structure for the drug benefit differs in the two bills.

Both designs have similar deductibles. The House benefit structure imposes lower total cost-sharing on beneficiaries than the Senate benefit structure imposes. While the "coverage gap" in the House bill design is more than twice the size of the gap in the Senate bill design, the House bill provides for a true beneficiary "stop-loss." (An insurance "stop-loss" refers to the level beyond which the coverage pays 100 percent of the additional claims and the losses therefore stop for the policyholder.) However, the stop-loss in the House bill would be increased, on a sliding scale, for upper-income beneficiaries. In contrast, while the Senate bill does not vary the benefit by income, it also places no limit on beneficiary cost-sharing and thus lacks a true beneficiary stop-loss.

Interaction with Other Coverage

These benefit structures are unlike any that can be found in a normal, private health insurance market and are largely the product of political and budgetary constraints. But the benefit design is only

one part of the equation in determining how a new Medicare drug benefit will affect existing retiree drug coverage. Just as important are the provisions that govern how the new Medicare drug benefit will interact with existing employer-provided coverage and existing Medigap coverage.

In that regard, the drug benefit provisions in the Senate bill are both more complex and more likely to result in coverage displacement than the equivalent provisions in the House bill.

IMPACT OF THE SENATE BILL ON RETIREE DRUG COVERAGE

Within the Senate Medicare bill's 1,043-page jungle of legislation is a 214-page thicket of legal arcana that constitutes the prescription drug portion of S. 1. Twisting through that thicket is a trail of provisions that, if enacted, would reshape the prescription drug coverage currently enjoyed by millions of retirees.[4]

As noted, the CBO reportedly estimates that if S. 1 became law, 37 percent—about 4.4 million—of the 12 million seniors who currently have prescription drug coverage through plans sponsored by their previous employers would lose their private drug coverage.

However, in addition to the option of discontinuing private drug coverage for their retirees, employers who currently offer such coverage would be faced with three other options with respect to their existing plans. Those options would be to (1) keep the status quo, (2) conform their existing plan to the new law, or (3) drop their existing plan but provide retirees with "wrap-around" coverage to supplement the new Medicare plan.

Senate Trade-Offs. Each option has trade-offs for both the employers and the retired workers who are covered by those plans.

Option 1: Keep the status quo.

In this option, the employer keeps its existing retiree drug coverage plan as is and essentially ignores the new Medicare drug benefit.

Employer Pro: The employer would retain the flexibility to set and adjust the benefit design (within the context of any negotiated labor agreements) of its retiree drug plan. The employer could continue to offer a plan with deductibles, co-pays, and out-of-pocket limits different from those of the new Medicare standard plan. The employer's plan could be either more or less generous than the Medicare standard plan. Also, the employer would avoid the burden of having its plan subject to Medicare audits.

Employer Con: The employer would forgo receiving a subsidy from Medicare equal to 70 percent of the average national premium for standard coverage (about $840) for each qualified enrollee in its plan. The employer would also lose the option to claim additional "reinsurance" payments from Medicare for its high-cost retirees (those whose annual drug costs exceed $5,813 a year).

Retiree Pro: The retirees in the plan would keep the drug benefit structure they now have, since it would not need to meet the new Medicare standard. This would be advantageous to them if, and as long as, their employer plan is more generous than the Medicare standard (e.g., a lower deductible and/or cost-sharing requirements). Also, the retirees would not have to pay the new Medicare drug coverage premiums (about $420 a year in 2006).

Retiree Con: The employer would be free to change the design of the drug benefit in future years or to eliminate it altogether. However, because the plan was not a "qualified" one, if the employer later dropped the plan and the retiree sought to join the Medicare Part D program, he or she would be subject to the much higher premiums imposed for delayed enrollment.

Option 2: Conform the existing plan to the new law.

In this option, the employer modifies its existing retiree drug coverage plan to make it a "Qualified Retiree Prescription Drug Plan" under the new Medicare drug benefit. A "qualified" plan is one that offers either the same standard coverage structure

4. The table in Appendix A details the provisions of S. 1 that relate to existing employer-sponsored retiree drug coverage.

specified in the legislation, with or without reduced beneficiary cost-sharing, or a coverage structure that Medicare approves as "actuarially equivalent" to the standard coverage structure.

Employer Pro: The employer gains several advantages by conforming its existing plan to the new standard benefit design. First, if the employer's plan is more generous (e.g., lower deductibles and co-pays) than the standard design, it will be able to reduce plan costs by scaling back the benefits to meet the standard design (e.g., raising the deductible and/or co-pays). Second, Medicare will pay the employer a subsidy equal to 70 percent of the average national premium for standard coverage (about $840) for each qualified enrollee in its plan. Third, Medicare will pick up 80 percent of the additional costs of drugs for retirees in the plan who reach their annual out-of-pocket limit. Under the standard plan, in 2006, the $3,700 out-of-pocket limit is reached once total drug spending exceeds $5,813. Thus, for the 5,814th dollar, and for all subsequent dollars spent on drugs for the beneficiary, Medicare will pay 80 cents and the employer and the retiree will pay 10 cents each.

Employer Con: In the future, the employer could not scale back its plan to anything less than the standard coverage design without its plan ceasing to be a "qualified plan." The employer would need to get Medicare approval for its "qualified plan" and, once the plan became a "qualified plan," would be subject to Medicare reporting requirements and plan audits.

Retiree Pro: The employer would likely go through the trouble of getting its plan certified as a qualified plan only if it intended to keep the plan for the foreseeable future. Also, if or when the employer did discontinue its plan, the retiree would be able to buy one of the standard Medicare plans without being hit with the much higher premium for delayed enrollment. Thus, the retiree would be protected against losing coverage.

Retiree Con: If the current employer plan is a generous one, it is likely that the employer will be forced to scale back the benefits offered to meet the new Medicare standard coverage design or the actuarial equivalence standard. Also, if the employer did get approval for a plan that was more generous than the Medicare standard plan, it could always scale the plan back to the Medicare standard at any time. Indeed, given the complexity and restrictions associated with the actuarial equivalence standard in the Senate bill, plus the general desire of employers to scale back (if not eliminate) coverage, it is most likely that any employer electing to keep its plan and make it a "qualified" one would simply adopt the Medicare standard coverage structure into its new plan and blame Congress for forcing it to scale back coverage.

Option 3: Drop the existing plan but provide "wrap-around" coverage.

In this option, the employer discontinues its existing retiree drug coverage plan and has its retirees enroll in the new standard Part D Medicare drug plans. The employer compensates its retirees by providing "wrap-around" drug coverage that pays the out-of-pocket costs its retirees incur with the standard Part D Medicare drug plans. The employer might also pay the retirees' share of the premium for the Medicare drug coverage.

Employer Pro: The employer can reduce and cap its retiree prescription drug liability and greatly simplify its plan. In exchange for eliminating coverage, the employer simply agrees to pay its retirees' co-payments for their Medicare drug coverage up to a fixed annual amount. Thus, the employer shifts the majority of the price and volume risk for drug coverage onto Medicare and its own retirees. The employer also effectively creates a stop-loss for itself. Furthermore, the employer no longer needs to contract with an insurer or a pharmacy benefit manager (PBM) to manage its retiree drug benefit. Instead, it just hires a contractor to process reimbursements for employee cost-sharing. Nor is the employer plan subject to Medicare oversight as it would be if the employer sought to make its plan a "qualified" one. Of course, the employer is free to further scale-back or eliminate this wrap-around coverage at any time.

Employer Con: There really is no employer downside to this option other than the fact that some of its retirees (those with high drug costs) will not be happy with the new arrangement. How-

ever, the employer can blame it on Congress while pointing out that the above alternatives are not very attractive for retirees either. Also, the employer would forgo the subsidies offered for making its plan a qualified plan. But if the savings from substituting wrap-around coverage are worth more than the subsidies for converting its plan to "qualified" coverage, the smart move will be for the employer to shift to wrap-around coverage.

Retiree Pro: Depending on the generosity of the employer, the retiree still gets fairly comprehensive drug coverage. The coverage comes in two parts. The Medicare drug plan is the primary insurer, and the employer pays the deductible and the initial coinsurance with wrap-around coverage up to some employer-set limit. This is the same arrangement as currently exists with employer-paid wrap-around coverage for Medicare Parts A and B.

Retiree Con: As long as the retiree does not incur substantial drug costs, there is little to complain about in this arrangement. The retiree is still getting comprehensive drug coverage coming, as noted, in two parts. The problem with this option will be for those retirees with the highest drug costs. If the employer sets any limit (and most employers likely will set some limit) on the total amount of co-pays for which it will reimburse the retiree, then any retiree who exceeds the employer's cost-sharing limit will first need to spend $3,700 out-of-pocket before Medicare again kicks in and pays 90 percent of the cost. This is because, according to Section 1860D–6(c)(4)(C)(ii), none of the payments from the employer wrap-around coverage would count toward the retiree's $3,700 "out-of-pocket" spending limit. Indeed, under the provisions of Section 1860D–6(c)(4)(D), enrollees who are found to have claimed out-of-pocket expenses that were actually reimbursed by private insurance would have their Medicare drug coverage terminated.

The most likely result is that employers who currently offer coverage, if they don't drop it entirely, will adopt either the second or third option. They will either make their plan a "qualified plan" and scale-back current coverage or substitute "wrap-around" coverage for their current plan.

IMPACT OF THE HOUSE BILL ON RETIREE DRUG COVERAGE

While similar in design, the drug provisions in H.R. 1 are less complex than those in the Senate bill and, at 170 pages, also 44 pages briefer. Still, employers who currently offer retiree drug coverage would face the same basic set of options under the House bill as they would under the Senate bill.

However, there are three main differences in the House bill that would influence employer decisions in ways that might result in effects that are somewhat different from those that would be experienced under the Senate bill.

First, the House bill's definition of "actuarial equivalence" for the purpose of determining that an employer-sponsored plan offers an acceptable alternative to the standard coverage structure is less rigid than the definition in the Senate bill.[5] This makes it easier for existing employer-sponsored drug plans to meet the "qualified coverage" test if they elect to conform their plan to the new Medicare requirements. As a result, it is somewhat more likely that under the House bill, more employers would opt to make their existing plan a "qualified plan" with possibly less scaling back of coverage than would be the case under the Senate bill.

Second, for employer-sponsored qualified plans, the House bill provides a subsidy of 28 percent of the cost of drugs in excess of the $250 annual deductible for each qualified beneficiary, up to a maximum of $5,000 per year.[6] These subsidies to employers are less generous for beneficiaries with low drug costs and more generous for beneficiaries with high drug costs than those in the Senate bill.

Third, the lower front-end cost-sharing structure in the House bill's coverage design means that it will be less costly for employers who decide to offer wrap-around coverage. Under the Senate bill, an employer offering wrap-around coverage would spend $2,387.50 in paying the deductible and initial cost-sharing on the first $4,500 in drug

5. H.R. 1, Section 1860D–2(c).

6. H.R. 1, Section 1860D–8(f)(3).

expenses, or $2,807.50 if the employer also reimbursed the retiree for the estimated $420 annual premium. In contrast, under the House bill, an employer offering wrap-around coverage would spend only $600 in paying the deductible and initial cost-sharing on the first $2,000 in drug expenses, or $1,020 if the employer also reimbursed the retiree for the estimated $420 annual premium.

The House Paradox. The paradox, then, is that the House bill makes it easier than the Senate bill for employers to retain a more generous drug plan, but it also makes it cheaper for employers to scale back coverage by substituting a wrap-around plan for their current plan. On the one hand, the less onerous provisions in the House bill would make it easier for employers to have their current plan approved by Medicare as a "qualified" plan, and thus keep offering their retirees generous coverage.

On the other hand, the more comprehensive front-end coverage structure of the Medicare drug benefit in the House bill would make it easier, and much cheaper, than in the Senate bill for employers to offer wrap-around coverage. With basic wrap-around coverage, for just over $1,000 per retiree, employers could make the first $2,000 of drug costs totally free to their retirees and then off-load on to their retirees and Medicare all of the costs and risks for retiree drug spending in excess of $2,000 per individual.

EFFECT ON EMPLOYER WRAP-AROUND DRUG COVERAGE

Of the three options that either bill would present to employers, the simplest and most attractive one for them is the option of substituting wrap-around coverage for their current plans. With that approach, the employer off-loads most of the cost and risk of retiree drug coverage while still pleasing the majority of its retirees who have relatively low annual drug bills. Although some employers may drop their existing coverage entirely, the more likely scenario is that most employers will sooner or later substitute wrap-around coverage for their existing, more comprehensive plans.

The problem with this approach for the retiree is that, under both bills, none of the amounts paid by employer wrap-around benefits to cover the deductible and initial cost-sharing would count toward the out-of-pocket limits. This means that employer wrap-around coverage would have the effect of aggregating together all of the cost-sharing in one large coverage gap or "doughnut hole," which would then kick in at the point at which the employer's wrap-around coverage ended.

Effect of the Senate Bill

In practice, the Senate bill would set in motion the following dynamics. The retiree enrolls in one of the new Medicare drug plans and pays about $420 a year in premiums. Under the Senate version, the employer reimburses the retiree for the premiums and pays the $275 deductible as well as the 50 percent coinsurance on the next $4,225 in drug expenses (or $2112.50). At that point, the retiree has consumed $4,500 in drugs and not paid a single penny in either premiums or out-of-pocket cost-sharing. The employer has paid the $420 in premiums, the $275 deductible, and the $2,112.50 in coinsurance for a total cost of $2,807.50. Medicare has paid the remaining $1,692.50 in drug spending.

From that point on, Medicare pays nothing. If the employer also caps its program at that level, then the retiree must pay 100 percent of the cost of the next $3,700 in drug expenses, after which Medicare will then start paying 90 cents of each additional dollar with the retiree paying the remaining 10 percent.

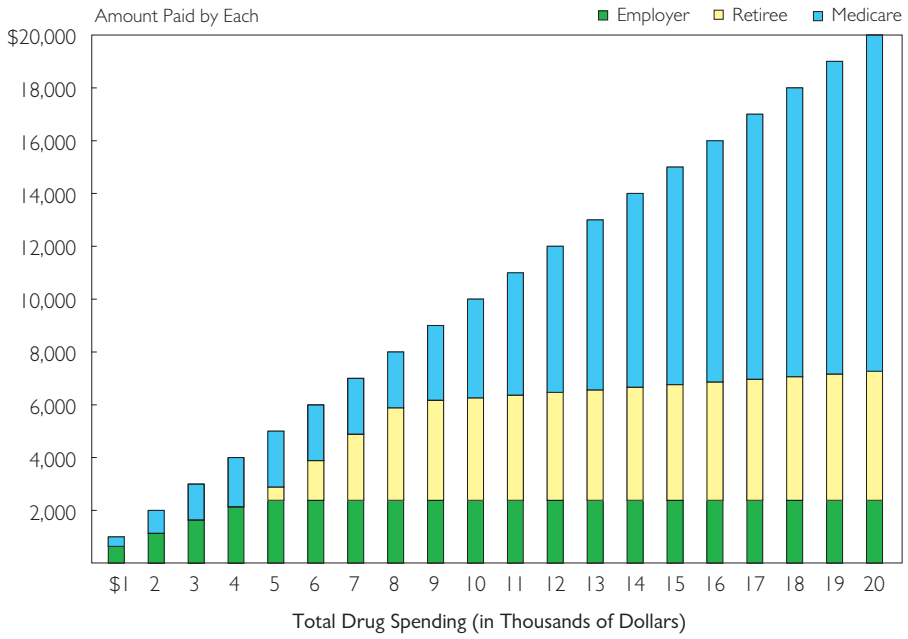
Chart 1 shows how, under the Senate bill, this scenario will result in retirees' drug spending being distributed among employers, retirees, and Medicare.[7] It also shows how employers will be able to create a stop-loss limit for themselves by converting their exiting retiree drug plans into wrap-around coverage.

As can be seen in the chart, under S. 1, an employer is able to create a stop-loss for itself at the level of $2,387.50 of the first $4,500 per year in drug spending per retiree. However, neither Medicare nor the retirees have a true stop-loss. The indexing of the deductible and the "initial coverage limit" for the coinsurance means that the employer's per-retiree drug spending stop-loss will rise over

7. For the data used to create Charts 1–4, see the table in Appendix B.

Chart 1 B 1668

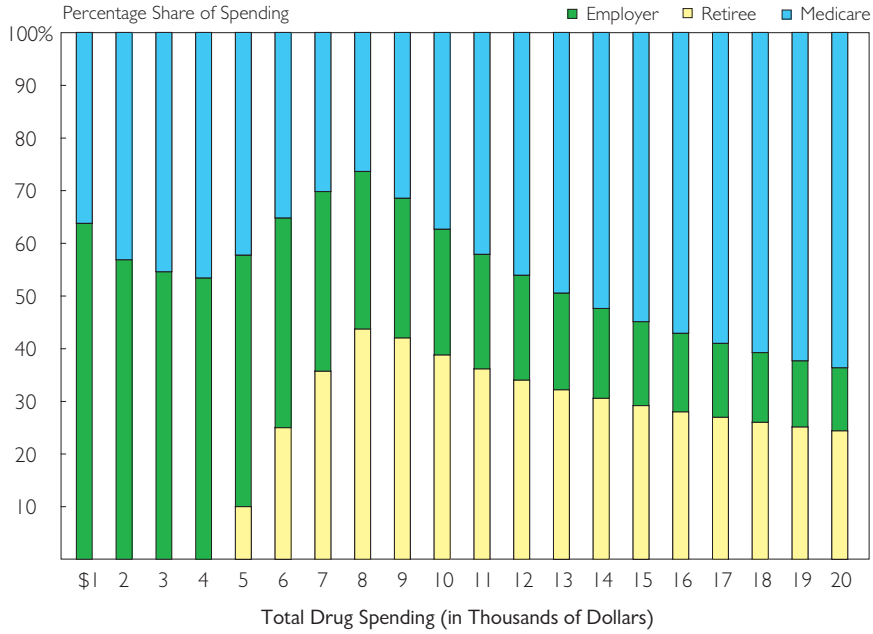
Distribution of Drug Spending Under S.1 For Retirees With Employer Wrap-Around Coverage for Drugs



Source: Author's calculations based on the Medicare Part D standard coverage design for 2006, as specified in the legislation. Data can be found in Appendix B.

Chart 2 B 1668

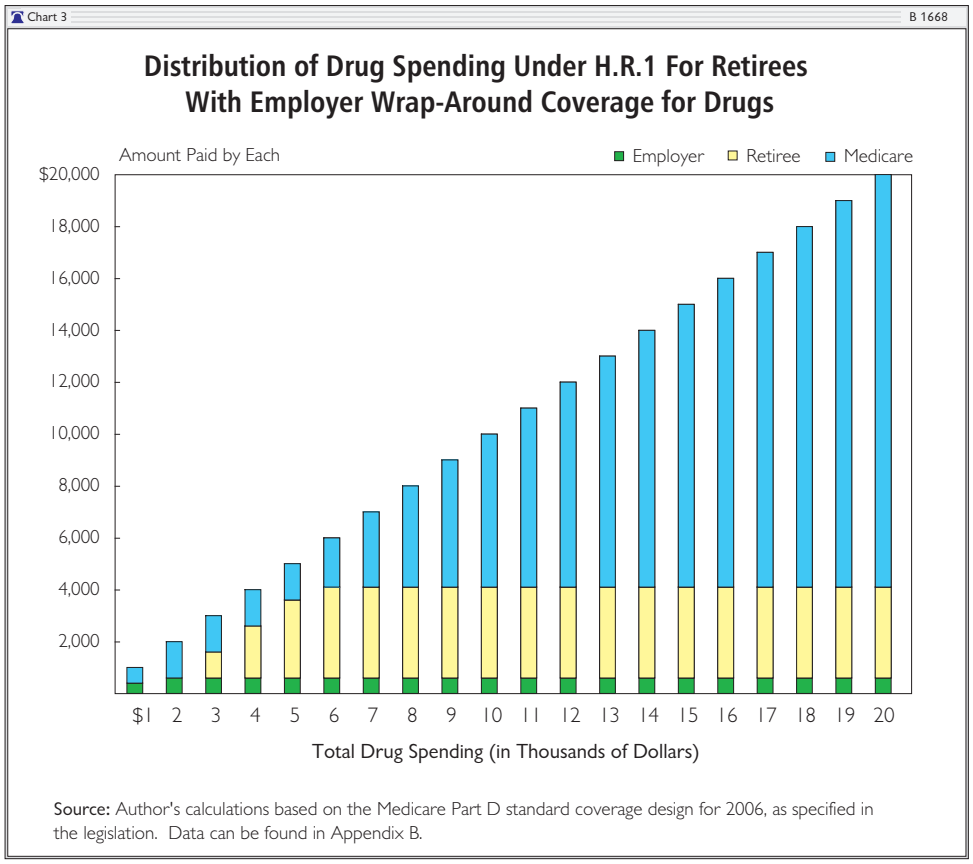
Percentage Share of Drug Spending Under S.1 For Retirees With Employer Wrap-Around Coverage for Drugs



Source: Author's calculations based on the Medicare Part D standard coverage design for 2006, as specified in the legislation. Data can be found in Appendix B.

time but will still remain a true stop-loss.

However, thanks to the generosity of the employer in providing wrap-around coverage, the point at which the program's "catastrophic level" co-pay of only 10 percent kicks in for the retiree has been pushed up from $5,812.50 in total drug spending to $8,200 in total drug spending. At that point, of the total $8,200 in drug spending, the employer will have paid $2,387.50, or 29 percent; Medicare will have paid $2112.50, or 26 percent; and the retiree will have paid $3,700, or 45 percent.



Thus, the effect of the employer's offering wrap-around coverage will be *to increase the burden on those retirees with higher drug costs*. This can be seen in Chart 2, which shows the percentage share of drug spending for the employer, the retiree, and Medicare at each level using the same data as in Chart 1.

Under the Senate bill, due to the employer's creating an effective stop-loss, the proportionate share paid by the employer declines as the level of drug spending increases. In contrast, the retiree's proportionate share of the spending increases dramatically once the employer's wrap-around coverage stops and only starts to decline once the retiree has spent an additional $3,700 and met Medicare's "out-of-pocket limit."

Effect of the House Bill

A similar, though somewhat different, effect occurs under H.R. 1. Under the House bill, the employer reimburses the retiree for the premiums and pays the $250 deductible as well as the 20 percent coinsurance on the next $1,750 in drug expenses (or $350). At that point, the retiree has consumed $2,000 in drugs and not paid a single penny in either premiums or out-of-pocket cost-sharing. The employer has paid the $420 in premiums, the $250 deductible, and the $350 in coinsurance for a total cost of $1,020. Medicare has paid the remaining $1,400 in drug spending.

From that point on, Medicare pays nothing. If the employer also caps its program at that level, then the retiree must pay 100 percent of the cost of the next $3,500 in drug expenses, after which Medicare will then pay all additional costs.

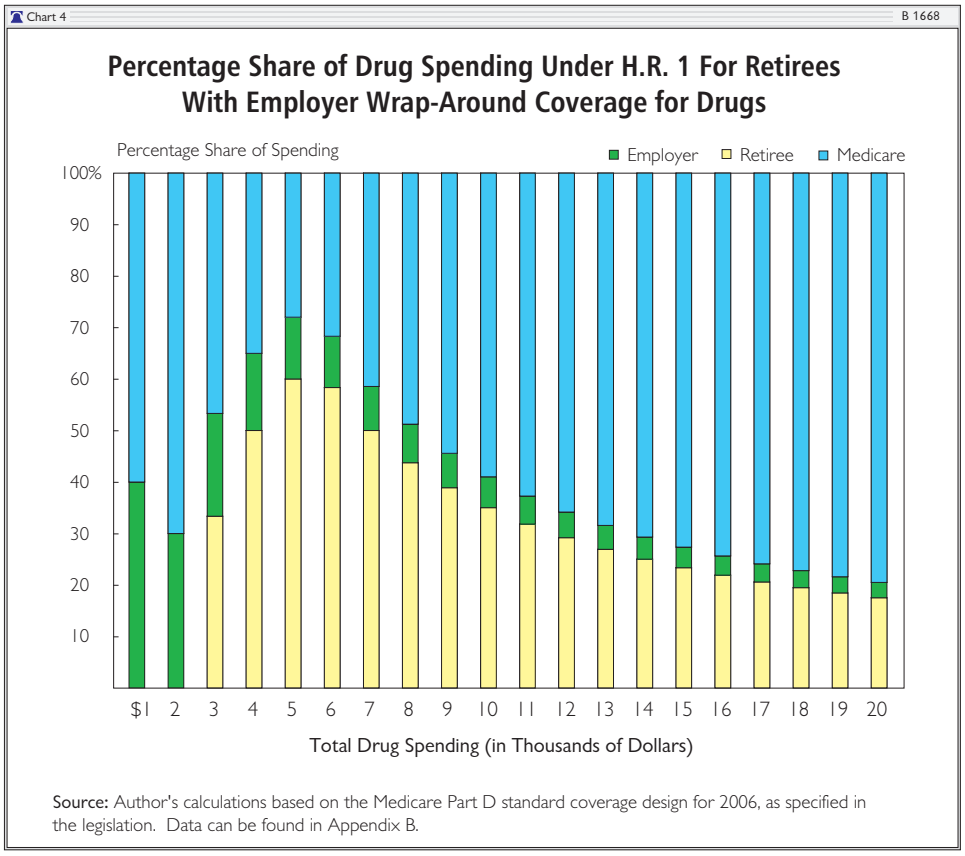
Chart 3 shows how, under the House bill, this scenario will result in retiree' drug spending being distributed among employers, retirees, and Medicare.

Once again, the chart shows how, under H.R. 1, the employer is able to create a stop-loss for itself. The difference in this case is that the employer can set that level as low as $600 of the first $2,000 per year in drug spending per retiree. However, in the House bill, after the retiree has spent $3,500 out-of-pocket, he or she also reaches a true stop-loss. The indexing of the deductible, the "initial coverage limit" for the coinsurance, and the retiree stop-loss means that both the employer's and the retiree's

stop-loss levels will rise over time but will still remain true stop-losses.

Again, thanks to the generosity of the employer, the point at which the program's stop-loss kicks in for the retiree has been pushed up from $4,900 in total drug spending to $5,500 in total drug spending. At that point, of the total $5,500 in drug spending, the employer will have paid $600, or 11 percent; Medicare will have paid $1,400, or 25 percent; and the retiree will have paid $3,500, or 64 percent.

Thus, the effect of the employer's offering wrap-around coverage will again be *to increase the burden on those retirees with higher drug costs, though not as much as in the Senate bill*. This can be seen in Chart 4, which shows the percentage share of drug spending for the employer, the retiree, and Medicare at each level using the same data as in Chart 3.



As with the Senate bill, the effect under the House bill is that, since the employer can create a stop-loss, the proportionate share paid by the employer declines as the level of drug spending increases. In contrast, the retiree's proportionate share of the spending *increases dramatically once the employer's wrap-around coverage stops* and starts to decline only after the retiree has spent an additional $3,500 and met Medicare's stop-loss. However, because the House bill includes a true stop-loss for the retiree, his or her share of the total cost declines more rapidly than in the Senate bill as the level of drug spending increases.

IMPACT OF S. 1 AND H.R. 1 ON EXISTING MEDIGAP COVERAGE

Medicare enrollees without employer-provided Medicare supplemental coverage are able to buy supplemental coverage on their own. Such plans are commonly called Medigap plans. Federal law permits insurers to sell 10 different types of standardized Medigap plans. Three of the plans (plans H, I, and J) provide "front-end" prescription drug coverage. In all three, the beneficiary pays a $250 deductible, and the plan reimburses the beneficiary 50 percent of the cost of drugs up to an annual maximum amount. In the case of plans H and I, the maximum amount is $1,250, and in the case of plan J, the maximum amount is $3,000. Thus, the beneficiary pays all of the first $250 a year in drugs plus half of the next $2,500 or $6,000 (depending on the plan), plus any drug costs beyond those limits.

An estimated 4.8 million Medicare beneficiaries currently have additional coverage for drugs through one of the three standard Medigap plans.

Impact of the Senate Bill

Section 103 of S. 1 would ban the sale or renewal of Medigap plans with prescription drug coverage after January 1, 2006, to any Medicare beneficiary who is enrolled in a new Medicare Part D prescription drug plan. Beneficiaries with coverage under one of those Medigap plans would be allowed to

switch to any other Medigap plan that did not include drug coverage.

Thus, beneficiaries with those plans would be forced to choose between their existing drug coverage and the new Medicare drug coverage. If they opted to keep their existing Medigap coverage, they would be penalized with higher premiums if they tried to enroll later in the Medicare Part D drug benefit.

The Senate bill, in effect, would all but eliminate Medigap plans with prescription drug coverage. The result would be that retirees would have no way of obtaining insurance, other than employer-sponsored wrap-around coverage, to pay the cost-sharing under the Senate version of the Medicare drug benefit.

Impact of the House Bill

The House bill differs from the Senate bill in that, while it eliminates current Medigap plans with drug coverage in the future, it "grandfathers" enrollees who already have such coverage and allows them to keep it. Under the House bill, any Medicare enrollee with a part H, I, or J Medigap policy in force on January 1, 2006, would be able to keep that policy or switch to a new policy of the same type. Also, the House bill instructs the National Association of Insurance Commissioners (NAIC) to develop two new standard Medigap plans that include coverage for the cost-sharing (other than the deductible) in the new Medicare Part D prescription drug plan.[8]

Thus, under H.R. 1, Medicare enrollees with Medigap plans that pay for prescription drugs could enroll in the new Medicare Part D drug benefit and keep their Medigap coverage to pay the cost-sharing. Also, in the future, Medicare beneficiaries would be able to buy new Medigap plans that covered some of the cost-sharing of the Part D drug benefit.

However, as with any payments made by employer wrap-around policies, any payments for drugs made by a Medigap plan would not count toward the beneficiary's stop-loss under the new Medicare Part D prescription drug plan.[9] The resulting effects are similar to those for employer wrap-around coverage.

Chart 5 shows the percentage share of drug spending for the retiree, Medigap, and Medicare for Medigap plans H and I, which offer "basic" drug coverage that reimburses $1,250 of the beneficiary's out-of-pocket costs. The effect is similar to that for employer wrap-around coverage under the House bill, as can be seen by comparing Chart 5 with Chart 4. In both cases, the beneficiary bears the largest share of the costs when total annual drug spending is at about the $6,000 level.

Similarly, Chart 6 shows the percentage share of drug spending for the retiree, Medigap, and Medicare for Medigap plan J, which offers "enhanced" drug coverage that reimburses $3,000 of the beneficiary's out-of-pocket costs. The effect is similar to that for employer wrap-around coverage under the Senate bill, as can be seen by comparing Chart 6 with Chart 2. In both cases, the beneficiary bears the largest share of the costs when total annual drug spending is at about the $8,000 level.

As the distributional effects in Charts 5 and 6 show, combining Medigap drug coverage with the new Medicare Part D drug benefit serves only to push the beneficiary's cost-sharing up to a higher level of total annual drug spending. It does not buy what the beneficiary really wants—coverage for the initial cost-sharing and the "doughnut hole" coverage gap in the Medicare drug benefit design.

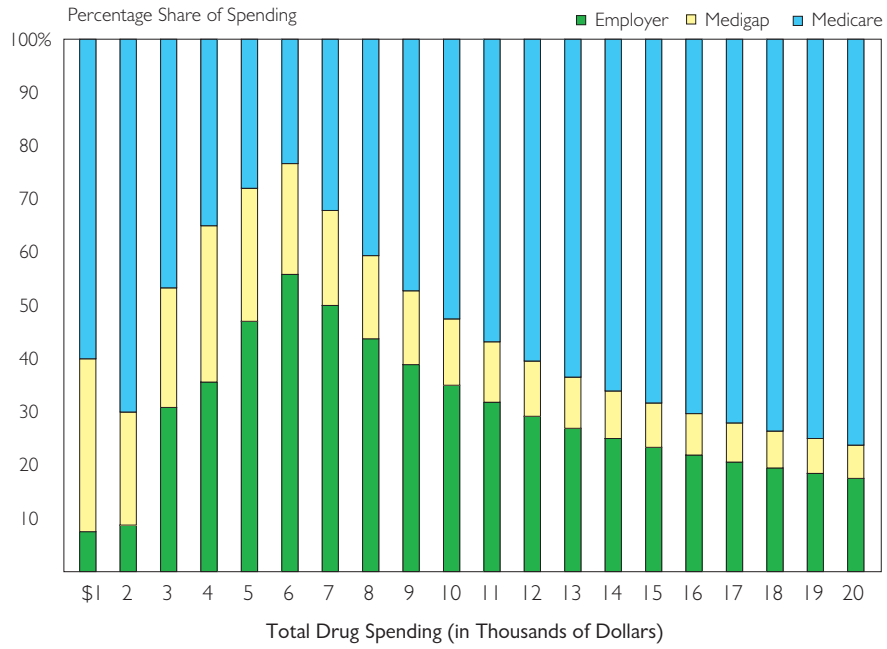
This means that the extra Medigap coverage is almost certainly not worth the much higher premiums beneficiaries must pay for plans H, I, and J. Consequently, under the House bill, most retirees who currently have Medigap plans that cover drugs will likely choose to switch to a Medigap policy without drug coverage (and with a lower premium).

Thus, under either the House or Senate bill, retirees without employer coverage will, in the future, have no realistic way to obtain private insurance to cover the costs of the deductible, cost-sharing, or coverage gap in the new Medicare Part D drug plan.

8. H.R. 1, Section 104.
9. H.R. 1, Section 1860D–2(b)(4)(C)(ii).

Chart 5 B 1668

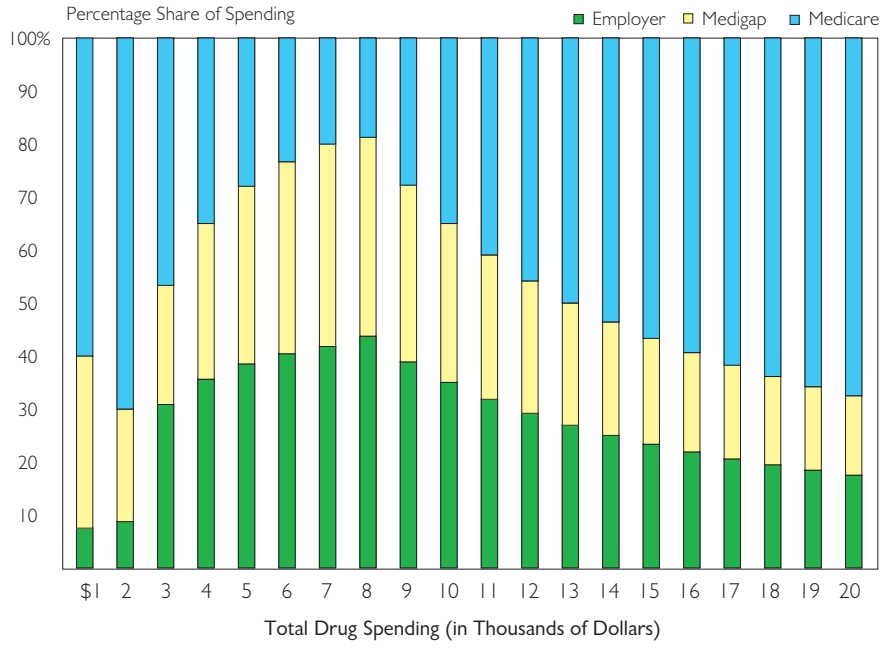
Percentage Share of Drug Spending Under H.R.1 For Retirees With Medigap "Basic" Drug Coverage



Source: Author's calculations based on current law specifications for Medicare supplemental insurance plans H and I and on the Medicare Part D standard coverage design for 2006, as specified in the legislation.

Chart 6 B 1668

Percentage Share of Drug Spending Under H.R. 1 For Retirees With Medigap "Enhanced" Drug Coverage



Source: Author's calculations based on current law specifications for Medicare supplemental insurance plan J and on the Medicare Part D standard coverage design for 2006 , as specified in the legislation.

GIVING A MEDICARE DRUG ENTITLEMENT TO SENIORS—AND COURTING A BACKLASH

Not surprisingly, as more and more retirees begin to digest the implications of the new Medicare drug benefit in S. 1 and H.R. 1, they are becoming less and less enamored of Congress's handiwork. Those who currently enjoy employer-provided retiree drug benefits are right to be concerned about the negative effects the legislation would have on their current coverage. As was the case with the 1988 Medicare Catastrophic legislation, those legitimate concerns hold the potential for a serious senior citizen backlash.

Federal Retirees' Conscientious Exemption. There is solid evidence that a backlash is already brewing. For example, the National Association of Retired Federal Employees (NARFE), a large and powerful organization representing retired federal workers, recently announced its opposition to both the House and Senate bills for exactly that reason.[10] NARFE is now seeking additional legislation to prevent the retiree drug coverage its members currently receive through the Federal Employees Health Benefits Program (FEHBP) from being reduced to the level of the new Medicare Part D drug coverage.[11] The House passed the legislation on July 8, but the Senate has yet to act on it.[12] While NARFE may succeed in protecting the current drug coverage of its members, retirees with drug coverage through private-sector or state and local government retirement plans may not be as fortunate.

And the Rest of Us. There is a curious political dynamic behind this coming retiree misfortune. Unlike federal retirees, private and state and local retirees who want to preserve their current drug coverage might find their interests opposed, not only by members of both houses of Congress—who are insisting on a universal drug entitlement of unknown cost—but also by their own former bosses and even their own union representatives. For example, according to the *Detroit Free Press*, United Auto Workers (UAW) retirees are voicing their concerns that if Congress passes a Medicare drug benefit that saves their former employers money while costing retirees more, their union representatives will simply shift to bargaining for other benefits instead.[13]

Then, of course, there are the nation's employers, particularly the large corporations. A recent report in *The New York Times* notes that the pending Medicare legislation offers

> some of the largest U.S. employers a long-sought prize: shifting at least some of their burden of soaring drug costs to the federal government. With billions of dollars at stake, those companies are lobbying hard to make sure that those gains survive in the final version of the law. The effort is being led by a shrinking number of companies that pay for health coverage for millions of retired workers—notably General Motors Corp., Ford Motor Co., Verizon Communications Inc., SBC Communications Inc., International Business Machines Corp. and Caterpillar Inc.… By some accounts, Ford alone could save $50 million a year.… "It is clear that employers will react by scaling back their drug coverage for retirees," said Jonathan Gruber, an economics professor at the Massachusetts Institute of Technology.[14]

10. Stephen Barr, "NARFE Fears Medicare Changes Could Cut Drug Coverage for Retirees," *The Washington Post*, June 20, 2003.
11. Robert Pear, "Plans Improve Federal Workers' Drug Benefits," *The New York Times*, July 8, 2003.
12. Spencer S. Hsu, "House Shields Federal Retirees: Drug Plans Surpass Medicare Reforms," *The Washington Post*, July 9, 2003, p. A1.
13. Sarah A. Webster, "Medicare Drug Plan May Save Carmakers Millions: Retiree Health Bills in Congress Likely to Affect UAW Talks," *Detroit Free Press*, July 8, 2003.
14. Freudenheim, "Medicare Drug Benefits Would Aid Big Employers."

THE CASE FOR GOING BACK TO THE DRAWING BOARD

Medicare is governed by central planning and administered pricing. Its problems stem from basic design flaws, and the current lack of coverage for outpatient prescription drugs is not the greatest of those flaws.

Rather, the biggest flaw is that Medicare is provider-centered instead of being patient-centered. Instead of subsidizing the elderly to buy private coverage, Medicare pays doctors and hospitals directly, on a per-procedure basis. The result is that Medicare patients are treated in an episodic, fragmented, acute-care fashion rather than an integrated, chronic-care fashion. Then, to control Medicare spending, Congress and the bureaucracy have piled on price and access controls that further distort or limit the care seniors receive.

Simply grafting a new drug benefit onto an unreformed Medicare program, as S. 1 or H.R. 1 would do, means not only that retiree health care will continue to cost more than it should, but also that Medicare will continue to deliver poorer results than it should.

Today, elderly health care is driven less and less by medical necessity and best practices and more and more by which services and treatment settings offer better Medicare reimbursement. This is bad health policy, but it is also inherent in Medicare's current structure.

The current Medicare structure also discourages innovation. Retirees now lag behind the non-elderly in getting access to new treatments, devices, and procedures. The Medicare bureaucracy must first approve every medical innovation—and give it a price before doctors can provide it to their elderly patients. The approval process can, and does, take years.

Furthermore, the inherent weakness in Medicare's design is not limited to the benefit gaps or the sluggish nature of its response to new treatments, procedures, and medical technologies. Added to all these other problems is the burden of the voluminous regulations and paperwork Medicare relentlessly imposes on doctors, hospitals, and other medical professionals. While most physicians today treat Medicare patients, it is not surprising that more and more doctors are refusing to accept new Medicare patients. In certain areas of the country, this problem is becoming increasingly serious. While the House bill contains some improvements in the current regulatory environment, only a major structural change will address the roots of these problems.

If Medicare remains unchanged, the baby boomers—the first of whom will join the program in just eight years—will find fewer doctors willing to treat them and a declining standard of care. If Congress fails to act or insists on bad policy, this lack of leadership will engender a genuine crisis of health care delivery for the nation's seniors.

CONCLUSION

Many Members of Congress firmly believe that Medicare should include a universal drug entitlement. Many also believe that liberal seniors' lobbies and organizations faithfully represent the legitimate interests of their members and constituents. They also believed the very same things when they enacted, with huge margins, the Medicare Catastrophic Coverage Act of 1988.

Notwithstanding the politically appealing and superficial rhetoric of universal drug coverage, it is the quality of the policy that will determine its reception among seniors and taxpayers alike. Based on the details of the Senate and House drug provisions, and the incentives and dynamics they are certain to set in motion, it is likely that retirees will not be thanking their representatives for the new Medicare drug entitlement. Now, as in 1988, the danger for Congress is that if it legislates in haste, it could end up repenting at leisure.

If Congress wants to avoid the kind of retiree backlash that occurred in response to the 1988 Medicare Catastrophic Coverage Act, it should scrap the drug provisions in both the House and Senate bills and go back to the 1999 recommendations of the majority of the membership of the National Bipartisan Commission on the Future of Medicare and provide Medicare beneficiaries with a choice between traditional Medicare as it exists today and new, private plans offering comprehensive, integrated benefits including outpatient prescription drug coverage.

The goal of true Medicare reform is to help tomorrow's retirees escape the growing problems that beset the current Medicare program—prob-

lems that are rooted in the absence of integrated, quality care. Congress should instead give retirees the option of choosing between the existing Medicare system and a set of new, private plans with comprehensive drug coverage subsidized by the government.

Only by covering outpatient prescription drugs through an integrated, flexible package of privately delivered health care benefits can Medicare realize the tremendous potential of modern pharmaceuticals both to reduce other health care costs and to improve the quality of health outcomes and the lives of America's current and future retirees.

—Edmund F. Haislmaier is a Visiting Research Fellow in the Center for Health Policy Studies at the Heritage Foundation.

Provisions in S. 1 Relating to Employer Plans and Their Covered Retirees

Description	Citation
A penalty is imposed on beneficiaries (higher premiums) for delayed enrollment.	1860D-2(b)(1)(A)
No penalty is imposed on the beneficiary for delayed enrollment if the beneficiary had creditable drug coverage and involuntarily lost that coverage.	1860D-2(b)(1)(C)
Creditable drug coverage includes employer plans.	1860D-2(b)(F)(ii)
But an employer plan is creditable drug coverage only if the actuarial value of the coverage to the beneficiary equals or exceeds the actuarial value of the standard plan (as determined under section 1860D-6(f)).	1860D-2(b)(G)
CMC establishes process and methods for determining actuarial valuation including "applying the same methodology for determinations of alternative coverage under subsection (d) as is used with respect to determinations of standard prescription drug coverage under subsection (c)."	1860D-6(f)(1)(A)(iii)
This means that the plan must apply for and receive approval from CMC for the benefit design.	1860D-6(d)
This also means that the actuarial value of the total coverage must at least equal the actuarial value of the standard coverage, and that the actuarial value of the unsubsidized coverage must at least equal the unsubsidized value of the standard coverage (e.g., the beneficiary must pay the same 30% of the cost of coverage after subtracting from the total cost of coverage any reinsurance payments from Medicare), and the plan must pay at least 50% of the costs between the deductible and the initial coverage limit ($4,500 in 2006).	1860D-6(d)(1)
This further means that the plan may not vary the deductible ($275 in 2006) or the limitation on out-of-pocket expenses ($3,700 in 2006) from that of the standard coverage.	1860D-6(d)(2)
The standard coverage sets an "out-of-pocket" limit ($3,700 in 2006), with the beneficiary paying only 10% of any additional costs above the limit.	1860D-6(c)(4)(A) 1860D-6(c)(4)(B)
The $275 deductible, the beneficiary-paid 50% of costs between the $275 deductible and the $4,500 initial coverage limit, plus any beneficiary-paid 100% of the costs above the $4,500 initial coverage limit all count toward the $3,700 out-of-pocket limit.	1860D-6(c)(4)(C)(i)
However, any reimbursements to the beneficiary of those costs by, "insurance, a group health plan or other third party payment arrangement," are not counted as beneficiary out-of-pocket costs in determining the $3,700 out-of-pocket limit.	1860D-6(c)(4)(C)(ii)
To enforce this prohibition, the next section of the bill requires that, "In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D-2(d)." Thus, if enrollees are found to have claimed out-of-pocket expenses that were actually reimbursed by private insurance, their Medicare drug coverage will be terminated.	1860D-6(c)(4)(D)
CMC will pay to an employer-sponsored "qualified retiree prescription drug plan" an annual subsidy equal to 70% of the national average premium for the standard coverage component of the plan for each "qualified individual" covered by the plan, after CMC applies to those costs the risk adjustors it is required to develop in section 1860D-11, and thus either increases or decreases its payment to the plan relative to the plan's actual costs.	1860D-21(a)
To become a "qualified retiree prescription drug plan," the sponsor of an employer-sponsored retiree drug plan must annually attest to CMC "that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard prescription drug coverage."	1860D-20(e)(4)(A)(i)
The plan sponsor must also "maintain (and afford the Administrator access to) such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this part to and by the plan."	1860D-20(e)(4)(A)(ii)
CMC will also pay the plan a "reinsurance payment" that is equal to 80% of the cost of drugs purchased by the plan for a covered individual after he or she has reached the out-of-pocket limit. (Under the standard plan, in 2006 the $3,700 out-of-pocket limit is reached once total drug spending exceeds $5,813.) Since beneficiaries must continue paying 10% co-insurance above the "out-of-pocket limit," (1860D-6(c)(4)(B)), the combined effect is that the employer plan will pay only 10% of the costs for drugs above the limit.	1860D-20(c)(1)

The Heritage Foundation Backgrounder

Appendix B B 1668

Effects of Adding Employer Wrap-Around Coverage to the New Medicare Drug Benefit

Total Drug Spending for a Given Retiree	Senate Bill						House Bill					
	Amounts			Percentage Shares			Amounts			Percentage Shares		
	Retiree	Employer	Medicare	Retiree	Employer	Medicare	Retiree	Employer	Medicare	Retiree	Employer	Medicare
$1,000	$0.00	$637.50	$362.50	0%	64%	36%	$0	$400	$600	0%	40%	60%
$2,000	$0.00	$1,137.50	$862.50	0%	57%	43%	$0	$600	$1,400	0%	30%	70%
$3,000	$0.00	$1,637.50	$1,362.50	0%	55%	45%	$1,000	$600	$1,400	33%	20%	47%
$4,000	$0.00	$2,137.50	$1,862.50	0%	53%	47%	$2,000	$600	$1,400	50%	15%	35%
$5,000	$500.00	$2,387.50	$2,112.50	10%	48%	42%	$3,000	$600	$1,400	60%	12%	28%
$6,000	$1,500.00	$2,387.50	$2,112.50	25%	40%	35%	$3,500	$600	$1,900	58%	10%	32%
$7,000	$2,500.00	$2,387.50	$2,112.50	36%	34%	30%	$3,500	$60	$2,900	50%	9%	41%
$8,000	$3,500.00	$2,387.50	$2,112.50	44%	30%	26%	$3,500	$600	$3,900	44%	8%	49%
$9,000	$3,780.00	$2,387.50	$2,832.50	42%	27%	31%	$3,500	$600	$4,900	39%	7%	54%
$10,000	$3,880.00	$2,387.50	$3,732.50	39%	24%	37%	$3,500	$600	$5,900	35%	6%	59%
$11,000	$3,980.00	$2,387.50	$4,632.50	36%	22%	42%	$3,500	$600	$6,900	32%	5%	63%
$12,000	$4,080.00	$2,387.50	$5,532.50	34%	20%	46%	$3,500	$600	$7,900	29%	5%	66%
$13,000	$4,180.00	$2,387.50	$6,432.50	32%	18%	49%	$3,500	$600	$8,900	27%	5%	68%
$14,000	$4,280.00	$2,387.50	$7,332.50	31%	17%	52%	$3,500	$600	$9,900	25%	4%	71%
$15,000	$4,380.00	$2,387.50	$8,232.50	29%	16%	55%	$3,500	$600	$10,900	23%	4%	73%
$16,000	$4,480.00	$2,387.50	$9,132.50	28%	15%	57%	$3,500	$600	$11,900	22%	4%	74%
$17,000	$4,580.00	$2,387.50	$10,032.50	27%	14%	59%	$3,500	$600	$12,900	21%	4%	76%
$18,000	$4,680.00	$2,387.50	$10,932.50	26%	13%	61%	$3,500	$600	$13,900	19%	3%	77%
$19,000	$4,780.00	$2,387.50	$11,832.50	25%	13%	62%	$3,500	$600	$14,900	18%	3%	78%
$20,000	$4,880.00	$2,387.50	$12,732.50	24%	12%	64%	$3,500	$600	$15,900	18%	3%	80%