Under Pressure: Prescription Drug Spending Trends in New York's Medicaid Program and Small Group Market

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Introduction

Public outrage over prices for drugs used to treat allergic reactions, hepatitis C, parasitic infections,[1] and other conditions has recently turned up the heat under long-simmering concerns about rising prescription drug costs. According to one periodic national survey, expenditures for retail drugs increased from $258.7 billion to $324 billion from 2011 to 2015.[2] Another study projected total expenditures of $535 billion in 2018 for retail and non-retail drugs.[3] Consumers are certainly feeling the impact of these increases: 24 percent of Americans (and 43 percent of those in fair or poor health) reported that paying for drugs was difficult in a 2015 poll.[4]

In this issue brief, we provide context for how these trends play out in New York State. We analyze recent growth in spending for prescription drugs by health plans in the state—and the implications of that growth for policymakers and consumers. Prescription drug cost increases are exerting considerable pressure on the state budget, public and private health plans, and enrollees, and they will likely continue to do so. Restraining the rate of growth in these costs will involve a difficult balancing act, and strong collaboration among all parties—particularly as federal proposals call for significant cuts in state Medicaid funding, and reductions in premium and cost-sharing subsidies for consumers.

Background

To give a picture of how prescription drug spending has changed in New York, we tracked data over time for health plans in two markets: Medicaid Managed Care and small group commercial. Though they function differently and operate in different sectors, these two types of plans share many of the same tools to control drug costs—medical necessity determinations, prior authorization for some drugs, encouraging generic substitutions for name-brand drugs, some flexibility to pick and choose which drugs are placed on the formulary of covered medications, seeking discounts from pharmacy network and mail-order providers, and hiring vendors (pharmacy benefit managers) to manage the benefit. Differences in rules and tools affecting health plans in these markets are discussed below.

From the public program sector, we selected Medicaid Managed Care (MMC) because of its size (4.64 million members at the end of 2015)[5] and relative stability (in terms of which health plans participate in it from year to year). We analyzed data from 2013 (to allow time for the administration of this benefit to stabilize after being "carved back in" to MMC in late 2011[6]), and 2015, the most recent year for which data is publicly available. On the commercial side, we selected the small group market for review, as it too has the most consistent lineup of participating plans. In

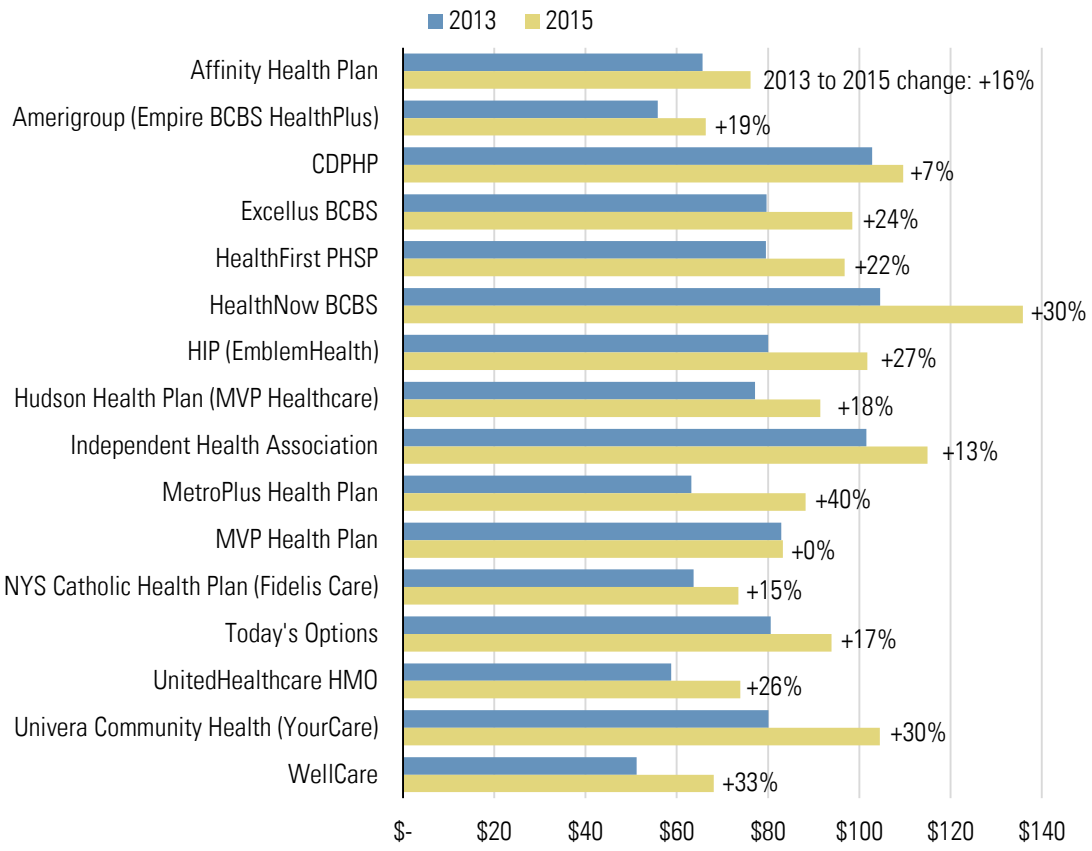
the individual market, many new plans first began writing coverage in 2014 with the implementation of the Affordable Care Act. In the large group market, recent and sizeable shifts in enrollment from fully-insured to self-funded mechanisms make comparisons difficult over time. We compared data from 2011, the first year licensee reporting followed uniform standards that facilitated comparisons, and 2016, the most recent year for which data is publicly available.

Rather than report aggregate figures for New York drug spending in these markets, we used per member per month (PMPM) data on drug spending that MMC plans filed with the New York State Department of Health (DOH), and that commercial insurers submitted to the New York State Department of Financial Services (DFS). These data sources have some advantages. Unlike aggregate spending data, which might reflect sharp increases or decreases related to enrollment, PMPM data represents average costs for each member in a given year. Also, DOH and DFS filing instructions[7] require health plans to adjust their reported spending to reflect the value of any rebates received from drug makers, eliminating that variable. One drawback of this approach is that, for MMC, it does not capture drugs injected or infused in a provider's office, unless the prescription for that drug was filled by a pharmacist. These expenses are reported in the medical rather than the drug category and can include often costly drugs—for example, those used to treat cancer or osteoporosis, or specialty medications for the eyes. For DFS, prescription drug charges that are included in a hospital billing are reported in a different category of expenses.

Medicaid Managed Care

We reviewed filings for 16 MMC plans for years 2013 and 2015 (Figure 1). There was considerable variation among plans, but drug expenses trended upwards across the board. HealthNow BCBS, which operates in western and northeastern New York, reported the highest PMPM spending in 2015 ($135.84 PMPM) and Amerigroup, now known as Empire BlueCross BlueShield Health Plus, the lowest ($66.38 PMPM). MVP Health Care reported the smallest jump between 2013 and 2015 (0.04 percent), and MetroPlus the largest (40 percent). Taken together, MMC plans reported an average $15.59 PMPM increase in 2015 compared to 2013, which translates to a roughly 21 percent average increase over 2013. In 2015, PMPM drug expenses exceeded hospital inpatient PMPM spending for half of the plans surveyed. At Fidelis Care, the state's largest MMC plan, the only service with a comparable jump from 2013 to 2015 was specialty care, but the 20 percent increase added only $7 PMPM in expenses.

Figure 1. Medicaid Managed Care PMPM Drug Spending, 2013 and 2015



Drug spending increases among plans falls within a wide range, varying for many reasons. Higher spending by upstate nonprofit plans like HealthNow BCBS, Capital District Physicians' Health Plan (CDPHP), Excellus BCBS (Rochester and central New York) and Independent Health Association (western New York) may be attributable in part to lesser enrollment than larger statewide plans like Fidelis Care, or New York City-based plans like MetroPlus, which can drive better volume-based discounts with pharmacy benefit managers. Some health plans may have more patients that need drug therapies, or patients who need multiple or more costly specialty drugs. Still, the increase in drug expenses overall has been steady, even without considering 2016 results and spending on often costly drugs administered in a provider's office. If the experience of HealthNow BCBS[8] is any indication—2016 PMPM spending for drugs rose to $160.20 from $135.84 in 2015—that trend will continue.

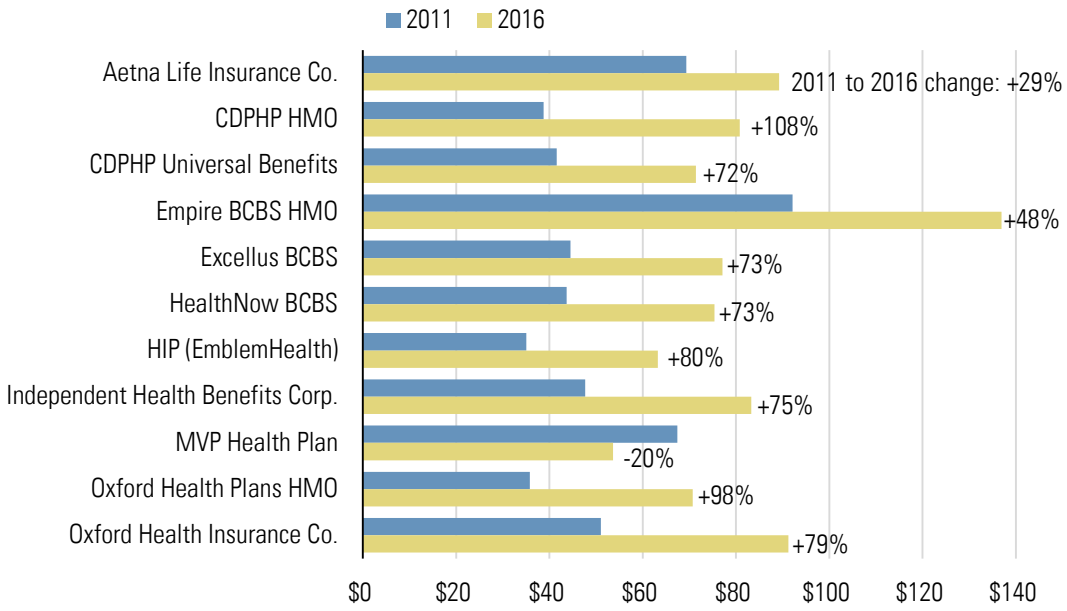
One factor that may have suppressed the growth MMC drug expenses is the federal "best price" law,[9] which requires drug manufacturers to charge Medicaid the lowest cost of some drugs. At the same time, MMC plans have limited ability to pass on price increases to enrollees through cost sharing.[10] One upstate plan, CDPHP, has taken the novel step of hiring staff to educate physicians about lower-cost effective drugs, as a counterweight to the "drug detailers" or sales reps from pharmaceutical companies that promote new drugs.[11]

Commercial Small Group

We analyzed PMPM drug expenses for 11 licensees operating in the small group market in 2011 and 2016, some within the same holding company structure (e.g., Oxford Health Plans HMO and Oxford Health Insurance Company). All told, these plans reported enrollment of over 1 million members in 2016.[12] We found considerable variation among plans, due to the same factors noted for MMC variation above, as well as some particular to the small group market: types of products offered (comprehensive coverage vs. high-deductible plans) and type of license used. As with the MMC market, most small group market plans reported a sharp rise in spending between 2011 and 2016.

The highest PMPM drug spending in 2016 (Figure 2) was by Empire BCBS HMO ($136.95 PMPM) and the lowest was by MVP Health Plan ($53.66 PMPM). MVP Health Care attributed its lower spending to changes in its overall mix of business, the transition of most of its small group business to a new license during this period, and the way that certain drug costs—such as so-called "biologics" administered in a physician's office and covered under medical benefits—may not be reflected in MVP's PMPM drug spending.[13] The next-lowest rate was reported by Oxford Health Plans HMO ($70.70). In terms of percentage growth of PMPM drug expenses from 2011 to 2016, CDPHP HMO had the largest rise (108 percent) and MVP Health Care had the smallest—actually a decline (-20 percent). The average PMPM increase for health plans participating in the small group market in 2016 was $27.73 PMPM, and the average of percentage increases across all plans was 62 percent.

Figure 2. Small Group PMPM Drug Spending, 2011 and 2016



With more flexibility on cost sharing than MMC plans, small group plans utilize copayments and coinsurance for three categories or "tiers" of drugs (typically, generic, brand-name, and non-preferred brand name) to control costs. This cost sharing offsets the premium impact of increased drug utilization and prices by transferring a portion of those costs to enrollees using the drugs. The state's largest small group plan, Oxford, offers a number of drug design options to employers. For products with low levels of cost sharing, Oxford offers a drug plan with $5/30/60 copayments not subject to the plan's overall deductible, but with a $100 deductible for tier 2 and 3 drugs. At the other end of the spectrum is a three-tier drug benefit to which the overall deductible ($3,200) applies, after which a 50 percent coinsurance rate kicks in (the enrollee pays half of the cost of the drug) until the maximum out-of-pocket limit ($6,550) is reached. This type of drug benefit is typically a feature of a high-deductible health plan paired with a health savings account.[14]

The two examples of Oxford's three-tier benefit are no accident; New York's unique requirement that health plans use cost-sharing designs with no more than three tiers is a valuable and unusual consumer protection. Enacted in 2010 and modeled on a DFS policy already in place,[15] this statute prevents health plans in New York from implementing four- and five-tier formularies, the norm in other states and in the Medicare program, and often used for costly specialty drugs. Used to treat diseases like multiple sclerosis or cancer, specialty drugs are a major driver of drug cost increases overall,[16] and the four- and five-tier drug plans typically apply coinsurance, under which enrollees are responsible for paying a percentage of the drug's costs, rather than fixed copays.[17] Within the constraints of the three-tier rule, some health plans in New York are applying an additional charge when a prescription drug on a higher tier is dispensed to a member and a chemically equivalent drug is available on a lower tier; in addition to the copayment, members are required to pay the difference between the low-tier drug and the higher-tier drug.

Other New York consumer protections also include provisions that specify that any cost sharing cannot exceed the actual cost of the drug,[18] allow consumers to fill mail order prescriptions at retail pharmacies,[19] and a range of provisions contained in the Affordable Care Act such as an exception process for consumers enrolled in a health plan that does not include a needed drug on its formulary.[20] In addition, New York State of Health requirements for Qualified Health Plans include other protections for individual purchasers that are not available to group enrollees. For example, separate deductibles for drugs and medical care, sometimes required in group coverage, are not permitted, and for platinum, gold, and silver-level plans, deductibles may not apply to prescription drugs, and coinsurance is not permitted, removing cost barriers for some consumers.[21]

One additional consumer protection adopted in New York across all markets this year highlights the tensions that crop up when health plans use tools to restrain the cost of high-priced drugs. Consumer groups cheered this year when

Governor Cuomo signed legislation[22] permitting eligible consumers to opt out of a requirement to try a lower-cost drug before gaining access to a higher-cost drug, a process known as step therapy. New York's health plan trade association, which opposed the bill,[23] estimated its passage would increase pharmacy costs by an estimated $222 to $530 million annually. Finding the right balance between cost control efforts like step therapy programs and ensuring consumer access to drugs is a key challenge going forward. These mechanisms on the health plan/pharmacy benefit manager side serve as a counterweight to drug manufacturers' direct-to-consumer advertising for brand-name drugs,[24] as well as coupon programs, which can reduce copays for consumers but not overall spending.[25]

Conclusion

Without a doubt, a portion of the increased prescription drug spending is money well spent, curing life-threatening diseases like hepatitis C, improving lives, reducing side effects, and preventing costlier interventions. Much of the increase in drug costs, however, is attributable to changes in the composition of existing drugs[26] or higher prices for them;[27] the price of insulin, for example, has increased nearly 300 percent in the past decade.[28] Some health plans and drug makers are experimenting with value-based agreements, under which the price of drug is linked to its effectiveness.[29] Despite strong public support for government intervention to restrain drug price increases,[30] and many examples of effective steps taken in other nations,[31] the federal government has yet to step in, leaving the field to states.

One organization tracking legislation on a state level counted 80 pending state bills in such areas as price regulation, transparency, and pharmacy benefit manager regulation;[32] the group recently announced a new grant program for states interested in tackling the drug spending problem.[33] New York is one of many states taking a more active role. This year's State budget included legislation authorizing the Commissioner of Health and the Drug Utilization Board to seek larger rebates from drug makers or improved disclosure, if an annual cap for Medicaid drug spending is exceeded.[34] The legislature demurred, however, on another proposal that would have required pharmacy benefit managers to meet DFS licensing and disclosure requirements.[35] Nevada adopted legislation this year focused on increased prices for diabetes drugs, requiring greater disclosure from manufacturers, pharmacy benefit managers, and salespeople.[36]

For the foreseeable future, public and private market health plans and enrollees will be under considerable pressure due to prescription drug cost increases. Because of cost-sharing limitations, increases in MMC drug spending have less of a direct impact on enrollees, and more of an impact on the overall program, creating pressures to reduce provider rates or benefits and placing a growing burden on the State budget. The cost trend could also complicate longer-term goals, such

as value-based payment arrangements under which providers take on risk for the total cost of care, a key component of New York's Medicaid strategy to improve quality and reduce costs. In order to undertake such an arrangement, these provider groups would then have the task of managing drug spending increases that are so challenging to health plans and pharmacy benefit managers.[37] Potentially dramatic reductions in federal Medicaid spending under consideration in Congress[38] would exacerbate these pressures.

On the commercial side, rising drug spending challenges New York's ability to find the right path between shielding individual enrollees from the full brunt of rising drug costs, and the imperative of tamping down overall premium increases that can force consumers and employers to drop coverage outright. New York's strategy of spreading the cost of pricy drugs over large pools of insureds, through mechanisms like the three-tier rule, reduces costs for those who need the drugs and improves adherence to drug regimens. While these risk-spreading efforts only increase premiums by a little bit, they add up over time. Here too, federal proposals to reduce premium subsidies for Exchange coverage[39] and increase allowable cost sharing while eliminating the ACA's cost sharing subsidies[40] will make a hard job even harder. This environment will place a premium on strong collaboration among all parties to closely track prescription drug spending and develop new tools to restrain the rate of growth.

Notes on Methodology

For MMC plans, data is from Medicaid Table 6, Statement of Revenue & Expenses, Row 0021 Pharmacy, Medicaid Managed Care Operating Reports for 2013 and 2015, obtained through a Freedom of Information Law request. 2015 data for MMC plans reporting may reflect acquisitions of other plans that may have reported separately in 2013. For example, Empire BlueCross BlueShield HealthPlus data reflects the acquisition of Amerigroup by its parent, Anthem Inc., in 2015, and prior to that acquisition, Amerigroup acquired HealthPlus in 2012.

For commercial small group plans, with two exceptions, data is from Statement of Revenue and Expenses by Line of Business, Part 1, Row 13 Prescription Drugs, Small Groups, from the 2011 and 2016 New York Supplements to the National Association of Insurance Commissioners Annual Statements, obtained through Freedom of Information Law requests. Data for HealthNow BCBS, which administers its small group prescription drug benefit through a separate rider, was obtained through personal communication with HealthNow officials. Data for Aetna Life Insurance Company, a national insurer licensed by another state that makes less detailed reporting to New York regulators, came from the 2011 Department of Health and Human Services Medical Loss Ratio Reporting Form, Rows 2.2 (Prescription Drugs) and 2.3 (Pharmaceutical Rebates), for Small Groups, obtained at https://www.cms.gov/apps/mlr/mlr-search.aspx and its Supplemental Health Care Exhibit for 2016, obtained from the National Association of Insurance Commissioners. Data is shown for insurers offering small group coverage in both 2011 and 2016 through the same licenses. Many companies shifted business among licenses during this period. For example, Aetna Health Inc. HMO wrote small group business in 2011 but that license was surrendered by the parent company; and MVP Health Services Company, a nonprofit Article 43 insurer, did not write small group business in 2011 but is now the main license the parent company uses for the small group market.

Endnotes

1 Duhigg C. June 4, 2017. Outcry Over EpiPen Prices Hasn't Made Them Lower. *New York Times*. https://www.nytimes.com/2017/06/04/business/angry-about-epipen-prices-executive-dont-care-much.html?_r=0; Hoadley J, T Neuman and J Cubanski. The Cost of a Cure: Revisiting Medicare Part D and Hepatitis Drugs. November 3, 2016. *Health Affairs Blog*. http://healthaffairs.org/blog/2016/11/03/the-cost-of-a-cure-revisiting-medicare-part-d-and-hepatitis-c-drugs/; Pollack A. September 20, 2015. Drug Goes from $13.50 a Tablet to $750, Overnight. *New York Times*. https://www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html

2 Centers for Medicare & Medicaid Services. National Health Expenditures 2015 Highlights. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf; and Table 16, Retail Prescription Drug Expenditures, Levels, Percentage Change, Distribution, by Source of Funds, Selected Calendar Years, 1970-2015

3 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. March 18, 2016. Observations on Trends in Prescription Drug Spending. https://aspe.hhs.gov/pdf-report/observations-trends-prescription-drug-spending

4 Kaiser Family Foundation. Most Say They Can Afford Their Prescription Drugs, but One in Four Say Paying Is Difficult, Including More than Four in Ten People Who Are Sick. Kaiser Family Foundation August Tracking Poll. August 20, 2015. http://www.kff.org/health-costs/press-release/most-say-they-can-afford-their-prescription-drugs-but-one-in-four-say-paying-is-difficult-and-more-than-four-in-ten-for-people-who-are-sick/

5 New York State Department of Health. Monthly Medicaid Managed Care Enrollment Reports. December 2015. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2015/docs/en12_15.pdf

6 New York State Department of Health. Medicaid Redesign Team Proposal #11. For background information, see https://www.health.ny.gov/health_care/medicaid/redesign/mrt_11_and_15.htm

7 For DOH: New York State Department of Health, Bureau of Managed Care Fiscal Oversight, Medicaid Managed Care Quarterly and Annual Operating Reports. For DFS: National Association of Insurance Commissioners, Instructions for Statement of Revenue and Expenses Exhibit, line 13.

8 Personal communication with HealthNow BCBS officials, June 11, 2017

9 42 CFR 447.505. https://www.law.cornell.edu/cfr/text/42/447.505

10 New York State Limits Drug Copayments to $1 to $3 for MMC Enrollees. NYS Social Services Law section 367-a(6)(c)(ii). http://codes.findlaw.com/ny/social-services-law/sos-sect-367-a.html

11 Hancock J. June 8, 2017. *Former Pharma Reps' New Mission: To School Docs on High Drug Costs*. Kaiser Health News. http://khn.org/news/former-pharma-reps-new-mission-to-school-docs-on-high-drug-costs/

12 Small group enrollment based on UHF analysis of NYS Department of Financial Services, Rating Actions by Company for 2017. https://myportal.dfs.ny.gov/web/prior-approval/rate-applications-by-company

13 Personal communication with MVP Health Care officials, June 14, 2017.

14 Oxford benefit design features based on UHF analysis of form and rate filings with DFS by Oxford Health Insurance Inc., an article 42 accident and health insurer, and Oxford Health Plans, Inc., an HMO.

15 Chapter 536 of the Laws of New York, 2010, added subsection (gg) to section 4303 of the Insurance Law

16 The Pew Charitable Trusts. December 2016. *Specialty Drugs and Health Care Costs* (fact sheet). http://www.pewtrusts.org/~/media/assets/2016/12/specialty_drugs_and_health_care_costs.pdf

17 Pearson CF. December 3, 2014. *Exchange Plans Increase Costs of Specialty Drugs for Patients in 2015*. Avelere Health. http://avalere.com/expertise/managed-care/insights/exchange-plans-increase-costs-of-specialty-drugs-for-patients-in-2015

18 New York State Insurance Law section 4325(h)

19 New York State Insurance Law section 4403(kk)

20 45 CFR Section 156.22(c)

21 New York State of Health. Attachment B, Standard Benefit Design Cost Sharing Description Chart (5/02/17). https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%20Standard%20Products%202018%20%28Cost%20Sharing%20Chart%29%20Revised%205.12.2017.pdf

22 Chapter 512 of the Laws of New York, 2016

23 New York Health Plan Association on Governor Signing "Step Therapy," Statement of Paul Macielak, president and CEO. January 3, 2017. http://nyhpa.org/2017/01/nyhpa-on-governor-signing-step-therapy/

24 Horovitz B and J Appleby. March 16, 2017. Prescription Drug Costs Are Up; So Are TV Ads Promoting Them. *USA Today.* https://www.usatoday.com/story/money/2017/03/16/prescription-drug-costs-up-tv-ads/99203878/

25 Ubel PA and PB Bach. December 2016. Copay Assistance for Expensive Drugs: A Helping Hand That Raises Costs. *Annals of Internal Medicine* 165(12):878-879

26 Allen M. June 20, 2017. *How Two Common Medications Became a $455 Million Specialty Pill*. ProPublica. https://www.propublica.org/article/horizon-pharma-vimovo-common-medication-455-million-specialty-pill

27 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. March 18, 2016. *Observations on Trends in Prescription Drug Spending*. https://aspe.hhs.gov/pdf-report/observations-trends-prescription-drug-spending

28 Ramsey L. May 15, 2017. The Price for Life-Saving Diabetes Medication Has Increased Again. *Business Insider.* http://www.businessinsider.com/insulin-prices-increased-in-2017-2017-5

29 Barlas S. January 2016. Health Plans and Drug Companies Dip Their Toes into Value-Based Pricing. *Pharmacy and Therapeutics* 41(1): 39, 40, 41, 53. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4699485/pdf/ptj4101039.pdf

30 Kaiser Family Foundation. May 1, 2017. Poll: Majorities of Democrats, Republicans and Independents Support Actions to Lower Drug Costs, including Allowing Americans to Buy Drugs from Canada. Kaiser Health Tracking Survey. http://www.kff.org/health-costs/press-release/poll-majorities-of-democrats-republicans-and-independents-support-actions-to-lower-drug-costs-including-allowing-americans-to-buy-drugs-from-canada/

31 Docteur E and R Lopert. March 2017. *Payment Policies to Manage Pharmaceutical Costs. Insights from Other Countries*. The Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/reports/2017/03/payment-policies-to-manage-pharmaceutical-costs

32 National Academy for State Health Policy. State Legislative Action on Pharmaceutical Prices. http://nashp.org/state-legislative-action-on-pharmaceutical-prices/

33 National Academy for State Health Policy, Center for State Rx Drug Pricing. Request for Proposals: State Drug Spending and Pricing Policy Initiatives. http://nashp.org/request-for-proposals-state-drug-spending-and-pricing-policy-initiatives/

34 A.3007-B/S.2007-B of 2017, Part D. For background information, see Appleby J. May 22, 2017. New York State Wants Its Prescription Drug Money Back—Or Else. *USA Today*. https://www.usatoday.com/story/news/2017/05/18/kaiser-new-york-state-wants-its-prescription-drug-money-back----else/101845050/

35 New York State Executive Budget, Fiscal Year 2017-2018. Health and Mental Hygiene Article VII Legislation, Part J. https://www.budget.ny.gov/pubs/executive/eBudget1718/ExecutiveBudget.html

36 Nevada Senate Bill 539. https://legiscan.com/NV/text/SB539/2017. For background information, see Ramsey L. June 15, 2017. Nevada Just Passed One of the Strictest Drug Pricing Transparency Laws in the Country. *Business Insider*. http://www.businessinsider.com/nevada-passes-insulin-drug-pricing-transparency-bill-2017-6

37 New York's final approved *New York State Roadmap for Medicaid Payment Reform* notes its desire to "not wholly exclude any cost categories" from value-based payment (VBP) arrangements, because excluding services can "undermine the principles of value based payment." High-cost specialty drugs (more than $600 a month in cost) are one of the services that may be excluded from VBP arrangements between health plans and providers. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf

38 Newell P. June 2017. *Rewind: New York Faces Familiar Issues and Challenges in the "Repeal and Replace" Era*. United Hospital Fund. https://www.uhfnyc.org/publications/881214

39 Newell P. June 2017. *Rewind: New York Faces Familiar Issues and Challenges in the "Repeal and Replace" Era*. United Hospital Fund. https://www.uhfnyc.org/publications/881214; Centers for Medicare & Medicaid Services, Office of the Actuary. June 13, 2017. *Estimated Financial Effect of the "American Health Care Act of 2017."* https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf, estimates an average increase in cost sharing for individuals of 61 percent.

40 The U.S. Senate Majority Discussion Draft, the Better Care Reconciliation Act, increases the cost sharing that insurers can build into their Exchange plans, and eliminates Affordable Care Act cost-sharing subsidies beginning in 2020. https://www.budget.senate.gov/imo/media/doc/BetterCareReconcilistionAct.6.26.17.pdf