MLRI MASSACHUSETTS LAW REFORM INSTITUTE

40 COURT STREET
SUITE 800
BOSTON, MA 02108

617-357-0700 PHONE
617-357-0777 FAX
WWW.MLRI.ORG

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The Honorable Jeffrey Sánchez
Chair, House Committee on Ways and Means
Massachusetts State House, Room 243
Boston, MA 02133

Re: The Governor's "proposal to transition non-disabled adults ≥ 100% FPL from MassHealth to ConnectorCare," House 2, Section 71

Dear Chairman Sánchez,

As the House Ways and Means Committee fashions the budget for fiscal year 2019, the Massachusetts Law Reform Institute (MLRI) appreciates the opportunity to share its concerns with the Governor's proposal to drop 140,000 non-disabled adults from the MassHealth program and shift them to ConnectorCare. We are grateful that the legislature did not enact this proposal as part of the FY 2018 budget as the Governor had asked. We urge you to once more carefully review this proposal.

While the Administration's fact sheet indicates that it has updated its proposal, we are particularly concerned that the actual language of the Governor's legislative proposal is unchanged from the 2017 bill. We welcome the Administration's intent to change the way ConnectorCare now operates in order to make it more affordable for the near-poor adults with income between 100-138% FPL. However, unless such protections are actually set forth in the legislation there is no assurance that these changes will continue to be honored over time. In addition, our analysis describes other concerns that the Administration has not addressed and that we fear will lead to a significant number of the near-poor who would no longer qualify for MassHealth being unable to enroll in ConnectorCare and becoming uninsured.

The attached analysis describes concerns with the Governor's proposal in more detail regarding the following points:

- The bill language in H-2 Section 71 does not assure affordable premiums and copayments or the addition of a dental benefit for individuals who transition to ConnectorCare, and no such protections exist in any other state statute.
- ConnectorCare does not offer mental health, substance use disorder and other important benefits comparable to the benefits in MassHealth.
- Many categories of individuals eligible for MassHealth will not be eligible for ConnectorCare which operates under different eligibility rules intended for a higher income population. There are no exceptions in the language of Section 71 for such individuals even the veterans who the Governor's fact sheet singled out for protection.

- As many as 40% of those eligible for ConnectorCare may not be able to successfully enroll by deadlines that apply to the Connector but not to MassHealth
- Individuals with special health needs who are now qualified for MassHealth Standard without a finding of disability may have access to long term services and supports denied or delayed before they can prove they are disabled.
- The working poor with income over 100% FPL will lose access to MassHealth programs that now provide important work incentives and supports even if their earnings go over 138% FPL or an employer offers insurance. In ConnectorCare, the working poor will face increased costs when earnings rise, and will be disqualified by employer offers that are not affordable under state standards.
- A large population shift in 2019 risks destabilizing new MassHealth Accountable Care Organizations and further disrupting care for thousands who will be changing MassHealth plans March 1, 2018. Further, in ConnectorCare, the near poor may have to change plans annually to remain in the lowest cost plan with no premium contribution.
- Federal approval of a partial Medicaid expansion is unprecedented and too uncertain to be the basis of FY 19 budget planning.
- If the House were to favor the Governor's proposal, the bill language requires amendment to include additional protections and clarification.

Thank you for taking these considerations under account as the Committee crafts its budget recommendations to the House. Please let me know if MLRI can provide any further information regarding this issue. vpulos@mlri.org, 617-357-0700 Ext. 318.

Yours truly,

Vicky Pulos
Senior Health Law Attorney

C: House Speaker Robert DeLeo
Members of the House Committee on Ways and Means

Massachusetts Law Reform Institute's Analysis of the Governor's "proposal to transition non-disabled adults ≥ 100% FPL from MassHealth to ConnectorCare", House 2, Section 71

The bill language in H-2 Section 71 includes no protections for the 140,000 low income people losing MassHealth under its provisions

Section 71 of House 2 will result in 100,000 low income parents losing the MassHealth Standard coverage that has been available to parents since 1997, as well as loss of MassHealth CarePlus for 40,000 non-disabled adults age 21-64. In his fact sheet, the Governor says this proposal has been updated from an earlier proposal rejected by the legislature in 2017. However, the language of section 71 is virtually identical to the bill language in the Governor's earlier proposal.[1] Section 71provides no assurance that the 140,000 people losing MassHealth coverage will be able to qualify for subsidized coverage for the Connector, and if they qualify, will be able to obtain coverage that is comparable to MassHealth.

The adults who will lose MassHealth under this proposal are those with income over 100% of the federal poverty level (FPL) who are not disabled, pregnant, HIV positive or in treatment for breast or cervical cancer. The current MassHealth upper income level for these adults is 138% FPL as shown in the Table below for 2018 .[2] If this provision were enacted and approved by the federal agency, it would make Massachusetts the first state among the 33 that expanded Medicaid under the Affordable Care Act to roll back the upper income limit for expansion adults to below 138% FPL.

Income range for 140,000 adults at risk of losing MassHealth		
Family Size	>100% FPL Monthly Income	≤138% FPL Monthly Income
1	$1012	$1397
2	$1372	$1894
3	$1732	$2391
4	$2092	$2887

The bill does not assure affordable premiums and copayments or the addition of a dental benefit for individuals who transition to ConnectorCare

According to the Administration's fact sheet, its proposal will preserve comparable coverage for the transitioning population by extending the income limit for ConnectorCare Plan Type 1 from the current 100% to 138% FPL, offer access to a least one $0 premium plan, $0 deductibles for all plans, and nominal copays equivalent to copays in MassHealth, and, in future, will provide a dental benefit. *However, none of these affordability features or the dental benefits are in section 71 or any other statute.*

State statutory protections for Plan Type 1 were repealed effective 1-1-2014.

Commonwealth Care, the predecessor of ConnectorCare, was created by Chapter 58 of the Acts of 2006 which enacted a new section of the General Laws, chapter 118H, that among other things prescribed premiums, cost-sharing and benefits, including a dental benefit, comparable to MassHealth, for the lowest income eligible individuals (income from 0-100% FPL).[3] This was Plan Type 1. However, after the enactment of the Affordable Care Act which provided for a Medicaid expansion up to 138% FPL at enhanced federal matching rates, and federal premium tax credits and subsidies for the purchase of private insurance for those not eligible for Medicaid up to 400% FPL, state law was amended. The Commonwealth Care statute was repealed.[4] It was replaced by a single new provision in the authorizing statute for the Connector giving the Connector Board the authority to provide added premium assistance payments and cost-sharing subsidies for individuals at or below 300 FPL.[5]

Connector regulations and subregulatory polices have eroded Plan Type 1 protections since statutory protections were repealed.

Today, the premiums, cost-sharing and benefits in ConnectorCare must meet minimum federal requirements, but otherwise are entirely at the discretion of the Connector Board. There is no state statutory protection for Plan Type 1 members in Connector Care as there was from 2006-2014 for those in Commonwealth Care. In its regulations, the Connector Board defines Plan Type 1 as 0-100% FPL.[6] Since the repeal of the statutory prohibition on charging premiums to Plan Type 1 members for any plan, the regulations now provide for at least one "affordable" plan option with no premium contribution for Plan Type 1.[7] There is no regulation limiting copayments for Plan Type 1 members to amounts comparable to those in MassHealth. There is no regulation addressing benefits beyond the 10 "essential health benefits" required by the ACA which do not include dental.[8]

We do not doubt the good faith of the Administration or its influence over the Connector Board. It may well be that the Connector will amend its regulations to redefine Plan Type 1 as 0-138% FPL, continue to offer at least one 0-premium plan to Plan Type 1 members, limit cost-sharing to nominal amounts allowed in MassHealth, and add a dental benefit. *However, nothing in state*

statutes requires these affordability protections or a dental benefit or provides assurance that if the Connector initially adds these protections, they will not erode over time.

ConnectorCare does not offer mental health, substance use disorder and other important benefits comparable to the benefits in MassHealth

The ten Essential Health Benefits that ConnectorCare is required to provide include mental health and substance use disorder services but do not include the same level of services as those in MassHealth. For example, in 2016, EOHHS obtained approval to expand MassHealth benefits to address the opioid crisis. MassHealth now covers residential rehabilitation services (RSS) and transitional support services (TSS), and its managed care plans offer recovery coaches and recovery navigators.[9] The federal matching funds for these Medicaid expenditures are paid into the Substance Use Disorder Federal Reinvestment Trust Fund to be used to expand available substance use services in the Commonwealth.[10] ConnectorCare does not offer any comparable benefits. To the extent any of the 140,000 adults losing MassHealth are able to obtain RSS and TSS through the Department of Public Health, the state costs will not generate federal revenue and will not be available for reinvestment.

There are also significant differences in other behavioral health services. Among non-elderly adults with mental illness, Medicaid beneficiaries are more likely to receive treatment than those with private insurance.[11] Commercial insurance plans, like ConnectorCare, do not cover the many diversionary levels of care that are covered by MassHealth and that help individuals live in the community and reduce the need for inpatient psychiatric admissions.

There are many other benefits that MassHealth covers but ConnectorCare does not including eyeglasses, hearing aids, over the counter drugs and non-emergency transportation. These are all services that low income individuals in Medicaid, unlike the higher income individuals who are more likely to be commercially insured, cannot easily afford.[12]

Many categories of individuals eligible for MassHealth will not be eligible for ConnectorCare which operates under different eligibility rules intended for a higher income population.

Because the federal rules for subsidized insurance were primarily designed for people with income from 100-400% of the poverty level, they are very different from Medicaid eligibility rules.[13] On the other hand, Medicaid (MassHealth) is designed specifically to meet the needs of the poor and near poor. The federal rules governing eligibility for subsidies in the Connector also differ from those in Medicaid because the insurance subsidies through the Connector are paid as advance premium tax credit subject to "reconciliation" through the tax filing process. As a result of these differences in eligibility rules, there are many groups who now qualify for MassHealth who will not qualify for subsidies from the Connector.

Some of the low income adults now covered by MassHealth who will not qualify for ConnectorCare include:

- Individuals offered employer sponsored insurance (ESI) that will cost less than 9.5% of family income to insure the employee only are not eligible, and if the cost of insurance is "affordable" for the employee, the employee's spouse and dependents are also ineligible, regardless of the added cost of family coverage.[14]
    - The ACA's failure to account for the added cost of family coverage is called "the family glitch," and would require Congressional action to correct which obviously is not likely.
- Veterans enrolled in the VA Health System but otherwise uninsured are not eligible.
    - The VA Health System is considered coverage that disqualifies these veterans from ConnectorCare. No such rule applies to MassHealth.
    - In its fact sheet, EOHHS stated that it would retain MassHealth for veterans, but they are not exempted by Section 71.
- Married couples who live apart, are financially independent and file taxes separately are not eligible for ConnectorCare unless the reason for not filing jointly is domestic violence or the whereabouts of the spouse is unknown. Married couples who live apart and file taxes separately may qualify for MassHealth if financially eligible based on their separate incomes.
- "Dreamers" (Deferred Action Childhood Arrivals or DACA) and other immigrants who are residing in the U.S. under color of law (PRUCOL) are not eligible to obtain insurance through the Connector, but are eligible for MassHealth Family Assistance.

As many as 40% of those eligible for ConnectorCare may not be able to successfully enroll by deadlines that apply to the Connector but not to MassHealth.

People found eligible for ConnectorCare must either enroll during the "open enrollment period" or within 60 days of being determined eligible for ConnectorCare outside of open enrollment. If they fail to enroll by the deadline, in most cases, they will be unable to enroll until the following year. Not only does this mean it is too late for them to enroll in ConnectorCare, they also lose their eligibility for Health Safety Net Services. This means hospitals and health centers that provide for their care will not be reimbursed except by pursuing collection from their uninsured patients.

Information we obtained from the Health Connector for July 14, 2017 shows that in Plan Type 2A, (100-150% FPL), over 40% of those found eligible for ConnectorCare were unenrolled. Some of these individuals may still have been within their 60 day window to enroll, but most

were likely unable to enroll in ConnectorCare until 2018. If 40% of 140,000 former MassHealth members similarly miss ConnectorCare enrollment deadlines, an additional 56,000 may be uninsured.

Count of individuals found eligible for ConnectorCare Plan Type 1 and 2A enrolled or unenrolled as of July 14, 2017		
Population	Plan Type 1 (0-100% FPL)	Plan Type 2A (100-150% FPL)
Eligible but unenrolled	9,606	19,924
Eligible and enrolled	15,021	29,082
Total Eligible	24,627	49,006

MassHealth operates very differently. In MassHealth, people may apply at any time of year and, if eligible, obtain health coverage for bills incurred up to 10 days prior to the date of application. If required to enroll in managed care, as most individual under age 65 are, MassHealth will automatically assign them to a plan if they have not selected one within 14 days.

Individuals with special health needs who are now qualified for MassHealth Standard without a finding of disability may have access to long term services and supports denied or delayed while they try to prove they are disabled.

Section 71 by its terms applies only to non-disabled adults. This means it will not affect those adults eligible for MassHealth Standard on the basis of disability. However, there are individuals with disabilities among the parents and childless adults who now have MassHealth Standard who may not be readily identifiable as disabled adults who will be adversely affected by the transition. For example, there is now no reason for adults who qualify for MassHealth Standard as parents to go through the lengthy and difficult process of establishing eligibility for MassHealth Standard on the basis of disability. If they lose MassHealth, these parents may have access to critical supports denied or delayed while they go through the process of proving they are disabled.

Unlike parents, most childless adults qualify for MassHealth CarePlus which does not include long term services and supports. However, "medically frail" childless adults initially found eligible for MassHealth CarePlus are able to obtain MassHealth Standard without a finding of disability if they have special health care needs.[15] These medically frail individuals can be readily identified, but may not be able to satisfy the more exacting criteria to qualify for MassHealth Standard on the basis of disability. Further, even if medically frail adults now known to MassHealth were provided some form of one-time protection, there would be no on-

going mechanism for the Connector to identify medically frail adults and no corresponding MassHealth program for which they could qualify.

Last summer, EOHHS suggested that medically frail adults with income over 100% FPL would not lose MassHealth. However, nothing in Section 71 or the 2018 fact sheet accompanying it refers to any protections for this population.

The working poor will lose access to MassHealth programs that now provide important work incentives and supports

The proposal to reduce the MassHealth income standard for non-disabled adults from 138% to 100% FPL will hit the working poor particularly hard. A single mother with one child working 35 hours a week at minimum wage would no longer qualify for MassHealth. Both MassHealth and Connector subsidies support the working poor who have no offer of employer sponsored insurance. However, the programs take a very different approach when there is an employer offer.

The Connector, which provides subsidies for those with incomes that go up to 400%FPL, will not help workers and their families unless they are uninsured and the cost of employer coverage for the worker alone exceeds 9.5% of family income.[16] For example, a worker and spouse earning $1500 per month and currently eligible for MassHealth would both be disqualified from ConnectorCare if the cost of ESI covering just the employee is less than $142 per month. In MassHealth, which provides subsidies for those with income up to only 138% FPL, the poor and near poor are not disqualified by an employer offer. Instead, if employer coverage is cost-effective, MassHealth will require the worker to take it, but will reimburse him or her for the costs through its Premium Assistance program.

Further, if working parents on MassHealth have earnings that put them over MassHealth income standards such as a pay raise, or increase in hours, they qualify for a 12-month transitional medical assistance program. ConnectorCare has no such work incentive program for working poor parents under 138% FPL when their earnings increase. Instead, depending on their income, parents trying to work their way out of poverty will face significantly increased copayments in Plan Type 2 (up to 150% FPL), higher copays and monthly premiums of at least $84-$126 per person in Plan Type 3 (up to 300% FPL). And of course, if more hours or a better job means an offer of employer insurance, they may lose all assistance with insurance costs immediately.

Finally, Section 71 appears to contemplate the termination of the MassHealth Small Business Premium Assistance Program. This program provides a limited subsidy towards the costs of employer sponsored insurance for certain small business employees age 19-64 with income over 133/138% of poverty who are ineligible for ConnectorCare.[17]

A large population shift in 2019 risks destabilizing new Accountable Care Organizations and further disrupting care for thousands

On March 1, 2018 over 1 million MassHealth members under age 65 will be changing to new health plans including thirteen new Accountable Care Organizations. Over 400,000 MassHealth members will no longer be affiliated with the same health plan. For example, state-wide enrollment in Neighborhood Health Plan which was 270,000 in March 2017 is projected to be just 30,000 in March 2018 for the new Neighborhood Health Plan Accountable Care Partnership Plan now operating only in the Merrimack Valley, not state-wide. This transformation in the MassHealth delivery system will require significant adjustments for members, providers, health plans and the state. Ten months later, the Administration is proposing a further dislocation for up to 140,000 nondisabled adults. This will disrupt care for members, destabilize the new ACOs and undermine their investment in prevention and coordination of care.

Further, under current ConnectorCare policies, only the lowest cost plan is available to Plan Type 1 members with no premium contribution. If the lowest cost plan in a Region changes, it requires members to change plans and often to change providers in order to avoid significant premium charges.

This transition may be no easier for the Connector. In preparation for its 2018 open enrollment, the Connector had to adjust to the loss of cost-sharing subsidies and later the repeal of the individual mandate at the federal level. For 2019 open enrollment, the Administration is proposing to increase ConnectorCare enrollment by up to 78% if all 140,000 adults losing MassHealth were to actually transition to ConnectorCare which currently has fewer than 180,000 members.

Federal approval of a partial Medicaid expansion is unprecedented and uncertain

The underlying savings assumptions of Section 71 are complex and depend on federal approval of two features not just the income change described in the bill. First, the federal agency must approve the reduction in income standards from 133% to 100% of poverty for parents and childless adults. This will reduce MassHealth accounts that now support the 140,000 individuals affected. Second, the federal agency must approve the State's continued right to enhanced matching funds for a Medicaid expansion for the estimated 260,000 childless adults with income that does not exceed 100% of poverty who will remain enrolled in MassHealth.

In 2018, the enhanced matching rate for Massachusetts' expanded Medicaid for childless adults is 89.6%, in 2019 it will be 93% and in 2020 and later years it will be 90%. [18] If the federal agency approves the reduction in the income standard for non-disabled adults, but determines that a "partial" Medicaid expansion to only 100% FPL does not qualify for enhanced funding, there will be no savings. While the state would still save 50% of the costs for 100,000 parents no

longer on MassHealth, without the enhanced match, the state share of spending for the 260,000 childless adults under 100% FPL who remain eligible for MassHealth will rise from 10% of the total cost to 50% of the total cost.[19]

To date, the federal agency has not approved enhanced matching for a "partial" Medicaid expansion to an income standard less than 133/138% of poverty.[20] Wisconsin unsuccessfully made such a request and chose to expand coverage to 100% of poverty with no enhanced match. Arkansas asked the new administration to approve a roll back in eligibility to 100% of poverty and to retain its enhanced matching in June 2017 anticipating approval and implementation by January 2018, to date the federal agency has not acted on its request.[21]

Unless the federal agency approves the enhanced matching rate for a Medicaid expansion that only goes up to the poverty level, Section 71 will not reduce state spending, on the contrary, it will increase state costs. It is not wise to assume that Section 71 will be a source of savings in the FY 19 budget when it is contingent on federal action that to date has no precedent. Further, if a partial Medicaid expansion is approved in Arkansas and Massachusetts, more states are likely to seek state savings by lowering Medicaid income levels with harmful results for low income individuals nation-wide.[22]

If the House were to favor the Governor's proposal, the bill language requires clarification

We urge the House to once more reject the Governor's proposal to drop 140,000 adults from MassHealth. However, were the House to adopt the proposal, we strongly recommend amending the language of Section 71.

Any statutory change should be expressly conditioned on federal approval of a partial Medicaid expansion with enhance matching and should sunset in 2022 when the current 1115 demonstration which reimburses the state for half the costs of the state subsidy for ConnectorCare will expire. Further, the protections promised by EOHHS in its fact sheet should be required in the legislation: individuals with income that does not exceed 138% FPL shall have at least one 0 premium plan choice, no deductible, copayments no higher than those in MassHealth, and a dental benefit, and veterans with access to the VA health system will be added to the exempt groups who may remain eligible for MassHealth with income over 100% FPL. Additional protections are needed to address adults affected by the "family glitch" and medically frail adults. Finally, we hope any such legislation will require EOHHS to report back on how many individuals lost MassHealth as a result, and of those, how many obtained subsidized coverage through the Connector.

Section 71 also requires amendment to clarify its scope. Because it does not mention MassHealth or any chapter of the General Laws, it is not clear if the 100% FPL limit is intended to apply to other programs under the 1115 demonstration. We do not think the Administration intended to apply the 100% FPL cap to the Health Safety Net which now reimburses hospitals and health centers for serving uninsured and underinsured state residents with income up to 300% FPL, but the language of the section is worrisome.

More information about this analysis is available from Vicky Pulos, vpulos@mlri.org , 617-357-0700 Ext 318

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[1] SECTION 71 of H2 provides: Notwithstanding any general or special law to the contrary, subject to federal approval under the commonwealth's waiver pursuant to section 1115 of the federal Social Security Act, 42 U.S.C 1315, non-disabled adults age 21 through 64 with income above 100 per cent of the federal poverty level, excluding pregnant women, individuals with HIV-AIDS and individuals with breast or cervical cancer, shall be determined eligible for and enrolled in subsidized insurance through the commonwealth health insurance connector only. At least 30 days before implementing eligibility changes under this section, the secretary of health and human services shall file a report with the house and senate committees on ways and means detailing the proposed changes and the anticipated fiscal impact of those changes.
Att. F (to FY 18 Budget) provided:
SECTION 27. Notwithstanding any general or special law to the contrary, subject to federal approval under the Commonwealth's 1115 Demonstration, non-disabled adults age 21 through 64 with income above 100% of the federal poverty level, excluding pregnant women and individuals with HIV-AIDS or breast or cervical cancer, shall be determined eligible for and enrolled in subsidized insurance through the Connector only. At least 30 days before implementing eligibility changes under this section, the secretary shall file a report with the house and senate committees on ways and means detailing the proposed changes and the anticipated fiscal impact of those changes.

[2] The upper income standard for parents and childless adults is 133% of poverty but their income is discounted by a standard deduction equal to 5% of the poverty level for their family size effectively raising the upper income limit to 138% of poverty.

[3] Chapter 58, §45, Acts of 2006, added a new c. 118H to the General Laws. G.L. 118H § 6 prescribed affordability and benefits for Plan Type 1. G.L. c. 118H was repealed by C. 35 §35 Acts of 2013.

[4] C. 35, §35 Acts of 2013

[5] G.L. c. 176Q, § 3(b).

[6] 956 CMR § 12.04(3)

[7] 956 CMR § 12.110(3).

[8] Under the ACA, the state chooses a commercial plan as a benchmark. Massachusetts has chosen the HMO Blue $2000 Deductible Plan. https://www.cms.gov/cciio/resources/data-resources/ehb.html#Massachusetts

[9] 130 CMR 418.400 et seq. (2017)

[10] G.L. c. 29 §2YYYY

[11] Kaiser Family Foundation, Fact Sheet, Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance and the Uninsured, (Nov. 27, 2017) https://www.kff.org/medicaid/fact-sheet/facilitating-access-to-mental-health-services-a-look-at-medicaid-private-insurance-and-the-uninsured/

[12] S. Syed, B. Gerber, and L Sharp, Traveling Towards Disease: Transportation Barriers to Health Care Access, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215
U.S. Government Accountability Office, Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf

[13] The ACA provided for a mandatory Medicaid expansion to 133% of poverty and disqualified Medicaid eligible individuals from federal premium tax credits and subsidies. The US Supreme Court decision in NFIB v. Sebelius made the Medicaid expansion a state option.

[14] The 9.5% percentage in the ACA is adjusted annually, for 2018 it is 9.56%.

[15] 130 CMR § 505.008(F) (the definition of "medically frail" includes individuals with chronic substance use disorders and those with serious and complex medical conditions as well as those with SSI-level disability)

[16] The 9.5% percentage in the ACA is adjusted annually, for 2018 it is 9.56%.
[17] 130 CMR §505.009.
[18] http://files.kff.org/attachment/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates-issue-brief
[19] Because of the generous federal matching rate for expansion adults and the state investment in ConnectorCare, any state savings in the proposal derive exclusively from shifting coverage for the pre-expansion category of parents.
[20] Jessica Schubel, Proposals to Lower Medicaid Expansion Eligibility Jeopardize Coverage for Low-Income Adults, Dec. 19, 2017, Center on Budget and Policy Priorities, https://www.cbpp.org/research/health/proposals-to-lower-medicaid-expansion-eligibility-jeopardize-coverage-for-low-income
[21] http://arknews.org/index.php/2017/12/01/arkansas-still-waiting-on-federal-approval-for-medicaid-changes/
[22] See, Schubel, cited above