The *Affordable Care Act*:

Implications for Public Safety and Corrections Populations

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Many people in correctional institutions have faced barriers obtaining needed health and behavioral health care services in the community either prior to their incarceration or upon reentry following incarceration. One-third to three-quarters of men booked into jails in ten major cities in 2010 were not covered by any type of health insurance.[1] This is largely because of high rates of unemployment and narrow Medicaid eligibility criteria. Unemployment limits access to employer-based health plans and the ability to purchase private insurance or pay health costs out-of-pocket. Additionally, people who have been incarcerated face enduring barriers to employment both because of legal barriers and the stigma associated with having a felony conviction. Consequently, they also face enduring challenges obtaining employer-based health insurance.[2, 3] Medicaid is an alternative for some individuals, but only for those who meet income requirements and who are also either pregnant, have dependent children, or are severely disabled.[4]

The *Affordable Care Act*

The *Affordable Care Act* (ACA) signed into law by the President in 2011 potentially can aid individuals who are at risk for incarceration and those who have been incarcerated through provisions that allow states to expand eligibility for Medicaid. The ACA creates new mechanisms for uninsured people to obtain coverage for physical and behavioral health care. First, by 2014 each state must have a health insurance exchange that will act as a regulated health insurance marketplace whereby uninsured individuals with incomes between 133% and 400% of the federal poverty limit can purchase coverage. Individuals will receive tax credits on a sliding scale to offset the cost of this coverage.[5]

Second, states have the option to expand Medicaid coverage to all individuals under age 65 with incomes below 133% of the federal poverty level who are not otherwise covered by Medicaid.[6] Additionally, prevention, early intervention, and treatment of mental health problems and substance use disorders will be considered essential health benefits.

To help states expand Medicaid coverage, the federal government will cover 100% of expenditures for the newly eligible population from 2014 to 2016, with the amount of federal funds decreasing yearly to 90% by 2020 and thereafter.[7] Many people at risk for being incarcerated and many who will be released from correctional facilities will be among those who are newly eligible for Medicaid in states that opt to expand eligibility.[8]

States are now in the process of planning and carrying out the implementation of the ACA. Groups concerned with high rates of incarceration and, in particular, with its accompanying racial disparities, will want to follow these decisions. What follows is a brief introduction to the implications the ACA has for:

(1) lowering the number of people cycling through the criminal justice system because of behaviors stemming from addictions and mental illness;
(2) lowering correctional health care expenditures through improved continuity of care; and
(3) reducing racial disparities in incarceration related to disparities in health care access.

HEALTH ISSUES AND CORRECTIONAL POPULATIONS

Approximately 10 million people spend time in correctional facilities at some point each year. They are more likely than are people in the general population to have behavioral health problems (i.e., mental health problems and addictions), communicable diseases (e.g., tuberculosis, Hepatitis C, and HIV infection), and chronic illnesses (e.g., diabetes, asthma, and hypertension).[9,10] Many of these individuals lack access to treatment for these problems outside of jails and prisons.

About half of all people in jails and prisons have mental health problems and about 65 percent meet medical criteria for alcohol or other drug abuse and addiction.[11,12] Because mental illness and substance abuse are associated with behaviors that can lead to incarceration and recidivism, barriers to community care play an indirect role

in people cycling in and out of correctional facilities. At the same time, the cost of locking up a record number of people limits the funds jurisdictions might otherwise have available for treatment services.[13]

In the case of medical problems, people enter correctional facilities with more acute health care needs than they might otherwise because of limited access to care in the community. Jails and prisons are constitutionally required to provide medical care to these individuals.[14] Therefore, county and state governments – the entities that bear fiscal responsibility for health care services for most people who are incarcerated – are indirectly paying for deficiencies in access to community-based health care at a time when correctional health services are one of the fastest growing areas of county and state budgets.[15,16]

Cycling In and Out of Correctional Facilities

Beginning in 2014, Medicaid will cover treatment for mental illness and substance abuse and, in states that opt to expand Medicaid eligibility, this coverage will be available to many people who are at risk for being incarcerated as well as people being released from correctional facilities.[17] By covering behavioral health care, more service providers can offer and be reimbursed for these services, resulting in more individuals having access to treatment. This is particularly important in the case of people at risk for criminal justice system involvement because of the high prevalence of mental illness and substance abuse within this population and the role these problems play in behaviors leading to arrest and recidivism.

The expansion of Medicaid means that states can essentially use federal Medicaid funds to increase treatment services that could reduce incarceration and recidivism and, in doing so, potentially lower associated local and state corrections expenditures. Research shows a direct relationship between county levels of funding for drug and alcohol services and courts sentencing people to intermediate sanctions rather than jail or prison.[18] Other evidence suggests that drug treatment significantly reduces criminal activity, incarceration, and recidivism.[19] Accordingly, states and local

governments that cover costs for jails and prisons can potentially benefit indirectly from expanded Medicaid eligibility through fewer people entering jails and prisons for crimes related to substance abuse and mental health problems and from decreases in recidivism rates. Pre-release and reentry programs might also be better able to connect people who are leaving jail or prison with community-based intervention services.

The ACA and Correctional Health Care

The cost of correctional health care is borne by local and state governments and is one of the fastest growing areas of county and state budgets.[20,21] Once the ACA is implemented, local and state governments will continue to bear the costs for correctional health care.[22] However, with more people having access to community-based care before entering correctional facilities, jails and prisons may see a decline in the acuity of health care problems.

Individuals will not be covered by health insurance plans purchased through exchanges while serving time in jail or prison, but pretrial detainees who are otherwise eligible may enroll and individuals who are already enrolled will remain insured up until they are sentenced to incarceration. As is currently the case, federal Medicaid funds cannot be used to pay for care for individuals while they are incarcerated except in certain limited instances in which people are hospitalized and temporarily not considered to be incarcerated under Medicaid rules.[23] However, Medicaid eligibility can be suspended rather than terminated while people are serving jail and prison sentences to avoid them having to go through the lengthy process of reapplying when released. Also, eligible individuals who are not enrolled can apply for Medicaid while incarcerated so that coverage for needed services is in place when they are released.

The ACA specifically requires states to conduct targeted outreach to facilitate the enrollment of underserved populations in Medicaid. Probation and parole agencies, jails, and prisons are in a position to identify individuals who are newly eligible for

Medicaid in states that elect to expand coverage.[24] Involving these entities in designing processes for enrolling individuals and for connecting them with community-based care upon release is important for improving the continuity of care between community- and corrections-based care and, in turn, maximizing the investment local and state governments make in correctional health care.

The ACA and Incarceration Disparities

African Americans and other minority groups experience serious health problems (e.g., heart disease, stroke, cancer) [25] and certain serious mental illnesses at higher rates than whites.[26] These disparities arise from multiple interrelated factors, some individual (e.g. drug use, genetics) and some societal. The societal factors include higher rates of poverty, lower socioeconomic status, greater exposure to environmental toxins, and stress related to discrimination.[27]

In addition to having greater health care needs, members of minority groups also experience greater disparities accessing physical and mental health treatment. This is partly because members of minority groups are significantly less likely than are whites to have health insurance. Although minority groups make up one-third of the U.S. population, they are more than half of the 50 million people who were uninsured prior to the ACA.[28, 29, 30]

As has been well documented, members of minority groups are overrepresented in correctional populations. For example, in 2010, African American males were incarcerated at seven times and Hispanic males at nearly three times the rate of whites.[31]

The ACA is not a panacea – it will not eradicate the societal factors that contribute to excessive poor health among African Americans and other minorities, nor will it eradicate other biases within the criminal justice system that contribute to disparate rates of incarceration. It does, however, pose an opportunity to level at least one dimension of the playing field – access to treatment for mental illness and addiction

– two problems that increase the likelihood of arrest and recidivism. In doing so, it may help reduce racial/ethnic disparities in incarceration.

PROSPECTS FOR IMPROVED ACCESS TO HEALTH CARE

States are in the process of planning and carrying out the implementation of the ACA. The extent to which the ACA will benefit individuals at risk for involvement in the criminal justice system and correctional populations will depend on decisions States make about:

(1) expanding Medicaid to all individuals with incomes below 133% of the poverty level,
(2) outreach to disadvantaged groups involved in or at risk for involvement in the criminal justice system,
(3) optimizing strategies for improving the coordination and continuity between community- and corrections-based care, and
(4) capitalizing on coverage for mental health and substance abuse treatment to divert people from the criminal justice system to the health care system.

For More Information

Many health care policy analysts, correctional health care organizations, and governmental associations are tracking the implementation of the ACA, including the evolving interpretation of its specifics by the Department of Health and Human Services (the federal agency responsible for promulgating rules and regulations). The following websites provide a starting point for criminal justice practitioners and advocates who are interested in learning more about the implications of the ACA for public safety and correctional populations:

- Community Oriented Correctional Health Services
  http://www.cochs.org/health_reform

- Council of State Governments
  http://reentrypolicy.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justice-involved-populations/FAQs_Federal_Health_Legislation_on_Justice_Involved_Populations_REV.pdf

- Health Care Reform GPS
  www.healthreformgps.org

- The Henry J. Kaiser Family Foundation
  http://www.kff.org/healthreform

- National Association of Counties
  http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf

- National Commission on Correctional Health Care:
  http://www.ncchc.org/pubs/CC/healthcarereform.html

- National Institute of Corrections
  http://nicic.gov/Library/024963

- Pew Center on the States
  http://www.pewstates.org/projects/stateline/headlines/medicaid-expansion-seen-covering-nearly-all-state-prisoners-85899375284

- Robert Wood Johnson Foundation
  http://www.rwjf.org/healthreform

- Substance Abuse and Mental Health Services Administration
  http://www.samhsa.gov/healthreform/index.aspx

- U.S. Department of Human Services
  http://www.healthcare.gov/law/resources/index.html

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[4] Kaiser Commission on the Uninsured (2012).*Who benefits from ACA Medicaid expansion?* ttp://www.kff.org/medicaid/quicktake_aca_medicaid.cfm
[5] Blair, P. & Greifinger, R. G. *The health care reform law: What does it mean for jails?* National Commission on Correctional Health Care *http://www.ncchc.org/pubs/CC/healthcarereform.html*
[6] Urban Institute Health Policy Center (2012). *Supreme Court decision on the Affordable Care Act: What it means for Medicaid*. http://www.urban.org/publications/412605.html
[7] *Ibid.* 4
[8] Substance Abuse and Mental Health Services Administration (2012). *Health reform.* http://www.samhsa.gov/healthreform/healthReform.aspx
[9] Maruschak, L.M. (2006). *Medical problems of jail inmates* (NCJ 210696). Washington, DC: Bureau of Justice Statistics.

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[11] Karberg, J. C. & James, D.J. (2005). *Substance abuse, dependence, and treatment of jail inmates* (NCJ 209588). Washington, DC: Bureau of Justice Statistics.
[12] The National Center on Addiction and Substance Abuse at Columbia University (2010). *Behind bars II: Substance abuse and America's prison population.* NY: Author. http://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf
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[20] *Ibid.* 15
[21] *Ibid.* 16
[22] *Ibid.* 17
[23] Association of State Correctional Administrators. *Policy: Resolutions, regulations & legal issues/The impact of health care reform on correctional health*. http://www.asca.net/articles/910.
[24] *Ibid.* 23
[25] Health and Human Services. *A nation free of health disparities: HHS action plan to reduce racial and ethnic health disparities.* http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
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[28] Lillie-Blanton, M. (2008). *Addressing disparities in health and health care: Issues for reform.* Testimony before the House Ways and Means Committee. http://www.kff.org/minorityhealth/upload/7780.pdf

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FURTHER READING AVAILABLE AT www.sentencingproject.org:

Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription

Reducing Racial Disparity in the Criminal Justice System: A Manual for Practitioners and Policymakers

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