Eligibility of Pre-trial Detainees Under The Patient Protection and Affordable Care Act

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**Perspective**

This paper is written from the perspective of the Criminal Justice Section of the American Bar Association, a member-based organization that provides law school accreditation, continuing legal education, information about the law, programs to assist lawyers and judges in their work and initiatives to improve the legal system for the public.

**Introduction**

Inmates have a constitutional right under the Eighth Amendment to health care under *Estelle vs. Gamble*. Although pre-trial detainees are not guaranteed this same Eighth Amendment protection because of their pre-punishment status, the U.S. Supreme Court has extended to detainees a similar right to health care. They are not convicted and therefore not inmates. However, they are temporarily detained in correctional settings. Does this temporary situation affect detainees’ eligibility to participate in health care plans as outlined under the Patient Protection and Affordable Care Act (ACA)? This paper first addresses whether detainees with health and behavioral health disorders, including those with substance abuse disorders, are qualified individuals under the ACA. It then briefly discusses detainees’ eligibility for Medicaid. Under the ACA, eligibility to participate in health care plans is determined solely by income. The paper describes various income-level scenarios based on detainees’ incarceration status. In addition, the paper discusses public policy challenges and opportunities and barriers that detainees face in seeking eligibility and obtaining appropriate health care. The paper concludes by recommending administrative action through official channels such as the regulatory and rule-making process of the U.S. Department of Health and Human Service (HHS) to resolve ambiguities, and by advising stakeholders to be attuned to and participate in the process of developing any relevant regulations, rules or guidelines that may be proposed by federal and state administrative entities. An Appendix pertaining to specific sections of the ACA that may apply to detainees has been provided.

**The Patient Protection and Affordable Care Act**

The general purpose of the Patient Protection and Affordable Care Act (ACA) is to improve access to health care in the U.S.\(^1\) Thus, for example, the ACA prohibits applicable health plans from imposing lifetime or annual dollar limits on participants’ or beneficiaries’ benefits; prohibits health plans from imposing pre-existing condition exclusions; provides funding to states to create mechanisms for purchase of health insurance by individuals and small business employers; improves access to Medicaid for certain persons based upon income; provides funding for certain public health programs; and increases funding for health professions training.\(^2\) However, somewhat similar to Medicaid coverage and Old Age and Survivors Insurance Benefit (“Social Security”) payments under the Social Security Act,\(^3\) the ACA excludes — with some exceptions — incarcerated persons from receiving certain benefits or otherwise being subject to the ACA’s provisions.

**Health Benefit Exchanges**

Title I, Subtitle D, Part II of the ACA (Consumer Choices and Insurance Competition Through Health Benefit Exchanges) establishes that the U.S. Department of Health and Human Services (HHS) will provide funding to states to establish health benefit exchanges so that certain qualified individuals and small business employers may purchase health insurance that may otherwise be unavailable. Incarcerated persons are specifically excluded\(^4\)
from eligibility to enroll in a health plan through a state health benefit exchange. In defining who may be included as a “qualified individual” eligible to enroll in a health benefit exchange plan, the ACA provides that “[a]n individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.” Several points bear mentioning here, particularly as to how the ACA may pertain to pre-trial detainees, including pre-trial detainees with mental health and substance abuse disorders.

First, the ACA does not explain why persons who are incarcerated at the time of enrollment in a health plan are not qualified to participate in a health plan, although generally absent a clearly expressed statement of purpose or intent provided at the preface of legislation such explanations are not offered. It may be that public sentiment or animus—or related concerns—compelled or convinced some members of Congress to single out persons who are incarcerated from participating in this well-publicized but obviously contentious benefit. Stigma against incarcerated persons, including persons with substance use and/or mental health disorders—which represent a substantial proportion of incarcerated populations—is well-documented, so any legislation that may confer a social or other benefit upon incarcerated persons is certain to be controversial.

Second, the term “incarcerated” is not further defined in the ACA and therefore may be broadly construed, creating needless ambiguity for purposes of determining precisely how a person’s incarcerated status may affect his eligibility to enroll in a health plan under this section of the ACA. Unfortunately, administrative action such as HHS regulations, rules or guidance may be the only means of resolving this issue of ambiguity suitably. Therefore, attention should be given to pursuing formal regulatory action on this issue.

Third, although “incarcerated individuals” are excluded as qualified individuals who are eligible to enroll in a health plan under this section of the ACA, an important exception may apply to persons being held in pre-trial detention. Under the Act, “[a]n individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.” This exception should be interpreted to mean that persons held in pre-trial detention (generally referring to persons being held before trial on criminal charges due to inability to post bail or denial of release) may be deemed under the ACA to be qualified individuals for the purpose of enrolling in a health plan. This suggests that many hundreds of thousands of pre-trial detainees may be covered by the ACA. Again, the ACA does not explain why this exception was made for certain pre-trial detainees. Further review of Congressional hearings, debate or testimony might shed some light on the reasoning or justification for making this exception. Put in the best possible light, it may be that drafters of the ACA did not want pre-trial detainees—who, like incarcerated prisoners, are in principle provided with a constitutional right to certain health care—foreclosed from sharing in a benefit program that is available to non-incarcerated persons, given that pre-trial detainees may not be found guilty of the offense for which they are incarcerated.

Interestingly, however, persons who have been adjudicated guilty but who are nonetheless released from incarceration, including those released with a sentence of time served, do not appear to be excluded as qualified individuals under the ACA, so these persons may be eligible to enroll in a health plan. Additionally, it is not clear how persons detained on probation or parole violations will fare under this section of the ACA. These are persons who have been adjudicated guilty on a prior offense and who are now detained for one or more violations of their release conditions—and for whom disposition of charges is also pending. Given the nuances that reasonable interpretations of this language and these terms in the ACA may be expected to generate, further explanation and perhaps related administrative action such as more precise regulations, rules or guidance on these issues may be forthcoming, to which advocates and constituents should be attuned and in which process they should anticipate participating.
Fourth, in setting out who may be included as qualified individuals eligible to enroll in a health benefit exchange plan, the ACA sets forth a time limit for which the exclusion of incarcerated persons as qualified individuals apparently applies. Again, the pertinent provision provides that “[a]n individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated . . . .” Read simply then, so long as an individual is not incarcerated—however the term “incarcerated” is eventually defined to mean—at the time that the individual is otherwise eligible to enroll in a health benefit exchange plan, this provision should have no effect. An important and somewhat related question that this may raise is whether persons who were not incarcerated at the time they enrolled in a health plan under this section of the ACA but later become incarcerated will continue to be covered under the health plan while incarcerated. Although there appears to be no reference in the ACA to these specific circumstances, the issue is almost certain to emerge as it has with other major publicly funded, publicly directed medical assistance or insurance programs, Medicaid and Social Security. Eligibility and continuing coverage under the Medicaid program generally are either suspended or terminated for persons who become incarcerated. Similarly, even if a person is eligible and actively receiving Social Security benefits, such benefits are generally suspended if the beneficiary is confined for more than 30 days in a jail, prison or other penal institution or correctional facility based upon a conviction for a criminal offense. As noted, advocates and constituents should be attuned to any possible regulatory action that might be pursued to circumscribe individuals’ participation in health plans based on incarceration status.

The ACA and Medicaid

Medicaid is a state-administered program mutually funded by federal and state governments. Within a broader framework of federal laws, each state may establish additional guidelines regarding eligibility and services. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Historically, the Centers for Medicare and Medicaid Services (CMS) has recognized three eligibility groups: mandatory eligibility groups, optional eligibility groups and medically needy groups. However, eligibility determination for health care coverage based solely on income has now created a fourth CMS-recognized eligibility group that covers uninsured childless adults. States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for most people who get federally assisted income maintenance payments, as well as related groups not getting cash payments. Even where otherwise eligible for Medicaid benefits, certain individuals such as prisoners may be foreclosed from getting needed health services through their state’s Medicaid program. This inmate exception under the Social Security Act is contentious, somewhat irrational and poorly understood, and has been interpreted by many states to justify restrictive procedures to ensure that both convicted prisoners and pre-trial detainees, without distinction, are denied access to Medicaid-supported health services. Unfortunately, many of these procedures serve to restrict the ability of these two groups to resume or acquire Medicaid coverage when they leave prison or jail. Ironically, these restrictive procedures of denying Title 19 benefits to otherwise eligible people can place undue financial and other burdens on taxpayers and counties. Inmates who are released without Title 19 benefits in place seek and obtain needed health care services in more acute stages of illness from over-burdened public hospital emergency departments. Use of emergency departments for non-emergent illnesses is extremely expensive. Thus, recently released inmates receiving this type of service ultimately cost taxpayers and counties more than the price of providing them with Title 19 benefits.

In many states, when a person receiving medical benefits under the Social Security Act becomes incarcerated, his enrollment in the medical benefits program is terminated. However, many detainees are released from
jail within days. CMS, pursuant to the Social Security Act, has entered into agreements with many state correctional facilities to pay them to notify the local Social Security offices of the incarceration of a person receiving Supplemental Security Income (SSI). Upon notification, the person’s benefits are terminated, often within a few days of the prisoner’s incarceration. Upon release, the person is required to complete and submit a new application to re-determine Medicaid eligibility. This process can take several months, resulting in further interruption of the person’s access to medications and other health care treatment.

Although state agencies may not use federal matching funds to cover any costs associated with a prisoner’s medical care, federal law does not require states to terminate the benefits of an otherwise eligible prisoner. Glenn Stanton, acting director of CMS, issued a memo on May 25, 2004, encouraging states to “suspend” rather than “terminate” Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD). Further, Stanton stated that “the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the eligibility of an individual for the Medicaid program.” In fact, Mr. Stanton indicated that “individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD.” Moreover, states and their correctional facilities are not precluded from assisting detainees and inmates with the process for determining eligibility and enrollment status prior to release. If this process is completed during incarceration, these individuals can then begin to receive covered services immediately upon release from correctional facilities.

Prior to the ACA, at least one court ruled that “a pre-trial detainee was not ineligible for Medicaid benefits by reason of his detention.” Sections of the ACA allow for enrollment of detainees with mental illness and/or substance abuse disorders into Medicaid. However, the enrollment process must be simplified (so as to be easily followed) and coordinated with state exchanges. States are required to streamline procedures for enrollment through an exchange and through state Medicaid, CHIP and health subsidy programs. Hospitals may make presumptive eligibility determinations for all Medicaid-eligible populations as eligibility is based on income. See the Appendix for other provisions applicable to this population.

Pre-trial Detainees Qualified Individuals for Health Care

As noted, pre-trial detainees are in jail awaiting disposition of charges against them. They have not been convicted of any crimes, and they are detained to ensure their attendance in court and to protect the community, victims, witnesses or any other person. As such, pre-trial detainees should not be precluded from being deemed qualified individuals for enrolling in a health plan under the ACA. Including pre-trial detainees as qualified individuals may serve to improve their access to health care services, including access to health services for mental illness and substance abuse disorders. Additionally, states have the option under the ACA to offer coverage earlier than 2014 and to offer presumptive eligibility to individuals based on income, which may serve to further benefit pre-trial detainees in need of health care. The following discussion describes a series of possible scenarios pertaining to pre-trial detainees’ eligibility for enrollment through the exchanges and into Medicaid, based on their incarceration status. (See Table 1 on page 5.)

Pre-trial Detainees Enrolled in a Plan Prior to Arrest

**Held Pre-trial Status**

The pre-trial detainee whose income is between 133 percent and 400 percent of the federal poverty level (FPL) at the time of arrest may be enrolled in the state’s exchange plan with subsidized coverage or, in lieu of the exchange, in a state-created basic health plan. Based on the interpretation advanced herein, the detainee should retain health care benefits as long as premiums are paid in a timely manner.
### TABLE 1: Maintenance or Loss of Eligibility:
How may eligibility for Medicaid and the exchange interface and/or change with incarceration?

Eligibility for persons who are enrolled in a plan and subsequently:

<table>
<thead>
<tr>
<th>% FPL</th>
<th>Held Pre-Trial</th>
<th>Convicted and Jailed</th>
<th>Held on Technicality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retain eligibility</td>
<td>Eligibility for plans not available</td>
<td>May retain eligibility depending on technicality factors</td>
</tr>
<tr>
<td>133%–400%</td>
<td>Premium payments current and/or is a beneficiary</td>
<td>Health care provided by jails and prisons under 8th Amendment right to health care (Estelle vs. Gamble, 429 U.S. 97 1976)</td>
<td>133%-400%: subsidized coverage in the exchange plan</td>
</tr>
<tr>
<td></td>
<td>Continue in enrolled plan: exchange or state's basic health plan</td>
<td>Eligibility recertification process starts in correction setting for reactivation on release</td>
<td>133%-200%: state's basic health plan</td>
</tr>
<tr>
<td>&lt;133%</td>
<td>Retain eligibility</td>
<td>Re-enroll eligibility status. Re-enroll in appropriate plan based on income</td>
<td>May retain eligibility depending on technicality factors</td>
</tr>
<tr>
<td></td>
<td>Continue in enrolled plan: state's basic health plan or Medicaid</td>
<td>133%-400%: eligible for subsidized coverage in the exchange plan</td>
<td>Plans available: Medicaid or state's basic health plan</td>
</tr>
<tr>
<td>&gt;133% prior to incarceration but &lt;133% while incarcerated</td>
<td>Retain eligibility, but require recertification for appropriate plan: state's basic health plan or Medicaid</td>
<td>Reinstates eligibility, but require recertification for appropriate plan: state's basic health plan or Medicaid</td>
<td>May retain eligibility depending on technicality factors</td>
</tr>
<tr>
<td></td>
<td>“Real-time income verification” deciding factor</td>
<td>“Real-time income verification” deciding factor</td>
<td>“Real-time income verification” deciding factor</td>
</tr>
</tbody>
</table>
For the detainee whose income is less than 133 percent of FPL at time of arrest, coverage in a state’s basic health plan or Medicaid should be retained.

The detainee whose income is greater than 133 percent of FPL at time of arrest but decreases below 133 percent of FPL while incarcerated may be reconsidered for eligibility retention in the exchange or certification to participate in a state basic plan or Medicaid. To make an accurate and efficient eligibility decision, states must “develop for applicable State health subsidy programs, a secure, electronic interface allowing an exchange of data (including information contained in the application) forms that allow a determination of eligibility for all such programs based on a single application.”

The detainee’s income is based on “real-time income verification” for which an application for medical assistance under the state plan or a waiver of the plan is processed. The policy and standards committees of the White House Office of the National Coordinator for Health Information Technology (ONCHIT) recommend that if information received from the applicant is incomplete or if the applicant’s circumstances have changed the accuracy of information in the eligibility system, the eligibility worker may request additional information from the applicant or third party. The eligibility worker would then send the applicant’s enrollment information to other programs and/or plans, as authorized by the applicant or otherwise permitted by law.

**Convicted and Released Status**

Regardless of income level, when a detainee or inmate is convicted and jailed (remaining in correctional custody), eligibility in any federal or state health plan is not available based on the ACA’s exclusion. As discussed, persons who are incarcerated are accorded a right to health care coverage under the Eighth Amendment of the U.S. Constitution, while further provisioning for certain health care coverage under the ACA is specifically excluded. Importantly, these provisions do not preclude health care providers, case managers or other qualified providers—including correctional health providers and correctional authorities—to take steps to assist inmates with the process of recertification or re-enrolling inmates in preparation for discharge from incarceration. Standards and protocols should be developed and implemented that allow for reuse of inmates’ stored eligibility (including documentation) to assist with resumption of eligibility. For those states that need financial, technical or other assistance to develop new or adapt existing technology systems to implement the health information technology for determining eligibility and appropriate enrollment, grants under the ACA are available.

**Convicted and Released Status**

For the detainee or inmate who has been convicted and released and whose income is between 133 percent and 400 percent of FPL, prior health care coverage should resume. The individual’s initial application and all subsequent documentation regarding coverage prior to conviction should be retained and available in a secure, electronic interface that allows a determination of current eligibility. Recertification for reactivation of the inmate’s health care benefits should begin prior to and in anticipation of release. Eligibility for either the state’s exchange plan with subsidized coverage or the state’s basic health plan or Medicaid is determined by the eligibility worker using “real-time income verification” information.

The detainee or inmate who has been convicted and released and whose income is less than 133 percent of FPL at the time of incarceration must recertify to participate in the enrolled plan. This recertification process should take place prior to release. The infrastructure should be in place to facilitate this process. Health care providers, case managers or other individuals should take steps to assist discharged inmates with enrolling for state health plan benefits through the state-run website in preparation for release from the criminal justice system.

The detainee or inmate who has been convicted and released and whose income is greater than 133 percent of FPL at the time of incarceration but decreases below 133 percent of FPL while incarcerated may be reconsidered for eligibility recertification in the exchange...
or certified for a state basic plan or Medicaid. Again, recertification for eligibility for participation in either the state’s basic health plan or Medicaid is determined by the eligibility worker using “real-time income verification” information.

**Pre-trial Detainees Not Enrolled In A Plan Prior To Arrest**

Inmates have higher morbidity from chronic disease and mental illness compared to non-inmates. Inmates generally enter and leave jails in poor health, and suffer disproportionately with regard to chronic and other disorders such as diabetes, hypertension, tuberculosis, AIDS, hepatitis C, traumatic brain injury and serious mental illness. Because of their indigence, absent their status as childless adults, they would qualify for Medicaid. However, only a few states have allowed adults 18 to 64 who do not have dependent children to receive Medicaid benefits. Many who are eligible to qualify prior to contact with the criminal justice system are not enrolled for participation. Whether states where these individuals reside actively seek them out for enrollment is unknown. Given the enactment of the ACA, such individuals will have immediate access to high-risk health insurance pools as individuals with pre-existing conditions. As of July 1, 2010, 22 states began accepting applications for enrollment for state-run high-risk health insurance pools. The premiums to participate in state-run programs range from $140 to almost $900 per month, depending upon state of residence — a cost that indigent detainees may be unable to afford. The ACA encourages states to enroll and cover newly eligible individuals by making available to the states federal funds for this particular purpose.

A state may elect to phase in the extension of eligibility for medical assistance to individuals not meeting eligibility criteria based on income through a subclause. Some states have options to offer coverage and presumptive eligibility before January 1, 2014. Between January 1, 2011, and December 31, 2013, a state may elect to provide medical assistance to individuals if the state’s subclause is effective before January 1, 2014. One incentive for states to opt in early is the receipt of federal funds to reduce their financial burden. Conditions for this incentive are: (1) the state cannot have eligibility standards, methodologies or procedures under the state plan or under any waiver of such plan that are more restrictive than the eligibility standards, methodologies or procedures, respectively, under the plan or waiver in effect on the date of enactment of the ACA; (2) the state does not extend eligibility to individuals with higher incomes before extending it to individuals with lower incomes; and (3) the state must maintain eligibility standards when the state exchange is fully operational. This requirement is known as “maintenance of effort.”

In light of these facts, what happens to the eligibility of pre-trial detainees who are not enrolled in a plan when they become involved with the criminal justice system? (See Table 2 on page 8.)

**Held Pre-trial**

For the detainee whose income is 133 percent to 400 percent of FPL at time of arrest, a designated correctional health care provider (nurse, case manager or otherwise qualified individual) should assist the detainee with applying for benefits through the state-run website. Nothing in the ACA prohibits screening for eligibility, based on income, while the person is held in pre-trial status. At this income level, the person may be eligible for subsidized coverage in the exchange. If the state has created a basic health plan that provides for premium subsidies in lieu of the exchange plan, the person may be certified for that plan. Group health plans and health insurance issuers offering group or individual health insurance coverage may not discriminate against individual participants and beneficiaries based on health situations. These include but are not limited to health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability or any other health status-related factor determined appropriate by HHS.

Based on income alone, the detainee whose income
**TABLE 2: Maintenance or Loss of Eligibility:**
How may eligibility for Medicaid and the exchange interface and/or change with incarceration?

Eligibility for persons who are *not enrolled* in a plan and subsequently:

<table>
<thead>
<tr>
<th>% FPL</th>
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<tr>
<td><strong>133%-400%</strong></td>
<td>Remain eligible</td>
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<td>Eligible</td>
<td>May remain eligible depending on technicality factors</td>
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<td>133%-400%: subsidized coverage in the exchange plan</td>
</tr>
<tr>
<td></td>
<td>133%-200%: state’s basic health plan</td>
<td></td>
<td>133%-200%: state’s basic health plan</td>
<td>133%-200%: state’s basic health plan</td>
</tr>
<tr>
<td><strong>&lt;133%</strong></td>
<td>Remain eligible</td>
<td>Eligibility recertification process starts in correctional setting for reactivation on release</td>
<td>Eligible</td>
<td>May remain eligible depending on technicality factors</td>
</tr>
<tr>
<td></td>
<td>May be enrolled in Medicaid or state’s basic health plan</td>
<td></td>
<td>May be enrolled in Medicaid or state’s basic health plan</td>
<td>Plans available: Medicaid or state’s basic health plan</td>
</tr>
<tr>
<td><strong>&gt;133% prior to incarceration but &lt;133% while incarcerated</strong></td>
<td>Remain eligible</td>
<td>“Real-time income verification” deciding factor for which plan</td>
<td>Eligible</td>
<td>May remain eligible depending on technicality factors</td>
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is less than 133 percent of FPL at the time of arrest should be deemed eligible to enroll in a plan. The most appropriate plan would be Medicaid, followed by the state’s basic health plan. As with detainees whose incomes are 133 percent to 400 percent of FPL, assistance by appropriate health care providers is crucial in facilitating the application process.

Then there is the situation of the detainee whose income is greater than 133 percent of FPL at time of arrest but decreases below 133 percent FPL while incarcerated. Based on “real-time income verification,” the detainee may be considered for eligibility in the exchange plan, the state basic health plan or Medicaid. Eligibility certification for either the state’s basic health plan or Medicaid is determined by the eligibility worker using “real-time income verification” information.

Convicted and Jailed Status
Regardless of income level, when a detainee is convicted and jailed, eligibility in any federal or state plan is not available, based on the ACA’s exclusion. Persons who are incarcerated have access to health care under the U.S. Constitution and further provisioning for incarcerated persons under the ACA is not necessary. Nothing in the ACA prohibits screening for eligibility, based on income, while the individual is incarcerated. Health care providers, case managers or otherwise qualified individuals are not precluded from helping the inmate begin the process of enrolling for benefits through the state-run website in preparation for release. Because these inmates were not enrolled prior to incarceration, the eligibility certification for enrollment is the same as for the pre-trial detainee.

Convicted and Released Status
The detainee who has been convicted and released and whose income is 133 to 400 percent of FPL at the time of incarceration is not precluded from enrolling for benefits, with assistance from health care providers, case managers or otherwise qualified individuals, through the state-run website in preparation for discharge. At an income level of 133 percent to 400 percent of FPL, the person may be eligible for enrollment in the state’s exchange plan with subsidized coverage or in the state’s basic health plan that provides for premium subsidies in lieu of the exchange plan for this population.

The detainee who has been convicted and released and whose income is less than 133 percent of FPL at time of incarceration is not precluded from enrolling for benefits, with assistance from health care providers, case managers or otherwise qualified individuals, through the state-run website in preparation for discharge from the criminal justice system. At an income level less than 133 percent of FPL, the person may be eligible for enrollment in the state’s exchange plan with subsidized coverage or in the state’s basic health plan that provides for premium subsidies in lieu of the exchange plan for this population.

There is also the detainee who has been convicted and released and whose income is greater than 133 percent of FPL at time of incarceration but decreases below 133 percent FPL while incarcerated. Depending on the timing of income reduction, the detainee may be eligible for enrollment in a state basic plan or Medicaid. With assistance from health care providers, case managers or otherwise qualified individuals, enrollment for benefits through the state-run website in preparation for discharge from the criminal justice system should commence at intake. When a reduction in income occurs, the inmate, with assistance, should update his application through the state-run website. At an income level of less than 133 percent of FPL, the individual may be eligible for enrollment in the state’s exchange plan with subsidized coverage or in the state’s basic health plan that provides for premium subsidies in lieu of the exchange plan for this population.

Eligibility certification for either the state’s basic health plan or Medicaid is determined by the eligibility worker using “real-time income verification” information.

Public Policy Challenges and Opportunities

Diversion programs that incorporate primary medical and mental health care with substance abuse treatment can improve personal health care and ultimately health status, timely access to care, continuity of care and
coordination of care. Most people understand that detainees with communicable diseases who are released without effective treatment may transmit these conditions in the community, compromising public health. However, similar dynamics operate in the realm of behavioral health. People with untreated addictions burden their communities in several ways. They may commit crimes against property and persons, divert money to illicit industries, drive more prosperous citizens out of marginal neighborhoods and generally destabilize communities. People who are released from jails and prisons without access to behavioral health services may decompensate unpredictably. As such, they impose serious psychosocial and diffuse financial burdens on their communities. Strategies to improve health status can be cost-effective for states and counties. Treatment for addiction reduces recidivism which, in turn, reduces the absolute number of incarcerated people, thereby reducing the cost of correctional facility operations. Some of these savings are shifted to community resources, but it is far less expensive to manage and provide care in the community than in expensive correctional facilities. In addition, improved health and mental well-being can preserve social infrastructure, maintain income levels and improve the supervision of children. All these factors redound to the benefit of the family, society, the government and taxpayers.

For those who cannot be released on recognizance or placed in other diversion programs, time spent behind bars is a unique window of opportunity to establish better disease control in the community by improving health care and disease prevention to detainees and inmates before they are released. Taking advantage of this opportunity can contribute significantly to improving community health.

Barriers

There are serious logistical barriers to improving health services in prisons and jails, even after effective health care coverage is established for pre-trial detainees (and perhaps sentenced prisoners) through health care reform. These include: few executive-level champions, scant data resources, little continuity of care, restricted public health programs, internal barriers (attitudes, policies and practices), limited communication of cost-effectiveness and community receptivity. Political barriers also need to be addressed. Even so, these logistical and political barriers can be addressed through capable leadership, community involvement and innovative planning and implementation.

Expanded Access through Enrollment

In the community, most people enroll for health care coverage through their employers; through their entitlements, such as Medicare and Medicaid; or by application for individual coverage. Pre-trial detainees with medical or mental illness and/or substance abuse are unlikely to have enrolled for such coverage. With implementation of health care reform, the first expanded role of jail authorities will be to establish linkages with Medicaid, Medicare, health plans or other entities, such as insurance exchanges. The ACA provides for expanded access to care. The ACA directs HHS to develop, within 180 days of the bill's passage, enrollment standards and protocols to facilitate enrollment in federal and state health and human services programs through methods that include providing individuals and authorized third parties notification of eligibility and verification of eligibility. This should provide correctional agencies with a conduit for streamlined bi-directional data exchange between state and community partners.

For those not currently enrolled with Medicaid or another health plan, the enrollment process must be timely and reliable. Agencies that are responsible for pre-trial detainee health care have a strong financial incentive to develop a seamless enrollment process. Once detainees are enrolled, these agencies will be eligible to recoup health care expenses on behalf of detainees. The income derived from this process can be substantial to agencies burdened with ever-increasing health care costs and limited resources.

Provider Networks and Payment

Physicians and other licensed independent health care practitioners who work behind bars are often isolated
from their professional colleagues. To the extent that physicians can affiliate with a network, barriers to diagnostic and specialty care will be reduced. Billing arrangements can be made through these networks.

**Communication of Health Information**
The second expanded role for jail authorities is to provide continuity and coordination of care into and out of custody through an electronic health record system (EHR), for which the ACA provides incentives. This can facilitate health care transitions, saving significant staff time. An EHR can contribute to patient safety and offset the costs of some of the new, expanded roles for jails by reducing medical record staffing requirements. As for any health care encounter, health information must be kept private and confidential, as required by law, including the ACA provisions for EHRs. Consent must be obtained to share such information. Correctional staff must not have access to any personal health care information, except on an individual “need-to-know” basis when there is a risk to public safety or public health.

**Standards of Care**
As payment for correctional health care is redesigned, it is important for policymakers and public authorities to meet the constitutional standard of care. As care behind bars becomes better integrated with care in the community, health status can be expected to improve. Correctional systems should get guidance from standards published by a variety of sources, including the World Health Organization, the American Bar Association, the National Commission on Correctional Health Care, the American Correctional Association and the American Public Health Association.

**Claims**
If the facility bills on a fee-for-service basis, the third expanded role for jails will be development and implementation of a billing and accounting system. Claims and health care staff will have to be familiar with the utilization management programs of the entitlement or insuring entity providing coverage. Collaboration with federally qualified health centers would facilitate this process.

**Oversight**
To achieve optimum health status and cost containment, a successful correctional health care program will have independent oversight and self-critical quality management programs.

**Throughcare**
At booking, it is as important to have access to the person’s health care information as it is to provide treatment planning and continuity of care on release.

Adequate staffing and training are elements that underlie successful programs in general and in correctional health care. The discharge planning program should be available in writing for staff and incorporated into any contracts for care with private vendors or other providers. Discharge planning begins during the initial risk assessment process. The basic elements of the discharge planning process are to:

- Define the target population, narrowly or broadly, depending on mission and resources. Discharge planning would be appropriate for as little as 5 percent of the outbound population if restricted to active contagious disease, acute conditions, severe chronic disease and uncompensated psychosis; 30 percent to 40 percent, when considering all chronic disease and mental illness; and ultimately, almost 100 percent, when considering alcohol and other substance abuse. Aiming for 30 percent to 40 percent at the start will give agencies time to step up the program and make determinations of its effectiveness.

- Develop formal linkages with providers of care and/or public health departments.

- Determine risk early, so that staff will be able to identify which patients get discharge planning.

- Summarize essential information to be transmitted to the outbound patient or to community providers.

- Promote access to care in the community,
by making an appointment for the patient with a community provider prior to release and providing the patient with written information specifying the time, date, place and telephone number for the appointment.

- Establish feedback loops to assess the frequency of kept appointments.

- Provide medication or a combination of medication with prescriptions to adequately bridge the gap between the release date and the date of access to community care.

- Distribute information to outbound detainees on gaining access to community-based organizations.

- Distribute information to outbound detainees on the increased risk of drug overdose following incarceration. One possible approach to address this issue is for jurisdictions with high rates of narcotic addiction to provide Narcan nasal spray to released addicts to reduce the number of overdose deaths in the community.

- Designate staff with a clearly defined discharge planning function.

Once the basic elements of the discharge planning process have been implemented, correctional agencies can expand their programs with options such as case management, discharge planning, groups to provide life-skills and re-entry re-entry education for patients with special needs, liaison with probation and parole agencies, training for staff on building community linkages and evaluation using valid and reliable performance measures.

**Conclusion**

Although at first impression the ACA appears to unduly restrict access to health services for millions of persons who may be incarcerated, a more careful analysis of the ACA suggests otherwise. Many persons who are detained pending disposition of criminal charges and not yet sentenced (pre-trial detainees) may still benefit under the ACA by being eligible to participate in state health plans, including state Medicaid plans for which eligibility generally is expanded under the ACA. Moreover, state agencies and other organizations that provide eligibility and enrollment services to prospective and current beneficiary populations have the opportunity under the ACA to pursue grants and other support or resources with which to improve their eligibility and enrollment outreach to prospective and current beneficiary populations. Such support may be tapped by correctional and other community or public health agencies in order to mainstream pre-trial detainees and released prisoners into community health networks so that needed health services, particularly mental health and substance abuse services, can be arranged. Importantly, given the record of restricted Medicaid eligibility and coverage that applies to offenders, correctional as well as community and public health agencies should remain vigilant about implementation of the ACA’s provisions by both federal and state regulatory agencies to ensure that pre-trial detainees retain their eligibility to participate in the range of health-related benefits provided under the ACA. Assuring adequate health care access for pre-trial detainees, as well as convicted prisoners scheduled for release, requires all agencies and professionals with interests in preserving and promoting public health among incarcerated populations to assume an active role in the administrative and regulatory process of ACA implementation.
Appendix

Resources Potentially available through The Patient Protection and Affordable Care Act, Pub. L. 111-148, for pre-trial detainees with mental illness and/or substance abuse disorders:

1. Immediate access to insurance for uninsured individuals with a pre-existing condition. Standards promulgated under this section will supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to qualified high-risk pools. (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title I, Subtitle B, Sec. 1101)

2. Prohibiting discrimination against individual participants and beneficiaries based on health status, including health status-related factors in relation to the individual's or an individual's dependent’s medication condition (including both physical and mental illnesses). (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title I, Subtitle C, Sec. 2705)

3. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid, especially for those individuals with chronic health conditions. Coordination with other state-administered health programs to maximize the efficiency of such programs and to improve the continuity of care is mandatory. (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title I, Subtitle D, Sec. 1331)

4. Allowing Medicaid coverage for the lowest income populations at or below 133 percent of the poverty line will see States receiving an increase of the Federal medical assistance percentage by the applicable percentage point increase with respect to amounts expended for medical assistance for newly eligible individuals for each fiscal year occurring during that period. (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle A, Sec. 2001)

5. Medicaid benchmark benefits for states seeking waivers must consist of at least minimum essential coverage. Coverage must include mental health services or substance use disorders benefits that are on par with medical and surgical benefits. (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle A, Sec. 2001)

6. Income eligibility for nonelderly is determined using modified gross income which makes individuals who are not mothers, pregnant or children qualified to receive Medicaid benefits. (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle A, Sec. 2002)

7. Adult health quality measures for Medicaid-eligible adults will be identified and published using existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid-eligible adults. (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle I, Sec. 2701)

8. Medicaid emergency psychiatric demonstration projects will be established by the Secretary of Health and Human Services. “An eligible State shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who have attained age 21 but have not attained age 65, are eligible for medical assistance under such plan and require such medical assistance to stabilize an emergency medical condition.” (Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle I, Sec. 2707)

References

4 In a strange twist, reference to incarcerated persons is also made under Subtitle F of Title I of the Patient Protection and Affordable Care Act, under which section “applicable individuals,” beginning in 2014, are required to maintain minimum essential health insurance coverage. Patient Protection and Affordable Care Act, Pub. L. 111-148, §1501 et seq. Here, however, the Act provides that the term “applicable individuals” shall “not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.” Thus, unlike persons incarcerated based upon conviction or final adjudication, persons in pre-trial detention are not excluded from this provision of the ACA and are subject to this requirement. For more detailed discussion pertinent to the ACA and the distinction between incarcerated individuals and persons in pre-trial detention, see infra text accompanying notes 9-10.
6 See infra text accompanying note 14 for definition related to pre-trial detainees.
7 See, for example, Office of National Drug Control Policy, Executive Office of the President. “Fact Sheet: Drug Treatment
10 However, an exception is made under the ACA for certain persons who are incarcerated. See supra text accompanying note 5.  
11 Although perhaps a stretch, such intervention might be possible for at least federal agencies and federal agency constituents of improved correctional health care through the ACA’s provisions related to the Interagency Working Group on Health Care Quality, which is tasked with working to achieve “[c]ollaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under the Public Health Service Act.” See Patient Protection and Affordable Care Act, Pub. L. 111-148, § 3012(a),(b)(1)-(3). The Federal Bureau of Prisons as well as the Department of Health and Human Services, among many other federal agencies, are designated as part of this Working Group, and should be encouraged to improve the quality of correctional health services by addressing and removing possible barriers—addressed elsewhere—to coverage and payment for offenders’ health services that may be occasioned by current restrictions and limitations upon such coverage or payment. See supra text accompanying notes 18-19. Progress in this area may serve to benefit state and local correctional agencies as well, and should therefore encourage State and local correctional agencies to work with and support the Federal Bureau of Prisons in their capacity as a member of the Working Group.  
13 See Black’s Law Dictionary 480 (8th ed. 2004) (Detention; pre-trial detention).  
14 See supra text accompanying notes 10-13.  
15 See 42 U.S.C. § 1396d(a)(29)(A) (2010). This section provides that, under the Social Security Act Medicaid provisions, the term medical assistance does not include Medicaid “payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)” (emphasis ours). See also 42 C.F.R. § 435.1009 (2010), which regulations reinforce the prohibition on federal financial assistance under Medicaid for incarcerated persons’ health services. The regulation provides that federal financial participation payments in Medicaid programs are “not available in expenditures for services provided to . . . [[individuals who are inmates of public institutions as defined in § 435.1010]].” The definitions at § 435.1010 related to institutional status further define an “inmate of a public institution” as a “person who is living in a public institution,” 42 C.F.R. § 435.1010 (2010). Oddly enough, under Title II, Subtitle A of the Patient Protection and Affordable Care Act, amendments are made to the Medicaid program under the Social Security Act to extend Medicaid coverage to additional persons based upon new eligibility criteria, including income, but no provisions are made that would improve Medicaid access for incarcerated persons. Pub. L. 111-148, §2001 et seq. 
16 See 42 U.S.C. § 402(x) et seq. Unlike Medicaid, Social Security benefits are generally paid directly to eligible individuals and are not intended as payment for health-related services. The relevant passage taken from the Social Security Act is provided as follows:

(x) Limitation on payments to prisoners, certain other inmates of publicly funded institutions, fugitives, probationers, and parolees  

(I)(A) Notwithstanding any other provision of this subchapter, no monthly benefits shall be paid under this section or under section 423 of this title to any individual for any month ending with or during or beginning with or during a period of more than 30 days throughout all of which such individual—  

(i) is confined in a jail, prison, or other penal institution or correctional facility pursuant to his conviction of a criminal offense,  

(ii) is confined by court order in an institution at public expense in connection with —  

(I) a verdict or finding that the individual is guilty but insane, with respect to a criminal offense,  

(II) a verdict or finding that the individual is not guilty of such an offense by reason of insanity,  

(III) a finding that such individual is incompetent to stand trial under an allegation of such an offense, or  

(IV) a similar verdict or finding with respect to such an offense based on similar factors (such as a mental disease, a mental defect, or mental incompetence),  

(iii) immediately upon completion of confinement as described in clause (i) pursuant to conviction of a criminal offense an element of which is sexual activity, is confined by court order in an institution at public expense pursuant to a finding that the individual is a sexually dangerous person or a sexual predator or a similar finding,  

(iv) is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or, in jurisdictions that do not define crimes as felonies, is
punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed, or
(v) is violating a condition of probation or parole imposed under Federal or State law.

18 Patient Protection and Affordable Care Act, Pub.L. 111-148, Title I, Subtitle E, § 1413.
20 See supra note 18.
21 42 CFR 365.1009(b): Inmate of a public institution means a person who is living in a public institution. An individual is not considered an inmate if he is in a public institution for a temporary period pending other arrangements appropriate to his needs.
22 American Bar Association, Criminal Justice Section. “Report to the House of Delegates,” August 2007. (The Criminal Justice Section concluded that “to best serve the medical needs of incarcerated persons and relieve unwarranted financial burdens on state and local governments, Congress should repeal the inmate exception to the Social Security Act to state government to continue receiving federal funds for health care provided to incarcerated persons. In the meantime, state agencies should suspend, rather than terminate, the Medicaid benefits of otherwise-eligible prisoners during their period of incarceration. Finally, state and local officials should partner with correctional agencies to identify prisoners who are eligible for Medicaid upon release and develop mechanisms for ensuring that these persons receive continuous care upon release from custody.”)
24 For example, in New York City, 25 percent of all jail admissions leave within three days and 65 percent are released within 30 days. City of New York, Department of Correction, internal reports.
28 See Bazelon Center, supra note 25.
30 At least one belief is that termination of benefits, as a standard practice in most states, appears to be largely a bureaucratic option. Systems such as those in Florida indicate that they are not currently able to suspend Medicaid eligibility in what is called an “incarceration span” once the individual is incarcerated based on the economic impact it would have on the state budget.
32 Patient Protection and Affordable Care Act, Pub.L. 111-148, Title I, Subtitle E, § 1413
33 Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle C, §2201
34 See infra note 48. The law directs the Secretary of Health and Human Services to develop an integrated enrollment system that permits enrollment into Medicaid or CHIP through the exchange. The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in and continue participation in, applicable state health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the state Medicaid plan under title XIX ... the individual is enrolled for assistance under such plan ...
35 Patient Protection and Affordable Care Act, Pub.L. 111-148, Title II, Subtitle C, § 2202. “Any hospital that is a participating provider under the state plan may elect to be a qualified entity for purposes of determining on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period.”
37 Pub.L. 111-148, Title I, Subtitle D, Part II, §2001. Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a state may elect through a state plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(a)(i) if that subclause were effective before January 1, 2014. A state may elect to phase-in the extension
of eligibility for medical assistance to such individuals based on income. Eligibility must start with lower income population (state options).

38 Pub.L. 111-148, Title II, Subtitle A, §2002 (States shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family for purposes of determining income eligibility for medical assistance under the state plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing).

40 Pub.L. 111-148, Title I, Subtitle E, Subpart B, §1413 (Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs).

43 See supra text accompanying note 5.
46 ibid.
47 Pub.L. 111-148, Title I, Subtitle E, Subpart B, §1413 (Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs).
48 Pub.L. 111-148, Title I, Subtitle D, Part II, §2001 (State options)
50 Pub.L. 111-148, Title I, Subtitle D, Part II, §2201 (Enrollment Simplification and coordination with State Health Insurance Exchanges that enables an individual for medical assistance under the State plan or under a waiver of the plan and to consent to enrollment in the State plan through electronic signature).
55 Pub.L. 111-148, Title II, Subtitle A, §2001(a)(4)(A) (Federal funding for cost of covering newly eligible individuals. The Federal medical assistance percentage shall be increased by the applicable percentage point increase for the quarter and the State).
56 Pub.L. 111-148, Title I, Subtitle D, Part II, §2001 (State Options to offer coverage earlier and presumptive eligibility).
57 Section 1903(a) [42 U.S.C. 1396b].
58 Pub.L. 111-148, Title I, Subtitle D, Part II, §2001 (Social Security Act, 42 U.S.C. 1396a Section 1902 has been amended to reflect this provision).
59 Pub.L. 111-148, Title I, Subtitle D, Part II, §2201 (Enrollment Simplification and coordination with State Health Insurance Exchanges that enables an individual for medical assistance under the State plan or under a waiver of the plan and to consent to enrollment in the State plan through electronic signature).
61 Pub.L. 111-148, Title I, Subtitle I, §2705 (Prohibiting discrimination against individual participants and beneficiaries based on health status).
65 Pub.L. 111-148, Title I, Subtitle D, Part II, §2201 (Enrollment Simplification and coordination with State Health Insurance Exchanges that enables an individual for medical assistance under the State plan or under a waiver of the plan and to consent to enrollment in the State plan through electronic signature).
76 For information on the EHR incentive program, see http://www.cms.gov/EHRIncentiveProgram/, accessed September 11, 2010.
77 Updates on the development of rules for privacy and security of data are available at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhsgov_regulations_and_guidance/1496.
80 Mellow and Greifinger.