

Increasing Access to Health Insurance Coverage for Pre-trial Detainees and Individuals Transitioning from Correctional Facilities 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.¹

Introduction

Offenders have a right to health care under the Eighth Amendment to the United States Constitution. 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 a similar right to them. Several questions arise: How does incarceration affect offenders' access to private and public health insurance? Are those who have not been convicted of crimes prevented from participating in individual health care plans authorized under the Patient Protection and Affordable Care Act (ACA)? How does incarceration affect access to Medicaid eligibility and coverage of services?

This paper first addresses the ACA provisions governing individual insurance coverage and subsidies and how they apply to incarcerated persons. It then discusses current statutory and regulatory rules affecting Medicaid coverage for incarcerated individuals. In addition, the

paper discusses public policy challenges and opportunities and barriers that detainees face in seeking eligibility and obtaining appropriate health care. The U.S. Department of Health and Human Services (HHS) is almost certain to issue regulations and guidance related to this issue and state governments will engage in implementing the requirements. Thus, stakeholders should monitor and participate in the process of developing relevant federal and state regulations and guidelines and implementation of the law. An appendix pertaining to specific sections of the ACA that may apply to detainees has also been provided.

Prisoners and Detainees

Incarcerated individuals have significantly higher rates of morbidity from chronic disease and mental illness than the general population. Offenders 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.² Mental and behavioral health problems are particularly prevalent in the incarcerated population. The U.S. Department of Justice estimates that 1.3 million individuals with mental illness were in state or federal prisons or local jails in 2005. Rates of serious mental illness are two to four times higher than among members of the general population. At least 100,000 individuals who left correctional facilities in 2004 had a mental illness.³

The majority of people who are in jail spend a very short period of time in custody. Sixty-four percent of the U.S. jail population turns over every week.⁴ Many individuals, however, particularly those in prisons, stay much longer. Correctional facilities have a duty to ensure that imprisoned persons receive proper care and, in most cases, facilities are responsible for providing the care themselves.⁵



The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (“ACA” or “the Act”) was enacted in March 2010.⁶ The primary purpose of the Act is to improve access to health care in the United States.⁷ To this end, the ACA prohibits most health plans from imposing lifetime or annual dollar limits on health benefits and from imposing pre-existing condition exclusions; provides funding to states to create mechanisms for individuals and small business employers to purchase health insurance; dramatically expands Medicaid eligibility to include most people with very low incomes; creates subsidies to help individuals purchase insurance; imposes limits on cost-sharing; and provides additional funding for certain public health programs and for training health professionals. The linchpin of the ACA is the requirement that Americans have “minimum essential coverage,” defined as coverage through government programs such as Medicaid, Medicare Part A, the Children’s Health Insurance Program (CHIP) and veterans’ programs; most employer-sponsored or individual health insurance plans; existing “grandfathered” health plans; and other coverage approved by the federal government.⁸ However, the ACA, existing Medicaid restrictions and state implementation may exclude many incarcerated individuals from health insurance eligibility or coverage.

Health Benefit Exchanges

The ACA requires HHS to provide funding to states to establish American Health Benefit Exchanges (“exchanges”), which are entities administered by government agencies or non-profits through which qualified individuals may purchase “qualified health plans” (“QHPs”).⁹ Qualified individuals are defined as those seeking to enroll in QHPs and who live in the state that established the exchange.¹⁰ Incarcerated persons are, however, specifically excluded from the definition of qualified persons, except for pre-trial detainees.¹¹ 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.”¹²

States are also given the option of operating basic health programs through which they can offer “standard health plans” (“SHPs”) to certain lower-income individuals, rather than covering them through QHPs purchased through the exchanges.¹³ Enrollment in SHPs must be open to “eligible individuals,” defined as those under age 65 who are ineligible for Medicaid or other minimum essential coverage and who have income greater than 133 percent up to 200 percent of the federal poverty level (FPL).¹⁴ In order to be eligible, a person must also satisfy the requirements governing who is a qualified individual eligible to enroll in QHPs.¹⁵ Thus, the same restriction on enrollment by incarcerated persons applies here as well.

The ACA also provides for tax credits, which are intended to help individuals enrolled in QHPs or SHPs afford payment of the monthly premiums. The intent is that the tax credit should pay for most of a monthly premium, with the individual being responsible for contributing the remainder. These tax credits will be available for citizens with incomes between 100 percent and 400 percent of FPL.¹⁶ Individuals and families with incomes up to 133 percent of FPL are responsible for 2 percent of the premium. The percentage for which individuals and families are responsible increases on a sliding scale up to 9.5 percent for individuals and households at 400 percent of FPL.¹⁷ Individuals with incomes between 100 percent and 400 percent of FPL will be entitled to cost-sharing reductions.¹⁸ The responsibility of eligible individuals for payment of cost-sharing will vary on a sliding scale, depending on household income.¹⁹

In addition, the ACA contains other non-financial protections intended to ensure access to health insurance. 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 status, medical condition (including both physical and mental illness), claims experience, receipt of health care, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability or any other health status-related factor determined to be appropriate by HHS.²⁰

Practical Issues

There are questions about how the exclusion of offenders from QHPs and SHPs and exception for pre-trial detainees will actually work. Several issues in particular bear consideration. First, because the term “incarcerated” is not further defined in the ACA, administrative action, including HHS regulations and guidance, will be necessary to provide enough detail to enable the federal government and states to implement the provision. Accordingly, advocates should anticipate that agency guidance is likely forthcoming and prepare to engage in the process, particularly by commenting on proposed regulations.

Second, the ACA only precludes incarcerated individuals from enrolling in QHPs and SHPs, specifying that “[a]n individual shall not be treated as a qualified individual if, *at the time of enrollment*, the individual is incarcerated . . .”²¹ It does not specify that incarcerated individuals cannot continue to be eligible if they were enrolled in a QHP or SHP at the time they were incarcerated after conviction. The ACA does not provide more detail on this issue, but it is almost certain to emerge as it has with other major publicly funded, publicly directed medical assistance or insurance programs, such as Medicaid and Social Security. As will be discussed below, eligibility and continuing coverage under the Medicaid program generally are either suspended or terminated for persons who become incarcerated. Similarly, eligibility for Social Security benefits is generally suspended if the beneficiary is incarcerated or fleeing prosecution.²² Accordingly, advocates and constituents should monitor any regulatory action that might be pursued to circumscribe individuals’ participation in health plans based on incarceration status.

Third, regardless of how the exception for persons who are incarcerated pending charges is defined, it will affect a significant number of people.²³ Notably, the ACA does not explain why the exception was made for certain pre-trial detainees. The intent may have been to avoid interruption in coverage for insured individuals who are arrested and charged but ultimately released. The drafters might not have wished to deprive individuals of

a benefit when they had not yet been convicted of any crime. In any case, if appropriate eligibility determination and enrollment procedures are put into place, many hundreds of thousands of pre-trial detainees could enroll in QHPs. Further, individuals who are convicted then released from incarceration, including those released with a sentence of time served, are not excluded as qualified individuals under the ACA. The ACA does not specifically mention persons who are detained on probation or parole violations. They are, however, also imprisoned pending charges and should be covered by the exception for pre-trial detainees.

Finally, the ACA does not explain why persons who are incarcerated at the time of enrollment in a health plan may not enroll in QHPs and SHPs. It may be that public animus or related concerns compelled 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 those with substance use and/or mental health disorders, who make up a substantial proportion of incarcerated populations, is well-documented, so any legislation that may confer a social or other benefit upon incarcerated persons is likely to be controversial.²⁴ The exclusion may also be motivated by the principle that health care for prisoners is the responsibility of the state or local government operating the correctional facility, rather than the responsibility of private insurers or the federal government. This is the basis of a comparable exclusion in the Medicaid program, as discussed below.

Medicaid and the ACA

The ACA greatly expands Medicaid coverage to include nearly all citizens with incomes below 133 percent of FPL. Thus, many individuals who are at risk of or being released from incarceration will likely qualify for Medicaid. Yet, the impact of this eligibility expansion on the incarcerated may be limited by rules restricting coverage of Medicaid services for incarcerated individuals.

Medicaid is the cooperative federal-state insurance

program for people with a limited ability to pay for necessary health care.²⁵ Medicaid services are paid for with a combination of federal and state funds, with the federal government covering at least half the cost of all services provided. In states with a lower per-capita income, a greater proportion of the costs are covered by the federal government – up to a high of 84.86 percent in 2010.²⁶ These funds are known as Federal Financial Participation (FFP).²⁷

Each state operates its own Medicaid program pursuant to a state plan.²⁸ The basic requirements for each program are prescribed by federal law, which gives the states flexibility to determine certain aspects of the program's administration, eligibility and service coverage. Medicaid is available only to certain low-income individuals and families who fit into eligibility groups established by federal and state law. Generally, those eligible are children, caretaker parents, people with disabilities and people over age 65. Thus, Medicaid coverage is rarely available to non-disabled young and middle-aged adults without dependent children.²⁹

This will change in 2014, when the ACA will require states to cover most uninsured individuals under age 65 who have incomes below 133 percent of FPL (about \$14,000 for an individual in 2011).³⁰ States have the option to begin phasing in eligibility now, but all eligible individuals must be included by 2014.³¹ The Congressional Budget Office estimates that this expansion will result in Medicaid eligibility for millions more people by the time the law is fully implemented in 2019.³² To help states meet this requirement, the ACA temporarily increases the amount of federal funds for services provided to certain newly eligible populations: those between the ages of 19 (or a higher state-set age) and 65 who were not previously eligible for or enrolled in a health plan through Medicaid. For most states and the District of Columbia, federal funds will cover 100 percent of the expenditures for services for these newly eligible individuals in 2014-2016, 95 percent for 2017, 94 percent for 2018, 93 percent for 2019 and 90 percent for 2020 and each year thereafter.³³

The “Inmate Exception”

Federal law expressly provides that federal funds cannot be used to pay for services for incarcerated individuals who are otherwise Medicaid-eligible. Medicaid law provides that FFP is not available “with respect for care or services for any individual who is an inmate of a public institution.”³⁴ The term “inmate” is defined as one who is living in a public institution, except if he is in an institution for “a temporary period pending other arrangements appropriate to his needs.”³⁵ A public institution is one that “is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.”³⁶ The ACA makes no change to this rule.

In a policy letter, CMS further explained that an individual is an inmate “when serving time for a criminal offense or confined *involuntarily* in State or Federal prisons, jails, detention facilities or other penal facilities.”³⁷ This includes:

- Individuals being held involuntarily in detention centers awaiting trial;
- Inmates involuntarily residing at wilderness camps that are under governmental control;
- Inmates involuntarily residing in halfway houses under governmental control; and
- Inmates receiving care on the premises of prisons, jails, detention centers, or other penal settings.³⁸

According to the Centers for Medicare & Medicaid Services (“CMS”), which administers the Medicaid program, “the intent of this provision is to ensure that Medicaid funds are not used to finance care which has traditionally been the responsibility of state and local governments.”³⁹ Ironically, however, these restrictive procedures can place undue financial and other burdens on taxpayers, insured persons and health care systems when released offenders seek and obtain needed health care services.

Most states have implemented policies and procedures that not only prohibit Medicaid coverage of services but also terminate Medicaid eligibility when an individual is incarcerated.⁴⁰ This means that the person must complete and submit a new application in order to become eligible again. This process can take several months, resulting in further interruption of the person's access to medications and other health care treatment.⁴¹ This is particularly true of people with mental illness, who experience greater difficulty following through with necessary appointments and interviews.⁴²

Eligibility Determination

The ACA aims to make it easier for individuals to apply for health insurance coverage. The HHS Secretary is required to establish a system through which individuals may apply for “applicable health subsidy program[s],” which include QHPs, SHPs, Medicaid, CHIP, premium tax credits and cost-sharing reductions.⁴³ Individuals applying for eligibility through an exchange must be screened for and enrolled in Medicaid or CHIP if they qualify.⁴⁴ In addition, the Medicaid enrollment process must be simplified and coordinated with state exchanges.⁴⁵

To make an accurate and efficient eligibility decision, states must develop a “single, streamlined form” that can be used to apply for all health subsidy programs as well as a “secure, electronic interface allowing an exchange of data (including information contained in the application forms) that allows a determination of eligibility for all such programs based on a single application.”⁴⁶ States must also “update eligibility for participation” in and use available data sharing for QHPs, SHPs, subsidies, Medicaid and CHIP.⁴⁷

States are also required to conduct outreach to and enroll in Medicaid or CHIP vulnerable and underserved populations, including unaccompanied homeless youth, children with special health needs, racial and ethnic minorities, pregnant women, rural populations, victims of abuse or trauma and individuals with mental health or substance-abuse disorders.⁴⁸ States should therefore consider the special issues applicable to individuals who move in and out of jails, including the many with

behavioral health disorders or who are otherwise vulnerable and underserved.

HHS has repeatedly emphasized that federal law “does not specify, or imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution.”⁴⁹ In fact, in 2004, HHS issued a letter encouraging states to “suspend” rather than “terminate” Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD).⁵⁰ The guidance 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 . . .”⁵¹ Indeed, federal law requires that states must allow individuals to apply for Medicaid at any time.⁵² Moreover, federal law does not preclude correctional facility employees or other state agency personnel from assisting detainees and offenders 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.⁵³

Implications for Coverage of Individuals in Pre-trial Detention, Incarcerated Pursuant to Conviction and Released from Custody

It is impossible to know, at this early stage of implementation, exactly how the ACA will affect access to health insurance coverage for pre-trial detainees and those being released from prison or jail. Federal regulations and guidance, as well as state implementation activities, will play a crucial role in determining how the restrictions on eligibility or coverage for health care services will affect pre-trial detainees and individuals being discharged from correctional institutions. Thus, any predictions about access for these individuals are premature. But it is clear that the expansion of Medicaid eligibility to include millions of poor, childless adults as well as the provision including pre-trial detainees in the category of qualified individuals who may enroll in QHPs or SHPs has the potential to dramatically improve access to health care services for this population.

The following discussion describes a series of possible scenarios pertaining to pre-trial detainees' eligibility to access QHPs, SHPs and Medicaid. It also addresses potential barriers to and opportunities for improving enrollment of this population.

Coverage Through QHPs and SHPs

As discussed, the ACA allows all individuals in custody pending disposition of charges to enroll in QHPs or SHPs. Accordingly, if an individual already is covered by a QHP or SHP when incarcerated, there is nothing in the ACA that suggests that person should lose coverage while in pre-trial detention. Once an individual is convicted and incarcerated, the ACA provides that he or she is not eligible "to enroll" in a QHP or SHP. This is not an explicit statement that such an individual cannot continue to be covered through such a plan (as opposed to enrolling). Accordingly, HHS should encourage states not to disenroll individuals from enrollment in QHPs and SHPs.

Medicaid Coverage

It is likely that many individuals entering and leaving prison and jail will have very low incomes. By 2014, nearly all citizens with income below 133 percent of FPL will qualify for Medicaid. Thus, Medicaid is perhaps the most likely coverage option for offenders. Of course, Medicaid's inmate exclusion means that federal funds cannot be used to cover services in jails, prisons and other penal settings. Although federal law does not require Medicaid eligibility to be terminated, the exclusion for federal matching funds leads many states to terminate Medicaid eligibility when notified of a beneficiary's incarceration. CMS has urged states to suspend, rather than terminate, eligibility for incarcerated persons.⁵⁴ The reorganization necessitated by the ACA's coverage rules, including the requirements to streamline eligibility determination processes for all insurance programs and subsidies, provides an excellent opportunity for states to change their policies to suspend, rather than terminate, Medicaid eligibility.

If states will accept applications, individuals who are jailed and who have incomes below 133 percent of FPL should be assisted in applying for Medicaid.⁵⁵ As noted above, nothing in the Medicaid law or the ACA precludes

health care providers, case managers or other qualified providers—including correctional health care providers and correctional authorities—to take steps to assist offenders with the process of recertifying or re-enrolling offenders in preparation for discharge from incarceration, regardless of whether they are there on a short-term or long-term basis. Indeed, CMS encourages it.⁵⁶ Per the ACA, standards and protocols should be developed and implemented that allow access to offenders' stored eligibility information and documentation to assist with resumption of eligibility.⁵⁷

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 mental and behavioral health, including substance abuse issues. 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 costly 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 before they are released. Taking advantage of this opportunity to apply for and enroll in insurance coverage can contribute significantly to improving community health.

Barriers

There are serious logistical and political barriers to improving health services for pre-trial detainees, sentenced and incarcerated prisoners and probationers, parolees and others being released from penal institutions. These include the fact that there are few executive-level advocates, scant data resources, little continuity of care, public health programs with restrictions on eligibility, internal barriers (attitudes, policies and practices), limited communication of cost-effectiveness and community receptivity.⁵⁸ These logistical and political barriers can, however, 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 state and federal agencies (for Medicare and Medicaid) or by application for coverage through individual health plans. Many pre-trial detainees with medical or mental illness and/or substance abuse issues are unlikely to have enrolled for such coverage. Implementation of the ACA provides opportunities for correctional authorities to establish linkages with the exchanges to improve access to Medicaid and individual coverage through QHPs and SHPs. The ACA's requirement for development of enrollment standards and protocols to facilitate enrollment in federal and state health and human services programs should provide correctional agencies with a conduit for streamlined bi-directional data exchange between state and community partners.⁵⁹

The ACA's provisions related to the Interagency Working Group on Health Care Quality may provide additional opportunity to improve health care coverage for individuals

in pre-trial detention or leaving custody. The group 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."⁶⁰ The Federal Bureau of Prisons and HHS are among the federal agencies designated as part of the Working Group, which should be encouraged to improve the quality of correctional health services by addressing and removing possible barriers to coverage and payment for offenders' health services that may be occasioned by current restrictions and limitations upon such coverage or payment.⁶¹ 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 members of the Working Group.

Communication of Health Information

Correctional authorities may increase continuity and coordination of care into and out of custody by adopting electronic health record systems (EHRs), for which the ACA provides incentives.⁶² An EHR can facilitate health care transitions, save staff time, contribute to patient safety and offset the costs of some of the new, expanded roles for correctional facilities 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.⁶³ Consent must be obtained to share such information.⁶⁴ 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

Policymakers and public authorities must work to ensure that correctional facilities 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.⁶⁵

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 discharge planning 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 medications 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.

- Designate staff with a clearly defined discharge planning function.⁶⁶

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

Conclusion

Although the ACA restricts access to health insurance coverage for many incarcerated individuals, it also creates many opportunities to improve access. The expansion of Medicaid eligibility will greatly benefit the population who is at risk for or transitioning out of penal settings. The ACA's requirements related to screening and for enrollment in private and public health insurance plans have the potential to greatly improve health care access for pre-trial detainees and all individuals transitioning out of the correctional system. 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 for offenders, correctional as well as community and public health agencies should remain vigilant about implementation of the ACA's provision. They should monitor implementation activities of both federal and state regulatory agencies to ensure that they are taking maximum advantage of 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 for Pre-trial Detainees and Individuals Transitioning from Correctional Facilities 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. No. 111-148, § 1101)

2. Prohibiting discrimination against individual participants and beneficiaries based on health status, including health status-related factors in relation to the individual or a dependent of the individual medical condition (including both physical and mental illnesses. (Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201)

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. No. 111-148, § 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. No. 111-148, § 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. No. 111-148, § 2001)

6. 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. No. 111-148, § 2701)

7. Medicaid emergency psychiatric demonstration project 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. No. 111-148, § 2707).

References

¹Sarah Somers, senior attorney at the National Health Law Program, assisted in the preparation of this article. The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP serves legal services programs, community-based organizations, the private bar and providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people.

²National Commission on Correctional Healthcare. *The Health Status of Soon-to-be-Released Inmates, a Report to Congress*, August 2002, www.ncchc.org/pubs_stbr.html.

³U.S. Department of Health and Human Services. *Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions*, July 2010, www.mathematica-mpr.org/publications/PDFs/health/medicaid_eligibility.pdf (accessed February 7, 2011).

⁴Minton TD. "Jail Inmates at Midyear 2009-Statistical Tables." *Bureau of Justice Statistics Statistical Tables* (NCJ 230122). Washington: U.S. Department of Justice, 2010. For further discussion, see Veysey B. "The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Reform," 2010, www.cochs.org/health_reform_conference/papers (accessed February 9, 2011).

⁵Cohen F and Dvoskin J. "Inmates with Mental Disorders: A Guide to Law and Practice." *Mental and Physical Disability Law Reporter*, 16: 339-346, 462-470, 1992. See also Veysey. The right to health care for incarcerated individuals was established in *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁶Patient Protection and Affordable Care Act (PPACA), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010).

⁷"Congressman Rangel Hails Passage by The House of Health Reform Legislation," a press release issued by the office of U.S. Representative Charles B. Rangel, March 21, 2010, <http://rangel.house.gov/2010/03/>.

⁸PPACA § 1501.

⁹*Id.* §§ 1311, 10104, 10203.

¹⁰*Id.* § 1312(f)(1).

¹¹A parallel requirement applies in the context of minimum essential coverage. Incarcerated persons are exempt from the requirement to maintain minimum essential coverage, other than those incarcerated pending the disposition of charges. Thus, unlike persons incarcerated based upon conviction or final adjudication, persons in pre-trial detention must have minimal essential coverage. ACA §1501.

¹²PPACA §1312(f)(1)(B). For this article, we use the term "pre-trial detainees" to describe those incarcerated pending disposition of charges. These individuals have not been convicted of any crimes and they are detained to ensure their attendance in court and to protect the victims, witnesses and the community. American Bar Association, *Criminal Justice Standards on Pre-trial Release* (3d ed. 2002); National Association of Pre-trial Services Agencies, *NAPSA Standards of Pre-trial Release* (3rd ed. 2004).

¹³*Id.* §§ 1331, 10104.

¹⁴*Id.* §§ 1331(e), 10104(o).

¹⁵*Id.* § 1331(e).

¹⁶*Id.* § 1401(a). These credits will also be available to lawfully present immigrants with incomes below 100 percent of FPL. *Id.* In 2010, for most states and the District of Columbia, 400 percent of FPL is \$74,120 for a family of three, and 100 percent is \$18,530 for a family of the same size. 76 Fed. Reg. 3637-38 (Jan. 20, 2011).

¹⁷PPACA § 1401(a); HCERA §§ 1001-1004.

¹⁸PPACA § 1402(b). These protections are also available for lawful permanent residents with incomes under 100 percent of FPL. *Id.* Cost-sharing is defined as deductibles, coinsurance, copayments and similar charges and other qualified medical expenses as defined by § 223(d)(2) of the IRS Code of 1986. It does not include premiums, balance billing for services provided by non-network providers, or spending on non-covered services. PPACA § 1302(c)(3).

¹⁹*Id.* § 1402(c); HCERA § 1001. These protections are also available for lawful permanent residents with incomes under 100 percent of FPL.

²⁰ACA § 1201; HCERA § 1001.

²¹PPACA §1312(f)(1)(B) (emphasis added).

²²Social Security Old Age and Survivor Disability

Insurance (OASDI) payments may not be paid to “prisoners, certain other inmates of publicly-funded institutions, fugitives, probationers, and parolees.” This exclusion applies when an individual is (1) confined to a jail, prison or other penal or correctional facility due to conviction of a criminal offense; (2) confined to a public institution as the result of a verdict of insanity or finding of incompetence to stand trial or similar finding; (3) confined to a public institution pursuant to a finding that an individual is a sexual predator; (4) fleeing to avoid prosecution; or (5) violating a federal or state condition of parole. 42 U.S.C. § 402(x), (v). For Supplemental Security Income Benefits (SSI), inmates of public institutions are excluded from eligibility, as are individuals fleeing to avoid prosecution, custody or confinement for a felony. 42 U.S.C. § 1382(e)(1)(A). See also U.S. Department of Health and Human Services, p. 16.

²³PPACA § 1312(f)(1)(B) (emphasis added).

²⁴See, e.g., Office of National Drug Control Policy, Executive Office of the President. “Fact Sheet: Drug Treatment in the Criminal Justice System.” NCJ-181857, Drug Policy Information Clearinghouse. Also, Corrigan PW, Watson AC, Heyrman ML. “Structural Stigma in State Legislation.” *Psychiatric Services* 56(5):557-563 (2005). Also, Corrigan PW. “How Stigma Interferes with Mental Health Care.” *American Psychologist*, 59(7): 614-625 (2004).

²⁵42 U.S.C. §§ 1396-1396w-5.

²⁶75 Fed. Reg. 66765 (Oct. 29, 2010).

²⁷*Id.* § 1396d(b).

²⁸42 U.S.C. § 1396a; 42 C.F.R. § 430.10.

²⁹42 U.S.C. §§ 1396a(a)(10)(A); see also Centers for Medicare & Medicaid Services, “Medicaid,” www.cms.gov/home/medicaid.asp (accessed September 16, 2010). There are more than 50 specific categories of eligibility. Some categories of eligibility are mandatory and must be included in all states’ Medicaid plans, such as children under age 6 of families with incomes under 133 percent of FPL. Others are optional, such as certain types of working people with disabilities.

³⁰PPACA § 1413, adding 42 U.S.C. § 1396a(a)(10)(A) (i)(VIII).

³¹42 U.S.C. § 1396a(k)(2).

³²Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, March 18, 2010, www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf (accessed Jan. 25, 2011), p. 7.

³³HCERA § 1201 (adding 42 U.S.C. § 1396b(y)(1)).

³⁴42 U.S.C. § 1396d(a)(27)(A); 42 C.F.R. §§ 435.1009(a)(1), 435.1010, 441.13(a)(1). This funding exclusion, however, does not apply for the part of the month that the individual is not an inmate. 42 C.F.R. §§ 435.1009(b).

³⁵*Id.* § 435.1010. Nor does it include individuals in public educational or vocational training institutions. *Id.*

³⁶*Id.* Certain types of institutions, such as medical or child care institutions are excluded from this definition. *Id.*

³⁷Letter from Robert A. Streimer, Director, HHS Disabled and Elderly Health Programs Group, to All Associate Regional Administrators, Dec. 12, 1997 (emphasis added) (“December 1997 policy letter”), p. 1. See also Health Care Finance Agency Program Issuance Transmittal Notice Region IV, March 6, 1998 (transmitting policies set forth in the December 1997 policy letter to Medicaid agencies in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee).

³⁸December 1997 Policy Letter, p. 4. In 1995, the highest Maryland state court held that federal law did not exclude pre-trial detainees from Medicaid coverage. *Brown v. County Commissioners of Carroll County*, 338 Md. 286, 300 (1995). This result is contrary to subsequent federal guidance, however, and thus should not be considered good law.

³⁹Federal Financial Participation for Inmates in Public Institutions and Individuals in an Institution for Mental Disease or Tuberculosis, 50 Federal Register 13196-01 (April 3, 1983).

⁴⁰U.S. Department of Health and Human Services. See also Judge DL. *A Better Life - A Safer Community, Helping Inmates Access Federal Benefits*, 2003. See also Ohio Association of County Behavioral Health Authorities. *Medicaid Termination Policy, Behavioral Health: Toward a Better Understanding*, 2006, www.oacbha.org. Committee on Ways and Means, Subcommittee on Human Resources. *A Decade Since Welfare Reform: Ending Waste, Fraud and Abuse of Welfare Benefits*, June 1, 2006, <http://waysandmeans.house.gov/media/pdf/welfare/>

060106welfarereport.pdf (accessed September 30, 2010).

⁴¹Conley C. *Helping Inmates Obtain Federal Disability Benefits: Serious Medical and Mental Illness, Incarceration, and Federal Disability Entitlement Programs*, National Institute of Justice, 2005, www.ncjrs.gov/pdffiles1/nij/grants/211989.pdf (accessed Sept. 30, 2010).

⁴²U.S. Department of Health and Human Services.

⁴³ACA § 1413(a), (e).

⁴⁴PPACA § 1413(a).

⁴⁵*Id.* §2201. States receiving any FMAP for Medicaid after January 1, 2014, must establish eligibility simplification procedures.

⁴⁶PPACA §§1413(a), (c)(1).

⁴⁷*Id.* § 1413(c)(3)(A), (e).

⁴⁸*Id.* § 2201(b)(1)(F).

⁴⁹December 1997 Policy Letter.

⁵⁰Letter from Glenn Stanton, Acting Director, to State Medicaid Directors, May 25, 2004 (discussing strategies for ending chronic homelessness), <http://documents.cshorg/documents/policy/cmsletter0504.doc> (accessed September 11, 2010). See also Bazelon Center, *supra* note 40.

⁵¹Stanton, *supra*, n. 51.

⁵²42 U.S.C. § 1396a(a).

⁵³U.S. Department of Health and Human Services.

⁵⁴See discussion, *supra*, at 12.

⁵⁵This would include detainees who had an income greater than 133 percent of FPL at time of arrest but fell below 133 percent of FPL while incarcerated. These individuals should also be screened and enrolled in the state's Medicaid programs, so that coverage is available when the individuals are released.

⁵⁶U.S. Department of Health and Human Services.

⁵⁷PPACA §§ 1413, 1561.

⁵⁸Mellow J and Greifinger RB. "Successful Reentry: The Perspective of Private Health Care Providers." *Journal of Urban Health*, 84(1): 85-98, January 2007.

⁵⁹PPACA §1413, 2201.

⁶⁰*Id.* § 3012(a).

⁶¹*Id.* § 3012(c).

⁶²*Id.* § 1561. For information on the EHR incentive program, see www.cms.gov/EHRIncentivePrograms/, (accessed September 11, 2010).

⁶³Updates on the development of rules for privacy and security of data are available at <http://healthit.hhs.gov> (accessed September 11, 2010).

⁶⁴PPACA §1561.

⁶⁵Moller L, Stover H, et al. (eds). *Health in Prisons—a WHO Guide to the Essentials in Prison Health*, www.euro.who.int/data/assets/pdf_file/0009/99018/E90174.pdf (accessed September 10, 2010).

⁶⁶Mellow and Greifinger, *supra*, n. 59.