

Consumer Rights Come to Jail: How the Affordable Care Act Changes the Rights of Individuals Pending Disposition

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Historically, health care policy in the United States has not considered the special needs of individuals who cycle in and out of jails. The reason is obvious: consumer-oriented issues related to choice and protection have been the primary drivers of health care policy, and until very recently, few people in jail could afford health insurance. They were not consumers.

Absent the interest of health care policymakers and payers, little research has been done at the intersection of health care and jail. Instead, case law largely based on the prison environment has driven health care policy in jail, resulting in minimally adequate legal standards that do not reflect the protections that consumers of commercial health insurance enjoy. These standards fail to recognize that passage of the Patient Protection and Affordable Care Act (ACA) has created an environment in which individuals in jail pending disposition of their charges may now have much higher levels of consumer capacity than individuals in prison. A constitutionally required minimum for care is light years away from the consumer rights built into most health insurance plans.

The ACA has expanded affordability of, and access to, health care and granted rights and responsibilities specifically to individuals in jail pending disposition. It is only a matter of time before correctional settings must incorporate the consumer-based insurance mechanisms and assurances established by the ACA. Recognition of serious, widespread deficiencies in the physical and mental health care services provided in jail underscores the urgency of this need.

The consumer-focused protections created for individuals under the ACA have changed the paradigm for individuals in jail pending disposition. No longer are detainees governed solely by constitutionally established standards for health care while in jail. As individuals enrolled in a qualifying health plan under the ACA, they now have legal rights as consumers. The criminal justice system must adapt in a way that allows individuals in jail pending disposition to exercise those rights.

This issue brief has two audiences: policymakers, in both the health care and criminal justice worlds, and lawyers. For policymakers, we describe the policy behind the consumer-focused protections in the ACA, the provisions within the ACA for individuals pending disposition, and how these provisions change the health care paradigm for individuals pending disposition. For lawyers interested in building a case to uphold the consumer-focused protections that the ACA created for individuals pending disposition, we describe the complicated state of constitutional jurisprudence for such cases and discuss how the ACA stops local jurisdictions from limiting access to health care insurance and services for individuals pending disposition.



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I. The Market-Driven Expansion of Health Care Insurance Access

Under the ACA, millions of individuals gained access to health insurance. To carry out such a vast expansion of health insurance coverage, Congress established several important regulatory structures that protect consumers while controlling insurance policy costs through free-market principles. By creating marketplaces where consumers can purchase qualified health plans, the ACA balances consumer protection with consumer choice.

There is a certain tension between principles of consumer protection and principles of consumer choice. On the one hand, policymakers understand that consumer protections limit consumer choices; this means that overly protective regulators could limit market forces by restricting entrance into the market. In drafting the ACA, federal legislators sought to protect consumers from substandard insurance plans that would not meet their health needs while allowing free markets to reduce costs. At the same time, consumers want choice, and they want assurances that they will have it.

To ease the tension between consumer protection and consumer choice, federal legislators constructed health insurance marketplaces that offer consumers a choice of private health insurance plans that meet federally mandated criteria. These marketplaces essentially serve as resources that allow individuals, families, and small businesses to compare health insurance plans; check their eligibility for subsidies; and ultimately choose a health insurance plan that meets their particular needs as purchasers. In states that fail to create a marketplace, consumers may participate in a federal marketplace.

The marketplace creates a minimal regulatory barrier to entry by requiring all health plans sold on the marketplace to meet certain criteria. These criteria ensure that individuals purchasing a policy receive a comprehensive health insurance plan that covers a wide array of services and items. This comprehensive package of services and items is known as “essential health benefits” (EHBs), which provide minimal insurance qualifications, as well as points for comparison among plans. Insurance plans that contain all ten mandated EHBs and meet other regulatory criteria may be sold on the marketplace and are deemed “qualified health plans” (QHPs).¹

The government’s involvement in creating QHPs is significant. In defining a QHP, the government spells out what is required to meet the needs of health insurance consumers. Previously, insurance companies had significant leeway in deciding what a basic insurance policy covered, which meant that consumers could unknowingly purchase plans that were in effect useless. The EHBs set a new minimal standard for what qualifies as a health plan that provides consumers with sufficient protection. By certifying health insurance plans for sale on a state or federal exchange, state insurance commissioners confirm that these plans include sufficient consumer protections.

The regulatory framework of the ACA includes other important consumer protections as well. For example, the ACA describes the responsibilities of a QHP in maintaining a sufficient network of providers. A “QHP issuer must ensure that the provider network of each of its QHPs... [m]aintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will

be accessible without unreasonable delay.”² The ACA creates regulations that govern both the content of services and the timely administration of those services. Determining what constitutes unreasonable delay is subject to regulatory interpretation, but Congress’s intent to ensure reasonable access to services is clear.

Once the adequacy of a plan is established, the marketplaces allow consumer choice in the context of a free market to direct resources more efficiently. An individual’s selection of a QHP will be based upon his or her own needs and self-interest. Because consumers have a choice of plans that provide varying levels of coverage, health insurance companies must design plans that meet consumers’ needs and expectations if they are to succeed in the marketplace.

As discussed, the ACA is not merely a law that governs the purchase and sale of health insurance policies. Instead, by establishing marketplaces, setting benchmarks for plans, and establishing other regulatory constraints, the ACA has created an environment that promotes consumer expectations of choice and protects the bargained-for rights that are part and parcel of their health insurance plan contracts. In addition, the ACA has established standards for what constitutes adequate health insurance coverage in the United States. In this paradigm, consumers can be better informed and better equipped to ensure that they receive the benefits of their bargained-for exchange. The ACA extends the consumer-based foundations of the health care system to all individuals.

Unfortunately, not all individuals belong to populations that have been treated as consumers in any market, let alone the health care market. In jails, where health care is a constitutional mandate and governed by legal standards, the idea of a detainee as a rights-bearing consumer has not existed. In crafting the ACA, Congress recognized that many individuals would be eligible for health insurance while in jail, but would still face a trial to determine guilt or innocence. To protect individuals pending disposition, Congress distinctly stated that an individual “incarcer[ated] pending disposition of charges” would remain eligible to participate on the health insurance marketplace and purchase a qualified health plan.³ In addition, individuals pending disposition of charges fall under the mandate to purchase a health plan.⁴ This mandate demonstrates that Congress wanted more than mere eligibility to be maintained—it wanted individuals pending disposition to be covered by health insurance.

To date, regulators have not weighed in on how the ACA’s “pending disposition” language should be interpreted. Does this mean that an individual may purchase insurance without receiving the benefit of that insurance? Correspondence from 2011 reveals the intent of the Senate on this matter.⁵ A letter from the National Association of Counties (NACo) to Cynthia Mann, then deputy administrator and director of the Center for Medicare & Medicaid Services (CMS), advises CMS to issue a directive to state Medicaid directors prohibiting states and health plans “from refusing to cover services for individuals enrolled in QHPs or SHPs while they are incarcerated.”⁶ The NACo letter was subsequently endorsed in a separate letter from Senator Jeff Bingaman, a member of both the Senate Committee on Health, Education, Labor, and Pensions Committee and the Senate Committee on Finance. He noted that NACo “ma[d]e the point that under the regulations individuals enrolled in Qualified Health Plans in jail awaiting disposition will continue to be enrolled and eligible for coverage of services whereas those on Medicaid in the identical situation will not.” In Sen. Bingaman’s opinion, NACo’s position was

“consistent with Congressional intent.”⁷ Sen. Bingaman’s endorsement of both eligibility and access to services while pending disposition provides the only insights available into Congress’s intent on this matter, but demonstrates that services should not be suspended merely because an individual is incarcerated pending disposition.

To recapitulate, the ACA creates a framework for consumer protection and consumer choice to drive health insurance markets. One of the ACA’s protections explicitly grants individuals in jail pending disposition the right and responsibility to have health insurance. As the letter from Sen. Bingaman clearly demonstrates, the protections and responsibilities for an individual pending disposition relate to both insurance eligibility *and* receipt of services.

II. Lay of the Correctional Terrain

Providing services for an individual pending disposition is a complicated undertaking. Correctional health care policies have developed as a result of legal actions that protect an incarcerated individual from cruel and unusual punishment. This *negative* legal protection to avoid cruel and unusual punishment is drastically different from the *positive* consumer rights created by the ACA that protect the services granted to a consumer.

The jail, where millions of individuals are held each year pending disposition or are serving short sentences, is an area where the ACA is certain to have a major impact. Individuals who cycle in and out of the jail are often poor, unemployed or underemployed, and have high rates of substance use disorders and mental illness.⁸ Before coverage expansion under the ACA, childless working-age adults were largely excluded from Medicaid eligibility, regardless of their income. Few individuals in jail had health insurance of any kind; few people received treatment prior to arriving in jail; and few left jail with health insurance.⁹ In addition, federal law prohibits states from obtaining federal Medicaid matching funds for health care services provided to incarcerated individuals who are otherwise Medicaid-eligible.¹⁰

Recent studies suggest that virtually all individuals who frequent the jail will be eligible for either Medicaid or health insurance subsidies.¹¹ The tax credits and subsidies of the ACA, as well as specific language targeting individuals who are in jail pending disposition, have made it possible for many people to obtain health insurance.

Delivery of the benefits of a purchased plan, however, is complicated by the jail’s traditional health care delivery model, which conflicts with the ACA’s consumer protections. To better understand how the contractual rights implicit in the ACA will change the correctional field, it is necessary to understand the responsibilities and limitations that governed health care delivery within jails prior to the ACA.

A. Institutional Care and Adequacy

The Constitution does not create an affirmative duty for the government to provide medical care to people who need it. In certain circumstances, however, where the government creates a danger to an individual, the government is obligated to provide health care services.¹² The Supreme Court has stated that if the government exhibits major control over individuals, the

government has a duty to ensure that appropriate services are provided. The Court clarified by stating that “[a]s a general matter, a State is under no constitutional duty to provide substantive services for those within its border. When a person is institutionalized—and wholly dependent on the State—it is conceded...that a duty to provide certain services and care does exist, although even then a State necessarily has considerable discretion in determining the nature and scope of its responsibilities.”¹³ The constitutionally adequate “essentials of care that a State must provide” are traditionally limited to “adequate food, shelter, clothing, and medical care.”¹⁴

What constitutes adequacy, however, is never positively described. Instead, as we discuss next, several court cases have described the responsibilities of an institution through negative proscriptions.

B. Duty of Care in Institutions

As discussed, there is a duty to care for people who have been placed under institutional care by the government, but in a correctional setting this duty is bounded by the proscriptions of the Eighth Amendment. Cases, however, rarely reach a trial court, let alone appellate courts and the Supreme Court. Despite many trial court cases regarding the treatment of individuals in jail and prison, there is no clear or singular jurisprudence. For on-the-ground practitioners concerned with adequacy of jail and prison care, there are many practical gaps.

Supreme Court jurisprudence in correctional settings is complicated. Broadly, the Eighth Amendment governs the conditions of confinement for individuals adjudicated in a criminal trial. For those being held in pre-trial detention, the Eighth Amendment is inapplicable because the individual has not been adjudicated and cannot, therefore, be punished. In these cases, the Supreme Court has deployed a Due Process analysis. Although two separate constitutional concerns are involved in pre-trial versus post-conviction analysis, the applicable tests essentially have become the same. For example, in attempting to describe the health care responsibilities in a correctional setting for pre-trial detainees, many of the circuit courts adopted standards relating to medical care that mirror Eighth Amendment analysis.

The 1976 case *Estelle v. Gamble* governs the constitutionally mandated care of an incarcerated individual.¹⁵ In *Estelle*, the Court stated that it was cruel and unusual punishment in contravention of the Eighth Amendment for a correctional facility to refuse to provide medical treatment to an inmate after he had injured his back.¹⁶ This case established that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain.’”¹⁷ The Court stated that the government has an “obligation to provide medical care for those whom it is punishing by incarceration.”¹⁸ While in a correctional facility, a detainee has no choice but to rely on the government for medical care. Taken to the extreme, the government’s deliberate indifference to the serious medical needs of an individual could produce “physical ‘torture or a lingering death.’”¹⁹

Estelle requires two proofs to demonstrate inadequate care inside a correctional facility. First, the medical need must be serious. Next, the correctional official must demonstrate the requisite intent, i.e., deliberate indifference. In *Estelle*, the Court did not articulate a clear definition of deliberate indifference, which remained undefined until eighteen years later in *Farmer v. Brennan*, where the Court stated that reckless disregard of a substantial risk of harm to a

prisoner constituted deliberate indifference.²⁰ This culpable mental state may be proven by circumstantial evidence or inferred from “the very fact that the risk was obvious,”²¹ or through direct evidence. The other required proof, the seriousness of medical need, lacks Supreme Court guidance, but has been defined by lower courts on the basis of several factors: “(1) whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment; (2) whether the medical condition significantly affects daily activities; and (3) the existence of chronic and substantial pain.”²² Other circuit courts have described specific conditions that constitute serious medical needs.²³

The deliberate indifference test in *Estelle* demonstrates how health care in correctional facilities has been handled in the past. The Court does not provide any constitutionally minimal standards of care, or any assurances to individuals who are incarcerated. Rather, the Court provided negative proscriptions that merely required that correctional facilities not ignore the serious medical needs of the individuals in their care. This negative proscription is vastly different from the positive rights that the ACA created for individuals pending disposition.

The guidelines from *Estelle* and subsequent related cases, however, have made their way into the jurisprudence for pre-trial detainees when referencing the medical care of a person in jail.²⁴ These guidelines created a policy universe in which a correctional facility had broad discretion to decide when and how the rights of an individual are exercised within a correctional facility.

C. Bringing Consumer Rights Inside the Jail

The consumer rights described here cannot simply be imported into a correctional environment to fill the gaps in jail health care. A large jurisprudence relates to a court’s deference to the needs of a correctional facility. In order to understand how the consumer rights from the ACA can be brought into the jail, we must first examine how and why courts defer to correctional facilities. Once we understand why this deference exists, we can examine how the ACA preempts the deference afforded to a correctional facility.

A court does not want to micromanage the day-to-day business of a correctional facility. Judges understand that a correctional facility has safety concerns that differ greatly from concerns outside the jail.²⁵ Because of this, courts are reluctant to create more rights for detainees and will defer to the “legitimate governmental objective[s]” of a correctional institution absent guidance from the legislative or executive branch.²⁶

The deference to correctional needs was articulated most clearly in *Turner v. Safley*, which involved two constitutional claims within a correctional facility: a First Amendment claim regarding inmate communication and a claim regarding the freedom to marry. The Court articulated the standard of deference that is due a penological institution by stating that “when prison regulation impinges on inmates’ constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests.”²⁷ The Court found that even though marriage is a fundamental right, in a correctional facility this right should not be judged based on strict scrutiny—the highest standard of review that essentially guarantees a plaintiff’s victory—but on a more deferential level of scrutiny that considers the penological objectives of the correctional facility administrators. Even when deferring to penological interests, the Court found that the

ban on inmate marriage was not reasonably related to a penological interest. With regard to First Amendment rights, however, the Court found that the ban on inmate communication does have a reasonable relationship to an important penological interest.

Turner is the harbor in which many correctional facilities seek shelter for their policies and practices, regardless of whether a constitutional right is in question. It is highly likely that a jurisdiction would argue that it cannot allow an individual to receive the bargained-for rights granted to him through the ACA because of concerns regarding the safety and security of the correctional facility and request that the courts defer to the policies of a correctional facility that keep individuals from accessing health care—outside the *Estelle*-mandated minimum.

The new policy framework created by the ACA establishes new expectations for correctional facilities by protecting the consumer rights of individuals pending disposition. This, in turn, limits a correctional facility's ability to claim that it requires a court's deference. The statutory language and Sen. Bingaman's letter describing Congress's intent signal that a jail can no longer appeal to the deference afforded by *Turner* or *Wolfish* to limit a health insurance consumer's eligibility and access to treatment. The ACA lays out explicit expectations for individuals who are pending disposition: they are still eligible and mandated to purchase health care insurance; this eligibility also relates to the ability to receive the bargained-for services in an insurance policy; and any attempt of a jail to limit this eligibility and mandate would contravene explicit federal policy. If the opposite were true—i.e., eligibility could be truncated by the penological interest of a correctional facility—federal statutes would be meaningless in the face of a correctional facility's prerogatives. *Turner* and *Wolfish* ruled in the vacuum caused by lack of federal guidance regarding individuals in correctional facilities. The ACA provides new guidance on the rights of an individual pending disposition.

III. Test Case: Benny and the Jail

Now that the broader policy implications have been described, questions remain as to how these policies will be worked out in the courts.²⁸ Here, policymakers may feel free to hand this document over to their more legally minded colleagues. In this section, we will examine the procedural and technical hurdles for an individual interested in challenging the policies of a jail. The hypothetical test case below offers an opportunity to examine the problems a health care consumer may face while in jail and help guide an interested reader through the legal hurdles to vindicating a claim.

Benny is an individual who signed up for a qualified health plan on the health care exchange. His plan contains a duty to the insurer to allow him to see an orthopedic specialist within 14 days upon the recommendation of a primary care physician. Benny went to a primary care physician because he was experiencing aching and painful joints. The primary care physician stated that Benny needed to see an orthopedic specialist. Benny immediately made an appointment. After leaving his primary care physician, Benny was arrested and taken to jail. Because he could not post bond, he was held in jail pending disposition of his trial. While in jail, the in-house jail doctor agreed that Benny needed to see an orthopedic specialist. The jail's unwritten policy is that all referrals to outside

specialists are placed on a waiting list, and Benny is told that it will take eight to ten weeks before he clears the waiting list. Because this is a written policy, there is no internal grievance procedure at the jail that would provide Benny a forum for a hearing.

The ACA creates government-incentivized, contracted-for rights that cannot be preempted by a local jurisdiction—even if they are granted broad discretion. Upholding Benny’s consumer insurance rights requires several steps that involve governmental players on federal, state, and local levels. The complicated interrelationship among federal statute, state regulation, and local practices creates a field in which a federal preemption claim may be available to vindicate Benny’s rights.

It should be noted that Benny has another path to achieving success by creating a claim that the jail is deliberately indifferent to his serious medical needs. As more people become knowledgeable of their own health conditions because they can access doctors, and as health records become more readily shared through new and developing health information technologies, jail officials will have much more knowledge about the serious medical needs of their inmates—assuming that the jails have policies and procedures to understand the medical needs of their detainees. With this knowledge comes the responsibility not to be deliberately indifferent to the serious medical needs of detainees. We will not go down that path here. Instead, we will look at the way in which jail policy can no longer operate under the auspices of *Turner* and penological interest in light of the ACA’s statutory protections.

A. Preemption

Preemption is a constitutional doctrine that arises from the Supremacy Clause.²⁹ Practitioners use the doctrine of preemption to challenge state or local government activities that conflict with federal statutes that do not contain explicit causes of action. If the activities of a state or local government, typically codified through state or municipal legislation, are “inconsistent with an act of Congress, they are void, so far as that inconsistency extends.”³⁰ Generally, preemption falls into one of three categories. A federal statute may expressly override a state law, the federal government may “occupy the field” and exclude even consistent state law, or a state or local law may conflict with a federal law.

The statutory framework of the ACA is new, so it will undoubtedly conflict with local laws and practices, but the extent and consequences of this conflict remain to be seen. In Benny’s case, the jail’s activities are in conflict with the ACA because his federally mandated, state-approved health insurance contract is being nullified by the jail’s local practices.

For a claim of preemption to work, a direct conflict does not need to occur. Rather, conflict preemption may occur where state or local activities become “an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”³¹ State and local regulations are most certainly subject to federal preemption analysis. Administrative orders are also subject to preemption analysis.³² Even policies that are codified in writing can be preempted. However, challenging an action that is based on unwritten policies, practices, customs, usage, inaction, or isolated violations are much more difficult to claim.

In Benny's situation, the ACA and Sen. Bingaman's letter clearly state that individuals pending disposition are eligible to purchase QHPs and must purchase insurance or face tax penalties. The ACA was instituted to expand insurance coverage and improve health care outcomes. To accomplish these goals, a person must have access to both insurance and services. Because of the jail's actions, Benny is unable to reap the benefits of the contract and receive important services.

Consumer Expectations and Consumer Redress: The Foundation of a Preemption Claim

Unfortunately, the reason that the jail is denying Benny's request to see a specialist is less clear. Is it the jail's policy or is one official acting out of line? A preemption claim will require more than pleading that the jail official's *activities* are conflicting with the federal government's intention to provide access to health insurance plans and the benefits associated with such a plan. In 2009, the Fifth Circuit stated that a litigant must identify a state or local law that conflicts with the federal statute—mere action on the part of officials is not enough.³³ Somehow, Benny needs to show that the actions of the jail official are reflected in the policy of either the jail or the state insurance commission that certifies the QHPs for sale on the state health insurance exchange. In Benny's case, the insurance contract's complicated administrative grievance process could be an asset.

Within the new consumer-driven insurance scheme are many rights associated with being a consumer. Health insurance policies have specific grievance procedures for a beneficiary to vindicate a claim. A state insurance commission approves these procedures, just like the other features of a QHP sold on a health care exchange. When Benny complains that he could not receive the benefits of the contract that he bargained for, he needs to submit a grievance claim to his insurance provider per the process described in his contract. As Benny's benefits grievance advances, he will eventually appeal to the insurance commissioner of the state who approved his plan for sale on the marketplace. This process, while cumbersome, may provide Benny with necessary documentation of the state and local policies for incarcerated individuals pending disposition. These policies will provide grounds for claiming that the state, through the insurance commissioner's deference to the jail or to the jail's policies that have now been documented, is in conflict with the ACA.

The administrative grievance process is essential to a preemption claim when a state's actions conflict with federal law. Without documentation that the jail is withholding the benefits of Benny's eligibility—thus rendering his eligibility to be in name only—or documentation that the state insurance commissioners have decided to suspend the benefits of the QHP in favor of the jail's penological interests, a federal court would not have the necessary proof of state or municipal policy. By understanding the redress available to an individual as a consumer, Benny can document policies that conflict with federal law.

Justiciability Issues

Preemption claims must be brought in federal court. A federal suit brings considerations of both jurisdiction and justiciability issues—questions about whether a federal court can hear a case. Preemption is self-evidently a federal question, allowing for this case to be heard in a federal court. Justiciability, or the appropriateness of parties and timing of a case, can be a

more difficult issue. Often, cases are dismissed out of hand before the merits of the case are reached because of justiciability issues. Benny would need to plead that he has standing to bring the suit, that the case is ripe, and that the case has not become moot.

Standing is a justiciability doctrine that establishes that Benny is the right person to bring a case. To demonstrate that he has standing to bring a suit, Benny must demonstrate an

‘injury in fact’—an invasion of a legally protected interest which is (a) concrete and particularized, and (b) ‘actual or imminent,’ not ‘conjectural’ or ‘hypothetical.’ Second, there must be a causal connection between the injury and the conduct complained of—the injury has to be ‘fairly . . . trace[able] to the challenged action of the defendant, and not...th[e] result [of] the independent action of some third party not before the court.’ Third, it must be ‘likely,’ as opposed to merely ‘speculative,’ that the injury will be ‘redressed by a favorable decision.’³⁴

Benny’s injury in fact occurred when his interest in his contracted-for right was removed by the actions of the jail authorities. It was actual and not conjectural. This actual injury can be documented by the actions of the jail authorities or the acquiescence of the insurance commissioner’s grievance board to those actions.

The issue of whether the injury can be redressed is a more peculiar aspect of standing. Often, the inquiry into redressability and causation are indistinguishable. However, the Supreme Court has held that there are instances where an alleged violation of a procedure can harm an individual. In these instances, the ordinary standards for redressability can be suspended. In *Massachusetts v. Environmental Protection Agency*, the Court held that “when a litigant is vested with a procedural right, that litigant has standing if there is some possibility that the requested relief will prompt the injury-causing party to reconsider the decision that allegedly harmed the litigant.”³⁵ In Benny’s case, his right to see a specialist may be a procedural right—allowing him to have standing to force jail officials to reconsider the actions that harmed him.

Benny’s claim of preemption could also be addressed *via* the more typical means of establishing standing. It is clear that judicial intervention could provide redress for Benny. The decision of the federal court will halt the actions that preempt the federal law. This will leave the jail with two ways to respond. First, jail officials could increase their staffing to assure Benny that his contracted-for rights are respected. Alternatively, the jail could release Benny pending disposition. It is merely the fact that Benny could not post bail that kept him from continuing his daily activities and seeing the orthopedist. Either of these results would allow Benny to receive the care for which he had contracted.

Even if Benny has standing to bring a suit, he must be able to claim that his case is ripe. While standing concerns who may bring a suit, ripeness concerns whether a case is brought at the appropriate time. In general, the Supreme Court holds that ripeness requires a two-part inquiry. First, for cases regarding government action, a court typically holds that an issue is ripe for review unless there is clear and convincing evidence that the legislature intended to preclude such a review. Second, if such preclusion does not apply, ripeness is determined by two considerations: the fitness of the issues for determination and the hardship of the parties if the court withholds review.

In Benny's case, there is no federal law that demonstrates an intention to preclude the review of the actions of an insurance commissioner or a jail official. Both parties have been subject to many court cases. As noted, the fitness of the record for review will depend upon whether Benny was able to provide an administrative record of the policies and practices of the state's insurance commissioner and the jail officials. The administrative record goes to the sufficiency of a preemption case, but also demonstrates that Benny exhausted his administrative remedies.

Benny's final hurdle for establishing the justiciability of the case is whether his case is moot. Mootness refers to whether the court could make a meaningful intervention. Article III of the United States Constitution limits the jurisdiction of federal courts to "cases and controversies," meaning that if a case would have resolved itself by the time the wheels of justice arrived at a decision, there is no need for court intervention. Benny's case could not make it through the administrative hurdles necessary to bring his case before he would be released from jail. Once Benny sees his orthopedist following his release, the jail will argue his case is moot because he was able to see his specialist.

In cases where a plaintiff seeks damages, mootness is not an issue because there is still the need to compensate for past harms. As we will discuss, Benny cannot sue for damages on an issue of preemption. This places him in a difficult situation. To avoid a determination that his case is moot, Benny must show that the conduct is "capable of repetition but evading review."³⁶ Conduct is capable of repetition but evading review when (1) the duration of the challenged action is too short to be litigated fully before the cessation or expiration of the challenged conduct, and (2) the plaintiff is reasonably expected to be subject to the same action in the future.³⁷

The duration of a case is too short when the duration of an action is "too short to be fully litigated prior to cessation or expiration."³⁸ When the action is too short in its duration, the court recognizes that it may still have to make a decision, even if the chance for a meaningful resolution is unavailable. Benny wants to see his specialist within his contracted-for two weeks. There is no chance that the court would decide such a case within that time. But, unless the case is heard, the jail would never be held responsible for its actions that frustrate federal law.

The jail will argue that Benny is not expected to be subject to the same action again. Unfortunately, courts are not completely consistent with what this prong of mootness requires. Courts tend to decide this issue based on two metrics: whether an individual has a "demonstrated probability" of experiencing the same action again, or the less exacting "reasonable expectation" of repetition.³⁹ In *City of Los Angeles v. Lyons*, the plaintiff challenged a city policy of using chokeholds to subdue suspected criminals. There, the Court held that a generalized showing that that conduct might recur was not sufficient to trigger the exception, stating the "doctrine applies only in exceptional situations, and generally only in those cases in which the named plaintiff can make a reasonable showing that he will again be subjected to the alleged illegality."⁴⁰ Based on the reasonable showing standard, Benny would need to demonstrate that he was going to suffer the same situation again. Because it is unlikely that this same mix of circumstances will occur again in the same way, this is a high bar.

However, the Court loosened the requirement in *Honig v. Doe*. There, the Court stated that it was "unwilling to assume that the party seeking relief will repeat the type of misconduct that

would once again place him or her at risk of that injury.”⁴¹ Based on this standard, a court would be less stringent in demanding the certainty of Benny committing the act that got him into the jail to begin with and with the same conditions that brought about his situation. A court would understand that if everything happened the way it had previously, then Benny would be in the same situation he is in now. This suggests that the court would accept that a “reasonable expectation of a recurrence” might overcome mootness rather than a “definite probability” of it recurring.

For Benny, the chance that he would be in the same situation is not demonstrably probable. It is unlikely that the events surrounding a doctor’s orders to see a specialist and a subsequent arrest would occur. However, he could show that should he ever find himself in the same situation, the policy would result in the same outcome—a denial of his contracted-for benefits of his insurance policy. If that is the jail’s policy, it is no longer a reasonable expectation—it is a certainty. Depending upon the court’s interpretation of a reasonable expectation, Benny’s claim is unlikely to be considered moot.⁴²

Relief

If Benny overcomes all these hurdles, the question remains as to what relief will be granted to Benny. A claim of preemption is a double-edged sword. An individual who claims that a law or regulation is preempted is unable to recover damages; he can only ask that the court prospectively enjoin enforcing such a policy. This means that even though Benny may be unable to recover anything for what he has suffered, he will ensure that these actions will not occur in the future. Another drawback is that preemption claims do not allow for the recovery of attorney’s fees, unlike a 42 USC § 1983 action or a 42 USC § 1988 action.

Despite the limited remedies available to Benny, a preemption claim has advantages over other claims that allow for damages. Typically, courts are highly unlikely to recognize implied statutory rights through either a §1983 suit or a *Bivens* suit because of the damages and attorney’s fees that are available. The Court has also stated that it views the injunctive relief as the appropriate means of preventing entities from acting unconstitutionally.⁴³ It may just be the case that a preemption suit has more opportunity for success because of its limited relief.

Conclusion: Limits of Deference post-ACA

Preemption doctrine demonstrates that the deference to a correction facility in *Turner* and *Wolfish* is an inappropriate standard of review in denying Benny access to his contracted-for rights. The laws of the federal government are the supreme law of the land, and no regulation by a lower governing body has the power to overcome the supreme law of the land. This includes even the legitimate penological interests of a correctional facility. The language in the ACA regarding individuals pending disposition means that deferring to correctional facilities will no longer provide a safe harbor for jail officials to deny the eligibility of an individual to receive the benefit of his bargained-for exchange. In the battle between the consumer-driven rights granted by the ACA and the world of correctional facilities, which operated outside any sort of consumer-driven paradigm for so long, the consumer-driven paradigm, by explicit language in a federal statute, will win the day.

Endnotes

- 1 42 CFR § 18021 (2010).
- 2 45 CFR §156.230(a)(2) (2010).
- 3 42 USC §18032(f)(1)(B) (2010).
- 4 See 26 USC §5000A(d)(4) (2010).
- 5 Letter from Larry E. Naake, Executive Director, National Association of Counties, to Cynthia Mann, Administrator and Director, Center for Medicare & Medicaid Services (July 22, 2011) (on file with author).
- 6 *Id.*
- 7 Letter from Jeff Bingaman, Senator, New Mexico, to Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services (June 12, 2012) (on file with author).
- 8 See, e.g., Amy Smith, *Health and Incarceration: A Workshop Summary* (2013).
- 9 Crime and Justice Institute, *Healthcare Reform and the County Criminal Justice Systems* (April 5, 2013), available at http://b3cdn.net/crjustice/16671a6ab4f86d6017_b8m6b60kk.pdf.
- 10 See 42 USC §1396(d). In 1997, U.S. Department of Health and Human Services issued a memorandum that carved out a specific exception that allowed for federal financial participation reimbursement “for any Medicaid covered services provided to an inmate while an inpatient.”
- 11 Susan Turner, Lois Davis, Russell Lundberg, Malcolm Williams, and Dan Han. *Meeting the Health Care Needs of the Realignment Population: Estimating Their Health Profiles and Eligibility for Medicaid*, Presentation at the 2014 Annual Meeting of the American Society of Criminology - San Francisco, California, November 20, 2014.
- 12 See *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189 (1989).
- 13 *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982).
- 14 *Id.* at 324.
- 15 *Estelle v. Gamble*, 429 U.S. 97 (1976).
- 16 *Id.*
- 17 *Id.* at 104.
- 18 *Id.* at 103.
- 19 *Id.*
- 20 511 U.S. 825, 836 (1994).
- 21 *Id.* at 842.
- 22 *Brock v. Wright*, 315 F.3d 158, 162 (2nd Cir. 2003) (internal quotation marks omitted).
- 23 See, e.g., *Boretti v. Wiscomb*, 930 F.2d 1150, 1154 (6th Cir. 1991) (denial of dressing and pain medication for wound); *Ellis v. Butler*, 890 F.2d 1001, 1003 (8th Cir. 1989) (nurse’s failure to deliver pain medication); *Washington v. Dugger*, 860 F.2d 1018, 1021 (11th Cir. 1988) (denial of treatments that could “eliminate pain and suffering at least temporarily”); *H.C. v. Jarrard*, 786 F.2d 1080, 1083, 1086 (11th Cir. 1986) (denial of medical care for injured shoulder was unconstitutional, although no permanent injury resulted); *Lavender v. Lampert*, 242 F.Supp.2d 821 (D. Or. 2002) (failure to provide pain medication for partial spastic paralysis of the foot).
- 24 See *City of Revere v. Massachusetts General Hosp.*, 463 U.S. 239, 240 (1983) (stating that “[b]ecause there had been no formal adjudication of guilt against [the plaintiff] at the time he required medical care, the Eighth Amendment has no application.”).

- 25 See, e.g., *Bell v. Wolfish*, 441 U.S. 520, 547 (1979) (stating “[p]rison administrators [] should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security.”).
- 26 *Id.* at 535-37.
- 27 *Turner v. Safley*, 482 U.S. 78, 89 (1987).
- 28 It is important to note, however, that the Supreme Court has taken up a case from the Ninth Circuit that may have a major effect on pre-trial detainees’ ability to challenge jail policies that contravene federal law. The case, *Armstrong v. Exceptional Child, Inc.*, 133 S. Ct. 44 (2014), deals with whether the Supremacy Clause gives Medicaid providers a private right of action to enforce a section of Medicaid where Congress did not create an explicit enforceable right. This case has the potential to limit preemption as a claim in the absence of explicit statutory right. If the Court’s decision in *Armstrong* limits preemption claims, the ramifications for individuals seeking a state’s compliance with federal law will be sweeping. The statutorily created duty to provide access to services described here would stand, but federal redress from a jurisdiction breaching this duty would be limited.
- 29 See U.S. Const. Art. VI. stating “This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any state to the Contrary notwithstanding.”
- 30 See *Gibbons v. Ogden*, 22 U.S. 1, 31 (1824).
- 31 See *Crosby v. Nat’l Foreign Trade Council*, 530 U.S. 363, 373 (quoting *Hines v. Davidowitz* 312 U.S. 52, 67 (1941)).
- 32 See, e.g., *Entergy Louisiana, Inc. v. Louisiana Pub. Serv. Comm’n* 539 U.S. 39 (2003); *Verizon Maryland, Incorporated v. Public Service Commission*, 535 U.S. 635 (2002); *Nash v. Florida Industrial Commission*, 389 U.S. 235 (1967).
- 33 *Equal Access for El Paso v. Hawkins*, 562 F.3d 724 (5th Cir. 2009).
- 34 *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992).
- 35 *Massachusetts v. Environmental Protection Agency*, 549 U.S. 497, 517-18 (2007).
- 36 See *Southern Pacific Terminal Co. v. ICC*, 219 U.S. 498 (1911).
- 37 See *Spencer v. Kemna*, 523 U.S. 1, 17 (1996); *Murphy v. Hunt*, 455 U.S. 478, 482 (1982).
- 38 *Kemna*, 523 U.S. at 17.
- 39 *Federal Energy Commission v. Wisconsin Right to Life*, 551 U.S. 449, 463 (2007) (referring to both formulations); see *Buckley v. Archer-Daniels-Midland Company*, 111 F.3d 524, 527-28 (7th Cir. 1997) (applying various standards of the possibility of recurrence, such as “reasonable expectation,” “demonstrated probability,” and not “highly unlikely”).
- 40 *City of Los Angeles v. Lyons*, 461 U.S. 95 (1983).
- 41 *Honig v. Doe*, 484 U.S. 305, 320 (1988).
- 42 Individuals who find themselves in this situation may be able to certify the class, but it seems unlikely that there would be enough people to certify the class. In addition, each of the state’s respective insurance commissioners would have different standards, further complicating a class action.
- 43 *Correctional Services Corporation v. Malesko*, 534 U.S. 61, 74 (2001).