JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

Frequently Asked Questions

Implications of the Federal Health Legislation on Justice-Involved Populations[*]

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA)[†] and the Health Care and Education Reconciliation Act.[‡] Together, these two laws are commonly referred to as the PPACA, or colloquially as the "health reform" law.[§] The changes brought about by the health reform law will have a significant impact on how people involved in the criminal justice system can access public health insurance and services.

Most notably, the PPACA expands eligibility for Medicaid. Experts have long recognized that expanding Medicaid eligibility and improving access to treatment services will promote better public and individual health outcomes and is likely to reduce state expenditures.[1] Individuals cycling through prisons and jails—many of whom have significant health needs, but are not currently enrolled in Medicaid—will soon be eligible for enrollment. Although the most significant changes to Medicaid eligibility do not take effect until 2014 (or earlier, if a particular state opts to accelerate implementation), state officials, including criminal justice system officials, are now planning to put protocols in place in time to meet the new federal requirements under the PPACA.

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This document addresses the implications of PPACA for justice-involved adults. It first considers their needs and barriers to treatment. The sections that follow address how the health reform legislation expands these adults' eligibility for Medicaid and what services will be made available, the requirements and exemptions specified by the legislation, and how enrollment will take place.[**]

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[†] Public Law 111-148.
[‡] Public Law 111-152.
[§] A consolidated version of the two laws can be found at http://docs.house.gov/energycommerce/ppacacon.pdf.
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What are the health needs of incarcerated people?

Individuals in the criminal justice system have disproportionately high rates of chronic disease and behavioral health disorders when compared to the general population. In a study of individuals newly released from U.S. prisons, one-half of men and two-thirds of women had been diagnosed with chronic physical health conditions such as asthma, diabetes, hepatitis, or HIV/AIDS.[2] Sixty-five percent of all adults in the U.S. corrections system meet medical criteria for drug and/or alcohol use disorders.[3] In a study of more than 20,000 adults entering five local jails, researchers documented serious mental illnesses in 14.5 percent of the men and 31 percent of the women, which taken together, comprises 16.9 percent of those studied. These jail rates are in excess of three to six times those found in the general population.[4] The prevalence of hepatitis C is six to seven times higher in jails and prisons than among the general population, and the rate of the prison population with an HIV diagnosis—nearly two percent—is four times higher than that of the general population.[5]

The health costs associated with their care have skyrocketed in states across the country; for example, Michigan's Department of Corrections increased its health care expenditures by 95.8 percent between fiscal year 1999–2000 and fiscal year 2008–09. Expenditures per prisoner increased by 89.9 percent during the same period.[6]

To address the health and safety of individuals and the public, officials should ensure that people leaving the justice system are connected to health care that meets their needs. Jail and prison interventions are essential to *continuity of care* and provide the foundation for individuals to comply with conditions of release and to make the most of corrections' investments in their treatment. The PPACA offers an opportunity to make these connections to community care on a greater scale.

What are common barriers to receiving health insurance for justice-involved individuals?

Survey data indicate that one year after release, as many as 60 percent of former inmates are not employed in the regular labor market.[7] Furthermore, many have barriers to employment: most of those leaving prison have low levels of education and few marketable job skills—for example, more than 35 percent of returning individuals lack a high school diploma or GED.[8] As a result, employer-sponsored insurance is often not available to individuals leaving prison or jail. Additionally, a large number of releasees lack the means to buy insurance plans or pay out of pocket: 40–60 percent of individuals exiting prison in 2006 lived in households earning less than $20,000 a year.[9]

Without insurance or adequate income to pay for health care services out of pocket, it is difficult for individuals returning to the community to access medical services and prescription drugs. As a result, their chronic conditions and health may deteriorate. The provisions of the PPACA may serve to break this cycle of un-insurance, poor health, and high costs.

ELIGIBILITY AND SERVICES

The questions and answers that follow focus on how the PPACA expands eligibility for Medicaid, provides guidelines for the minimum standard of services a plan must provide, and creates public exchanges for buying health insurance.

With health reform, will more justice-involved individuals be eligible for Medicaid?

Yes. Currently, justice-involved people, many of whom are low-income adult men, do not qualify for Medicaid unless they meet stringent disability requirements and are unable to work. This leaves many of those exiting correctional facilities uninsured. Starting January 1, 2014, individuals with household incomes at or below 133 percent of the federal poverty level (FPL) will be eligible for Medicaid regardless of disability status. For single adults, the eligibility ceiling equals an income of approximately $14,400 per year; for a family of four, this comes to about $29,300 annually.*

The Congressional Budget Office has estimated that 16 million newly eligible individuals are projected to enroll in Medicaid.[10] Another analysis has determined that strong state-level outreach and enrollment efforts could reach as many as 23 million new enrollees.[11]

How will the costs of expanded Medicaid eligibility be shared between federal and state governments?

Although there are administrative costs associated with this expansion, states can receive significant reimbursement to develop services for those who will be newly covered under Medicaid. The federal government will initially cover 100 percent of the *newly* eligible Medicaid recipients. Gradually, this will be reduced—from 100 percent for years 2014 through 2016, to 95 percent in 2017, to 94 percent in 2018, and to 93 percent in 2019—so that by 2020 and thereafter, the federal share will be 90 percent, whereas the states will pay 10 percent.† The new law does not affect the federal-state share for those who were eligible previously for Medicaid.

What happens to people who were covered by Medicaid previously?

The PPACA does not eliminate Medicaid eligibility for groups that are currently served by it—e.g., children, the elderly, people with disabilities, pregnant women, or the blind. Rather, it establishes a new classification based on income alone for those who are a) under 65 years of age, b) not pregnant, and c) not entitled to or enrolled in Medicaid benefits under another category.‡[12]

How will health reform affect benefits for individuals with disabilities?

Although the health reform law does not change the process for establishing disability for state or federal financial income entitlements (such as Supplemental Security Income or Social Security Disability Insurance), individuals with income below the defined levels will qualify for Medicaid

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* These estimates use 2010 FPL guidelines, which vary by family size. See https://www.cms.gov/MedicaidEligibility/downloads/POV10Combo.pdf.

† There are some exceptions to this formula. Arizona, Hawaii, Delaware, Maine, Massachusetts, Vermont, and New York have already expanded their Medicaid programs (through 1115 Waivers) to include single adults up to at least 100 percent. The health reform law refers to these states as "expansion states" and provides a separate federal matching rate. For these states, the federal share of Medicaid reimbursement will be phased in starting at 50 percent in 2014 and going up to 90 percent in 2020 and thereafter.

‡ The rate for reimbursement is higher for the *newly* eligible than it is for the *previously* eligible. Therefore, states will still have to determine if people are eligible according to the pre-PPACA categories. It is important to note that making these distinctions will be complex for states, yet the online applications, and simplified requirements for enrollment should make the determination appear simpler to the consumer. At this writing, the federal government is expected to issue regulations based on a statistical formula to determine the financial responsibilities of the states and the federal government as it relates to newly versus previously eligible individuals.

immediately and should have access to those medical care benefits while they continue working through the disability determination process.

What services must be covered under the new Medicaid package?

Beginning in 2014, Medicaid coverage must include, at minimum, "essential health benefits" such as preventive services for chronic diseases, prescription drugs, rehabilitative (or habilitative) services and devices,* pediatric services (including oral and vision care), and mental health and substance abuse services.[13] The inclusion of mental health and substance abuse services as an essential health benefit is of particular importance to the criminal justice population because of the overrepresentation of people with behavioral health problems involved with the justice system. This is in addition to the set of services provided under Medicaid prior to PPACA, which includes (but is not limited to) inpatient and outpatient hospital visits, physicians' surgical and medical services, and laboratory and x-ray services.

The DHHS secretary will be providing additional guidance to states on the type and level of coverage that will be required, with notice and opportunity to comment. When defining these essential health benefits, the secretary is required to consider the healthcare needs of diverse segments of the population (which may include the needs of those leaving correctional facilities). The law also requires the secretary to periodically evaluate and report to Congress on the essential health benefits to determine whether enrollees are facing any difficulty accessing needed services either because of the extent of the coverage or the cost, or whether any gaps to coverage remain.[14]

What are state health insurance exchanges and who is eligible to use them?

State health insurance exchanges are online marketplaces through which consumers can easily review, compare, and select from a variety of private health insurance plans. They are designed to help individuals obtain private market coverage. By 2014, each state can either establish a state health insurance exchange or use a federally established exchange. HHS will establish criteria to accredit each plan for quality and to ensure they provide the same essential health benefits as detailed above. The exchange plans will make available sliding-scale tax credits and subsidies for households earning 100-400 percent of the federal poverty level.[15] (For a household of four, 100 percent of the federal poverty level is $22,350; 400 percent is $89,400.†[16]) Generally, the credits and subsidies are not available to those who are eligible for employer-sponsored insurance, *except* if the individual demonstrates that he or she cannot afford the employer-sponsored plan (if the employee's share of the coverage exceeds 9.8 percent of his or her household income or if he or she must pay more than 40 percent of the premium). In these cases, employees have the option of using the exchange to purchase coverage. Eligibility for both the exchange and Medicaid plans will be determined using the same simplified, online enrollment form. (The DHHS secretary will issue more specific guidelines about how these exchanges will be designed.)

Can individuals who are incarcerated enroll in state health insurance exchanges?

It depends. Sentenced individuals who are currently serving time in prison or jail are prohibited from using the state health insurance exchanges to enroll in a coverage plan. However, individuals who are incarcerated *while awaiting adjudication* of charges may enroll in the exchanges.[17] Because

* Habilitative services are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills. (Iowa Administrative Code)
† Excludes Hawaii and Alaska.

the exchanges are not operational until January 1, 2014, there may be opportunities to amend this provision in support of reentry efforts to establish connections with a medical provider before a sentenced individual's release.

INDIVIDUAL REQUIREMENTS AND EXEMPTIONS

The PPACA establishes an individual requirement for most citizens and legal residents to have some minimum level of health insurance coverage (a "mandate"). Until the implementation of PPACA in January, 2014, no such mandate has existed. There are penalties for non-compliance as well as exemptions to this provision. The mandate remains a controversial issue and, at the time of this writing, is a basis for legal challenges to the health reform law. The individual requirements and exemptions are discussed in this section.

Are people in prison and jail exempt from the mandate to obtain health insurance coverage?

In most cases.[18] Though nearly everyone is required to be enrolled in an approved health insurance plan every month from January 1, 2014, onwards, people who are incarcerated for more than a month are exempted from this requirement during the term of their incarceration. (Those incarcerated less than a month and those pending disposition do not have this exemption.) As soon as an individual is released from incarceration, either with or without community supervision, this exemption no longer exists (assuming they meet the other requirements).

What are the penalties for lacking coverage? Are there exemptions to these penalties?

The annual penalty for non-participation will increase over time. In 2014, the penalty will be $95; by 2016, it increases to $695, or 2.5 percent of the individual's household income, whichever is greater. It is also noteworthy that the penalty is assessed through tax filings; those with incomes below the filing threshold will not be fined. Exemptions to the penalties are established for individuals who cannot afford coverage (yet do not otherwise qualify for Medicaid), members of Indian tribes, those experiencing short coverage gaps lasting less than three months, or individuals experiencing hardships.[19] Importantly, there is no penalty if individuals meeting PPACA income eligibility criteria fail to enroll in Medicaid. Furthermore, formerly incarcerated people with higher taxable incomes (incomes above the Medicaid eligibility limit) returning to the community will have three months to obtain coverage without a penalty being assessed.

ENROLLMENT

Enrolling individuals into health insurance programs who leave prisons and jails is the key to connecting them to services that can improve individual and public health outcomes. This section discusses how enrollment will take place.

What can corrections officials do to facilitate Medicaid enrollment?

State corrections officials can work with local and state health officials to ensure that individuals are enrolled in Medicaid at the time of release. Ideally, corrections officials will have established relationships with community health care providers who can assist in enrollment to better serve individuals with significant health issues and with continuity of care needs (especially for substance use and/or mental health treatment). The law specifically requires the process for enrollment in

Medicaid to be simplified and promotes targeted outreach to vulnerable populations. People enrolling either for the first time or renewing their application can use secure online systems; their data will be matched against federal and state data to ensure eligibility. Although not a population specifically cited in the PPACA, individuals exiting correctional facilities may be considered members of a vulnerable and underserved population; states could consider incorporating these groups into their planning for assertive outreach and enrollment. In addition, correction officials in states that terminate a person's Medicaid eligibility upon incarceration should work with state policymakers to suspend coverage instead so individuals will not have to reapply for the benefit.

Will corrections databases be used to determine eligibility for participation in Medicaid?

The PPACA stipulates that each state create a data-matching system for "determining eligibility for participation" in Medicaid.[20] Eligibility will be determined on the basis of reliable third-party data, such as vital records, employment history, enrollment systems, tax records, and other data determined by the DHHS secretary. State and federal corrections data—such as incarceration status—could serve as evidence of a person's income status and could be used as part of the standards and protocols to determine eligibility. The data-matching program will apply only to individuals who are seeking Medicaid eligibility or subsidies through the state-level exchange system.[21] Even if states are not required by HHS to include corrections data in their data-matching arrangement, by planning to include criminal justice system data, they can ease proof of income burdens on applicants who are leaving prison or jail.

Does PPACA apply to services provide by correctional facilities?

No. The PPACA provisions do not apply to health care provided by the criminal justice system, so correctional facilities do not have to meet these mandates for minimum health benefits.

How soon can Medicaid eligibility be established for those exiting the corrections system?

Currently, individuals who are incarcerated are prohibited from participating in Medicaid (or the state exchanges), and the PPACA makes no change to this rule. Transition and reentry staff should continue to help enroll individuals at the time of their return to the community. (There may be opportunities to influence upcoming regulations that clarify enrollment processes, including regulations to improve reentry planning and help ensure that healthcare services are not interrupted.)

What is the role of community health centers as venues for enrollment and care?

As part of the healthcare safety net, community health centers (sometimes referred to as federally qualified health centers) provide comprehensive primary care to individuals on a sliding-fee scale. They can also help enroll people in Medicaid using the streamlined procedures described previously. Many of these clinics also provide behavioral health care (either on site or through offsite referrals). PPACA provides significant funding starting in 2011 to create additional community health centers and expand existing ones. Staff at reentry programs should promote partnerships with nearby centers to help facilitate individuals' healthy transition from a correctional facility to the community.

MOVING FORWARD

How can corrections officials and health administrators better collaborate to achieve improved health and safety outcomes?

Although many components of the health reform law are already being slowly phased in, its two major components—Medicaid expansion and the start of state exchanges—are not operational until January 1, 2014 (unless states opt to expand Medicaid earlier). While states await specific guidance from the DHHS secretary regarding enrollment procedures and essential health benefits, many officials have established working groups to plan and oversee health reform implementation. Through these working groups, corrections and healthcare practitioners may find opportunities to influence the decision making that could benefit individuals involved with the criminal justice system as well as the communities to which they return. For example, many states are already drafting legislation on insurance exchanges and putting together innovative practices in health care (such as, integrated care models or health homes*) to present to DHHS as potential demonstration projects and as budget-balancing initiatives. Corrections and health administrators can draw on evidence-based practices to proactively plan for the distinct needs of people who have involvement with the criminal justice system.

CONCLUSION

By expanding Medicaid and service capacity in communities, the PPACA provides a number of improvements for access to health care for individuals leaving prison or jail. Principally, the legislation expands Medicaid to nearly all low-income populations. With most of the provisions of the legislation set to take effect in 2014, state health and justice systems should collaborate to influence upcoming decisions about

- the types of services that Medicaid will cover,
- the procedures for enrollment, and
- when enrollment can occur.

New federal guidelines are to be released in late 2011, with an expected opportunity for public comment. A follow-up report from the CSG Justice Center will highlight some of these new guidelines and responsive state efforts to coordinate health and criminal justice activities. Ensuring that justice-involved populations are included in targeted outreach and enrollment and that their health needs are taken into consideration will be important to improving individual health, public safety, and community health outcomes.

* Integrated care models bring substance abuse and mental health treatment under the same roof. Health homes are patient-centered facilities where comprehensive primary care is provided.

NOTES

[1] Sarah E. Wakeman, Margaret E. McKinney, and Josiah D. Rich, "Filling the Gap: The Importance of Medicaid Continuity for Former Inmates," *Journal of General Internal Medicine* 24 (July 2009): 860—62.
[2] Kamala Mallik-Kane and Christy Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* (Washington, DC: Urban Institute, 2008), http://www.urban.org/url.cfm?ID=411617.
[3] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. *Behind Bars II: Substance Abuse and America's Prison Population* (New York: Columbia University, February 2010), p. 35.
[4] Henry Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Estimates on the Prevalence of Adults with Serious Mental Illnesses in Jails," *Psychiatric Services* 60 (June 2009): 761—65, http://www.consensusproject.org/publications/prevalence-of-serious-mental-illness-among-jail-inmates/PsySJailMHStudy.pdf.
[5] CASA, *Behind Bars II*, p. 35.
[6] Steve Angelotti and Sara Wycoff, "Michigan's Prison Health Care: Costs in Context," Michigan Senate Fiscal Agency, November 2010, http://www.senate.michigan.gov/sfa/Publications/Issues/PrisonHealthCareCosts/PrisonHealthCareCosts.pdf.
[7] Harold Watts and Demetra Smith Nightingale, *Adding It Up: The Economic Impact of Incarceration on Individuals, Families, and Communities. The Unintended Consequences of Incarceration* (New York: Vera Institute of Justice, 1996).
[8] Diana Brazzell, Anna Crayton, Debbie A. Mukamal, Amy L. Solomon, Nicole Lindahl, *From the Classroom to the Community: Exploring the Role of Education during Incarceration and Reentry* (New York: The Urban Institute and John Jay College of Criminal Justice, 2009), http://www.jjay.cuny.edu/Roundtable_Monograph.pdf.
[9] CASA, *Behind Bars II*, p. 35.
[10] Congressional Budget Office (CBO), Letter to Speaker Pelosi from CBO Director Douglas W. Elmendorf. March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.
[11] J. Holahan and I. Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2010), http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.
[12] PPACA, Section 2001(a)(1).
[13] PPACA, Section 1302.
[14] PPACA, Section 1203(b)(4)(C, G, H).
[15] PPACA, Sections 1401 and 1402.
[16] Department of Health and Human Services, *Annual Update of the HHS Poverty Guidelines* (Washington, DC: DHHS, January 20, 2011), http://www.federalregister.gov/articles/2011/01/20/2011-1237/annual-update-of-the-hhs-poverty-guidelines.
[17] PPACA, Section 1312 (f)(1)(B) INCARCERATED INDIVIDUALS EXCLUDED.—"An 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."
[18] PPACA, Title 1, Subtitle F, Part 1, Section 1501(d)(4) "INCARCERATED INDIVIDUALS.—Such term [applicable individual] shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges."
[19] PPACA, Subtitle F, Part 1, Section 1501 (e) (1) to (5).
[20] PPACA, Sections 1413 (c) and 1561, respectively.
[21] Beth Morrow and Julia Paradise, *Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges* (Menlo Park, CA: Kaiser Family Foundation, 2010), http://www.kff.org/healthreform/upload/8090.pdf.