Health Coverage for People in the Justice System: The Potential Impact of Obamacare

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THE ENACTMENT AND gradual implementation of the Affordable Care Act (ACA), the health care reform legislation familiarly known as Obamacare, has important implications for those in the justice system. While health care reform has the potential to provide health coverage for millions of Americans who are uninsured, implementation of the Act has not been without controversy, and uncertainty remains about its precise impact. However, a number of organizations and criminal justice agencies have been gearing up in an attempt to realize the potential of the Act. This article explores models that have been established for enrolling individuals involved in the justice system in health coverage through Obamacare. We will focus specifically on special populations such as people living with mental illnesses and the need for linking these individuals to treatment.

Obamacare Expands Medicaid Coverage for Low-Income Americans

One key provision of the Affordable Care Act required states to expand the Medicaid program for low-income Americans. However, the United States Supreme Court decision on the Affordable Care Act said that states could not be required to expand Medicaid and could therefore opt out of doing so (DiPietro, 2013). As of June 10, 2014, 26 states and the District of Columbia were implementing Medicaid expansion (Kaiser Foundation, 2014).[1]

Medicaid should be distinguished from Medicare. Medicare is a federal insurance program for health care coverage of individuals who are ages 65 or older, and for individuals under age 65 with certain disabilities. Medicaid, on the other hand, offers health care coverage to the poor (Medicare FAQs, 2012). Medicaid is administered by the states in partnership with the federal government, and is funded by both state dollars and federal matching funds. The availability and amount of coverage depends on age, disability, or family status and on an individual's or family's ability to pay based on income and available resources. Benefits are paid directly to providers, not to consumers (Center for Medicare Advocacy, 2006).

In states that have expanded Medicaid, this health coverage will be available to all individuals below the age of 65, including adults without children, who have incomes up to 133 percent of the federal poverty level (FPL). Individuals and families with incomes between 133 and 400 percent of FPL will be eligible for financial assistance to help them purchase private health insurance coverage through health exchanges recently established in every state (Cardwell & Gilmore, 2012).[2] For example, based on the year 2013 figures, the 133 percent FPL for an individual was set at $15,281.70 and at $31,321.50 for a family of four (Poverty Guidelines, 2013).

Expansion of Medicaid Could Provide Significant Benefit to the Criminal Justice System

The expansion of Medicaid is significant for the criminal justice system because an estimated 90 percent of persons entering jails in America today do not have any health insurance, with health care costs primarily incurred by states and counties (Hamblin & Heiss, 2013). In terms of health care costs shifted to states and counties, the Affordable Care Act does not eradicate what has come to be known as the "inmate exception" in traditional Medicaid. In other words, federal funds cannot be used to pay for services for individuals who are inmates (Hamblin & Heiss, 2013). While Medicaid cannot pay for treatment provided in the correctional facility, it can pay for inmates to receive inpatient treatment if the inmate needs to be

[1] In addition to the District of Columbia, the states opting for Medicaid expansion under the Affordable Care Act are Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia. Three states (Indiana, Pennsylvania, and Utah) were still considering adoption of the Affordable Care Act as of July, and the remaining 21 states were not expanding Medicaid at this time.

[2] Individuals with incomes of $11,490 were considered at 100 percent of the federal poverty level (FPL), and for a family of four at 100 percent of the FPL the associated income level was $23,550. Percentages above 100 percent of the FPL reflect incomes that are typically associated with guidelines for health care disbursements (Federal Poverty Guidelines, 2013).

transported to a hospital or intermediate care facility (Cardwell & Gilmore, 2012).

The Affordable Care Act makes it easier for people in jails and prison—whether or not they were previously enrolled in Medicaid—to *apply* for coverage. About 11.8 million people are booked into jails each year in the United States (Minton, 2012), and at any given time approximately two-thirds of these are awaiting trial. People who have not been convicted of a crime but are incarcerated and awaiting trial are qualified to enroll in Medicaid or private health plans; if they are enrolled in private plans, they can receive coverage while awaiting trial (Regenstein & Christie-Maples, 2012). Similarly, those out on bail and awaiting trial are eligible to apply for and receive Medicaid services. Regenstein and Christie-Maples (2012) make a strong case that the Affordable Care Act should be used to provide health care to this sizeable population. They argue that coverage for this group targets a highly vulnerable population with significant physical, mental health, and substance abuse needs. By providing health insurance for this disproportionately chronically ill population, Obamacare can reduce correctional health care costs, reduce involvement in the justice system, and offer health care at low cost to states. Jails are ideally placed to enroll people in this population.

For people with mental illness or other medical conditions, Medicaid coverage means swift access to care upon their release. In states where an individual's Medicaid benefits can be suspended rather than terminated during a short jail stay, re-entrants leave jail with immediate access and receive care more quickly. Access to health coverage and an array of other services, including housing, income supports, and employment services, can reduce the risk that people with serious mental illness will decompensate, experience homelessness, or re-enter the criminal justice system. Enrollment in Medicaid is a powerful tool for ensuring better outcomes for this population.

Immediate Access to Medicaid is Seen as a Key to Successful Reentry

Immediate access to Medicaid on release from jail or prison has long been seen as a key to successful reentry. Over a decade ago the Council of State Governments (2002) recommended that Medicaid benefits be suspended instead of terminated for people in jail awaiting disposition of their cases. Suspension means that as long as the inmate is in jail or prison, he or she remains on the Medicaid roll, but the jail or prison cannot receive any reimbursements from Medicaid for medical treatment delivered within the correctional facility (Lipton, 2001). The Council of State Governments also recommended that discharge planning should begin at booking and continue throughout detention, to make sure that health care coverage is available for detainees as soon as possible upon their release.

Federal law doesn't require that people in jails or prisons have their Medicaid benefits terminated; however, most states choose to terminate rather than suspend these benefits. As a result, even people with relatively short jail stays must apply for Medicaid on their release. Reinstating these benefits can take 6 to 12 weeks in the best of circumstances, and most people leaving jail and prison require assistance to reapply for benefits. State Departments of Corrections vary significantly in how much assistance they offer inmates applying for benefits: Some offer no assistance, while others assist with applications and connect re-entrants with medical or mental health providers (Human Rights Watch, 2003).

A number of states have implemented policies or procedures for the suspension of federal benefits, such as Medicaid, for inmates instead of the termination of such benefits.[3] In these states, inmates receive the benefit of expedited access to medical care upon return to the community, and outcomes should logically improve for this population.

Sequential Intercept Model

For people with serious mental illness and other chronic health conditions, interacting with police is often the first step in a long cycle of involvement with the justice system. Once involved in the system, people with serious mental illness have an especially hard time getting good care and re-entering the community successfully. In an effort to help criminal justice agencies and advocates understand how to help this population, Munetz and Griffin (2006) devised the sequential intercept model, which visually represents points within criminal justice/mental health processing where interventions can help return individuals to society, link them to treatment, and prevent them from either entering or descending further into the criminal justice system.[4] The specific intercept points include police and emergency services, initial detainment and hearings, "[j]ail, courts, forensic evaluations, and forensic commitments, [r]eentry from jails, state prisons, and forensic hospitalizations, [and c]ommunity corrections and community support services" (Munetz & Griffin, 2006, p. 545).

The sequential intercept model is only effective if the professionals at each of the intercept points have been properly trained to recognize the signs and symptoms of mental illness and if there are adequate services divert persons in need of treatment in the community. For more than a decade, mental health and criminal justice organizations have been advocating for enhanced community treatment services and improved training for criminal justice employees who encounter individuals with mental illnesses in crises (Council of State Governments, 2002). In many jurisdictions, their advocacy has been realized with improvements and expansion of police training, mental health screening protocols, pretrial interventions, mental health courts, coordinated treatment of co-occurring disorders, correctional treatment, evidence-based practices, and reentry programs. However, most communities still have a long way to go to implement criminal justice reforms and create a robust community mental health system.

Boundary Spanners

Employees on the front lines of the criminal justice and mental health systems have been referred to in the research literature as *boundary spanners* due to their ability to connect and navigate systems in an attempt to meet the multi-faceted needs of their clients (Steadman, 1992). Lutze (2014) indicates, for example, that the name community corrections officers implies that they must consider and manage the dual interests of the community and corrections worlds. These *boundary spanners* often act as *resource brokers*, identifying community resources, including mental health, housing, and vocational/employment services, and then matching those services to the needs of clients under their supervision (McCampbell, 2001; Steadman et al., 2001).

An area ripe for influence from boundary spanners is reentry from jails and prisons. Regardless of whether an inmate's benefits

[3] States that suspend Medicaid rather than terminate it for those incarcerated include Florida, New York, Minnesota, Ohio, and Oregon (Cardwell & Gilmore, 2012).

[4] The Sequential Intercept Model may be viewed at https://www.dbhds.virginia.gov/documents/Adm/080513MGArticle.pdf

have been suspended or terminated while incarcerated, he or she will need assistance with necessary paperwork.

Jails often do not offer reentry planning to those being released; the rapid turnover of inmates makes this population difficult to serve (Steadman & Veysey, 1997). Departments of Corrections (DOC) vary in their procedures for allowing their employees to serve as boundary spanners in ensuring the securing of benefits for inmates reentering society. The majority of state Supplemental Security Income and Medicaid offices refuse to receive applications from incarcerated individuals who are asking for reinstatement of benefits upon release, with DOC authorities in one state admitting that they had no idea how to assist inmates with reinstatement of benefits. Release into the community often at best results in a short-term supply of medication and an appointment slip with no follow-up (Human Rights Watch, 2003). The Council of State Governments (CSG) (2007) has identified common elements for success in ensuring access to benefits and treatment for inmates upon release: interagency involvement (boundary spanning); the establishment of new programs or agencies, sometimes with specialized caseloads for securing benefits; and identification of inmates eligible for release and discharge planning sooner rather than later in the process. The CSG also recommends specification of which agency is responsible/accountable for each component of the interagency agreements, the technological sharing of information to facilitate the release process, doing so early, and providing over a month's supply of medication to ease a releasee's transition into the community. The early linkage to treatment for someone released from custody into the community is essential, because the first six months after release from prison is when an offender is most likely to re-offend (Council of State Governments, n.d.).

The Council of State Governments (CSG) (December 17, 2013) has identified 10 ways for navigating the health insurance marketplace and linking individuals who encounter the criminal justice system to health coverage. The CSG, in boundary spanning fashion, provides customized factsheets for courts, jails, prison systems, and probation and parole officers.

Example Programs

With the expansion of Medicaid programs in many states, it is has been projected that 4 to 6 million of the 10 million individuals jailed each year will be eligible for Medicaid, which represents one-third of the population who will be covered by the newly expanded Medicaid programs (Regenstein & Christie-Maples, 2012).

Many jurisdictions around the country have already begun enrolling people involved in the justice system in Medicaid health coverage, in jails, reentry programs, probation centers, and other sites throughout the criminal justice system. Each jurisdiction has emphasized the importance of strong collaborations between criminal justice agencies and public health service or health care provider agencies (Aungst, 2014). Sheriffs' departments and other criminal justice agencies can take the lead in bringing these partners together.

Cook County, Illinois

The Cook County Jail, which serves the Chicago area, is one of the nation's largest jails. In late 2012, Illinois received permission for a Medicaid waiver allowing them to start the expansion of Medicaid early. In an effort to alleviate costs for indigent care and connect more inmates with health care, the Cook County Sheriff's Office began working with the Cook County Health & Hospitals System and a sentencing alternative program called Treatment Alternatives for Safe Communities (TASC) to enroll jail inmates in the County Care (Medicaid) system (McDonnell, 2014).

TASC, which provides case management services to people with substance abuse and mental health conditions in the justice system, began enrolling their jail diversion clients in County Care in December 2012. In April of 2013, TASC placed a team of enrollment specialists in the Cook County jail seven days per week. The enrollment specialists assist inmates during a waiting period in the booking process in enrolling in health coverage. As of July 2014, more than 16,000 applications for health care have been initiated from inside the jail. Clients can start getting services as soon as their applications are approved.

TASC reports that enrollment efforts have faced some challenges, but overall have been very successful. Despite being in a fast-paced environment with 200–300 individuals booked into the jail each day, they have found a niche which provides an opportunity to enroll any inmate who is interested in health coverage. One challenge case managers have faced is that inmates often lack identification and proof of residence. In these cases, they use the fingerprint-based identity documentation from jail booking as documentation so that the application can be completed immediately.

According to Maureen McDonnell, for criminal justice agencies considering expansion of Medicaid benefits for their clientele, implementation may initially be easier to accomplish in probation settings where social service and human service providers are already known entities to officers (Enroll America, 2014). Probation administrators in the Chicago area have initiated two pilot projects to enlist the services of probation officers in helping probationers to enroll in Medicaid and link them to treatment in the community (Council of State Governments, 2013). This same report indicated that the ultimate goal of such endeavors is to reduce recidivism and enhance the opportunities for diversion from jail. In a white paper, the Bureau of Justice Assistance (2014) has created a guide in Illinois for jail, correctional, and probation personnel to enroll justice-involved individuals with expanded Medicaid and to link them to treatment services.

San Francisco County Sheriff's Department

The sheriff in San Francisco, Ross Mirkarimi, recognized the significant positive impact health insurance and access to medical care post-release would have on inmates' lives and has made obtaining health insurance for inmates a priority component of the Department's overall reentry and recidivism reduction efforts. Sheriff Mirkarimi also believes that linkage to health care will save up to $2,500 per inmate per year and could cut repeat incarceration by 20 percent (Niquette, 2014).

The San Francisco Sheriff's Department has been collaborating with the Human Services Agency, the Department of Public Health, and the Adult Probation Department since late 2013 to implement a health coverage enrollment program in the San Francisco City and County Jail. The ultimate goal is to offer health insurance enrollment assistance to all inmates so that they can leave custody with active benefits. As of July 2014, just over 350 individuals have received assistance with the enrollment process.

Challenges that have been faced so far include determining whether health insurance applications should be done on paper or online. Online enrollment can be a problem due to limited time and access to technology and obtaining follow-up documentation to complete the application. Overall, inmates are interested in enrolling in health insurance and enthusiastic about the new opportunity

to get health insurance due to the Affordable Care Act.

Minnesota Department of Corrections

For the last several years, Minnesota's Department of Corrections has been working on enrolling people in prisons in Minnesota's Medicaid program. An agreement between the Minnesota Department of Corrections and the Minnesota Department of Human Services allows the Department of Corrections to submit applications to counties up to 45 days before release. Even prior to Medicaid expansion, most inmates qualified for medical assistance programs based on low income.

The Department of Corrections has specialized release planning staff. After the passage of the Affordable Care Act, the department trained approximately 20 staff members to be healthcare navigators. These navigators assist inmates with higher needs, including those with mental illness, with enrollment. This effort is part of a broader Transition from Prison to Community initiative, with all staff focused on reentry from intake.

The department faces challenges with technology. Most applications for MNSure are completed in real-time over the Internet, but inmates do not have access to that system. Filing paper applications is more time-consuming. The department has also had to work diligently to coordinate among all of Minnesota's 87 counties (Rebertus, 2014).

Ohio Department of Rehabilitation and Correction

Director Gary Mohr of the Ohio Department of Rehabilitation and Correction announced at the 2014 winter meeting of the American Correctional Association that Ohio Governor Kasich shared his belief that the Affordable Care Act provides the best opportunity of reducing recidivism, decreasing crime, lessening the number of crime victims, and restoring families (ACA Plenary, 2014). Mohr contends that in his correctional career the Affordable Care Act with its expansion of Medicaid will be the largest catalyst for turning lives around in 40 years. Fifty-one mental health and drug addiction counselors are being hired and navigators are being employed so that every prisoner eligible for release in Ohio will have the opportunity to sign up for temporary Medicaid coverage for up to 60 days. This coverage will then become permanent upon linkage to community services via appointments set up by prison employees. Projections are that the Affordable Care Act will result in a savings of $18 million annually for the state of Ohio (ACA Plenary, 2014). While costs would be shifted to the federal government, estimates are that savings for Ohio, which elected to expand Medicaid, could ultimately balloon to $34 million annually and would likely affect 95 percent of the 20,000 inmates released each year in Ohio (Bernard-Kuhn, 2014).

Conclusion

These examples are just a few of the efforts by criminal justice systems around the country to enroll people involved in the justice system in health coverage. Bernard-Kuhn (2014) indicates that similar efforts are underway in Maryland, Minnesota, and Oregon. Michigan is another state that has been acknowledged for embracing Medicaid expansion for inmates (Gugliotta, 2013). Viola Riggin, Director of Health Services for the Kansas Department of Corrections, reports that even those states which have not embraced Medicaid expansion under the Affordable Care Act, such as Kansas, may find coverage for inmates upon release under health care plans in other states (ACA Plenary, 2014). Some states, without embracing the Affordable Care Act, have allowed for a private option for health care coverage, whereby federal expansion funds can be used to purchase private insurance as part of a partnership marketplace exchange (Goodnough, 2014).

While the long-term impact of Obamacare on criminal justice systems is uncertain, there is significant opportunity to enroll uninsured people who are involved in the justice system in health coverage. Criminal justice agencies should take the lead in planning these enrollment efforts, to ensure that criminal justice systems get the most out of the opportunity to reduce cost and recidivism offered by Obamacare.

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