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Health Reform and Correctional Health Care: How the Affordable Care Act Can Improve the Health of Ex-Offenders and Their Communities

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HEALTH REFORM AND CORRECTIONAL HEALTH CARE: HOW THE AFFORDABLE CARE ACT CAN IMPROVE THE HEALTH OF EX-OFFENDERS AND THEIR COMMUNITIES

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INTRODUCTION

A few years ago, the United States reached an infamous milestone: estimates of individuals incarcerated in the nation's jails and prisons pegged the number at one in ninety-nine.[1] Within that statistic dwell other macabre figures: on any given day there are more than 2.2 million adults locked up;[2] local jails process nearly thirteen million admissions each year;[3] per capita, the United States incarcerates more people than any other country in the world[4] and imprisons them for significantly longer than most other industrialized countries.[5] However one slices the data, the statistics tell a grim story.

Another story, wrapped inside the generalized statistics of U.S. jail and prison rates, is the unique story of offender health care. Unlike the vast American population not behind bars, individuals inhabiting the nation's jails and prisons enjoy a constitutional right to adequate health care.[6] This right, carved out of the federal Constitution's Eighth Amendment right forbidding cruel and unusual punishment by state actors, amounts to nothing less than an entirely separate system of health care for some of the nation's poorest and most vulnerable people. The underlying structure of correctional health care is unique, as well. In the non-correctional context, American health care is primarily delivered by a patchwork of providers and facilities, delineated by type of care needed: a patient seeks preventive care from her primary care physician in one location,

1. THE PEW CTR. ON THE STATES, ONE IN 100: BEHIND BARS IN AMERICA 2008, at 5 (2008), *available at* http://www.pewstates.org/uploadedFiles/PCS_Assets/2008/one%20in%20100.pdf.

2. PAIGE M. HARRISON & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2005, at 2 (2005), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/p05.pdf.

3. Bonita M. Veysey, The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Care Reform 1 (Jan. 2011) (unpublished manuscript), *available at* http://www.cochs.org/files/Rutgers%20Final.pdf.

4. Andrew P. Wilper, et al., *The Health and Health Care of US Prisoners: A Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 666 (2009). To see comparisons to all other countries, and to other first-world countries in particular, see *Entire World—Prison Population Rates per 100,000 of the National Population*, INT'L CTR. FOR PRISON STUDIES, http://www.prisonstudies.org/info/worldbrief/wpb_stats.php?area=all&category=wb_poprate (last visited March 5, 2013).

5. Mark Mauer, The Sentencing Project, Comparative International Rates of Incarceration: An Examination of Causes and Trends (June 20, 2003) (unpublished manuscript), *available at* http://www.sentencingproject.org/doc/publications/inc_comparative_intl.pdf.

6. Estelle v. Gamble, 429 U.S. 97 (1976).

obstetrical care from a specialist in another location, urgent care from a separate clinic, and so on. This is not the case in the correctional setting: the entire spectrum of care is often delivered to prisoners on site.[7] Looked at this way—a system of mandatory health care delivered under one roof designed for a relatively sick population—correctional health care has the potential to be a model in terms of the efficiency and quality of care provided.

Unfortunately, this modeling has yet to come to fruition. In fact, nearly the opposite has been true: prisoner health services historically have been substandard.[8] Even in spite of longstanding reform efforts,[9] unhealthy and unsafe living conditions in American jails and prisons and denials of legitimate requests for health care have been normative and frequently documented.[10] Furthermore, as a result of social factors beyond their control, jails and prisons are regularly boxed into providing care that would not meet the professional standard of health outside a correctional setting. For example, because many non-correctional state-operated treatment centers and hospitals for the mentally ill have been closed over the last couple of decades, correctional facilities are now a centerpiece of the mental health care "system" in the United States,[11] even though they are

7. This is so regardless of whether governments design their correctional health delivery models using prison staff or outside contractors to provide health care services. *See* Seena Fazel & Jacques Baillargeon, *The Health of Prisoners*, 377 LANCET 956, 962 (2011).

8. *See, e.g.*, Wilper et al., *supra* note 4.

9. *See* John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 464 (2005) ("Prison reform movements have sought to ameliorate inhumanely harsh prison conditions, including inadequate medical care, almost since the time of American independence. These movements first focused on humanitarian principles, and more recently on individual rights principles. Humanitarian arguments largely failed to improve prison conditions because society, outside the small committed groups of reformers, was uninterested or unwilling to commit the resources needed to enact reforms. After a period of success, individual rights arguments faced growing resistance from Congress and the courts. Society also became apathetic as interests in punishment and incapacitation seem more salient than prisoners' arguments for decent health care.").

10. Cynthia Golembeski & Robert Fullilove, *Criminal (In)Justice in the City and Its Associated Health Consequences*, 95 AM. J. PUB. HEALTH 1701, 1701 (2005).

11. *See* Dora M. Dumont et al., *Public Health and the Epidemic of Incarceration,* 33 ANN. REV. PUB. HEALTH 325, 329 (2012). Between 2000 and 2006, the number of mentally ill inmates in U.S. prisons quadrupled. *See U.S.: Number of Mentally Ill in Prisons Quadrupled*, HUM. RTS. WATCH (Sept. 6, 2006), http://www.hrw.org/news/2006/09/05/us-number-mentally-ill-prisons-quadrupled). The rate of mental illness among the offender population greatly exceeds that of the non-incarcerated population. *See* DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES

poorly equipped to treat large-scale mental illness properly and effectively.[12] Similarly, with inadequate substance abuse treatment services available in many communities, judges often purposely funnel arrested substance abusers into jails, knowing that treatment for their condition is mandatory.[13] Although laudatory on one level, this approach leaves correctional administrators and clinicians in a predicament: while they must treat these offenders, they have insufficient resources relative to the influx of offenders whose complex constellation of physical and social conditions demand more sustained treatment than they are able to provide.

Social determinants aside, the generally substandard quality of health care that the nation's jails and prisons provide represents a moral failure on the part of society, an important health policy issue, and a major public health concern for correctional facilities, their inmates and staff, and for ex-offenders and the communities they reenter upon release. Yet despite the moral implications and the generally poor health of inmates as a whole, the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA")[14] did little to address head-on the care of incarcerated individuals. In fact, the ACA excludes incarcerated individuals from eligibility in one of the ACA's most important endeavors—the new insurance exchanges meant to guide and facilitate the purchase of health insurance coverage by individuals and small groups who historically have found affordable coverage beyond their reach.[15] That said, other aspects of the ACA may indirectly benefit the incarcerated population, including the expanded use of electronic medical records and the ability of individuals aged twenty-six and younger to remain on their parents' insurance plans.[16]

(2006); *see also* Susan D. Phillips, The Sentencing Project, The Affordable Care Act: Implications for Public Safety and Corrections Populations 2 (Sept. 2012) (unpublished manuscript), *available at* http://www.sentencingproject.org/doc/publications/inc_Affordable_Care_Act.pdf.

12. HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 1 (2003), *available at* http://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

13. Veysey, *supra* note 3, at 1.

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

15. ACA Exchange Eligibility Standards, 45 C.F.R. § 155.305 (2012). This issue is discussed in more detail *infra* Part III(A).

16. 42 U.S.C. § 17901 (2012) (relating to implementation of new health information technology systems); 42 U.S.C. § 300gg-14 (2012) (extension of dependent coverage).

There are, however, two populations connected to correctional services that stand to gain—potentially dramatically—from the passage and implementation of the ACA: former offenders and the communities they return to upon release from jail or prison. The ACA could be revelatory for the former group, in part because the law provides states with the option to expand Medicaid eligibility to single adults at or below 133% of the federal poverty level (FPL),[17] regardless of disability status—a population group that is remarkably reflective of the incarcerated population[18] and one that long has struggled to gain access to any insurance coverage and, as a result, to health care services.[19] The Medicaid expansion could be particularly meaningful to ex-offenders who seek treatment for drug addictions, a common cause of illness, recidivism, and mortality within this population.[20] Beyond the Medicaid expansion, the ACA's inclusion of new funding for mental health care home visits, its expanded reliance on the use of medical homes, and its incentives to increase the use of electronic medical records should all help to improve the

17. *See* 42 U.S.C. § 1396a (2012). The ACA's statutory text indeed limits the expansion to 133% of FPL, but the law also developed a new methodology for calculating an income, which will in practice set the new effective minimum threshold at 138% of FPL. Pre-ACA, the methodology for determining whether an individual meets the eligibility threshold varied by state, and involved complicated calculations of income, assets, and "disregards" (i.e., the disregarding of some income and/or assets for the purpose of determining eligibility). Under the ACA, however, the approach is simplified and made universal across states, with a single standard disregard for most populations: a flat 5%. As a result, an individual applying for Medicaid benefits may have income up to 138% of FPL, but because of the standard 5% disregard, he will effectively meet the 133% threshold designated in the statute. *See Medicaid Expansion*, AM. PUB. HEALTH ASS'N, http://www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm#Medi5 (last visited May 29, 2013). .

18. *See* Marsha Regenstein & Jade Christie-Maples, Medicaid Coverage for Individuals in Jail Pending Disposition: Opportunities for Improved Health and Health Care at Lower Costs 15 (Nov. 2012) (unpublished manuscript), *available at* http://sphhs.gwu.edu/departments/healthpolicy/publications/DHP%20Report%20Regenstein%2010%20reasons%20November%206.pdf ("The ACA's Medicaid expansion provision offers an unprecedented opportunity to extend health insurance coverage to very low-income adults, many of whom have significant medical and behavioral health issues that make them particularly susceptible to criminal justice involvement.").

19. ACA "[c]overage reforms, the most important of which take effect January 1, 2014, intend to eliminate Medicaid's historic exclusion of low-income adults who are neither pregnant, disabled, nor extremely poor parents of minor children." Sara Rosenbaum, Joel Teitelbaum & Katherine Hayes, *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 527, 528 (2011).

20. Veysey, *supra* note 3, at 10. This topic is discussed in more detail *infra* Part III.C.

health of individuals leaving jails and prisons and returning to community living.

Similarly, by virtue of the fact that ex-offenders themselves stand to gain access to health coverage and expanded medical benefits, the communities to which ex-offenders return should also benefit from the ACA. Upon release, former inmates continue to experience high morbidity and mortality rates from infectious disease, drug overdoses, cardiovascular and other chronic disease, and violence. It is no surprise that ex-offenders can infect family members, friends, and strangers with diseases contracted and/or not treated in correctional settings, and family members, neighborhoods, and cities suffer as a result of the violence that often arises in connection with substance abuse.

This Article describes the ways in which passage of the Affordable Care Act may enhance treatment options for and improve the health of incarcerated individuals pending disposition,[21] individuals recently released from incarceration, and the communities into which recently released individuals return upon completion of their sentences. Part I describes prisoners' constitutional right to adequate health care. Part II provides an overview of the health status of incarcerated populations[22] and of individuals recently released from imprisonment,

21. Approximately two-thirds of the jail population are held "pending disposition," meaning that individuals are being detained prior to trial but have not been convicted of a crime. Regenstein & Christie-Maples, *supra* note 18, at 2. For most of these individuals, confinement is less about their threat to the public and more a function of their inability to post bail. *Id.*

22. For purposes of this Article, we generally do not distinguish between jail and prison. Also, unless otherwise noted, when we use terms such as "prison population," "inmates," "incarcerated individuals," or the like, we are referring to both detainees and inmates. Nonetheless, certain distinguishing facts are worth mentioning. A jail is where persons who are lawfully detained—most often, those awaiting trial—are confined, whereas prison is a place where convicted persons are confined. *See generally* Daron Hall, *Jails vs. Prisons*, AM. CORRECTIONAL ASS'N, http://www.aca.org/fileupload/177/prasannak/1_1_1_Commentary_web.pdf (last visited May 29, 2013). As a result, jails have a more transient population than prisons, a critical factor to consider when determining health care needs and reentry strategies. *Id.* Further, because jails are essentially the entry point into the correctional system, the transition from street to jail is often more challenging compared to the transition from jail to prison:

> Immediately upon reception of an inmate, jail staff must gather information concerning an arrestee's physical health, mental health, criminal history, previous institutional history and potential incompatibles (inmates who cannot be housed together, e.g., rival gang members, codefendants, etc.). Additionally, jail intake staff deal with many unknown variables such as possible drug ingestion prior to entering jail, high risk of suicide and mental instability, as well as exposure to diseases such as tuberculosis . . . [T]he

and also discusses the public health implications of low-quality correctional health care. In Part III, we describe the ways in which the ACA may improve the health of ex-offenders and their communities. We conclude with descriptions of some state and private innovations in correctional health care that are occurring alongside the implementation of the ACA and with concluding thoughts about the ACA.

I. PRISONERS' RIGHT TO HEALTH CARE

As persons under government control, prisoners are almost entirely unique in their ownership of a constitutional right to a minimal level of health care.[23] The right, however, is amorphous and difficult to enforce: correctional facilities struggle to understand their health care responsibilities,[24] resources directed at meeting the right vary dramatically,[25] health care quality standards designed to be used in the correctional context have not been systematically tested[26] (and where tested, there is little evidence showing that an institution's adoption of quality standards does anything to improve the well-being of inmates)[27], and in response to a rise in prisoner litigation, Congress enacted the Prison Litigation Reform Act ("PLRA")[28] in 1996 to make it harder for prisoners to file federal lawsuits aimed at remedying what they believe to be substandard health care and

> person is generally stable when entering a prison and the intake process can take several weeks.

Id.

23. *See* KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., R40846, HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 6 (2012), *available at* http://www.fas.org/sgp/crs/misc/R40846.pdf.

24. Feldesman Tucker Leifer Fidell LLP, *Contracting for Health Care Services in Local Jails and Juvenile Detention Facilities: Achieving a Community-Based Standard of Care*, COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES (2010), http://www.cochs.org/files/dncochs_manual_2010.pdf.

25. HUMAN RIGHTS WATCH, *supra* note 12.

26. *See* Marc F. Stern, Robert B. Greifinger & Jeff Mellow, *Patient Safety: Moving the Bar in Prison Health Care Standards*, 100 AM. J. PUB. HEALTH 2103, 2103 (2010). Three organizations are viewed as leaders in correctional health care standard-setting: the American Public Health Association, the National Commission on Correctional Health Care, and the American Correctional Association. *Id.*

27. *Id.* ("Does an institution's adoption of any of the existing sets of standards, by itself, ensure that its patients will be safe? We were unable to find high-quality evidence to answer this question. However, in our anecdotal experience, lapses in quality of care occur at accredited institutions—albeit less commonly than at nonaccredited institutions.").

28. Pub. L. No. 104-134, 110 Stat. 1321 (1996) (codified as amended at 42 U.S.C. § 1997e (1994 ed. & Supp. II)).

unhealthy living conditions.[29] These challenges, in our view, help to explain the poor health of prisoners and recently released former offenders, discussed *infra*. We describe in this section the evolution and scope of prisoners' right to health care in order to juxtapose it and its effectuation against the general health of the incarcerated population and that of ex-offenders who have regained their freedom.

Historically, jails and prisons were built to incarcerate and rehabilitate the poor.[30] Then, in response to nineteenth century reformist theories of punishment, the number of jails and prisons dramatically increased.[31] Idealism regarding the benevolence of prison rehabilitation, however, quickly clashed with the realities of prison life: buildings crumbled, inmates and their jailors fought, and the public became disenchanted with the idea that jails and prisons could be centers of reform.[32] As time went on and the number of incarcerated individuals grew, conditions continually worsened to the point where, in the 1970s, federal courts were forced to examine legal standards for prison conditions, including standards related to health and health care.[33] In so doing, they began to create a legal framework of care to ensure that inmates would receive a "civilized level of medical attention" while not drowning the courts in malpractice actions and administrative responsibilities.[34]

By 1976, the issue of prison health care had reached the United States Supreme Court. In *Estelle v. Gamble*, the Court first established an individual's constitutional right to receive medical care while incarcerated.[35] Plaintiff J.W. Gamble, an inmate of the Texas Department of Corrections, was injured while performing a prison

29. Woodford v. Ngo, 548 U.S. 81, 84 (2006). Several aspects of the PLRA restrict prisoners' ability to file federal lawsuits: the requirement that a prisoner exhaust all administrative remedies before seeking a remedy in court, *see* 42 U.S.C § 1997e(a), unless, for example, prison administrators fail to respond within the administrative system's established time limits, *see, e.g.*, Miller v. Norris, 247 F.3d 736, 740 (8th Cir. 2001); Powe v. Ennis, 177 F.3d 393, 394 (5th Cir. 1999), or a prisoner is at risk for suffering irreparable injury, *see* Jackson v. District of Columbia, 254 F.3d 262, 268 (D.C. Cir. 2001); a prohibition against suits solely for mental or emotional injury in suits seeking monetary damages, since any claim for monetary compensation based on mental or emotional injury must also show a physical injury, 42 U.S.C § 1997e(e); and the requirement that prisoners pay filing fees for all actions.

30. Douglas Shenson, Nancy Dubler & David Michaels, *Jails and Prisons: The New Asylums?*, 80 AM. J. PUB. HEALTH 655, 655 (1990).

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

work assignment.[36] As a result of his injury, medical personnel saw Gamble on seventeen occasions over a three-month period.[37] Health care providers at the correctional facility where Gamble was incarcerated treated his back injury, high blood pressure, and heart problems, although not to Gamble's satisfaction.[38] In February 1974, Gamble instituted a civil rights action under 42 U.S.C. § 1983,[39] claiming that as the result of inadequate treatment and the lack of a proper diagnosis,[40] he was subjected to cruel and unusual punishment in violation of the U.S. Constitution's Eighth Amendment.[41] Noting that an inmate has no other option than to rely on prison authorities to treat his medical needs, the Court held that the government must provide medical care to those it incarcerates, marking the first time that the Court recognized a constitutional right to health care for any group of Americans.[42]

In its ruling, the Court made clear that its conclusion did not mean that every claim by a prisoner that he or she has not received adequate medical treatment constitutes a violation of the Eighth Amendment. For example, the Court noted that in a medical context, an inadvertent failure to provide adequate medical care is not an unconstitutional "infliction of pain".[43] Medical malpractice does not, in other words, morph into a constitutional violation merely because the patient who suffered the malpractice is a prisoner. In order to state a viable Eighth Amendment claim, according to the Court, a prisoner must allege "acts or omissions sufficiently harmful to demonstrate deliberate indifference to serious medical needs."[44] In sum, the *Estelle* Court stated that although a § 1983 cause of action

36. *Id.* at 98.

37. *Id.* at 99–101.

38. *Id.*

39. Section 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

42 U.S.C. § 1983 (2012).

40. Estelle v. Gamble, 429 U.S. 97, 107 (1976).

41. U.S. CONST. amend. VIII.

42. *Estelle*, 429 U.S. at 103.

43. *Id.* at 105; *see also* Gregg v. Georgia, 428 U.S. 153, 173 (1976).

44. *Estelle*, 429 U.S.at 104.

may exist in the case of "deliberate indifference to serious illness or injury," the Eighth Amendment is not necessarily implicated simply because an incarcerated individual has received inadequate medical care.[45] Subsequent court opinions have refined and explored the nuances of this standard.[46]

At the same time, subsequent decisions have extended the rationale in *Estelle*. For example, the U.S. Court of Appeals for the Fourth Circuit found "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."[47] Fleshing out this ruling, the court wrote that prison inmates are entitled to psychological or psychiatric treatment

45. *Id.* at 105.

46. For example, in the case of *Wilson v. Seiter*, 501 U.S. 294 (1991), the Supreme Court considered whether a culpable state of mind on the part of prison officials is a requisite element of a claim for cruel and unusual punishment and, if so, what state of mind is required. The petitioner had alleged ongoing deprivations in his correctional setting, including overcrowding, unsanitary dining facilities, and unclean restrooms. According to the *Seiter* Court, *Gamble* and its progeny established a two-part inquiry regarding cruel and unusual punishment claims: the first part is an objective inquiry as to whether the deprivation at issue was sufficiently serious, and the second component is a subjective inquiry as to whether the prison officials' actions amounted to an "unnecessary and *wanton* infliction of pain." *Seiter*, 501 U.S. at 298 (quoting *Estelle*, 429 U.S. at 104). Based on this standard of "wanton infliction of pain," the Court concluded that cruel and unusual punishment claims do require inquiry into the prison officials' state of mind. The Court next considered what precise state of mind applies in claims involving prison conditions. The Court cited precedent in explaining that while the offending conduct must be *wanton*, wantonness does not have a fixed meaning, but instead must be determined with "due regard for differences in the kind of conduct against which an Eighth Amendment objection is lodged." *Id.* at 302 (quoting Whitley v. Albers, 475 U.S. 312, 320 (1986)). The Court compared the ongoing denial of medical care with prison guards taking acute remedial action in response to a prison disturbance to illustrate the dynamic nature of the wantonness standard. *Id.* The former requires a minimum of "deliberate indifference," *id.* (citing *Estelle*, 429 U.S. at 106), while the latter requires the mental state to rise to the level of "maliciously and sadistically for the very purpose of causing harm," *id.* (citing *Whitley*, 475 U.S. at 320–21). In extrapolating this metric to prison condition cases, the Court rejected prison officials' argument that wantonness is determined by the effect of the action on the prisoner and held instead that wantonness depends on the constraints facing the official. *Id.* The Court concludes by indicating that some prison conditions that would otherwise not violate the Eighth Amendment might rise to the level of a violation when considered in combination with other conditions. *Id.* at 304. For this to be the case, a claim concerning "overall conditions" will not suffice to show an Eighth Amendment violation, but rather the conditions must interact with each other to produce an identifiable deprivation of a singular human need. *Id.*

47. Bowring v Godwin, 551 F.2d 44, 47 (4th Cir. 1977); *see also* Newman v. Alabama, 503 F.2d 1320 (5th Cir. 1974).

> if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.[48]

The Fourth Circuit noted, however, that the right to treatment is "limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable."[49]

Furthermore, a correctional facility's obligation to provide medical care to incarcerated individuals does not necessarily end when inmates are released.[50] In the case of *Wakefield v. Thompson*, the U.S. Court of Appeals for the Ninth Circuit held that an inmate's constitutional rights were violated when a correctional officer refused to provide the inmate with a two-week prescription of psychotropic medication upon his release from prison, even though the medical staff had ordered continued treatment to control the inmate's delusions.[51] The court further stated that "the state has a responsibility under the Eighth Amendment to provide outgoing prisoners being treated for a medical condition with a sufficient supply of medication to cover their transition to the outside world."[52] Recognizing the need for continuity of care in the context of juveniles, California passed legislation to allow juveniles to remain eligible for the state's Medicaid program, Medi-Cal, after their release from a juvenile detention facility.[53]

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48. *Godwin*, 551 F.2d at 47.

49. *Id.* at 48.

50. *See* Feldesman Tucker Leifer Fidell LLP, *supra* note 24, at 3.

51. Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999).

52. *Id.* Also noteworthy in this context are ethical rationales for post-release care. Feldesman Tucker Leifer Fidell LLP, *supra* note 24, at 3. The American Medical Association's Code of Ethics not only states that patients have the right to continuity of health care, but also that physicians "may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care." *Code of Ethics, Opinion 10.01—Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page (last visited Mar. 8, 2013).

53. CAL. WELF. & INST. CODE § 14011.10 (West 2012). Legislation like California's is not only ethically and medically appropriate, but also efficient: less administrative time is spent by both the state and released youths on Medi-Cal

With this background, the Article now turns to the health status of inmates and former prisoners. The picture that emerges is one of an incarcerated population that is in dire need of consistent, comprehensive, organized, quality medical care.

II. HEALTH STATUS OF INMATES AND FORMER PRISONERS

At the end of 2011, 6.98 million individuals were under the supervision of the adult correctional systems.[54] Put another way, approximately one out of every thirty-four adult residents of the United States lived under the authority of probation officers, parole agencies, state and federal prisons, or local jails.[55] Of those, nearly 1.6 million people were incarcerated.[56]

Generally speaking, inmates and detainees share certain characteristics. They are less well-educated and "disproportionately young, male, persons of color and poor."[57] They often lack the skills needed for employment and tend to struggle with alcohol or substance abuse.[58] Prisoners also have high rates of injuries, chronic conditions, infectious disease, and mental health conditions.[59] Irrespective of gender or race, prisoners are sicker than the general population, both when they become incarcerated and when they are released.[60] On average, prisoners are four to ten times more likely than the general population to suffer from infectious disease, and their rates of chronic disease are even higher when compared to the non-incarcerated population.[61] We describe below specific data concerning prisoner rates of chronic disease, infectious disease, substance use disorders, and mental health conditions, and touch briefly on what these rates of illness mean for the public's health as prisoners transition to ex-offenders.

reapplication processes after release. Feldesman Tucker Leifer Fidell LLP, *supra* note 24, at 3.

54. LAUREN E. GLAZE & ERIKA PARKS, BUREAU OF JUSTICE STATISTICS, NCJ 239972, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2011 (2012), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/cpus11.pdf.

55. *Id.*

56. *Id.*

57. Veysey, *supra* note 3, at 1; see also Jacobi, *supra* note 9, at 450.

58. Golembeski & Fullilove, *supra* note 10, at 1701.

59. Veysey, *supra* note 3, at 1.

60. Jacobi, *supra* note 9, at 450.

61. Golembeski & Fullilove, *supra* note 10, at 1701.

Chronic Disease

Between 39% and 44% of prisoners have some type of chronic condition.[62] The National Commission on Correctional Health Care reports that approximately 18% of inmates have hepatitis C, and slightly over 7% have tuberculosis—rates far higher than found in the U.S. population as a whole.[63] Also common among inmates are asthma (8.5%), diabetes (4.8%), and hypertension (18.3%), though of the three conditions, only asthma is elevated relative to the general U.S. population.[64]

Infectious Disease

One of the most common risk factors for blood-borne viruses such as HIV and hepatitis C is injection drug use.[65] Injection drug use also happens to be the most common offense for which people are arrested in the United States.[66] As a result, those entering the corrective system have a higher rate of HIV, hepatitis C, and other communicable diseases as compared to the general population.[67] Many prisoners have higher rates of gonorrhea, syphilis, and chlamydia, as well.[68] The prevalence of HIV in incarcerated women is higher than in the general population and is higher than incarcerated males; 2.1% of female inmates in state prisons are HIV positive, as opposed to 1.5% of male inmates.[69]

Substance Use Disorders

Research has found that the rate of substance use disorders is seven times higher among jail inmates than in the general

62. Jason Schnittker, Michael Massoglia, & Christopher Uggen, *Incarceration and the Health of the African American Community*, 8 DU BOIS REV. 1 (2011), *available at* http://www.soc.umn.edu/~uggen/Schnittker_Massoglia_Uggen_DR_11.pdf.

63. NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS 18 (2002), *available at* https://www.ncjrs.gov/pdffiles1/nij/grants/189735.pdf.

64. *Id.* at 21.

65. Sandra A. Springer, *Improving Healthcare for Incarcerated Women*, 19 J. WOMEN'S HEALTH 13–15 (2010).

66. *Id.* at 14

67. *Id.*

68. Jacobi, *supra* note 9, at 451.

69. LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, NCJ 228307, HIV IN PRISONS, 2007–08, at 2 (2009), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf.

population.[70] For example, a U.S. Department of Justice study found that "53 percent of state and 45 percent of federal male prisoners meet the DSM-IV criteria for drug dependence or abuse."[71] Similarly, the Bureau of Justice Statistics found that 60% of women in state prison and 43% of women of federal prison are estimated to have drug problems.[72]

Mental Health Conditions[73]

Up to 25% of incarcerated individuals have been given a psychiatric diagnosis of one kind or another.[74] One recent study of more than 20,000 adults entering five local jails found that 16.9% of them had a serious mental illness,[75] and additional studies suggest similar rates of severe mental illness in prisons.[76] Although rates of depression are lower among federal prisoners than in the general population, rates of schizophrenia, dysthymia, and bipolar disorder are higher.[77] Overall, incarcerated women have a much higher rate of mental illness (31%) than incarcerated men (14.5%),[78] and the rates

70. Aileen B. Rothbard et al., *Effectiveness of a Jail-Based Treatment Program for Individuals with Co-Occurring Disorders,* 27 BEHAV. SCI. & L. 643–44 (2009).

71. *Frequently Asked Questions: Health, Mental Health, and Substance Use Disorders*, NAT'L REENTRY RESOURCE CENTER, http://www.nationalreentryresourcecenter.org/faqs/health#note (last visited Mar. 8, 2013).

72. CHRISTOPHER MUMOLA & JENNIFER C. KARBERG, BUREAU OF JUSTICE STATISTICS, NCJ 213530, DRUG USE AND DEPENDENCE, STATE AND FEDERAL PRISONERS, 2004, at 7 (2006), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/dudsfp04.pdf.

73. Mental illness and substance abuse often go hand-in-hand. *See* Steven Belenko, *Implementing Effective Substance Abuse Treatment in the Criminal Justice System: The Public Safety and Public Health Benefits of Expanding Treatment Services*, NAT'L INST. ON DRUG ABUSE 10 (March 27, 2009), http://www.thefriendsofnida.org/briefing-2009-03.php (follow "Dr. Volkow's presentation" hyperlink) (30.6% of total inmate population has both drug problem and mental health disorder).

74. Schnittker et al., *supra* note 62, at 2.

75. *Frequently Asked Questions: Health, Mental Health, and Substance Use Disorders*, *supra* note 71 (citing Henry Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761 (2009)).

76. H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVS. 483 (1998), *available at* http://ps.psychiatryonline.org/article.aspx?articleID=81232.

77. Schnittker et al., *supra* note 62, at 2.

78. *Frequently Asked Questions: Health, Mental Health, and Substance Use Disorders*, *supra* note 71 (citing Steadman et al., *supra* note 75).

for women are "more than three to six times" those in the general population.[79]

Re-Entry Into the Community and the Public's Health

Given the statistics above, we touch on but do not belabor the point that the health of communities to which nearly 700,000 ex-offenders return each year[80] is negatively impacted by the generally poor health of inmates and the low quality of health care provided in the nation's jails and prisons. When prisoners' diseases go undetected or untreated, or when inmates are not educated about self-harming behaviors and taught behavior-changing strategies, ex-offenders have the potential to spread their untreated conditions back home, risking the health of their friends, families, and even strangers, should ex-offenders engage in violent crime.[81] Sadly, it is not uncommon for prisoners to encounter inadequate and inconsistent screening and treatment programs;[82] receive spotty notification from prison officials of their own infections and conditions;[83] transmit infectious diseases to one another due to overcrowding;[84] lack access to adequate transition programs as they reach the soon-to-be-released stage;[85] and lack, upon release, options for affordable and safe housing.[86] All of these failures affect reentered communities, and therefore the public

79. *Id.*

80. E. ANN CARSON & WILLIAM J. SABOL, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2011, at 1, 12 (2012), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/p11.pdf.

81. *See* Zulficar Gregory Restum, *Public Health Implications of Substandard Correctional Health Care*, 95 AM. J. PUB. HEALTH 1689, 1691 (2005). These concerns are not theoretical, for upon release inmates experience very high mortality rates from drug overdoses, cardiovascular disease, homicide, and suicide. Ingrid A. Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 161 (2007).

82. Restum, *supra* note 81, at 1690.

83. *Id.*

84. *Id.* at 1689–90.

85. *See* NANCY LA VIGNE ET AL., URBAN INST. JUSTICE POLICY CTR., RELEASE PLANNING FOR SUCCESSFUL REENTRY (2008), *available at* http://www.urban.org/UploadedPDF/411767_successful_reentry.pdf.

86. Little is known about quality and accessibility of housing for former prisoners, though it is clear not only that housing arrangements impact health, *see* Golembeski & Fullilove, *supra* note 10, at 1704, but also that homelessness is significant problem for both prisoners prior to their incarceration and for ex-offenders. *Id.* Indeed, the large scale deinstitutionalization of mentally ill people during the 1970s began an unfortunate trend, in which unstable individuals who were unsuccessful in finding neither necessary health care treatment nor affordable housing began being jailed on minor violations of the law. Shenson et al., *supra* note 30, at 655.

would not be asking too much if, as a matter of public health policy, it insisted on more and better health education, health promotion and disease prevention, health screening, quality treatment, and continuity of care in jails and prisons, and also accountability on the part of correctional agencies and officials who oversee the care of inmate populations.[87]

This Article is not the place to discuss at length the approaches best suited to correcting what ails correctional health care, focused as it is on the specific role the ACA may play in creating healthier environments for ex-offenders and their communities. It is worth noting, however, some recommendations which experts in the field believe would optimize jails and prisons as locations for personal and public health improvement, so that inmates can become better educated and healthier, which in turn would improve the health of those with whom they come in contact:

> 1) Link jails with diversion programs (for example, station health personnel at jail intake points to work with law enforcement officers and judges in cases where mental illness has played a role in the underlying criminal offense);[88]
>
> 2) Use early assessment techniques (e.g., examination of prisoners within twenty-four hours of arrival at a new facility);[89]
>
> 3) Prompt, effective treatment in jails and prisons performed to the standard of care expected of clinicians functioning outside the correctional context;[90]
>
> 4) Use infection control programs to trace infections and isolate suspected cases;[91]
>
> 5) Use comprehensive health education/literacy programs, presented in culturally competent ways;[92]
>
> 6) Use expanded prevention measures (e.g., confidential HIV testing for inmates and facility staff[93] and regular tuberculin skin testing for inmates and staff;[94]

87. *See* Golembeski & Fullilove, *supra* note 10, at 1702, 1705; *see also* Jacobi, *supra* note 9, at 467 ("The concern for prisoner reentry is increasingly wide-spread; it is not an ideological movement, but rather a practical one engaging organizations broadly representative of public and private interests.").

88. Shenson et al., *supra* note 30, at 656.

89. Jordan B. Glaser & Robert B. Greifinger, *Correctional Healthcare: A Public Health Opportunity*, 118 ANNALS INTERNAL MED. 139, 142 (1993).

90. Veysey, *supra* note 3, at 2.

91. Glaser & Greifinger, *supra* note 89, at 144.

92. Veysey, *supra* note 3, at 2.

7) Link correctional institutions with community mental health and substance abuse treatment programs for purposes of reentry;[95] and

8) To the extent possible, continue care as ex-offenders return to the community.[96]

III. THE AFFORDABLE CARE ACT AND THE HEALTH OF EX-OFFENDERS AND THEIR COMMUNITIES

A. Overview of the Affordable Care Act

A full exploration of the breadth of the ACA is well beyond the scope of this Article. A brief overview, however, will help inform the discussions below. The ACA is an enormously complex law that represents the most dramatic federal health policymaking since the establishment of Medicare and Medicaid in the mid-1960s. As transformational laws often do, the ACA fundamentally realigns several relationships among the various stakeholders in the health care system in order to, above all else, make health insurance newly available to millions of Americans.[97] Indeed, all players in the nation's health care system—patients, providers, insurers, employers, and governments—are forced under the ACA to alter long-standing behaviors and practices in response to the legal and policy reforms engineered by the law. In brief, this social reordering is represented by four seminal policy decisions.[98]

The first major shift is the ACA's requirement that all individuals obtain "minimum essential coverage"[99]—whether through an

93. Glaser & Greifinger, *supra* note 89, at 143.

94. *See id.* at 143.

95. Shenson et al., *supra* note 30, at 656.

96. See, e.g., the discussion of the District of Columbia's program between its Department of Correction and Unity Health Care, *infra* Conclusion.

97. At the same time, the ACA is about much more than just insurance reform—health care quality, the health workforce, public health practice, health disparities, community health centers, health care fraud and abuse, health information technology, long-term care, and many other key elements of the health system all received attention under the ACA. There is no doubt, however, that at least in the mind of the public, the insurance coverage and insurance market reforms have served as a proxy for discussing the law, in large part due to the specific legal issues that percolated up to the U.S. Supreme Court over many months in the lead up to the Court's 2012 decision in *NFIB v. Sebelius*, discussed *infra*.

98. For a detailed discussion of these changes, see Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL LAW 1 (2011).

99. Under the Act, those required to maintain minimum essential coverage "shall not include an individual for any month if for the month the individual is

employer-sponsored health plan, an individual health plan, a government program such as Medicaid, Medicare, or veterans' program, or other government-approved coverage—or face financial penalties (in the form of a tax) set out in the law.[100] This provision, commonly known as the "individual mandate," is critical to the fabric of the ACA: on one hand, policymakers assumed that the penalty would be enough to drive individuals who otherwise might go without coverage (e.g., the young, the healthy) to purchase coverage, thereby creating a large new pool of people paying insurance premiums; on the other hand, insurers would not have been likely to swallow other market reforms demanded by the ACA that force them to insure less healthy populations without the influx of new, relatively healthy insured individuals.[101]

The second key change is represented by reforms that force insurers to alter normative practices. New rules concerning the use of preexisting condition exclusions, enrollment decisions based on health status, the renewability of existing insurance policies, and mandated benefits are all included in the ACA. For example, the statute prevents insurers and group health plans from denying coverage to all individuals based on age, illness, or disability.[102] The ACA further prohibits post-enrollment insurance cancellations

incarcerated, other than incarceration pending the disposition of charges." 26 U.S.C. § 5000A (2012).

100. 26 U.S.C. § 5000A (added by ACA § 1501). The ACA provides subsidies to individuals who are unable to purchase on their own the minimum coverage required by the ACA and who cannot otherwise comply with the mandate (for example, by qualifying for Medicaid or gaining coverage through an employer), 26 U.S.C. § 36B (added by ACA § 1401), and it exempts from the mandate individuals whose income fall below the tax filing threshold of $9,350. One study estimates that 34.0–39.7% of released inmates would fall into the exempted group but would nonetheless be eligible for Medicaid (assuming they satisfied residency requirements). *See* Alison Evans Cuellar & Jehanzeb Cheema, *As Roughly 700,000 Prisoners Are Released Annually, About Half Will Gain Health Coverage and Care Under Federal Laws*, 31 HEALTH AFFAIRS 931, 935 tbl.1 (2012). The same study estimates that up to 23.5% of prisoners released annually could be eligible for federal tax subsidies. *Id.* Separate estimates indicate that approximately 90% of jail inmates and 85% of individuals incarcerated in state and federal prisons lack health insurance. *See* Katti Gray, *The Prison Health Care Dilemma*, CRIME REPORT (Aug. 2, 2012), http://www.thecrimereport.org/news/inside-criminal-justice/2012-08-the-prison-health-care-dilemma; *see also* Emily Wang et al., *Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail*, 98 AM. J. PUB. HEALTH 2182, 2182–84 (2008).

101. Rosenbaum et al., *supra* note 19, at 550.

102. *Id.* at 552.

(except in the case of fraud or misrepresentation on the part of the insured individual),[103] and guarantees insurance policy renewals.[104]

Third, the ACA created regulated health insurance "marketplaces"[105] to assist individuals and small groups to search for and compare competing health plans.[106] Those eligible to shop on the exchanges include citizens and persons legally present in the United States without access to affordable coverage at a level demanded by the ACA's insurance mandate, and small employers.[107] To help subsidize the exchanges, large employers who do not offer coverage or do not offer sufficiently affordable coverage must pay a fee to the exchanges.[108] In the event that individual states elect not to operate their own exchanges, the ACA authorizes the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an exchange in those states.[109]

Finally, the ACA expanded eligibility for coverage under the Medicaid program for all U.S. citizens and legal immigrants between the ages of nineteen and sixty-four with incomes below 138% of the federal poverty level (133% plus 5% that the Affordable Care Act

103. 42 U.S.C. § 300gg-12 (2012).

104. *Id.* § 300gg-2.

105. "Marketplaces" is the term now used by the Obama Administration to describe the health insurance "exchanges," as they were originally called, established under the Affordable Care Act. *See With New ACA Marketing Push, 'Exchanges' Become 'Marketplaces'*, ADVISORY BOARD COMPANY (Jan. 17, 2013), http://www.advisory.com/Daily-Briefing/2013/01/17/With-new-ACA-marketing-push-exchanges-become-marketplaces.

106. For a general overview of the ACA insurance marketplaces, see JOEL B. TEITELBAUM & SARA E. WILENSKY, ESSENTIALS OF HEALTH POLICY AND LAW 171–72 (2013). For an overview of a project sponsored by the Robert Wood Johnson Foundation and housed at the Hirsh Health Law and Policy Program at the George Washington University that tracks and analyzes implementation of the Affordable Care Act, see HEALTHREFORMGPS, http://www.healthreformgps.org (last visited Feb. 11, 2013).

107. Small employers are defined as those with 100 or fewer employees. Beginning January 1, 2016, states have the option of lowering the threshold for employers that may purchase through an exchange from those with fifty or fewer employees. 42 U.S.C. § 1304(b)(3). In addition, beginning in 2017, states may permit large employers to purchase coverage through an exchange. *Id.* § 1312(f)(2)(B)(i).

108. *Id.* § 1513.

109. *Id.* § 18041(c). At the time of this writing, seventeen states and the District of Columbia have elected to operate their own exchange, seven have elected to work in tandem with HHS to operate exchanges, and twenty-six have opted to let the federal government design and run their exchange. *See State Decisions for Creating Health Insurance Exchanges*, STATEHEALTHFACTS.ORG, http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17 (last visited Feb. 28, 2013).

requires that states disregard when they calculate eligibility).[110] This reform is discussed in more detail in the following section and in Parts IV(c) and (d), *infra*.

These major policy shifts were not made in an environment of bipartisanship and national commitment -- quite the contrary. The ACA was voted into law along strict party lines and by the slimmest of margins, with passage in doubt until the very end.[111] Once passed, the law was challenged immediately, as members of nearly forty state legislatures proposed legislation for constitutional amendments limiting or opposing certain provisions of the law (most of which targeted the individual requirement to purchase insurance), individuals and advocacy groups lodged dozens of separate claims with the courts, and half of the states collaborated on a lawsuit challenging the constitutionality of the ACA. As the lawsuits percolated up through state and federal courts, it was only a matter of time before the Supreme Court was faced with the prospect of determining the reach—and the lifespan—of the Affordable Care Act.

B. The U.S. Supreme Court Decision in the Case of *National Federation of Independent Business v. Sebelius*

In November 2011, the U.S. Supreme Court granted *certiorari* on four issues related to the ACA: (1) whether the ACA's individual insurance coverage mandate should be considered a tax for purposes of the federal Anti-Injunction Act; (2) whether Congress had the power under Article I of the Constitution to enact the insurance coverage requirement; (3) whether, if the Court determined that the individual coverage mandate was unconstitutional, it was severable from the remainder of the ACA; and (4) whether it was

110. 42 U.S.C. §1396a(a)(10) (as amended by ACA § 2001). This reform is, by any definition, monumental. Medicaid was originally designed as a program to finance health care services for four particular populations: the blind, the disabled, the elderly, and needy families with children. Further, in the years between Medicaid's inception in 1965 and passage of the ACA in 2010, a Medicaid expansion effectively amounted to increased coverage for one or more of the original population groups. The ACA, however, effectively authorizes Medicaid coverage for the entire age nineteen to sixty-four low-income population, regardless of one's categorical neediness.

111. For a description of how national health reform was enacted in 2010 not just in an environment of extreme partisanship, but also against a backdrop of a faltering economy and the recent passage of two huge federal spending bills, and for a description of the ACA vote breakdown itself, see TEITELBAUM & WILENSKY, *supra* note 106, at 165–69.

unconstitutionally coercive for Congress in the ACA to threaten states' extant Medicaid funding in the event that states did not implement the Medicaid expansion described *supra*.

The following June, the Court handed down a remarkable 5-4 decision[112] in the case of *National Federation of Independent Business v. Sebelius*.[113] The opinion was surprising both because it defied expectation—few thought that the entirety of the ACA would survive the Court's constitutional scrutiny—and because Chief Justice Roberts sided with the Court's more liberal members (Justices Ginsburg, Breyer, Sotomayor, and Kagan) to fashion a response that effectively saved the ACA.[114]

The Supreme Court began its substantive analysis of the ACA by considering whether under the Commerce Clause, Congress exceeded its authority in passing the minimum coverage requirement. It concluded, not unexpectedly given recent Commerce Clause jurisprudence,[115] that the "individual mandate" amounted to an unconstitutional reach on the part of federal legislators:

> The individual mandate . . . does not regulate existing commercial activity. It instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely *because*

112. In addition to the majority opinion, Justice Ginsburg authored a concurrence; Justices Scalia, Kennedy, Alito, and Thomas wrote a jointly issued dissent; and Justice Thomas also penned a separate, short dissent. For summaries and analyses of the various opinions, see Taylor Burke et al., *Summary of the U.S. Supreme Court Decision in the Case of* National Federation of Independent Businesses et al. v. Secretary of Health and Human Services et al., HEALTHREFORMGPS (June 28, 2012), http://www.healthreformgps.org/resources/summary-of-the-u-s-supreme-court-decision-in-the-case-of-national-federation-of-independent-businesses-et-al-v-sebelius-secretary-of-health-and-human-services-et-al/.

113. 132 S. Ct. 2566 (2012).

114. For purposes of this Article, it is enough to say that the Court dispensed with the jurisdictional issue posed by the Anti-Injunction Act, and reached the merits of the insurance mandate and Medicaid issues. *Id.* at 2584 ("The Affordable Care Act does not require that the penalty for failing to comply with the individual mandate be treated as a tax for purposes of the Anti-Injunction Act[].") Further, because the Court determined that the individual coverage mandate was constitutional, there was no need for it to reach the question of severability.

115. *See* United States v. Morrison, 529 U.S. 598 (2000) (federal Violence Against Women Act of 1994 is unconstitutional violation of congressional Commerce Clause power); United States v. Lopez, 514 U.S. 549 (1995) (possession of a gun near school is not an economic activity that has a substantial effect on interstate commerce).

> they are doing nothing would open a new and potentially vast domain to congressional authority.[116]

Then, however, in a surprise ruling few predicted, the Court majority shifted its attention to Congress's power to tax in ruling that the individual insurance coverage requirement constituted an acceptable exercise of legislative power.[117] According to the Court:

> The exaction the Affordable Care Act imposes on those without health insurance [i.e., the financial penalty assessed on those who do not obtain minimum health insurance coverage] looks like a tax in many respects. . . . In distinguishing penalties from taxes, this Court has explained that "'if the concept of penalty means anything, it means punishment for an unlawful act or omission.'" While the individual mandate clearly aims to induce the purchase of health insurance, it need not be read to declare that failing to do so is unlawful. Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS.[118]

In not permitting the individual coverage requirement under the Commerce Clause but allowing it under congressional taxing powers, the Court effectively interpreted the requirement in a way that prevented Congress from *commanding* Americans to buy health insurance, but authorized Congress to *tax* those who elected not to do so.

After upholding the individual coverage requirement, the Court considered the second major constitutional question in *NFIB v. Sebelius*: whether the ACA's expansion of Medicaid to capture individuals with incomes below 133% of the federal poverty level amounted to unconstitutional coercion on the part of Congress.[119] According to the twenty-six states who initiated the litigation, the answer to this question was yes, because the ACA permitted, in the part of the statute announcing the expansion, the HHS Secretary to terminate *all* Medicaid funding to those states that did not implement the expansion.[120] According to the plaintiff-states, this amounted to a coercively unacceptable Hobson's choice: either they adopt the ACA

116. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2587.

117. Here the Chief Justice noted that the Court has the authority to uphold a statutory provision even where the congressional power underpinning the provision was not the one that Congress contemplated when it initially passed the law. *Id.* at 2593.

118. *Id.* at 2594–97.

119. *Id.* at 2601.

120. *Id.*

Medicaid expansion, or they potentially receive no federal Medicaid financing at all.[121]

The Court responded to the states' argument in two ways. First, it upheld the constitutionality of the Medicaid expansion itself, and states have spent the intervening months deciding whether to implement it.[122] The Court, however, did strike down the enforcement mechanism attached to the expansion, ruling that it was unconstitutional to penalize a non-conforming state with the termination of all its Medicaid funding:

> The Constitution simply does not give Congress the authority to require the States to regulate. That is true whether Congress directly commands a State to regulate or indirectly coerces a State to adopt a federal regulatory system as its own. When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes. Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.[123]

Underlying this decision was the majority's belief that unlike previous amendments to and expansions of the Medicaid program, the ACA expansion was unique in that it "accomplishes a shift in kind, not merely degree,"[124] and that "[a] state could hardly anticipate that Congress's reservation of the right to 'alter' or 'amend' the Medicaid program included the power to transform it so

121. *See id* (describing the argument that the government coerced states to adopt certain changes by threatening to withhold Medicaid grants).

122. As of the time of this writing, twenty-four states and the District of Columbia announced plans to implement the ACA Medicaid expansion, with four more leaning toward implementation; fourteen states announced that they do not plan to participate in the expansion, with two more leaning against it; and six states are undecided. *See Where Each State Stands on ACA's Medicaid Expansion*, ADVISORY BOARD COMPANY (Mar. 4, 2013), http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap. States that implement the expansion will be reimbursed 100% by the federal government, from 2014–2016, for expenditures related to covering costs for individuals included in the expansion. Thereafter, federal reimbursement rates will drop yearly before settling for good at 90% beginning in 2020. 42 U.S.C. § 1396d(y) (2012).

123. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2602–07.

124. *Id.* at 2605.

dramatically."[125] In the end, the two-pronged ruling—upholding the Medicaid expansion as a lawful use of congressional power but transforming it into a non-compulsory option for states—preserves the ability of states to insure some of their most vulnerable citizens while sparing them the potential loss of all federal Medicaid funding, the latter of which is the normative enforcement remedy in the event that a state fails to comply with mandatory program requirements.[126]

C. Effect of the ACA Medicaid Expansion on Inmates and Former Offenders

The fact that the ruling in *NFIB v. Sebelius* left the ACA, and the Medicaid expansion in particular, intact has potentially major implications for inmates and for former offenders returning to their communities. For example, it is estimated that up to six million of the ten million individuals who are jailed over the course of a year will gain Medicaid coverage as a result of the expansion passed as part of the ACA,[127] which should create a healthier jail-involved population overall (because relatively more individuals entering jail will have had access to care as a result of the Medicaid expansion) and should improve continuity of care for individuals who cycle in and out of the penal system.[128]

At the same time, because the Supreme Court determined that the Medicaid expansion cannot be enforced as a mandate, there is little doubt that it will not reach as many currently uninsured individuals as originally intended. Furthermore, there remains in place a federal Medicaid rule, which the ACA does not address, that prevents federal Medicaid funds from being used to pay for services for "individuals who are inmates in a public institution," even when inmates' Medicaid eligibility is otherwise not in question.[129] This rule, dubbed

125. *Id.* at 2606.

126. Rosenbaum, *supra* note 98.

127. Regenstein & Christie-Maples, *supra* note 18. The broad estimate represents the fact that until states make conclusive decisions about whether to implement the ACA's Medicaid expansion, more specific figures are elusive.

128. A study of mentally ill jail inmates in two counties (one in Washington State, the other in Florida) who entered jail with Medicaid coverage determined that, upon release, the coverage resulted in a 30–60% greater likelihood that the former inmates would be able to access community mental health services, compared to inmates released without Medicaid coverage. Morrissey et al., *The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness*, 58 PSYCHIATRIC SERVS. 794 (2007).

129. 42 U.S.C. § 1396d(a)(29)(A) (2012). An exception to this rule exists in the case of an inmate transferred to a hospital for acute health services; in this instance,

the "inmate exception," has two major implications, one for states and counties, the other for inmates otherwise eligible for program benefits. For states and counties, the rule means that they share the financial weight of their prisoners' mandatory right to health care, a burden that represents one of the fastest-growing aspects of their budgets.[130] For otherwise eligible prisoners, the inmate exception leads to unnecessary breaks in coverage and accessibility to care even upon release from incarceration. The latter problem results from the way in which many states interpret the inmate exception. Under federal Medicaid law, the only thing that is technically terminated pursuant to the exception is federal matching funds to cover health care costs,[131] and federal guidance specifically states that where an individual's coverage is not linked to Supplemental Security Income (SSI),[132] inmates' eligibility status need only be suspended.[133] Most states, however, interpret the law as terminating an inmate's eligibility for benefits under Medicaid,[134] meaning that a former inmate must reapply for Medicaid once released from prison, a process that in the best of circumstances can take weeks or months.

Putting aside the inmate exception, there are important and concrete examples of the way in which the ACA Medicaid expansion

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the hospital can claim federal reimbursement for the care of the prisoner. 42 C.F.R. § 435.1009(b) (2012).

130. PHILLIPS, *supra* note 11, at 3; *see also* Tom Puleo & Lisa Chedekel, *Dollars and Lives: The Cost of Prison Health Care*, NEW ENG. CTR. FOR INVESTIGATIVE REPORTING (Mar. 27, 2011), http://necir-bu.org/investigations/taxpayer-watchseries/dollars-and-lives-the-cost-of-prison-health-care-2/.

131. "The term 'medical assistance' means payment of part or all of the cost of the following care and services or the care and services themselves . . . except . . . such term does not include any such payments with respect to care or services for any individual who is an inmate of a public institution." 42 U.S.C. § 1396d(a)(29)(A).

132. "[T]he situation for inmates who qualify for Medicaid through their eligibility for SSI can be complicated. Everyone whose SSI eligibility is terminated will lose Medicaid. When SSI benefits are suspended due to incarceration, states have the option to—and generally do—terminate an inmate's Medicaid eligibility. When an inmate's Medicaid eligibility is not tied to SSI, the state has the flexibility under federal law to suspend the eligibility status during incarceration. But the federal Medicaid rules establish only minimum requirements, while states are permitted to impose more restrictive policies." *An Explanation of Federal Medicaid and Disability Program Rules*, COUNCIL ST. GOV'TS, http://consensusproject.org/the_report/appendix/federal-benefits (last visited Mar. 4, 2013).

133. *See id.*; Regenstein & Christie-Maples, *supra* note 18, at 3.

134. *See* ANITA CARDWELL & MAEGHAN GILMORE, NAT'L ASS'N OF CNTYS., COUNTY JAILS AND THE AFFORDABLE CARE ACT: ENROLLING ELIGIBLE INDIVIDUALS IN HEALTH COVERAGE (2012), *available at* http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf.

should improve the health of former inmates,[135] and critical issues that must be addressed by corrections policymakers and planners in anticipation of the expansion's implementation. For example, starting in 2014, mental health and substance use disorder services will be part of the "essential health benefits" package[136] that certain plans, including Medicaid plans, must cover.[137] Thus, all justice-involved individuals who become eligible for Medicaid will have a baseline level of coverage for mental health and chemical dependency issues both pre- and post-incarceration, which may reduce recidivism levels.[138]

In addition to the financial resources created by enhanced Medicaid coverage of costs for treatments paramount to many justice-involved individuals and their communities, ACA reforms pave the way for new and stronger partnerships among those institutions involved in correctional health and in community health. As these partnerships unfold in a post-ACA environment, state and county policymakers, corrections officials, and community health advocates and providers should begin to reimagine Medicaid enrollment processes, diversion programs, detainee health care, and post-release continuity of care for former offenders.[139] Among the issues and questions to consider are the following:

- Since the ACA requires states to undertake targeted outreach to vulnerable and underserved populations in order to make them aware of, and where appropriate facilitate their enrollment to, Medicaid,[140] in what ways should state Medicaid agencies collaborate with jails and prisons, since these institutions serve as points of contact for many individuals newly eligible for Medicaid?[141]

135. For example, in the Washington State and Florida study noted *supra* note 128, individuals released from jail with Medicaid coverage had notably fewer subsequent detentions. Morrissey et al., *supra* note 128.

136. 42 U.S.C. § 18022 (2012). This package will be discussed further *infra*, Part IV(E).

137. Letter from Cindy Mann, Director, Ctrs. for Medicare and Medicaid Services, to State Medicaid Director (Nov. 20, 2012), *available at* http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

138. Michael DuBose, *Medicaid Expansion and the Local Criminal Justice System*, AM. JAILS 8, 9 (2011).

139. *Id.* at 11.

140. 42 U.S.C. § 1396w-3(b)(1)(F).

141. CARDWELL & GILMORE, *supra* note 134, at 3. For example, corrections administrators could be given access to Medicaid enrollment and eligibility data systems. Cuellar & Cheema, *supra* note 100, at 937 (indeed, some states already

- How might effective diversion programs that address offenders' health needs best be designed and implemented? [142]
- How can corrections officials and care providers inform the development of Medicaid benefits aimed at addressing the needs of justice-involved populations?[143]
- What protocols are needed to improve the continuity of care for soon-to-be-released prisoners?[144]
- States should reconsider policies that terminate rather than suspend inmates' Medicaid eligibility.

D. Effect of the ACA on Individuals Incarcerated Pending Disposition of Charges

Although the ACA does not address the exception prohibiting federal Medicaid cost sharing for inmate health care, it does state that individuals who are incarcerated "pending the disposition of charges" are qualified to enroll in and receive services from health plans participating in the new insurance marketplaces.[145] The full meaning of this provision remains unknown. As of the time of this writing, HHS has not issued interpretive guidance pertaining to "incarceration pending the disposition of charges." Yet it seemingly creates an unjustifiable distinction between two different "pending the disposition of charges" populations. On one hand, there is the population pending disposition of charges that remains in a community setting. These are the approximately 50% of people who, after being detained in jail for twenty-four to seventy-two hours, are released back into the community either under their own recognizance or through a bail arrangement.[146] These individuals, assuming eligibility, have access to publicly subsidized insurance coverage—either through Medicaid (since they are not currently inmates of a public institution) or the ACA-inspired marketplaces.

utilize such a process in their juvenile justice systems), *see* SARABETH ZEMEL & NEVA KAYE, NAT'L ACAD. FOR STATE HEALTH POLICY, MEDICAID ELIGIBILITY, ENROLLMENT, AND RETENTION POLICIES: FINDINGS FROM A SURVEY OF JUVENILE JUSTICE AND MEDICAID POLICIES AFFECTING CHILDREN IN THE JUVENILE JUSTICE SYSTEM (2009), *available at* http://nashp.org/sites/default/files/MacFound11-09.pdf.

142. DuBose, *supra* note 138, at 10.

143. *Id.*

144. *Id.*

145. 42 U.S.C. § 18032(f)(1)(B) ("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.").

146. Regenstein & Christie-Maples, *supra* note 18, at 4.

On the other hand, there is the portion of the population that is incarcerated pending disposition of their charges who, if Medicaid-eligible (and thus not ACA marketplace-eligible), are nonetheless denied access to insurance coverage as a result of the "inmate exception." According to our colleagues Marsha Regenstein and Jade Christie-Maples, this distinction "is short sighted and inconsistent with other health reform provisions, which seek to aggressively reach out to the most vulnerable individuals and bring them into Medicaid and other health insurance plans."[147]

Indeed, providing coverage to this specific "pending disposition of charges" population would offer states and localities the opportunity to provide a comprehensive set of physical, mental, substance abuse, and support services to a relatively needy population prior to a longer spell of incarceration or to their return to the community (depending, of course, on the disposition of their charges). According to Regenstein and Christie-Maples, there are several specific reasons why covering inmates pending disposition through Medicaid makes good policy and public health sense:

1. Such a policy targets a group of poor adults with substantial physical, mental health, and substance abuse needs;[148]
2. It meets one of the main goals of the ACA, namely, to make health insurance available to as many individuals as possible;[149]
3. It advances equity;[150]
4. It increases coordination and continuity of care;[151]
5. It positions jails as points of enrollment for otherwise hard-to-reach populations;[152]
6. It has the potential to reduce health care, criminal justice, and other costs;[153]
7. It has the potential to improve the health of populations with relatively little effect on state budgets;[154]
8. It advances social stability;[155] and

147. *Id.* at 4–5.
148. *Id.* at 5–6.
149. *Id.* at 6–7.
150. *Id.* at 7–8.
151. *Id.* at 9.
152. *Id.* at 10.
153. *Id.* at 10–12.
154. *Id.* at 12.
155. *Id.* at 12–13.

9. It could improve the quality of care received by jail-involved populations.[156]

E. Additional ACA Provisions That May Positively Affect the Health of Ex-Offenders and Their Communities

Beyond the Medicaid expansion and insurance marketplaces, the ACA includes new benefits, models of care, and policies that should accrue to the benefit of former offenders and their communities. The first is a set of comprehensive health care services and items that must be covered by certain plans—those offered in the individual and small group markets (both inside and outside of the new ACA marketplaces), Medicaid, and others—known as "essential health benefits" (EHBs).[157] The ACA describes EHBs as consisting of 10 benefit classes: (A) ambulatory patient services; (B) emergency services; (C) hospitalization; (D) maternity and newborn care; (E) mental health and substance use disorder services, including behavioral health treatment; (F) prescription drugs; (G) rehabilitative and habilitative services and devices; (H) laboratory services; (I) preventive services and wellness services and chronic disease management; and (J) pediatric services, including oral and vision care.[158] As alluded to previously, the inclusion of substance use disorder services in the essential benefits package may represent "[t]he single largest and [most] predictable outcome that the ACA may have on corrections . . . . Early intervention, together with an array of treatment resources, including inpatient, residential, outpatient and medication-assisted support, means more people in the community in recovery with longer periods of abstinence."[159]

A second additional aspect of the ACA that should benefit some justice-involved individuals is a new requirement that private health insurance issuers that offer group or individual coverage, as well as group health plans that provide coverage to dependents, must provide coverage for dependent children (married or otherwise) who are under age twenty-six.[160] Although over time this requirement will no doubt be beneficial to detainees and inmates (who, recall, are

156. *Id.* at 13–14.
157. 42 U.S.C. § 18022 (2012).
158. *Id.*
159. Veysey, *supra* note 3, at 10.
160. 42 U.S.C. § 300gg-14.

disproportionately young) and to correctional facility budgets,[161] it does raise the question of how correctional facility administrators will communicate with private insurers so that the potential of this requirement can be maximized for all involved.

Also included in the Affordable Care Act are incentives and demonstration programs that promote new models of care delivery, including "health homes,"[162] an approach to health care that aims to be comprehensive, coordinated, efficient, and high-quality. This delivery model is particularly promoted for individuals with chronic conditions, and the ACA creates an optional Medicaid benefit for states that would like to test out health homes for populations with chronic conditions.[163] Because of their focus on patient-centeredness and chronic conditions, health homes have enormous potential for justice-involved populations. In order for them to take hold with former inmates and individuals whose socioeconomic predictors leave them at high risk for being jailed, medical homes will need to link with community mental health and substance abuse treatment providers and coordinate with corrections and probation officers.[164]

A final potentially important change for the health of the population that moves between freedom and incarceration is the requirement under the ACA for HHS to develop, for the first time, a comprehensive "national quality strategy" (NQS).[165] Specifically, the ACA requires the establishment of a national strategy "to improve the delivery of health care services, patient health outcomes, and population health"[166] and to establish priorities that, among other things, "have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness"[167] and reducing "health disparities across health disparity populations."[168] To carry out this mandate, HHS created the Interagency Working Group on

161. Some care provided to prisoners aged twenty-six and younger who remain on their parents' private insurance may be newly reimburseable. *Id.*

162. *Id.* § 300gg-2. They are also referred to by some as "patient-centered medical homes." *See, e.g.*, *Patient Centered Medical Home Resource Center*, AGENCY FOR HEALTHCARE RES. & QUALITY, http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483 (last visited May 29, 2013).

163. 42 U.S.C. § 300gg-2.

164. Cuellar & Cheema, *supra* note 100, at 936.

165. 42 U.S.C. § 280j. *See generally* Joel Teitelbaum, Lara Cartwright-Smith & Sara Rosenbaum, *Translating Rights into Access: Language Access and the Affordable Care Act*, 38 AM. J.L. & MED. 348, 369–71 (2012).

166. 42 U.S.C. § 280j(a)(1).

167. *Id.* § 280j(a)(2)(B)(i).

168. *Id.* § 280j(a)(2)(B)(vii).

Health Care Quality, of which the Federal Bureau of Prisons is a member.[169] Due to the disproportionately poor health of justice-involved populations, a national approach to health care quality aimed at increasing care coordination and reducing health disparities has the potential to greatly benefit former inmates and their communities.

CONCLUSION

In addition to changes being driven directly by the ACA, it is worth mentioning that states and private entities have stepped up their innovations in the context of correctional health care. As is true with any major public policy issue, states vary with regard to whether and how they choose to modernize their approach to correctional health care; key topics that emerge as frequent targets of innovation, however, include health literacy among incarcerated populations, transition services, electronic medical records, and medical-legal partnerships.

For example, in Minnesota, the Lino Lakes Correctional Facility sponsors annual health fairs as part of a campaign to teach healthy habits to inmates.[170] The fairs cover topics such as sexually transmitted diseases, the effects of substance abuse, the effects of being overweight, and more. One of the prisons on the facility compound is a minimum-security site that serves a transitional role for inmates who will soon gain freedom, and it was for this reason that the health fairs were started: to assist a typically unhealthy population in achieving better health upon release from prison and to indirectly improve the health of the communities into which these ex-offenders will move. Correction officials hope the health fairs will eventually migrate to other prisons in the Minnesota system.[171]

Since 2006, the District of Columbia has used a model of community-oriented health care inside D.C. Department of Corrections facilities.[172] The model, first designed in the early 1990s

169. U.S. DEP'T OF HEALTH AND HUMAN SERVS., 2012 ANNUAL PROGRESS REPORT TO CONGRESS, NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE 8 n.2 (2012), *available at* http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf.

170. Paul McEnroe, *Behind Bars, But Health Conscious*, STAR TRIBUNE, Oct. 3, 2012, http://www.startribune.com/local/172578871.html.

171. *Id.*

172. *See* Press Release, District of Columbia Department of Corrections, Department of Corrections' and Unity Health Care Achieve National Re-Accreditation for Inmate Health Services (Apr. 10, 2012), *available at*

in Massachusetts, relies on the use of community health centers not just for treating individuals who enter jail, but also continuously after their release.[173] In D.C., Unity Health Care[174]—the District's largest federally qualified health center—partners with the Department of Corrections to manage the health care of inmates across a continuum of primary care, specialty care, emergency care, and hospitalization.[175] Once released from custody, ex-offenders are encouraged to connect with a Unity community-based clinic to continue to receive services as needed.[176]

In New York City, where one-third of the city's jail population suffers from mental illness, Mayor Michael Bloomberg recently initiated a program to provide courts with real-time information about a particular defendant's record and mental health status in order to assist judges in determining whether to divert offenders to treatment centers, rather than order them to jail.[177] The program was established after the city commissioned a report on the mental health of its inmates which uncovered, among other things, that mentally ill offenders are far more expensive to incarcerate than inmates without mental health concerns; more likely than non-mentally disabled inmates to have longer stays in jail once incarcerated; and less likely than their healthy counterparts to make bail, primarily due to financial constraints.[178]

In Texas, the Department of Criminal Justice has reduced state spending by approximately one billion dollars over the past decade through use of an electronic medical records system that tracks medical, dental, mental health, and pharmacy services across state,

http://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DOC_DOC_Health_Services_Reacreditation.pdf.

173. *See History*, COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVS., http://www.cochs.org/about/history (last visited Feb. 28, 2013).

174. Ms. Hoffman, in her position at Feldesman Tucker Leifer Fidell LLP, serves as general counsel to and Interim Associate Compliance Officer of Unity Health Care.

175. *See* Press Release, D.C. Dep't of Corrections, Department of Corrections Institutes Community-Oriented Healthcare Services to Inmates (Oct. 2, 2006), *available at* http://doc.dc.gov/release/department-corrections-institutes-community-oriented-healthcare-inmates.

176. *Id.*

177. Editorial, *Treatment, Not Jail, for the Mentally Ill*, N.Y. TIMES, Jan. 31, 2013, http://www.nytimes.com/2013/02/01/opinion/treatment-not-jail-for-the-mentally-ill-in-new-york-city.html.

178. *Id.*

federal, and youth prisons and county jails.[179] Other states and localities, including Arizona, Georgia, Philadelphia, and Los Angeles County have begun using electronic medical records as well in an effort to reduce costs and improve health care quality.[180]

As a final non-ACA example of an innovation that benefits the health of both prisoners and former offenders, we mention the role of medical-legal partnership (MLP), a health care delivery model that directly integrates legal assistance into patient care.[181] The aim of MLP is to improve the health and well-being of vulnerable populations by addressing unmet legal needs and removing legal barriers that impede good health. In MLPs, legal aid lawyers, law school clinics, and private sector pro bono attorneys partner with physicians, nurses, case managers and others to provide direct legal assistance to patients and develop and align strategies to improve institutional practices. One example of the MLP model in the correctional context is represented by Prisoners' Legal Services (formerly Massachusetts Correctional Legal Services), which focuses on health and mental health care, guard-on-prisoner violence, physical conditions of confinement, and segregation and isolation.[182]

For ex-offenders and the communities to which they return after incarceration, the implications of the ACA have the potential to be profound. The most likely agents of change are the Medicaid expansion and new insurance marketplaces for individual purchasers, which together should greatly expand insurance coverage to populations that historically were viewed as "uninsurable" or "bad

179. *Texas Curbs Spending by $1B by Deploying EHRs, Telehealth in Prisons*, IHEALTHBEAT (Aug. 26, 2011), http://www.ihealthbeat.org/articles/2011/8/26/texas-curbs-spending-by-1b-by-deploying-ehrs-telehealth-in-prisons.aspx.

180. *See* Melissa M. Goldstein, Health Information Privacy in the Correctional Environment 1–2 (Apr. 2012) (unpublished manuscript), *available at* http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_C199DFF7-5056-9D20-3D2099CBB55AC369.pdf.

181. Professor Teitelbaum is co-Principal Investigator of the National Center for Medical-Legal Partnership (MLP) at the George Washington University School of Public Health and Health Services, Department of Health Policy. For more information about MLP, visit http://www.medical-legalpartnership.org/.

182. *See Prisoners' Legal Services (formerly Massachusetts Correctional Legal Services)*, MASSLEGAL SERVS., http://www.masslegalservices.org/programs/prisoners-legal-services-formerly-massachusetts-correctional-legal-services (last visited Feb. 1, 2013). Nationally, there are nearly one hundred medical-legal partnerships across more than 275 healthcare institutions. *See The Movement*, NAT'L CTR. FOR MED. LEGAL P'SHIP, http://www.medical-legalpartnership.org/movement (last visited Feb. 19, 2013).

risks" due primarily to indigency or preexisting illness.[183] Given the link between substance abuse, incarceration, and rearrest,[184] it may be that the longer reach of addiction treatment services into populations that historically were denied insurance coverage may be the most important aspect of the ACA for ex-offenders. The expansion of individual insurance coverage and the services and treatments that flow from it should, in turn, inure to the benefit of broader communities. Studies have shown that having health insurance after release from incarceration is associated with lower rates of rearrest and drug use (and the violence often associated with it),[185] and community rates of infectious diseases such as HIV, hepatitis and sexually transmitted diseases may decline as well.[186]

183. The Medicaid expansion may singlehandedly reduce both state incarceration rates (since the expanded treatment services should help individuals curb or eliminate substance-use disorders) and correctional health-related budgets (since reducing incarceration and recidivism rates should reduce inmate populations generally). *See* Phillips, *supra* note 11, at 3.

184. *See* Ojmarrh Mitchel, David B. Wilson & Doris L. MacKenzie, *Does Incarceration-Based Drug Treatment Reduce Recidivism? A Meta-Analytic Synthesis of the Research*, 3 J. EXPERIMENTAL CRIMINOLOGY 353 (2007).

185. *See, e.g.*, Marisa Elena Domino, Edward C. Norton, Joseph P. Morrisey & Neil Thakur, *Cost Shifting to Jails After a Change to Managed Mental Health Care,* 39 HEALTH SERVS. RES. 1379 (2004); *see also* Nicholas Freudenberg et al., *Coming Home from Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725 (2005).

186. Veysey, *supra* note 3, at 10. It is worth noting that jails in particular, given their local nature, are in a unique position to utilize a public health approach to correctional and post-correctional health care and to leverage the assessment, prevention, and continuity of care innovations trumpeted by the ACA. Their connection to substance abuse and mental health diversion programs could prove particularly fruitful. At the same time, it is important to bear in mind that for the ACA innovations to take hold in a correctional context,

> Medicaid agencies must be encouraged to establish policies that will increase service availability and expand the breadth of services that are reimbursable. This is particularly true for persons with alcohol and other drug addictions. Since individuals cycling through jails are community patients as well, keeping these individuals in their communities carries enormous health benefits while not increasing, and potentially decreasing, community (i.e., taxpayer) health care costs. Finally, if indeed detainee health care coverage is allowable, there are important consequences for jail health care staffing and standards of care . . . . In the future, jails and/or contract providers will be required to hire physicians and other health care staff who meet the highest standards of community treatment to be compliant with Medicaid requirements.

Id.