

Implications of The Affordable Care Act on People Involved with the Criminal Justice System

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA).¹ Following the Supreme Court's June 2012 decision upholding the constitutionality of the most critical components of the law,² states have been focused on efforts to implement health care reform, including deciding whether to adopt the expansion of Medicaid to nondisabled adults earning at or below 133 percent of the federal poverty level (FPL). This brief provides an overview of the implications of the ACA for adults involved with the criminal justice system, as well as information about how professionals in the criminal justice field can help this population access the services now available to them.³

The Opportunity

The implementation of the ACA represents an important opportunity to increase access to community health care for people involved with the criminal justice system by removing financial barriers to obtaining health insurance. The majority of this population is currently uninsured, low-income, and has high rates of chronic and communicable illnesses, as well as mental health and substance use disorders.⁴ Under the provisions of the ACA, more than half of the 730,000 federal and state prisoners reentering the community each year are estimated to be newly eligible for either Medicaid or for federal subsidies to help buy health insurance from state health insurance exchanges (HIX).⁵ Large numbers of individuals in jail and on probation and parole will also be newly eligible for health insurance.

There is a clear opportunity for court and corrections administrators to be actively involved in connecting this population with the health care services now available to them through the ACA. Pre-trial or pre-release transition planning that

includes assistance in determining eligibility and enrolling newly eligible individuals for Medicaid or another health plan in the HIX, as well as a facilitating “warm handoffs” to local health care providers could be critical to the success of many of those returning to their communities after incarceration.

Court and corrections agencies also have a role in the dialogue and decision making related to the implementation of the ACA at the state and local level. By encouraging policymakers to target and prioritize the justice-involved population in their planning, criminal justice professionals will have a direct stake in the law's success. The effective implementation of the ACA has the potential to improve the overall health status of this population, which in turn will provide long-term public health benefits, as well as enhance public safety by reducing crime, revocations, and the social costs associated with unmet mental health and substance abuse needs.

What ACA Means to People Involved with the Criminal Justice System

The ACA includes a range of provisions that are especially relevant to people involved with the criminal justice system, including:

- State options to expand minimum income eligibility threshold for Medicaid
- Premium tax credits and cost-sharing subsidies in state health insurance exchanges
- Dependent coverage
- Protection for pre-existing conditions
- Coordinated medical and behavioral health care for chronic illnesses
- Essential Health Benefits

Beginning January 2014, states have the option to expand Medicaid coverage to adults under the age of 65, with incomes at or below 133 percent of the Federal Poverty Level (FPL) without having to meet disability requirements.⁷ For single adults, that is approximately \$14,856 per year.⁸ Many people involved in the criminal justice system will be included in this new eligibility group increasing their access to needed health care services.

The creation of state health insurance exchanges (HIX) is one of the key features of the ACA. These exchanges provide individuals and small businesses a way to easily purchase coverage from a range of options. The HIX also establish an individual's eligibility for subsidies including tax credits and cost sharing, which may be important to people reentering their community after incarceration who often are low income or lack employment. Dependent coverage is also a key feature of ACA, which allows for coverage of dependent children up to the age of 26, as is guaranteed coverage for pre-existing conditions, which are a significant concern for this chronically health-challenged population.

Essential Health Benefits are required for those newly eligible for Medicaid and for those plans offered in the HIX, and are defined broadly as ten

The Individual Mandate

The "individual mandate" is an ACA requirement that most individuals in the United States have a prescribed minimum level of health insurance coverage beginning in 2014. Among those exempt from the penalty associated with the individual mandate to carry a minimum level of coverage are people who are below the filing threshold for federal income taxes (set at \$9,750 for single individuals under age 65 in 2012), as well as people who are incarcerated.⁶ For those not exempt, penalties are assessed through IRS income tax filings, starting at \$95 in 2014, and rising to \$325 in 2015 and \$695 in 2016. Those with incomes of between 100 and 400 percent of the FPL will be eligible for financial assistance to purchase private insurance plans through state exchanges. For people with incomes of 100 to 133 percent of the FPL, premium contributions will be limited to 2 percent of their income.

categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care. The inclusion of mental health, behavioral health, and substance abuse disorder services is of critical importance to this population. States have the option of establishing "Health Homes" as a means to provide comprehensive case management and coordination of community and social supports, for people with multiple chronic conditions including serious and persistent mental disorders.

The Role of Criminal Justice Agencies

Corrections and court personnel are in a unique position to help individuals access critical health care services, specifically by creating processes and training to:

- Determine eligibility for coverage as a step at intake to correctional agencies and review insurance status prior to release;
- Facilitate the application and enrollment of eligible individuals in Medicaid or other coverage through a HIX;
- Collaborate with state or local health administrators on protocols to connect these individuals with appropriate community health care providers.

Determine Eligibility

ACA requires U.S. Department of Health and Human Services (HHS) to develop a single streamlined application form people can use to apply for coverage through Medicaid, CHIP, qualified health plans, as well as premium credits for health coverage in the HIX. State Medicaid offices must enter into an agreement with a HIX to coordinate eligibility determination and enrollment. Eligibility for coverage for Medicaid or a HIX is based on two criteria: immigration status and income.⁹ People will be able to access the application online or at locations designated by the states' Medicaid Office. The submission of the application online, over the telephone, or by mail will trigger the electronic verification of an applicant's identity, citizenship, and whether his or her income meets eligibility requirements for Medicaid or some other form of assistance through the HIX. This verification is facilitated by a "data hub" that links information from the Social Security Administration and the Internal Revenue Service. The data hub will be operated by the Centers for Medicare and Medicaid Services (CMS), a division of HHS. Physical identification for verification of eligibility will not be required unless the electronic verification system is unable to verify the identification and citizenship information provided.

Regulations have allowed a 45-day limit on Medicaid eligibility determinations for non-disability applications. However, it is expected that the new streamlined process and on-line application will make real-time eligibility

determinations for many of those who are clearly eligible.

Facilitate Enrollment

After determining eligibility, enrollment or re-enrollment in Medicaid or other coverage on the HIX should also be a step in pre-trial processing for discharge and pre-release reentry planning. It is important to facilitate enrollment before discharge from pre-trial detention or incarceration, or immediately at the start of supervision in order to enable the swiftest connection to community health care. The earlier administrators initiate the enrollment process for eligible individuals and are able to select a provider that can meet their health care needs, the better the chances are of avoiding a lapse in care or treatment as they transition back to their communities.

If an individual loses his or her health coverage while incarcerated, re-enrollment is necessary prior to discharge or immediately at the start of supervision. While the re-enrollment process may vary from state to state, to re-enroll, all that is needed is the individual's personal information (i.e., Social Security number, date of birth, and legal name). The CMS data hub will verify income to confirm eligibility. A mailing address is still required, but a permanent home address is no longer a requirement. New rules also define residency as the state where the individual lives or intends to live.¹⁰

Collaborate

With sufficient staff and appropriate training, corrections and supervision agencies could effectively connect the more than 700,000 people returning to communities from state and federal prison to the critical health care services for which they are now eligible. The long-term public health and safety implications of these connections would be invaluable.

By providing assistance with enrollment prior to discharge from custody, prison and jail administrators can provide immediate benefit to the individuals transitioning to community supervision. As part of the facilitation of the enrollment process, corrections administrators should also have an efficient method for responding to requests for medical records or other

information from community health care providers. When possible, advance visits from community health care and treatment providers would allow for “warm handoffs” to minimize disruption of care, especially for those with chronic diseases and/or behavioral health disorders. This kind of collaboration and relationship building with community health care providers can also benefit corrections personnel by providing access to valuable information about medical and behavioral health disorders of individuals newly entering detention facilities, which can enhance safety and security.

Supervision agencies can play a significant role in promoting the health of the nearly five million adults on probation and parole¹¹ by confirming or initiating enrollment during an office visit or by referring clients to support services that can assist with enrollment in Medicaid or another plan on the HIX. Supervision agencies are also in a unique position to help the individual identify, access, and remain engaged with the health care services available to them, which may significantly improve chances for successful reentry and reduce recidivism.

Finally, criminal justice agencies can help ensure that the expansion of benefits results in improved

public health and safety outcomes by collaborating with policymakers in the implementation of the ACA at the state and local levels. To provide meaningful, impactful input in the planning process, criminal justice agencies should:

- Document the demographics and health care needs of individuals entering jails and prisons;
- Identify service gaps in the community specifically related to the population involved with the criminal justice system;
- Identify their own workforce training needs;
- Identify IT systems that require upgrades in order to link to Medicaid and HIX systems and other critical information infrastructure;
- Develop a financial statement demonstrating projected cost savings to criminal justice agencies under several scenarios (e.g., low, medium, and high participation in health care reform).

These efforts can help inform decision making, strengthen partnerships, and achieve public health and safety goals across multiple systems. In the future, criminal justice agencies should explore how ACA provisions may increase opportunities for diversion and promote continuity of care and treatment within their jurisdictions.

Illinois Prepares for Newly Eligible Medicaid Population in Corrections

The Illinois Governor’s office took early steps to prepare local and state agencies for the state’s estimated 200,000 individuals under correctional supervision that would be newly eligible for Medicaid. In March 2011, the Governor’s Health Care Reform Implementation Council formed the Workgroup on Justice Populations (WJP). The workgroup goals include establishing universal enrollment, screening, and connection to community medical and behavioral health treatment. This is expected to result in significant reductions in rearrests and future costs for incarceration. The workgroup was charged with developing a health reform implementation guide for justice-involved populations to assist system planning efforts in the county jail system, the court services system, the Illinois Department of Corrections, and the health and human services provider network. To achieve these goals, the WJP is considering options, such as expanding the Illinois Jail Data Link to cross match current Medicaid recipients with new inmates, improving the state’s capacity to share information within federal regulations, and streamlining processes for reengagement into Medicaid-funded services upon release from incarceration.

Early planning has also involved the development of pilot projects including one led by Illinois’ probation departments and a full implementation project in Chicago. Probation administrators in two counties are developing standardized processes to assist probationers with Medicaid applications and make referrals to human services providers and community health centers. In Chicago, Circuit Judge Paul P. Biebel, Jr. convened criminal justice and health system leaders at the Justice and Health Initiative. The goal is to align health reform resources across all points in the justice process, with a view to decreasing recidivism and creating options for jail diversion. Criminal justice and health agencies are building Medicaid enrollment processes and linkages to community medical and behavioral health services, leveraging Illinois’ early expansion of Medicaid (2010).

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Conclusion

The ACA is the most significant reform in health care in 45 years and much of the implementation will depend on the states. Most of the processes and objectives discussed in this brief depend on each state's decision on whether, and how, to participate in Medicaid expansion and the availability and capacity of community health care providers to meet the health needs of those who are involved with the criminal justice system. States have a number of choices they can make that could lead to improved health outcomes for this population, including facilitating more effective community partnerships, planning better reentry programs, and improving

linkages to public health services. Should states successfully enable access to needed health services for people involved with the criminal justice system, it may be possible to reduce recidivism, decrease corrections expenditures for health care services, increase federal funding for health services delivered in the community, and decrease safety risks within the corrections system. Criminal justice administrators who emphasize at every opportunity the benefits of ensuring sufficient community health care have the potential to realize significant, measurable benefits within their own agencies.

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Endnotes

1. The ACA encompasses Public Laws 111-148 and 111-152. A consolidated version of the law can be found at <http://docs.house.gov/energycommerce/ppacacon.pdf>.
2. 567 U.S. (2012). *THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS* case was heard together with *FLORIDA V. DEPARTMENT OF HEALTH AND HUMAN SERVICES*. For more information, see: The Henry J. Kaiser Family Foundation, *FOCUS ON HEALTH REFORM, A GUIDE TO THE SUPREME COURT'S AFFORDABLE CARE ACT DECISION* (Menio Park: The Henry J. Kaiser Family Foundation, July 2012), available at <http://www.kff.org/healthreform/upload/8332.pdf>.
3. For more detailed information related to eligibility, financing, services, exemptions to the individual mandate, and enrollment, see: Barbara DiPietro, "Frequently Asked Questions: Implications of the Federal Health Legislation on Justice-Involved Populations," (New York: Council of State Governments Justice Center, 2011), available at http://www.reentrypolicy.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justice-involved-populations/FAQs_Federal_Health_Legislation_on_Justice_Involved_Populations_REV.pdf.
4. For more information on health risks of incarcerated populations and people returning from jail and prison, see: the National Reentry Resource Center, "Frequently Asked Questions: Health, Mental Health, and Substance Use Disorders" (New York: Council of State Governments Justice Center), available at: <http://www.nationalreentryresourcecenter.org/faqs/health>; Kamala Mallik-Kane and Christy Visser, *HEALTH AND PRISONER REENTRY: HOW PHYSICAL, MENTAL, AND SUBSTANCE ABUSE CONDITIONS SHAPE THE PROCESS OF REINTEGRATION* (Washington: Urban Institute, 2008), available at <http://www.urban.org/url.cfm?ID=411617>; The National Center on Addiction and Substance Abuse at Columbia University, *BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION* (New York: Columbia University, February 2010), p. 35; Henry Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Estimates on the Prevalence of Adults with Serious Mental Illnesses in Jails," *PSYCHIATRIC SERVICES* 60 (June 2009): 761—65, available at <http://www.consensusproject.org/publications/prevalence-of-serious-mental-illness-among-jail-inmates/PsySJailMH-Study.pdf>.
5. Estimate is based on 100 percent state participation. Allison Evans Cuellar and Jehanzeb Cheema, "As Roughly 700,000 Prisons Are Released Annually, About Half will Gain Coverage And Care Under Federal Laws," *HEALTH AFFAIRS*, 31 no. 5 (2012): 931—938.
6. For more information on 2012 filing thresholds, see: Internal Revenue Service, "Your Federal Income Tax" Publication 17, 2012, available at <http://www.irs.gov/publications/p17/ch01.html#d0e1532>.
7. On June 28, 2012, the Supreme Court ruled that the federal government could not withhold Medicaid funding from states that opt out of the Medicaid expansion. Medicaid income eligibility will be based on modified adjusted gross income (MAGI) with no asset test. Special adjustments will bring the effective eligibility to 138 percent of Federal Poverty Level (FPL). Prior to ACA, states had to apply for a waiver to expand Medicaid coverage for non-disabled adults without dependents. States may choose to maintain their current income thresholds or set income thresholds at or higher than 133 percent FPL.
8. Based on 2012 FPL Guidelines for the 48 Contiguous States and the District of Columbia. Federal Register, Volume 77 Number 17, Thursday, January 26, 2012.
9. Medicaid financial eligibility will be based on monthly modified gross adjusted income (MAGI), as defined by the IRS, at the time of the application. There will be no asset/resource tests for eligibility. Eligibility for premium credits will be based on annual income.
10. 42 CFR §435.403.
11. L.E. Glaze and T.P. Bonczar, *PROBATION AND PAROLE IN THE UNITED STATES, 2010 NCJ 236019* (Washington: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, November 2011), available at: <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2239>.