ASPE
ISSUE BRIEF

The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities

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The Affordable Care Act (ACA) provides generous Federal support to states that elect to expand the Medicaid program to all adults with incomes below 133 percent of the Federal Poverty Level. This newly eligible group contains many people who are justice involved. More than one quarter of Americans have had some sort of encounter with the criminal justice system, mostly for relatively minor, non-violent offenses.[1] Justice involved individuals have disproportionately high rates of chronic conditions, infectious disease, and behavioral health problems. This issue brief explains why Medicaid and access to the health benefits the program covers can play a key role in improving the health of these individuals, especially as they reenter society, as well as provide important benefits to their communities, including reduced recidivism.

What is meant by justice involved?

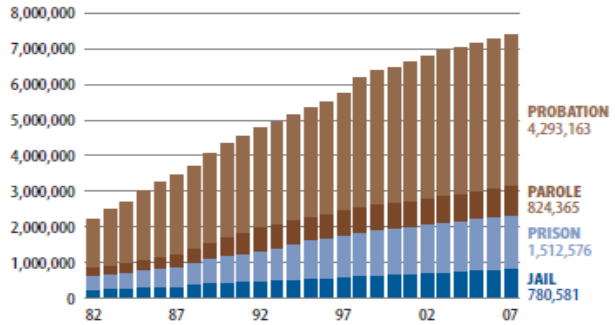
Justice involved individuals include anyone who is currently or has been involved with the criminal justice system. This includes individuals who are awaiting trial, convicted of a crime, on probation, under home confinement, incarcerated in jail or prison, under community residential supervision, or on parole. Many justice involved individuals are eligible for Medicaid if they meet the state's financial and non-financial eligibility criteria (including citizenship or eligible immigration status and state residency).

Prior to the passage of the ACA, most justice involved individuals did not meet Medicaid's income or categorical eligibility requirements, and typically would have been uninsured with limited access to needed services. Medicaid expansion for adults, made possible by the ACA, offers new opportunities to increase health coverage for this population, which may contribute to improvements in their ability to access care as well as greater stability in their lives and reduced recidivism rates.

What are the Characteristics of the Justice Involved Population?

Size of the population: There are 2.2 million people currently incarcerated and 4.7 million people under probation or parole in the United States.[2] The rate of incarceration in the US (716 per 100,000 people) is among the highest in the world.[3,4] Growing incarceration rates largely reflect changes in penal policy and law that reclassified a wide variety of criminal behaviors and punishments and enacted new sentencing laws, including mandatory minimum sentences, resulting in many more people going to prison and for longer periods of time. [5, 6]

Figure 1
Led by Probation, the Correctional Population Tripled Between 1982 and 2007

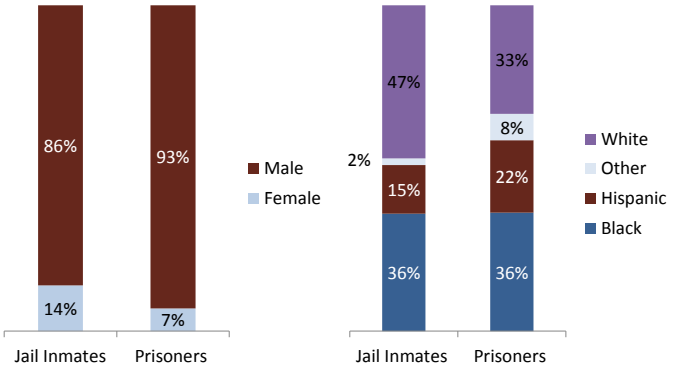


SOURCE: Bureau of Justice Statistics Correctional Surveys available at http://www.ojp.usdoj.gov/bjs/glance/tables/corr2tab.htm.
NOTE: Due to offenders with dual status, the sum of these four correctional categories slightly overstates the total correctional population.

It is important to note that far more justice involved Americans are under correctional supervision in their communities than in prison or in jail. (Figure 1) The number of Americans under all forms of correctional supervision, including people in jail or on parole or probation, has remained about seven million over the past decade or about 1 in 36 adults in 2014.[7]

Race, ethnicity, and gender: Adult males of color comprise the majority of the incarcerated population in jails and prisons. Though African Americans represent only 12 percent of the population, they account for more than a third of people in both jails and prisons. Twenty-two percent of prison inmates are Hispanic (Figure 2).[8] For black men the incarceration rate is 4,777 per 100,000, six times higher than the rate for white men and nearly two and a half times higher than the rate for Hispanic men. [9] American Indians also have higher rates of incarceration than whites, and although the incarcerated population is overwhelmingly male, women account for roughly 7 percent of the population in state and federal prisons and 13 percent of the jail population (Figure 2).[10] While women make up a small fraction of the prison population, female incarceration is on

Figure 2
Jail Inmates and Prisoners by Gender and Race/Ethnicity



Source: Bureau of Justice Statistics, Jail Inmates at Midyear 2013 Statistical Tables, U.S. Department of Justice, May 2014, and Bureau of Justice Statistics, Prisoners in 2012, Trends in Admissions and Releases, 1991-2012, US Dept of Justice December 2013.

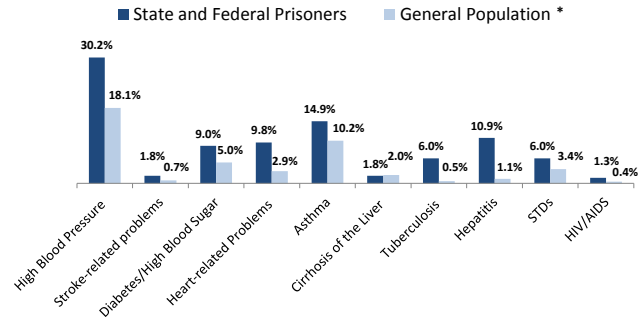
the rise, increasing 757 percent between 1977 and 2000.[11] The number of women in the jail population is also increasing. For the 2014 midyear count, 105,754 women were confined in local jails, an increase of 18.1 percent over four years.[12]

Age. People aged 55 years and older are also a fast growing segment of the prison population.[13] According to an Urban Institute analysis of Bureau of Justice Statistics data, between 1995 and 2010 the number of state and federal prisoners aged 55 or older almost quadrupled while the overall growth in prisons was less than half that rate.[14] By 2030 the number of incarcerated individuals over the age of 55 is projected to reach over 400,000, amounting to over one-third of those incarcerated in the United States.[15] This projection does not include prisoners aged 50-54, for whom data over time are harder to access, nor does it include the numbers of people over the age of 50 projected to be under correctional supervision in the community, such as parole. The numbers of older individuals on parole will likely grow, as people over the age of 50 are the most expensive to imprison, due to their significant health needs, yet pose the least threat to public safety.[16]

Health Needs of the Justice Involved Population

Physical Health. Incarcerated individuals have disproportionately high rates of chronic conditions and infectious disease (Figure 3).[17] In 2011-2012 half of people in state and federal prison and local jails reported ever having a chronic condition.[18] Twenty-one percent of people in prison and 14 percent of people in jail reported ever having an infectious disease, including tuberculosis, hepatitis B and C, and other sexually transmitted diseases, compared with 4.8 percent of the general population.[19]

Figure 3
Prevalence of Ever Having a Chronic Condition or Infectious Disease Among State and Federal Prisoners and the General Population



*Comparison Group
**All differences with the comparison group are significant at the 95% confidence level.

Source: L. Maruschak, M. Bersofsky, and J. Unangst. *Medical Problems of State and Federal Prisoners and Jail Inmates*. Bureau of Justice Statistics Special Report NCJ 248491, U.S. Department of Justice, February 2015.

Even though jails and prisons are legally responsible for providing necessary health services to incarcerated individuals, data show that many people go without needed health care while incarcerated. For example, a 2009 study found that, among incarcerated individuals with a persistent medical problem, approximately 14% of people in federal prison, 20% of people in state prison, and 68% of people in local jails did not receive a medical examination while incarcerated.[20] About two thirds of people in prison and less than half of people in jail who had previously been treated with a psychiatric medication had taken medication for a mental condition since incarceration.[21]

Mental Health. Mental and behavioral health issues are common in this population. According to the Bureau of Justice Statistics, in 2005, fifty-six percent of people in state prison, 45 percent of people in federal prison, and 64 percent of people in jail report symptoms of a mental health disorder.[22] Many of these mental health disorders are serious. Using criteria specified in the Diagnostic and Statistical Manual of Mental Disorders IV, 43.2 percent of people in state prison, 35 percent of people in federal prison, and 54.5 percent of people in jail report symptoms consistent with bipolar disorder.[23] One study that examined the number of individuals in prison or jails with mental illness and the number of inpatients in public psychiatric hospitals, private psychiatric hospitals, and psychiatric units of general hospitals found that there are more than three times the number of people with serious mental illness in prisons and jails than in hospitals.[24]

Substance Use Disorders. According to the Bureau of Justice Statistics, 53 percent of all state prisoners and 45 percent of all federal prisoners met the DSM-IV criteria for drug dependence.[25] Estimates for the jail population indicate 47 percent have problems with alcohol use and 53 percent suffer from drug dependency or abuse.[26] Furthermore, mental health and substance abuse conditions tend to be comorbid, with an estimated 42 percent of individuals in state prisons and 49 percent of those in local jails exhibiting both conditions.[27] When present, co-occurring disorders complicate treatment and often aggravate physical health problems.[28] In 2004, over a third of incarcerated individuals who reported problems with drug and alcohol dependency reported substance use at the time they committed their offense and 17 percent of state and 18 percent of federal prisoners reported that they committed their crime to obtain money for drugs.[29]

Who Pays for Health Care?

People involved with the criminal justice system are generally low-income and uninsured. Overall, data on the income and insurance status of people moving into and out of the criminal justice system is limited. However, survey data from 2002, prior to the enactment of the ACA, shows that nearly six in ten people in jail reported monthly income of less than $1,000 before their arrest.[30] Historically, this population has been largely uninsured. For example, a survey of San Francisco county jails found that about 90 percent of people who entered county jails in 2005-2006 had no health insurance.[31] Another survey of people returning to the community from Illinois jails (prior to the ACA) found that more than eight in ten were uninsured at 16 months post-release.[32,33] Medicaid eligibility for non-disabled, non-elderly adults prior to the passage of the ACA was generally very limited, and low-income adults without dependent children were particularly unlikely to be eligible for the program.[34,35] As a consequence, Medicaid has historically played a very limited role in covering justice involved individuals.[36]

There are various estimates for the number of justice involved individuals eligible for Medicaid. One study examining enrollment in Massachusetts' Medicaid program, MassHealth, found that 91 percent of individuals released from correctional facilities between July 1, 2008 and December 31, 2008 were eligible.[37, 38] According to a recent Government Accountability Office (GAO) study, health officials from New York and Colorado estimated that 80 to 90 percent of people in their respective state prison systems would be eligible for Medicaid as of 2014.[3940]

Health care while incarcerated. The Supreme Court decision in *Estelle v Gamble* held that while incarcerated, when individuals are physically confined and unable to seek care for themselves, prisons, jails and other penal institutions are required to ensure the provision of appropriate and necessary health care.[41] The provision of health care varies significantly across states and types of correctional facilities. Some larger prisons have infirmaries on-site, and many prisons hire independent doctors or contract with private or hospital staff to provide care off-site, with the majority of prisons creating a hybrid system. In jails, health care is primarily provided through contracts with local health care providers, such as public hospitals, or safety-net providers who come to the jails to provide services. As with large prisons, some large jails have on-site primary care, pharmacy, and mental health and substance abuse centers.[42] Federal law prohibits Medicaid federal financial participation (FFP) for most health care services provided to eligible individuals while incarcerated, under a policy known as the Medicaid Inmate Payment Exclusion.[43] The payment exclusion does not prohibit individuals from being enrolled in Medicaid while incarcerated; however, even if they are enrolled, Medicaid FFP will not cover any services, except for care received as an inpatient in a hospital or other medical institution. [44]

Health care while under community supervision. The responsibility for criminal justice institutions to ensure that health care is provided is predicated on the status of one's confinement, rather than on health care needs or correctional status. In other words, the responsibility for institutions to provide health care is determined by the inability of the individual to seek and obtain health care on their own.[45] Justice involved individuals become responsible for their own health care after release from jail or prison, including while under probation, parole, home confinement, or residing in non-secure community facilities. Generally, prisons and jails do not provide health care to individuals once released, nor while in a community corrections setting. Lack of health coverage often results in relapses or deterioration of health status that can lead to more expensive interventions, treatments and premature deaths.[46, 47]

To support individuals in obtaining needed care, the Centers for Medicare and Medicaid Services (CMS) recently released guidance that clarifies that individuals who are currently on probation, parole or are in home confinement are not inmates of a public institution. It revises prior guidance to extend Medicaid FFP to individuals residing in state and locally operated halfway houses if the individual has freedom of movement consistent with the requirements specified in the CMS guidance; consequently, individuals that have freedom of movement and association while residing in community residential facilities are not considered inmates of a public institution and are therefore not subject to the Medicaid Inmate Payment exclusion.[48] The revised policy does not apply to residents of federal Residential Reentry Centers. In states that have expanded Medicaid many of these individuals may not only be eligible for Medicaid coverage, but also able to receive Medicaid services immediately upon release from prison or jail. HHS analysis estimates that this guidance may apply to up to 96,000 individuals residing in halfway houses over the course of the year.[49]

Coverage and Access to Care are Critical for Reentry Success

Over 95 percent of incarcerated individuals eventually return to the community.[50] Uninterrupted access to health coverage helps individuals maintain continuous health care. Continuity of care

has been associated with lower health care costs, fewer hospitalizations, and decreased mortality.[51] Continuity of care is also linked to reduced emergency department use and reductions in unnecessary procedures. [52, 53]

Untreated or undertreated behavioral health disorders contribute to higher risk for poor health outcomes and recidivism. Reentry is a particularly crucial period for those with behavioral health conditions because it is associated with significant stress and high risk of relapse or crisis. Direct behavioral health support can maintain treatment gains established in a correctional environment and prevent reversion to the behavioral patterns, such as substance abuse, that increase risk for reoffending. Individuals with opioid use disorder are at particular risk for death post release. A large study found that overdose from opioids was the leading cause of death for former prisoners with highest risk present in the first week of release.[54] The ACA expansion of health coverage has expanded access to Medication Assisted Treatment (MAT), which combines medication with counseling and behavioral therapies, and can substantially reduce continued drug use and mortality associated with Opioid Use Disorder.[55] Recent CMS guidance has identified best practices and established strong benefit design for medication assisted treatment and substance use disorder and identified opportunities for states to prevent and address opioid addiction.[56, 57, 58] A systematic review of pharmacological interventions aimed at reducing drug use found that in justice involved populations, MAT can meaningfully reduce criminal activity and rates of re-incarceration.[59]

Medicaid is a key source of coverage for this high needs, high risk population, facilitating access to much needed physical and behavioral health services. Coverage, access, and continuity of care are particularly important for reentering persons, as they face higher mortality rates than other individuals.[60] In addition, poor health and poor access to care after release are associated with higher rates of recidivism.[61] Improved health status and access to health care during reentry may also lead to improved employment, housing, and family support outcomes.[62] Uninterrupted access to health care services is especially important for reentering persons with ongoing care needs, such as individuals with mental health and chemical dependency issues, and/or chronic physical conditions. Access to Medicaid coverage for justice involved persons can provide continuity of care that may improve health outcomes, reduce recidivism, improve public safety, and lower the costs of incarceration. [63, 64, 65]

This Issue Brief, authored by Jhamirah Howard, Madeleine Solan, Jessica Neptune, Linda Mellgren, Joel Dubenitz, and Kelsey Avery presents information about the importance of Medicaid coverage for criminal justice involved individuals. For additional information about this subject, visit the DALTCP home page at https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE authors at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201 (Jhamirah.Howard@hhs.gov).

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[43] For more information on the Medicaid Inmate Coverage Exclusion see recent CMS guidance at: https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html
[44] Subparagraph (A) in the matter after section 1905(a)(29) of the Social Security Act.
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