Game Changer: The Potential of the Affordable Care Act to Improve Public Health, Increase Public Safety, and Save Taxpayer Dollars

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Good morning. It is great to be here at John Jay College of Criminal Justice. Thank you to Steve and colleagues for bringing us together for this timely and important discussion. I can't help but think about the first time I visited John Jay. It was February 2000, and I was a young Department of Justice staffer, travelling with then-Attorney General Janet Reno and one Jeremy Travis, who is now President of John Jay and was then Director of the National Institute of Justice. The AG was here to give the first national speech on the topic of prisoner reentry and to launch the first federal pilot projects. This was largely Jeremy's brainchild, and the seeds he planted in this area have significantly reshaped the public safety landscape.

In her speech, AG Reno talked about the large and growing numbers of people behind bars, and she shined a bright light on the increasing number of people released each year. She discussed the high rates of substance abuse and mental health problems in this population and the public safety risks they presented if left untreated. She lamented the low base of in-prison treatment and even lower rates of treatment after release, despite the fact that when drug treatment is delivered in prison and in the community, it can substantially cut recidivism.

In many ways, we have moved mountains since then, as most states approach reentry very differently now. Three U.S. Presidents, starting with President Clinton, have supported and strengthened reentry efforts, one Administration after another. It was President Bush, in fact, who said in his 2004 State of the Union that "America is the land of second chance[s], and when the gates of the prison open, the path ahead should lead to a better life."

I'm proud to say that improving reentry is a priority in the Obama Administration. Attorney General Holder has established a Cabinet-level Reentry Council that works across 20 federal agencies to reduce recidivism and the collateral consequences of incarceration that make it so difficult for returning prisoners to get a job, attain housing, support their families, and rejoin society as productive citizens.

This is even an area where there's impressive bi-partisan support on Capitol Hill, where Congress has worked across the aisle to pass and support the Second Chance Act. In state

houses, city halls, and community centers around the country—in jurisdictions both red and blue—we've seen broad support for evidence-based reentry strategies that increase public safety and save taxpayer money. And in many states we are seeing results. Several states report significant reductions in recidivism, and we are bending the national incarceration curve after 40 years of unchecked increases.

These are big shifts and we are making great strides. But to be frank, we have not made good progress on the health front. I think the Patient Protection and Affordable Care Act (ACA) could change that.

So, I am going to spend a few minutes laying out six core facts that set the backdrop for this discussion. I will then talk about why access to healthcare can make a huge, positive difference for this population and how health care reform has the potential to improve public health, enhance public safety, and save taxpayer dollars.

Fact #1: We have a lot of people locked up in this country – totaling some 2.2 million. The U.S. locks up more people than any country in the world: We've got about 5 percent of the world's population, yet 25 percent of the world's prisoners.[i] On any given day, the U.S. holds about 1.5 million people in state and federal prisons, 700,000 in local jails, and another five million people are supervised in the community, on probation or parole.[ii] Many refer to these levels as "mass incarceration," as sizable shares of some neighborhoods—mostly the young men in these neighborhoods—are behind bars. This costs us about $80 billion each year, with generally poor returns[iii] and many collateral impacts.

Fact #2: The incarcerated population carries a high disease burden, with substantially higher rates of medical, psychiatric, and addiction problems than the general public.[iv] The prevalence of Hepatitis C, for example, is nine to 10 times higher in the inmate population than in the general population. The prevalence of active tuberculosis is four times higher, and HIV infection is eight to nine times higher. Chronic health problems such as hypertension, diabetes, and asthma are significant also, particularly now given the aging prison population. In fact, an estimated 39-43 percent of all inmates have one or more chronic health conditions.[v] In terms of behavioral health, inmates are three times higher than the general population to have serious mental illness and four times higher to have substance abuse problems.[vi] And often, substance abuse and mental illness go hand in hand.

Looked at through a different lens, a large share of the U.S. population carrying communicable diseases passes through a correctional facility each year. Think about this: about one third of all people with TB and Hepatitis C pass through our prisons and jails each year, as do 17 percent of those with AIDS and 12-16 percent of people with Hepatitis B.[vii] From a public health standpoint, this presents a huge intervention opportunity.

Fact #3: As coined by President Travis, "they all come back." The iron law here is that unless people die while incarcerated, and thankfully about 95 percent do not, individuals return to their families and communities after they've served their time. In terms of numbers, this

translates into about 670,000 releases from state and federal prisons each year.[viii] Another 11.8 million cycle thru local jails, where they spend less than a year—often a handful of days or weeks.[ix]

So we've got lots of people who are in poor health incarcerated in our nation's prisons and jails, and almost all are destined to return to our neighborhoods after they've served their time.

Fact #4: Prisoners have a constitutional right to medical care while incarcerated—and indeed some people's health actually improves while confined—however, we also know that there is not nearly enough high-quality treatment to meet the need. The gap is particularly acute when it comes to substance abuse and mental illness, where less than 20 percent of those who need treatment get it.[x]

Fact #5: After release, there's even less care in the community. All the while—as noted by Janet Reno, a large body of research, and a recent panel of expert physicians—continuity of care is essential if you want to see health and safety benefits.[xi] Whether it be for substance abuse disorders, mental illness, infectious or chronic conditions, continuity of care must be a priority, particularly in the first days and weeks after release when the risk of relapse, reoffending, and even death, is most acute.[xii]

Fact #6: Correctional health care costs are substantial, and when there's no continuity of care, it's a poor investment. Hard dollar figures are hard to come by, but estimates suggest some $7 to 10 billion is spent on correctional health care annually.[xiii] And while the per capita expenditures are roughly in line with the general population trends,[xiv] these investments are essentially squandered without adherence to treatment regimens begun in prison.[xv]

Taken together, these facts suggest a massive opportunity to treat substance abuse, mental health, chronic and communicable health problems while people are incarcerated and especially upon release and in the community. If we do that—deliver the right treatment to the right people at the right times—then we can improve public health, increase public safety, and save taxpayer dollars.

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Now so far, I have said nothing new. All of these facts are widely known to experts in the field. In fact, John Jay Professor Bob Greifinger pointed out much of this in a seminal article in the mid-1990s.[xvi] What's new here is the Affordable Care Act. Here's the game-changing part:

Most people with criminal justice involvement have neither private nor public health insurance. Estimates range on the order of 70-90 percent without coverage.[xvii] The ACA will change that by potentially expanding health coverage to almost everyone. This means access to care for individuals who have previously not been covered. But just as critically, ACA gives a much-needed financial incentive to providers to deliver that care to the justice-involved population. Individuals who were primarily treated for free, if they were treated at all, now will have coverage.

Let's start with Medicaid expansion. Medicaid has historically covered low income families with children and the disabled. But starting in January 2014, Medicaid eligibility will be based on income and citizenship status. In the states that opt in, U.S. citizens who make under 133 percent of the federal poverty level (about $15,000) will be eligible for coverage. As of September 30, 25 states have said they will participate,[xviii] and the hope is that more states will come around over time. The incentive is big: The federal government provides 100 percent of the cost for the Medicaid expansion population through 2016, and at least 90 percent thereafter.

In addition, in all states, federally subsidized health coverage will be available to U.S. citizens making between 100 percent and 400 percent of the federal poverty level. So between Medicaid expansion and the federal subsidies, low-income men will largely be eligible for health insurance for the first time.

ACA also brings new consumer protections and more comprehensive coverage than currently exists. The law eliminates pre-existing condition exclusions and prohibits annual and lifetime benefit limitations. And it requires most plans to offer ten categories of Essential Health Benefits including treatment for mental health and substance use disorders.[xix] Parity protections require that coverage for mental health and substance use disorder services be no more restrictive than coverage provided for other medical and surgical services.

In sum, the ACA will greatly increase the portion of the justice-involved population eligible for health care coverage. It will ensure that coverage for the newly eligible includes essential health benefits, including mental health and substance use benefits at parity. And it will increase the focus on delivering high-quality, integrated care.

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Now some are questioning why taxpayers should be paying for prisoners to be covered under the ACA, and particularly Medicaid. First, to clarify misinformation that's out there, Medicaid cannot—by statute—pay for health care provided in a public institution such as a prison or a jail. This is known as the "Medicaid exclusion" and the only major exception to it is when care is provided in a community hospital—outside the jail or prison—for a period of more than 24 hours.[xx] The confusion comes because even though the federal government will not pay for care while incarcerated, prisoners are eligible to enroll in Medicaid—and this is important so that treatment can begin or resume immediately upon release.[xxi]

In terms of the criticism that taxpayers shouldn't be supporting Medicaid for returning prisoners, let me be clear: Taxpayers are already spending on this population—to the tune of $80 billion a year in corrections costs. If we can reduce recidivism by even a few percentage points—and according to the research we can – then we'd save a lot more than we spend by expanding treatment.

In Washington State, for example, they expanded state funding for substance abuse treatment to low-income individuals who were frequently involved with the criminal justice system—a population that essentially mirrors the Medicaid expansion population. In the 12 months that

followed treatment, arrests declined by more than 17 percent compared to a control group that did not receive treatment. This decline in arrests resulted in almost $3 in justice-related savings for every dollar spent on treatment.[xxii] At the same time, medical expenditures for this group went down. The study authors characterized the outcomes as "bending the health care cost curve by expanding alcohol and drug treatment."[xxiii]

Other studies in Florida and Colorado show similar trends.[xxiv] And the broader body of research shows that for every dollar spent on addiction treatment, there is an estimated $4 to $7 reduction in the cost of drug-related crimes.[xxv] One recent study indicated that providing more—and more effective—treatment in prison and immediately upon release would save $17 billion in criminal justice costs.[xxvi]

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So the Affordable Care Act has a lot of potential.

It has the potential to significantly improve public safety outcomes. If people get high quality substance abuse treatment immediately following release, they will be less likely to relapse and reoffend.

The Affordable Care Act has the potential to significantly improve public health outcomes. If there is increased follow-up treatment for communicable diseases such as tuberculosis and Hepatitis C, there is less likelihood of further transmission in the community.

The Affordable Care Act has the potential to significantly reduce spending on corrections, both by increasing treatment diversion options on the front end and by reducing reoffending and return to prison after release.

And health care savings will be realized if prevention and treatment services are utilized, thereby reducing costly emergency room and hospitalizations.[xxvii]

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Will roll out be perfect? I think we know the answer to that. Will poor people in non-Medicaid expansion states fall through the cracks? Yes. Is there enough treatment capacity in the community to accommodate the need? I'm not sure there is. Will all this require some rethinking of roles? I think it will.

But this is a long term game. And I think that society will benefit if the justice-involved population has more access to preventative and remedial health care and treatment.

I think the real story here is about the underlying health needs of the justice-involved population, who come from and return to some of the most disadvantaged communities in our country. The Affordable Care Act is a new tool that could help increase the quantity and quality of treatment for this population. The benefits of treatment are compelling and cost-effective—and the beneficiaries are not only those individuals who receive treatment, but their families and communities and the public at-large.

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So how do I hope this will play out?

A few years from now, I hope that prisons, jails, probation and parole offices will systematically help people enroll in healthcare as part of intake and discharge processes. Justice system personnel will automatically set first appointments for care in the community—and perhaps the treatment provider is even co-located in the probation office or jail and treatment has begun. Jails, prisons, and community providers will have built secure, real-time health information bridges to inform one another about patients' healthcare and treatment regimens. States will suspend—not terminate—Medicaid when someone is incarcerated, so that treatment can begin immediately upon release. And ultimately I hope judges will have viable community-based treatment options so that they won't be compelled to lock up someone with mental illness just because there is nowhere else to send them.

Taken together, these mundane-sounding policies and procedures would represent an about face to business-as-usual. They would help more people get the treatment they need. If more people get the treatment they need, they are more likely to get out and stay out of the criminal justice system, and they are more likely to be able to work, to support themselves and their families, to pay their taxes and contribute to our communities. That serves our collective interest.

I will end with this hope: that 13 years from now, when Attorney General Glazer comes to John Jay to deliver her remarks, she will reflect on how very far we've come.

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[i] Walmsley, Roy, "World Prison Population List. 9th Edition," (London: International Centre for Prison Studies, 2011), available at http://www.idcr.org.uk/wp-content/uploads/2010/09/WPPL-9-22.pdf.

[ii] Carson, A., and Sabol, W., *Correctional Populations in the United States, 2011*, (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 2011), available at http://bjs.ojp.usdoj.gov/content/pub/pdf/cpus11.pdf.

[iii] More than two-thirds of state prisoners are rearrested within three years of their release and half are reincarcerated. Langan, P.A. & D.J. Levin, *Recidivism of Prisoners Released in 1994*, (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 2002), available at bjs.ojp.usdoj.gov/content/pub/pdf/rpr94.pdf

[iv] National Commission on Correctional Health Care, *The Health Status of Soon-to-Be-Released Inmates: A Report to Congress*, (Chicago: National Commission on Correctional Health Care, 2002).

[v] Wilper A.P., Woolhandler, S., Boyd J.W., Lasser K.E., McCormick D, Bor D.H., et al, "The Health and Health Care of US Prisoners: Results of a Nationwide Survey," *Am J Public Health* 99 no. 4 (2009):666-72, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661478/.

[vi] In the jail population, 15 percent of men and 31 percent of women have serious mental illness. Steadman, H.J., Osher, F.C., Robbins, P.C., Case, B., and Samuels, S., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 6O no. 6 (2009), 761-765. In state prisons, these numbers are 24 percent of women and 16 percent men. Ditton, P.M., *Mental Health and Treatment of Inmates and Probationers,* (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 1999), available ay http://www.bjs.gov/content/pub/pdf/mhtip.pdf. Regarding substance abuse, 53 percent of state prisoners meet any substance abuse or dependence criteria as specified by *the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Mumola, C., and Karberg, J., *Drug Use and Dependence, State and Federal Prisoners, 2004*, (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 2006). Alcohol and drug abuse is even more acute in jail populations, where 68 percent meet DSM-IV criteria. Karberg, J., and James, D.,

Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002, (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 2005).

[vii] The exact figures are 17 percent of the AIDS population, 13-19 percent of those with HIV, 12-16 percent of those with Hepatitis B, 20-32 percent of those with Hepatitis C, and 35 percent of those with tuberculosis. National Commission on Correctional Health Care, *The Health Status of Soon-to-Be-Released Inmates: A Report to Congress*, (Chicago: National Commission on Correctional Health Care, 2002).

[viii] Carson, A., and Sabol, W., *Correctional Populations in the United States, 2011*. NCJ #239972, (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 2012), available at http://bjs.ojp.usdoj.gov/content/pub/pdf/cpus11.pdf.

[ix] Minton, T., *Jail Inmates at Mid-year 2012, Statistical Tables*, (Washington: U.S. Department of Justice, Bureau of Justice Statistics, 2013).

[x] Chandler RK, Fletcher B.W., Volkow N.D., "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," *JAMA* 301 no. 2)(2009):183-90.

[xi] Rich, J.D., Dumont, D., and Allen, S., *Incarceration and Health,*(Working paper prepared for the National Academies Workshop on Health and Incarceration, Dec. 5, 2012, Washington), available at http://sites.nationalacademies.org/DBASSE/CLAJ/DBASSE_083370.

[xii] Recent releases are also 13 times more likely to die in the first 12 weeks after release. Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., et al., "Release from Prison—A High Risk of Death for Former Inmates," *New England Journal of Medicine*, 356 no. 2 (2007): 157-165.

[xiii] There is no authoritative, comprehensive figure here. State estimates are available; county estimates are more elusive. Industry estimates range from $7 to $10 billion. Kosiak, "Healthcare and Medical Assistance for Prisoners," in Chambliss, William J. (Ed.), *Corrections*, (Thousand Oaks: SAGE Publications, Inc., 2011); Hoffmann, C., "How Correctional Facilities Are 'Walking the Line' toward Healthcare Cost Improvement," (2012), available at http://healthworkscollective.com/chris-hoffman/41181/how-correctional-facilities-are-walking-line-toward-healthcare-cost-improvement; Hallworth, Richard, Q2 2009 America Service Group Inc. Earnings Conference Call, 2009.

[xiv] http://kff.org/other/state-indicator/health-spending-per-capita/ and http://www.bjs.gov/content/pub/pdf/scefy8210.pdf

[xv] National Research Council and Institute of Medicine, *Health and Incarceration: A Workshop Summary,* A. Smith, Rapporteur, Committee on Law and Justice, Division of Behavioral and Social Sciences and Education and Board on the Health of Select Populations, Institute of Medicine, (Washington: The National Academies Press, 2013), citing Chandler, p. 20.

[xvi] Glaser, Jordan B., and Greifinger, Robert B., "Correctional Health Care: A Public Health Opportunity," *Annals of Internal Medicine* 118 no. 2 (1993): 139-145.

[xvii] Mallik-Kane, Kamala and Visher, Christy A., *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* (Washington: Urban Institute, February 2008); Wang, E.A., White, M.C., Jamison, R., Goldenson, J., Estes, M., and Tulsky, J.P., "Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail," *American Journal of Public Health* 98 no. 12 (2008): 2182-2184.

[xviii] http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

[xix] Essential Health Benefits include these ten 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; preventative and wellness and chronic disease management; and pediatric services, including oral and vision care.

[xx] This is not new under the ACA, although the pool of people who may now be eligible for Medicaid may be larger if a state opts for Medicaid expansion.

[xxi] While prisoners can enroll in Medicaid while incarcerated, they cannot use the Marketplace to buy private health insurance for themselves, unless they are "pending disposition of charges." About 60 percent of the jail population fit into this category, meaning they have not been convicted of a crime.

[xxii] The decline in arrests associated with improved access to treatment resulting in $1.06 in savings per dollar spent when taking into account criminal justice system costs, and $2.58 in benefits when also taking into account crime victims.

[xxiii] Mancuso, D., and Felver, B., *Chemical Dependency Treatment, Public Safety*, (Olympia: Washington State Department of Social and Health Services Research and Data Analysis Division, 2009) available at www.dshs.wa.gov/pdf/ms/rda/research/11/140.pdf

[xxiv] Studies in counties in Washington State and Florida tracked the impact of Medicaid coverage for jail releases with serious mental illness. They found 16 percent fewer detentions of those covered compared with a similar group who did not have Medicaid. Morrissey, J., "Medicaid Benefits and Recidivism of Mentally Ill Persons Released from Jail," (Washington: Justice Systems Research Division, Office of Research and Evaluation, National Institute of Justice, 2004), available at https://www.ncjrs.gov/pdffiles1/nij/grants/214169.pdf.] And in Colorado, which implemented a Medicaid outpatient substance abuse treatment benefit, an audit found that the $2.4 million in treatment outlays was more than offset by $3.5 million in reduced medical expenditures. Colorado Department of Health Care Policy and Financing, "Medicaid Outpatient Substance Abuse Treatment Benefit, Performance Audit," (Denver: Office of the State Auditor, 2010.), available at http://www.leg.state.co.us/OSA/coauditor1.nsf/All/80EE029745B4C589872577F30060F888/$FILE/2079SubstanceAbuseFinalReport12132010.pdf.

[xxv] National Institute on Drug Abuse, *Principles of Drug Abuse Treatment: A Research-Based Guide*, National Institutes of Health Publication No. 00-4180, (Washington: U.S. Department of Health and Human Services, 1999).

[xxvi] Zarkin, G. A., Cowell, A. J., Hicks, K. A., Mills, M. J., Belenko, S., Dunlap, L. J., Houser, K. A. and Keyes, V. (2012), "Benefits and Costs of Substance Abuse Treatment Programs for State Prison Inmates: Results from a Lifetime Simulation Model," *Health Econ*. 21 (2012): 633–652.

[xxvii] A study in MA documented that most released prisoners got MassHealth coverage upon release. Notably, they were more likely to get preventive care and behavior health treatment than the overall MassHealth population, and less likely to visit emergency rooms for inappropriate, nonemergent reasons. Kirby, P., Ferguson, W., Lawthers, A., "Post-Release MassHealth Utilization: An Evaluation of the MassHealth/DOC Prison Reintegration Pilot," (Worcester: University of Massachusetts Medical School Center for Health Policy and Research, 2011).