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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE PRETRIAL SYSTEM: A "FRONT DOOR" TO HEALTH AND SAFETY

BY THE NATIONAL ASSOCIATION OF PRETRIAL SERVICES AGENCIES

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) provides an historic opportunity for millions of low-income individuals to obtain insurance coverage for their physical and behavioral health care needs. For the last several years, diverse behavioral health advocates, health care providers and community-based prevention organizations, have worked to understand the implications of the ACA on the justice-involved population. Much of the conversation has been centered on the disproportionately high rates of physical and behavioral health care needs amongst this previously uninsured population. While many criminal justice systems are engaging in conversations with their health partners about implementing the ACA, much of the conversation is focused on services for convicted offenders returning to the community from jail or prison rather than the pretrial population. It is expected that roughly 5.9 million[1] (one-third) of the newly insured Medicaid population in 2016 will be people who will have been booked into jails during the year.[2] By 2022, that number is estimated to increase to approximately 7 million. Access to treatment services through the ACA at pretrial decision points creates a notable opportunity to interrupt the cycle of crime exacerbated by chronic physical and behavioral health issues. The purpose of this document is to summarize the ACA and its relevance among pretrial populations. It includes:

- An Overview of the ACA;
- Major Opportunities for Pretrial Justice;
- Doorways to Coverage; and
- A Call to Action.

1 Kaiser Commission on Medicaid and the Uninsured, Nov 2012 "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis" pg. 19.

2 George Washington University School of Public Health and Health Services Department of Health Policy, Nov 2012 "Medicaid Coverage for Individuals in Jail Pending Disposition"

OVERVIEW OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The ACA provides two mechanisms to access coverage, including the health insurance marketplace or exchanges, and the expansion of Medicaid eligibility.

Health Insurance Marketplace: By January 2014, every state will offer insurance coverage through a health insurance marketplace (either state or federally operated) that provides a regulated venue for uninsured individuals with incomes between 133% and 400% of the federal poverty limit (FPL) to purchase coverage. Health insurance is expensive, and its cost is out of reach for many lower and moderate-income individuals and families, particularly if they are not offered health benefits at work. To make coverage obtainable for individuals and families that otherwise could not afford it and to encourage broad participation in health insurance, the ACA includes provisions to lower premiums and cost-sharing obligations for people with low and modest incomes. Individuals will also receive tax credits on a sliding scale to offset the cost of this coverage.[3, 4]

Medicaid Eligibility Expansion: The ACA also expands Medicaid eligibility to childless adults with a minimum eligibility floor of 133% FPL (Table 1), which provides a new method of coverage for many currently uninsured adults, including many justice-involved individuals[5] The Supreme Court's 2012 decision on the ACA allowed states to opt out of the Medicaid expansion component, so some states have chosen not to implement this component at this time.[6] While the final number of states choosing to expand the Medicaid population is yet to be determined, the opportunity to improve the health of the proposed expansion population, in addition to the initial federal match of 100% of costs (2014-2016), may provide sufficient incentive for most states to participate over the next few years.

3 https://www.healthcare.gov/how-can-i-get-an-estimate-of-costs-and-savings-on-marketplace-health-insurance/

4 http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf

5 Stephens, J. "The Single Streamlined Application Under the Affordable Care Act: Key Elements of the Proposed Application and Current Medicaid and CHIP Applications." Kaiser Family Foundation. February 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8409.pdf

6 Tracking Medicaid Expansion Decisions. State Reform. https://www.statereforum.org/medicaid-expansion-decisions?gclid=COGq987417cCFbE-MgoddXwAXA

Table 1

2013 Federal Poverty Level Guidelines* For All States (Except Alaska and Hawaii) and DC	
Family Size	133% of Poverty Annual Guideline
1	15,281.70
2	20,628.30
3	25,974.90
4	31,321.50
5	36,668.10
6	42,014.70
7	47,361.30
8	52,707.90

* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf

There are exemptions from the requirement of obtaining insurance coverage, including those listed below. If pretrial defendants are not eligible for Medicaid, these exemptions (especially the no filing requirement and unaffordable coverage options exemptions) may allow them to opt out of purchasing insurance on the exchange.

1. **Religious conscience.** Members of religious sects that are recognized as conscientiously opposed to accepting any insurance benefits. The Social Security Administration administers the process for recognizing these sects according to the criteria in the law.
2. **Health care sharing ministry**. Members of a recognized health care sharing ministry.
3. **Indian tribes**. Members of a federally recognized Indian tribe.
4. **No filing requirement**. Individuals whose income is below the minimum threshold for filing a tax return. The requirement to file a federal tax return depends on filing status, age and types and amounts of income. To find out if an individual is required to file a federal tax return, use the IRS Interactive Tax Assistant (ITA).

5. **Short coverage gap**. The individual went without coverage for less than three consecutive months during the year.[7]
6. **Hardship**. The Health Insurance Marketplace, also known as the Affordable Insurance Exchange, has certified that the individual has suffered a hardship that makes him/her unable to obtain coverage.
7. **Unaffordable coverage options**. The individual cannot afford coverage because the minimum amount that must be paid for the premiums is more than eight percent of the household's income.
8. **Incarceration**. The individual is detained in a jail, prison, or similar penal institution or correctional facility after the disposition of charges.
9. **Not lawfully present**. The individual is not a U.S. citizen, a U.S. national or an alien lawfully present in the U.S.[8]

In most cases, these exemptions do not preclude individuals from enrolling in Medicaid or purchasing insurance through the marketplace. There are circumstances in which individuals are not eligible for Medicaid coverage, such as sentenced, incarcerated individuals and those not lawfully present in the U.S.

The ACA has immense potential to increase access to physical and behavioral health services for criminal justice system involved individuals, but infrastructure must be developed to enroll those individuals in coverage and connect them to services. Agencies that serve pretrial populations may chose to develop internal capacity or collaborate with community partners, but regardless, must recognize the opportunity and responsibility associated with acting as the front door of the criminal justice system. Developing methods of enrolling and supporting access to care for these individuals helps to address chronic physical health, and behavioral health issues, which in turn, reduce recidivism and allow for public safety resource savings. The lack of access and capacity limitations under the current system has detrimental effects on individuals and the system. These effects will continue if pretrial services fail to take advantage of the opportunities presented by the ACA.

7 In general, a gap in coverage that lasts less than three months qualifies as a short coverage gap. If an individual has more than one short coverage gaps during a year, the short coverage gap exemption only applies to the first gap. Retrieved from http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

8 http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

Major Opportunities for Pretrial Justice

Since the criminal justice system is often seen as a gateway to physical and behavioral health services, increased access to those services through the ACA will very likely have a substantive impact on pretrial system decision points. Voluntarily accessing treatment services allows defendants to address critical needs, and may influence decisions regarding diversion from prosecution. Behavioral health needs are often a factor in pretrial detention decisions. Access to insurance coverage and community-based services may prevent unnecessary detention while creating a stable tie to local health and behavioral health care. Educating partners and expanding their perception of pretrial as an access point to services may limit penetration into the criminal justice system, potentially reducing long term recidivism.

Individuals involved in the criminal justice system will represent a large percentage of the Medicaid expansion population and, to a lesser extent, those purchasing health insurance coverage through the health insurance marketplace. Table 2 summarizes the eligibility for accessing the two mechanisms by criminal justice status and income. Pretrial detainees, who are otherwise eligible to enroll in a health insurance plan through the marketplace, will retain that coverage from private insurance unless **sentenced** to incarceration (some private plans may have rules that limit coverage during any incarceration period). Some jails are exploring the possibility of billing private insurance companies for health services delivered to incarcerated pretrial defendants who are covered by such insurance. Some local and state jurisdictions already bill Medicaid for costs incurred while inmates (jail and prison) are hospitalized in the community for more than 24 hours. Taking advantage of the pretrial window to establish sustainable health care access, either through Medicaid or private insurance, can simultaneously contribute to public health and public safety, and potentially result in jail health care cost savings and reduced barriers to treatment for the defendant.

Since most pretrial defendants will be eligible for Medicaid if not detained, there is increased incentive to avoid detaining defendants, and instead, enroll them in Medicaid and connect them to health care and behavioral health treatment in the community. This type of practice change should be paired with the use of a validated pretrial risk assessment tool that assesses for failure to appear and risk to reoffend as well as any voluntary assessment of behavioral health needs. Assessment results can then be used to inform case management and referral while in the community.

Table 2

Status & Income Eligibility		
Status	**Medicaid Expansion (participating states)**	**Insurance Marketplace (all states)**
Pretrial (not detained)	Yes (under 133% of FPL)	Yes (133%-400% of FPL)
Pretrial detainees	No	Potentially, depending on specific eligibility requirements of the selected plan.
Other criminal justice involved individuals in the community	Yes (under 133% of FPL)	Yes (133%-400% of FPL)
Individuals sentenced to and incarcerated in jail or prison	No (unless in community-based hospital care for >24hrs)*	No†

* Since 1997, the federal government has allowed matching Medicaid funds to pay for specialized hospital care for 24 hours or more outside the prison system for inmates who were enrolled in or eligible for Medicaid before their incarcerations http://www.kaiserhealthnews.org/stories/2013/december/04/medicaid-to-cover-former-prisoners.aspx.

† http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

Pretrial defendants who are not covered by insurance will be eligible for either Medicaid (in participating states) or for purchasing insurance from the Health Care Marketplace. Both types of coverage are required to provide a core package of items and services, known as Essential Health Benefits (EHB). Under the ACA, EHB must include items and services within at least the following ten categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. **Mental health and substance use disorder services, including behavioral health treatment**
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services

9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care[9] [10]

In addition to the traditional health care benefits, the EHB that is key to the criminal justice system, and has the potential to most impact pretrial decision points, is the requirement that Medicaid and Marketplace providers cover mental health and substance use disorder services, including behavioral health treatment. **Sixty-five percent of all adults in the US corrections system meet medical criteria for drug and/or alcohol use disorders, and treatment participation reduces subsequent criminal activity by 33%-70%, depending on the model**[11]. Given the high percentage of criminal justice system involved individuals with behavioral health and health care needs, increased access to treatment through Medicaid or Marketplace insurance has the potential to substantially improve the health and decrease the criminal activity of this population.

The ACA provided Medicaid and marketplace insurance coverage breaks down current barriers to treatment and enhances public safety by addressing some of the root causes of criminal behavior, such as chronic health conditions, mental illness, addiction, and other behavioral health issues. Enrolling pretrial

9 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html

10 The Affordable Care Act also directs that EHB be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, the final rule defines EHB based on a state-specific benchmark plan. States can select a benchmark plan from among several options, including the largest small group private health insurance plan by enrollment in the state. The final rule provides that all plans subject to EHB offer benefits substantially equal to the benefits offered by the benchmark plan. This approach best strikes the balance between comprehensiveness, affordability, and state flexibility. The final rule also gives issuers the flexibility to offer innovative benefit designs and a choice of health plans.

The benchmark plan options include: (1) the largest plan by enrollment in any of the three largest products by enrollment in the state's small group market; (2) any of the largest three state employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the Health Maintenance Organization (HMO) plan with the largest insured commercial non-Medicaid enrollment in the state. Twenty-six states selected their own benchmark. The final rule also clarifies that in the remaining states that do not make a selection, Health and Human Services (HHS) will select the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default base-benchmark plan. The selected benchmark plans are already finalized for benefit year 2014.

If a benchmark plan is missing any of the 10 statutory categories of benefits, the final rule provides direction on how the state, or HHS where the default base-benchmark plan applies, will supplement the benchmark plan in that category. The final rule also includes standards to protect consumers against discrimination and ensure that benchmark plans offer a full array of EHB benefits and services. For example, the final rule:

- Prohibits discriminatory benefit designs;
- Includes special standards and options for coverage of benefits not typically covered by individual and small group policies today, including habilitative services; and
- Includes standards for prescription drug coverage to ensure that individuals have access to needed prescription medications.

11 Mancuso, D., & Felver, B. (2009). Providing chemical dependency treatment to low-income adults results in significant public safety benefits. Retrieved from http://publications.rda.dshs.wa.gov/1372/

defendants in coverage and facilitating access to treatment through referrals and diversion opportunities will result both in decreased criminal activity and cost savings to tax payers.

A Front Door to Coverage

ACA uses the no wrong door approach to enrollment. It requires a coordinated and streamlined eligibility and enrollment process for all Insurance Affordability Programs (IAPs), including Medicaid, the Children's Health Insurance Plan (CHIP), and advance premium tax credits/cost sharing reductions to purchase marketplace plans. To meet the demand of the millions of enrollees, states are required to "maximize automation and minimize paperwork by deploying new technology, simplifying eligibility policies/processes, and integrating systems so individuals are efficiently directed to their correct coverage."[12] Individuals only need to complete a single, streamlined application to enroll in coverage, and that application may be submitted on line, by telephone, through the mail, or in person. [13] [14]

Financial eligibility will be verified primarily through self-attestation, although to the extent possible, state systems are required to conduct electronic income verification by matching data with the Social Security Administration and the Internal Revenue Service through a federally operated data hub. States may request documentation from individuals, but only when electronic data is not available.[15] Medicaid eligibility determination is also simplified and no longer includes requirements such as in-person interviews, paper documentation, and asset tests. Other non-financial eligibility criteria for Medicaid that still remain include federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.[16]

The ACA includes provisions for several types of consumer assistance providers (Navigators and Certified Application Counselors) who are trained to provide individuals with assistance in completing the enrollment application and often have financial incentives to increase enrollment. Pretrial agencies and other public safety partners may choose to partner with other public agencies or community organizations to access these resources or assign their own staff to participate in the training, achieve certification, and deliver the enrollment assistance. Either way, consumer assistance providers will be trained to support all consumers, including pretrial defendants, to enroll in coverage.

12 The ACA introduces a simplified eligibility standard, based on modified adjusted gross income (minimum level of 133% FPL), for public and publicly subsidized coverage, including Medicaid, CHIP, and coverage through Exchanges, and requires seamless, no wrong door enrollment systems. States will need to upgrade or replace eligibility system technology, and develop policies and processes aligned with new federal standards for simplification and integration to ensure that consumers can enroll in coverage through one process. https://www.statereforum.org/discussions/eligibility-and-enrollment

13 http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Downloads/Realtimebrief.pdf

14 http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Real-Time-Determinations.pdf

15 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/income-verification-8-5-2013.pdf

16 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html

Navigators: Navigators play a vital role in helping individuals establish eligibility and enroll in coverage. This includes assisting enrollees to determine if they qualify for insurance affordability programs (including a premium tax credit, cost sharing reductions, Medicaid and the Children's Health Insurance Program). Navigators will also provide outreach and education to consumers to raise awareness about the ACA coverage opportunities and will refer consumers to ombudsmen and other consumer assistance programs when necessary.[17] Navigators receive 20-30 hours of comprehensive training to be certified, additional training throughout the year, and must renew their certification annually. They provide unbiased information in a culturally competent manner to consumers about health insurance and are required to adhere to strict security and privacy standards.[18]. Funding for Navigators is provided through state and federal grants and is available to eligible private and public organizations and individuals.[19]

Certified Application Counselor Organization: Organizations that meet certain criteria may apply online to certify application counselors (CACs) who perform many of the same functions as Navigators.[20] These organizations include community health centers or other health care providers, hospitals, or social service agencies.[21] While not funded directly through the ACA, other funding (federal, state, and private) may be available to support this work. Once certified, staff from CAC organizations can access a five-hour, on-line training to get certified to provide consumer assistance.[22]

A Call to Action for Pretrial Services

Medicaid and Marketplace insurance coverage will increase access to health care and behavioral health care services for pretrial defendants, improving health, decreasing addiction and criminal behavior, and decreasing public safety costs. In order to ensure this occurs, pretrial agencies and their public safety partners must ensure that pretrial defendants are screened and enrolled in the appropriate coverage. Currently, in most states and local jurisdictions, limited resources translate to a limited number of affordable behavioral health treatment slots available for pretrial defendants, and often there is a substantial wait to access those limited slots. This limitation results in increased use of jail resources as defendants are detained while waiting for available treatment slots. Enrolling defendants in insurance coverage expands their ability to access services, as

17 http://www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf

18 http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-08-15.html

19 On August 15, 2013, CMS awarded $67 million in Navigator Cooperative Agreements to 105 entities to serve in the 34 Federally-facilitated and State Partnership Marketplaces. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf

20 http://marketplace.cms.gov/help-us/cac.html

21 http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html

22 http://marketplace.cms.gov/help-us/common-qandas-about-cac-designation.pdf

treatment providers will now be able to bill Medicaid and Marketplace insurance plans for services provided to these defendants. This enhanced access to treatment should decrease or eliminate the practice of delaying release decisions until treatment slots are available and will result in cost savings for public safety agencies, reduced lengths of stay, and more efficient case processing.

Pretrial agencies are in a position to take a leadership role in these system changes by enrolling defendants in insurance coverage and working with partners to implement related system changes. A few key steps are outlined below to guide pretrial leaders in this effort.

1. Actively Represent Pretrial in Collaborative Planning Efforts

The implementation of the ACA has implications for practice change across the criminal justice system. From booking and arraignment, to community-based supervision, to release from prison, almost all criminal justice decisions points will need to consider the implications of the ACA. Jurisdictions that have convened criminal justice coordinating councils (CJCCs) or similar cross-agency bodies are well positioned to approach these changes in a coordinated way. All system partners stand to save resources and decrease recidivism by enrolling criminal justice involved individuals in health insurance coverage, thereby facilitating access to treatment. CJCCs should engage in conversations and plan for how they will integrate this new resource throughout their systems.

Pretrial services agencies should consider building collaborations with their local and state partners to better integrate ACA opportunities into their current practice. For example, a pretrial agency may partner with their local health department, which has been certified as an application counselor organization, to co-locate pretrial and health department CAC staff. This would allow CACs direct access to pretrial defendants to assist them with eligibility determination and enrollment. Similar partnerships are being developed between jails and local CAC organizations to enroll inmates prior to release.

In addition to working closely with criminal justice partners, agencies interested in integrating enrollment into their practice should join in and participate in the ACA related health care coalitions that are occurring in their state and local jurisdictions. State and local agencies responsible for Medicaid, insurance marketplaces, public health, behavioral health, mental health, and substance abuse treatment are meeting regularly and discussing logistics around ACA implementation. While corrections health staff sometimes participate in these forums, it is rare that staff from organizations that operate pretrial or probation participate. It is imperative that criminal justice agencies join those conversations whenever possible. By participating in these conversations, criminal justice agencies can provide valuable information about the needs and special circumstances of a large portion of the newly insured population.

2. Develop a Plan for Screening and Enrollment

Developing a plan for screening and enrollment will require thoughtful consideration. Pretrial agencies should work closely with their partners to determine how best to integrate this new activity into the existing practice and what resources will need to be allocated to do so. Bringing key stakeholders together from

both the criminal justice and health care fields to map the criminal justice system and identify enrollment opportunities can help facilitate this process. Fully integrating the enrollment process into existing pretrial protocols and systems is necessary to maximize the health and safety opportunities presented by ACA. Starting in October 2013, agencies can begin enrolling defendants in coverage and in January 2014 that coverage will become effective. Pretrial agencies may choose to have their own staff trained as CACs or to work closely with local organizations that have certified Navigators or CACs to integrate eligibility determination and enrollment support into pretrial operations. Once defendants are enrolled in coverage, support for access to treatment through referral or diversion opportunities should be provided as much as possible. This is a key component of improving the health of this population, addressing root causes of offending behaviors, reducing related criminal activity, and making better use of criminal justice resources. Ongoing assessment of screening and enrollment protocols is also necessary to troubleshoot issues and support continuous improvement efforts.

3. Begin Addressing Larger Policy Questions

Implementation and integration of ACA is not without challenges for the criminal justice system, including lack of funding for administrative costs, unanswered questions regarding enrollment logistics, and issues of treatment provider capacity and readiness. Jurisdictions may want to consider and address some of the following challenges as part of their planning process:

- Are local treatment providers prepared to bill Medicaid and private insurance providers for services delivered to pretrial and other criminal justice involved individuals?
- Is there sufficient treatment capacity within the local system to serve the influx of new insurance enrollees?
- How can criminal justice agencies ensure that the treatment provided to pretrial defendants is in alignment with evidence-based approaches when the treatment is funded via Medicaid or private insurance?
- What will happen to existing funding that is currently used for substance abuse and mental health treatment for defendants? Can it be shifted to fund wrap around/support services and/or enrollment infrastructure?
- What happens when the federal funding for newly eligible adults phases down (coverage is funded at 100% for three years, beginning in 2014, phasing down to 90% by 2020.) [23]
- If a pretrial detainee is covered by Medicaid, what are the state level rules for suspension versus termination of benefits while incarcerated (federal regulations allow for suspension, but some states still terminate)?
- At what point prior to release can pretrial detainees complete the enrollment application?
- What follow-up support will be available to defendants after they are enrolled in coverage?
- How can we measure the impact of increased insurance coverage on pretrial detention, diversion, jail populations, and recidivism?

23 http://www.medicaid.gov/AffordableCareAct/Provisions/Financing.html

CONCLUSION

Implementation of the ACA has moved at a quick pace and there remain many unanswered questions, especially about how criminal justice and health care systems will interact and coordinate services. These issues should not delay planning and preparation of the needed changes for pretrial agencies. Through discussion and coordination with partners, pretrial agencies can effect immediate change for defendants involved in the criminal justice system and improve the health and safety of the communities they serve.

For More Information, contact:

- Your local health department
- Your state's Medicaid administrator
- Your state's Insurance Marketplace administrator
- The federal health insurance marketplace managed by the U.S. Centers for Medicare and Medicaid Services
  » https://www.healthcare.gov/
- The U.S. Department of Health and Human Services (HHS) hub for information about ACA and the insurance marketplace
  » http://www.hhs.gov/healthcare/
- The U.S. Centers for Medicare & Medicaid Services which provides coverage through Medicare, Medicaid, the Children's Hospital Insurance Program and soon, through the Health Insurance Marketplace.
  » http://www.cms.gov/
- An online toolkit to help Criminal Justice organizations and agencies prepare for open enrollment provided by the Substance Abuse and Mental Health Administration (SAMHSA).
  » http://tiny.cc/CriminalJustice
- A hub of information offering health reform information and resources provided by the Henry J. Kaiser Family Foundation.
  » http://kff.org/health-reform/
- The Commonwealth Fund, a private foundation working toward a high performance health system offering a variety of health reform resources.
  » http://www.commonwealthfund.org/Topics/Health-Policy-Reform.aspx

PRETRIAL JUSTICE AND THE AFFORDABLE CARE ACT: FREQUENTLY ASKED QUESTIONS

1. What role can the Affordable Care Act (ACA) play in pretrial?

Behavioral health services are Essential Health Benefits under the ACA. Defendants who are enrolled in coverage can access services while in the community. More generally, connecting defendants to health insurance and health services offers a stabilizing connection to the community and has the potential to reduce criminal risk.

2. Are pretrial defendants eligible for coverage under the ACA?

Defendants who are not incarcerated are eligible to purchase private insurance through the Marketplace and may be eligible for Medicaid, depending on state requirements. Depending on state policy, incarcerated defendants may be eligible to enroll in Medicaid, but are not eligible for coverage until they are released (or placed in a community-based hospital for over 24 hours). Incarcerated defendants may be eligible for private Marketplace insurance coverage depending individual policy rules.

3. How can defendants access coverage?

Defendants can enroll online, by phone, or by paper, or they can seek assistance through the process from Certified Application Counselors or Navigators. Pretrial agencies can collaborate with local health departments or other agencies to access these services, or pretrial agencies or jails may choose to have staff seek certification.

4. When will new insurance policies take effect?

Coverage eligibility through Medicaid (for participating states) and the insurance Marketplace begins on January 1, 2014. For most participating states, once enrolled, coverage will take effect immediately or within 24 hours of enrollment.

5. What happens if defendants do not pay premiums?

Like any insurance plan, if a defendant has private insurance through the Marketplace and does not pay the required premiums, the policy may be terminated. This could have tax implications for the defendant, and more immediately could affect access to behavioral health treatment and the ability to fulfill court conditions.

6. How do I find out what my state is doing to implement the ACA?

Your state Medicaid administrator or Insurance Marketplace administrator are good sources for information, and general information is available through the federal Department of Health and Human Services at http://www.hhs.gov/healthcare/

7. How do I find out what my county is doing to implement the ACA?

Many counties have collaborative groups working on ACA implementation. Your own agency administrator may have information, or the county health department would be a likely source as well.