

ARTICLES

The Reincorporation of Prisoners into the Body Politic: Eliminating the Medicaid Inmate Exclusion Policy

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Incarcerated people are excluded from Medicaid coverage due to a provision in the Social Security Act Amendments of 1965 known as the Medicaid Inmate Exclusion Policy (“MIEP”). This Article argues for the elimination of the MIEP as an anachronistic remnant of an earlier era prior to the massive growth of the U.S. incarcerated population and the expansion of Medicaid eligibility under the Patient Protection and Affordable Care Act of 2010. It explores three reasons for eliminating the MIEP. First, the inclusion of incarcerated populations in Medicaid coverage would signify the final erasure from the Medicaid regime of the distinction between the “deserving” and “undeserving” poor and is consistent with and in furtherance of the ACA’s ultimate goal of universal health insurance coverage. Second, elimination of the MIEP furthers the bipartisan criminal legal system reform focus on reducing recidivism through effective reentry. Current efforts to use Medicaid to facilitate reentry require careful workarounds of the MIEP. Elimination of the policy would reduce logistical hurdles to ensuring continuity of care and enhance rehabilitation services provided during incarceration. Third, eliminating the MIEP coalesces with the goals of the emerging discourse around health justice, and specifically, its focus on how social determinants of health drive inequities. In including a health justice framework, this Article seeks to enrich the discussion in two directions. In the first instance, health justice illuminates structural factors such as discrimination and poverty that are root causes of health inequities and must be addressed alongside immediate health needs. At the same time, this Article aims to deepen the health justice discussion with a sharper focus on the role of incarceration in perpetuating health inequities, and the ways in which extending Medicaid access to incarcerated populations can improve treatment of

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immediate needs while also addressing structural inequities that cause and are caused by justice system involvement.

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I. INTRODUCTION

Incarcerated and formerly incarcerated people in the United States have long been treated as less deserving of basic human rights and full citizenship on account of their crimes. In addition to numerous other forms of marginalization, they have frequently been excluded from eligibility for public benefits, whether through statutory design or subsequent rulemaking. It is in this tradition that the Social Security Amendments Act of 1965, which established Medicaid and Medicare, excluded from eligibility “inmate[s] of a public institution.”¹ This provision has come to be termed the Medicaid Inmate Exclusion Policy (“MIEP”). Initially, the MIEP had little practical effect. In its initial iteration, Medicaid eligibility was limited to low-income families, children, pregnant women, seniors, and disabled individuals, so the predominately adult male prison population was already largely ineligible. Furthermore, in 1965, the entire state and federal prison population was a paltry 210,895.²

1. The MIEP and the IMD Exclusion discussed below are both found in 42 U.S.C. § 1396d (“except as otherwise provided in paragraph (16), such term does not include—(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases (except in the case of services provided under a State plan amendment described in section 1396n (l)).”).

2. BUREAU OF JUST. STATS., U.S. DEP’T OF JUST., NCJ-111098, HISTORICAL STATISTICS ON PRISONERS IN STATE AND FEDERAL INSTITUTIONS, YEAR END 1925-86, (1988), <https://www.ncjrs.gov/pdffiles1/Digitization/111098NCJRS.pdf>.

In recent years, however, the significance of the MIEP has grown enormously because of two important and separate shifts: (1) the tremendous growth of the state and federal prison population and (2) the significant expansion of Medicaid eligibility. In 2020, there were nearly 2.3 million people incarcerated in the U.S., including 1,291,000 in state prisons, 631,000 in local jails, and 226,000 in federal prisons.³ For “low-skill” Black men in particular, incarceration has become a “routine life event,” with some 1 in 5 spending some portion of their lives incarcerated.⁴ Under the Patient Protection and Affordable Care Act of 2010 (“ACA”), 39 states expanded Medicaid by raising income eligibility limits to 138% of the federal poverty level and adding categorical eligibility to include adults without dependent children.⁵ These two policy shifts greatly expanded Medicaid eligibility among the population of impoverished Americans, which overlaps to a significant extent with the U.S. incarcerated population.⁶ Indeed, some advocates and scholars consider Medicaid to be one of the most significant anti-poverty programs in the United States today.⁷ Yet because of the MIEP,

3. Press Release, Wendy Sawyer & Peter Wagner, Prison Policy Initiative, *Mass Incarceration: The Whole Pie 2020* (Mar. 24, 2020), <https://www.prisonpolicy.org/reports/pie2020.html>. The 2.3 million figure also includes juvenile correctional facilities, immigration detention facilities, Indian Country jails, military prisons, civil commitment centers, state psychiatric hospitals, and prisons in U.S. territories. Note that the jail figure dramatically understates the number of people incarcerated in a given year. Because of short-term stays, there is high turnover of the jailed population, with some 10.6 million jail admissions in 2016, down from the 2008 peak figure of 13.6 million. U.S. DEP’T OF JUST. BUREAU OF JUST. STATS., NCJ-230394, *JAIL INMATES IN 2016* (2016). In this Article, I am primarily focused on the population of adult U.S. citizen inmates, as that is the population that would be newly eligible for Medicaid if MIEP were eliminated. Although there are certain distinctions between jail and prison populations and conditions, my arguments do not distinguish between the two except where otherwise specified.

4. Most statistical work about life chances of incarceration are based on incarceration rates from the late 1990s, at which point it was estimated that 1 in 4 Black men would spend some time in prison. U.S. DEP’T OF JUST. BUREAU OF JUST. STATS., NCJ-160092, *LIFETIME LIKELIHOOD OF GOING TO STATE OR FEDERAL PRISON* (Mar. 1997). See also Bruce Western & Becky Pettit, *Mass Imprisonment and the Life Course: Race and Class Inequality in U.S. Incarceration*, 69 AM. SOCIO. REV. 2 (2004) (finding that for those born between 1965 and 1969, 3% of white men and 30% of Black men had served time in prison by their early 30s, with 30% of those without college education and 60% of high school dropouts going to prison by 1999); Bruce Western & Christopher Wildeman, *The Black Family and Mass Incarceration*, 621 ANNALS AM. ACAD. POL. & SOC. SCI. 221 (2009). Incarceration rates for Black men have fallen modestly since 2008, so a 1 in 5 statistic is likely more accurate today, but precise recalculations have not been reported in the research literature.

5. *Overview of the Affordable Care Act and Medicaid*, MEDICAID & CHIP PAYMENT & ACCESS COMM’N, <https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid/> (last visited May 13, 2021) [hereinafter *Overview of the ACA and Medicaid*]. Under the statute, the level is actually set at 133% of poverty, but with a 5% disregard.

6. *Id.* See also Adam Looney and Nicholas Turner, BROOKINGS INST., *Work and opportunity before and after incarceration* (Mar. 14, 2018), <https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/>.

7. See, e.g., Naomi Zewde & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions Over Time*, 38 HEALTH AFFAIRS 132 (2019) (finding a .917% reduction in poverty in states that opted into the ACA Medicaid expansion, for a total of 690,000 people lifted out of poverty); Dahlia K. Remler, Sanders D. Korenman & Rosemary T. Hyson, *Estimating the Effects of Health Insurance and other Social Programs on Poverty Under the Affordable Care Act*, 36 HEALTH AFFAIRS 1828 (2017) (finding that one-third of overall poverty reduction from public benefits came from public health insurance benefits, and that Medicaid had a larger effect on child poverty than all non-health means-tested benefits combined); Benjamin D. Sommers & Donald Oellerich, *The Poverty-Reducing Effect of Medicaid*, 32 J. HEALTH ECON. 816-32 (2013) (finding that even prior to the ACA, Medicaid was the U.S.’s third largest anti-poverty program, keeping 2.6 million to 3.4 million people out of poverty in 2010).

federal Medicaid dollars remain largely unavailable for medical or mental health treatment for the incarcerated population.⁸

Despite its increasing significance, the MIEP has received relatively little attention from either criminal legal system scholars and advocates, or poverty and health law scholars and advocates. This Article is the first in the law review literature to address repealing the MIEP in furtherance of decarceration and reduction of health inequities. Although the focus in this Article is on repeal of the MIEP, I posit this as one of many measures that should be undertaken to reincorporate the currently and formerly incarcerated into society as full-fledged citizens. I view this as one small and relatively technocratic contribution to the larger project of ending the racialized othering of incarcerated people toward the goal of reducing mass incarceration and building a more racially and economically equitable society.⁹

This Article explores three reasons the MIEP should be repealed. First, the inclusion of prisoners in Medicaid coverage is consistent with the ACA's ultimate goal of achieving universal health insurance coverage.¹⁰ Insofar as Black men remain disproportionately incarcerated with respect to every other demographic group, their exclusion from Medicaid while incarcerated significantly and unacceptably reduces the program's purported universality in racially disparate fashion.¹¹ Eliminating the MIEP would signify the final erasure from the Medicaid

8. The few exceptions are described below in Section I. Because Medicaid is a joint federal-state program, the MIEP operates by restricting the availability of Federal Financial Participation ("FFP"), which is the federal government's share of Medicaid expenditures, rather than a blanket prohibition. FFP constitutes the majority of Medicaid funding, although the exact ratio of federal to state funding varies by state. Under the ACA, the FFP was initially 100% of expansion costs for states that opted into the expansion and reduced to 95% in 2020. Thus, in practical terms, FFP restrictions are equivalent with benefit restrictions. See Andrew Hammond, *Litigating Welfare Rights: Medicaid, SNAP, and the Legacy of the New Property*, 115 NW. U. L. REV. 361, 366-67 (2020) (noting that Medicaid is the third most expensive domestic program in the federal budget, the largest contribution that the federal government makes to state budgets, and still the second largest expenditure by states).

9. For accounts of the radical and racialized othering of prisoners, see Mona Lynch, *The Contemporary Penal Subject(s)*, in AFTER THE WAR ON CRIME: RACE, DEMOCRACY, AND A NEW RECONSTRUCTION 98 (Mary Louise Frampton et al. eds., 2008). See also Joseph E. Kennedy, *Monstrous Offenders and the Search for Solidarity Through Modern Punishment*, 51 HASTINGS L.J. 829 (2000); KHALIL GIBRAN MUHAMMAD, *THE CONDEMNATION OF BLACKNESS: RACE, CRIME, AND THE MAKING OF MODERN URBAN AMERICA* (2010). For approaches to reintegration of formerly incarcerated people, see Joy Radice, *The Reintegrative State*, 66 EMORY L. REV. 1315, 1318 (2017) (developing "a holistic framework sequencing reintegration approaches throughout the criminal justice system – not just after sentencing or after release – that are automatic, proportional, and intentional"). Recent aspects of the reintegrative project have been affected through reforms to restore the vote to people with felony convictions, restore Pell grant eligibility to prisoners, lift restrictions on TANF benefits to people with felony convictions, and expand criminal record sealing expungement (e.g., Michigan, Illinois, Colorado).

10. Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y L. & ETHICS 67 (2015); David A. Super, *A Hiatus in Soft-Power Administrative Law: The Case of Medicaid Eligibility Waivers*, 65 UCLA L. REV. 1590, 1609 (2018).

11. See Ruqaiyah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1286-87 (2012).

regime of the long-standing distinction between “the deserving poor” and “the undeserving poor.”¹²

Second, elimination of the MIEP would further the “Smart on Crime” bipartisan criminal legal system reform focus on reducing recidivism through effective reentry. On average, the justice-involved population exhibits high rates of mental illness and substance abuse which go largely untreated in prisons and jails, and are partly responsible for high recidivism rates.¹³ Efforts are already underway in many jurisdictions to ensure continuity of care by facilitating Medicaid enrollment and/or reactivation for individuals just prior to release.¹⁴ Eliminating the MIEP would significantly reduce the logistical hurdles to such programs and make federal Medicaid funding available to provide effective treatment long before release, reinvigorating the rehabilitation focus that once animated American penal philosophy but that was abandoned several decades ago in favor of more punitive policies.¹⁵

12. Nicole Huberfeld, *Federalism in Health Care Reform*, in HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197, 203, 205 (Ezra Rosser ed. 2019).

13. Edward P. Mulvey & Carol A. Schwert, *Mentally Ill Individuals in Jails and Prisons*, 46 CRIME & JUST. 231 (2017); E. Lea Johnston, *Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness*, 71 FLA. L. REV. 515 (2019)

14. See, e.g., Arielle McPherson, *Controlling Crime Through Medicaid Expansion: The Convergence of Medicaid and the Criminal Justice System in the Effort to Reduce Re-Incarceration*, 28 ANNALS HEALTH L. ADVANCE DIRECTIVE 131 (2018); JENNIFER RYAN, LUCY PAGEL, KATY SMALL, SAMANTHA ARTIGA, ROBIN RUDOWITZ & ALEXANDRA GATES, KAISER FAM. FOUND., CONNECTING THE JUSTICE-INVOLVED POPULATION TO MEDICAID COVERAGE AND CARE: FINDINGS FROM THREE STATES (June 1, 2016), <https://www.kff.org/medicaid/issue-brief/connecting-the-justice-involved-population-to-medicaid-coverage-and-care-findings-from-three-states/view/print/>; KAMALA MALLIK-KANE ET AL., URB. INST. USING JAIL TO ENROLL LOW-INCOME MEN IN MEDICAID (2016), https://www.urban.org/sites/default/files/publication/86666/using_jail_to_enroll_low_income_men_in_medicare.pdf; Natasha Camhi et al., *Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System*, COMMONWEALTH FUND (Nov. 18, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system>; Risdon N. Slate & Laura Usher, *Health Coverage for People in the Justice System: The Potential Impact of Obamacare*, 78 FED. PROBATION J. 2, 19 (2014); Shane Levesque, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711 (2010); Sabeena Bali, *The Economic Advantage of Preventative Health Care in Prisons*, 57 SANTA CLARA L. REV. 453 (2017); David Cloud, *On Life Support: Public Health in the Age of Mass Incarceration*, VERA INST. FOR JUST. (Nov. 2014), <https://www.vera.org/publications/on-life-support-public-health-in-the-age-of-mass-incarceration>; NAT'L CONF. OF STATE LEGISLATURES, RETURNING HOME: ACCESS TO HEALTH CARE AFTER PRISON (July 2009), <https://www.ncsl.org/documents/health/returninghome.pdf>; Sachini N. Bandara et al., *Leveraging the Affordable Care Act to Enroll Justice-Involved Populations in Medicaid: State and Local Efforts*, 34 HEALTH AFF. 12, 2044-51 (2015); Juhie L. Kumar, *Criminal Justice and Public Health: A Need for Cross-System Collaboration Between Jails and Medicaid to Reduce Recidivism* (2015) (M.P.H. thesis, University of Washington) (on file with the Suzzallo and Allen Libraries, University of Washington); Evelyn Malave, *Prison Health Care After the Affordable Care Act: Envisioning an End to the Policy of Neglect*, 89 N.Y.U. L. REV. 700 (2014); Elizabeth Snyder, *Medicaid and Prisoner Reentry: Suspension is the New Black*, 26 KAN. J.L. & PUB. POL'Y 84 (2016).

15. See, e.g., MARIE GOTTSCHALK, CAUGHT: THE PRISON STATE AND THE LOCKDOWN OF AMERICAN POLITICS 9, 16-17 (2015) (describing the turn against rehabilitation and judicial discretion in the 1970s, resulting in broad legislative and policy shifts at both state and federal levels leading to harsher sentences and fewer opportunities for early release on the backend); Jonathan Simon, *The Return of the Medical Model: Disease and the Meaning of Imprisonment from John Howard to Brown v. Plata*, 48 HARVARD C.R.-C.L. L. REV. 217 (2013) (tracing “the medical model” of penology through history, and noting the shift away from a rehabilitation focus in the 1970s).

Third, eliminating the MIEP is consistent with the goals of the emerging health justice discourse—specifically, its focus on how social determinants of health drive inequities in healthcare access, treatment, and outcomes. My hope in including a health justice framework in this Article is to enrich the discussion in two directions. In the first instance, health justice illuminates that structural factors such as discrimination and poverty are root causes of health inequities and must be addressed alongside immediate health needs. Health justice thus underscores the importance of extending Medicaid benefits to incarcerated people, who are in statistically poorer health than the general population as they face structural inequities before involvement in the criminal legal system, are subjected to health-harming conditions while incarcerated, and face even greater struggles with discrimination and poverty upon conviction and incarceration. Whereas the Smart on Crime lens focuses on evidence-based policymaking that avoids moral considerations in the interests of maintaining bipartisan agreement, health justice reengages with the righteousness of reducing health inequities largely along racial lines through collective action.

At the same time, while the emerging health justice literature has nodded to incarceration as a factor, it has yet to grapple fully with the role that incarceration plays as a social determinant of health, alongside unequal access to healthcare, housing, and food insecurity, and un- and underemployment. As of 2020, 77 million Americans had a criminal record.¹⁶ Poor people – and particularly poor people of color – are disproportionately represented within that number. The reasons for that disparity include a wide range of structural factors, including disproportionate policing of poor neighborhoods, the criminalization of poverty, constrained life choices, and racially disparate impacts at every stage of the criminal legal system from police stops through sentencing.¹⁷ For the historically marginalized communities that health justice takes as its subject, entanglement with the criminal legal system cannot be ignored. I hope this Article will enrich the health justice discussion with a sharper focus on the role of incarceration in

16. Sawyer & Wagner, *supra* note 3. Not everyone with a criminal conviction spends time incarcerated. In fact, in 2020, there were some 840,000 people on parole and 3.6 million people on probation. *See id.* The detrimental effects of community supervision and the growing use of e-carceration as a problematic path out of mass incarceration is a topic of new focus for advocates and scholars. *See, e.g.,* Chaz Arnett, *From Decarceration to E-Carceration*, 41 CARDOZO L. REV. 641 (2019). While less disruptive than incarceration, these forms of surveillance negatively affect the ability of individuals to work, care for themselves and others, and move freely about the world, which all undoubtedly impact their health and their dependents' health. And regardless of what the sentence is, the effects of a criminal conviction itself on access to secure housing, employment, education, and public benefits, among other social determinants of health, are well-documented.

17. *See generally* MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010); ELIZABETH HINTON, *FROM THE WAR ON POVERTY TO THE WAR ON CRIME: THE MAKING OF MASS INCARCERATION IN AMERICA* 1-26 (2016); JOHN PFAFF, *LOCKED IN: THE TRUE CAUSES OF MASS INCARCERATION AND HOW TO ACHIEVE REAL REFORM* 45-49 (2017); BRUCE WESTERN, *HOMeward: LIFE IN THE YEAR AFTER PRISON* 156-173 (2018); DANIELLE SERED, *UNTIL WE RECKON: VIOLENCE, MASS INCARCERATION, AND A ROAD TO REPAIR* 1-15 (2019); Mariame Kaba, *The System Isn't Broken in We Do This 'Til We Free Us: ABOLITIONIST ORGANIZING AND TRANSFORMING JUSTICE* (2021); PETER EDELMAN, *NOT A CRIME TO BE POOR: THE CRIMINALIZATION OF POVERTY IN AMERICA* (2017); Loïc Wacquant, *Class, Race & Hyperincarceration in Revanchist America*, 139 DAEDALUS 3, 74-90 (2010); Western & Wildeman, *supra* note 4 at 621; Nicole Smith Futrell, *Vulnerable, not Voiceless: Outsider Narrative in Advocacy Against Discriminatory Policing*, 93 N.C. L. Rev. 1597, 1599-1603 (2015).

perpetuating health inequities and how extending Medicaid access to the incarcerated population can improve treatment of immediate needs while also beginning to alleviate structural inequities that cause and are caused by justice system involvement.

This Article proceeds as follows. Part II briefly provides the background and context of the MIEP and compares it to the only similar exclusion in the Medicaid statute: the Institutions of Mental Disease (“IMD”) Exclusion. This section highlights how the federal government has chosen to fund aspects of state-level criminal legal systems that have contributed to mass incarceration, despite falling within the quintessential state exercise of the police power, while choosing not to fund other aspects of those systems such as correctional health and mental health treatment, on the grounds that they constitute traditional state concerns. Part II also describes how these policy choices have contributed to a U.S. incarcerated population that is massively larger and significantly sicker than ever before, underscoring the increasingly anomalous nature of the MIEP.

Part III situates the case for repealing the MIEP within the context of the ACA’s underlying purpose of providing universal healthcare coverage and its intent to eliminate the distinction between the “deserving” and “undeserving” poor. Part IV turns to the “Smart on Crime” bipartisan reform agenda and examines how Medicaid is already facilitating effective reentry and yielding reduced recidivism, and the ways in which repeal of the MIEP would further enhance such efforts. Part V draws on emerging health justice literature to argue that repealing the MIEP is not only a pragmatic solution to the revolving door of the criminal legal system but also the morally righteous path to addressing health inequities caused by racial bias and other social determinants of health, including incarceration.

II. HISTORY AND CONTEXT OF THE MEDICAID INMATE EXCLUSION POLICY

The 1965 Social Security Amendments Act that created Medicaid and Medicare was one of the centerpieces of President Lyndon Johnson’s Great Society program. Largely due to lobbying by the elderly and by the states, Medicare was designed as a program that would be universally available to elderly Americans and would be fully funded and administered by the federal government.¹⁸ While its creation was a contested process, over time, Medicare has become one of the most popular social programs in the U.S. in large part because its universality has given rise to widespread buy-in.¹⁹

By contrast, Medicaid was built on the scaffolding of an earlier generation’s Poor Laws, distinguishing between the “deserving poor” and the “undeserving poor,” or the “able-bodied,” and expanding on existing federal-state partnerships around healthcare coverage for the indigent.²⁰ Thus Medicaid eligibility was limited to low-income families, children, pregnant women, seniors, and disabled individuals, with income eligibility capped at 133% of the federal poverty level

18. Huberfeld, *supra* note 12, at 203. My understanding of this history largely draws on the work of Professor Nicole Huberfeld.

19. *See id.* This reflects a dynamic that is frequently replicated in which programs for the poor are considered forms of “welfare,” while programs that redistribute wealth to middle- and upper-class Americans are never viewed through that lens.

20. Huberfeld, *supra* note 12, at 201.

(“FPL”) for children aged 1-5 and 100% FPL for children aged 6-18.²¹ Although it varied by state, the average income eligibility limit for a family of 3 in the United States in 2013, prior to the expansion taking full effect, was 64% of the federal poverty limit.²² As discussed below, the distinction between the deserving poor and the able-bodied, while rooted in Elizabethan notions of moral worth, took on a distinctly American character during the 18th century, drawing on racist notions about the productive capability of enslaved and formerly enslaved people.²³ As Professor Nicole Huberfeld has demonstrated, one barely has to scratch the surface to see how this way of thinking carried into congressional debates over Great Society programs, and even into the debates about the ACA’s Medicaid expansion.²⁴

Aside from the eligibility limitations based on these conceptions of relative vulnerability, the Medicaid statute contained only two categorical exclusions. The first, and the focus of this article, is the Medicaid Inmate Exclusion Policy (“MIEP”), which prohibits federal Medicaid funding for the care of “inmate[s] of a public institution.”²⁵ There is one narrow exception to this exclusion: when an inmate is “a patient of a medical institution,” which has been interpreted to mean being hospitalized for 24 hours or longer, Medicaid coverage is available.²⁶ The language of the MIEP was imported from a nearly identical provision in the original 1935 Social Security Act, which precludes inmates from receiving old age cash benefits.²⁷ The 1935 exclusion was likely based on the same distinction between the “deserving” and the “undeserving” poor.²⁸ The 1965 exclusion was more explicitly tied to the justification that corrections is an area of traditional state

21. *Overview of the ACA and Medicaid*, *supra* note 5.

22. Erkmen Aslim, Murat Mugnan, Carlos Navarro & Han Yu, *The Effect of Public Health Insurance on Criminal Recidivism* 7 (Geo. Mason U. L. & Econ. Working Paper, No.19-19, 2019); *See also Medicaid Income Eligibility Limits for Parents, 2002-2021*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 13, 2021) [hereinafter *Medicaid Income Eligibility Limits for Parents 2002-2021*].

23. Huberfeld, *supra* note 12, at 201.

24. *See id.* at 202 (quoting Senator Byrd characterized SSA as paying “able-bodied Negroes to sit around in idleness”).

25. 42 U.S.C. § 1396d et seq 2000.

26. Alexandra Gates, Samantha Artiga & Robin Rudowitz, *Health Coverage and Care for the Adult Criminal Justice-Involved Population*, KAISER FAM. FOUND. (Sept. 5, 2014), <https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/>; Cristine Vestal, *For Aging Inmates, Care Outside Prison Walls*, PEW CHARITABLE TR. (Aug. 12, 2014), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/08/12/for-aging-inmates-care-outside-prison-walls>.

27. Tyler Winkelman, Amy Young, & Megan Zakerski, *Inmates are Excluded from Medicaid – Here’s Why it Makes Sense to Change That*, UNIV. MICH. INST. HEALTHCARE POL’Y & INNOVATION (Feb. 27, 2017), <https://ihpi.umich.edu/news/inmates-are-excluded-medicaid-%E2%80%93-here%E2%80%99s-why-it-makes-sense-change>.

28. LESLIE ACOCA, JESSICA STEPHENS, & AMANDA VAN VLEET, KAISER COMM’N ON MEDICAID AND THE UNINSURED, HEALTH COVERAGE AND CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM: THE ROLE OF MEDICAID AND CHIP, 13 (2014), <https://www.kff.org/wp-content/uploads/2014/05/8591-health-coverage-and-care-for-youth-in-the-juvenile-justice-system.pdf> (citing 1935 Old Age Security Staff Report which included survey of state old age assistance laws and their focus on ensuring that “recipients of relief are ‘deserving’ citizens” and may have formed the basis for the inmate exclusion in 1935 Social Security Act).

concern, and thus states should remain responsible for the care of inmates.²⁹ The result of the MIEP is that the cost of correctional medical costs falls entirely on state correctional budgets, despite the fact that these same individuals, if not incarcerated, would now be covered by federal Medicaid funding.

The other exclusion is the Institutions for Mental Disease (or “IMD”) Exclusion, which originated in the 1965 Act.³⁰ The Act made federal Medicaid funding available for community mental health services, while, through the IMD Exclusion, excluding from coverage any treatment provided in mental hospitals. Like the MIEP, the IMD Exclusion was also justified, in part, on the grounds that care for the mentally ill was a traditional state concern. In addition, the IMD Exclusion was an intentional effort to encourage deinstitutionalization of state mental hospitals. In the years leading up to the Act, there was growing awareness and horror regarding the abysmal conditions in the nation’s mental hospitals.³¹ There had been efforts to close mental hospitals prior to 1965, with limited success, but it was the creation of Medicaid with the IMD Exclusion that radically accelerated deinstitutionalization.³² As a result, large numbers of state mental hospitals closed over the successive decades, and by 2000, the state mental health population had dropped more than 90% from 1955 levels.³³

However, the robust community mental health services that were envisioned never materialized due to chronic underfunding.³⁴ As it turned out, the emptying of mental institutions was easier to accomplish than the construction of sufficient community mental health treatment centers. Thus, while the concept behind deinstitutionalization was well-intentioned, there have been a host of perverse consequences, including an extreme shortage of in-patient psychiatric beds, the shunting of patients in psychiatric distress to general hospitals unequipped to treat them, and most saliently for present purposes, the cycling of mentally ill people

29. There have been some slight changes around the edges over the years. For instance, in 1978, the relevant regulations were amended to indicate that FFP continued to be available “to eligible individuals during the month in which they become inmates of a public institution or a patient in an institution for mental disease,” and in 1985, the rule was amended to prevent FFP from being available from “the date of admission until the date of discharge.” Fed. Reg. Vol. 43, No. 190, 45217 (Sept. 29, 1978); Fed. Reg. Vol. 50, No. 64, 13196-13200 (April 3, 1985). The agency noted in its rulemaking, “As explained in the preamble to the NPRM, we decided to change our regulations and ensure that Medicaid funds are not used to finance care for institutionalized individuals who have traditionally been the responsibility of State and local governments.” Fed Reg. Vol. 50, No. 64, 13198.

30. 42 U.S.C. § 1396d.

31. Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641 (2003); Bernard Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53 (2011); Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J.L. & MED. 159 (2003); E. FULLER TORREY ET AL., TREATMENT ADVOC. CTR. & NAT’L SHERIFF’S ASS’N, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 2 (2010), https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf (describing deinstitutionalization as “one of the most well-meaning but poorly planned social changes ever carried out in the United States”).

32. Marie Gottschalk, *Cellblocks and Red Ink: Mass Incarceration, the Great Recession and Penal Reform*, 139 DAEDALUS 62, 68-69 (2010).

33. *Id.* at 67-68 (noting that in 1955 the state mental hospital population was 559,000, which was close to the 2010 prison population on a per capita basis and had dropped to 100,000 by 2000).

34. Slovenko, *supra* note 31, at 651.

through incarceration, homelessness, and other forms of marginality.³⁵ It is now clear that deinstitutionalization was in fact transinstitutionalization, as jails and prisons began to fill with people with mental illness and frequently accompanying substance abuse disorders.³⁶ This was not the first time that people with mental illness found themselves incarcerated; state mental hospitals were built in response to the reform movement led by Dorothea Dix that advocated treatment rather than punishment for mentally ill persons previously housed in jails and prisons.³⁷ The effects of the IMD Exclusion caused the pendulum to swing back again, but did not lead to creation of the hoped for ubiquitous, humane treatment for the mentally ill in the community. Deinstitutionalization is thus widely considered to have been a public policy failure and another significant contributor to mass incarceration.³⁸

The exact magnitude of the transinstitutionalization effect is uncertain. One study suggests that deinstitutionalization may account for as much as 4-7% of incarceration growth between 1980 and 2000.³⁹ While the causal connection is difficult to establish, the growth in the number of prisoners with serious mental illness is uncontested. Numerous studies conducted since 1995 have concluded that between 15-20% of prisoners in the United States experience serious mental

35. See TORREY ET AL., *supra* note 31 (noting that in 1955 there was one psychiatric bed for every 300 Americans and in 2005 one psychiatric bed for every 3,000 Americans, the majority of which were taken by court-ordered cases; and summarizing studies demonstrating incarceration-homelessness cycle of people with mental illness); Slovenko, *supra* note 31, at 655-56.

36. See also Bernard Harcourt, *An Institutionalization Effect: The Impact of Mental Hospitalization and Imprisonment on Homicide in the United States, 1934-2001*, 40 J. LEGAL STUD. 39 (2011) (noting “patterns of mental health hospitalization versus incarceration are practically inverted over the 20th and 21st centuries,” and suggesting that homicide rates rose in the wake of deinstitutionalization not primarily because mentally ill people were perpetrators of violence but because they were frequently victims of violence.)

37. TORREY ET AL., *supra* note 31, at 2; Slovenko, *supra* note 31, at 641-42.

38. It also contains lessons for decarceration, however, as it demonstrates the ways in which federal Medicaid funding can be used as a carrot or a stick to affect state policies. Indeed, if the cost of correctional health were shifted to the federal government, as discussed below, there would be a much greater incentive for the federal government to solve the problem of mass incarceration that it helped to create. See Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s* (John M. Olin L. & Econ. Working Paper No. 542, 24, 2011). For other suggested allocations of federal dollars to facilitate decarceration, see Pfaff, *infra* note 59. For a forward-looking analysis of what decarceration of prisons could mean for the population of people with SMI and suggestions for how mental health systems should respond, see H. Richard Lamb & Linda E. Weinberger, *Decarceration of U.S. Jails and Prisons: Where Will Persons with Serious Mental Illness Go?*, 42 J. AM. ACAD. PSYCHIATRY & L. 489, 489-94 (2014).

39. Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187, 187 (2013); *But see* E. Lea Johnston, *Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness*, 71 FLA. L. REV. 515, 515 (2019) (suggesting that criminalization theory be reconsidered in light of normalization theory, and criminal justice programs for offenders with mental illness be accordingly adjusted); Frederick E. Vars & Shelby B. Calambokidis, *From Hospitals to Prisons: A New Explanation*, 102 CORNELL L. REV. ONLINE 101, 104-05 (2017) (positing theory that the dramatic increase in prisoners with mental illness cannot be explained by deinstitutionalization but instead was caused by Supreme Court’s 1990 decision that reduced costs of incarcerating the severely mentally ill by approving the cheap and easy forced medication of prisoners); Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illness in the Criminal Justice System?* 47 CMTY. MENTAL HEALTH J. 716, 716-17 (2011) (questioning causal relationship between deinstitutionalization and overrepresentation of people with serious mental illness in jails and prisons and arguing for a more nuanced approach to developing criminal justice and mental health policy strategies).

illness, as compared to estimates of 5-11% during the 1980s and early 1990s.⁴⁰ Recent data also suggest that some 40% of individuals with serious mental illnesses have been in jail or prison at some point in their lives.⁴¹ According to one study, almost ten times as many seriously mentally ill people are in jails and prisons today than in hospitals.⁴² Substance abuse, a frequent comorbidity with mental illness, also disproportionately affects the incarcerated population, with estimates that 70-85% of state prisoners need drug treatment – yet only 13% get treatment while incarcerated.⁴³

Therefore, the two Medicaid exclusions interact. The IMD Exclusion is responsible for a small percentage of the overall growth of the prison population, but potentially a much greater increase in the percentage of mentally ill prisoners. Then, while incarcerated, the MIEP prevents prisoners from receiving Medicaid-funded mental health, behavioral health, or medical treatment that might ameliorate their conditions and lead to some sort of genuine rehabilitation. Instead, incarceration tends to exacerbate mental illness, as well as other health conditions, and individuals leave prison sicker than they were when they entered, released into other forms of marginality, and more primed for recidivism.⁴⁴

Because of the host of ills caused by the IMD Exclusion, advocates and scholars have long pushed for its elimination.⁴⁵ At present, there are a large number of states that have been granted section 1115 waivers to work around the IMD

40. TORREY ET AL., *supra* note 31, at 3-4 (citing studies conducted by the American Psychiatric Association, the National Commission on Correctional Health Care, Human Rights Watch, and the Department of Justice, among others). *See also* Tala al-Rousan, et al., *Inside the Nation's Largest Mental Health Institution: A Prevalence Study in a State Prison System*, 17 BMC PUB. HEALTH (2017) (cross-sectional study of Iowa inmate health records demonstrating substantial occurrence of mental illness among prison population with details about different mental health diagnoses); Seth J. Prins, *The Prevalence of Mental Illnesses in U.S. State Prisons: A Systemic Review*, 65 PSYCHIATRY SERVS. 862-872 (2014); U.S. DEP'T OF JUST., BUREAU OF JUST. STATS., NCJ-250612, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12* (2017), <https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf> (some 37% of prisoners had been diagnosed with a mental disorder at some point and 14% of state and federal prisoners met the threshold for serious psychological distress in the 30 days prior to the data collection period). When expanded to include any DSM-IV mental disorder, the rates are even higher: over half of inmates have some mental disorder, and among jail populations 63% of Black and 71% of whites self-report symptoms or diagnoses of mental illness. Dora M. Dumont, Brad Brockmann, Samuel Dickman, Nicole Alexander & Josiah D. Rich, *Public Health and the Epidemic of Incarceration*, 33 ANN. REV. PUB. HEALTH 325, 328-29 (2012).

41. TORREY ET AL., *supra* note 31, at 4.

42. E. FULLER TORREY, MARY T. ZDANOWICZ, SHERRIFF AARON D. KENNARD, H. RICHARD LAMB, DONALD F. ESLINGER, MICHAEL C. BIASOTTI & DORIS A. FULLER, TREATMENT ADVOC. CTR., *THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 6* (2014), <https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>.

43. Josiah D. Rich et al., *How Health Care Reform Can Transform the Health of Criminal Justice-Involved Individuals*, 33 HEALTH AFF. 462, 463 (2014); Jessica Bresler & Leo Beletsky, *COVID-19, Incarceration, and the Criminal Legal System* (Northeastern Univ. Sch. of L. Working Paper, No. 395-2020, 230, 2020), <https://ssrn.com/abstract=3675919> (reporting 65% of incarcerated people have diagnosable substance use disorders, more than seven times the rate in the general population); al-Rousan, *supra* note 40, at 8 (reporting substance use disorders eight times as common in individuals with any other mental illness).

44. Lauren Brinkley-Rubinstein, *Incarceration as a Catalyst for Worsening Health*, 1 HEALTH & JUST. 3 (2013).

45. *See, e.g.*, TORREY ET AL., *supra* note 31; Davoli, *supra* note 31.

Exclusion, suggesting that the provision could finally be on its way out, whether through formal repeal or through near universal waivers that render it irrelevant.⁴⁶ While elimination of the IMD Exclusion could improve access to treatment for those with serious mental illness, it alone will not end the revolving door for this population. Transinstitutionalization is one key contributor to mass incarceration but far from the only one. There are other factors that have led to the astronomical growth in the U.S. prison population, and federal funding has played a significant role in those developments as well.

A. Federal Funding Stimulated Mass Incarceration in the States

The interplay between federal funding and state carceral policies have contributed to the growth of mass incarceration. The dramatic increase in the U.S. incarcerated population over the course of the 1980s and 1990s is well-covered territory. Although there remains some debate as to the most significant factors leading to mass incarceration, it is incontrovertible that by 2008, the overall U.S. incarceration rate had peaked at 536 per 100,000 – as compared to 93 per 100,000 in 1972 – and has been slowly and unevenly declining since then.⁴⁷

Frequent laments about the destructiveness of “the criminal justice system” can serve to obscure the reality that there is no single criminal justice system, but rather, “a loosely coupled web of bureaucratic agencies endowed with wide discretion and devoid of an overarching penal philosophy or policy.”⁴⁸ Recent scholarship has begun to tease-out the degree to which mass incarceration has been

46. See *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Apr. 16, 2021), <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state>. Section 1115 waiver authority derives from Section 1115 of the Social Security Act of 1962, which allows the Secretary of Health and Human Services to waive compliance with statutory requirements in order to enable states to carry out demonstration waiver projects. Under the statutory language, such waivers must be “likely to assist in promoting the objectives” of the Act, but historically waivers have sometimes been used to undercut the objectives of Medicaid. See Super, *supra* note 10, at 1595-96. Without wading into the debate over whether and when 1115 waivers might be proper generally, I would suggest that the IMD Exclusion and MIEP waivers should not trouble us because they both further the objectives of Medicaid, particularly in its post-ACA iteration, of expanding access to healthcare for lower-income Americans. See *id.* at 1609 (“As amended by the Affordable Care Act, Medicaid is particularly focused on achieving as nearly universal coverage as possible to minimize the inefficiencies that result when hospitals and others provide large amounts of care for which they are not compensated.”)

47. PFAFF, *supra* note 17, at 2. See also *id.* at 242, n.23 (noting that national and state incarceration rates peaked in 2008 but the national and state prison populations peaked in 2009 because the U.S. population grew faster than the prison population between 2008 and 2009). There have been notable decreases in incarceration rates during the COVID-19 pandemic, but the causes and permanency of such decreases have yet to be established. Some seem to be caused by reduced uptake due to law enforcement and court systems operating at reduced capacity, and so the effects are likely to subside when the pandemic does, while others, such as the increased use of compassionate release in the federal system and certain states, could provide the jolt that was needed to decongest the system.

48. Loïc Wacquant, *The Place of the Prison in the New Government of Poverty*, in *AFTER THE WAR ON CRIME: RACE, DEMOCRACY, AND A NEW RECONSTRUCTION* 32 (2008). See generally JAMES FORMAN JR., *LOCKING UP OUR OWN: CRIME AND PUNISHMENT IN BLACK AMERICA* (2017); PFAFF, *supra* note 17; Rachel E. Barkow, *Prisoners of Politics: Breaking the Cycle of Mass Incarceration*, 104 MINN. L. REV. 2625 (2019).

more of a state and local story than previously recognized.⁴⁹ While the components were assembled at the local level, however, federal funding – and the withholding of federal funding – provided the scaffolding in both direct and indirect ways.⁵⁰

In her book “From the War on Poverty to the War on Crime,” Professor Elizabeth Hinton provides a masterful account of how federal anti-poverty legislation passed under Presidents Kennedy and Johnson created block grants to the states that were used to build the institutions of mass incarceration.⁵¹ Building on earlier federal legislation developed in response to perceived juvenile delinquency,⁵² President Johnson declared a War on Crime with the passage of the Law Enforcement Assistance Act of 1965, which inserted the federal government into law enforcement as never before. The legislation created the Office of Law Enforcement Assistance (“OLEA”) as a federal crime control agency to support local police surveillance of low-income urban communities.⁵³ Beginning with the Safe Streets Act of 1968, \$400 million was administered through block grants intended to push states to prioritize law enforcement and crime control policies while providing them with relative autonomy in shaping the particular contours of those policies.⁵⁴ Hinton argues that these federal programs stimulated state spending of hundreds of billions of additional dollars in criminal justice and law enforcement, laying the foundation for mass incarceration even as the walls of the fortress were raised at the state and local levels.⁵⁵

Subsequent federal interventions also impacted state carceral policies. In the 1990s, the Violent Offender Incarceration and Truth in Sentencing Incentive (“VOI/TIS”) Formula Grant Program rewarded states for the passage of truth-in-sentencing legislation.⁵⁶ One study found that the VOI/TIS grant program had a marginal effect on state sentencing laws and the authors concluded that the program merely reflected what was already happening in the states amidst the “tough on crime” zeitgeist.⁵⁷ Nevertheless, during fiscal years 1996–2001, some \$2.7 billion in federal funding was allocated through the program to build and

49. PFAFF, *supra* note 17, at 13 (noting that 87% of all U.S. prisoners are in state correctional facilities and emphasizing that rather than a single criminal justice system, there is a “vast patchwork of systems that vary in almost every conceivable way”); FORMAN, *supra* note 48; Barkow, *supra* note 48.

50. See generally HINTON, *supra* note 17; But see Lisa L. Miller, *The Invisible Black Victim: How American Federalism Perpetuates Racial Inequality in Criminal Justice*, 44 L. & SOC’Y REV. 805 (2010) (providing an account of how federalism impedes the representation of low-income racial minorities’ interests in addressing crime and violence).

51. See generally Hinton, *supra* note 17.

52. *Id.* at 32-34 (describing the Youth Offenses Control Act of 1961 as purported anti-poverty welfare programs arguing that “youth crime was more of a moral concern rooted in long-held racial fears than it was a measurable problem.”).

53. *Id.* at 56-57.

54. *Id.* at 2, 16.

55. *Id.* at 2, 32, 33.

56. WILLIAM SABOL, KATHERINE ROSICH, KAMAL MALLIK KANE, DAVID P. KIRK & GLENN DUBIN, URBAN INST., *THE INFLUENCES OF TRUTH-IN-SENTENCING REFORMS ON CHANGES IN STATES’ SENTENCING PRACTICES AND PRISON POPULATIONS* iii (2002), <https://www.urban.org/sites/default/files/publication/60401/410470-The-Influences-of-Truth-in-Sentencing-Reforms-on-Changes-in-States-Sentencing-Practices-and-Prison-Populations.PDF>.

57. *Id.* at iv.

expand jail and prison facilities.⁵⁸ While as a dollar figure the VOI/TIS grants were not a significant percentage of corrections spending in the states, federal support for such measures almost certainly contributed to prison expansion.⁵⁹ VOI/TIS is just one of many targeted criminal justice grants administered by the Department of Justice (DOJ) to the states. These grants are administered by eight agencies within the DOJ and have totaled more than \$32 billion between 1993 and 2012.⁶⁰ Of greater notoriety are the Department of Defense's 1033 grants, which transfer old military hardware to police departments, thereby militarizing policing in an unprecedented fashion.⁶¹

At the same time that the federal government was accelerating deinstitutionalization through the IMD Exclusion, as described above, these federal interventions stimulated and bolstered the growth of the prison-industrial complex. For too many individuals with serious mental illness, deinstitutionalization did not result in freedom, but rather in incarceration and other forms of marginality. In short, although criminal legal policies are largely crafted at the state and local level, the impact of federal funding on the policies giving rise to mass incarceration has been significant. If federal funding seeded the carceral state, then federal funding should play a major role in dismantling it. Insofar as the building blocks of mass incarceration were assembled at the state and local levels, decarceration must also be enacted through state and local reforms.⁶² As the most significant joint federal-state program, Medicaid can play a role in facilitating the necessarily joint federal-state project of mass decarceration and reincorporating prisoners as citizens of equal need and equal worth.⁶³

B. *The Sick and Aging Prison Population*

Inherent to any discussion about the bloated prison population is the increasingly advanced age and correspondingly poor health of the prison population. The aging of the prison population in part reflects the aging of the general population, as Baby Boomers reach old age.⁶⁴ However, it is also a

58. U.S. DEP'T OF JUST., BUREAU OF JUST. ASSISTANCE, REPORT TO CONGRESS: VIOLENT OFFENDER INCARCERATION AND TRUTH IN SENTENCING INCENTIVE FORMULA GRANT PROGRAM 2 (2012), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/voitis-final-report.pdf>.

59. John F. Pfaff, *Federal Sentencing in the States: Some Thoughts on Federal Grants and State Imprisonment*, 66 HASTINGS L. J. 1567, 1590 (2015).

60. *Id.* at 1592.

61. *Id.* at 1595.

62. PFAFF, *supra* note 17, at 14, n. 24. Variations in criminal justice policies and realities among the states are tremendous. For instance, between 2010 and 2014, there was a net 4 percent decline in the overall U.S. prison population, but the national average obscures notable state discrepancies. *See also* John F. Pfaff, *Why the Policy Failure of Mass Incarceration are Really Political Failures*, 104 MINN. L. REV. 2673, 2688-89 (2020). During that time period, the prison populations of 25 states decreased by 77,000 prisoners while 25 states *added* 21,000 prisoners for a net decline of 56,000. Furthermore, California, as part of the Realignment Process in response to the Supreme Court's decision in *Brown v. Plata*, actually represented 62% of the 56,000 net decline, reducing its population by 35,000.

63. *See* Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L. J. F. 1, 3 (2017) (arguing that healthcare reform must be a national project because states are hampered by their inability to engage in deficit spending like the federal government, and because the Employee Retirement Income Security Act of 1974 creates restrictions that impede state expansion of healthcare coverage).

64. J.J. Prescott, Benjamin Pyle & Sonja Starr, *Understanding Violent-Crime Recidivism*, 95 NOTRE DAME L. REV. 1643, 1653 (2020).

function of harsher sentencing laws passed during the 1980s and 1990s. Mandatory minimum provisions have played a significant role, along with the ratcheting-up of sentences that accompanied the passage of mandatory sentencing guidelines, most notoriously within the federal system.⁶⁵ More significant at the state level, however, have been broad restrictions on early release mechanisms as a result of Truth-in-Sentencing laws passed in most states, partially in response to federal funding incentives, as well as the then pervasive tough-on-crime mood.⁶⁶

The changing use and meaning of life sentences have also had significant impacts on prison populations. Though differentiated across jurisdictions, there has been a marked increase in the prevalence of life sentences imposed; changes to backend provisions so that increasingly “life means life;” and an expansion of the use of life without possibility of parole (“LWOP”) sentences.⁶⁷ Life sentences account for only 9.5% of the prison population nationally, but a greater percentage in a number of states. In Alabama, California, Massachusetts, Nevada, and New York, at least 1 in 6 people in prison are serving a life sentence.⁶⁸ Nationally, 29% of people serving life sentences (41,095) have no possibility of parole.⁶⁹ Significantly, the racial disparities pervasive throughout the criminal legal system manifest in even more extreme form in this area: nationally, 66.4% of people with life sentences are non-white, with rates as high as 83.7% in New York.⁷⁰

All of these factors have resulted in the national population of prisoners over 50 growing significantly during the past few decades.⁷¹ In 1993, only 45,000 people, or 5.3% of the prison population, were over the age of 50; by 2013, there were 243,700 people, or 18.4% of the prison population, over 50.⁷² Despite recent sentencing reforms somewhat modifying these effects, such reforms are rarely retroactive and thus do not affect older prisoners serving decades-old sentences—particularly when they are serving sentences for “violent offenses.”⁷³

65. MICHELLE ALEXANDER, *supra* note 17, at 53-56 (analyzing the War on Drugs, including the creation of new mandatory minimum terms, and the resulting growth in prison populations); Matthew C. Lamb, *A Return to Rehabilitation: Mandatory Minimum Sentencing in an Era of Mass Incarceration*, 41 J. Legis. 126, 128 (2014) (describing the “steep fiscal and social costs” of mandatory minimum sentencing); Lynn Adelman, *What the Sentencing Commission Ought to Be Doing: Reducing Mass Incarceration*, 18 Mich. J. Race & L. 295, 296 (2013) (attributing the “unremitting growth of the federal prison population” to the Sentencing Reform Act of 1984, the Federal Sentencing Guidelines, and mandatory minimum prison sentences).

66. Prescott et al., *supra* note 64, at 1655; SABOL ET AL., *supra* note 56, at 16.

67. ASHLEY NELLIS & RYAN S. KING, NO EXIT: THE EXPANDING USE OF LIFE SENTENCES IN AMERICA, SENTENCING PROJECT 3 (2019) (finding that the number of people serving LWOP sentences increased by 22% between 2003 and 2009); *But see* PFAFF, *supra* note 17, at 54 (arguing that while maximum statutory penalties have grown, time actually served has not increased significantly and therefore is not a primary driver of prison growth).

68. *Id.* at 3.

69. *Id.*

70. *Id.*

71. B. JAYE ANNO ET AL., U.S. DEP’T OF JUST., NIC Accession No. 018735, CORRECTIONAL HEALTH CARE: ADDRESSING THE NEEDS OF ELDERLY, CHRONICALLY ILL, AND TERMINALLY ILL INDIVIDUALS (2004).

72. Prescott et al., *supra* note 64, at 1652-53.

73. *Id.* at 1656. *But see* DENNIS SCHRANTZ, STEPHEN DEBOR & MARC MAUER, DECARCERATION STRATEGIES: HOW 5 STATES ACHIEVED SUBSTANTIAL PRISON POPULATION REDUCTIONS, SENTENCING PROJECT 28 (2018) (one state made some changes retroactive).

While a 50-year-old in the general population would still be considered to be in the prime of his life in the United States in 2021, it is well-documented that living in prison for decades leads to accelerated aging.⁷⁴ In addition to suffering from inadequate nutrition, insufficient access to preventative healthcare, and the general stresses of prison living, the demographic sector from which the majority of the prison population is drawn tends to have preexisting vulnerabilities due to poverty and race, and the corresponding exposures to toxic substances and violence, as well as inadequate access to healthy food, clean water, and healthcare.⁷⁵ As Professor Becky Pettit has astutely highlighted, most national population surveys do not count prison inmates in calculating the health status of the overall Black population in the United States, and so, in addition to ignoring the dismal health statistics of prisoners, such surveys overstate progress of the Black population at large in regards to health, as well as other metrics.⁷⁶ As a result of worse health histories on average, the normal indignities of aging—a susceptibility to diabetes, high blood pressure, cognitive decline, Alzheimer’s and other forms of dementia, and cancer—also tend to hit prisoners even earlier.⁷⁷ Recent research reveals that prisoners are also at greater risk for chronic traumatic encephalopathy (CTE) and other forms of dementia associated with brain injuries.⁷⁸

Even among younger incarcerated people, the general state of health is poor. Half of people incarcerated in jail and prison report having a chronic condition, including cancer, high blood pressure, stroke-related problems, diabetes, kidney-related problems, arthritis, asthma, and cirrhosis of the liver.⁷⁹ Some 21% of

74. Although there is no uniform definition of a geriatric prisoner, 50 or 55 is the most common age at which it is fixed. *See, e.g.*, Brie A. Williams et al., *Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care*, 102 AM. J. PUB. HEALTH 8 (2012); Maurice Chammah, *Do You Age Faster in Prison?*, MARSHALL PROJECT (Aug. 24, 2015 7:15AM), <https://www.themarshallproject.org/2015/08/24/do-you-age-faster-in-prison>.

75. Cyrus Ahalt, Robert L. Trestman, Josiah D. Rich, Robert B. Greifinger & Brie A. Williams, *Paying the Price: The Pressing Need for Quality, Cost and Outcome Data to Improve Correctional Healthcare for Older Prisoners*, 61 J. AM. GERIATRIC SOC’Y 1855 (2013); KiDeuk Kim & Bryce Peterson, *Aging Behind Bars: Trends and Implications of Graying Prisoners in the Federal Prison System*, URBAN INST. (Sep. 5, 2014), <https://www.urban.org/research/publication/aging-behind-bars-trends-and-implications-graying-prisoners-federal-prison-system>; *See also* Linda Villarosa, *Pollution is Killing Black Americans. This Community Fought Back*, N.Y. TIMES (July 28, 2020), <https://www.nytimes.com/2020/07/28/magazine/pollution-philadelphia-black-americans.html>.

76. BECKY PETTIT, *INVISIBLE MEN: MASS INCARCERATION AND THE MYTH OF BLACK PROGRESS* 8 (2012) (noting that national health surveys generally exclude inmates); *id.* at 102 (“Incorporating inmates into accounts of American inequality dispels myths of black progress by revealing that decades of penal expansion have concealed continued black disadvantage from public view.”).

77. Chammah, *supra* note 74.

78. David M.N. Garavito, *The Prisoner’s Dementia: Ethical and Legal Issues Regarding Dementia and Healthcare in Prison*, 29 CORNELL J. L. & PUB. POL’Y 211, 213 (2019).

79. U.S. DEP’T OF JUST., BUREAU OF JUST. STATS., *MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES* 4 (2016), <https://www.bjs.gov/content/pub/pdf/mpsfjji112.pdf> [hereinafter *MEDICAL PROBLEMS OF PRISONERS AND JAIL INMATES*]. *See also* Emily Widra, *Incarceration Shortens Life Expectancy*, PRISON POL’Y INITIATIVE, (June 26, 2017), https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/ (referencing a 2016 study that concluded in comparison of developed democracies, that mass incarceration has shortened overall U.S. life expectancy by 5 years and 2013 student that concluded that for every year lived behind bars, a person’s life expectancy is reduced by 2 years). *But see* Rich et al., *supra* note 43, at 463 (2014) (noting that for some individuals coming from chaotic environments, prison may present certain health-enhancing factors

prisoners and 14% of jail inmates report having infectious diseases, including tuberculosis, hepatitis B and C, and other STDs excluding HIV and AIDS, while 74% of prisoners and 6% of jail inmates were overweight, obese, or morbidly obese.⁸⁰ Rates of HIV infection among prisoners, while lower than during the height of the epidemic, remain four to six times higher than in the general population, and one third of prisoners are estimated to be infected with Hepatitis C.⁸¹ And as noted earlier, rates of mental illness and substance abuse among the incarcerated population are far higher than in the general population.⁸²

There is some evidence suggesting that Black male prisoners actually experience decreased mortality on average as compared to the population of Black men in the general population, which only highlights the extreme degree of racialized health inequities in this country.⁸³ Because the population of Black men without a college education face the full panoply of health-harming factors, the guaranteed minimum access to healthcare for prisoners can be an improvement. The incarcerated population is more likely to come from impoverished communities, to be victims of crime and other forms of trauma, to have lower educational levels, to experience chronic un- and underemployment, and to receive lower quality of care.⁸⁴ Because access to healthcare in these communities is so limited, some 40% of incarcerated people with chronic medical conditions are first diagnosed while incarcerated.⁸⁵ Nonetheless, one study has shown that each additional year in prison led to a 15.6% increased likelihood of death for parolees, or a 2-year decline in life expectancy for each year in prison.⁸⁶ Other studies have shown elevated mortality rates during the first weeks and years after release, frequently due to drug overdoses, revealing that any health benefit that may accrue from incarceration is temporary when underlying mental health and substance use disorders go untreated.⁸⁷

Both chronic and acute conditions are extremely expensive to treat in a correctional setting. When hospital treatment is necessary, it is also expensive to

such as stable meals, reduced access to alcohol, drugs and cigarettes, and increased access to health care, at the same time that prison is health-harming in other respects, particularly due stress and necessary psychological adaptations).

80. MEDICAL PROBLEMS OF PRISONERS AND JAIL INMATES, *supra* note 79, at 4.

81. Brinkley-Rubinstein, *supra* note 44, at 2. *See also* Dumont et al., *supra* note 40, at 3.

82. *See supra* Part I.

83. *See* Seena Fazel & Jacques Baillargeon, *The Health of Prisoners*, 377 THE LANCET 956, 962 (2011) (suggesting “greater health-care resources should be targeted at prisons since they provide a rare public health opportunity to screen and treat a young, marginalized, and diseased group.”); Evelyn J. Patterson, *Incarcerating Death: Mortality in U.S. State Correctional Facilities, 1985-1998*, 47 DEMOGRAPHY 3 (2010) (noting that Black male prisoners had lower death rates than Black male non-prisoners and theorizing that although prison is an unhealthy environment, it appears to be healthier than the typical environment of the nonincarcerated Black male population).

84. Brinkley-Rubinstein, *supra* note 44, at 5.

85. Christopher Wildeman & Emily A. Wang, *Mass incarceration, public health, and widening inequality in the USA*, 389 THE LANCET 1464, 1467 (2017).

86. Brinkley-Rubinstein, *supra* note 44, at 3 (omitting internal reference). *See also* Michael Massoglia & Brianna Remster, *Linkages Between Incarceration and Health*, SAGE PUB. HEALTH REPORTS 2019, Vol. 134, 9S (Supplement I) (2019) (noting studies finding elevated mortality risk during and after incarceration).

87. Dumont et al., *supra* note 40, at 331 (citing studies that released prisoners are 12 times as likely as the general population to die of any cause in the two weeks after release, and 129 times as likely to die of a drug overdose).

arrange secure escort to and from hospitals and correctional supervision while receiving treatment. The cost of treating an aging patient with chronic conditions in a correctional setting can be twice as much as under normal circumstances, while costs incurred by prisons for aging prisoners are at least two to three times what it is for younger prisoners.⁸⁸ As the population of aging prisoners grows, their care takes up an increasing percentage of state correctional budgets.⁸⁹ Deficit spending is not an option for states, so there are strong incentives to cut costs. Unlike other areas of state spending, such as road repair and education, the population most directly affected by prison spending are prisoners, who lack political power to make their voices heard.⁹⁰ The effect is almost invariably a reduction in availability and quality of prison healthcare—though it is difficult to say that there was ever much of a highwater mark.⁹¹

C. Correctional Healthcare

From the Attica Uprising in 1971 to the litigation that led to the Supreme Court's seminal 2011 decision in *Brown v. Plata*, the dismal state of prison healthcare has remained a constant concern for prisoners and advocates.⁹² In *Estelle v. Gamble*, the Supreme Court held that the failure to provide adequate medical care for prisoners could constitute an Eighth Amendment violation.⁹³ The Court held that negligent or inadvertent failure to provide adequate medical care was not enough to establish a constitutional violation. Rather, “deliberate indifference to serious medical needs constitutes ‘the unnecessary and wanton infliction of pain’” in violation of the Eighth Amendment.⁹⁴ In practice, the deliberate indifference standard has proven to be a powerful gatekeeper to all but the most egregious violations, and subsequent development in prison conditions jurisprudence has done little to expand prisoners' rights.⁹⁵ The Prison Litigation Reform Act (“PLRA”) passed in 1996 further restricted prisoners' ability to bring suit, including with regard to inadequate medical care.⁹⁶ Despite the strictures of the PLRA, the Supreme Court found in *Brown v. Plata* that the Ninth Circuit's remedy of forcing a reduction in the state prison population by 38,000 to 46,000 individuals was warranted by the long-standing and severe overcrowding in

88. Matt McKillop & Alex Boucher, *Aging Prison Populations Drive Up Costs*, PEW CHARITABLE TR. (Feb. 20, 2018), <https://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs> (citing 2004 National Institute of Corrections study for the two-to-three times the average figure, and a 2020 study suggesting the differential may be wider, but data is lacking).

89. *Id.*

90. Bagley, *supra* note 63, at 3 (noting states' inability to engage in deficit spending).

91. GOTTSCHALK, *supra* note 15 at 9. (During Great Recession 36 of 44 states reported corrections staffing cuts, half eliminated or reduced programs for inmates, several cut back on health services, and a nearly third cut back on food services).

92. 563 U.S. 493 (2011). See generally Susan M. Reverby, *Can There be Acceptable Prison Health Care? Looking Back on the 1970s*, 134 SAGE PUB. HEALTH REPS. 89, 89-93 (2019). For a detailed historical account of the Attica uprising and the role that complaints about medical care played, see HEATHER ANN THOMPSON, *BLOOD IN THE WATER: THE ATTICA PRISON UPRISING OF 1971 AND ITS LEGACY* (2016).

93. 429 U.S. 97 (1976).

94. *Id.* at 104.

95. Garavito, *supra* note 78, at 224-225.

96. Rich et al., *supra* note 43, at 3.

California prisons, resulting in the “grossly inadequate provision of medical and mental health care” for years.⁹⁷

The reality is that correctional healthcare is notoriously substandard, even by comparison to the inadequate health care available for the general population of poor people outside of prison.⁹⁸ Healthcare has long been considered a privilege rather than a right in this country, and the United States’ excessively punitive penal philosophy has led to a reluctance to accord prisoners any privileges. Prisoners with medical complaints are frequently suspected of malingering, and so access to medical care may be denied, thus leading to early signs of illness going undetected.⁹⁹ The quality of the actual medical care provided is variable, with reported problems including inadequate hygiene, medical errors, denial of treatment without co-payment, and a range of medication errors (including delay in administering, side effects, administration of incorrect medications, medications incorrectly stopped, or allergic reactions to medications).¹⁰⁰ Studies have found a delay in medical treatment and poor-quality care for HIV-positive inmates and those with other pre-existing medical conditions.¹⁰¹ Despite high levels of mental health and substance abuse disorders among prisoners, only a quarter of incarcerated individuals receive treatment for those disorders while incarcerated.¹⁰²

As the prison population has exploded, overcrowding in facilities built to hold far fewer people creates further health and safety hazards. Poor ventilation is a frequent issue due to the security-focused design of correctional facilities.¹⁰³ Infectious diseases can spread more easily in crowded, poorly ventilated facilities, as has been demonstrated so devastatingly with the COVID-19 pandemic, and overwhelmed prison staff becomes further inured to the pain and suffering of prisoners.¹⁰⁴ Security also becomes a growing concern in overcrowded facilities, and more vulnerable prisoners can be victimized by other prisoners and prison staff.

As the prison population ages, there has been an increase in chronic conditions, including memory disorders, which are expensive to treat and manage.¹⁰⁵ While

97. *Brown v. Plata*, 563 U.S. 493, 502 (2011).

98. Reverby, *supra* note 92, at 89.

99. *Id.* See also JONATHAN SIMON, MASS INCARCERATION ON TRIAL: A REMARKABLE COURT DECISION AND THE FUTURE OF PRISONS IN AMERICA 99 (2016) (“The *Plata* case revealed the huge disconnect between mass incarceration and the ethos of caregiving... Custodial officers were routinely hostile to medical providers, and they treated prisoners’ medical complaints as impositions, a tactic in the ongoing war and an opportunity to retaliate.”)

100. Brinkley-Rubinstein, *supra* note 44, at 3 (internal reference omitted).

101. *Id.* at 8 (internal references omitted).

102. *Id.* (internal references omitted).

103. *Id.* at 7 (internal references omitted).

104. See, e.g., Kathryn Nowotny, Zinzi Bailey, Marisa Omori & Lauren Brinkley-Rubinstein, *COVID-19 Exposes Need for Progressive Criminal Justice Reform*, 110 AM. J. PUB. HEALTH 967 (2020) (describing particular risks that COVID-19 poses to prisoners in overcrowded, poorly ventilated facilities with limited access to medical care).

105. See, e.g., Jonathan Simon, *Clearing the “Troubled Assets” of America’s Punishment Bubble*, 139 DAEDALUS 91, 97 (2010) (“Very long sentences doom many California prisoners to die in prison: a fifth of the prison population is serving a life term. Thus, the state is very likely to be financially responsible for the medical management of a population that is already sick and aging faster than people outside of prison. The costs of this unfunded legacy are probably in the tens of billions of dollars. Removing ill

some jurisdictions' responses have included the designation of specialized geriatric or memory disorder wards, there is a widespread sense that prisons were not built to house or care for disabled and elderly people, and cannot do so as effectively as a non-prison facility could. Elderly prisoners are also particularly vulnerable to safety risks. Similarly, the increase in prisoners with serious mental illness both increases the safety risks and social instability within the facility and puts those individuals at greater risk of physical and mental harm. Prisoners with serious mental illness can end up in solitary confinement due to anti-social behaviors, which frequently leads to further deterioration of their mental state.¹⁰⁶ In short, prisons are being expected to do the work of nursing homes and mental hospitals, but in facilities and with systems and staff ill-suited to the care of elderly and ill populations.

The privatization of prison medical care has been one widely implemented solution intended to control costs and improve the quality of care.¹⁰⁷ The results have been a further decline in quality of care, sometimes egregiously so.¹⁰⁸ Requiring co-pays for medical visits has been another frequently utilized response to control costs and to limit the use of medical services.¹⁰⁹ Some prison systems have increased their reliance on telemedicine, which can be effective in certain contexts, but frequently inadequate to deliver comprehensive, high-quality medical care to a population that is, by and large, experiencing chronic and complex health problems.¹¹⁰

The medical profession was slow to develop standards for correctional healthcare, with the American Medical Association holding the first National Conference on Improved Medical Care and Health Services (now the National Conference on Correctional Health Care) in 1977.¹¹¹ Yet forty years later, correctional health continues to operate as a separate field. Public health experts

prisoners to community custody settings, where their treatment can be delivered at much lower costs, represents an opportunity to dramatically lower future liabilities.”).

106. ASS'N OF STATE CORR. ADM'RS, LIMAN CTR. FOR PUB. INT. L. AT YALE L. SCH., REFORMING RESTRICTIVE HOUSING: THE 2018 ASCA-LIMAN NATIONWIDE SURVEY OF TIME-IN-CELL 4 - 5 (2018) (reporting some 61,000 individuals were held in restrictive housing in the fall of 2017, including more than 4,000 people with serious mental illness); Jeffrey L. Metzner & Jamie Fellner, *Solitary confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY L. 104 (2010).

107. Reverby, *supra* note 92, at 90; Dumont et al., *supra* note 40, at 6 (citing studies indicating that privatization has not been cost effective and results in substandard health care).

108. Reverby, *supra* note 92, at 91 (citing a 2103 lawsuit against the Arizona Department of Corrections based on its use of privatized medical care in prisons, in the context of which correctional health expert Robert Cohen called the system “disorganized, under-resourced, understaffed, and completely lacking in the capacity to monitor itself and correct the systemic dysfunctions that currently exist.”).

109. Michael Ollove, *No Escaping Medical Copayments, Even in Prison*, PEW CHARITABLE TR. (July 22, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/07/22/no-escaping-medical-copayments-even-in-prison>.

110. PETER L. NACCI, C. ALLAN TURNER, RONALD J. WALDRON & EDDIE BROYLES, IMPLEMENTING TELEMEDICINE IN CORRECTIONAL FACILITIES, JOINT PROGRAM STEERING GROUP REPORT, U.S. DEP'T JUST. (2002); Michael Ollove, *State Prisons Turn to Telemedicine to Improve Health and Save Money*, PEW CHARITABLE TR., (Jan. 21, 2016), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/21/state-prisons-turn-to-telemedicine-to-improve> (describing advantages and disadvantages of telemedicine use in correctional settings).

111. Reverby, *supra* note 92, at 90.

still find it necessary to argue for reducing barriers between correctional and community health providers and ensuring that correctional health is not allowed to operate under a separate set of regulations with a lower standard of care.¹¹²

The COVID-19 pandemic has given greater visibility to the poor healthcare conditions in prisons, and to the endemic indifference to the pain and suffering of prisoners. The rates of infection in prisons and jails have far outstripped rates in the general population, and there have been numerous outbreaks.¹¹³ A study published in August 2020 indicated that the COVID-19 case rate for prisoners was 5.5 times higher than in the general population.¹¹⁴ The death rate was also higher, at thirty-nine deaths per 100,000 prisoners as compared to twenty-nine per 100,000 in the general population – despite the more vulnerable sixty-five and older population constituting only 3% of the prison population as compared to 16% of the general population.¹¹⁵ By December 2020, there had been at least 276,235 reported COVID-19 cases among prisoners nationally, meaning one in five U.S. prisoners had tested positive for COVID-19 – more than four times the rate in the general population.¹¹⁶

And yet, despite the clear lethal danger presented to inmates, very few jurisdictions released prisoners in any significant number because of the risks posed by COVID-19.¹¹⁷ As mass vaccination has gotten underway, states have taken a variety of approaches in how they prioritize incarcerated populations for vaccination, but incarcerated populations have frequently been differentiated from residents of other congregate living settings like nursing homes.¹¹⁸ Even when

112. Rich et al., *supra* note 43, at 464.

113. See KEVIN T. SCHNEPEL, COVID-19 IN U.S. STATE AND FEDERAL PRISONS, NAT'L COMMISSION ON COVID-10 & CRIM. JUST. (2020), <https://covid19.counciloncj.org/2020/09/02/covid-19-and-prisons/> (unadjusted rate of infection in state and federal prisons 4 times the rate in the general population, and the mortality rate was twice as large after adjusting for sex, age, and race/ethnicity); *A State-by-State Look at Coronavirus in Prisons*, MARSHALL PROJECT (May 28, 2021, 3:30 PM), <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>.

114. Saloner et al., *COVID-19 Cases and Deaths in Federal and State Prisons*, 324 JAMA 602, 603 (2020).

115. *Id.*

116. MARSHALL PROJECT, *supra* note 113; Beth Schwartzapfel, Katie Park & Andrew Demillo, *1 in 5 Prisoners in the U.S. Has Had COVID-19*, MARSHALL PROJECT (Dec. 18, 2020, 6:00 AM), <https://www.themarshallproject.org/2020/12/18/1-in-5-prisoners-in-the-u-s-has-had-covid-19>.

117. Although the national population in state and federal prisons dropped by than 100,000 people, or 8%, between March and June of 2020, the decrease was primarily due to COVID-related consequences rather than motivated by COVID-related public health concerns: prisons stopped accepting newly sentenced prisoners from county jails; fewer people were sentenced because of court closures; and more parole supervision took place remotely, leading to fewer revocations. Damini Sharma, Weihua Li, Denise Lavoie & Claudia Lauer, *Prison Populations Drop by 100,000 During Pandemic*, MARSHALL PROJECT (July 16, 2020, 7:00AM), <https://www.themarshallproject.org/2020/07/16/prison-populations-drop-by-100-000-during-pandemic>.

118. Fourteen states and territories including incarcerated people in Phase 1 (though 2 of those prioritized only medically vulnerable prisoners); twenty states and territories including incarcerated people in Phase 2; and 2 including them in Phase 3; while the remaining fourteen have not stated how they would prioritize incarcerated people. See Morgan Maner, *An Analysis of Interim COVID-19 Vaccination Plans*, COVID PRISON PROJECT (May 14, 2021), <https://covidprisonproject.com/blog/data/data-analysis/an-analysis-of-interim-covid-19-vaccination-plans/>. As with everything else during the pandemic, the priority groups have been somewhat in flux. For example, Colorado initially gave priority to prisoners, but Governor Jared Polis caved to public pressure, saying “There’s no way (the vaccine) is going to go to prisoners ... before it goes to the people who

decision makers have chosen to include prisoners in the same priority group as nursing home residents, they have faced political attacks, further underscoring the continued otherizing of prisoners and how far we have to go before healthcare is conceptualized as a basic right belonging to all people.

D. Limited Medicaid Coverage of Inmates Before the Affordable Care Act

Prior to the Affordable Care Act, there was one exception to the Inmate Exclusion Policy as indicated in the statute: federal Medicaid funding is available when the inmate is a “patient in a medical institution.”¹¹⁹ Pursuant to agency rulemaking, this has been interpreted to allow coverage if a prisoner is admitted to a hospital for in-patient treatment for twenty-four hours or longer.¹²⁰ In reality, states did not often take advantage of this loophole, as the number of inmates who were eligible for Medicaid was relatively small until the expansion and administrative costs were considered too high relative to the benefit – even though it was permitted to enroll the individual in Medicaid after hospitalization.¹²¹

In 2004, the Centers for Medicare and Medicaid Services (“CMS”) issued guidance clarifying that neither the MIEP nor the IMD Exclusion required the termination of Medicaid enrollment, and encouraged states to suspend rather than terminate Medicaid enrollment to facilitate continuity of care upon release and reduce homelessness.¹²² Prior to the Medicaid expansion, few states chose to go the suspension route, which is likely why in 2016 CMS reissued its guidance in the wake of the 2014 expansion.¹²³ Currently 42 states suspend rather than terminate Medicaid eligibility for enrollees who become incarcerated in jails and 43 states do the same for those entering prisons, with 23 states maintaining electronic automated data exchange processes between corrections departments and the state agencies that administer Medicaid to facilitate the suspension and reinstatement of enrollment.¹²⁴

Since the expansion, the exclusion of prisoners from Medicaid has become more anomalous.¹²⁵ Now – because Medicaid is available to all impoverished

haven’t committed any crime.” Ames Alexander, *NC to Offer Inmates Incentives to get COVID Shots. Will New Plan Stem Deadly Tide?*, CHARLOTTE OBSERVER (Jan. 29, 2021, 11:40AM), <https://www.charlotteobserver.com/news/coronavirus/article248866464.html#storylink=cpy>; *But see* Sydney Hoover, *Kansas Inmates Will Get the COVID-19 Vaccine Before Most of the Public. Here’s Why*, KANS. CITY STAR (Jan. 11, 2021, 4:18PM), <https://www.kansascity.com/news/coronavirus/article248381570.html> (explaining that residents and staff in congregate living settings, including prisons, will be in Priority Group 2, despite Republican Party opposition to prisoners getting any priority).

119. Social Security Act §1905(a), 42 U.S.C. 1396d(a) (2019).

120. 42 C.F.R. § 435.1009 (2019); 42 C.F.R. § 435.1010 (2019).

121. Letter from Vikki Wachino, Director, Ctrs. for Medicare & Medicaid Services, to State Health Officials, SHO # 16-007, *RE: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities* (April 28, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf> [hereinafter Letter to State Health Officials].

122. Snyder, *supra* note 14, at 87–88.

123. Letter to State Health Officials, *supra* note 121.

124. *States Reporting Corrections-Related Medicaid Enrollment Policies in Place for Prisons or Jails*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails/> (last visited May 13, 2021).

125. Pre-ACA, some portion of the incarcerated population would have been Medicaid-eligible without MIEP, including those who were elderly, disabled, pregnant, or under 21. This was, however, a

adults in expansion states and because most incarcerated people are impoverished – the vast majority of incarcerated people in the 39 expansion states would be Medicaid-eligible but for the MIEP.¹²⁶ Because of the shockingly disproportionate incarceration of Black men, their exclusion from Medicaid has a racially disparate effect. As discussed below, *infra* section V, the MIEP represents yet another form of health inequity along racial lines. While repealing the MIEP would not come close to rectifying health inequities, it would be one more way to chip away at it.

The remainder of this Article lays out the arguments for why elimination of the MIEP would further existing U.S. healthcare policy, as embodied in the ACA; would enhance bipartisan criminal legal system reform efforts to reduce recidivism, optimize reentry, and reinvest criminal justice dollars more effectively; and finally, resonates with the health justice framework for reducing health inequities through addressing the social determinants of health in a supported and empowering way.

III. THE ACA MEDICAID EXPANSION AIMS FOR UNIVERSALITY

One of the most significant aspects of the Affordable Care Act of 2010 was its expansion of Medicaid. This section explores the potential of this groundbreaking legislation to improve the availability and quality of healthcare within prisons; to reduce recidivism by improving physical and behavioral health prior to release, as well as continuity of care during reentry; and, at the same time, to put in motion a paradigm shift from massive state spending on corrections to increased spending of federal dollars on social welfare measures. Eliminating the MIEP would enable these developments, while also realizing the ACA’s promise of eliminating the distinction between the deserving and the undeserving poor, as part of the move toward true universality. For too long, healthcare has been thought of as a privilege, not a right, in this country. The ACA began to move the needle on that concept. Ending the exclusion of prisoners – the population least considered worthy of privileges, but nonetheless entitled to rights – will complete the argument that all people in this country are entitled to accessible and quality healthcare.

Medicaid was traditionally available only to low-income families, children, pregnant women, seniors, and disabled individuals. In addition, income eligibility limits were strict.¹²⁷ As a result, prior to the ACA expansion, Medicaid never covered more than half of poor Americans.¹²⁸ Nonetheless, Medicaid did increase the availability and quality of healthcare for a subset of impoverished Americans.¹²⁹

minority of the population. *Inmate Age*, FED. BUR. OF PRISONS, https://www.bop.gov/about/statistics/statistics_inmate_age.jsp (last visited May 13, 2021).

126. See Looney & Turner, *supra* note 6 (presenting data that three years prior to incarceration only 49% of “prime-age men” were employed and when employed, their median earnings were \$6,250 with only 13% earning more than \$15,000; and in the first full calendar year after release, only 55% of former prisoners reported any earnings, and among those with jobs, median annual earnings were \$10,090 with only 20% earning more than \$15,000 in that year).

127. See *Medicaid Income Eligibility Limits for Parents 2002-2021*, *supra* note 22.

128. Huberfeld, *supra* note 10, at 70.

129. *Id.* at 71 n. 20–21 (noting the very limited healthcare options for the indigent uninsured before Medicaid).

When the ACA was passed in 2010, a dramatic expansion of Medicaid was a key component of the Act's aspirations for universal healthcare coverage. Although the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* undercut this goal by rendering the Medicaid expansion optional, as of this writing, 39 states have chosen to expand Medicaid eligibility under the ACA.¹³⁰ The expansion includes two primary provisions. First, the income eligibility limit was raised to 138% of the federal poverty level.¹³¹ Second, categorical eligibility was expanded to include adults without dependent children.¹³² As a result, enrollment has dramatically increased. Between 2013 and 2020, total Medicaid and CHIP enrollments increased 24% for a total of 71.3 million enrolled in the two programs by January 2020.¹³³ Newly qualifying adults make up 20% of new Medicaid enrollment.¹³⁴ The ACA dramatically reduced socioeconomic disparities in healthcare access, with the Medicaid expansion playing a key role in that development. In states that opted into the Medicaid expansion, the gap in insurance coverage between people in households with annual incomes below \$25,000 and those above \$75,000 decreased by 46%, while in non-expansion states there was a 23% reduction.¹³⁵

With Medicaid eligibility expanded under the ACA to include nearly all impoverished adults, the vast majority of the U.S. incarcerated population would now be Medicaid-eligible but for MIEP.¹³⁶ Prior to the Medicaid expansion, there was little incentive to eliminate MIEP because a majority of U.S. incarcerated people did not qualify for Medicaid coverage due to the income and category exclusions. Today the continued exclusion of incarcerated people is a substantial

130. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 575–589 (2012); *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (April 13, 2021), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

131. *Overview of the ACA and Medicaid*, supra note 5 (“The ACA also set a single income eligibility disregard equal to 5 percentage points of the FPL. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.”); Aslim et al., supra note 22, at 7–8.

132. Huberfeld, supra note 10, at 72.

133. CHIP is the Children's Health Insurance Program, which provides low-cost health coverage to children in families that earn too much to qualify for Medicaid but too little to purchase private insurance. *Total Monthly Medicaid/CHIP Enrollment and Pre-ACA Enrollment*, KAISER FAM. FOUND., <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 28, 2021).

134. Madeline Guth, Bradley Corallo, Robin Rudowitz, & Rachel Garfield, *Medicaid Expansion Enrollment and Spending Leading up to the COVID-19 Pandemic*, KAISER FAM. FOUND. (Jan. 12, 2021), <https://www.kff.org/medicaid/issue-brief/medicaid-expansion-enrollment-and-spending-leading-up-to-the-covid-19-pandemic/>.

135. Kevin Griffith, Leigh Evans & Jacob Bor, *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFF. 1503 (2017). See also Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10*, 21 HOUS. J. HEALTH L. & POL'Y (manuscript at 2–3) (forthcoming 2020) (describing the ACA's success insofar as it “sharply decreased uninsurance rates, improved access to care, reduced health disparities, decreased financial strain in low income households, and rendered economic benefits for both states and health care providers.”) Add mention of increase in preventative health and other health outcomes resulting from Medicaid expansion.

136. Stephen A. Somers, Elena Nicoletta, Allison Hamblin, Shannon M. McMahon, Christian Heiss, & Bradley W. Brockmann, *Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals*, 33 HEALTH AFF. 455, 455 (2014) (noting “sizable overlap between the Medicaid expansion population and the jail-involved population”).

departure from the ACA's general Medicaid regime. Insofar as Black men are disproportionately represented within the incarcerated population, their exclusion from Medicaid continues to echo the racist distinction between the "deserving poor" and the "able-bodied," which the ACA ostensibly erased.¹³⁷

As Professor Huberfeld describes, although this distinction originated in the Elizabethan Poor Laws, the term "able-bodied" took on a specifically racialized meaning in the colonies.¹³⁸ Enslaved people, particularly adult men, were advertised as "able-bodied" at auction, and the classification continued after the Civil War through the work of the Freedman's Bureau in determining and limiting grants of federal assistance to the formerly enslaved. As one system of subordination led to the next, "convict lease" programs in the South appropriated the forced labor of "able-bodied" freedmen convicted of such transparently pretextual crimes as "vagrancy."¹³⁹ The resistance of Southern legislators to the Social Security Act of 1935 resulted in exclusion of agricultural and domestic workers, who were primarily formerly enslaved people and their children, and was explicitly based on distaste for paying "able-bodied Negroes to sit around in idleness."¹⁴⁰ Efforts to create national health insurance failed for the same reason.¹⁴¹ Against this historical backdrop, the ACA's move toward universality, particularly through the Medicaid expansion, is significant and in some senses, an act of racial justice.¹⁴²

Lack of healthcare insurance disproportionately affects racial minorities. In 2008, 45.7 million non-elderly Americans were uninsured, including 32% of the Latino population and 21% of the Black population.¹⁴³ For half a century, employer-provided health insurance has been the prevailing model in this country and low-wage jobs rarely include such benefits, leading Black and Latino people to rely disproportionately on Medicaid.¹⁴⁴ Prior to the ACA, Medicaid's narrow eligibility criteria left millions uninsured, and accordingly vulnerable to worse health outcomes and dramatically increased mortality rates, as well as medical debt when they finally sought care.¹⁴⁵ By 2019, the number of uninsured people had dropped to 26.1 million, including 18.7% of the Latino population and 10.1% of

137. *But see generally* Super, *supra* note 10, at 1594–95 (describing Trump Administration's attempts to introduce work requirements through 1115 waivers).

138. Huberfeld, *supra* note 12, at 199, 201.

139. *Id.* at 201 (citing DOUGLAS A. BLACKMON, *SLAVERY BY ANOTHER NAME: THE RE-ENSLAVEMENT OF BLACK AMERICANS FROM THE CIVIL WAR TO WORLD WAR II* 50, 64, 348 (2009)); *see generally* ALEXANDER, *supra* note 17; DAVID M. OSHINSKY, *WORSE THAN SLAVERY: PARCHMAN FARM AND THE ORDEAL OF JIM CROW JUSTICE* (1997).

140. Huberfeld, *supra* note 12, at 202 (quoting Senator Byrd). *See also* Bagley, *supra* note 62, at 8 (noting that the states that have resisted the Medicaid expansion most strongly are the ones with more history of racial discrimination).

141. Huberfeld, *supra* note 12, at 202.

142. *Id.* at 205 ("The ACA ended federal categorization of the 'deserving' poor in health care by creating a federal baseline of universal health care coverage.").

143. Yearby, *supra* note 11, at 1308.

144. *Id.*

145. *Id.* at 1309.

the Black population, due to expansion of healthcare access effected by the ACA through various mechanisms including the Medicaid expansion.¹⁴⁶

While the ACA dramatically expanded access to health insurance for people below 138% federal poverty line, which increased the availability of insurance coverage for BIPOC, Professor Ruqaiyah Yearby argues that the ACA failed to directly address systemic racism within our healthcare system.¹⁴⁷ Without programs to directly address the three levels of implicit bias that infect the healthcare system, she argues that Black people will continue to experience the consequences of structural, institutional, and interpersonal bias.¹⁴⁸ The continued exclusion of incarcerated people, among whom Black and Latino men are disproportionately represented, is consistent with these shortcomings.

As Michelle Alexander and others have described, mass incarceration marks the next locus of subordination from slavery to convict leasing to Jim Crow.¹⁴⁹ While the ACA's expansion of Medicaid coverage to include the "able-bodied" is close to revolutionary against this historical backdrop, continued exclusion of incarcerated people represents a significant shortcoming in distinguishing this distinction. We cannot separate the particular disdain and exclusion reserved for the incarcerated or formerly incarcerated in this country from the racist origins of our policing and prison system.¹⁵⁰ While the population of prisoners becomes ever less "able-bodied," as the average prisoner grows older and more disabled, there can be little doubt that they remain "undeserving" of most things in the American imagination.

The ACA's quest for universality enacts the public health insight that the health of a population depends on the health of the individuals within that population.¹⁵¹ The COVID-19 pandemic has demonstrated more decisively than ever before that the fortress walls of prisons are permeable, and what happens inside prisons affects what happens outside of prisons. Failing to deliver adequate healthcare to the incarcerated population harms public health. Eligibility for Medicaid – and along with it a higher standard of healthcare delivery, access to much-needed mental health and substance abuse treatment, and continuity of care from inside prisons and jails to outside – should not depend on racialized distinctions among the deserving and the undeserving poor.

146. KATHERINE KEISLER-STARKEY AND LISA N. BUNCH, U.S. CENSUS BUR., HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2019 3, Appendix Table 2 (2020), <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>.

147. Yearby, *supra* note 11, at 1315. "BIPOC" stands for "Black, Indigenous, and people of color." "BIPOC" is becoming the preferred terminology to refer collectively to non-white population groups in a way that highlights "the specific injustices affecting Black and Indigenous people." Crystal Raypole, *Yes, There's a Difference Between "BIPOC" and "POC" – Here's Why It Matters*, HEALTHLINE (Sept. 17, 2020), <https://www.healthline.com/health/bipoc-meaning>.

148. Yearby, *supra* note 11, at 1315.

149. See ALEXANDER, *supra* note 17.

150. See Jill Lepore, *The Invention of the Police*, NEW YORKER (July 13, 2020), <https://www.newyorker.com/magazine/2020/07/20/the-invention-of-the-police>; see generally ALEXANDER, *supra* note 17; Wacquant, *supra* note 17.

151. See Dumont et al., *supra* note 40, at 331 (describing mutually reinforcing conditions of incarceration, homelessness, and unemployment).

IV. SMART ON CRIME AND SMART ON HEALTHCARE

Over the past decade, criminal legal system reform has benefitted from a convergence of conservatives concerned with the fiscal costs of mass incarceration and progressives concerned with the social costs of mass incarceration.¹⁵² The focus of this bipartisan “Smart on Crime” reform wave has been on “The Three Rs”: Reentry, Recidivism, and Justice Reinvestment.¹⁵³ Those working within this framework seek nonpartisan solutions to mass incarceration by focusing on “rational, cost-effective, evidence-based” approaches, while deemphasizing the racial nature of the carceral state.¹⁵⁴ The left-right convergence around criminal justice reform began in 2007, when the Texas Public Policy Foundation, a conservative think tank, launched “Right on Crime.” This criminal justice reform initiative was inspired by traditionally conservative concerns with limited government, individual liberty, and free enterprise, and garnered support from prominent conservatives like Grover Norquist, Newt Gingrich, and Edwin Meese III.¹⁵⁵ By 2011, the NAACP had allied itself with the Right on Crime initiative in campaigning against mass incarceration.¹⁵⁶

The Council of State Governments, a nonpartisan organization representing state officials, has played an important role through its Justice Center in forging this bipartisan reform project, along with the Pew Center on the States and the U.S. Department of Justice under President Obama.¹⁵⁷ In 2013, Attorney General Eric Holder first announced the Department of Justice’s “Smart on Crime” initiative, which included the promotion of alternatives to incarceration such as drug courts and reentry initiatives to reduce recidivism, as well as changes to charging and sentencing practices so that “low-level, nonviolent drug offenders, with no significant ties to large-scale organizations, gangs, or cartels, [would] no longer be charged with offenses triggering mandatory minimum sentences.”¹⁵⁸ Clemency Project 2014, the Obama Administration’s effort to use executive clemency to rectify some of the effects of the harsh sentencing policies of the 1980s and 1990s, also fit into the initiative, with its similar focus on low-level, nonviolent drug offenders “who ha[ve] a clean record in prison, do[] not present a threat to public safety, and who [are] facing a life or near-life sentence that is excessive under current law.”¹⁵⁹

While there has been justified criticism that bipartisan criminal legal system reform will never be sufficient, and even leads to perverse consequences, there is

152. GOTTSCHALK, *supra* note 15, at 7-10.

153. *Id.* at 3. See generally Barbara McQuade & Sally Q. Yates, *Prosecutors and Voters Are Becoming Smart on Crime*, 46 LITIG. 22 (2019).

154. GOTTSCHALK, *supra* note 15, at 3.

155. *Id.* at 7-8; see also RIGHT ON CRIME, rightoncrime.com (last visited May 13, 2021).

156. GOTTSCHALK, *supra* note 15, at 8.

157. *Id.* at 3; see also *About Us*, JUST. CTR.: COUNCIL OF STATE GOV’TS, <https://csgjusticecenter.org/about-us/> (last visited May 13, 2021).

158. See *For Holder, ‘Smart’ is the new ‘Tough’ on Crime*, PBS (Aug. 12, 2013, 11:44AM), <http://www.pbs.org/newshour/rundown/for-holder-smart-is-the-new-tough-on-crime>; see also U.S. DEP’T OF JUST., SMART ON CRIME: REFORMING THE CRIMINAL JUSTICE SYSTEM FOR THE 21ST CENTURY (2013).

159. James Cole, *Remarks as Prepared for Delivery by Deputy Attorney General James Cole at the New York State Bar Association Annual Meeting*, DEPT. OF JUST. (Jan. 30, 2014), <https://www.justice.gov/opa/speech/remarks-prepared-delivery-deputy-attorney-general-james-cole-new-york-state-bar>.

no question that this convergence has created new potential for change.¹⁶⁰ As Professor Allegra McLeod emphasizes, even if present efforts are limited, they demonstrate a real shift in discourse and open the door “to confront entrenched interests toward more transformative ends.”¹⁶¹ Extending Medicaid and a concomitant improvement in access and quality of medical and mental healthcare to the incarcerated population has the potential to improve reentry services through improved continuity of care; to reduce recidivism rates by treating mental health, behavioral, and medical conditions during incarceration so that people are healthier rather than sicker upon release; and represents a natural manifestation of justice reinvestment goals, shifting to addressing the root causes of marginality, including through the provision of adequate healthcare.¹⁶²

Indeed, the loudest voices calling for repeal of the MIEP have come out of the Smart on Crime camp. The National Association of Counties (“NACO”) issued a report urging repeal of the MIEP for pre-trial detainees. The organization argues that because pretrial detainees have not been convicted of a crime, it violates the Fifth and Fourteenth Amendments to deprive them of their property interest in Medicaid.¹⁶³ Pre-trial detainees constitute the majority population in jails, which fall under the jurisdiction and the budgets of counties, so it is not surprising that the national organization representing counties has an interest in distinguishing between pre-trial detainees and convicted inmates.¹⁶⁴ Counties are drowning in the medical costs of jail inmates and have even less budget elasticity than states.¹⁶⁵

On Capitol Hill, bipartisan criminal legal system reformers have also started paying attention to the MIEP. In 2019, New Hampshire Congresswoman Annie Kuster introduced a bill, the Humane Correctional Health Care Act, to repeal the

160. GOTTSCHALK, *supra* note 15, at 19 (“Framing the problem of mass imprisonment as largely a fiscal problem (i.e., we just cannot afford it anymore) will not sustain the political momentum needed over the long haul to slash the prison population and dismantle the carceral state.”).

161. Allegra M. McLeod, *Beyond the Carceral State*, 95 TEX. L. REV. 651, 680 (2017) (“Particularly in this moment of a growing commitment in many quarters to decarcerate, rather than resign ourselves to the limitations of the present, we should remain alert to opportunities to tactically engage the gap between expressed desires for change and the inadequacy of current proposals.”).

162. Justice reinvestment is essentially the bipartisan way of saying “defund the police”: that is, a redistribution of government funding from the criminal legal system to social welfare programs like education, housing, health care, and living wage employment. “Defund the police” itself means different things to different people, but for a sizable number of defund activists, the focus is on redistribution of funding to non-carceral solutions and social problems. *See, e.g., #DefundThePolice*, BLACK LIVES MATTER (May 30, 2020), <https://blacklivesmatter.com/defundthepolice/> (“We call for a national defunding of police. We demand investment in our communities and the resources to ensure Black people not only survive, but thrive.”).

163. NAT’L ASS’N OF COUNTIES, FEDERAL POLICY IMPACTS ON COUNTY JAIL INMATE HEALTHCARE & RECIDIVISM: HOW FLAWED FEDERAL POLICY IS DRIVING HIGHER RECIDIVISM RATES (2019), <https://www.naco.org/sites/default/files/documents/Medicaid%20and%20County%20Jails%20Presentati%20on.pdf>; *see also Medicaid Coverage and County Jails*, NAT’L ASS’N OF COUNTIES (Feb. 28, 2019), <https://www.naco.org/resources/medicaid-coverage-and-county-jails>; Press Release, Nat’l Ass’n of Counties, Report: Federal Policy on Inmate Health Care Leads to Poor Health Outcomes and Increased Likelihood of Reoffending (Mar. 2, 2020), <https://www.naco.org/resources/press/report-federal-policy-inmate-health-care-leads-poor-health-outcomes-and-increased>.

164. NAT’L ASS’N OF COUNTIES, *supra* note 163, at 11 (noting that “65% of local jail inmates are in pretrial status and low risk” and that “Counties operate 2,875 of 3,160 local jails”).

165. Lisa Valder, *Local Spending on Jails Tops \$25 Billion in Latest Nationwide Data*, PEW CHARITABLE TR. (Jan. 29, 2021), [https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/01/local-spending-on-jails-tops-\\$25-billion-in-latest-nationwide-data](https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/01/local-spending-on-jails-tops-$25-billion-in-latest-nationwide-data).

MIEP.¹⁶⁶ Companion legislation was introduced by New Jersey Senator Corey Booker, who has been a leading voice in Congress for the Smart on Crime agenda, speaking extensively about criminal legal system reform and working on related legislation. Booker was a co-sponsor of the First Step Act, which was the bipartisan criminal legal system reform bill par excellence, and signed into law by President Trump.¹⁶⁷ The press release issued regarding the Humane Correctional Health Care Act emphasized the enhancement of reentry, the reduction of recidivism, and the burden on state budgets, as well as noting that “[h]ealth care is a fundamental human right that should never be stripped from any person, for any reason.”¹⁶⁸ The bill did not make it out of committee after Kuster and Booker introduced their respective versions in 2019.¹⁶⁹ However, there is reason to believe that President Biden’s criminal justice and healthcare reform agendas could converge to make passage of a similar bill possible during his administration.

Many more entities and individuals have been talking about and working on ways to use Medicaid, particularly since the ACA expansion, to facilitate reentry and reduce recidivism by working around the MIEP.¹⁷⁰ As described above, the high rates of mental illness and substance use disorders among the incarcerated population have effects on recidivism, public health, and mortality rates. Therefore, it should come as no surprise that researchers and policymakers jumped at the opportunity to use Medicaid for justice-involved individuals – particularly

166. H.R. 4141, 116th Cong. (1st Sess. 2019); S. 2305, 116th Cong. (1st Sess. 2019).

167. H.R. 5682, 115th Cong. (2d Sess. 2018); S. 756, 115th Cong. (2d Sess. 2018). Booker has also introduced the REDEEM Act, the CAREERS Act, the PRIDE Act, the MERCY Act, the Fair Chance Act, the Equal Justice Under Law Act, the Gideon Act, the Dignity for Incarcerated Women Act, the Reverse Mass Incarceration Act, and the Marijuana Justice Act, as well as the Bipartisan Smarter Sentencing Act, which was a precursor to the First Step Act. *Booker Statement on Senate Passage of Landmark Criminal Justice Reform Bill*, U.S. SENATE (Dec. 18, 2018), <https://www.booker.senate.gov/news/press/booker-statement-on-senate-passage-of-landmark-criminal-justice-reform-bill>.

168. Press Release, Congresswoman Ann McLane Kuster, Senator Booker Introduce Legislation to End Outdated Policy that Prevents Incarcerated Individuals from Accessing Medicaid (Aug. 2, 2019) (on file with author).

169. See *H.R. 4141 – Human Correctional Health Care Act*, U.S. CONGRESS, <https://www.congress.gov/bill/116th-congress/house-bill/4141/all-actions?s=1&r=2> (last visited May, 28, 2021); *S. 2305 – Human Correctional Health Care Act*, U.S. CONGRESS, <https://www.congress.gov/bill/116th-congress/senate-bill/2305/all-actions> (last visited May 28, 2021). There are also two other bills that have been introduced with respect to MIEP. The Equity in Pretrial Medicaid Coverage Act, introduced by Sen. Ed Markey (D-Mass), Sen. Jeff Merkley (D-Ore.), Sen. Sherrod Brown (D-Ohio) and Sen. Dick Durbin (D-Ill.), would remove eligibility limitations for pretrial detainees. The Restoring Health Benefits for Justice-Involved Individuals Act of 2019, introduced by Sen. Merkley, would remove limitations on inmate eligibility for Medicare, CHIP, and veteran’s health benefits. Rachel Looker, *Proposed Policy Change Aims to Fix Loss of Benefits for Pre-trial Detainees*, NAT’L ASS’N OF COUNTIES (Mar. 10, 2020) <https://www.naco.org/articles/proposed-policy-change-aims-fix-loss-benefits-pre-trial-detainees>.

170. See Amy E. Boutwell & Jonathan Freedman, *Coverage Expansion and the Criminal Justice-Involved Population: Implications for Plans and Service Connectivity*, 33 HEALTH AFF. 482 (2014) (suggesting approaches for Medicaid providers dealing for the first time with justice-involved population of young men, most of whom were previously uninsured and have high rates of undiagnosed chronic and infectious diseases, behavioral health conditions, and trauma); Kavita Patel, Amy Boutwell & Bradley W. Brockmann, *Integrating Correctional and Community Health Care for Formerly Incarcerated People Who Are Eligible for Medicaid*, 33 HEALTH AFF. 468 (2014) (describing various reentry initiatives aimed at improving healthcare delivery and reducing recidivism); Somers et al., *supra* note 136, at 459 (suggesting collaboration between Medicaid and corrections agencies to facilitate access to Medicaid benefits for individuals recently released from jail).

since the ACA also expanded Medicaid coverage of behavioral health services – to the extent not prohibited by the MIEP. Because Medicaid benefits cannot be used during incarceration for the most part, efforts have been focused on using incarceration as a point of enrollment, incorporating reactivation or enrollment of Medicaid as part of reentry procedures, and accessing Medicaid coverage immediately after release to ensure continuity of care.

Partly in response to pressure from service providers to make Medicaid coverage available as part of the reentry process, CMS has changed certain policies and issued clarifying guidance to open up additional possibilities. Most notably, CMS revised its guidance regarding the availability of federal Medicaid funding for individuals residing in halfway houses and for parolees in specialized nursing homes.¹⁷¹ In both instances, CMS previously decreed federal Medicaid funding unavailable in those settings because of the MIEP and because it determined that individuals in those settings were under correctional control in a way that conflicted with federal Medicaid regulations requiring freedom of movement, speech, and association for residents.¹⁷²

CMS subsequently changed course and decided that Medicaid funding would indeed be available for individuals residing in halfway houses in the process of re-entering society,¹⁷³ as well as for elderly parolees released to specialized nursing homes.¹⁷⁴ While making clear that parolees in Medicaid-funded nursing homes must have no greater restrictions on their freedoms than non-parolee residents, CMS concluded that their status as parolees did not preclude Medicaid funding for their care.¹⁷⁵ Despite revising its guidance, enabling the establishment of two Medicaid-certified specialized nursing homes in recent years — one in Connecticut and one in Georgia — in each case the process was long and arduous due to CMS pushback, as well as community resistance.¹⁷⁶ Little has been done to publicize this development and not enough states have sought to take advantage of this possibility. It is quite likely that the hefty price tag that would be associated with widespread implementation of the Connecticut model is the reason for this. Again, keeping in mind that states already bear these expenses, and that caring for these individuals in prison costs two to three times what it would to deliver the

171. Memorandum from Ctr. for Medicare & Medicaid Servs., *Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals* (Issued May 3, 2016, Revised Dec. 23, 2016), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf> [hereinafter 2016 CMS Letter].

172. See 42 C.F.R. § 483.10(a)-(b).

173. *How and When Medicaid Covers People Under Correctional Supervision*, PEW CHARITABLE TR. (Aug. 2, 2016), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision> [hereinafter *How and When Medicaid Covers People Under Correctional Supervision*].

174. See 2016 CMS Letter, *supra* note 171.

175. *Id.*

176. See David Drury, *Feds: No Medicaid Reimbursement for Prisoners at Rocky Hill Nursing Home*, HARTFORD COURANT (Sept. 5, 2015), <https://www.courant.com/community/rocky-hill/hc-rocky-hill-nursing-home-0905-20150904-story.html>; Rhonda Cook, *Nursing Home for Prison Inmates Opening in Milledgeville*, ATLANTA J. CONST. (Dec. 20, 2016), <https://www.ajc.com/news/local/nursing-home-for-prison-inmates-opening-milledgeville/bxy42FvMBDkO7T8jla8WP/>; see also PEW CHARITABLE TR., *supra* note 173.

same services in a nursing home setting, it is nonetheless true that it would impose additional costs on the federal government.

Due to the high rates of mental health and substance abuse disorders among the incarcerated population, the first weeks and months after release are a crucial time during which both recidivism and mortality rates are extremely elevated.¹⁷⁷ With many states shifting to suspension, rather than termination, of Medicaid enrollment during incarceration, reactivation of Medicaid enrollment is increasingly part of the reentry process.¹⁷⁸ As a result of the Medicaid expansion and broad efforts to enroll incarcerated people so that their suspensions could be lifted quickly upon release, more individuals had Medicaid coverage during the crucial first few weeks and months of reentry.¹⁷⁹

These efforts have been successful to a significant degree. One empirical study found a substantial increase in access to substance abuse treatment by released prisoners now covered under the Medicaid expansion, noting that the Medicaid expansion “significantly reduce[d] the probability of returning to prison for violent and public order crimes among multi-time reoffenders,” by as much as 31-40% between 2010 and 2016.¹⁸⁰ These improved outcomes for individuals also suggest benefits in terms of public health and safety. Encouraging early enrollment in

177. See SUSAN D. PHILLIPS, THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PUBLIC SAFETY AND CORRECTIONS POPULATIONS, SENTENCING PROJECT 2-3 (2012), <https://www.sentencingproject.org/publications/the-affordable-care-act-implications-for-public-safety-and-corrections-populations/>; Ingrid A. Binswanger et al., *Release from Prison – A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 157 (2007) (finding that during a mean follow-up period of 1.9 years after release, the adjusted risk of death among former Washington state prison inmates was 3.5 times that of other state residents, while during the first 2 weeks after release, the risk of death among former inmates was 12.7 times that of other state residents, particularly from drug overdose); DEP’T OF JUST., BUREAU OF JUST. STATS., *RECIDIVISM OF PRISONERS RELEASED IN 30 STATES IN 2005: PATTERNS FROM 2005 TO 2010* 1 (2014) (reporting study results that 36.8% of state prisoners who were rearrested within 5 years of release were arrested within the first 6 months after release, and 56.7% were rearrested within the 12 months after release); WESTERN, *supra* note 17, at 123 (reporting among Boston Reentry Study cohort that respondents with a history of substance abuse who relapsed after release were reincarcerated within 12 months at twice the rate of the remaining respondents and triple the rate of respondents with a substance abuse history who remained sober after release (56% v. 22% v. 12%)).

178. See, e.g., JESSE JANNETTA ET AL., STRATEGIES FOR CONNECTING JUSTICE-INVOLVED POPULATIONS TO HEALTH COVERAGE AND CARE, URB. INST. 18-22 (2018); *How and When Medicaid Covers People Under Correctional Supervision*, *supra* note 173, at 6-7; Jennifer Ryan et al., *Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States*, KAISER FAM. FOUND. (June 1, 2016), <https://www.kff.org/report-section/connecting-the-justice-involved-population-to-medicaid-coverage-and-care-issue-brief/>; MARTHA R. PLOTKIN & ALEX BLANDFORD, COUNCIL OF STATE GOV’TS, CRITICAL CONNECTIONS: GETTING PEOPLE LEAVING PRISON AND JAIL THE MENTAL HEALTH CARE AND SUBSTANCE USE TREATMENT THEY NEED 4-5 (2017), <https://bja.ojp.gov/sites/g/files/xyckuh186/files/publications/Critical-Connections-Full-Report.pdf>; CATHERINE MCKEE ET AL., STATE MEDICAID ELIGIBILITY POLICIES FOR INDIVIDUALS MOVING INTO AND OUT OF INCARCERATION, KAISER COMM’N ON MEDICAID AND THE UNINSURED 8 (2015).

179. Presentation, *Medicaid and Justice-Involved Populations: Strategies to Increase Coverage and Care Coordination*, Medicaid and CHIP Learning Collaboratives (2017), <https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/justice-involved-populations.pdf>; PEW CHARITABLE TR., HOW MEDICAID ENROLLMENT OF INMATES FACILITATES HEALTH COVERAGE AFTER RELEASE 2-4 (2015), [https://www.pewtrusts.org/~media/assets/2015/12/statesfiscalhealth_medicaidcoverageinmatesbrief-\(1\).pdf](https://www.pewtrusts.org/~media/assets/2015/12/statesfiscalhealth_medicaidcoverageinmatesbrief-(1).pdf).

180. Aslim et al., *supra* note 22, at 30.

Medicaid makes good sense from a public health standpoint, and from a fiscal standpoint, to the extent that continuity of care can cover preventative health measures that are cheaper than emergency services to subsequently address acute conditions. Similarly, reduced recidivism rates indicate the commission of fewer crimes and the victimization of fewer individuals.

There have even been some pilot projects to use the jail intake process as an opportunity to enroll previously unenrolled individuals. Since 2004, the Connecticut Department of Corrections (“DOC”) and Department of Social Services (“DSS”) have collaborated to facilitate Medicaid enrollment for prisoners during the last 30 days of their sentence as part of discharge-planning.¹⁸¹ Initially that program focused on those with more severe medical and mental health needs, but after the ACA expansion, was extended to include the larger eligible population.¹⁸² In 2012, DOC and DSS adapted the prison discharge-based Medicaid enrollment process to an intake-based process for pretrial detainees in jail at the Hartford Correctional Center.¹⁸³ During the study period, approximately half of the people who were enrolled in Medicaid through the study lost coverage by the time of their release because of automatic disenrollment mechanisms after 30 days of incarceration.¹⁸⁴

Finally, a small number of states requested section 1115 waivers in order to use federal Medicaid funds during the last 30 days of a sentence. In June 2020, Utah sought such a waiver, consistent with the directive of the 2018 Support Act, to allow Medicaid coverage during the 30 days prior to release for justice-involved individuals with chronic physical or behavioral conditions, mental illness, or opioid use disorder.¹⁸⁵ Several other states have sought 1115 waivers to cover COVID-19 testing and treatment, in order to reduce the risk of releasing a contagious individual into the community.¹⁸⁶

All of these efforts involve significant inefficiencies caused by the MIEP. Repealing the MIEP would eliminate the bureaucratic hurdles of enrolling, suspending, and later reactivating enrollment. Even more significantly, the

181. MALLIK-KANE ET AL., *supra* note 14, at 5.

182. *Id.*

183. *Id.* at 6.

184. *Id.* at 13, 22.

185. Letter from Joseph K. Miner, Exec. Dir., Utah Dep’t of Health, to Seema Verma, Adm’r, Ctr. for Medicare and Medicaid Servs. (June 29, 2020), <https://medicaid.utah.gov/Documents/pdfs/1115WaiverAmendmentJusticeInvolved6-20.pdf>.

186. *See, e.g.*, Letter from Cal. Dep’t of Health Care Servs., to Judith Cash, Dir. State Demonstrations Grp. (Apr. 3, 2020), <https://www.dhcs.ca.gov/Documents/COVID-19/CMS-Ltr-and-CA-COVID-19-1115-Waiver-040320.pdf> (seeking waiver of inmate exclusion to allow Medicaid funding for COVID-19 testing and treatment of jail and prison populations, in addition to other non-inmate related waivers); ILL. DEP’T OF HEALTHCARE & FAMILY SERVS., ILLINOIS COVID-19 SECTION 1115(A) DEMONSTRATION APPLICATION (2020), <https://www.illinois.gov/hfs/SiteCollectionDocuments/03262020IllinoisCOVID19Section1115DemonstrationProposalFinal.pdf> (seeking waiver of inmate exclusion to allow Medicaid funding for “testing, diagnosis, and treatment of COVID-19 or other services” of jail and prison populations so as to eliminate the need to transport inmates to outside hospital facilities, in addition to other non-inmate related waivers); Letter from Joshua D. Baker, Dir., to Judith Cash, Dir. State Demonstrations Grp. (Mar. 27, 2020), <https://msp.scdhhs.gov/covid19/sites/default/files/%282020-03-27%29%20SC%201115%20Inpatient%20COVID19.pdf> (seeking waiver of inmate exclusion to allow Medicaid funding when “inpatient care is provided in a medical facility that is under the control of a state correctional agency,” to avoid transfer of COVID-positive inmates to outside hospital facilities).

availability of federal Medicaid dollars could significantly expand the scope of mental health and substance abuse treatment offered to inmates while incarcerated. Eliminating the MIEP could enable the provision of more substance abuse treatment within jails and prisons, which would likely further improve public health and recidivism outcomes.¹⁸⁷ As discussed above, mental health and substance abuse treatment options available in jails and prisons are grossly inadequate to meet needs. With correctional health already burdening state budgets,¹⁸⁸ and the political weakness of prisoners and prisoner advocates, there has been little attempt to supply comprehensive mental health treatment to the incarcerated population. Instead, psychiatric medication is often the extent of the treatment available. Substance abuse treatment available in jails and prisons is similarly limited.¹⁸⁹ Traditionally, such treatment has also been in short supply in the community; however, the ACA's Medicaid expansion included greater coverage for behavioral health treatment, which has increased access for the general population.¹⁹⁰ The MIEP prevents the parallel expansion of treatment options for the incarcerated population, where the need is proportionally greater.

The health-related successes described above and the role that CMS played in each should serve as a model for other ways in which Medicaid could improve health outcomes for the justice-involved population, and by extension, the general population.¹⁹¹ By eliminating the MIEP altogether, federal Medicaid funding would become available to cover a significant portion of correctional medical costs, including mental health and behavioral health treatments.¹⁹² Importantly, Medicaid funding would raise standards of care, and include incentives to improve care quality and reduce costs.¹⁹³

187. See Barkow, *supra* note 48, at 2634 n.28 (citing Nat'l Center on Addiction & Substance Abuse at Columbia Univ.).

188. *But see* GOTTSCHALK, *supra* note 15, at 9 (noting that state corrections expenditures were less than 3% of total state budgets in 2010).

189. Steven Belenko, Matthew Hiller & Leah Hamilton, *Treating Substance Use Disorders in the Criminal Justice System*, 15 CURRENT PSYCHIATRY REPS. 1, 2 (Oct. 17, 2013) (noting that “[o]nly about 10% of state and 6% of jail inmates report receiving any clinical treatment” for substance use disorders despite some 80% having used an illegal drug, including 55% in the month prior to arrest, and 53.4% meeting the DSM IV criteria for drug abuse or dependence).

190. *See id.*, at 2, 4 (noting in 2013 that among new arrestees, 7-26% had ever been in outpatient treatment and 13-32% in residential or inpatient treatment, despite more than 80% of state prison and local jail inmates having used an illegal drug, including 55% in the month prior to arrest); Rich et al., *supra* note 43, at 465 (noting the ACA's expanded coverage for behavioral health treatment and its significance for the justice-involved population); James S. Marks and Nicholas Turner, *The Critical Link Between Health Care and Jails*, 33 HEALTH AFF. 443, 445 (2014) (discussing ACA's expansion of coverage for mental health and substance use disorder treatment, and estimating that one-fifth of Medicaid expansion population would be jail-involved, in urging greater continuity of care between correctional health and community health care providers).

191. Simon, *supra* note 15, at 221 (“the emerging correctional health care crisis produced by the concentration of chronically ill and geriatric prisoners threatens to exacerbate a broader crisis of chronic illness in America's aging society.”).

192. *It's Time to End the Callous Policy of the Inmate Medicaid Exclusion*, WASH. POST (May 12, 2019, 4:23 PM), https://www.washingtonpost.com/opinions/its-time-to-end-the-callous-policy-of-inmate-medicare-exclusion/2019/05/12/9f69c7d4-4cd2-11e9-9663-00ac73f49662_story.html; Winkelman et al., *supra* note 27; Rich et al., *supra* note 43, at 464 (regarding Medicaid incentives for quality of care).

193. Rich et al., *supra* note 43, at 464.

V. HEALTH JUSTICE

Within the field of public health, it is now widely recognized that reducing health inequities and improving the overall health of the population requires devoting as much or more attention to the social determinants of health as to the delivery of healthcare itself.¹⁹⁴ The World Health Organization has delineated the social determinants of health as consisting of structural determinants, and intermediary or intermediate determinants.¹⁹⁵ Discrimination and poverty are the primary structural determinants, which in turn impact intermediate determinants such as access to quality health care, housing, and employment.¹⁹⁶

Health justice is an emerging analytical and advocacy framework for addressing health inequities. While the term has previously gotten some play in the public health world, scholars have begun to articulate and theorize health justice as a legal framework as well.¹⁹⁷ Drawing on movements from the arenas of environmental justice, reproductive justice, and food justice, Professor Lindsey Wiley articulates health justice as a framework with three key tenets that she argues ought to inform the field of health law writ large.¹⁹⁸ First, health justice emphasizes the consideration of the social determinants of health. Second, it interrogates the social bias and structural advantage built into individualistic approaches to reducing health disparities. Third, it focuses on community engagement and the development of communitarian solutions to reduce health disparities.¹⁹⁹ In Professor Wiley's formulation, health justice prescribes moving away from a focus on individual responsibility and toward structural analysis and community-generated solutions.²⁰⁰

194. See generally Paula Braveman, Susan Egerter, and David R. Williams, *The Social Determinants of Health: Coming of Age*, ANNU. REV. PUB. HEALTH 391 (2011) (describing the awareness of social determinants of health developed over the past two decades and identifying gaps in the research). See also Bresler & Beletsky, *supra* note 43, at 228 (describing contact with the criminal legal system as a public health crisis); RUQAIJAH YEARBY, CRYSTAL N. LEWIS, KEON L. GILBERT, & KIRA BANKS, DATA FOR PROGRESS, RACISM IS A PUBLIC HEALTH CRISIS: HERE'S HOW TO RESPOND (2020) <https://www.filesforprogress.org/memos/racism-is-a-public-health-crisis.pdf>.

195. WORLD HEALTH ORG. COMM'N ON SOC. DETERMINANTS OF HEALTH, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 6 (2010), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf?ua=.

196. Emily A. Benfer, Seema Mohapatra, Lindsay Wiley & Ruqaijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, YALE J. OF HEALTH POL'Y L. & ETHICS (2020) (citing WHO).

197. Emily Benfer, *Health Justice: A Framework (And Call to Action) For the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275 (2015); Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758 (2020); Lindsay Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 86 (2014); Raqaijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & Biosciences 1 (2020).

198. Wiley, *supra* note 197, at 57; See also Lindsay Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 833 (2016) (offering further articulation of health justice as an alternative to existing health law models, with focus on collective interests, universal access to affordable health care, prioritization of prevention, and collective oversight).

199. Wiley, *supra* note 197, at 86.

200. Wiley, *supra* note 197, at 95-104.

While Professor Wiley seeks to broaden the scope of health law to situate the fundamental importance of health justice, Professor Emily Benfer focuses on law itself as a social determinant of health. Under the banner of health justice, Benfer calls for a focus on primary prevention policies to address the social determinants of health, and significantly, modification or repeal of laws that negatively affect health. In addition to addressing these intermediate factors, she also calls for an end of discrimination and racial bias, both structural factors that cause health inequities. Finally, like Wiley, Benfer emphasizes the importance of engagement with affected communities.²⁰¹

A number of scholars have sought to amplify the racial justice aspect of health justice, particularly in the context of the COVID-19 pandemic, which has had a well-documented racially disparate impact.²⁰² By nearly every marker, the COVID-19 pandemic has disproportionately impacted Black, Latino, and Indigenous communities. Not only are rates of infection, hospitalization, and death higher in communities of color, but the economic consequences of the pandemic have hit these same communities harder.²⁰³ Health justice provides the insight that the heightened risk that COVID-19 poses for people of color is due to the same array of structural and intermediate factors that cause health inequities in normal times. These factors include inadequate access to quality healthcare, inability to take sick days, reliance on public transportation, employment insecurity, housing insecurity, food insecurity, and no financial cushion to get through difficult times.²⁰⁴ Echoing Benfer's focus on law as a social determinant of health,

201. Benfer, *supra* note 197, at 346.

202. See generally Sheila Foster, Yael Cannon & Gregg Bloche, *Health Justice is Racial Justice: A Legal Action for Health Disparities*, HEALTH AFF. (July 2, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200701.242395/full/>; Yearby & Mohapatra, *supra* note 197; Benfer et al., *supra* note 196.

203. See *Health Equity Considerations and Racial and Ethnic Minority Groups*, CTR. FOR DISEASE CONTROL AND PREV. (Apr. 19, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html> (reporting disproportionate effects of the pandemic on racial and ethnic minority groups due to long-standing systemic health and social inequities); *The COVID Racial Data Tracker*, COVID TRACKING PROJ. (Mar. 7, 2021), <https://covidtracking.com/race> (reporting that Black people have died at 1.4 times the rate of white people, and that death rates for American Indian, Hispanic/Latino, Native Hawaiian and other Pacific Islander have also been vastly disproportionate to their percentage of the population); Mark Hugo Lopez, Lee Rainie, & Abby Budiman, *Financial and health impacts of COVID-19 vary widely by race and ethnicity*, PEW RSCH. CTR. (May 5, 2020), <https://www.pewresearch.org/fact-tank/2020/05/05/financial-and-health-impacts-of-covid-19-vary-widely-by-race-and-ethnicity/> (indicating April 2020 survey results that 61% of Hispanic Americans, 44% of Black Americans, and 38% of white Americans reported that they or someone in their household had lost their job or wages due to COVID-19; and that 48% of Black adults, 44% of Hispanic adults, and 26% of white adults reported difficulty paying their bills in April 2020); Steven Brown, *The COVID-19 Crisis Continues to Have Uneven Economic Impact by Race and Ethnicity*, URB. INST. (July 1, 2020), <https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity> (indicating by June 2020 that household employment income losses were reported by 48% of all households but 53% of Black households and 62% of Hispanic households).

204. Yearby & Mohapatra, *supra* note 197, at 4 (analyzing how “structural racism in employment causes disparities in exposure; structural racism in housing causes disparities in susceptibility; and structural racism in healthcare causes disparities in treatment.”).

Professors Yearby and Mohapatra have analyzed the laws or lax enforcement of laws that have contributed to the racially disparate impact of COVID-19.²⁰⁵

In earlier work, Professor Yearby drew out the three levels on which racial bias in health care operates: interpersonal, institutional, and structural.²⁰⁶ These biases negatively impact the health of Black people in the general population; the effects are even more devastating when combined with the racially disparate nature of our system of mass incarceration. A 2002 study by the Institute of Medicine was one of the first to provide empirical evidence of interpersonal bias in health care delivery, revealing that health care providers treated Black people differently because of their race, thereby impeding access to health care and causing worse health outcomes.²⁰⁷ This reality has been further documented in the two decades since, with studies showing that Black patients' pain is taken less seriously and inadequately treated;²⁰⁸ that Black babies delivered by white doctors have higher rates of infant mortality;²⁰⁹ and, during the pandemic, that Black patients suffering from COVID-19 have had their symptoms minimized by healthcare workers and have been denied hospitalization with frequently fatal consequences.²¹⁰ Indifference to the suffering of disproportionately BIPOC incarcerated populations, during the COVID-19 pandemic and prior to it, is entirely consistent with these documented instances of interpersonal bias.

Institutional bias “operates through organizational structures within institutions, which establish separate and independent barriers to health care services.”²¹¹ The closure of hospitals in Black communities is one demonstration of institutional bias; the inadequate nature of correctional healthcare is another.²¹² Because of the racially disparate character of mass incarceration, incarceration constitutes a form of institutional racial bias that further exacerbates health inequities along racial lines.²¹³ While the state of correctional healthcare affects all incarcerated people, including white people, the racialized nature of our carceral

205. *Id.* (identifying gaps in the Fair Labor Standards Act; the CARES Act; Title X of the Housing and Community Development Act of 1992; and enforcement problems with Title VI of the Civil Rights Act of 1964, the Affordable Care Act, and the CARES Act).

206. Yearby, *supra* note 11, at 1285.

207. *Id.* at 1284 (citing *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, INST. OF MED. (Brain D. Smedlye et al. eds., 2003)).

208. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. U.S. 4296 (2016).

209. Brad N. Greenwood, Rachel R. Hardeman, Lauren Huang & Aaron Sojourner, *Physician-Patient Racial Concordance and Disparities in Birthing Mortality for Newborns*, 117 PROC. NAT'L ACAD. SCI. U.S. 21194 (2020).

210. John Eligon & Audra D.S. Burch, *Questions of Bias in COVID-19 Treatment Add to the Mourning for Black Families*, N.Y. TIMES (May 10, 2020), <https://www.nytimes.com/2020/05/10/us/coronavirus-african-americans-bias.html>; John Eligon, *Black Doctor Dies of Covid-19 After Complaining of Racist Treatment*, N.Y. TIMES (Dec. 23, 2020), <https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html>.

211. Yearby, *supra* note 11, at 1286 (internal quotation marks omitted).

212. *Id.* at 1302-1305.

213. Zinzi D. Bailey, Nancy Krieger, Madina Agenor, Jasmine Graves, Natalie Linos & Mary T. Bassett, *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 LANCET 1453, 1458 (2017).

system creates harshness inspired by disdain for Black suffering, even when it has consequences for non-Black individuals.²¹⁴

Finally, structural bias operates at a societal level, conferring privilege on some while denying resource access to others.²¹⁵ The majority of the incarcerated population comes from environments of resource deprivation, and that deprivation is only exacerbated by incarceration and its consequences upon release. These three levels of racial bias in healthcare are overlaid on the long-standing indifference to prisoner pain and suffering, and the racial disparities within the incarcerated population. The marginalized status of incarcerated people and of Black people creates a mutually reinforcing disregard for the health of this population on interpersonal, institutional, and structural levels.

A. Applying the Health Justice Framework to MIEP

Health justice offers a framework for considering the importance of providing healthcare coverage to prisoners, regardless of their crimes, as members of communities that have been historically deprived of equal access to healthcare and for whom the social determinants of health include poverty, unequal access to education, chronic un- and underemployment, over-policing, and disproportionate victimization through cycles of violence, trauma, and abuse. Drawing on analyses of the health-harming effects of incarceration in the public health literature, this Article suggests that incarceration is another intermediate factor leading to health inequities. The stresses of living in prison, and the inadequate access to healthcare while incarcerated, can lead to long-term health consequences that remain even after release.²¹⁶ Incarceration has effects on physical as well as mental health. In addition to the environmental factors and limited access to healthcare that contribute to the poor health of the incarcerated population even prior to incarceration, racial bias intrinsic to the delivery of healthcare presents another health-harming effect.

Eliminating the MIEP is one modest step toward addressing the social determinants of health, by improving the quality of healthcare delivered in prison in accordance with Medicaid standards; by creating more opportunities for Medicaid-funded mental health and substance abuse treatment, to which access has previously been inadequate; and by facilitating continuity of care for those leaving prison so that there is no gap in coverage during the crucial first weeks out of prison – when a gap can mean the difference between staying out or returning to prison, or quite literally life or death.²¹⁷

In addition to emphasizing the social determinants of health for incarcerated and formerly incarcerated people, health justice offers the opportunity to shift our

214. McLeod, *supra* note 162, at 661 (discussing the “historical practices of racial subordination that have led blackness and criminality to be connected in the American imagination” leading to “American tolerance for penal severity, thoroughly infecting U.S. penal practices and modes of thought about crime and punishment” regardless of the race of the particular individual).

215. Yearby, *supra* note 11, at 1286 (internal citation, quotation marks, and ellipses omitted).

216. Massoglia & Remster, *supra* note 86, at 10S.

217. See Fazel & Baillargeon, *supra* note 83, at 960 (citing studies from Europe, Australia, and the US demonstrating high mortality upon release from prison, including one Washington state study showing mortality 29 times more likely for men and 69 times more likely for women during the first week of release).

focus from personal responsibility for health outcomes to structural analysis. After several decades focused on punishment for individual bad acts by purportedly individual bad actors, penal philosophy is finally shifting back toward a more nuanced understanding of what drives criminal behavior and recognition of the disjuncture between crimes committed and time done.²¹⁸ Consistent with this renewed interest in what I will term “the social determinants of crime,” health justice also offers the opportunity to shift our focus from blaming the formerly and currently incarcerated for their own circumstances, including their own poor health. Repealing the MIEP opens up the whole range of Medicaid-funded services to support formerly and currently incarcerated people as they work to improve their own physical and mental health. Rather than blaming individuals for their drug addiction or mental illness, repealing the MIEP offers the possibility of support to treat those conditions while incarcerated.²¹⁹

Finally, health justice urges that the affected communities be involved in developing solutions to reducing health inequities. The Black Lives Matter movement and related abolitionist organizations have articulated as one of their key goals the shift of funding from carceral institutions to social welfare spending – particularly in the areas of education, housing, and health.²²⁰ Particularly since its expansion under the ACA, Medicaid has become one of the most significant anti-poverty and health-promoting programs in the United States. While attention must also be paid to other social determinants of health, further expanding access to healthcare coverage – and the corresponding access to preventative healthcare – is one of the best first steps that we can take in this direction. Medicaid is expensive and will become more so with the incorporation of an additional 2 million incarcerated people.²²¹ But what better way to signal the beginning of a shift away from carceral spending to social welfare spending than to enroll incarcerated people in Medicaid? Expanding Medicaid to cover not only residents of states that have opted out of the expansion – which President Biden has articulated as a goal of his administration – but also incarcerated people in every state, would signal in a materially significant way that Black lives matter.

Health justice dictates that the incarcerated, whatever their crimes, receive adequate and humane healthcare. This is a population that had statistically unequal

218. See, e.g., Sharon Dolovich & Alexandra Natapoff, *Mapping the New Criminal Justice Thinking* in *THE NEW CRIMINAL JUSTICE THINKING* (Sharon Dolovich & Alexandra Natapoff eds., 2019) (suggesting that after three decades of our “war on crime” there is “an emerging willingness on all sides to question, challenge, and rethink our existing approach to preventing and punishing crime”); SMART ON CRIME: REFORMING THE CRIMINAL JUSTICE SYSTEM FOR THE 21ST CENTURY, U.S. DEP’T. OF JUST. (2013) (laying out the Justice Department’s new approach under Attorney General Eric Holder and including among five key goals “To promote fairer enforcement of the laws and alleviate disparate impacts of the criminal justice system; To ensure just punishments for low-level, nonviolent convictions; [and] To bolster prevention and reentry efforts to deter crime and reduce recidivism.”).

219. Arguing for Medicaid-covered mental health and substance abuse treatments for incarcerated populations does not diminish my belief that as a society we are overincarcerating on a massive scale and that a great proportion of our prison population should be diverted to non-jail alternatives or simply not arrested in the first place.

220. See BLACK LIVES MATTER, <https://www.blacklivesmatter.com> (last visited May 14, 2021).

221. Under the ACA, Medicaid already increased costs by about 14% and expanding Medicaid coverage to all prisoners would increase it further. Naomi R. Cahn & June Carbone, *Uncoupling*, 53 *ARIZ. STATE L. J.* 1 (2021). The federal government is far more capable of absorbing these costs than the states, which are currently bearing the burden of nearly all correctional healthcare costs.

access to healthcare, and disproportionate exposure to health risks, prior to their incarceration. Compounding those health-harming factors, the standard of care that they have received while incarcerated remains inadequate by most measures. While health justice emphasizes that access to healthcare is just one of many social determinants of health, expanding Medicaid coverage to the incarcerated population would be an important step toward reincorporating prisoners into our concept of the nation, and would contribute to reconceiving of health as a right. Because incarcerated people face adverse social determinants in every other regard – and thus face extreme health inequities – ultimately, health justice would inform an entirely new approach to dealing with so-called anti-social behavior. In short, health justice could help inject more justice into criminal justice.

B. Deepening Health Justice Analysis

Our civil and criminal legal systems have begun to converge in the criminalization of poverty, including driver's license suspensions based on unpaid civil fines thereafter resulting in criminal convictions for unlicensed driving; jail and probation sentences for unpaid civil fines; and the ever-growing regime of collateral consequences of conviction.²²² Increasingly, particularly for poor people in this country, it is difficult to distinguish between civil legal problems and criminal legal problems. At the end of the day, for most folks entangled with the legal system, regardless of what court they appear in, what they are facing are just big problems.

This is not a small portion of the population. In fact, nearly 1 in 3 adult Americans of working age has a criminal conviction.²²³ By the age of 23, nearly half of Black men and almost 40% of white men have been arrested.²²⁴ Entanglement with the criminal legal system is a fact of life. Incarceration is not a tangential factor; it is a fundamental aspect of being poor in this country, just like eviction and unstable employment.

As the health justice literature has documented, the social determinants of health interact in ways that can cause downward spirals into poor health. Yet health justice has not fully grappled with the role that incarceration and entanglement with the carceral state plays in a significant percentage of people's lives.²²⁵

222. See similarly, Allegra M. McLeod, *The U.S. Criminal-Immigration Convergence and its Possible Undoing*, 49 AM. CRIM. L. REV. 105 (2012).

223. Matthew Friedman, *Just Facts: As Many Americans Have Criminal Records as College Diplomas*, BRENNAN CTR. FOR JUST. (Nov. 17, 2015), <https://www.brennancenter.org/our-work/analysis-opinion/just-facts-many-americans-have-criminal-records-college-diplomas>.

224. *Id.*

225. *But see* Benfer et al., *supra* note 197, at 5 (noting that decarceration and deinstitutionalization should be included in policy responses to the pandemic). The serious health consequences of incarceration have been given more attention in the public health literature. See, e.g., Bailey et al., *supra* note 213, at 1458; Wildeman & Wang, *supra* note 85, at 1464-74 (documenting negative health consequences of incarceration on individuals, their families, and their communities, and the racially disparate nature of such impacts due to the overrepresentation of Black men in the incarcerated population). See also Lisa Bowleg, *Reframing Mass Incarceration as a Social-Structural Driver of Health Inequity*, 110 AM. J. PUB. HEALTH (2020); Jaquelyn Jahn, *A Multilevel Approach to Understanding Mass Incarceration and Health: Key Directions for Research and Practice*, 110 AM. J. PUB. HEALTH 50 (2020); David H. Cloud et al., *Introduction, Documenting and Addressing the Health Impacts of Carceral Systems*, 110 AM. J. PUB. HEALTH 5 (2020).

Incarceration is a social determinant of health and interrelated with the other identified intermediate factors. Even being arrested and subjected to pre-trial detention without ever being convicted can lead to the loss of employment, housing, and custody of one's children. Currently, it can also lead to the loss of one's healthcare coverage. The health justice literature would be enriched by increased attention to incarceration and involvement with the criminal legal system as social determinants of health that are as consequential for an individual, and as consequential on a population level, as any others thus far identified.

VI. CONCLUSION

After four decades of growth of the carceral state and economic inequality, the conversation is beginning to shift, and we are beginning to see real change. Prison populations are decreasing for the first time in 40 years, the #BlackLivesMatter movement has changed the conversation around racial justice, and we are moving toward universal healthcare. Retrograde forces remain potent but there is reason to hope. As we begin to decarcerate, we must think carefully about how to reincorporate the masses of formerly incarcerated people into our society. The COVID-19 pandemic has demonstrated more clearly than ever that our fates are bound up with each other. If we fail to tend to the health and safety of prisoners, it is not only a moral failing but also irrational from a public health and safety perspective.

It is time to repeal the Medicaid Inmate Exclusion Policy, and to extend the benefits of Medicaid to that last population of "undeserving poor": the incarcerated. Doing so would fulfill the ACA's vision of universal healthcare access and raise the standards of care for healthcare provided within correctional facilities. Importantly, this move would take us closer toward erasing the distinction between healthcare for the incarcerated population and healthcare for the rest of us. Eliminating the MIEP would greatly improve the availability of mental health, behavioral health, and substance use treatment during incarceration, helping to restore the rehabilitation focus of penal policies. Increased access to such treatment would improve the chances of successful and healthy reentry for these at-risk individuals, thereby reducing recidivism and mortality rates. While we must continue to push for non-carceral responses to social problems like poverty and addiction through justice reinvestment strategies, we can at the same time seek to improve the capacity of correctional institutions to provide incarcerated people with adequate services so that they can begin to address their struggles.

Finally, eliminating the MIEP would begin to mitigate the health-harming effects of incarceration by providing support for health improvement strategies – a reinvestment in health, as called for by the affected community. The COVID-19 pandemic has only made more visible the extreme health inequities along racial lines in this country. Remedying this injustice will require a multifaceted approach and must be informed by community needs and priorities. Including incarcerated people in Medicaid coverage would signal a reincorporation of the incarcerated population into general health-promoting policies and programs. Let us take this tentative but important step toward replacing carceral approaches with social

welfare approaches, and toward reconceptualizing a fundamental human right to health for all.