HEALTHCARE NOT HANDCUFFS

Putting the Affordable Care Act to Work for Criminal Justice and Drug Policy Reform

Written by Chloe Cockburn, Daliah Heller, and gabriel sayegh

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) sets the stage for a new health-oriented policy framework to address substance use and mental health disorders. By dramatically expanding and funding healthcare coverage to millions of currently uninsured people, the ACA represents a remarkable opportunity for criminal justice and drug policy reform advocates to advance efforts for policies promoting safe and healthy communities, without excessive reliance on the criminal justice solutions that have become so prevalent under the War on Drugs.

This paper is intended as a starting framework for criminal justice and drug policy advocates to navigate the ACA, and to take advantage of the conceptual and practical opportunities it offers for shifting the conversation and the landscape.

Part One of this paper describes some of the major provisions of the ACA relevant to our work: the health insurance requirement; the places many people will buy insurance, called health exchanges; Medicaid expansion; insurance coverage requirements for substance use and mental health disorders; and opportunities for improved models of coordinated care.

From a criminal justice and drug policy reform perspective, these provisions of the ACA stand to transform the political, social and policy landscape in three important ways, though advocates will need to drive this shift to win real reforms. First, at a conceptual level, the legislation represents an opportunity to recast substance use disorders and drug use as a matter for public health rather than criminal justice. Second, the dramatic expansion of healthcare coverage, enabling participation in community-based care and treatment, is likely to substantially improve the quality of life for millions of people, and particularly for low-income populations and communities of color, by expanding the social safety net through access to healthcare. In turn, this expansion may serve to reduce both criminal justice system involvement and the social exclusion so familiar under the structures that have developed through the far-reaching War on Drugs.

There is no better time than now to engage with healthcare providers and advocates to forge new partnerships and alliances that can serve broader reform objectives. The implementation of the ACA means the entire healthcare field is now embarking on a course of dramatic transition: implementing new models of coordinated care; expanding access; promoting retention in care and improving health outcomes; adjusting to new funding streams; and critically, incorporating substance use and mental health treatment into primary care practice.

Part Two of this paper outlines a series of practical recommendations, including program and policy examples and suggested action steps, across three broad categories:

1. Ensuring access to care for people most likely to be steered into the criminal justice system under the current framework:

   I. *Support* Expansion of Medicaid and Other Healthcare Coverage

   - Highlight the particular impact of Medicaid expansion and other forms of healthcare coverage on access to care for people with substance use disorders, including the resulting cost savings to the state.

   II. *Increase* Insurance Enrollment of People in the Criminal Justice System

   - Urge pretrial, probation, parole and department of corrections officials to implement policies requiring that people be assessed for eligibility and enrolled in coverage.

   III. *Maintain* Active Medicaid Enrollment During Periods of Incarceration

   - Push for a change in rules stating that Medicaid coverage for people who are incarcerated and awaiting trial or sentenced to a jail or prison facility shall be suspended, not terminated, during the time of incarceration, and shall be automatically reinstated upon release.
   - Push state Medicaid programs and the Departments of Correction to ensure that currently incarcerated people who are eligible for Medicaid are signed up *before* release from prison, so that coverage begins on the day the person leaves the facility.

2. Leveraging the ACA to reduce incarceration and criminal justice involvement:

   IV. *Expand* Use of Alternatives to Incarceration

   - Use the ACA to amplify the demand for reducing the use of incarceration, particularly by using probation as a viable, low-cost, and frequently more effective alternative to incarceration for certain defendants with substance use and/or mental health disorder diagnoses.

   V. *Push* for Use of Pre-Booking Diversion Programs (i.e. Front-End Diversion)

   - Learn about and promote the adoption of pre-booking diversion programs, such as the LEAD program in Seattle, Washington, for local jurisdictions where this approach is viable.

3. Moving from a criminalization-based drug policy approach to one rooted in health:

   VI. *Promote* Changes in the Care Delivery System to Improve Outcomes for People Who Use Drugs

   - Learn more about the local context of ACA implementation from local service providers – especially groups providing HIV/AIDS care, harm reduction services such as syringe access and naloxone distribution, and innovative, results-driven substance use disorder treatment – and work with them to identify and implement the coordinated healthcare models supported by the ACA.
   - Push for state Benchmark plans to include appropriate substance use disorder treatments.
   - Make sure that health plans do not exclude court-ordered treatment. If the exclusion persists, educate judges about the need to give the probation department discretion over treatment requirements, so that the resulting treatment is not “court-ordered.”

   VII. *Advocate* for the Decriminalization of Drug Possession and Drug Paraphernalia

   - Maximize the unique opportunity created by the ACA for questioning the role and value of criminalization itself.

INTRODUCTION

The Affordable Care Act (ACA) is the most significant expansion of healthcare coverage in generations, and there is almost no area of the U.S. healthcare system that is not impacted by the reform in some way. Even as debate about the ACA continues, it is now the law of the land, and implementation is fully under way. For criminal justice reform and drug policy reform advocates,[1] the ACA represents a remarkable opportunity to advance efforts to end both mass incarceration and the criminalization-based approach to drug policy often known as the War on Drugs.

Under the ACA, tens of millions of people in the United States will gain healthcare coverage for a broad array of health services and conditions, including, for the first time, substance use and mental health disorders.[2] Of course, there are also problems with the ACA and its implementation, not the least of which is that millions of people will remain uninsured even after the law is fully operational. Yet even with these challenges, the ACA sets the stage for a new health-oriented policy framework to address substance use and mental health disorders – health problems that have been largely relegated to the criminal justice system for more than 40 years.

This is an enormous paradigm shift that has yet to fully register with criminal justice and drug policy reform advocates, let alone with health policy advocates and the general public. The financial benefits of providing substance use disorder treatment instead of incarceration are well established. But by fully incorporating substance use and mental health disorders *into* healthcare – by truly treating them as *health* issues and requiring public and private insurance plans to cover their treatment – the ACA creates an opening and financial incentives to shift drug policy into a public health framework, undermining the rationale for a criminal justice approach. For example, while a drug court judge might incarcerate a defendant for relapsing to drug use, a diabetic patient is never even arrested – let alone incarcerated – for failing to follow his prescribed treatment regimen.

The health-based approaches outlined in the ACA recognize that treatment must be tailored to the needs of the patient, including, where appropriate, supportive services and other wraparound healthcare interventions. By expanding and fundamentally altering the availability and provision of health-oriented services for people with substance use and mental health disorders, this shift could transform how communities approach drug-related problems. The ACA even includes an explicit requirement to track, report on, and evaluate progress toward reducing racial disparities in health outcomes.[3]

The passage and implementation of the ACA coincides with the growing momentum across the political spectrum to end the War on Drugs, reverse the incarceration boom, and abandon criminal justice policies that have resulted in the criminalization of whole communities. But the paradigmatic shift from criminalization to health will not occur unless criminal justice and drug policy reform advocates seize the moment and leverage the ACA to realize its full transformative potential.

Given the length and complexity of the ACA, and the uncertainties surrounding its implementation, many advocates are understandably hesitant to engage, or simply confused about where and how to begin. Fortunately, one need not become an expert in the ACA to engage with it for criminal justice and drug policy reform.

To assist advocates in navigating this new terrain, this paper outlines some of the major provisions of the ACA immediately relevant to criminal justice and drug policy reform (Part One), and then explores specific applications of those provisions, including program and policy examples and suggested action steps (Part Two).

This is not a comprehensive summary of the ACA. For readers interested in a brief, accessible, and non-technical primer on healthcare reform, we suggest watching the series of helpful animated videos produced by the Kaiser Family Foundation.[4] For health policy advocates unfamiliar with the world of criminal justice and drug policy reform, this paper may be helpful in illuminating some of the major intersections among policies related to health and healthcare, drug policy, and criminal justice.

This is a unique, perhaps even once-in-a-lifetime scenario for criminal justice and drug policy reform advocates: with the ACA, we can start to build true alternatives to the criminal justice response to substance use, the enforcement of which has fundamentally undermined community health and safety. Addressing substance use as a health condition has the potential to lower health costs, dramatically reduce the number of people involved in the criminal justice system, and improve health outcomes and overall wellbeing for millions of people. Our task now is to make the most of this opportunity.

PART ONE: Basics Of The Affordable Care Act For Advocates

To understand why the ACA can serve criminal justice and drug policy reform efforts, we first briefly describe the basic elements of the ACA: the health insurance requirement and the places many people will buy insurance, called health exchanges. We then lay out the provisions of the ACA that are most relevant to criminal justice and drug policy reformers: Medicaid expansion, coverage requirements for substance use and mental health disorders, and opportunities for improved models of coordinated care. These provisions can be adapted to support drug policy and criminal justice reforms, ideas which are further described in Part Two.

I. Insurance

A. Who Must Buy Insurance?

Beginning January 1, 2014, nearly everyone will be required to own health insurance, or pay a penalty that is collected through IRS via the income tax.[5] The ACA exempts a number of groups from this requirement: undocumented immigrants, incarcerated people, individuals and families who can't afford it,[6] members of some religious groups,[7] Native American tribes, and people without insurance for less than three months.

Many poor and low-income people who are not exempt and required to have insurance will be eligible for Medicaid (discussed below). Among the millions who aren't covered under Medicaid or who lack employer-provided insurance, many individuals and households will qualify for premium tax credits and federal cost-sharing assistance to reduce the cost of purchasing insurance.[8]

The Bureau of Justice Assistance has found that nearly 25% of those released from incarceration annually will qualify for these subsidies.[9] However, even with subsidies, coverage will remain out of reach for a large number of people with substance use disorders, particularly poor people, and those currently vulnerable to the criminal justice system or underserved by it, including many crime survivors. This lack of coverage will be especially widespread in states that have chosen not to expand Medicaid (see below).[10]

B. Where Do People Buy Healthcare Insurance? Health Exchanges

Health exchanges are the state-level, regulated insurance marketplaces for individual consumers and small business employers purchasing coverage, and where plans can be compared by cost, quality, provider network, and benefits. Plans must offer four comparable tiers of coverage (bronze, silver, gold, or platinum), each with varying co-pays and in/out-of-network coverage benefits. For a person seeking to purchase health insurance, the plans offer an avenue for accessing coverage and are generally much cheaper than what was previously available before the ACA.

States may operate their own exchanges, create a state-federal partnership exchange, or accept the federal government exchange run by the Department of Health and Human Services (DHHS). (It was the federally-run healthcare exchange, at www.healthcare.gov, that came under fire in October 2013

for its poorly-designed website.) Consumers can sign up for insurance during rolling enrollment periods,[11] or if they experience a "life changing event," which includes release from incarceration.

II. Medicaid Expansion: Healthcare Insurance for Poor and Low-Income People

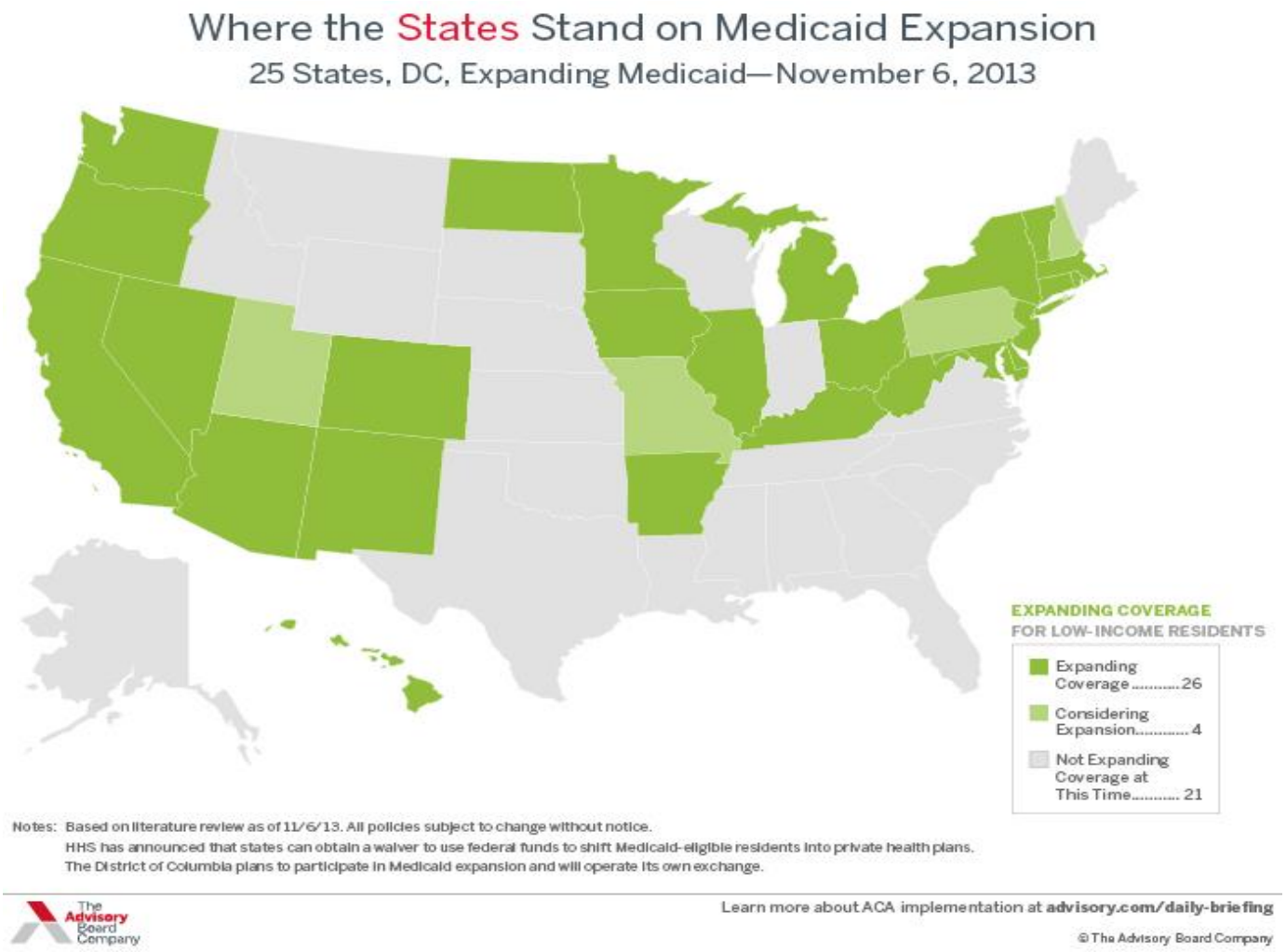
The ACA's expansion of Medicaid, which is voluntary for states,[12] represents a change of singular importance for criminal justice and drug policy reform advocates. In the 25 states that have decided to expand Medicaid, there is now funding to support a health-based infrastructure – outside the criminal justice system – for substance use disorder treatment, and mental health services and other essential healthcare for the very same populations that have for decades often been able to access these services only after arrest and/or incarceration.

Historically, Medicaid covered only those falling into certain demographic categories, such as children, parents of a dependent child, or pregnant women. Most low-income people – particularly those with chronic substance use disorders who are vulnerable to the criminal justice system, or who are crime survivors, or who are both – were not included in the demographic categories covered by Medicaid. Nor were single men, who were excluded from many other public benefits as a result of the 1996 Welfare Reform Act signed by President Clinton.

In a major shift, under the ACA people in Medicaid-expansion states[13] will now qualify for coverage based on *income*, rather than on *demographic categories*. Benefits are extended to those with incomes up to 138% of the federal poverty level.[14] (It's important to note that this does not include undocumented immigrants, who are explicitly ineligible for Medicaid under the ACA.[15]) According to one study, more than one-third of people released from incarceration, at least 200,000 people every year, will be newly eligible for the expanded Medicaid coverage.[16]

Voluntary Medicaid expansion comes with a significant financial benefit for states. For the first three years of expansion (from 2014 through 2016), the federal government will pay for 100% of the Medicaid cost for newly eligible people, and 90% in subsequent years.[17] This means the federal government is paying for states to significantly increase healthcare coverage for low-income people.

This arrangement presents a tremendous opportunity for criminal justice and drug policy reform advocates: instead of criminalizing and incarcerating people for drug use or activities that relate to a substance use or mental health disorder, Medicaid coverage will create large financial incentives to build capacity to address these issues *outside* the criminal justice system. (See Part Two for examples of putting this idea into practice.)



States choosing not to expand Medicaid will likely face serious healthcare-related budget challenges in the years ahead. For example: the high cost of emergency room visits and other acute healthcare services for patients without healthcare coverage, the high cost of repeat incarcerations for low-level drug offenses in comparison with healthcare and substance use disorder treatment services, and the end of federal subsidies to hospitals for the cost of indigent care,[18] will all come at a very steep cost to states who do not expand Medicaid. One study estimates that fourteen states not planning to expand Medicaid stand to lose, in aggregate, $8.6 billion in federal payments, in addition to the economic repercussions of leaving 3.6 million people uninsured.[19] Thus, in advocating for Medicaid expansion in these states (more on this below), criminal justice and drug policy reformers will find common cause with healthcare reformers, healthcare providers, insurers, and especially hospitals.

III. What is Covered? Essential Health Benefits

Starting January 1, 2014, most insurance policies sold in the new insurance marketplace and all state-contracted Medicaid plans must cover ten core categories of care known as the "Essential Health Benefits." Critically, this list *includes mental health and substance use disorder services, including behavioral health treatment.*[20] The law requires comparable levels of coverage for substance use and

mental health disorders as is provided for other medical needs in all private large group plans and new individual or small group plans, and in all public insurance covered through state-contracted Medicaid, including managed care organizations.[21] This means that an estimated *32 million people* will gain access to coverage for substance use and mental health disorders, including 27 million who are currently uninsured, and *nearly 31 million more* will gain additional benefits as a result of the federal parity protections.[22]

Mandating coverage for these conditions rebukes the current practice of funneling people with substance use disorders into the criminal justice system, which has devolved into a kind of catchment system for poor people and people of color – at great financial and human cost. Under the current system, one of the few, if not the only, way(s) for low-income people to obtain access to drug treatment or mental health services is to get arrested and hope for participation in a drug, mental health, or other specialty court or diversion program. In these courts, judges and prosecutors – not healthcare providers – have final say over the defendant's participation in treatment, and usually require costly, abstinence-based episodes of treatment. Non-adherence to the program often results in incarceration, ultimately making the criminal justice system *more* punitive to substance use disorders, not less. In some cases, these courts do not reduce incarceration, improve public safety, or save money more than the model they replace.[23]

By significantly expanding insurance and mandating coverage for substance use and mental health disorders, the ACA creates both greater financial incentives and healthcare capacity to address substance use and mental health issues outside the criminal justice system. While it is difficult to predict the many wide-ranging effects of expanding treatment coverage, one promising study in Washington State found that extending substance use disorder treatment to low-income people resulted in: (1) an average medical cost savings of $2,500 per person treated; (2) reductions in arrest rates ranging from 17% to 33%; (3) estimated law enforcement savings of $5,000 to $10,000 per person due to reduced criminal justice system contact, and; (4) an increase of $2,000 in average annual income for people receiving treatment.[24]

Moreover, the requirement will substantially transform the field of substance use disorder treatment, which has historically operated outside the mainstream healthcare system, in part due to a lack of consensus for their relevance to physical health and traditional conceptions of healthcare.[25] Now, insurance coverage for these services will be "parity enforced," meaning that the financial requirements (such as co-pays and deductibles) and treatment opportunities (such as the number of visits or types of medications covered) are comparable to the medical care provided in a plan.[26]

In short, by expanding Medicaid coverage and providing parity for substance use and mental health disorder treatment, the ACA creates opportunities for improving both public safety and public health, while reducing costs for both systems.

However, just because substance use and mental health disorders must be covered by insurance does not mean that all treatment modalities for these conditions will be covered. The Department of Health and Human Services has given states the power to set the minimum level of coverage that all plans must meet for all ten Essential Health Benefits, called the "benchmark."[27] About half the states have set minimum benchmarks,[28] and if a state doesn't set the minimum benchmark, the federal

government will set the minimum benchmark, basing it on the largest small-group private insurance plan in the state.[29]

Of particular concern is the absence of coverage in most state benchmark plans for maintenance and agonist therapies, namely methadone[30] or buprenorphine[31] for opioid dependence, and naltrexone for alcohol dependence[32] – currently the most effective treatments available for these disorders. Without these treatments, many hundreds of thousands of people suffering from drug dependencies will not receive the best possible coverage for their treatment,[33] undermining a major plank of the reform.

IV. Healthcare Access and Coordinated Care Models Under the ACA

The ACA outlines and funds new models of healthcare access and coordinated care, which is critically important given that current approaches are often costly, inefficient, ineffective, and decidedly not patient-centered, resulting in high dropout rates for substance use disorder treatment programs. Criminal justice and drug policy reform advocates need to understand the basic elements of these structures to explain to policymakers and allies alike *how* people who use drugs and the communities in which they live will be better served through healthcare and coordinated healthcare services than through the criminal justice system.

A key element of these models is their orientation to the patient's perspective, organizing the healthcare system around the patient's experience instead of making it beholden to the insurance provider for access and coordination. This approach is intended to reduce the potential for gaps in coverage or care, and to prevent people from falling through cracks. These features will help to improve the availability and accessibility of substance use disorder care and treatment, at very low cost to the states. Moreover, as substance use disorder services become integrated into mainstream healthcare through these and other provisions in the ACA, the role and relative power of the criminal justice system as the arbitrator for treatment access will diminish considerably.

A. Identifying and Enrolling the Uninsured: Health Navigators

The ACA offers states funding to hire, train, and deploy "health navigators" and "non-navigator assisters" to provide public information and assistance with healthcare enrollment.[34] Navigators must reflect the demographic characteristics of communities where they will be working and provide culturally and linguistically appropriate services.[35] They are required to receive 20-30 hours of training, pass a federally-administered exam annually, and participate in continued training during their employment.

Navigators are compensated in relation to the number of new enrollees they bring to the state health exchange, and because of this arrangement, they will focus on groups likely to be uninsured, including the working poor and younger adults. In the course of their work conducting outreach and education to expand coverage, they are also equipped to provide information and guidance for Medicaid-eligible people, enabling them to promote a broad expansion in coverage, especially in states expanding Medicaid. The ACA allows formerly incarcerated people to apply for these positions. While some state health exchanges, such as in California's, have set eligibility requirements that may restrict access to

these jobs, these requirements can be changed, suggesting an opportunity for advocates to engage in reform efforts leading to job-creation for people directly impacted by the criminal justice system.

To find Navigators in your state, visit www.healthcare.gov or your local Department of Health website.[36]

B. Case Management and Supportive Services: "Health Homes" for Medicaid Beneficiaries

States can opt to develop and implement the "Health Home" model, wherein patients receive case management and care coordination services, for Medicaid beneficiaries with one or more diagnoses from a specified list of chronic health conditions, including substance use disorder.[37],[38],[39] The key to the model is ensuring that there is one point person responsible for coordinating a patient's care: the care manager, who facilitates and coordinates communication between each patient's caregivers. Historically, many states have implemented this type of Medicaid-funded service for groups dealing with chronic health problems, including serious mental illness and those living with HIV/AIDS; in many places, these services will now be folded into the Health Home model. Of note, a Health Home may also include healthcare and specialty care providers in its network, and other services tailored to the patient population it serves. But importantly, the care manager acts as the central lead in the Health Home; the model's function is to coordinate, support, and facilitate participation in healthcare for low-income patients with chronic health conditions.

For criminal justice and drug policy reform advocates, the key innovation in this model is the inclusion of substance use disorders as an eligible diagnosis for case management services. Historically, case management services for people with substance use disorders – if they existed at all – were largely reliant on periodic and discretionary grant funding, making it difficult to provide services that are continuous, coordinated, and consistent. Now, the ACA incentivizes case management-type services with Medicaid coverage via the Health Home model, bolstering and reinforcing the ACA's goal of improving healthcare access, coordination, and retention for low-income people with chronic health conditions, including substance use disorders.

Importantly, this approach targets a health-related service to people with substance use disorders without requiring that they engage in traditional, abstinence-based treatment. The Health Home model positions case management services to become a key component of the core healthcare model, benefiting a low-income population with services to address the broader health and social problems that complicate healthcare access and utilization.

People are less likely to end up in the criminal justice system when they have a case manager focused on their access to and participation in tailored healthcare services, and case management helps ensure they do not fall through the cracks and out of care. For example, a person who suffers from a chronic substance use disorder, has diabetes, and has difficulty securing housing – each of which contributes to overall poor health – can work with a single case manager to obtain care, treatment, and support in a coordinated fashion. Rather than being treated as an isolated problem with moral overtones, substance use is addressed as one of many factors affecting a person's health.

Many service providers who are often strong supporters of criminal justice and drug policy reforms – including some drug treatment, housing, HIV/AIDS, and syringe exchange providers – are registering as

Health Homes in order to better serve their clients. As further incentive for effective coordinated care, the ACA includes provisions for financial awards to those Health Homes that successfully address health problems, including substance use and mental health disorders.

C. Coordinating and Providing Patient-Centered Healthcare: "Patient-Centered Medical Homes" and "Accountable Care Organizations"

A Patient-Centered Medical Home ("PCMH" or "medical home," or "patient-centered health home") is a network model for organizing healthcare providers around the patient. Each PCMH is an inter-disciplinary network of providers (such as doctors, social workers, and counselors), led by a primary physician provider, who share in the care of their patients, whether they have private insurance, Medicaid, or Medicare. Providers in the network use a shared electronic health record to ensure care coordination.

This approach is an alternative to the usual "fee-for-service" model, in which payers – mostly insurance companies with some contribution by patients (i.e., co-pays) – reimburse a largely uncoordinated group of providers for individual services. Every PCMH must include providers who can provide mental health and substance use disorder services alongside the other primary care services.

The Accountable Care Organization ("ACO") model is similar to a PCMH because it is about networking providers to provide care centered around the patient. But whereas a PCMH is led by a primary physician provider and functions as a single consolidated practice, an ACO is a network of several practices, which may include hospitals, sharing care of the patient.

For criminal justice and drug policy reform advocates, an important feature of ACOs is their capacity to include community-based health and social service organizations in the network, enabling the incorporation of these roles into the primary care model. Organizations such as syringe exchange programs play a central healthcare role for some of the most marginalized and vulnerable people with substance use disorders, providing provide health education, tools (including clean syringes for injecting drug users and naloxone for opioid overdose reversal), basic screenings (such as HIV, HCV), and comprehensive care and treatment access, coordination, and follow-up. These services, provided in a community-based context, have reduced healthcare costs by protecting the health and improving health outcomes among people who are actively using drugs.

PART TWO: Putting the ACA to Work for Criminal Justice and Drug Policy Reform

From a criminal justice and drug policy reform perspective, the provisions of the ACA described above stand to transform the political, social, and policy landscape in three important ways.

First, at a conceptual level, the legislation represents an opportunity to recast substance use disorders and drug use as a matter for public health rather than criminal justice, though advocates need to drive this shift to win real reforms.

Second, the dramatic expansion of healthcare coverage, enabling participation in community-based care and treatment, is likely to substantially improve the quality of life for millions of people, and particularly for low-income people and people of color. If leveraged effectively, this expansion of the social safety net through access to healthcare may serve to reduce both criminal justice system involvement and the social exclusion so familiar under the structures that have developed through the far-reaching War on Drugs.

Finally, for criminal justice and drug policy reformers, there is no better time than now to engage with healthcare providers and advocates to forge new partnerships and alliances that can serve broader reform objectives. The implementation of the ACA means the entire healthcare field has now embarked on a course of dramatic transition: implementing new models of coordinated care; expanding access; promoting retention and improving health outcomes (including reducing racial disparities in healthcare); adjusting to new funding streams; and critically, incorporating substance use and mental health treatment into primary care practices. These shifts create new openings for cross-sector collaboration in the fields of criminal justice, drug policy, and healthcare reform. Such collaboration will be necessary to realize the full potential of the ACA.

The following section outlines seven areas of advocacy for criminal justice and drug policy reformers who seek to harness the potential of the ACA for their work. The first three areas are geared toward ensuring access to care for people most likely to be steered into the criminal justice system. Areas 4 and 5 describe ways that the ACA can be leveraged to reduce incarceration and criminal justice involvement. Areas 6 and 7 explore reforms that put the ACA to work for drug policy reform, unlocking the potential of the ACA to bring about a paradigm shift in how the United States responds to drug use, moving from a criminalization-based approach to an approach rooted in health.

I. ***Support*** Expansion of Medicaid and Other Forms of Healthcare Coverage
II. ***Increase*** Insurance Enrollment of People in the Criminal Justice System
III. ***Maintain*** Active Medicaid Enrollment During Periods of Incarceration
IV. ***Expand*** Use of Alternatives to Incarceration
V. ***Push*** for Use of Pre-Booking Diversion Programs (i.e. Front-End Diversion)
VI. ***Promote*** Changes in the Care Delivery System to Improve Outcomes for People Who Use Drugs
VII. ***Advocate*** for the Decriminalization of Drug Possession and Drug Paraphernalia

I. Support Expansion of Medicaid and Other Forms of Healthcare Coverage

For advocates living in the 25 states that have yet to expand Medicaid, pushing for this expansion represents the most immediate priority.[40] Without it, two major problems emerge. First, millions will never see the benefits of healthcare reform, including treatment for substance use and mental health disorders. Second, state and local municipalities have less incentive and capacity to reduce the role of the criminal justice system in addressing health issues.

Even in states that have chosen to expand Medicaid access, millions will remain uninsured, including undocumented immigrants, who are explicitly excluded from the ACA. For instance, in California, even after fully implementing the ACA, approximately three to four million people will remain uninsured, including nearly one million undocumented immigrants.[41]

In most states, campaigns are underway to expand Medicaid and other forms of health coverage, though many such campaigns do not yet include criminal justice and drug policy reform advocates. Advocates need to join these conversations to ensure that the impact of expansion on current criminal justice structures and vulnerable populations is properly understood and incorporated.[42]

II. Increase Insurance Enrollment of People Currently in the Criminal Justice System

Given the enormously beneficial effect of health coverage that includes substance use mental health disorder services, reformers should urge pretrial, probation, parole, and department of corrections officials to implement policies requiring that people be assessed for eligibility and enrolled in coverage.[43] An estimated half of the 730,000 state and federal prisoners released from correctional facilities this year will be newly eligible for either Medicaid or subsidized insurance.[44] According to recent studies, those who possess healthcare coverage are far less likely to get caught up in the criminal justice system again after their release, making health insurance enrollment a critical component of reentry services.[45] Moreover, agencies will be eligible for reimbursement for the costs of enrollment through Medicaid administrative claims.

New Jersey offers an example of a state putting enrollment policies into place, convening a Department of Corrections-Medicaid taskforce to address issues of enrollment and eligibility, and obtaining a federal grant to hire a Medicaid eligibility worker and an enrollment manager to enroll eligible people onto Medicaid within 24 hours of their release from state prison.[46] This quick turnaround is crucial, as people with substance use disorders who are released from prison are at heightened risk of overdose in the period immediately following their release. New York, Oklahoma, Florida, Illinois and California have also implemented pre-release Medicaid enrollment programs.[47] Sheriffs in several jurisdictions including Cook County, IL, Alameda County, CA, Denver County, CO, and Middlesex County, MA, are instituting programs to enroll detainees during booking or upon release. More sheriffs will likely follow. In some states, like California, healthcare-focused foundations have provided funding to criminal justice reform advocates to engage with law enforcement agencies around the opportunities presented by the ACA.

III. Maintain Active Medicaid Enrollment During Periods of Incarceration

In most jurisdictions, a jail or prison term results in the automatic termination of Medicaid coverage for the period of incarceration, however brief (more than half of the people incarcerated in US jails remain for less than 30 days). People must then reapply for Medicaid upon release, which can be an arduous process that can take weeks, even months. This interruption in coverage interferes with healthcare continuity and coordination, and prevents people from accessing lifesaving services, including prescription medication (such as for HIV) and access to substance use disorder treatment.

However, states may choose to *suspend* rather than terminate Medicaid coverage, without making any changes to the federal rules. Advocates should push for a rule that Medicaid coverage for people sentenced to a correctional facility shall be suspended, not terminated, during the time of incarceration, and shall be automatically reinstated upon release. Advocates in New York State helped to pass legislation in 2008 requiring that Medicaid be suspended, rather than terminated, upon incarceration for less than a year, with reinstatement occurring immediately upon release.[48] Advocates in New York and other states are now pushing to suspend, rather than terminate, Medicaid during *any* episode of incarceration, regardless of length.

Additionally, Medicaid should be suspended, rather than terminated, for people who are jailed and awaiting trial and have not been convicted of any crime, a which group makes up *two thirds* of the United States jail population. Changing these rules would significantly reduce costs to states.[49]

Finally, advocates should push state Medicaid programs and the Departments of Correction to ensure that currently incarcerated people who are eligible for Medicaid are signed up *before* release from prison, so that coverage begins on the day the person leaves the facility.

IV. Expand Use of Alternatives to Incarceration

The ACA broadens the options for care and treatment in the community with the expansion of Medicaid to cover low-income single adults, and the requirement for parity coverage of substance use and mental health disorder services by public and private health insurance. The availability of federally-funded Medicaid for newly-eligible individuals and more accessible private coverage creates a compelling financial incentive against the incarceration of people who do not pose a significant threat to the community, and who have health conditions such as a substance use and/or mental health disorder.

Advocates should use the ACA to amplify the demand for reducing the use of incarceration, particularly by using probation and pretrial release as viable, low-cost, and frequently more effective alternatives to incarceration for certain defendants with substance use and/or mental health disorder diagnoses.

By increasing federal dollars for expanding community mental health and substance use treatment options, including case management services that can coordinate care needs, the ACA enables jurisdictions to reduce their misplaced reliance on jails and prisons for treatment. Under the ACA,

community-based options become the cost-effective solution for jurisdictions, with the added benefit of reducing unnecessary criminal justice system involvement in addressing health conditions.

Implementing this change will be more complex than simply asking judges to assign more defendants to treatment as a condition of probation. Advocates must educate judges and other law enforcement stakeholders about the individualized case management available to many affected groups under the ACA (i.e., the Health Homes model for Medicaid beneficiaries), and how that service can significantly transform outcomes for many who have in the past been unable to succeed under probation conditions and other mandated programming.

Advocates must further contend with existing structures established around mandated treatment, including drug courts and other structures that have contracts with certain treatment providers who may not accept Medicaid, or who may not be arranged to support a person making it to recovery after the inevitable relapses to drug use. Moreover, many jurisdictions currently lack capacity to meet the huge demand for substance use and mental health disorder treatment. The influx of federal money will incentivize the creation of new services, but there is likely to be a difficult transition period when the criminal justice and healthcare systems struggle to synchronize with one another.

Notwithstanding these implementation challenges, advocates should work now to ignite the imaginations of policymakers regarding the alternatives that exist to using criminal justice to solve substance use and mental health related problems – problems that criminal justice is ill-equipped to solve. The ACA enables criminal justice reformers to envision a future when the health system, not the criminal justice system, catches those who fall through the cracks.

V. Push for Use of Pre-Booking Diversion Programs (i.e. Front-End Diversion)

The most innovative criminal justice programs in the country have already been moving in the direction of utilizing case management models similar to those outlined in the ACA (i.e., Heath Homes). One particularly notable program in Seattle, the Law Enforcement Assisted Diversion (LEAD) program, allows police officers, at their own discretion, to divert people arrested for certain crimes directly to an intensive case management program.[50]

As a front-end diversion program, LEAD provides assistance to participants with expedited access to healthcare and substance use disorder treatment programs, harm reduction services, education, and even sometimes housing services – all by bypassing traditional diversion processes such as drug courts. The program is the result of a joint collaboration between the Seattle Police Department, King County Sheriff, Seattle City Attorney, King County Prosecutor, Seattle Mayor, King County Executive, Seattle and King County Councils, defense advocates, service providers, the ACLU, and the local downtown business improvement district.

In the LEAD program, still in its pilot stages, people arrested for drug possession, low-level drug sales, and prostitution are eligible for pre-booking diversion. Preliminary data from the program's first two years of operation show that many LEAD participants are successfully engaging in social services and decreasing their criminal activity. Area residents, program stakeholders (including the business community and law enforcement) and lawmakers are also strongly supportive of LEAD, which has

resulted in the City of Seattle providing public funds for expanded operation of the LEAD program in 2014.[51] A full evaluation is currently underway.[52]

By ensuring access to healthcare, including treatment, and by coordinating participant services and follow-up among providers, LEAD helps people escape the cycle of repeated arrests and incarceration for substance use. Rather than being processed through jails and the court system before gaining accesses to coercion-based treatment services, participants are connected directly to services by police officers exercising their own discretion. The initial arrest report is forwarded to the prosecuting attorney's office, but no charges are filed as long as the participant remains engaged with or completes the program. The participant is not held in jail, does not go to court, and, because the program is oriented by a harm reduction treatment philosophy, the participant does not face incarceration if they relapse to drug use.

LEAD demonstrates that a case management and integrated care approach for people with substance use disorders (as well as for people involved in sex work and low-level drug sales) can work in partnership with *existing* criminal justice structures to reduce the role of the criminal justice system, keeping people out of court altogether – while yielding very promising outcomes. The ACA offers an opportunity to expand on the LEAD model in Seattle and elsewhere since the program's case management services – currently funded by private donors – can be funded as a Health Home for Medicaid-eligible program participants.

Advocates should educate themselves further about pre-booking diversion programs such as LEAD and identify local jurisdictions where such programs may be viable. Santa Fe, New Mexico is already moving forward with its own LEAD pilot,[53],[54] and other jurisdictions, including Atlanta, Georgia and Albany, New York are currently exploring LEAD-like programs as innovative options for front-end, pre-booking diversion.

VI. Promote Changes in the Care Delivery System to Improve Outcomes for People Who Use Drugs

Each of the new healthcare models described in Part One is constructed on the premise that healthcare services should integrate substance use and mental health services alongside physical healthcare, because they are health conditions. These models equip and incentivize healthcare providers with resources to learn about and address a person's 'whole health.' [55]

A. Implications for Whole Health

The significance of this shift is profound, for two primary reasons important to criminal justice and drug policy reformers.

First, over the last 40 years, the treatment system has developed largely outside of the healthcare system, leading to a range of problems such as continued vulnerability to the criminal justice system when people relapse to drug use after a time-limited episode of treatment, and disconnection from physical healthcare services despite participation in treatment. These gaps in care have contributed to poorer health outcomes and fragmented healthcare access for people with substance use disorders. By

requiring these services to coordinate – and ideally, to integrate – treatment with ongoing primary and preventive healthcare, the ACA presents an unprecedented pathway for ensuring that people with substance use disorders remain engaged in healthcare services and have continued access to treatment, despite their current drug use.

Second, under the drug war, the criminal justice system has developed its own responses to substance use disorders (and to substance use in general), which have extended to other realms such as mental health. In addition to straightforward incarceration, there are now an abundance of models, such as drug courts and mental health courts, that rely on a coercive court or probationer model, mandating treatment under threat of prosecution and incarceration. While drug courts may in some cases be better than incarceration for their participants, this is a backwards approach for any health condition, and particularly ill-suited to the longer-term realities of relapse to and recovery from substance use disorders.[56]

By treating substance use and mental health disorders as health conditions, the 'whole health' approach embodied in the ACA further situates substance use in a public health framework and exposes the contradictions inherent in employing a criminal justice approach to address health concerns. No one would stand for a "diabetes court," nor for a "cancer court," nor would it be appropriate or humane to incarcerate a person with cancer or diabetes for failing to follow a particular treatment regimen. Yet this is exactly what we do to many people with substance use and mental health disorders.

B. Working with Providers and Health Homes

The coordinated care approaches outlined in the ACA are geared toward the 'whole health' of the patient, and include supportive services and other wraparound healthcare interventions, potentially transforming how state and local jurisdictions address drug-related problems. For example, Vermont is considering submitting a targeted Health Home application to implement a comprehensive care and treatment system for people with opiate dependence.[57] If approved, this model will establish a network, led by a care management team and incorporating general medical, mental healthcare, and substance use disorder treatment providers, that is tailored and responsive to the complexity of substance use disorders.

Opioid dependence is a serious problem in rural Vermont, as it is elsewhere in the U.S. The state's proposed health-based response, however, is dramatically different than the criminal justice-focused approach dominant over the last 40 years. By addressing opioid dependence primarily through healthcare providers and coordinated care, rather than with prosecutors and the local police force, Vermont's health policy will support safe and healthy communities more effectively, at less cost, and with less collateral damage.

In Medicaid expansion and non-expansion states alike, organizations providing treatment, syringe exchange, and/or other healthcare services to Medicaid-eligible people they already serve are well-positioned to form a Health Home for people who use drugs, and some have already done so. Reformers can work with and/or support these providers to approach the state health authorities with a Health Home plan and gain approval from the Centers for Medicaid and Medicare Services (CMS) for

implementation.

Criminal justice and drug policy reform advocates should seek to sit down with existing Health Homes and other local service providers – especially groups providing HIV/AIDS care, harm reduction services (such as syringe exchange, innovative, results-driven substance use disorder treatment, and behavioral health services) – to learn more about the local context of ACA implementation, including the utilization of Health Homes to provide coordinated services to vulnerable populations.[58]

C. Ensuring Appropriate Benchmarks

As described in Part One, the government entity operating the state's health exchange, whether it is the state or federal government, has established benchmarks to set the minimum standard for what services must be covered under private insurance plans, and most exchanges have pegged their benchmarks to existing small-group plans. States can choose to align Medicaid coverage with the health exchange benchmark for particular groups of Medicaid beneficiaries,[59] creating "benchmark benefits"[60] and enabling comparability between private and public coverage. This approach could be especially useful for people with household incomes at less than 250% the federal poverty level, for whom coverage eligibility may shift between the private and the public market as they experience gains or losses in income.

Because substance use disorder services were historically under-insured or un-insured, the decision to use the state's largest small-group plan as the benchmark has resulted in minimum guaranteed coverage that does not include the full scope of treatment for substance use disorders. One particular concern is the absence of coverage in most state benchmark plans for maintenance agonist therapy, namely methadone or buprenorphine for opioid dependence, and naltrexone for alcohol dependence. Accordingly, for the full potential of the Act to be realized, reformers and their healthcare allies should pressure state officials to expand the benchmark plan to include these medication-assisted therapies.

Relatedly, a common standard exclusion from insurance coverage for substance use disorders is "court mandated treatment," meaning that if a judge orders a person to attend substance use disorder treatment as a condition of probation or release, there will be no coverage. Advocates should identify and challenge court-mandated treatment provisions. Another approach is to urge judges to order defendants to engage in treatment "as directed by probation," thus ensuring that the particular treatment plan is not directly mandated by the court.

VII. Advocate for the Decriminalization of Drug Possession and Drug Paraphernalia

In the U.S., there is a growing debate about the profound failures of the War on Drugs and mass incarceration, and elected officials and leaders from across the political spectrum are calling for new approaches to criminal justice and drug policy.[61],[62],[63],[64] The transformative changes represented by the ACA present an important opportunity to develop a new contextual framework for approaching drug policy as a health concern, instead of a criminal justice matter. Innovations in other countries suggest possible approaches for what a truly health-based approach looks like in practice.

In 2001, Portugal adopted the groundbreaking approach of decriminalizing personal use of all drugs and drug paraphernalia, and implementing a public health approach to provide care and treatment to

people who use drugs and need help. Under the policy, police officers who find a person in possession of an amount of drugs determined to be for personal use (as opposed to drugs for sales or distribution) direct that person to the local government's "dissuasion commission." Here, social workers and other trained staff work with people to identify their health and social needs, including for substance use disorder treatment, if warranted, and also for housing, healthcare, legal assistance, and other social supports. Prevention and outreach services have also been expanded. For instance, to better treat people with opioid dependence in their local communities, mobile methadone units are deployed, alongside expanded syringe access programs. Other healthcare services have also expanded, in conjunction with the decriminalization process (Portugal, like nearly all industrialized nations, provides universal healthcare).

The positive effects of the policy have been remarkable. In the ten-year period following implementation of the law, drug-related crime, disorder, addiction and overdose fatalities are down. Drug arrests dropped by half, as did the prevalence of people in prison convicted of drug offenses. Treatment uptake and use of related health services increased by more than one half.[65] And there is a significant reduction in the stigma associated with "drug addiction" or substance use disorders. These good results came about through a combination of reducing the role of the criminal justice system in addressing drug use and substance use disorders, and increasing the investment in public health and healthcare services for people who use drugs.

The ACA presents a basic framework, complete with funding and conceptual models of care, for achieving these same effects in the U.S.[66] Advocates should maximize the unique opportunity created by the ACA for questioning the role and value of criminalization itself, and should push policymakers to consider decriminalization of the use and possession of all drugs.

To achieve this goal, reformers should look for opportunities to exploit the contradictions exposed in the current historical moment. These contradictions are glaring: under the ACA, substance use disorders are presented as health problems, yet under the War on Drugs, these problems have been largely treated as a criminal behavior. As the public and policymakers increasingly understand substance use disorders as a health problem, and drug use as a health issue, reformers should focus on dramatically reducing the size and role of the criminal justice system. While the introduction, let alone passage, of state or federal legislation to decriminalize personal use of all drugs may seem like a distant proposition to some, decriminalization is *already* underway – particularly with marijuana, but also for other drugs, through focused initiatives. Programs like LEAD in Seattle, which is led by law enforcement, represent *de facto* forms of decriminalization for drug possession and low-level sales, *of all drugs*. It is up to criminal justice and drug policy reformers to make the most of this moment.

CONCLUSION

In this paper, we have briefly described some of the major provisions of the ACA, and key features of innovative models and services that could be developed and implemented within this framework. Criminal justice and drug policy reform advocates have an opportunity to move forward by promoting these ideas, while reflecting the experiences and needs of communities to healthcare providers, public officials, and other healthcare experts involved with making and moving policy into action.

The opportunities presented by the ACA are enormous, but the necessary changes will not come about without pressure by advocates rooted in criminal justice and drug policy reform work. With the many changes the ACA introduces to U.S. healthcare, the transformative potential it presents for people who use drugs or who are vulnerable to criminal justice involvement is not necessarily at the forefront of policymakers' planning or healthcare administrators' implementation strategies.

We have the opportunity to leverage the ACA for a better system of care, grounded in a public health approach, to meet the true health needs of people who have all too often been relegated to jails and prisons for a health condition. Now we have an opportunity to ensure that health, rather than criminal justice, will be the system to catch those who fall through the cracks. But it will take an enormous effort to get there. We hope that this paper is just the beginning of an energetic discourse between criminal justice and drug policy reformers and their colleagues in the health policy fields as we continue to unpack the potential of the ACA.

[1] Given the potential transformative effect of the ACA on this country's drug and criminal justice policies, we have made an effort to present information and ideas that are relevant to both criminal justice and drug policy reformers.

[2] The term 'substance use disorder' is used throughout this document to refer to the health problem which has also been labeled 'addiction,' 'substance abuse and dependence,' or 'problematic drug use.' Even as we strongly believe we lack accurate, non-pejorative, and meaningful language to describe this phenomenon, we have chosen to use the term 'substance use disorder' in this document to match the terminology used in the ACA.

[3] *How Does the Affordable Care Act Address Racial and Ethnic Disparities in Healthcare?* Robert Wood Johnson Foundation. December 2011. Retrieved from: http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/12/how-does-the-affordable-care-act-address-racial-and-ethnic-dispa.html.

[4] *The YouToons Get Ready for ObamaCare: Health Insurance Changes Coming Your Way Under the Affordable Care Act*, The Henry J. Kaiser Family Foundation. July 2013. Retrieved from: http://kff.org/health-reform/video/youtoons-obamacare-video/. An older video, produced and released by KFF in 2010 after passage of the healthcare reform law, provides a general summary of healthcare reform: *Health Reform Hits Main Street*, The Henry J. Kaiser Family Foundation. September 2010. Retrieved from: http://www.youtube.com/watch?v=vmdbllWOOzs.

[5] Beginning in 2014, anyone who is not insured will pay either $95 per person or 1% of their total household income (whichever is greater), increasing to $695 per person or 2.5% of total household income in 2016 and beyond.

[6] The Secretary of Department of Health and Human Services grants a "hardship waiver" to people whose incomes are so low that they don't have to file taxes (currently $9,500 for individuals and $19,000 for married couples), or people for whom insurance premiums exceed 8% of family income.

[7] The Affordable Care Act has adopted a similar methodology for determining religious exemptions as the Social Security Administration for Social Security requirements, which is managed by the Internal Revenue Service.

[8] The Kaiser Family Foundation provides a useful summary of these subsidies and the eligibility in a brief factsheet: "Citizens and legal residents in families with incomes between 100% and 400% of poverty who purchase coverage through a health insurance exchange are eligible for a tax credit to reduce the cost of coverage. People eligible for public coverage are not eligible for premium assistance in exchanges. In states without expanded Medicaid coverage, people with incomes less than 100% of poverty will not be eligible for exchange subsidies, while those with incomes at or above poverty will be. People offered coverage through an employer are also not eligible for premium tax credits unless the employer plan does not have an actuarial value of at least 60% or unless the person's share of the premium for employer-sponsored insurance exceeds 9.5% of income. People who meet these thresholds for unaffordable employer-sponsored insurance are eligible to enroll in a health insurance exchange and may receive tax credits to reduce the cost of coverage purchased through the exchange." *Focus On Health Reform*, The Henry J. Kaiser Family Foundation. July, 2012. Retrieved from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf.

[9] *Affordable Care Act and Criminal Justice: Intersections and Implications,* Bureau of Justice Assistance, U.S. Department of Justice. July 2012. Retrieved from: https://www.bja.gov/Publications/ACA-CJ_WhitePaper.pdf.

[10] *Millions of Poor are Left Uncovered by Health Law*, The New York Times. October, 2013. Retrieved from: http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html?_r=0.

[11] For information on the enrollment periods, *see* https://www.healthcare.gov/glossary/open-enrollment-period/.

[12] In 2012, the Supreme Court ruled that the receipt of federal Medicaid dollars could not be contingent upon states' expansion of the program (*See* National Federation of Independent Business v. Sebelius, 132 S.Ct. 2566). As a result, the

decision of whether to expand Medicaid is voluntary and up to the state.

[13] A growing number of states are moving towards Medicaid expansion; for the current status of state Governor and legislative positions. *See*: *Status of State Action on the Medicaid Expansion Decision, as of November 22, 2013,* The Henry J. Kaiser Family Foundation. November 2013. Retrieved from: http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[14] This amount is $15,281.70 for single adults, $21,403.80 for married couples, or $31,321.50 for a family of four. For a list of qualifying incomes, *see*: *2013 Poverty Guidelines*, CMCS/CAHPG/DEEO. Retrieved from: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf. This expansion will not cover anyone who does already meet residency and lawful citizenship requirements.

[15] In addition to the exclusion from Medicaid, undocumented immigrants are not eligible to even purchase insurance on the Health Exchanges. Legal immigrants in the U.S. for less than five years cannot get Medicaid, but can buy insurance on the Exchanges, though cost may be a barrier. *See*: *Affordable Care Act Leaves out Many in State,* Jasmine Brown, California News Service. December 2013. Retrieved from: http://www.recordnet.com/apps/pbcs.dll/article?AID=/20131202/A_NEWS/312020314.

[16] *Solicitation for a Cooperative Agreement—Evaluating Early Access to Medicaid as a Reentry Strategy*, Department of Justice, National Institute of Corrections. July 2011. Retrieved from: http://www.gpo.gov/fdsys/pkg/FR-2011-07-06/html/2011-16844.htm; and *Jail Inmates at Midyear 2010—Statistical Tables,* Todd Minton, Bureau of Justice Statistics. April, 2011. Retrieved from: http://bjs.ojp.usdoj.gov/content/pub/pdf/jim10st.pdf.

[17] Full federal funding is only available for individuals who were *not previously eligible*, not individuals who were eligible but not previously enrolled.

[18] *Can the Affordable Care Act Reverse the Longstanding Trend in Uncompensated Care in Emergency Departments?* Robert Gladder, M.D., Forbes.com. October 29, 2013. Retrieved from: http://www.forbes.com/sites/robertglatter/2013/10/29/can-the-affordable-care-act-reverse-the-long-standing-trend-in-uncompensated-care-in-emergency-departments/.

[19] *For States That Opt Out of Medicaid Expansion, 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments*, Carter Price and Christine Eibner, Health Affairs. June 2013. Retrieved from: http://content.healthaffairs.org/content/32/6/1030.short.

[20]For more information and a list of other essential health benefits, *see*: *Essential Health Benefits,* Healthcare.gov. Retrieved from: https://www.healthcare.gov/glossary/essential-health-benefits/.

[21] *FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation,* United States Department of Labor. November 2013. Retrieved from: http://www.dol.gov/ebsa/faqs/faq-aca17.html. For specific Medicaid information, *see*: *Mental Health Services,* Medicaid.gov. Retrieved from: *http*://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Mental-Health-Services-.html.

[22] *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million,* Kirsten Beronio, Rosa Po, Laura Skopec, Sherry Glied, Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation. February 2013. Retrieved from: http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm.

[23] *See Drug Courts are Not the Answer: Toward a Health-Centered Approach to Drug Use*, Drug Policy Alliance. March, 2011. Retrieved from: http://www.drugpolicy.org/sites/default/files/Drug%20Courts%20Are%20Not%20the%20Answer_Final2.pdf.

[24] *FAQ: The Affordable Care Act and Justice Involved Populations*, Community Oriented Correctional Health Services. October 2013. Retrieved from: http://cochs.org/files/ACA/COCHS_FAQ_ACA.pdf. The facts presented in the FAQ are based on the following papers: *Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits*, David Mancuso and Barbara Felver, Washington State Department of Social and Health Services, Research and Data Analysis Division. February 2009. Retrieved from: http://www.dshs.wa.gov/pdf/ms/rda/research/11/140.pdf; *The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults*, Melissa Ford Shah, David Mancuso, Sawir Yakup, Barbara Felver, Washington State Department of Social and Health Services, Research and Data Analysis Division. November, 2009. Retrieved from: http://www.dshs.wa.gov/pdf/ms/rda/research/4/79.pdf; *The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State,* Thomas Wickizer, Antoinette Krupski, Kenneth Stark, David Mancuso, Kevin Campbell. Milbank Quarterly, 84(3), 555-576, 2006.

[25] The 2008 Mental Health Parity and Addiction Equity Act called for coverage comparable with medical and surgical care benefits, but many plans were not in compliance with the law, and most did not provide mental health and drug treatment services coverage to begin with. *See*: *Since 2008, Insurers Have Been Required By Law to Cover Mental Health – Why Many Still Don't*, Judith Graham, The Atlantic. March 2013. Retrieved from: http://www.theatlantic.com/health/archive/2013/03/since-2008-insurers-have-been-required-by-law-to-cover-mental-health-why-many-still-dont/273562/. The ACA will require insurers to come into compliance with the parity law.

[26] For more detailed information on what the parity requirement entails, *see*: *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation,* United States Department of Labor. Retrieved from: http://www.dol.gov/ebsa/faqs/faq-aca7.html.

[27] Every state's benchmark plan must at a minimum provide coverage equal to the state's largest small-group plan. For more detailed information on the terms of each state's benchmark plan, *see*: *Additional Information on Proposed State Essential Health Benefits Benchmark Plans,* Centers for Medicare & Medicaid Services. Retrieved from: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

[28] Most states adopting benchmarks have pegged them to the largest small-group insurance plan in the state.

[29] For a more detailed explanation about how benchmarks work, *see*: *State Health Insurance Mandates and the ACA Essential Benefits Provisions*, National Conference of State Legislatures. October 31, 2013. Retrieved from: http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx.

[30] *Medication-Assisted Treatment for Substance Use Disorders - Methadone*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Division of Pharmacologic Therapies. Retrieved from: http://www.dpt.samhsa.gov/medications/methadone.aspx.

[31] *About Buprenorphine Therapy*, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved from: http://buprenorphine.samhsa.gov/about.html.

[32] *Medication-Assisted Treatment for Substance Use Disorders - Naltrexone*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Division of Pharmacologic Therapies. Retrieved from: http://www.dpt.samhsa.gov/medications/naltrexone.aspx and *Naltrexone, a Relapse Prevention Maintenance Treatment of Alcohol Dependence: A Meta-Analysis of Randomized Controlled Trials*, C. Streeton and G. Whelan, Oxford Journals, Alcohol and Alcoholism. October 20, 2000. Retrieved from: http://alcalc.oxfordjournals.org/content/36/6/544.full.

[33] For estimates of need for drug and alcohol treatment in the US, *see*: *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings - Illicit Drug Use Treatment and Treatment Need*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and

Quality. September 2011. Retrieved from: http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#7.3.2.

[34] For grant information, *see*: *Press release: New resources available to help consumers navigate the Health Insurance Marketplace,* U.S. Department of Health & Human Services. August 15, 2013. Retrieved from: http://www.hhs.gov/news/press/2013pres/08/20130815a.html, and for a list of grantees, *see*: *In-person Assistance in the Health Insurance Marketplace*, Centers for Medicare & Medicaid Services. Retrieved from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html.

[35] For details, *see*: *Implementing Health Reform: Proposed Regulations for Exchange "Navigators"* Timothy Jost, Health Affairs Blog. April 4, 2013. Retrieved from: http://healthaffairs.org/blog/2013/04/04/implementing-health-reform-proposed-regulations-for-exchange-navigators/.

[36] For instance, the official New York State Health Exchange includes a listing of organizations that have on-site navigators. *See*: *IPA/Navigator Site Locations*, New York State of Health, The Official Health Plan Marketplace. November 6, 2013. Retrieved from: http://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations.

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HEALTHCARE NOT HANDCUFFS

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