

Health Care for California's Jail Population

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SUMMARY

The Affordable Care Act (ACA) has created a new opportunity for California to reach and enroll a medically vulnerable population—the jail population—in health insurance coverage. While inmates receive health care services from county jail systems while incarcerated, few have coverage after they are released from custody. Expansion of the state's Medicaid program (Medi-Cal) under the ACA has extended insurance eligibility to much of the currently uninsured jail population. As a complement to the ACA, California recently signed into law Assembly Bill 720 (AB 720), which facilitates the use of jails as sites of health insurance enrollment. Increasing enrollment levels for the jail population holds the potential to reduce corrections costs, as well as improve public health and safety.

THE JAIL POPULATION IS HIGH NEED AND HARD TO REACH

The jail population has high health needs but faces substantial barriers to accessing health care. Available data suggests that rates of infectious diseases (such as tuberculosis and hepatitis) and chronic conditions (such as hypertension and asthma) are higher among incarcerated individuals compared to the general population.¹ Inmates also have higher rates of mental health and substance use issues—in fact, national statistics suggest that local jail inmates are more likely to have mental health problems than even state and federal prisoners are.² These challenges are exacerbated by the low rate of health insurance coverage among incarcerated individuals—who are disproportionately young adults, male, and low income.³

Prior to the ACA, few among California's jail population were eligible for public health insurance. This population also has limited access to employer- or school-based health insurance and, as a result, they are hard to reach through traditional enrollment mechanisms. The Medi-Cal expansion under the ACA has extended eligibility for public health insurance to all adults with incomes up to 138 percent of the federal poverty line, creating the opportunity to expand coverage for many among the uninsured jail population. California's passage of AB 720 compliments the ACA by facilitating the use of jail systems to connect inmates to coverage before they are released from custody.

In this report, we take advantage of the Jail Profile Survey (JPS) to assess the recent level of health care provision in county jail systems, as well as trends in care over the past decade. We then discuss how the ACA coverage expansion, along with California's recently passed AB 720, provides local corrections systems with new tools to reduce costs, lower recidivism, and improve public health.

JAILS ARE IMPORTANT HEALTH CARE PROVIDERS

Because of the disproportionately high health needs of jail inmates and their relatively low access to health services outside of custody, jail systems are important providers of health care in California. In 2012, there were nearly 2.3 million health care visits provided to California's county jail inmates (Table 1).⁴ The vast majority of these visits were "sickcalls," whereby inmates requesting medical attention are treated by onsite jail medical staff.⁵ Depending on the medical need, a sickcall may result in a scheduled medical appointment with a physician or mid-level practitioner. Of the more than half a million scheduled medical appointments in 2012, nearly 95 percent occurred within the jail facility.⁶ There were also nearly 80,000 dental visits provided by local jails in 2012.

In 2012, county jails provided almost 200,000 medical visits each month, an average visit rate of nearly 2.4 medical visits per inmate. As a point of comparison, in 2012 the state's network of more than 1,000 free and



community clinics provided an estimated 1.17 million visits from males age 20 to 34, which translates into a visit rate of 0.73 visits per uninsured male age 20 to 34.⁷

Jail inmates also have significant mental health needs. In 2012, the statewide monthly average of active mental health cases open was nearly 13,000, or about 20 percent of ADP among reporting jurisdictions (Table 2).⁸ About 8,300 jail inmates received psychiatric medication, and another 2,800 were assigned to mental health beds.⁹

TABLE 1. JAILS PROVIDED NEARLY 2.3 MILLION HEALTH CARE VISITS IN 2012

	Annual total	Monthly average	Monthly average per inmate
Sickcalls	1,682,431	140,203	1.74
Onsite medical appointments	500,702	41,725	0.51
Offsite medical appointments	29,960	2,497	0.04
Dental	78,837	6,569	0.09
Total encounters	2,291,930	190,994	2.38

SOURCE: Jail Profile Survey, Board of State and Community Corrections.

NOTE: The analysis is restricted to jurisdictions reporting at least six months of data for all medical encounter measures in 2012. Fifty-one jurisdictions are included, representing 88 percent of ADP statewide. The jurisdictions excluded due to underreporting are Fresno, Riverside, San Joaquin, Siskiyou, Sutter, and Tulare. Monthly average per inmate is calculated for each jurisdiction using the monthly number of visits divided by the average daily population (ADP) for that month. These monthly values are averaged for each jurisdiction and then averaged across the state.

TABLE 2. SIZABLE SHARES OF JAIL INMATES HAVE MENTAL HEALTH NEEDS

	Monthly average	Monthly average percent of ADP
Active mental health cases	12,802	20%
Inmates receiving psychiatric medication	8,340	14%
Inmates assigned to mental health beds	2,835	2%
New mental health cases	7,728	15%

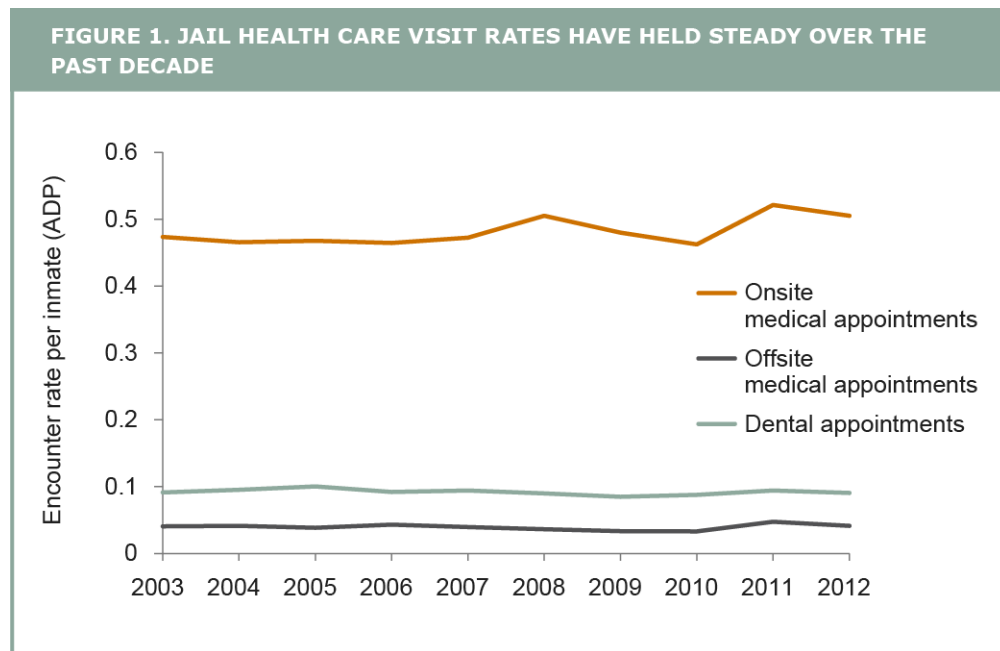
SOURCE: Jail Profile Survey, Board of State and Community Corrections.

NOTE: The measures listed in the first three rows are counted on the last day of the month and so represent a point-in-time estimate of mental health cases in county jails. "New mental health cases" is the cumulative total of new mental health cases in the month. The analysis is restricted to jurisdictions reporting at least six months of data for all mental health measures in 2012. Forty-two jurisdictions are included, representing 75 percent of ADP statewide. The jurisdictions excluded are Alameda, El Dorado, Fresno, Inyo, Lassen, Marin, Monterey, Riverside, Sacramento, San Joaquin, Siskiyou, Sutter, Tehama, Trinity, and Tulare.

When it comes to health care provision and, in particular, visit rates, it is important to acknowledge the flow of inmates through county jail systems. The number of inmates counted on any given day—the only metric we have—does not give us the total number of people entering the jail system who could require medical attention. County jail inmates have relatively short stays; in 2012 the average county jail stay in California was about 21 days, but the majority of jail stays were even shorter. This underscores the high level of inmate turnover in the course of a year.¹⁰ The Bureau of Justice Statistics estimates that the number of people admitted to local jail systems nationwide was about 16 times higher than the average daily population.¹¹

This would suggest that about 1.25 million people were admitted to California jails during 2012 and would yield visit rates comparable to those presented in Table 1.¹²

The average number of monthly onsite medical appointments in county jails has increased over the past decade. But when we account for changes in the size of the jail population, it seems that jails, on average, have been providing a fairly constant level of health care (Figure 1).



SOURCE: Jail Profile Survey, Board of State and Community Corrections.

NOTE: The analysis is restricted to jurisdictions reporting at least six months of data for each measure in every year. Forty-six jurisdictions, representing 85 percent of ADP statewide, are included. The jurisdictions excluded are Contra Costa, Fresno, Glenn, Napa, Riverside, San Joaquin, Shasta, Siskiyou, Sutter, Trinity, and Tulare.

Recent changes—notably California’s 2011 public safety realignment—have affected the size and composition of jail populations. In addition to increasing the population pressure, realignment has increased the sentenced and felony shares of California’s jail population¹³ and lengthened the amount of time an individual can serve in county jail. These changes may affect the underlying health status and needs of the jail population, and it will be important to monitor future trends in jail health care provision.

THE ACA EXPANDS ELIGIBILITY FOR THE JAIL POPULATION

California’s implementation of ACA, including the Medicaid expansion, has extended eligibility and enhanced access to health insurance for the jail population. Nationally, an estimated 35 percent of those newly eligible for Medicaid are individuals who have been involved with the criminal justice system, largely due to relatively low incomes and low insurance rates.¹⁴ Prior to the ACA, the few who were enrolled often lost coverage when they entered the corrections system. To better facilitate the enrollment of jail inmates in public health insurance, the state recently enacted AB 720. The legislation removes enrollment barriers by:

- Authorizing counties to designate an entity to assist inmates in applying for health insurance coverage;
- Authorizing this designated entity to act on behalf of inmates to apply for Medi-Cal coverage for inpatient hospital services;
- Changing state law to suspend, rather than terminate, Medi-Cal coverage while in county jails, allowing inmates to retain or initiate coverage while in custody; and
- Clarifying that county welfare departments are not precluded from processing applications for the Medi-Cal program because a person is an inmate in a county jail.

While AB 720 does not require the enrollment of jail inmates, there are several reasons counties may see this legislation as an opportunity to reduce corrections costs, lower recidivism rates, and advance public health goals.

OPPORTUNITIES FOR COUNTIES TO REDUCE COSTS AND IMPROVE HEALTH AND SAFETY

Given the jail population’s substantial health needs, it is not surprising that inmate health care is an important driver of corrections costs. According to national estimates, 9 to 30 percent of the total cost of incarceration is attributable to health care expenditures.¹⁵ Although we have limited information about health care costs in jails, the Legislative Analyst’s Office (LAO) reports that more than a quarter of the average cost of prison incarceration per inmate in California is attributable to health care expenditures,¹⁶ and that inmate health care costs are an important driver of recent increases in corrections costs.¹⁷ In the context of corrections realignment, counties may find that enrolling this population in public insurance programs can help them reduce costs, improve recidivism outcomes, and improve public health.

Jail systems can realize direct savings by shifting acute inpatient hospitalization costs to the federal government for inmates enrolled in Medi-Cal. The federal “inmate exception” rule does not allow counties to claim reimbursement through Medi-Cal for most health services provided within the jail system,¹⁸ but Medi-Cal does cover the cost of inpatient hospital care for inmates who remain offsite for more than 24 hours. In addition, given the degree to which jail inmates cycle in and out of custody, their access to health care outside of the jail system could allow for preventative intervention and management of chronic conditions that indirectly reduce the cost of in-custody care.

Counties may derive public health benefits from enrolling the jail population in health insurance coverage.

Health insurance enrollment could also help reduce the likelihood that individuals will cycle back into the corrections system.

Evidence suggests that well-targeted substance abuse treatment can substantially reduce recidivism. A recent cost-benefit analysis of substance abuse treatment in 13 California counties found that the intervention substantially reduced recidivism, as well as corrections and health care costs.¹⁹ Similar research conducted in Washington demonstrated that treatment for chemically

dependent individuals reduced recidivism.²⁰ Under the ACA, individuals enrolled in Medi-Cal can receive coverage for substance abuse and mental health services.²¹ Additional funding for these reentry services would stretch local expenditures further and could lead to greater reductions in recidivism.

Finally, counties may derive public health benefits from enrolling the jail population in health insurance coverage. Given the particularly high rates of infectious disease among those cycling between jails and the community, diagnosis and treatment are key components in maintaining their health and the health of their families and communities.

The potential for savings will depend on the relationship between corrections and health systems and the degree of health service provision in the jail system in each county. Many counties are still coping with the burden of realignment; they may lack resources for enrollment efforts. County constituencies may also have differing perspectives on whether health care enrollment for the jail population should be a priority. As a result of these differences in incentives, capacities, and priorities, we anticipate substantial variation in county efforts to utilize jails as sites of health insurance enrollment.

CONCLUSION

The ACA and AB 720 offer opportunities for California’s local jail systems—which have been important health care providers—to become sites of health insurance enrollment for high-need populations. Health services are an important driver of corrections costs statewide, and there is now an opportunity for local systems to cover a share of the direct costs of health care and reentry services with federal funds. In addition, the provision of post-release health care—including mental health and substance abuse services—could reduce recidivism and improve public health and safety.

NOTES

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1. See Lois Davis et al. *Understanding the Public Health Implications of Prisoner Reentry in California*, (RAND Corporation, 2009).
2. Nationally, about 60 percent of local jail inmates have symptoms of mental health disorders and more than two-thirds meet the criteria for substance dependence or abuse. Symptoms of mental health problems were based on responses to structured clinical interviews and used criteria specified in the DSM of Mental Disorders. A recent history of mental health problems was also reported by 21 percent of local inmates, which was measured as a clinical diagnosis or treatment by a mental health professional in the past 12 months. See Doris James and Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates* (Bureau of Justice Statistics, 2006).
3. Available estimates suggest high rates of uninsurance—between 70 and 90 percent—among corrections populations. See Kamala Mallik-Kane and Christy Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* (Urban Institute, 2008).
4. California's local jurisdictions report information on their jail populations, including medical encounters and mental health cases, in the monthly JPS collected by the Board of State and Community Corrections (BSCC). These data provide snapshots of the amount of care local jail systems are providing to those in custody.
5. Sickcalls do not include scheduled physician appointments, medication administration, 14-day health evaluations, or emergency sick calls.
6. Onsite medical encounters are the total number of scheduled doctors' appointments in the facility, including follow-up or specifically scheduled appointments with physicians or mid-level providers. Offsite medical appointments can be either scheduled or unscheduled; they include specialty consults, surgery, diagnostic exams, emergency room visits, abortions, and oral surgery.
7. Authors' calculations from Office of Statewide Health and Planning and Development (OSHPD) Clinic Primary Care Clinic Annual Utilization Data report for 2012. Clinics reported a total of 16,767,731 encounters in 2012, and we reduced that by the 581,239 encounters paid for by the Healthy Families or Child Health and Disability Program because those would be for children under the age of 19. Given that 7.2 percent of clinic patients were men between the ages of 20 and 34, we estimated a total number of encounters for this demographic group of 1.165 million. We use estimates of population and insurance coverage from the 2012 American Community Survey as the denominators for the visit rates. See OSHPD clinic data.
8. This is consistent with national estimates (see James and Glaze, "Mental Health Problems of Prison and Jail Inmates," second note) that about 20 percent of local jail inmates reported a clinical diagnosis or treatment by a mental health professional in the past 12 months.
9. Because a number of jurisdictions did not submit mental health data, these reported statewide totals are undercounts.
10. Authors' calculations from the BSCC quarterly reports for 2012.
11. Bureau of Justice Statistics, "Jail Inmates at Midyear 2012 – Statistical Tables."
12. Visit rates calculated in this manner would be 1.85 visits per inmate including sickcalls or about .44 visits per inmate, including only scheduled medical appointments.
13. See Magnus Lofstrom and Steve Raphael, *Impact of Realignment on County Jail Populations* (Public Policy Institute of California, 2013).
14. See National Institute for Corrections (NIC) report in the July 6, 2011 Federal Register, page 39440.
15. See Elizabeth Davies, Reed Jordan, and Reena Chakraborty, *Opportunities for Cost Savings in Corrections without Sacrificing Service Quality: Inmate Health Care* (Urban Institute, 2013).
16. The California Legislative Analyst's Office (LAO) reports that, on average, it costs \$47,000 annually to hold an inmate in state prison. Of that total, \$12,442 (or about 26 percent) of the total cost of incarceration were health care costs.
17. The LAO also reports that inmate health care has been the fastest growing component of prison incarceration costs in California.
18. If individuals in the custody of the prison or jail systems and enrolled in Medicaid receive inpatient hospital care of a period of 24 hours or more, the state or county systems may draw down federal funds to compensate for this health care.
19. See Susan Ettner et al., "Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself?'" *Health Services Research* 41 (2006): 192–213.
20. See David Mancuso and Barbara E. M. Felver, "Chemical Dependency Treatment, Public Safety" (Washington State Department of Social and Health Services Research and Data Analysis Division, Report 11.140, 2009).
21. The federal government is financing 100 percent of the costs of Medicaid coverage for the population made newly eligible under the ACA from 2014 through 2016. After that, the federal contribution will phase down to 90 percent by 2020 and beyond, with the state government covering the remaining share.

ABOUT THE AUTHORS

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