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PRISON HEALTH CARE AFTER THE AFFORDABLE CARE ACT: ENVISIONING AN END TO THE POLICY OF NEGLECT

EVELYN MALAVÉ*

Inadequate prison health care has created a health crisis for reentering prisoners and their communities—a crisis that is exacerbated by barriers to employment and other collateral consequences of release. This Note will first examine how current Eighth Amendment doctrine has failed to sufficiently regulate prison health care so as to have any significant effect on the crisis. Next, it will argue that the Affordable Care Act (ACA) alters the Eighth Amendment analysis by triggering a change in the “evolving standards of decency” that guide the doctrine. Specifically, this Note will argue that, after the passage of the ACA, releasing sick, Medicaid-eligible prisoners without enrolling them in the federal benefits program violates the Eighth Amendment.

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* Copyright © 2014 by Evelyn Lia Malavé. J.D. Candidate, 2014, New York University School of Law; B.A., 2005, Yale University. I am grateful to Professor Anthony C. Thompson for encouraging me to write, Professor Sylvia A. Law for her class on health policy, Julia Torti for her crucial edits and vision during the early stages of this Note, and Kate Berry for her skillful edits at the end. I also want to thank Arin Smith, Michele Yankson, and the rest of the New York University Law Review staff for their hard work. Finally, thank you to Benjamin Foley and the Malavé family for their support and understanding.

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INTRODUCTION

The United States has the highest rate of imprisonment in the world, incarcerating approximately 2.3 million people,¹ or more than one in 100 adult Americans.² This phenomenon of mass incarceration has led to calls for reform of the criminal justice system.³ Behind the crisis of mass incarceration, a public health crisis is also unfolding.

Prisoners have significantly higher rates of physical and mental illness than the general population⁴—including higher rates of communicable diseases such as HIV/AIDS,⁵ Hepatitis B and C,⁶ chronic

¹ *Criminal Justice Fact Sheet*, NAACP, <http://www.naacp.org/pages/criminal-justice-fact-sheet> (last visited Mar. 17, 2014).

² See Adam Liptak, *More Than 1 in 100 Adults Are Now in Prison in U.S.*, N.Y. TIMES, Feb. 29, 2008, at A14 (reporting on results from a Pew Center on the States study).

³ See, e.g., MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010) (arguing that current criminal justice and drug policies comprise a system of racial control, comparable to slavery or Jim Crow).

⁴ See John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 450 (2005) (“The prevalence of chronic illness, communicable diseases, and severe mental disorders among people in jail and prison is far greater than among other people of comparable ages.” (quoting THE REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 157 (2005))); Adrienne Lyles-Chockley, *Transitions to Justice: Prisoner Reentry as an Opportunity to Confront and Counteract Racism*, 6 HASTINGS RACE & POVERTY L.J. 259, 297–98 (2009) (“The prevalence of certain infectious diseases, substance abuse problems, and mental health disorders is significantly greater in inmate populations than in the general American population.” (footnotes omitted)); Harold Pollack et al., *Health Care Delivery Strategies for Criminal Offenders*, 26 J. HEALTH CARE FIN. 63, 65 (1999) (describing how the prison population suffers from a “prevalence of mental health problems, infectious diseases, substance abuse, and other morbidities”); Michele Westhoff, *An Examination of Prisoners’ Constitutional Right to Healthcare: Theory and Practice*, HEALTH LAW, Aug. 2008, at 1, 8–9 (noting the high rates of communicable diseases, substance abuse disorders, and mental illness in prison).

⁵ A 2003 Department of Justice study found that 22,028 state inmates and 1631 federal inmates were infected with HIV, accounting for “1.1% of all federal inmates and 2.0% of state inmates, or 1.9% of the entire prison population in the United States.” Kari Larsen, *Deliberately Indifferent: Government Response to HIV in U.S. Prisons*, 24 J. CONTEMP. HEALTH L. & POL’Y 251, 251 (2008). The report also found that the rates of HIV varied significantly from state to state. In New York, for example, 7.6% of state prisoners were HIV positive. *Id.*

diseases,⁷ and mental illness.⁸ Tuberculosis, rare outside prison walls and once thought eradicated, is prevalent in the prison population.⁹ The “high population of mentally ill inmates housed in correctional facilities has made the U.S. penal system the nation’s largest provider of mental health services.”¹⁰ A recent Bureau of Justice Statistics report found that over half of all inmates in United States prisons and jails experience mental illness.¹¹ The overall rate of mental illness in prison is estimated to be four times that of the general population.¹² Female prisoners, in particular, face a higher rate of mental illness than females within the nation’s general population.¹³ Additionally, many mentally ill prisoners are dually diagnosed with substance abuse

⁶ Hepatitis B and Hepatitis C are grossly overrepresented in the prison population, with rates nine to ten times the national average. Westhoff, *supra* note 4, at 8.

⁷ For example, the asthma rate in prisons and jails in 1995 was higher than that of the general population. Jacobi, *supra* note 4, at 452.

⁸ See Shane Levesque, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711, 713 (2010) (citing data that “suggest that over half of the men and women incarcerated in prisons and jails throughout the United States suffer from some form of mental illness”).

⁹ Rates of tuberculosis among prisoners have been estimated to be four to seven times higher than in the general population. Jacobi, *supra* note 4, at 451. In 1996, “released prisoners accounted for 35% of all people in the United States with tuberculosis, 29% of those with hepatitis C, 12% of those with hepatitis B, and 13% of those with HIV infection.” *Id.*

¹⁰ Levesque, *supra* note 8, at 713.

¹¹ *Id.* at 715. About one in five of these inmates are reported to experience serious mental illness, a category that includes major depression, bipolar disorder, schizophrenia, and other psychotic conditions. *Id.* When researchers count inmates with specific symptoms sufficient to support a diagnosis of mental illness, the rates of mental illness are even more dramatic: Fifteen percent of state prison inmates meet the criteria for psychotic disorder and twenty-three percent meet the criteria for major depression. *Id.*

¹² *Id.* The rate of schizophrenia in state prisons is three to five times higher than in the general population, and the rate in jails is two to three times higher. Jacobi, *supra* note 4, at 453.

¹³ See Amy Vanheuverzwyn, *The Law and Economics of Prison Health Care: Legal Standards and Financial Burdens*, 2009–2010 U. PA. J.L. & SOC. CHANGE 119, 126 (“Female inmates typically have higher rates of mental illness than their male counterparts . . .”). Compounding rates of mental illness is the fact that many women in prison have histories of physical or sexual abuse. See Haegyung Cho, Note, *Incarcerated Women and Abuse: The Crime Connection and the Lack of Treatment in Correctional Facilities*, 14 S. CAL. REV. L. & WOMEN’S STUD., 137, 144 (2004) (stating that “[f]orty-three percent of female inmates reported physical or sexual abuse at some time in their lives prior to their incarceration”); MARY E. GILFUS, WOMEN’S EXPERIENCES OF ABUSE AS A RISK FACTOR FOR INCARCERATION, NAT’L ONLINE RESOURCE CENTER ON VIOLENCE AGAINST WOMEN 4 (2002), available at http://www.vawnet.org/Assoc_Files_VAWnet/AR_Incarceration.pdf (finding, in a study of the intersection of abuse and incarceration, that “[abused] women often experience extreme stress, symptoms of complex PTSD, anxiety, depression, sleep deprivation, and physical pain”).

disorders.¹⁴ Despite these high rates of illness among prisoners, prison health care is alarmingly inadequate.

This Note will explain how inadequate prison health care has created a significant health crisis for reentering prisoners and their communities. It will examine how Eighth Amendment doctrine, which governs prison health care, can be a tool in addressing this public health crisis. Part I will describe the health crisis faced by reentering prisoners and their communities, explain how it developed, and analyze its implications for poor communities of color in particular. Part II will describe the doctrinal framework of the Eighth Amendment as it applies to prison health care and will explain how the doctrine in its current state has failed to regulate prison health care sufficiently. Part III will then turn its attention to the Affordable Care Act (ACA)¹⁵ and argue that it presents an opportunity to strengthen Eighth Amendment prison health care doctrine so that it can better address the health crisis for reentering prisoners and their communities. Specifically, the ACA represents a sea change for Eighth Amendment prison health care doctrine because by changing access to health care for non-prisoners, the ACA marks a shift in the “evolving standards of decency” that guide the doctrine. As an example of the effect of the ACA, Part III will argue that the Eighth Amendment now requires prisons to treat a sick prisoner’s non-enrollment in Medicaid as a serious medical need.

I

INADEQUATE PRISON HEALTH CARE AND THE RESULTING HEALTH CARE CRISIS FOR REENTERING PRISONERS AND THEIR COMMUNITIES

Inadequate health care in prisons has created a pressing health crisis for reentering prisoners and their communities. The crisis is well understood and well documented by prison health care scholars; however, the crisis remains unremedied.¹⁶ Part I will outline this problem

¹⁴ More than one-third of mentally ill state prisoners reported a history of alcohol dependence. Lyles-Chockley, *supra* note 4, at 298. Three-quarters of mentally ill prisoners also have a substance abuse problem. Jacobi, *supra* note 4, at 452–53.

¹⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 19, 20, 26, and 42 U.S.C.).

¹⁶ See, e.g., Jacobi, *supra* note 4, at 448 (arguing that because of the public’s indifference to the plight of prisoners, prison health care reform will only occur if concern about the spillover effects of the “mismanagement of prison health care” on communities becomes widespread); Westhoff, *supra* note 4, at 10 (“[T]he consequences of poor health-care in prisons do not fall exclusively on prisoners.”).

and its likely causes. Subpart I.A will provide an overview of the health crisis, describing how inadequate prison health care has spillover effects on reentering prisoners' communities. Subpart I.B will analyze how the collateral consequences of incarceration exacerbate the health crisis. Subpart I.C will examine the implications of the health crisis for poor, minority communities in particular, arguing that (1) the effects of the health crisis are concentrated in poor, minority communities because the effects of mass incarceration are concentrated in those communities and (2) as a result of this concentration, high incarceration and poor health outcomes are locked in a mutually reinforcing dynamic.

A. The Health Crisis: How Inadequate Prison Health Care Harms Reentering Prisoners and Their Communities

Despite a dire need for health care services among prisoners, prison health care has been inadequate and has led to adverse health outcomes for reentering prisoners, resulting in a major health crisis for the communities to which they return. This section will describe how and why prison health care falls short, and how the inadequacy of prison health care has had a negative impact on the health of both reentering prisoners and their communities.

Prisoners are disproportionately sick compared to the general population, and the prison environment itself contains so many health risks that prisons have been called “hotbeds for infectious diseases.”¹⁷ Prisoners are at a high risk of contracting HIV while incarcerated due to alarming rates of sexual assault, as well as the occurrence of consensual sex, intravenous drug use, and unsafe tattooing.¹⁸ High rates of HIV,¹⁹ overcrowding, and poor ventilation facilitate the spread of tuberculosis.²⁰ In a study by the Urban Institute, “[o]ne-half of men (49 percent) and two-thirds of women (67 percent) had chronic physical health conditions requiring long-term management and care at the

¹⁷ Westhoff, *supra* note 4, at 8.

¹⁸ See Larsen, *supra* note 5, at 257–60 (detailing “the perils of prison”).

¹⁹ See Jacobi, *supra* note 4, at 451 (“Compared to the general population, it has been estimated that ‘rates of human immunodeficiency virus (HIV) infection among [prisoners] . . . are 8 to 10 times higher’” (quoting Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health*, 78 J. URB. HEALTH 214, 217 (2001))).

²⁰ See Westhoff, *supra* note 4, at 8 (describing how overcrowding and poor ventilation exacerbate tuberculosis, and how prisoners with HIV are more susceptible to contracting tuberculosis). Poor ventilation also exacerbates asthma. Amy L. Katzen, *Commentary, African American Men’s Health and Incarceration: Access to Care upon Reentry and Eliminating Invisible Punishments*, 26 BERKELEY J. GENDER L. & JUST. 221, 243 (2011).

time of their release.”²¹ The conditions most reported were “asthma, high blood pressure, and diabetes.”²² The uniquely stressful nature of the prison environment, with its lack of privacy, highly regimented schedule, and typical overcrowding, takes its toll on prisoners’ physical²³ and mental health.²⁴ Prisons are also “incubators” for mental illness: Many people who have not previously shown any sign of mental illness become symptomatic in prison.²⁵

Despite the urgent need for medical and mental health services in prison, prison health care is at best inadequate and, at worst, an atrocity.²⁶ Of the many inmates the Urban Institute study found to be leaving prison with chronic physical conditions requiring long-term management, only sixty-four percent of the men and seventy-three percent of the women reported receiving treatment for those condi-

²¹ KAMALA MALLIK-KANE & CHRISTY A. VISHER, URBAN INST., HEALTH AND PRISONER REENTRY: HOW PHYSICAL, MENTAL, AND SUBSTANCE ABUSE CONDITIONS SHAPE THE PROCESS OF REINTEGRATION 11 (2008).

²² *Id.*

²³ Stress in prison has been linked to hypertension. See Katzen, *supra* note 20, at 230 (“[D]ysregulation of stress hormones can cause hypertension, and prison is an extremely stressful environment.”). Stress can also exacerbate some illnesses, such as asthma. See *id.* at 229–30 (“Prison violence may increase psychological stress, which in turn may also aggravate asthma.”).

²⁴ See Levesque, *supra* note 8, at 722 (relating how prison overcrowding and lack of privacy negatively impact mentally ill prisoners); Bonnie J. Sultan, *The Insanity of Incarceration and the Maddening Reentry Process: A Call for Change and Justice for Males with Mental Illness in United States Prisons*, 13 GEO. J. ON POVERTY L. & POL’Y 357, 366 (2006) (explaining how people with mental illness tend to adjust poorly to the environment of incarceration with its “dormitories . . . set up in cafeterias, single occupancy rooms housing three residents, deteriorating hygiene and sanitation, and a hostile environment due to lack of space and privacy”). Additionally, mentally ill people in prison are often “unable to understand the unspoken laws of prison culture, and therefore make slight ‘errors’ that can lead to their victimization”—and to their getting disciplined more than other prisoners. Sultan, *supra*, at 369, 371. The presence of mentally ill prisoners may also increase the risk of violence for other prisoners as well. Sultan argues that hyper-masculine prison culture dictates that non-mentally ill prisoners should meet mentally ill prisoners’ aggressions with even more violence. *Id.* at 370. Prisoners with physical and mental disabilities are three times more likely to be sexually assaulted. *Id.* at 368.

²⁵ See HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 3 (2003) (portraying prison as an “incubator” for mental illness); Sultan, *supra* note 24, at 360 (noting how many prisoners with no previous mental illness history develop post-traumatic stress disorder in prison).

²⁶ See HUMAN RIGHTS WATCH, *supra* note 25, at 94–126 (describing poor mental health care in prisons, including overreliance on medication, lack of intake screening, and understaffing); Jacobi, *supra* note 4, at 455 (noting how many prisons and jails have failed to adhere to Centers for Disease Control and Prevention standards for screening and treatment of tuberculosis and have inconsistently administered HIV antiretroviral drugs); see also Scott Burris, *Prisons, Law and Public Health: The Case for a Coordinated Response to Epidemic Disease Behind Bars*, 47 U. MIAMI L. REV. 291, 307 (1992) (“Prisons often provide only a low standard of general health care.”).

tions in prison.²⁷ A lack of funding causes prisons to eliminate all but the most essential programs.²⁸ Mental health care in prisons is particularly abysmal: Many prisons have inadequately trained staff²⁹ and tend to rely on mostly medication-based treatment³⁰—rather than emphasizing therapy and counseling—and the segregation of mentally ill prisoners, which often means minimal access to the vocational training and educational services that may be available in the general prison population.³¹ Correctional officers’ frequent punishment of inmates for behavioral manifestations of mental illness exacerbates the effects of prisoners’ inadequate mental health care.³² For certain illnesses—HIV/AIDS and substance abuse disorders, in particular—prison health care contravenes evidence-based standards of treatment. Prisons resist condom distribution³³ and needle exchanges³⁴ in large

²⁷ MALLIK-KANE & VISHER, *supra* note 21, at 11.

²⁸ As a result of budget pressures, many prisons also contract out their health care to private contractors with the lowest bid, a system that ultimately results in lesser quality care and monopoly profits for the contractors. See Richard Siever, Note, *HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System*, 58 VAND. L. REV. 1365, 1378–80 (2005) (explaining how many states require awarding prison health care contracts to the lowest bidder, and how “[l]ong-term relationships between prison authorities and private contractors can undermine competitive markets”).

²⁹ See Levesque, *supra* note 8, at 723 (outlining how “‘counselors’ who are typically not required to hold any formal credentials, overwhelmingly outnumber licensed mental health professionals” in prisons).

³⁰ See Jacobi, *supra* note 4, at 472 (noting how treatment is most often provided in the form of prescription medication); Levesque, *supra* note 8, at 721 (same); Sultan, *supra* note 24, at 375 (describing how prison officials are tempted to rely exclusively on medication, but this is “not a complete solution to mental illness”). See generally Josiah D. Rich et al., *Medicine and the Epidemic of Incarceration in the United States*, 364 NEW ENG. J. MED. 2081, 2081–82 (2011) (explaining that prisons are not designed to provide mental health care, provide very little treatment, and tend to aggravate mental illness instead).

³¹ See Sultan, *supra* note 24, at 375 (criticizing segregating housing units as “asylum-like boarding units, many times enforcing 23-hour-a-day lock-up, lacking access to care or specially-trained staff”). See generally James R. P. Ogloff et al., *Mental Health Services in Jails and Prisons: Legal, Clinical, and Policy Issues*, 18 LAW & PSYCHOL. REV. 109 (1994) (highlighting the need for better correctional mental health services and providing a model that relies less on segregation).

³² Guards are not trained to react appropriately to mentally ill prisoners and tend to punish violence more harshly when it is accompanied by symptoms of mental illness. This leads to mentally ill people staying in prison longer because they are written up more frequently. See Sultan, *supra* note 24, at 371 (explaining how guards are not properly trained and—because they are concerned that mentally ill prisoners will act irrationally violent—tend to punish “‘assaultive acts coupled with disturbed behavior’” more harshly than other assaults (quoting HANS TOCH & KENNETH ADAMS, ACTING OUT: MALADAPTIVE BEHAVIOR IN CONFINEMENT 118 (2002))); see also Jacobi, *supra* note 4, at 472 (“[M]any symptoms of severe mental illness are treated by prisons as signs of disrespect or willful misbehavior, and the symptomatic prisoners are therefore confined in punitive solitary confinement rather than referred for treatment.”).

³³ See Larsen, *supra* note 5, at 258 (“96% of state prison systems consider condoms to be contraband, and do not allow them inside facilities.”).

part because sexual activity and drug use are illegal in prison.³⁵ However, even the less controversial preventive approach of education has been ineffectively delivered.³⁶ Furthermore, despite evidence that methadone maintenance is an effective treatment for heroin addiction,³⁷ prisons typically force heroin-addicted prisoners to detoxify when they enter prison—sometimes without medical supervision.³⁸

³⁴ See *id.* at 260 (stating that needles and bleach, which could be used to sterilize needles, are contraband and thus not allowed within prison facilities).

³⁵ See *id.* at 265 (describing how U.S. prison systems refuse to distribute condoms for fear that, among other reasons, it “would implicitly suggest that sex is permitted”); Kate Abramson, Note, *Unfairly Condemned to Disease: The Argument for Needle-Exchange Programs in United States Prisons*, 16 GEO. J. ON POVERTY L. & POL’Y 695, 711 (2009) (explaining how prison officials fear that needle-exchange programs will send mixed messages about drug use). For condom distribution, resistance is also rooted in homophobia. See Larsen, *supra* note 5, at 266 (“Unfortunately, there still exists a strong current of denial in many places about male to male sex (especially in prison) and a corresponding refusal to do anything which might be seen as condoning it.” (quoting UNAIDS, PRISON AND AIDS 6–7 (1997))). Nevertheless, condom distribution and needle exchange programs have succeeded in other countries, and the Centers for Disease Control and Prevention, World Health Organization, and National Commission on AIDS all recommend that prisoners be given the means to prevent HIV transmission. See *id.* at 265–66, 300 (noting that Canada and the vast majority of European countries provide condoms to prisoners and describing a successful needle exchange program in Switzerland).

³⁶ See Larsen, *supra* note 5, at 266–67 (characterizing education provided to inmates about HIV prevention as “woefully inadequate”). Part of prisons’ collective failure can be attributed to the lack of guidance from the federal government: The United States still does not have a national policy for HIV management in prisons. See *id.* at 261 (noting that formal guidelines regarding the prevention of HIV in correctional facilities have never been issued by the federal government). And despite having populations that exhibit eight to twenty times higher rates of Hepatitis C than the general population, many prisons have blanket, restrictive policies for Hepatitis C treatment that contravene current standards of care—including policies that withhold treatment from drug users. See Andrew Brunsden, Comment, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform*, 54 UCLA L. REV. 465, 471, 482–83 (2006) (describing how prisons have failed to update their protocols to reflect evolving standards of care that recommend individually-tailored treatment).

³⁷ See LEGAL ACTION CTR., LEGALITY OF DENYING ACCESS TO MEDICATION ASSISTED TREATMENT IN THE CRIMINAL JUSTICE SYSTEM 2 (2011) (“Methadone maintenance treatment (‘MMT’) . . . has been confirmed clinically effective for opioid dependence in more than 300 published research studies.”).

³⁸ See *id.* at 4 (noting how the majority of jails and prisons not only do not provide methadone maintenance treatment but also “fail [] to use a specific standardized treatment protocol for opiate detoxification,” and how some fail to provide any medical supervision at all). Much of the resistance to methadone maintenance treatment is based on the idea that it is fundamentally “better” for inmates to detoxify completely. See David Lebowitz, “Proper Subjects for Medical Treatment?” *Addiction, Prison-Based Drug Treatment, and the Eighth Amendment*, 14 DEPAUL J. HEALTH CARE L. 271, 303 (2012) (outlining a struggle “between the lay understanding of drug treatment as a supererogatory luxury (or potentially a pretext for recreational drug use) and scientific understandings of addiction as a medical disorder requiring treatment”); Dan Frosch, *Plan to End Methadone Use at Albuquerque Jail Prompts Alarm*, N.Y. TIMES, Jan. 7, 2013, at A9 (“Some wardens are resistant to introducing another narcotic that could be exploited by inmates. . . . And there

Perhaps the most damaging aspect of poor prison health care is inadequate discharge planning. Discharge planning in the health care context is defined as the process of connecting prisoners—either right before their release or as early as the day they are incarcerated³⁹—with health care services in the community. It can involve providing prisoners with written discharge plans that include a list of resources and health care referrals,⁴⁰ making appointments with health care providers in the community, or collaborating with outside providers.⁴¹ Discharge planning is particularly important because reentering prisoners are most vulnerable at release: They are twelve times more likely to die from health problems and 129 times more likely to die of a drug overdose in the first two weeks of release than the general population.⁴² As for reentering prisoners with mental health problems, even those who achieved some stability during incarceration are unlikely to transition well from a regimented environment to being “subsequently released to the streets with no home, no source of income, [and] no social network.”⁴³

Despite the great need for it, the current state of discharge planning is deficient to non-existent: Many prisoners are released with prescriptions, but without the identification necessary to fill them or with no supply of medication at all.⁴⁴ “Releases typically receive minimal

remains a feeling among correctional institutions that it is wiser for prisoners to complete a total detoxification.”)

³⁹ See JEFF MELLOW ET AL., *MAPPING THE INNOVATION IN CORRECTIONAL HEALTH CARE SERVICE DELIVERY IN NEW YORK CITY*, at ix (2008) (describing how discharge planning at the New York City Department of Corrections begins at intake).

⁴⁰ See NANCY LA VIGNE ET AL., *URBAN INST., RELEASE PLANNING FOR SUCCESSFUL REENTRY 6* (2008) (“Release activities typically include, at a minimum, an individualized assessment and a written release plan.”).

⁴¹ See Katzen, *supra* note 20, at 246 (explaining how to improve discharge planning by making substance abuse appointments within twenty-four hours of release for those with a history of abuse, requiring prisons to bear the cost of this initial visit, and collaborating between prisons and outside providers).

⁴² LA VIGNE ET AL., *supra* note 40, at 17, 21. Prisoners with dual diagnoses of mental illness and substance abuse tend to suffer the most upon release without treatment. *Cf.* Lyles-Chockley, *supra* note 4, at 290 (noting how negative pressures on reentering prisoners “coalesce” at the time of release).

⁴³ Levesque, *supra* note 8, at 712.

⁴⁴ See Jacobi, *supra* note 4, at 469–70 (noting how adequate discharge planning should include making appointments with providers and not just referrals, providing interim supplies of medication, giving prisoners copies of their medical records, and helping them to enroll in public benefits); Levesque, *supra* note 8, at 712 (expressing how prisoners are frequently released with no supply of medication); Lyles-Chockley, *supra* note 4, at 298 (describing how ex-offenders leave incarceration without any means of finding or contacting treatment providers); Rich et al., *supra* note 30, at 2082 (explaining how this results in a heavy burden on emergency rooms and the public sector). Discharge planning may be particularly hampered in its effectiveness because, unlike other health care services in prisons, it requires collaboration with communities, which raises questions of ownership

guidance on how to access healthcare and medications,” and even for those who leave prison with health care referrals, “it is unusual to have an appointment already lined up.”⁴⁵ Only forty-four percent of prisons provide mentally ill prisoners with a written discharge plan and only thirty percent provide such a plan to prisoners with substance abuse disorders.⁴⁶ Discharge planning is particularly hampered by the fact that many prisons do not enroll eligible prisoners in Medicaid before their release, which decreases the chance that these prisoners will be able to access health care upon their reentry into the community.⁴⁷

Inadequate prison health care not only leads to detrimental health outcomes for reentering prisoners, but also leads to detrimental health outcomes for their communities, both directly and indirectly. On a very basic level, reentering prisoners are part of the communities to which they return. Thus, anything that affects them must also be seen as affecting their communities. High rates of illness among prisoners returning to a particular community yield higher rates of illness for that community. The effects of poor prison health care also extend beyond the reentering prisoners. Communities are impacted directly by the treatment of communicable diseases in prison. High rates of Hepatitis C and HIV in prison pose transmission risks to communities.⁴⁸ For example, prisons and jails are partly responsible for high

and accountability. As with many services targeting the moment of reentry, the question of which actors are responsible for what services creates a leadership vacuum. See Michael Pinard & Anthony C. Thompson, *Offender Reentry and the Collateral Consequences of Criminal Convictions: An Introduction*, 30 N.Y.U. REV. L. & SOC. CHANGE 585, 593 (2006) (describing how “attempts to address reentry remain fragmented,” because criminal and civil justice actors and service providers have yet to develop a coordinated approach to providing services for individuals reentering society).

⁴⁵ LA VIGNE ET AL., *supra* note 40, at 18.

⁴⁶ *Id.* at 20–21.

⁴⁷ Under federal law, prisoners cannot receive Medicaid benefits while they are incarcerated. Sarah E. Wakeman et al., *Filling the Gap: The Importance of Medicaid Continuity for Former Inmates*, 24 J. GEN. INTERNAL MED. 860, 861 (2009). “The reasoning was that states and local governments had historically taken responsibility for inmate health care so the federal-state Medicaid plan was not needed.” Christine Vestal, *Medicaid Expansion Seen Covering Nearly All State Prisoners*, STATELINE, Oct. 18, 2011, <http://www.governing.com/blogs/politics/Medicaid-Expansion-Covering-Nearly-All-State-Prisoners.html>. Federal law does not require states to terminate Medicaid enrollment for prisoners while they are incarcerated, “so an inmate could theoretically leave prison and immediately resume coverage.” Wakeman et al., *supra*, at 861. Nevertheless, ninety percent of states currently terminate enrollment upon incarceration. *Id.* And many states do not pre-enroll prisoners. See Michael Ollove, *Ex-Felons Are About to Get Health Coverage*, STATELINE, Apr. 5, 2013, http://www.huffingtonpost.com/2013/04/05/ex-felons-medicaid_n_3021207.html (noting that New York, Oklahoma, Florida, Illinois, and California already have pre-release programs).

⁴⁸ See Westhoff, *supra* note 4, at 10 (describing how prisoners with HIV or Hepatitis C could pass on those diseases to other people in the community through sex or needle

rates of tuberculosis in poor communities.⁴⁹ Additionally, prison officials' poor adherence to treatment protocols pose risks of drug-resistant strains of some diseases, which could affect prisoners, prison staff, and the rest of the public.⁵⁰

Communities are also impacted indirectly by poor prison health care because their health care systems and social networks become overwhelmed by reentering prisoners' health care needs. Because formerly incarcerated people tend to lack health insurance, many receive health care only when they must visit the emergency room,⁵¹ creating tremendous stress on already limited local resources.⁵² This stress results in fewer resources being available for treatment.

Some may argue that prison health care is not causing a health crisis for reentering prisoners and communities, but rather that reentering prisoners and their communities were already in a health crisis, irrespective of any role played by prisons.⁵³ It is true that the majority of reentering prisoners are poor people of color, who are more likely than any other group to be in poor health.⁵⁴ Still others may argue

sharing); Brunsden, *supra* note 36, at 471 (outlining transmission risks to communities posed by high rates of Hepatitis C in prison).

⁴⁹ See Jacobi, *supra* note 4, at 448 (noting how prisons and jails can amplify infectious conditions, transform diseases into treatment-resistant strains, and—when ex-offenders return to their communities—result in infections among the general public).

⁵⁰ See *id.* at 475 (explaining the risk of outbreak and virus mutation posed by poor adherence to treatment protocols).

⁵¹ One study found that eighty percent of jail detainees and inmates with chronic health problems “did not receive any regular medical care prior to entering jail. Ninety percent have no health insurance and over half used their local emergency room to receive needed care.” BONITA M. VEYSEY, CMTY. ORIENTED CORR. HEALTH SERVS., *THE INTERSECTION OF PUBLIC HEALTH AND PUBLIC SAFETY IN U.S. JAILS* 4 (2011) (footnoted omitted); see also MALLIK-KANE & VISHER, *supra* note 21, at 2 (finding that within ten months of release, one-third of recently released inmates had used the emergency room and one-fifth had been hospitalized); Vanheuverzwyn, *supra* note 13, at 133–34 (discussing how poor prison health care leads to higher emergency room usage among female ex-offenders).

⁵² See Jacobi, *supra* note 4, at 471 (noting how the failure to properly treat prisoners will ultimately burden underfunded health care facilities in poor communities); Levesque, *supra* note 8, at 716 (explaining how high rates of mental illness in prison pose challenges to communities, which must address the needs of ex-offenders who lack treatment); Rich et al., *supra* note 30, at 2082 (describing how recently released prisoners rely on emergency room visits for their health care, which is costly for local communities).

⁵³ See, e.g., Burris, *supra* note 26, at 299 (“Prison populations . . . represent a distillate of the major public health problems in the communities from which prisoners are drawn.”); Bryan L. Sykes & Alex R. Piquero, *Structuring and Re-Creating Inequality: Health Testing Policies, Race, and the Criminal Justice System*, 623 *ANNALS AM. ACAD. POL. & SOC. SCI.* 214, 214–15 (2009) (“The communities from which these [incarcerated] men are drawn suffer from high rates of morbidity and mortality as a consequence of various . . . health disparities.” (citation omitted)).

⁵⁴ See Katzen, *supra* note 20, at 225–26 (listing health disparities between African American men and the general population); David Satcher, *Our Commitment to Eliminate Racial and Ethnic Health Disparities*, 1 *YALE J. HEALTH POL'Y L. & ETHICS* 1 (2001)

that pinning the blame on the prison health care system for creating a health crisis among reentering prisoners ignores the bigger culprit: laws and policies that send a disproportionate number of sick people to prison in the first place by punishing drug use and mental illness.⁵⁵

(cataloguing six areas of health disparity experienced by racial and ethnic minorities); Sykes & Piquero, *supra* note 53, at 214 (noting racial health disparities). Racial health disparities can be traced to patterns of housing segregation and unequal distribution of resources among racial groups, combined with a primarily market-based health care system that bases care on ability to pay. See Jacobi, *supra* note 4, at 470 (explaining the “low-income communities to which prisoners frequently return” as having “limited health services”); Brunsdén, *supra* note 36, at 469–70 (“[P]risons disproportionately contain poor, minority populations that have traditionally lacked access to adequate health services.”); Caroline Sommers, *There Is No Perfect Solution to Health Care in America*, 2 J. BUS. ENTREPRENEURSHIP & L. 424, 427–30 (2009) (describing the United States as having a market-based health care system and providing a general history of health care in the United States). Racial minorities, because they are more likely to be low-income, are more likely to be uninsured. See Ruqaiyah Yearby, *Racial Inequities in Mortality and Access to Health Care: The Untold Peril of Rationing Health Care in the United States*, 32 J. LEGAL MED. 77, 84 (2011) (“32% of Latinos are uninsured, 28% of Native Americans are uninsured, and 21% of African Americans are uninsured, compared to 13% of Caucasians.”). People of color are also more likely to be insured by Medicaid, which many providers do not accept because it tends to have low reimbursement rates compared to many private insurance plans. See *id.* at 81 (outlining how many Medicaid recipients forgo care or rely on emergency rooms because physicians often refuse to accept Medicaid). Disproportionately low rates of insurance and low rates of reimbursement for poor people (and, consequently, many racial minorities) can be classified as a type of rationing. *Id.* at 77–78. Yearby argues that this rationing leads to unnecessary deaths, which are concentrated among poor people of color. *Id.* at 82. Yearby additionally argues that the entire system of basing health care on ability to pay is a form of structural racial bias. *Id.*

⁵⁵ See Rich et al., *supra* note 30, at 2081 (addressing the effect of the War on Drugs on incarceration and the deinstitutionalization of the mentally ill). The tough-on-crime policies of the War on Drugs led to the incarceration of many people for drug offenses. See Brunsdén, *supra* note 36, at 478 (describing how punitive drug policies lead to the incarceration of drug offenders). This incarceration in turn increased the number of people in prison with Hepatitis C, since drug use is a risk factor for Hepatitis C. See *id.* at 471 (noting how injection drug use is the primary mode of transmission for Hepatitis C). The policy of deinstitutionalization of mental health care—or “transinstitutionalization” as it has been termed by several scholars—has also been linked to an increase in mentally ill prisoners. See Jacobi, *supra* note 4, at 452 (describing how the failure of community health services to provide for those cleared from psychiatric hospitals, combined with harsher criminal sentences, led to this result); Levesque, *supra* note 8, at 718 (noting how, during deinstitutionalization, federal funds were withdrawn from psychiatric institutions and never, as planned, reinvested in community health centers). “Without needed care and treatment, many individuals with mental illness are frequently unable to participate in daily societal activities, and for some this is the beginning of the road to incarceration.” Sultan, *supra* note 24, at 364. Without sufficient care in the community, mentally ill people are susceptible to being arrested, particularly after the advent of “quality of life” laws, which criminalized nonviolent offenses that do not cause direct harm to others, such as drug or alcohol use. Levesque, *supra* note 8, at 719; see Jacobi, *supra* note 4, at 452 (outlining the effect of prosecutions of “quality of life” crimes); Levesque, *supra* note 8, at 719 (same); Rich et al., *supra* note 30, at 2081 (noting how mentally ill people are susceptible to arrest without treatment). Other institutional factors, such as the fact that many outpatient mental health clinics do not accept people who are considered “dangerous,” further

However, even if reentering prisoners and their communities were already in crisis, prison health care is still to blame for exacerbating poor health in prisoners and missing opportunities to improve health outcomes for this population. Public health scholars have described prison health care as a “public health opportunity”⁵⁶: In theory, the prison system’s total control of its inhabitants’ lives could be harnessed in service of the goal of releasing prisoners in better health, with the added effect of decreasing rates of illness in their communities as well. But instead of operating like a public health opportunity, prison health care operates more like a “public health disaster,”⁵⁷ both missing opportunities to improve health outcomes and actively making health outcomes worse for reentering prisoners and their communities.

B. Sick, Without a Job, and Without Health Insurance: How the Collateral Consequences of a Criminal Conviction Exacerbate the Health Crisis for Reentering Prisoners and Their Communities

In addition to the challenge of being in poor health, reentering prisoners also face a myriad of “collateral consequences,” such as laws that bar people with criminal records from employment and occupational licensing,⁵⁸ housing (including public housing), food stamps,

ensnare people with mental illness in the criminal justice system. *See* Levesque, *supra* note 8, at 719 (expressing how mentally ill people with a history of violence can be excluded from community mental health services). Lack of training for police officers on how to recognize signs of mental illness is also a problem. Confronted with a mentally ill person violating the law, a police officer may not recognize that the person is mentally ill, or simply may find it too hard to civilly commit the person. *See id.* (discussing how police are more likely to charge a disruptive mentally ill person with a crime than to find her treatment, since the latter is more onerous).

⁵⁶ Jacobi, *supra* note 4, at 471; *see also* Burris, *supra* note 26, at 302 (describing prison as a public health opportunity); Sykes & Piquero, *supra* note 53, at 216 (noting that, with the right policies, prisons and jails can help improve health inequalities); Westhoff, *supra* note 4, at 11–12 (arguing that, because prisoners come from underprivileged communities with little access to health care and health education, prison provides an opportunity to teach prisoners about health maintenance and to diagnose and treat mental illness); Brunsden, *supra* note 36, at 216, 479–81 (arguing that improving prisoner health care could be justified on utilitarian and humanitarian grounds because it would improve both prisoner and community health, and responding to criticisms that prisons are not good environments for public health initiatives because prisoners are difficult patients).

⁵⁷ *See* Jacobi, *supra* note 4, at 473 (“With respect to []transmissible diseases, prisons’ neglect and mismanagement of health care services is a public health disaster, no matter how narrowly one construes public health functions.”).

⁵⁸ Even in states with laws that prohibit criminal record-based discrimination, these laws are incredibly difficult to enforce. Meg Leta Ambrose et al., *Seeking Digital Redemption: The Future of Forgiveness in the Internet Age*, 29 SANTA CLARA COMPUTER & HIGH TECH. L.J. 99, 144 n.310 (2013) (arguing that readily obtainable information about criminal

and voting.⁵⁹ Ultimately, poor prison health care cannot be examined out of the context of the collateral consequences of incarceration. Excluding the effect of collateral consequences of reentry, poor prison health care would still have negative health effects on reentering prisoners and their communities,⁶⁰ but collateral consequences—by entrenching poverty and straining community resources—magnify those effects and turn them into an alarming health crisis. This Subpart will first address how collateral consequences affect reentering prisoners' health and then proceed to address the ripple effects on the health of their communities.

records allows employers to discriminate against people with criminal records without ever revealing that their decisions were based on an applicant's criminal history). Furthermore, many laws do not outright prohibit discrimination based on criminal record, but rather effectively create blanket restrictions for certain occupations based on "good moral character" licensing requirements. See Pinard & Thompson, *supra* note 44, at 597 (discussing the exclusionary effect of "good moral character" licensing requirements). Other laws permit criminal-record based discrimination when the criminal record is deemed to be related to the license sought (such as a person convicted of a sex offense against children seeking to drive a school bus). See LEGAL ACTION CTR., *AFTER PRISON: ROADBLOCKS TO REENTRY: A REPORT ON STATE LEGAL BARRIERS FACING PEOPLE WITH CRIMINAL RECORDS* 10 (2004) (describing laws that bar specific employment based on a criminal record).

⁵⁹ See Avi Brisman, *Double Whammy: Collateral Consequences of Conviction and Imprisonment for Sustainable Communities and the Environment*, 28 WM. & MARY ENVTL. L. & POL'Y REV. 423, 432–48 (2004) (discussing barriers to successful reentry—specifically relating to housing, employment, and welfare—and how these collateral consequences are especially worse for people with drug convictions); Pinard & Thompson, *supra* note 44, at 594–99 (same). The barriers to reentry that people with criminal records face are so pervasive that the term "collateral consequences" does not quite capture their severity. Collateral consequences are also particularly pernicious because they are scattered throughout the law, making it hard for even experienced advocates to keep track of them. Additionally, many collateral consequence laws rely on ambiguous standards. For example, many occupational licensing laws permit only people with "good moral character" to obtain licenses and, while a criminal record does not automatically result in rejection, a person with a criminal record is clearly at a disadvantage. Pinard & Thompson, *supra* note 44, at 597. Finally, barriers to reentry also compound each other: "[A]n inability to find housing makes it almost impossible to secure employment; a lack of employment makes it difficult to convince a family court judge that you are fit to regain custody of your children." Alina Ball, Comment, *An Imperative Redefinition of "Community": Incorporating Reentry Lawyers to Increase the Efficacy of Community Economic Development Initiatives*, 55 UCLA L. REV. 1883, 1902 (2008).

⁶⁰ See Jacobi, *supra* note 4, at 467 (describing how even when prisoners suffer from non-infectious diseases, such as asthma or schizophrenia, poor prison health care of those conditions "frustrate[s] the process of reintegration for released prisoners and fosters recidivism, unemployment, [and] homelessness for the former prisoner" and an "economic and emotional strain on . . . family and community"). However, it should be noted that Jacobi's view represents a broader view of public health that has fallen into disfavor lately, with more and more public health scholars adhering to the narrow view which is limited to the study of communicable diseases. See, e.g., *id.* at 466 n.193 (noting this opposition and citing Richard A. Epstein, *In Defense of the "Old" Public Health: The Legal Framework for the Regulation of Public Health*, 69 BROOK. L. REV. 1421, 1423–26 (2004)).

Because employment is a main source of health insurance, criminal-record based barriers to employment lead to low health insurance rates among people with criminal records and a resultant inability to access necessary medical care other than through the emergency room.⁶¹ Additionally, barriers to employment, housing, and food stamps lead to high rates of poverty⁶² among reentering prisoners, which are associated with negative health outcomes.⁶³ Barriers to food stamps impede access to proper nutrition, which aggravates certain chronic illnesses such as diabetes and is a negative factor for health generally.⁶⁴ Barriers to housing lead to increased rates of homelessness and substandard housing for reentering prisoners—more risk factors for poor health.⁶⁵ Barriers to employment, food stamps, and housing do not affect just reentering prisoners, but also health out-

⁶¹ See Levesque, *supra* note 8, at 725 (noting how difficulties finding a job compound formerly incarcerated people's difficulty accessing mental health treatment).

⁶² See Brett C. Burkhardt, Book Note, *Criminal Punishment, Labor Market Outcomes, and Economic Inequality: Devah Pager's Marked: Race, Crime, and Finding Work in an Era of Mass Incarceration*, 34 L. & SOC. INQUIRY 1039, 1044, 1055 (2009) (discussing studies that have found reductions in both the employment and earning rates of former prisoners and discussing the disadvantages wrought by the collateral consequences of a criminal record); Margaret E. Finzen, Note, *Systems of Oppression: The Collateral Consequences of Incarceration and Their Effects on Black Communities*, 12 GEO. J. ON POVERTY L. & POL'Y 299, 317–18 (2005) (noting that while research shows that “young, unskilled minority men who are most likely to go to jail have poor job opportunities even in the absence of incarceration,” incarceration itself has negative economic effects (quoting Bruce Western et al., *Black Economic Progress in the Era of Mass Imprisonment*, in *INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT* 165, 176 (Marc Mauer & Meda Chesney-Lind eds., 2002))).

⁶³ See Paula A. Braveman et al., *Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*, 100 AM. J. PUB. HEALTH S1, S186–96 (2010) (linking poverty to poor health); Frank McClellan, Essay, *Health Disparities, Health Care Reform, Morality, and the Law: “Keep Your Government Hands Off My Medicare,”* 82 TEMP. L. REV. 1141, 1154 (2010) (stating that researchers have linked health disparities to class and race).

⁶⁴ See Katzen, *supra* note 20, at 238–41 (describing how barriers to benefits such as food stamps and federally assisted housing impact reentering prisoners' health because they do not have access to proper food and because stress increases as a result of homelessness); William M. Wiecek, *Structural Racism and Law in America Today: An Introduction*, 100 KY L.J. 1, 18 (2012) (describing the link between poor nutrition and diabetes).

⁶⁵ See Katzen, *supra* note 20, at 240 (noting how barriers to housing cause many reentering prisoners to live in substandard housing that aggravates asthma); Levesque, *supra* note 8, at 725–26 (conveying how homelessness can cause substance abuse disorder relapses and make it difficult to pay for medications); Gerald P. L—pez, *How Mainstream Reformers Design Ambitious Reentry Programs Doomed to Fail and Destined to Reinforce Targeted Mass Incarceration and Social Control*, 11 HASTINGS RACE & POVERTY L.J. 1, 48 (2014) (stating that more than ten percent of people reentering society from prison or jail are homeless).

comes for their families and communities by increasing rates of poverty, homelessness, and access to nutrition across the board.⁶⁶

Indeed when an entire community becomes entrenched in poverty, studies have shown that health care resources begin to leave the community in search of wealthier patient populations, thus worsening health care outcomes even further for the first community.⁶⁷ Many hospitals strategically avoid poor and minority patients and their concomitant lower reimbursement rates through relocation, patient dumping, separate wings for poor patients, limits on the size of emergency rooms, and restrictive admissions policies.⁶⁸

C. *Bad Health and Incarceration: A Mutually Reinforcing Dynamic*

The health crisis brought about by poor prison health care is particularly severe in the communities most acutely impacted by mass incarceration: poor communities of color. The effect of this concentration is a mutually reinforcing relationship between incarceration and poor health outcomes. This Subpart will argue that the concentration of the effects of inadequate prison health care in poor communities of

⁶⁶ See ELIZABETH GAYNES, *THE ANNIE E. CASEY FOUND., REENTRY: HELPING FORMER PRISONERS RETURN TO COMMUNITIES* 13–16 (2005) (explaining how incarceration often leads to poverty and homelessness for the prisoner's family, collateral consequences which often continue after release); URBAN INST., *WHEN RELATIVES RETURN: INTERVIEWS WITH FAMILY MEMBERS OF RETURNING PRISONERS IN HOUSTON, TEXAS* 6–8, 12 (2009) (describing how family members of reentering prisoners experienced financial strain and emotional strains as a result of their relatives' reentry); Burkhardt, *supra* note 62, at 1056 (“Thus, any negative extralegal consequences experienced by the offender that result from his or her own incarceration will be amplified upon return to a community that has itself been debilitated by high rates of imprisonment.”); Pinard & Thompson, *supra* note 44, at 595 (outlining how public housing bans have “fractured family structures” and how “[f]amilies who reside in public housing often have had to sign agreements that ex-offender family members not only could not live with them but also would not visit the public housing unit”).

⁶⁷ See Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1024 (2005) (noting the trend of hospitals “clos[ing] or terminat[ing] services in areas populated by minorities, while relocating services to more affluent, predominantly white neighborhoods”).

⁶⁸ See Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239, 248–52 (1994) (“[M]any private [hospitals] have used specific, identifiable tactics to avoid treating poor people of color altogether or limiting their numbers.”); McClellan, *supra* note 63, at 1158 (describing how when a “majority of patients who rely on the hospital are poor, uninsured, and people of color, other potential patients who have private insurance choose other hospitals for their care, thus depriving the urban hospital of a potentially lucrative source of funds that could offset . . . cost[s] of caring for the poor”). Another troubling fact is that the clinics and hospitals where residents have the most responsibility are disproportionately populated by the poor and uninsured, because “people with education and resources insist on the most experienced doctors providing their care.” McClellan, *supra* note 63, at 1154.

color contributes to recidivism rates, which ultimately results in more exposure to poor prison health care, thus locking incarceration and poor health outcomes in a mutually reinforcing dynamic.

Reentering prisoners disproportionately return to poor communities of color.⁶⁹ Indeed, it is important to note just how concentrated the effects of the criminal justice system are. In New York City, for example, “neighborhoods that are home to 18% of the city’s adult population account for more than 50% of prison admissions each year.”⁷⁰ As a result, the effects of poor prison health care and the collateral consequences of incarceration are concentrated in low-income communities of color.

Ultimately, this concentration creates a mutually reinforcing dynamic between poor health outcomes and incarceration. As the previous Subpart discussed, the collateral consequences of incarceration entrench prisoners and their communities in poverty and strain social networks, exacerbating the effects of poor prison health care. However, when collateral consequences are particularly concentrated in a community, as they are in poor communities of color with high rates of incarceration, their effects may become greater than the sum of their parts. For example, not only may reentering individuals have difficulty finding employment but also the whole community may have difficulty finding employment because, as studies have shown, an influx of reentering prisoners in a community tends to drive away business.⁷¹ This loss of employment opportunity further entrenches the community in poverty and puts it at a higher risk of poor health out-

⁶⁹ See Lyles-Chockley, *supra* note 4, at 263 (“Research indicates that the exit and reentry of prison inmates is geographically concentrated in America’s poorest minority neighborhoods.”); Ball, *supra* note 59, at 1893–94 (“Returning prisoners are concentrated in a few states, a few core urban counties within those states, and a few neighborhoods within those counties”) (quoting JEREMY TRAVIS ET AL., URBAN INST. JUSTICE POLICY CTR., FROM PRISON TO HOME: THE DIMENSIONS AND CONSEQUENCES OF PRISONER REENTRY 40–41 (2001), available at www.urban.org/uploadedPDF/ACF1FD.pdf). This is not a coincidence but rather the result of the interaction between patterns of housing segregation that persist into the present day, and criminal justice policies that disproportionately target poor people of color. See Ball, *supra* note 59, at 1895, 1890 (noting how “[n]eighborhoods that were racialized as black, or of color, under de jure segregation were specifically designed to be impoverished, overcrowded, underresourced, and unprotected communities” and were further marginalized by the disappearance of manufacturing jobs); see also Katzen, *supra* note 20, at 230–31 (outlining reasons why Black men are disproportionately incarcerated).

⁷⁰ Justice Mapping Center Launches First National Atlas of Criminal Justice Data, JUST. MAPPING CENTER (Oct. 5, 2010), <http://www.justicemapping.org/archive/category/news/>.

⁷¹ See Brisman, *supra* note 59, at 430 (discussing the negative economic impacts of high rates of incarceration on communities); Lyles-Chockley, *supra* note 4, at 273 (describing employers’ tendency to locate away from urban areas); Pinard & Thompson, *supra* note 44, at 594 (noting that high rates of incarceration impact communities through the “loss of young men who are potential wage earners”). This is particularly problematic given that

comes. Additionally, just as each reentering individual bears the stigma of a criminal record, the entire community may come to bear a stigma of being “dangerous,”⁷² which is intertwined with the community’s experience of racism.⁷³ The compounded effects of the stigma of incarceration and the stigma attached to being simply a poor and minority community can negatively affect health outcomes.⁷⁴ Eventually, the combined effects of poor prison health care and collateral consequences of incarceration become so strong that incarceration and poor health outcomes become locked in a mutually reinforcing relationship. Poor health outcomes for reentering prisoners increase their risk of recidivism, particularly for prisoners with mental illness and substance abuse disorders.⁷⁵ Recidivism leads to more incarceration, which in turn leads to more negative health outcomes, exacerbating already existing racial disparities in health and incarceration.⁷⁶

many areas to which reentering prisoners return may already be lacking in economic opportunity in the first place.

⁷² See Lyles-Chockley, *supra* note 4, at 270 (noting how incarceration stigmatizes families as “social failures” and communities as “not . . . good place[s] to live or conduct business”); see also Pinar & Thompson, *supra* note 44, at 599–601 (discussing the particular effects of stigma on women with criminal records).

⁷³ Because “[r]ace is strongly associated with deviance, particularly sexual depravity, economic irresponsibility, and lawbreaking,” even innocent minority youth “bear a stigma that connects them with criminality.” Regina Austin, “*The Shame of It All*: Stigma and the Political Disenfranchisement of Formerly Convicted and Incarcerated Persons,” 36 COLUM. HUM. RTS. L. REV. 173, 178 (2004). When the communities that are deemed not worthy because of their high incarceration rates are also the communities that have been subject to “heightened scrutiny” by the police, it becomes impossible to separate the stigma of incarceration from the stigma of race. *Id.* Each reinforces the other.

⁷⁴ See *id.* at 175 (describing how stigmas produce “significant social and psychological effects”).

⁷⁵ See Levesque, *supra* note 8, at 726 (“Without access to housing, income, necessary mental health care or safety net programs, the mentally ill former inmate will almost certainly be re-incarcerated, typically within the first six months following release.”).

⁷⁶ Poor communities of color already suffer from high levels of disparity in health and incarceration. See ALEXANDER, *supra* note 3 (describing mass incarceration as the “new Jim Crow”); Katzen, *supra* note 20, at 225–27 (explaining racial health disparities and listing transportation, neighborhood conditions, and air quality among potential explanations). Racial health disparities exist even when taking into account socioeconomic status and genetics. *Id.* at 225–27. Indeed, one scholar argues that studies should *not* control for socioeconomic status when studying racial health disparities. Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 745 (2005) (arguing that researchers should not control for socioeconomic factors to “determine if any residual impact of race remains” because given that people of color suffer socioeconomic disparities, “[i]f race (or racism) is *prior* or *antecedent*, then all of these [socioeconomic status] variables are co-morbidities or simultaneous symptoms rather than confounding variables” (emphasis in original)). Although the health crisis is highly racialized both in its causes and its impact, scholars writing about racial health disparities have not explicitly connected them to prison health care and vice versa. Compare M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95 (2001) (discussing racial health disparities in the provision of medical care),

II

FALLING SHORT: HOW CURRENT EIGHTH AMENDMENT
DOCTRINE FAILS TO SUFFICIENTLY REGULATE
PRISON HEALTH CARE

The health crisis presented in Part I has many different potential points of intervention. For instance, decreasing mass incarceration or decreasing the collateral consequences of a criminal record would mitigate the effects of the health crisis. Yet one of the most salient points of intervention is the prison health care system itself. Improving the prison health care system, particularly as it relates to discharge planning, could alleviate many of the effects of the health crisis for reentering prisoners and their communities. The Eighth Amendment's prohibition on cruel and unusual punishment has already been specifically interpreted to regulate health care in prison. This Part will describe the doctrinal framework for the application of the Eighth Amendment to prison health care, and explain how the doctrine in its current state has not been helpful in addressing the inadequacies of prison health care.

A. The Eighth Amendment and Prison Health Care

The Eighth Amendment of the United States Constitution prohibits cruel and unusual punishment.⁷⁷ Beginning in 1976 with *Estelle v. Gamble*,⁷⁸ the Supreme Court has interpreted this prohibition to require that prisons provide a minimum amount of health care for prisoners. In *Gamble*, a prisoner injured his back after a work assignment and alleged that the prison's treatment of the injury violated the Eighth Amendment. The Court reasoned that once the State has denied prisoners of their liberty and thus their ability to access health care for themselves, denying prisoners access to health care may subject them to cruel and unusual punishment.⁷⁹ Justice Marshall wrote: "An inmate must rely on prison authorities to treat his medical needs;

Engelman Lado, *supra* note 68, at 240–52 (examining racial health disparities), and Yearby, *supra* note 54, at 84 (examining the structural racial bias of managed care), with Jacobi, *supra* note 4, at 448–49 (arguing that poor prison health care impacts communities and that the reentry movement could be a catalyst for improving prison health care), and Levesque, *supra* note 8, at 713–26 (examining the revolving door problem of mental illness and the criminal justice system, and suggesting increased enrollment in Medicaid as one solution). However, the health crisis brought about by poor prison health care only adds fuel to the fire. Thus, it is all the more urgent that a remedy be brought to bear on the health crisis.

⁷⁷ U.S. CONST. amend. VIII. ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.")

⁷⁸ 429 U.S. 97 (1976).

⁷⁹ *Id.* at 103.

if the authorities fail to do so, those needs will not be met.”⁸⁰ However, the Court did not hold that all failures to provide medical care constitute a violation of the Eighth Amendment. In fact, the Court explicitly held that medical negligence alone did not violate the Eighth Amendment: “[A] complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.”⁸¹ Instead, the Court established a higher standard for determining when inadequate medical care violates the Eighth Amendment. Justice Marshall wrote that in order to establish a cognizable claim, a “prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”⁸² *Gamble* was a landmark case in that it established a constitutional right to some level of provision of health care for prisoners. However, it also left unclear exactly when inadequate medical care would violate the Eighth Amendment. Later cases further elucidated the test.

The *Gamble* test can be divided into two prongs: “deliberate indifference” and “serious medical need.” In *Wilson v. Seiter*,⁸³ the Supreme Court held that the deliberate indifference standard applies to all cases challenging conditions of confinement and defined acting with “deliberate indifference” as acting with a “sufficiently culpable state of mind.”⁸⁴ In *Farmer v. Brennan*, the Supreme Court further clarified the meaning of the term.⁸⁵ The petitioner argued that deliberate indifference was based on the objective standard for civil suits, but the Supreme Court rejected that argument.⁸⁶ The Court instead held that in order for a prison official to be held liable under the Eighth Amendment for inhumane conditions of confinement, the “official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.”⁸⁷

⁸⁰ *Id.*

⁸¹ *Id.* at 106.

⁸² *Id.*

⁸³ 501 U.S. 294 (1991).

⁸⁴ *Id.* at 298.

⁸⁵ 511 U.S. 825 (1994). *Farmer* was a conditions of confinement case that did not involve inadequate medical care. However, its treatment of the “deliberate indifference” standard is still relevant to cases that involve medical care because, after *Wilson*, all conditions of confinement cases use the “deliberate indifference” standard.

⁸⁶ *Id.* at 837.

⁸⁷ *Id.*

Later cases have also clarified what constitutes a serious medical need. Though the Court did not clearly define the term in *Gamble*, it did provide some guidance. After reasoning that prisons were responsible for providing medical care because prisoners could not get care on their own, Justice Marshall wrote, "In the worst cases, such a failure [to provide medical care] may actually produce physical 'torture or a lingering death,' In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose."⁸⁸ This suggests either that all cases in that range represent serious medical needs or that serious medical need falls somewhere in that range. In *Helling v. McKinney*, the Supreme Court clarified that for a serious medical need to exist, serious harm need not have actually occurred, but rather there must be at least "an unreasonable risk of serious damage to [the prisoners'] future health."⁸⁹

Lower courts have also given more specific definitions to the term. In 1977, the U.S. District Court for the District of New Hampshire defined a serious medical need as "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."⁹⁰ This definition has been adopted by the First, Third, Tenth, and Eleventh Circuits.⁹¹ The Ninth Circuit defined serious medical need as "[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain"⁹² The Second Circuit relied on a multifactor test in *Brock v. Wright*:

There is no settled, precise metric to guide a court in its estimation of the seriousness of a prisoner's medical condition. In many cases, however, we have set forth factors that should guide the analysis.

⁸⁸ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (citing *In re Kemmler*, 136 U.S. 436, 447 (1890)).

⁸⁹ 509 U.S. 25, 35 (1993) (holding that an inmate's exposure to secondhand smoke constituted a serious medical need to which prison officials were deliberately indifferent).

⁹⁰ *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D.N.H. 1977).

⁹¹ See *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990) ("A medical need is 'serious' if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." (citing *Laaman*, 437 F. Supp. at 311)); *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) (same); *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980) (same); *Hill v. Dekalb Reg'l Youth Det. Ctr.*, 40 F.3d 1176, 1187 (11th Cir. 1994) (same).

⁹² *McGuckin v. Smith*, 974 F.2d 1050, 1059–60 (9th Cir. 1992), *overruled on other grounds by* *WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997).

Thus, in *Chance v. Armstrong*, we referred to a non-exhaustive list of such factors, including: (1) whether a reasonable doctor or patient would perceive the medical need in question as “important and worthy of comment or treatment,” (2) whether the medical condition significantly affects daily activities, and (3) “the existence of chronic and substantial pain.”⁹³

The Supreme Court has also stated that the serious medical need standard can change over time. Indeed, it must be evaluated in the context of evolving “standards of decency”: As Justice O’Connor wrote in *Hudson v. McMillian*,⁹⁴ “[t]he objective component of an Eighth Amendment claim is therefore contextual and responsive to ‘contemporary standards of decency.’”⁹⁵ For this reason, courts now consider serious mental health needs to be on par with serious physical health needs.⁹⁶ Case law has further clarified that a serious medical need does not need to be life threatening, and may include “basic mental health care needs or a broken hand.”⁹⁷ In holding that an untreated cavity was a serious medical need, the Second Circuit stated that “[a] serious medical condition exists where ‘the failure to treat a prisoner’s condition could result in further significant injury or the unnecessary and wanton infliction of pain.’”⁹⁸

While on its face the deliberate indifference to a serious medical need standard may seem to provide sufficient protection against poor prison health care, the next section will show that the standard has fallen short in practice.

B. Setting the Bar Low: How the Eighth Amendment Fails to Sufficiently Regulate Prison Health Care

In its current state, Eighth Amendment doctrine is inadequate to address the health crisis for reentering prisoners and their communities because the deliberate indifference and serious medical need requirements protect prisoners from only a narrow range of conduct. Under the deliberate indifference prong, negligent and even grossly

⁹³ Brock v. Wright, 315 F.3d 158, 162 (2d Cir. 2003) (quoting *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998)).

⁹⁴ 503 U.S. 1 (1992).

⁹⁵ *Id.* at 8 (quoting *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)).

⁹⁶ See, e.g., *Gates v. Cook*, 376 F.3d 323, 343 (5th Cir. 2004) (“In analyzing this argument, it is important to remember that mental health needs are no less serious than physical needs.”).

⁹⁷ See Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 939–40 (1992) (citing *Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986) (mental health); *Robinson v. Moreland*, 655 F.2d 887, 890 (8th Cir. 1981) (broken hand)).

⁹⁸ *Harrison v. Barkley*, 219 F.3d 132, 136 (2d Cir. 2000) (quoting *Chance*, 143 F.3d at 702).

negligent care automatically escapes constitutional scrutiny, and even actual deliberately indifferent conduct sometimes escapes constitutional scrutiny because it is too difficult for prisoners to prove in practice.⁹⁹ Additionally, the serious medical need prong fails to account for all the effects of the current health crisis,¹⁰⁰ thus ensuring that the current doctrine falls short on both prongs.

The first problem with the deliberate indifference standard is that it automatically excludes negligent—and even grossly negligent—care from constitutional consideration.¹⁰¹ It is also important to realize that in practice, the deliberate indifference standard does not even reach all deliberately indifferent conduct. First, it is extremely difficult, as a practical matter, for prisoners to prove that prison officials acted with deliberate indifference.¹⁰² As Justice White wrote in his concurrence in *Wilson v. Seiter*, “[i]nhumane prison conditions often are the result of cumulative actions and inactions by numerous officials inside and outside a prison, sometimes over a long period of time. In those circumstances, it is far from clear whose intent should be examined”¹⁰³

Second, since prison officials are frequently motivated by security concerns, it is difficult to isolate when a prison official has acted with a motivation of deliberate indifference. Court rulings that the subjective prong depends not on the conduct’s effect on the prisoner, but instead on the constraints faced by the prison official, exacerbate this issue.¹⁰⁴ Indeed, prison officials may even take advantage of this evidentiary

⁹⁹ See Burris, *supra* note 26, at 321–27 (discussing barriers to effective litigation of prison health care cases including a narrowly applied constitutional standard, poor facts, and poor lawyering).

¹⁰⁰ See *supra* Part I.A (discussing the health crisis faced by reentering prisoners and their communities as a result of inadequate prison health care).

¹⁰¹ The *Gamble* majority’s decision to explicitly hold that negligent care could not be a constitutional violation spurred a protest by Justice Stevens. In his dissent, Stevens argued that “whether the constitutional standard has been violated should turn on the character of the punishment rather than the motivation of the individual who inflicted it.” *Estelle v. Gamble*, 429 U.S. 97, 116 (1967) (Stevens, J., dissenting).

¹⁰² See Powley et al., *supra* note 97, at 947 (“As a practical matter, it is virtually impossible for inmate plaintiffs to prove the intent of prison officials or medical personnel.”).

¹⁰³ *Wilson v. Seiter*, 501 U.S. 294, 310 (1991) (White, J., concurring). A claim may come down to credibility: Will the court believe what the prisoner argues was the motivation of the prison official, or will the court believe the prison official? Prison health care litigation suffers from a bias towards institutional players—a bias that reflects a deep-seated notion that prisoners are “supposed to lose” to their jailers. Burris, *supra* note 26, at 326. Class and race bias factor in as well. See *id.* (“The impact of class, race and AIDS stigma on litigation outcomes is now being documented, and is reflected particularly in inmate cases.”).

¹⁰⁴ See *Wilson*, 501 U.S. at 303 (stating that whether conduct is “wanton” depends not on the effect on the prisoner but on the “constraints facing the official”).

difficulty.¹⁰⁵ The unique nature of the prison environment allows prison officials to justify inadequate care as motivated by something other than indifference: “[T]he exigencies of prison life enable corrections officers to attribute their actions to the unique safety concerns associated with prisons, rather than a disregard for prisoners’ needs.”¹⁰⁶

Furthermore, whenever prison officials’ motivations are not clear, federal courts are likely to find that they were not motivated by deliberate indifference, because federal courts have a long history of deferring to the discretion of prison officials.¹⁰⁷ Indeed, even failing to provide treatment for cost reasons may be deemed an acceptable defense to a deliberate indifference claim. Some courts have found that cost considerations cannot be a justification for failure to provide treatment;¹⁰⁸ however, the Supreme Court has not ruled out the possibility that costs could be a factor.¹⁰⁹

Third, and finally, deliberate indifference is difficult to prove because as long as some type of medical treatment was provided, courts have been reluctant to determine that the treatment constituted deliberate indifference to a serious medical need.¹¹⁰ If medical treat-

¹⁰⁵ See Westhoff, *supra* note 4, at 6 (noting that corrections officers can offer evidence regarding their state of mind to avoid liability).

¹⁰⁶ *Id.*

¹⁰⁷ See Burris, *supra* note 26, at 324 (stating that there is a “general rule or posture of deference” to prison officials that causes courts to “accept patently absurd justifications for practices like isolation” and to “give medical evidence far less weight in prison cases than in cases outside the prison context”).

¹⁰⁸ See, e.g., *Ancata v. Prison Health Servs.*, 769 F.2d 700, 705 (11th Cir. 1985) (finding that inadequate funds cannot justify an unconstitutional lack of medical treatment).

¹⁰⁹ See Brunsdon, *supra* note 36, at 488 & n.146 (citing *Wilson*, 501 U.S. at 302 for the proposition that the Supreme Court has not ruled on the availability of a “cost defense”).

¹¹⁰ Why has the Court interpreted the deliberate indifference standard to impose such a high burden of proof? Eighth Amendment scholars have theorized that the Supreme Court was motivated to interpret the deliberate indifference standard as a high bar to keep at bay what it saw as a possibly endless tide of litigation from prisoners. See Herbert A. Eastman, *Draining the Swamp: An Examination of Judicial and Congressional Policies Designed to Limit Prisoner Litigation*, 20 COLUM. HUM. RTS. L. REV. 61 (1988) (describing how the Supreme Court and Congress reacted to the increasing number of prisoner lawsuits during the 1970s by narrowing civil rights doctrine and implementing legislation to restrict remedies for prisoners); Lisa Davie Levinson, *Tenth Circuit Survey: Prisoners’ Rights*, 75 DENV. U. L. REV. 1055, 1060 (1998) (outlining how after the courts were inundated with prisoner complaints in the 1960s and 1970s, “courts began to abandon their commitment to protecting prisoners’ rights in hopes of freeing up the dockets”); cf. Leading Cases, *Eighth Amendment, Cruel and Unusual Punishments Clause—Treatment of Prisoners*, 106 HARV. L. REV. 220, 229 (1992) (arguing that the Court established a heightened standard of review in excessive force cases as a “screening device for the vast number of suits brought by prisoners”). Indeed, Justice Thomas posited as much in *Farmer v. Brennan*, arguing in his concurrence that *Estelle v. Gamble* “transform[ed] federal judges into superintendents of prison conditions nationwide,” and because the Court was “unwilling to accept the full consequences of its decision,” it “resort[ed] to the ‘subjective’ . . . component of post-

ment has been denied or delayed, the mere fact of denial or delay can be used to meet the deliberate indifference standard.¹¹¹ When medical treatment is given promptly but inadequately, however, the line between deliberate indifference and negligence, or “mere” malpractice, gets blurry.¹¹² In such situations, if prison staff make any attempt at care, “no matter how feeble,”¹¹³ then the federal courts are likely to interpret the claim as a negligence claim and thus constitutionally barred under *Gamble*.¹¹⁴

However, as explained above, the deliberate indifference standard is not the only problem with current Eighth Amendment prison health care doctrine. The serious medical need standard is also problematic. The fact that only deliberate indifference to a serious medical need can comprise a constitutional violation automatically excludes many prison health care decisions from constitutional scrutiny. For example, fevers,¹¹⁵ headaches and blurred vision resulting from eye-

Estelle Eighth Amendment analysis in an attempt to contain what might otherwise be unbounded liability” for prison officials under the Eighth Amendment. 511 U.S. 825, 860 (1994) (Thomas, J., concurring); see also Brunsden, *supra* note 36, at 490 (describing how prison health care litigation is limited in its potential for success because “courts are likely hesitant to intervene in disputes about prison healthcare policies because they are not experts in medicine or public health”). If this was the message the Court intended to send, then that message has been received, for many scholars and advocates no longer see the Eighth Amendment as a viable path for addressing poor prison health care. See Burris, *supra* note 26, at 321 (listing as one reason why litigation is unlikely to succeed the fact that “courts generally have been cautious in prescribing measures to deal with communicable diseases in prisons”); Katzen, *supra* note 20, at 242–45 (discussing how litigation is an unlikely route to improve health care because of the deliberate indifference standard and the exhaustion requirements of the Prison Litigation Reform Act).

¹¹¹ See, e.g., *Hoelt v. Menos*, 347 F. App’x 225, 227 (7th Cir. 2009) (finding that “six months of extensive pain from untreated cavities and tooth loss that prevented [an inmate] from properly chewing his food” qualified as a serious medical condition); *Harrison v. Barkley*, 219 F.3d 132, 138 (2d Cir. 2000) (finding that a one year delay in treating a tooth cavity constituted an Eighth Amendment violation).

¹¹² Westhoff, *supra* note 4, at 6.

¹¹³ *Id.*

¹¹⁴ In *Williams v. Vincent*, the Second Circuit held that prison staff behaved with deliberate indifference when a prisoner lost his ear in a fight and the staff did not attempt to reattach the ear but merely stitched the stump together. 508 F.2d 541, 544 (2d Cir. 1974). In coming to this conclusion, the court relied on the fact that “Williams was told simply that ‘he did not need his ear’ by doctors who then threw the severed portion away in front of him,” and also on the fact that doctors did not even try to stitch Williams’s ear back to his head. *Id.*; see also *Hathaway v. Coughlin*, 99 F.3d 550, 553 (2d Cir. 1996) (finding that medical malpractice may constitute deliberate indifference when it involves “culpable recklessness”); *West v. Keve*, 571 F.2d 158, 162 (3d Cir. 1978) (“If ‘deliberate indifference caused an easier and less efficacious treatment’ to be provided, the defendants have violated the plaintiff’s Eighth Amendment rights by failing to provide adequate medical care.” (quoting *Williams*, 508 F.2d at 544)).

¹¹⁵ See *Gibson v. McEvers*, 631 F.2d 95, 98 (7th Cir. 1980) (finding that a cold does not constitute a serious medical need under the Eighth Amendment).

glasses with incorrect prescriptions,¹¹⁶ and tinnitus¹¹⁷ have all been held not to be serious medical needs. In *Roe v. Crawford*, the Eighth Circuit held that the need for an “elective, non-therapeutic abortion” is not a serious medical need.¹¹⁸ The definition of serious medical need has, however, evolved over time to include medical practices such as hormone treatments.¹¹⁹ Indeed, “courts have shown a willingness to look outside ‘traditional’ models of illness in defining medical needs,”¹²⁰ protecting the rights of transgendered people undergoing transitional surgery, for example, and mandating protections for prisoners prone to suicidal ideation and self-harm.¹²¹

However, the fact that serious medical need is tied to evolving standards of decency can also limit the term’s definition. For instance, there is a strong societal consensus that prisoners should not be better off than non-prisoners when it comes to access to health care. “There is a common perception that society’s criminals should not be treated more favorably than this country’s worst-off noncriminals,” and because “[s]ubstantial segments of the American population receive either inadequate medical treatment or no treatment at all,” the seemingly inevitable conclusion is that prisoners may be overprotected by the Eighth Amendment if it is held to protect all of their medical needs.¹²² When it comes to evolving standards of decency for health care, prisoners’ fates are linked to the fates of non-prisoners.¹²³

The Eighth Amendment cannot be a useful vehicle for mitigating the health crisis caused by poor prison health care unless the understanding of the Eighth Amendment doctrine dictating what care is constitutionally required changes. The deliberate indifference standard is entrenched, but as the previous section has discussed, what

¹¹⁶ See *Davidson v. Scully*, 155 F. Supp. 2d 77, 89 (S.D.N.Y. 2001) (“Plaintiff’s blurry vision, headaches, and tearing are not conditions that produce degeneration or extreme pain and are not a sufficiently serious condition under the Eighth Amendment.”).

¹¹⁷ See *id.* at 84 (finding that tinnitus is not a serious medical need under the Eighth Amendment).

¹¹⁸ 514 F.3d 789, 801 (8th Cir. 2008). The Eighth Circuit did find that the prison policy of prohibiting the transportation of inmates offsite for elective abortions violated the due process clause of the Fourteenth Amendment. *Id.* at 794–98, 801.

¹¹⁹ See *Phillips v. Dept. of Corr.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), *aff’d*, 932 F.2d 969 (6th Cir. 1991) (reprimanding a prison for withholding a prisoner’s hormone treatment).

¹²⁰ Lebowitz, *supra* note 38, at 297.

¹²¹ See *id.* at 297–98 (describing various court actions protecting the rights of transsexual prisoners and mandating protection from prisoners prone to self-harm and suicidal ideation).

¹²² Powley et al., *supra* note 97, at 935.

¹²³ See *infra* notes 145–53 and accompanying text (arguing that Eighth Amendment prison health care doctrine has started with the assumption that access to health care for prisoners should be inferior to access to health care for the general public).

constitutes a serious medical need is contextual and responsive to evolving standards of decency. The next Part will address how the ACA represents a change in evolving standards of decency—a change that has significant ramifications for the definition of serious medical need and the reach of Eighth Amendment doctrine.

III

INTERPRETING THE EIGHTH AMENDMENT AFTER THE AFFORDABLE CARE ACT

The ACA presents an opportunity to strengthen Eighth Amendment prison health care doctrine so that it can better address the health care crisis for reentering prisoners and their communities. The ACA is not usually associated with prisoners. The many debates that its passage triggered across the country centered around almost every kind of controversy but prison health care: Rationing,¹²⁴ death panels,¹²⁵ and socialism¹²⁶ were the headlines in the summer of 2009, but prisoners were not mentioned. However, the ACA does affect prisoners because in states that opt into its Medicaid expansion component¹²⁷ it is estimated that approximately one third of prisoners will be eligible for Medicaid,¹²⁸ with some estimates placing this number even higher.¹²⁹ The ACA also represents a sea change in Eighth

¹²⁴ See David Leonhardt, *Health Care Rationing Rhetoric Overlooks Reality*, N.Y. TIMES, June 17, 2009, <http://www.nytimes.com/2009/06/17/business/economy/17leonhardt.html> (discussing rationing rhetoric, and arguing that rationing already exists in the U.S. health care system).

¹²⁵ See Jim Rutenberg & Jackie Calmes, *False 'Death Panel' Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 13, 2009, <http://www.nytimes.com/2009/08/14/health/policy/14panel.html> (discussing rumors that health care reform would include “death panels” to “decide which patients were worthy of living”).

¹²⁶ See Emily Friedman, *Health Care Stirs Up Whole Foods CEO John Mackey, Customers Boycott Organic Grocery Store*, ABC NEWS (Aug. 14, 2009), <http://abcnews.go.com/Business/story?id=8322658&page=1#.UW3ppY5kIgY> (discussing Whole Foods CEO John Mackey’s criticism of health care reform as socialist, and the subsequent backlash).

¹²⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (expanding Medicaid coverage for individuals under sixty-five who are at or below 133% of the federal poverty line and who have resided lawfully in the United States for the last five years and are not eligible for Medicare), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 19, 20, 26, and 42 U.S.C.). If all states were to adopt the Medicaid expansion, seventeen million low-income people would become insured. JANUARY ANGELES, CTR. ON BUDGET & POLICY PRIORITIES, *HOW HEALTH REFORM’S MEDICAID EXPANSION WILL IMPACT STATE BUDGETS 2* (2012).

¹²⁸ BARBARA DIPIETRO, *NAT’L HEALTH CARE FOR THE HOMELESS COUNCIL, MEDICAID EXPANSION & CRIMINAL JUSTICE-INVOLVED POPULATIONS 4* (2013), *available at* <http://www.nhchc.org/wp-content/uploads/2011/10/NHCHC-MedicaidExpansion-Justice-Final.pdf>.

¹²⁹ See ANDREA A. BAINBRIDGE, *BUREAU OF JUSTICE ASSISTANCE, THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE: INTERSECTIONS AND IMPLICATIONS 6* (2012)

Amendment prison health care doctrine for prisoners across all states because it represents an evolution in evolving standards of decency. Prior to the ACA, evolving standards of decency did not require that prisoners have unfettered access to health care, in part because society did not expect anyone—prisoners or free people—to have unfettered access to health care.¹³⁰ The ACA changes this calculus: By mandating that every person enroll in a health insurance plan¹³¹ and by expanding Medicaid to make this possible,¹³² the ACA establishes a new order where access to health care is vastly improved. The ACA therefore changes the baseline against which prisoners' access to care is compared. The result must be an evolution in society's expectations of what prisoners should be entitled to in terms of access to care—an evolution in evolving standards of decency.

Subpart III.A first explains how the ACA signals an evolution in evolving standards of decency. To illustrate how this change would manifest, this Subpart uses an example of the enrollment of sick, Medicaid-eligible prisoners in Medicaid before they are released. Subpart III.B argues that following enactment of the ACA, lack of insurance for sick prisoners constitutes a serious medical need. The failure to enroll sick, Medicaid-eligible prisoners in Medicaid prior to their release therefore violates the Eighth Amendment. Subpart III.C will address counterarguments to this proposal.

A. *The ACA and Evolving Standards of Decency*

The ACA's mandate that every person enroll in a health insurance plan,¹³³ together with its Medicaid expansion component,¹³⁴ represents a step forward in the evolving standards of decency that guide

(explaining that state or local estimates of the percentage of the criminal justice-involved population that will be newly eligible for Medicaid may be as high as sixty and eighty percent); cf. Guy Gugliotta, *Medicaid Expansion to Cover Many Former Prisoners*, KAISER HEALTH NEWS (Dec. 4, 2013), <http://www.kaiserhealthnews.org/stories/2013/december/04/medicaid-to-cover-former-prisoners.aspx> (citing Department of Justice estimates that thirty-five percent of people who will qualify for Medicaid coverage in states opting into the Medicaid expansion will be former inmates and detainees). Research has shown that the majority of people with criminal records are low-income, and thereby more likely to qualify for Medicaid. Kathleen F. Donovan, *No Hope for Redemption: The False Choice Between Safety and Justice in Hope VI Ex-Offender Admissions Policies*, 3 DEPAUL J. FOR SOC. JUST. 173, 193 (2010).

¹³⁰ See *Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (discussing how certain deprivations and certain medical needs are part of the “routine discomfort” of incarceration).

¹³¹ See Patient Protection and Affordable Care Act § 1501(b) (codified as amended 26 U.S.C. § 5000A) (requiring that certain individuals and their dependents maintain “minimum essential [health insurance] coverage”).

¹³² *Id.* § 2001.

¹³³ See *supra* note 131 and accompanying text (noting that the ACA requires that applicable individuals and their dependents maintain health insurance).

the Eighth Amendment doctrine discussed in Part II. This Subpart will first provide an overview of the ACA. Next, it will argue that the ACA creates a change in evolving standards of decency for prison health care that the Eighth Amendment should recognize as legally enforceable.

The ACA is an enormous piece of legislation that has dramatic effects on health care access. The ACA aims to “provide affordable, quality health care for all Americans”¹³⁵ by reforming a health care system that is “the world’s most expensive” and “not readily accessible to millions.”¹³⁶ Specifically, the ACA seeks to provide coverage for the uninsured through (1) health insurance exchanges that will act as regulated health insurance marketplaces for uninsured people with incomes between 133% and 400% of the federal poverty line,¹³⁷ (2) the expansion of Medicaid coverage to all individuals under age sixty-five with incomes below 133% of the federal poverty level,¹³⁸ and (3) a mandate of outreach¹³⁹ to underserved populations that “specifically requires states to conduct targeted outreach to facilitate the enrollment of underserved populations in Medicaid.”¹⁴⁰ The Medicaid expansion is not required, but states can opt in, and the federal government will cover 100% of the costs of insuring the newly eligible population from 2014 to 2016, and a decreasing amount of the costs each year after 2016.¹⁴¹

¹³⁴ Patient Protection and Affordable Care Act § 2001 (expanding Medicaid coverage for individuals under sixty-five at or below 133% of the federal poverty line who have resided lawfully in the United States for the last five years and are not eligible for Medicare).

¹³⁵ H.R. REP. NO. 111-299, pt. 3, at 1 (2009).

¹³⁶ H.R. REP. NO. 111-443, at 1 (2010).

¹³⁷ See Patient Protection and Affordable Care Act § 1311 (establishing funding and standards for health insurance exchanges). Health care exchanges are required to inform individuals of the eligibility requirements for Medicaid, facilitate enrollment in Medicaid for eligible individuals who approach the exchanges, and coordinate enrollment with local Medicaid agencies. *Id.* The exchanges are also required to facilitate eligibility determination for tax credits and cost-sharing assistance available under section 1401 of the Act. *Id.* §§ 1311, 1401. The regulations governing the exchanges are still being formulated, and therefore further detail is beyond the scope of this Note.

¹³⁸ *Supra* note 134.

¹³⁹ See Patient Protection and Affordable Care Act § 2201 (requiring enrollment simplification and outreach as a condition of federal financial assistance). Courts have not yet found that the ACA creates an individually enforceable cause of action. This makes it unlike Medicaid, where there is a history of courts implying an individual cause of action under 42 U.S.C. § 1983 (1996). Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1502 (2008) (“[I]ndividual [Medicaid] beneficiaries seeking to force states to abide by federal Medicaid requirements historically have turned to 42 U.S.C. § 1983.”).

¹⁴⁰ SUSAN D. PHILLIPS, THE SENTENCING PROJECT, THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PUBLIC SAFETY AND CORRECTIONS POPULATIONS 4 (2012).

¹⁴¹ *Id.* at 2.

Eighth Amendment doctrine has been tied to evolving standards of decency since the Supreme Court coined the term in *Trop v. Dulles*.¹⁴² Evolving standards of decency can be seen as an Eighth Amendment value that is repeatedly drawn on throughout the case law. In *Rhodes v. Chapman*, the Court explicitly stated that there is no static test for when conditions of confinement violate the Eighth Amendment, but rather the test must draw on “evolving standards of decency.”¹⁴³ In the death penalty context, the Court has drawn on evolving standards of decency to progressively restrict application of capital punishment. In *Roper v. Simmons*, the Supreme Court struck down the juvenile death penalty as a violation of evolving standards of decency after reviewing “objective indicia of consensus, as expressed in particular by the enactments of legislatures that have addressed the question,”¹⁴⁴ which included “the rejection of the juvenile death penalty in the majority of States; the infrequency of its use even where it remains on the books; and the consistency in the trend toward abolition of the practice.”¹⁴⁵

In the prison health care context, evolving standards of decency influence the question of what is a serious medical need. As previously discussed, evolving standards of decency can lead the definition of serious medical need to change over time.¹⁴⁶ In *Helling v. McKinney*, for example, the Supreme Court found that an evaluation of current public attitudes was a critical factor in determining whether exposure to second-hand smoke constituted a serious medical need.¹⁴⁷ However, progress for the standard has been limited by public outrage over prisoners’ receipt of better access to health care than the general public.¹⁴⁸ While the Supreme Court’s decisions are not ruled by pop-

¹⁴² 356 U.S. 86, 101 (1958) (“The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”).

¹⁴³ 452 U.S. 337, 346 (1981) (quoting *Trop*, 356 U.S. at 101) (internal quotation marks omitted).

¹⁴⁴ 543 U.S. 551, 552 (2005).

¹⁴⁵ *Id.*

¹⁴⁶ See *supra* Subpart II.A.

¹⁴⁷ 509 U.S. 25, 36 (1993). In the case below, the Ninth Circuit relied on the fact that “smoking is banned on all domestic airline flights, except flights to and from Alaska and Hawaii” and that over “eighty cities and counties have enacted smoking laws” to come to the conclusion that “society sees a need to protect non-smokers from involuntary exposure.” *McKinney v. Anderson*, 924 F.2d 1500, 1508–09 (9th Cir.), *vacated*, 502 U.S. 903 (1991).

¹⁴⁸ See, e.g., Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME & JUST. 427, 472 (1998) (asserting that the public will not support improved prison health care especially in an “increasingly expensive health care market, in which restrictions on access are becoming tighter”); Michael Daly, *California Inmates Get Better Health Care than Ordinary Citizens*, DAILY BEAST (Apr. 10, 2012), <http://www.thedailybeast.com/articles/2012/04/10/california-inmates-get-better-health-care-than-regular-citizens.html> (“[T]he people

ular opinion, social expectations have repeatedly influenced the Court's analysis of what constitutes a serious medical need. For instance, in *Hudson v. McMillian*, Justice O'Connor stated that the objective prong of an Eighth Amendment claim is always "contextual and responsive to 'contemporary standards of decency.'"¹⁴⁹ Regarding medical needs specifically, she wrote, "[b]ecause society does not expect that prisoners will have unqualified access to health care, deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are 'serious.'"¹⁵⁰ Justice O'Connor made this statement in the context of comparing different types of Eighth Amendment claims. She wrote that medical needs claims are similar to conditions of confinement claims in that, for the latter, deprivations must also be extreme because "routine discomfort is 'part of the penalty that criminal offenders pay for their offenses against society.'"¹⁵¹ In other words, just as prisoners must not be protected from any kind of deprivation—because they must pay a price as prisoners—prisoners also must not receive unqualified access to health care. The implication of the comparison is that prisoners must be treated, in the conditions of confinement and medical needs contexts, as inferior to non-prisoners as part of their punishment. Giving prisoners unqualified access to care would violate this rule when non-prisoners do not have unqualified access to care.

This logic appears in lower federal court opinions as well. In *Maggert v. Hanks*, Judge Posner wrote that "a prison is not required by the Eighth Amendment to give a prisoner medical care that is as good as he would receive if he were a free person, let alone an *affluent* free person."¹⁵² The health care status of non-prisoners is thus the yardstick against which the health care status of prisoners is measured: If a prisoner would be treated better than a non-prisoner by holding a particular need to be a serious medical need, then that need cannot be deemed a serious medical need.¹⁵³ As another lower court stated, "It

of . . . California need only get convicted of a serious crime . . . as a sure way to get adequate health care."); Bryan Robinson, *Death-Row Inmate Seeks Organ Transplant*, ABC NEWS, <http://abcnews.go.com/US/story?id=90611&page=1#.UU-0oo5kIgY> (last visited Mar. 17, 2014) ("Thanks to the state of Oregon, a law-abiding citizen in need of a kidney transplant may have to die so that [a] death-row prisoner . . . can live.").

¹⁴⁹ 503 U.S. 1, 8 (1992) (quoting *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)).

¹⁵⁰ *Id.* at 9 (quoting *Gamble*, 429 U.S. at 103–04).

¹⁵¹ *Id.* (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)).

¹⁵² 131 F.3d 670, 671 (7th Cir. 1997) (emphasis added).

¹⁵³ Lebowitz, *supra* note 38, at 295 ("Ailments that constitute a 'serious' harm to a free person may not always be 'serious' in the eyes of the law when that same affliction befalls a prisoner.").

is not required that the medical care provided to a prisoner be perfect, the best obtainable, or even very good.”¹⁵⁴

The ACA has an impact on evolving standards of decency with respect to the definition of serious medical need because it changes the yardstick against which standards for prisoners are measured. Although the ACA does not establish a “right” to health care, its mandate has the potential to have a substantially similar effect in terms of changing social expectations about access to care. Regardless of whether or not individuals would otherwise choose to be insured, the ACA now mandates that they maintain health insurance.¹⁵⁵ For many individuals, that insurance will now be subsidized and must provide “essential health benefits.”¹⁵⁶ Health insurance plans will also be required to report on steps they are taking to improve quality of care.¹⁵⁷ The mandate changes social expectations around health care in both states that opt into the Medicaid expansion and states that do not, because in both categories the mandate applies to the same extent. The only difference between states that opt in and states that do not is the source of health insurance; in both categories of states, people will be required to enroll in insurance plans.¹⁵⁸

The ACA also affects the evolving standards of decency analysis with respect to the serious medical need prong by redefining access to health care as something that benefits the health of the collective as well as the health of the individual. The ACA’s mandate was motivated by the belief that requiring everyone to be insured will improve health outcomes for everyone. This motivation is reflected in President Obama’s February 2010 proposal for amendments to the Senate Health Care Reform Bill: “All Americans should have affordable health insurance coverage. This helps everyone, both insured and uninsured, by reducing cost shifting, where people with insurance end up covering the inevitable health care costs of the uninsured”¹⁵⁹ Other early incarnations of health care reform reflected the same concern. For example, the Senate Finance Committee’s report on the

¹⁵⁴ *Brown v. Beck*, 481 F. Supp. 723, 726 (S.D. Ga. 1980).

¹⁵⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 242 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in 42 U.S.C. § 18091 (2010)).

¹⁵⁶ *Id.* § 1302; *see also* PHILLIPS, *supra* note 140, at 1 (stating that under the ACA “prevention, early intervention, and treatment of mental health problems and substance abuse disorders will be considered essential health benefits”).

¹⁵⁷ Patient Protection and Affordable Care Act § 1311.

¹⁵⁸ *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (upholding the individual mandate as a tax within Congress’s taxing powers).

¹⁵⁹ THE PRESIDENT’S PROPOSAL (2010), *available at* <http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>.

America's Healthy Future Act of 2009 included the following language:

Hospitals and clinics provide an estimated \$56 billion annually in uncompensated care to people without health insurance, and those with health coverage pay the bill through higher health care costs and increased premiums. This so-called 'hidden health tax' cost the average family over \$1000 in high premiums last year.¹⁶⁰

Because prisoners tend to be high users of health care services, ensuring that prisoners have better access to care—both while they are incarcerated and when they are released through discharge planning—could actually benefit society as a whole. The converse is also true: Providing inadequate care to prisoners negatively affects society as a whole.¹⁶¹ Therefore, after the enactment of the ACA, the logic that prisoners must receive less access to health care than society as a whole, and the resulting norm of underenforcement, is increasingly out of step with evolving standards of decency.

The change of evolving standards of decency represented by the ACA calls into question current Eighth Amendment prison health care doctrine as under-protective of prisoners' access to care. Because addressing all of the implications of the ACA for Eighth Amendment doctrine would be beyond the scope of this Note, the next Subpart will give an example of how Eighth Amendment doctrine should work after the ACA by analyzing the question of whether or not the Eighth Amendment requires prisons to enroll sick, Medicaid-eligible prisoners in Medicaid before they are released.

B. Releasing Sick, Medicaid-Eligible Prisoners Without Enrolling Them in Medicaid Violates the Eighth Amendment

This Subpart will examine one prison health care issue—pre-enrollment in Medicaid for sick prisoners—as an example of how the new conception of serious medical need should be applied after the ACA.¹⁶² It argues that after the ACA, the Eighth Amendment

¹⁶⁰ H.R. REP. NO. 111-89, at 2 (2009).

¹⁶¹ See *supra* Part I.A (discussing how inadequate prison health care negatively affects both reentering prisoners and their communities).

¹⁶² This Subpart focuses on whether or not the lack of pre-enrollment for sick prisoners constitutes a serious medical need, not on the second prong of the analysis, which is whether prison officials would be deliberately indifferent in not pre-enrolling prisoners. Attacking the deliberate indifference prong would likely raise many of the same challenges discussed in Part II. It may be sufficient for plaintiffs to show that prison officials knew that prisoners were eligible to be pre-enrolled in Medicaid, or plaintiffs may be required to show that prison officials knew that a particular prisoner would be harmed if he or she was released without being pre-enrolled. Prison officials may be able to excuse their failure based on the "exigencies" of prison life. See *supra* note 106 and accompanying text (noting that corrections officers can attribute inadequate care to the unique safety concerns of

requires prisons to enroll all sick, Medicaid-eligible prisoners in Medicaid before they are released. Prisons would not be required to actually provide Medicaid benefits, but simply to facilitate enrollment, so that when prisoners are released they have access to Medicaid benefits.¹⁶³ This question is particularly significant in the context of the Medicaid expansion, because in states that opt in, many prisoners will be newly eligible for Medicaid when they are released.¹⁶⁴ Even in states that do not opt in, there will still be prisoners who were eligible for Medicaid before the ACA who would be affected by a ruling that prisons must facilitate enrollment in Medicaid.

Furthermore, this question is significant because improving prison health care discharge planning—specifically through pre-enrollment in Medicaid—would likely have an enormous impact in improving health outcomes for reentering prisoners and their communities.¹⁶⁵ These outcomes would improve because many reentering prisoners are low-income and would otherwise be uninsured and unable to access care upon their release, except through the emergency room.¹⁶⁶

In light of the ACA's effect on evolving standards of decency with respect to prison health care, the lack of health insurance must be considered a serious medical need for prisoners with chronic health conditions, including substance abuse disorders and mental illness. Without insurance, these prisoners are highly unlikely to obtain access to the medication and follow-up care necessary to manage their health

prisons rather than indifference). And, as in other prison health care litigation, plaintiffs may have to show a pattern of failure to pre-enroll, rather than an isolated incident, in order to succeed on their claims. *See id.* (implying a need to show a pattern of violations in order to succeed in prison health care litigation). If the Court does move in the direction of expanding the idea of a serious medical need, then there will be opportunities for prisoners' rights lawyers to test how the deliberate indifference standard would apply.

¹⁶³ Prisons would therefore be responsible for coordinating with Medicaid to facilitate pre-enrollment. It should be noted that the Eighth Amendment does not create any obligation for Medicaid to facilitate pre-enrollment, because Medicaid, unlike prison, does not administer punishment, and the Eighth Amendment only applies to punishment.

¹⁶⁴ *See supra* note 129 and accompanying text (discussing estimates of how many prisoners will be eligible for Medicaid upon release, ranging from one-third to four-fifths).

¹⁶⁵ *See Westhoff, supra* note 4, at 11 (describing the negative impact that the current prison health care system has on the health of both prisoners and their communities).

¹⁶⁶ *See Kamala Mallik-Kane & Christy A. Visher, URBAN INST., HEALTH AND PRISONER REENTRY: HOW PHYSICAL, MENTAL, AND SUBSTANCE ABUSE CONDITIONS SHAPE THE PROCESS OF REINTEGRATION 2* (2008) (noting how the majority of reentering prisoners lacked health insurance and were heavy users of emergency rooms, with one-third reporting emergency room visits within eight to ten months after their release from prison). It is worth noting that pre-enrollment will also ensure that all the benefits of the ACA accrue to reentering prisoners, and consequently to their communities.

conditions.¹⁶⁷ Many reentering individuals are homeless or jobless because of the bars to housing or employment discussed in Part I and therefore are particularly vulnerable and in need of continuous access to health care.¹⁶⁸ However, not only is the lack of insurance likely to put sick reentering prisoners at risk of harm, but release without insurance also places them in an inferior state to the rest of society because, after the ACA, all persons are required to be enrolled in an insurance plan. Additionally, the release of large numbers of sick prisoners without enrollment in Medicaid increases the percentage of the uninsured, in contravention of the ACA's goal of lowering the numbers of uninsured people in order to keep health care costs down and improve health outcomes for all of society.¹⁶⁹

C. Counterarguments

This Subpart will address several counterarguments. First, it will address the argument that prison officials cannot be held responsible for addressing a medical need that would occur after the moment of release. Second, it will address the counterargument that the Eighth Amendment cannot be interpreted to require pre-enrollment since not all states have opted into the Medicaid expansion, and therefore different states would be held to different Eighth Amendment standards based on whether or not they opted in. A third policy counterargument that follows from this is that even if the Eighth Amendment were interpreted as requiring pre-enrollment, such an interpretation would further disincentivize already reluctant states from opting into the Medicaid expansion.¹⁷⁰

The first counterargument is that prison officials are only responsible for prisoners up until the moment of release. However, in two cases, *Wakefield v. Thompson*¹⁷¹ and *Lugo v. Senkowski*,¹⁷² federal courts held that prison officials remain accountable for serious med-

¹⁶⁷ See *supra* notes 16–47 and accompanying text (discussing high rates of illness and inadequate treatment among reentering prisoners).

¹⁶⁸ See *supra* Subpart I.B. (discussing the effect of collateral consequences on health outcomes).

¹⁶⁹ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(a)(2), 124 Stat. 119, 243 (2010) (stating that the individual responsibility requirement, also known as the mandate, will lower health insurance premiums by “significantly reducing the number of the uninsured”), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended at 26 U.S.C. § 5000A (2011)).

¹⁷⁰ Cf. Rick Lyman, *Tennessee Governor Hesitates on Medicaid Expansion, Frustrating Many*, N.Y. TIMES, Nov. 17, 2013, at A16 (describing several of the current political incentives for states to not opt into the Medicare program).

¹⁷¹ 177 F.3d 1160 (9th Cir. 1999).

¹⁷² 114 F. Supp. 2d 111 (N.D.N.Y. 2000).

ical needs past the moment of release. In *Wakefield*, prison officials released an inmate with an organic delusional disorder without any medication supply.¹⁷³ The officials sought to defend themselves by relying on the fact that the Due Process Clause does not generally place an affirmative duty on the state to provide health care,¹⁷⁴ a claim bolstered by holdings like that of *DeShaney v. Winnebago County Department of Social Services*, in which the Supreme Court held that states are only obligated to provide medical and mental health care to persons in physical custody.¹⁷⁵ However, the Ninth Circuit found that the broad principle supported by cases like *DeShaney* was not applicable in this instance.¹⁷⁶ The court instead referred back to the reasoning in *Gamble* that the state must provide medical care for prisoners because by incarcerating them, it has taken away their power to seek medical care for themselves.¹⁷⁷ Following that logic, the court reasoned that prisons cannot be blind to the fact that prisoners do not instantly become able to seek medical care for themselves upon the moment of release, but rather may take days or weeks to access care on their own.¹⁷⁸

In *Lugo*, George Lugo had surgery for kidney stones shortly before his release date and was released with a metal stent in his kidney that needed to be surgically removed shortly after his release.¹⁷⁹ However, prison officials, including his parole officer, provided him no assistance in obtaining the second surgery outside the prison walls.¹⁸⁰ As a result, Lugo was admitted to the hospital in severe pain only five days later.¹⁸¹ Applying the logic of *Wakefield*, the Northern District of New York held that the state “has a duty to provide medical services for an outgoing prisoner who is receiving continuing treatment at the time of his release for the period of time

¹⁷³ 177 F.3d at 1162.

¹⁷⁴ *Id.* at 1163.

¹⁷⁵ 489 U.S. 189, 199–200 (1989). A literal interpretation of this holding would “end[] the state’s obligation to provide care to a prisoner at the moment of that prisoner’s release.” Doug Jones, Comment, *Discharge Planning for Mentally Ill Inmates in New York City Jails: A Critical Evaluation of the Settlement Agreement of Brad H. v. City of New York*, 27 PACE L. REV. 305, 310 (2007). *But see* Fred Cohen, *Correctional Mental Health Law & Policy: A Primer*, 7 UDC/DCSL L. REV. 117, 140–41 (2003) (discussing less literal interpretations of *DeShaney*).

¹⁷⁶ *See Wakefield*, 177 F.3d at 1163 (“Over twenty years ago, however, the Supreme Court recognized a critical exception to this [broader *DeShaney* supported] rule.”).

¹⁷⁷ *Id.* (citing *DeShaney*, 489 U.S. at 198–202).

¹⁷⁸ *See id.* (“[T]he period of time during which prisoners are unable to secure medication ‘on their own behalf’ may extend beyond the period of actual incarceration.”).

¹⁷⁹ 114 F. Supp. 2d 111, 115 (N.D.N.Y. 2000).

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

reasonably necessary for him to obtain treatment ‘on his own behalf.’”¹⁸²

The logic of *Wakefield* and *Lugo*, must be extended to pre-enrollment after the ACA. In the post-ACA world, if prisons choose not to enroll prisoners in Medicaid before release, then prisoners will face a delay of at least several weeks before they can receive Medicaid benefits.¹⁸³ Just as it is unconstitutional to release a prisoner without a supply of medication when it may take days or weeks for the prisoner to get medication on his own and it is within the power of the prison to release him with medication, it is also unconstitutional to release sick prisoners without Medicaid when the prison has the ability to pre-enroll them. As previously discussed, after the ACA, evolving standards of decency require recognition of the fact that being sick and without insurance places prisoners at risk of serious medical harm.¹⁸⁴ The fact that the serious medical harm would occur in the few weeks after the moment of release does not excuse prison officials of responsibility.

A second counterargument takes issue with the interpretation of the Eighth Amendment as requiring prison officials to pre-enroll prisoners in Medicaid before they are released. The logic of this argument is that since not all states opted into the Medicaid expansion, requiring pre-enrollment will look very different in states that opted in than in states that opted out, resulting in states being held to different Eighth Amendment standards. However, “opt-in” states and “opt-out” states would not in fact be held to different standards. The Eighth Amendment can be interpreted only to require prison officials to enroll *eligible* prisoners for Medicaid. In all states, there will be some prisoners who are eligible for Medicaid upon release. Regardless of whether a state has opted into the Medicaid expansion, under all states’ existing Medicaid programs, people with disabilities are eligible for Medicaid, and in most states pregnant women are also eligible.¹⁸⁵ Therefore, the Eighth Amendment analysis applies to every

¹⁸² *Id.* (quoting *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999)).

¹⁸³ The application process for Medicaid benefits is time-consuming and confusing. See Levesque, *supra* note 8, at 732 (describing how the application process to reinstate Medicaid lost for any reason during incarceration requires individuals to navigate confusing administrative procedures).

¹⁸⁴ See *supra* Part III.B (arguing that releasing sick prisoners without enrolling them in Medicaid violates the Eighth Amendment).

¹⁸⁵ See *Individuals with Disabilities*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/People-with-Disabilities/Individuals-with-Disabilities.html> (last visited Mar. 8, 2014) (explaining coverage guaranteed to individuals with disabilities and optional coverage states can choose to provide); *Pregnant Women*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Preg->

state, although with slightly different effects since the eligible population will be much greater in states that opt into the Medicaid expansion.

Moreover, ruling that the Eighth Amendment requires pre-enrollment will not disincentivize states from opting into the Medicaid expansion because whether a state opts in or not, the state will still be required to expend costs in determining which prisoners are eligible for Medicaid. Secondly, research has shown that opting into the Medicaid expansion and enrolling prisoners in Medicaid actually would save states money in the form of (1) reduced recidivism as a result of access to mental illness and substance abuse treatment and (2) reduced costs of uncompensated care.¹⁸⁶ Currently many reentering prisoners fall into the category of uninsured people for whom state governments are already paying a large amount of money in uncompensated care costs.¹⁸⁷ To the extent states considering opting out are concerned about incurring extra costs, this research—and the experience of states that opt in—could persuade them otherwise.

CONCLUSION

The very nature of incarceration perpetuates the fiction that prisoners are no longer members of society: Prisoners are literally walled off, “out of sight,” and—for many who live in communities that are

nant-Women/Pregnant-Women.html (last visited Mar. 8, 2014) (describing optional coverage for pregnant women that most states can choose to provide).

¹⁸⁶ See NAT’L ASS’N OF CNTYS., COUNTY JAILS AND THE AFFORDABLE CARE ACT: ENROLLING ELIGIBLE INDIVIDUALS IN HEALTH COVERAGE 8 (2012) (“The ACA’s expansion of health coverage can better connect individuals involved in the criminal justice system to appropriate medical and behavioral health care services, which in turn has the potential to reduce recidivism rates as well as county health care costs.”).

¹⁸⁷ See JOHN HOLAHAN ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 6 (2012) (stating that states and localities pay thirty percent of uncompensated care costs for the uninsured); Wakeman et al., *supra* note 47, at 860 (“Without Medicaid, the recently incarcerated are forced to rely on emergency rooms for medical care, shifting the burden of cost to hospitals as well as local city and state agencies.”). By opting into the Medicaid expansion, studies have shown that the states would save eighteen billion dollars in uncompensated care costs, resulting in a net savings of ten billion dollars for states. HOLAHAN ET AL., *supra*, at 1. Notably, if prisons enroll prisoners in Medicaid as soon as they *enter* prison, then state governments will see additional cost savings. Although Medicaid prohibits funds from covering prisoners while they are incarcerated, there is an exemption for inpatient hospitalizations lasting more than twenty-four hours: The federal government will cover those costs as long as the person hospitalized is eligible for Medicaid. CTR. FOR HEALTHCARE RESEARCH & TRANSFORMATION, THE AFFORDABLE CARE ACT’S MEDICAID EXPANSION: ANALYZING THE MICHIGAN IMPACT 9 (2012). Thus, the more prisoners that are eligible for Medicaid, the more the state saves on inpatient hospitalization costs for prisoners. In Michigan the savings were estimated to be forty-four million dollars. *Id.*

unaffected by mass incarceration—“out of mind.” Detailed in Part I, the effects of what is, at best, the neglect of prisoners’ health are powerful. They go beyond the individual ill prisoner who leaves prison without a supply of needed medication or who contracts HIV while incarcerated, extending to that prisoner’s entire family and community. This Note has attempted to find a solution for the health crisis faced by reentering prisoners and their communities by arguing that the ACA necessarily represents an evolution of standards of decency under Eighth Amendment prison health care doctrine. The ACA represents a seismic shift in access to health care for non-prisoners. Because Eighth Amendment prison health care doctrine has relied on access to health care norms for non-prisoners as a yardstick against which to judge prison health care, the ACA necessarily alters the doctrine. Just as a “rising tide lifts all the boats,”¹⁸⁸ when society progresses, prisoners must not and cannot be left behind.

¹⁸⁸ President John F. Kennedy, Remarks in Pueblo, Colorado Following Approval of the Fryingpan-Arkansas Project (Aug. 17, 1962).