Medicaid Eligibility and Accessibility:
Exploring the Intersection of Poverty, Mental Health, and Incarceration from an Ethical Perspective

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Panic, loneliness, depression, and the unfamiliarity of life outside of the prison walls accompanied AJ's first weeks following incarceration, as recorded by Bruce Western during the Boston Reentry Study (2018). Diagnosed with a learning disability, attention deficit disorder, and bipolar disorder before the age of ten, AJ grew up poor, first becoming involved with the criminal justice system at twelve years old for attempting to stab a bus driver. After spending time in juvenile detention, AJ cycled in and out of prison, serving much of his time in solitary confinement. He believed that his severe anxiety and adverse mental health were further exacerbated by his incarcerations, despite receiving medical care and medication in prison. Because of his mental condition, accessing Medicaid to receive healthcare following release was a necessity, but this help was slow in coming, making it impossible for AJ to find work or leave home most days.

Introduction

As of 2018, over 2 million people were behind bars in the United States (Walmsely, 2018). Upon release, these individuals are deposited into communities, most frequently poor, where they are shocked into a completely different pace of life, leading to stress, anxiety, and depression. Poverty is both a predictor and an outcome of incarceration, as those imprisoned are more likely to come from poverty and return to poverty following release (Western & Pettit, 2010). Individuals living in poverty are significantly more likely to experience negative mental health than the general population due to increased stresses associated with inequality. Since those in poverty typically have fewer financial resources, this community is less likely to have insurance and either remains uninsured or relies on Medicaid to access mental healthcare treatments. As a nation with a large portion of the population that relies on Medicaid to acquire mental health treatment, the American public must politically support and fund government-

provided healthcare for the low-income community and those with criminal records to promote the capabilities of these individuals. However, the issues surrounding publicly-funded healthcare do not exist merely within the health or political spheres. They also present moral problems, as American society must decide what healthcare resources are owed to its' most disadvantaged. This paper will argue that Medicaid ought to be expanded and enhanced in all 50 states to provide equal access to crucial mental healthcare and services to the low-income community, which explicitly includes the growing number of formerly incarcerated individuals.

This paper will address the many facets of why Medicaid mental health resources should be expanded and enhanced for low-income individuals, specifically those recently released from incarceration. First, the connection between incarceration and mental health challenges will be outlined to demonstrate the prominent need for mental healthcare for this population. Next, the intersection between poverty and incarceration will be explored to highlight the financial constraints and heightened mental health challenges present in the considered communities. The paper will then discuss the current layout of Medicaid mental health resources, including limitations and strengths of mental health benefits today, while also considering which populations ought to receive access. Next, this paper will walk through the benefits of eligibility and accessibility to covered Medicaid mental health services. To conclude, three popularly cited oppositions to increased coverage, as well as ethical counterarguments through the lens of Contractualist thinker, John Rawls, will be acknowledged.

According to the Rawlsian Theory of Justice, all free and rational persons concerned to further their own interests determine the original agreement, which defines equality as the fundamental terms that any person would accept behind the veil of ignorance (Rawls, 10). Without knowledge of class, social status, or place within society, behind the veil, Rawls argues

that a rational man that commits to the original agreement would not accept a basic structure that requires lesser life prospects for some simply for the sake of a greater sum of advantages to be enjoyed by others (Rawls, 13). The Rawlsian veil of ignorance promotes fair distribution of rights, resources, and capabilities for all groups within society. This paper will utilize Rawls' moral framework to argue that the negative impacts from a lack of access to mental healthcare reduce the life prospects for the low-income formerly incarcerated population and, therefore, comprehensive coverage of Medicaid mental healthcare is morally necessary for a just society.

Connection Between Incarceration and Mental Health Challenges

Many of the challenges that individuals face following release have been more accentuated in recent studies through higher retention rates and more reliable results. Programs like Bruce Western's Boston Reentry Study follow individuals via a four-step process that emphasizes retention through incentives, phone check-ins, secondary contacts, and community program participation. Consequently, Western's approach retained more than 90% of participants more than one year after release, and has allowed researchers to estimate the impact of transition on the recently released more accurately. As we consider the results of Western's research, we must be mindful of any bias involved in the results due to the type of people who might choose to participate in a multi-year in-depth interview process.

These challenges often revolve around the jarring impact of transition causing a drastic change of life pace between incarceration and freedom. Bruce Western defines this freedom as "not a status granted by release, but something attained gradually" (Western, 26). He states that "becoming free first requires adjusting to the everyday tasks and interactions of free society and leaving behind the habits of the institution" (Western, 26). Successful social integration upon reentry requires shedding away the habits of the institution, a concept described by Donald

Clemmer as “prisonization” (Martin, 2018). Clemmer believes that the intense authority structure of prison forces small changes in behavior that poorly fit into the world of human interaction outside of prison (Martin, 2018). Liam Martin considers these changes in behavior as a change in habitus that is caused by incarceration, which “becomes inscribed in the convict body as lasting dispositions, motor schemes, and bodily automations” that hinder transition (Martin, 2018).

Adapting to these changes led participants in Bruce Western’s Boston Reentry Study to experience feelings of overwhelming stress, loneliness, and nervousness in everyday life situations (Western, 27). Before release, some participants in the study attended workshops in prison on social programs, made plans to visit doctors and secure living arrangements, or registered for MassHealth, while others were locked up in disciplinary segregation for 23 hours a day. Individuals like AJ transitioned from daily medications for anxiety attacks and 23 hours of isolation, to the freedom of the streets without even a prescription to access his medication (Western, 29). The transition made trips to the grocery store, doctor’s office, and shopping mall lead to anxiety in crowds and clumsiness with completing small tasks for interview respondents. Consequently, approximately 40% of Western’s interview respondents experienced anxiety after release (Western, 33).

Additionally, severe mental illness, characterized as schizophrenia or bipolar disorder, was almost four times more likely in participants of the reentry study than in the general population (Western, 49). These symptoms of anxiety were exacerbated for the two most socially isolated groups in the study: older respondents and those experiencing mental illness or drug addiction, as their needs were more acute (Western, 43). The mental health challenges of transition proved difficult for a large portion of the individuals analyzed by Western. Still, these difficulties were even more detrimental to those already experiencing symptoms of mental illness

while incarcerated, such as AJ. As a result of these mental health challenges, formerly incarcerated individuals have a pronounced need for high-quality, accessible mental health resources. However, because the incarcerated population is disproportionately more likely to be poor, reduced financial means are an obstacle to receiving treatment.

Connection Between Incarceration and Poverty

Researchers argue that the prison population contains a greater number of low-income individuals than those from any other income bracket (Wheelock & Uggen, 2006). These numbers, quantified in a report conducted by the Prison Policy Initiative, indicate that those incarcerated had a median annual income 41% lower than non-incarcerated individuals of similar ages (Wagner & Rabuy, 2017). While low-income individuals are more likely to be convicted and incarcerated, they are also more likely to face poverty upon release. Bruce Western and Becky Pettit argue that not only are young men in impoverished communities more likely to go to prison than the general population, but they also return home less employable and more detached from their families (2010). Their findings indicate that those in the bottom quintile of earnings prior to imprisonment have significantly less economic mobility following release than their non-incarcerated counterparts (Western & Pettit, 2010). Thus, according to much of the accepted literature on this topic, mass incarceration in America disproportionately affects low-income individuals by incarcerating them more frequently and by decreasing their economic and social mobility following release.

In addition to the connection between incarceration, release, and poverty, there is also a strong association between social inequality and mental health. Poverty is linked to an increased risk of mental disorders and suicide across many studies (Weich, Lewis, & Jenkins, 2001; Burns, Tomita, & Kapadia, 2014). Utilizing data and research compiled by the World Health

Organization, Wahlbeck et al. states that "on the one hand, poor and unequal circumstances increase the risk of developing mental health problems (social causation), while on the other hand, people suffering from mental health problems have a higher likelihood of poverty and being treated in an unequal way (social drift)" (2017). This issue is so pressing because the link between income and ill-health has been determined to be stronger for mental health than for general health through a concentration index approach conducted in Britain by Mangalore, Knapp, and Jenkins (Wahlbeck et al., 2017). The connections between poverty, incarceration, and diminished mental health compound to create numerous barriers for the formerly incarcerated upon release that can be combatted through Medicaid mental health resources.

Disallowing access to Medicaid mental health services for individuals with a criminal record would contradict the purpose of incarceration. As argued by scholars and moral theorists, justifications for imprisonment fall into a series of categories: retribution, incapacitation, deterrence, and rehabilitation (Western, 179; Cullen, Cullen, & Wozniak, 1988). A prison sentence achieves these goals by imposing a punishment correlated to the severity of the crime committed, removing an individual from society for some time, and serving as a reminder of the undesirable result of committing a crime. However, if the goal of incarceration is to rehabilitate offenders, further punishment by refusing access to government-aided healthcare following completion of the court-ordered prison sentence serves as an invisible punishment that hinders reintegration into society (Travis, 2002). Ultimately, these additional barriers restrict the formerly incarcerated from the community, creating fewer opportunities for them to remain law-abiding, which is inconsistent with the goal of rehabilitation and reintegration of the formerly incarcerated back into society (Travis, 2002). The result is a systematically excluded population that has no realistic hope of satisfying their debt to society or regaining a place within it (Love,

2002). Therefore, disallowing access to Medicaid based on criminal background exists as a never-ending invisible punishment outside of the court-ordered prison sentence. This additional punishment is unjust because it excludes a person from regaining the rights and privileges granted to them by the social-contract despite serving their sentence.

In considering poverty, mental health, and incarceration, it is essential to note that negative mental health can be triggered by stressors of life in poverty prior to incarceration, during incarceration, or following release. However, this paper seeks to map a path towards positive mental health during the re-entry process, regardless of when poor mental health enters a person's life. While this path looks different for every individual, like many other low-income individuals, the formerly incarcerated most typically must rely on Medicaid or some other publicly funded health program, which problematically varies state-by-state.

Problems with Medicaid Access and Programs

There are two main problems with current access to Medicaid. First, low-income individuals in some states may not qualify for Medicaid and, therefore, may remain uninsured. Second, an examination of the services provided to qualifying low-income communities indicates that the services available might not be accessible or sufficient to address mental health care needs adequately. In considering current Medicaid access and programs, it might not be possible to extrapolate data from a specific location to make sweeping judgments about the entire Medicaid or criminal justice system because these programs vary nationally. Additionally, federal and state policies are consistently changing, which might limit decisions and recommendations based on necessary or available resources. Finally, the statistics on the impact of these programs can only be fully considered if the services are completely provided in at least one area and are not provided at all in another.

Medicaid Accessibility Qualifications

Since Medicaid is jointly federal and state-funded, the coverage and amount of benefits differ by locality based on income level and family status; however, no state currently bars access for any criminal conviction. States like Massachusetts, the location of the Boston Reentry Study, provide expanded Medicaid coverage, which allows individuals of any age to access Medicaid if they are deemed "low-income," quantified as 138% of the Federal Poverty Line (FPL) (MACPAC, 2016). However, some states, like Mississippi, opted out of the expanded Medicaid program in the 2010s, leading to what is called "the Coverage Gap." In Mississippi, non-disabled adults without children cannot access Medicaid regardless of their income levels, and parents with dependent children can only qualify if their income is less than 127% of the FPL (MACPAC, 2016). Expanded Medicaid, currently available in 37 out of 50 states, grants significantly larger access to health care and behavioral resources for many low-income individuals, but a sizeable population of individuals still need access to health resources and do not qualify for Medicaid (MACPAC, 2016). In all the 14 states without expanded Medicaid, primarily in the Southeastern region, and in expanded states where individuals earn income slightly above the 138% cutoff, if employers do not provide healthcare benefits, or if the individual does not make enough to purchase private healthcare, they will remain uninsured and most likely, go without care.

Currently, one's criminal record does not disqualify them from receiving Medicaid; however, government-funded benefits cannot be received while the individual is under correctional supervision leading to difficulties with accessibility. Depending on the state a person is incarcerated in, if the individual is receiving Medicaid before incarceration, Medicaid benefits will be either suspended indefinitely or terminated during the time behind bars (Wakeman,

McKinney, & Ritch 2009). Typically, this means that there will be a time lag between release from prison and re-accessing Medicaid benefits—Wakeman, McKinney, and Ritch's research suggests that this process can take up to 3 months (2009). Studies indicate that the re-enrollment process is particularly difficult for those with severe mental illness, who often face additional challenges due to homelessness, lack of transportation, or addiction. The risk of death is also sharply increased for the formerly incarcerated during the period following release, particularly in the first two weeks, a time when most individuals will not have access to their Medicaid benefits (Binswanger et al., 2007). However, merely accessing Medicaid does not necessarily indicate that an individual will receive appropriate treatment or care, as some methods have proven to be more effective than others and might not be available in their state of residency.

Medicaid Services Provided

There are specific mandatory Medicaid benefit categories that all states must cover by federal law, which encompass some mental and behavioral healthcare, including inpatient and outpatient hospital services, physician services, and rural health clinic services (MACPAC, 2016). However, optional benefits are not required to be provided and can be determined by state discretion, include certain inpatient psychiatric disorder services, case management, and prescription drugs. Therefore, these treatment options might be available in some states but are not guaranteed to be available in others. In a 2016 report summarizing mental health services covered by Medicaid in all 50 states and the District of Columbia conducted by MACPAC, the disparities across treatments and availability become much more evident. Of the 17 types of services described in the MACPAC project, half of the states cover merely ten or less of these services with Medicaid, with South Dakota as the lowest providing only 5 of the 17. However, there are vast disparities amongst the quantity and quality of services covered, as states like

Arizona and Illinois offer 15 out of the 17 resources with robust offerings in each category. A full list of treatments and the number of states that cover these resources is available in the table below.

Service	Definition of Service	# of states providing service
Institution for mental diseases (IMD)	A hospital, nursing facility, or other institution with 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.	38 (under 21), 45 (over 65)
Other inpatient	Psychiatric residential treatment facilities, inpatient hospital care, residential habilitation, and acute care facilities.	44
Partial hospitalization	Allows the beneficiary to live at home but commute to a treatment center for care.	30
Case management	Includes case management, targeted case management, and care or service coordination.	37
Day services	A social model providing socialization, supervision and monitoring, personal care, and sometimes nutrition services	47
Psychosocial rehabilitation	Can include reducing symptoms through appropriate pharmacotherapy, psychological treatment, and intervention; providing support to families of individuals with a mental disorder; and ensuring social support to cover basic needs.	18
Psychotherapy	A general term for treating mental health problems by talking with a psychiatrist, psychologist, or other mental health provider.	43
Other therapy	Assisted outpatient treatment, counseling, multi-systemic therapy, adjunctive therapy, activity therapy, electroconvulsive therapy, maintenance therapy, dialectic behavioral therapy, neurotherapy, illness management, and rehabilitation therapy.	50
Peer support	Services that allow trained peer support providers with similar experiences to beneficiaries to listen, educate, and give guidance.	18
Crisis intervention	Crisis intervention/stabilization, psychotherapy for crisis, crisis residential treatment services, crisis intervention facilities, and crisis case management.	46
Home-based services	Home-based habilitation, personal care services, and other services that support beneficiaries living in their own homes.	16
Round-the-clock services	Group and shared living, as well as in-the-home round-the-clock services.	21
Supported employment	Job development, career planning, and ongoing supported employment services.	14
Caregiver support	Respite care, caregiver training and education, and other family supports.	15
Telemedicine	Uses telecommunication and information technologies to provide clinical health care at a distance.	39
Other services	Services offered that do not fit into any other category. Examples include transportation, community transitional supports, occupational therapy, and home or environmental modifications.	18

While Medicaid coverage is critical to accessing mental health services, Allen et al. demonstrate that barriers to accessing services still exist, even with coverage (2017). Persons utilizing Medicaid must find medical practices that will accept public health insurance, which is difficult for many recipients as most clinics have a limited number of slots available to this population. As of 2013, the average rate of Medicaid acceptance was just 46% in 15 major cities, determined by a Merritt Hawkins survey in which surveyors contacted 10-20 physicians' offices in each municipality inquiring about wait times for new patients and acceptance of Medicaid or Medicare as a suitable form of payment (Allen et al., 2017). In addition to low acceptance rates, low-income Medicaid recipients face barriers to care due to long wait times or inaccessible appointment availability (defined by Merritt Hawkins as 24.1 days for a new patient with the most prolonged period being 109 days in Boston), out-of-pocket expenses, lack of geographic accessibility, and low levels of trust in physicians (Merritt Hawkins, 2014, Hall et al., 2008, Allen et al., 2017). Even if Medicaid is available to a population, additional barriers are in place that make utilizing much-needed resources more costly, timely, and sometimes impossible. Therefore, Medicaid ought to be both expanded and enhanced in all states to reduce availability and accessibility barriers, improving the quantity and quality of mental health care services to low-income communities.

To make a claim for expanding and enhancing Medicaid for the low-income community, numerous arguments against these measures must also be investigated. First, some may doubt the overall effectiveness of mental healthcare resources in general for individuals recently released. Second, some may underestimate the positive impacts of increased eligibility and access to mental healthcare. In fact, several essential benefits may come with improved access, including

improved overall health, reductions in incarceration rates, and decreased financial stress. Finally, others might object to expanded and enhanced Medicaid for economic or political reasons.

Efficacy of Mental Health Services

To establish the effectiveness of expanded and enriched Medicaid mental healthcare resources, the efficacy of standard mental healthcare treatment programs: pharmacotherapy and psychotherapy, must be confirmed. These treatments are considered because they are widely prescribed, and both studied and considered by researchers as productive. According to the compendium of mental health resources, 43 states reportedly covered psychotherapy, and 50 included other sources of therapy. The MACPAC compilation excludes data specifically on pharmacotherapy; however, telemedicine and case management services can encompass mental health medication treatments. As of 2019, the American Psychiatric Association recommends psychotherapy or second-generation antidepressants as the most effective treatments to treat depression in young and middle-aged adults (American Psychiatric Association, 2019). Additionally, other common medications, including selective serotonin reuptake inhibitors, have been demonstrated as effective in treating anxiety disorders, as evidenced through numerous APA approved clinical trials (American Psychiatric Association, 2009).

Pharmacotherapy

Pharmacotherapy has been widely used to treat mental illness and improve mental health since the 19th century (Ban, 2001). Nevertheless, there has been a deep distrust surrounding the field of psychiatry due to articles and studies calling into question the effectiveness of both psychotherapy and pharmacotherapy (Leucht et al., 2012). In response to critics, Leucht et al. conducted a study on the efficacy of psychiatric drugs used to treat adverse mental health and compared the results to success rates of general medical medications used for common diseases

such as chronic asthma, rheumatoid arthritis, and breast cancer (2012). The study determined that psychiatric drugs are no less efficacious than medications marketed and used to treat common diseases. In a study performed by Singh et al. on individuals with chronic schizophrenia, the combination of two types of pharmacotherapies, antipsychotics and antidepressants, were most effective in treating the negative symptoms of mental illness (2010). These studies demonstrate that pharmacotherapeutic therapy is efficacious in addressing a selection of mental health disorders and mental illnesses. Insofar that this research is accurate, then pharmacotherapy can be considered as a resource to increase positive mental health outcomes for the formerly incarcerated.

Psychotherapy

More recently, Cognitive-Behavioral Therapy (CBT) has emerged as an additional form of mental health treatment. In this paper, CBT refers to the class of interventions that are based on the fundamental premise that emotional disorders are maintained by cognitive factors, and that psychological treatment leads to changes in these factors through cognitive and behavioral techniques (Beck, Emery, & Greenberg, 2005). In multiple studies conducted by Young et al., Hofmann & Smits, and Tarrier et al., the effectiveness of CBT was considered regarding depression, anxiety disorders (panic disorders, OCD), and schizophrenia.

Young et al. determined the efficacy of CBT to be equivalent to that of antidepressant medications and other psychopharmacological interventions in treating depression, while also suggesting the combination of both CBT and medication could present even more significant positive outcomes (2014). In a systematic review of CBT versus placebo treatment for adult anxiety disorders, CBT was confirmed to be efficacious (Hofmann & Smits, 2008). Regarding schizophrenia and CBT, Tarrier et al. performed a study to determine whether routine care,

supportive counseling, and cognitive behavioral therapy reduced relapse over two years (2000). The research indicated that individuals receiving routine care alone were significantly more likely to relapse and experience greater symptoms than individuals who received both CBT and routine care, suggesting that CBT led to a reduction in mental illness. Thus, CBT and routine care have a positive impact on individuals with chronic schizophrenia symptoms. While psychotherapy has received scrutiny in the medical field, the above research indicates that CBT can have a positive effect on individuals experiencing symptoms of depression, anxiety disorders, and schizophrenia. Given that there is research to back the idea that widely available, popularly used mental health treatments are efficacious, we must consider why these resources should be offered.

Consideration of Eligibility and Access to Provided Medicaid Services

Pros of Eligibility and Access

While considering the benefits of increased access to mental health resources, the intrinsic value of positive mental health to every individual must not be overlooked. Expanded accessibility to Medicaid mental health resources improves the overall health of the community, reduces incarceration rates, and decreases financial stressors on individuals and families.

Improved Overall Health

In the Oregon Experiment, 10,000 low-income individuals on a Medicaid waitlist were randomly assigned to receive access to health care through Medicaid. More than half of the individuals who received benefits were tracked against their counterparts in the community who did not gain access to publicly funded insurance for approximately 2-years after the random assignment to help determine the impact of expanded public health resources on the low-income community. The results of the 2010 study demonstrate the numerous benefits that expanded

Medicaid has on health and well-being. Research from this study indicates that health improves dramatically when insurance eligibility is extended, evidenced by the increased utilization of health care resources, increased mental health and general health outcomes, and decreased mortality rates (Baiker & Finkelstein, 2011; Baicker et al., 2013; Sommers, Baicker & Epstein, 2013).

Data indicates that utilization of health care resources increased drastically following the receipt of Medicaid, raising the probability of the use of outpatient care by 35%, prescription drugs by 15%, and hospital admission by 30% (Baiker & Finkelstein, 2011). These increases resulted in more consistent primary care and more usage of preventative care, including both mental health resources and general health resources (Baiker & Finkelstein, 2011). The increased usage of health care resources and preventative care improves the overall health of the individual utilizing the resources and saves money in the long run. By reducing total spending on costly emergency room visits when negative mental health outcomes become dire, regular physician appointments can treat symptoms earlier and cheaper for patients before they need the immediate attention that an emergency treatment provides (Maciosek et al., 2010). The increased utilization of health care resources in the Oregon Experiment resulted in improved health outcomes because conditions were treated earlier.

Medicaid coverage led to a substantial decrease in the number of depression cases and an increase in general health, including diabetes detection and management (Baicker et al., 2013). In the control group of the Oregon Experiment, 30% of survey respondents had positive screening results for depression (Baicker et al., 2013). In comparison, those receiving Medicaid coverage experienced a 9.15% absolute decrease in positive screening for depression (Baicker et al., 2013). Although self-reported happiness rates varied minimally across the study, self-

reported mental health outcomes improved for individuals as their Medicaid coverage grew (Baicker et al., 2013). Declining depression rates and improving self-reported mental health outcomes indicate that the expanded access to Medicaid improved mental health for those within the study, leading to overall better health. Insofar as this data can be extrapolated to other populations, then Medicaid access improves mental health measures.

As health outcomes improved for low-income Medicaid recipients in recently expanded locations studied during the Oregon Experiment, so did mortality rates (Sommers, Baicker, & Epstein, 2012). Medicaid expansion led to a significant reduction of 19.6 deaths per 100,000 adults in adjusted all-cause mortality. These effects were felt the greatest by older adults, nonwhites, and residents of poorer counties (Sommers, Baicker, & Epstein, 2012). Medicaid expansion leads to increased utilization of care, increases in self-reported mental health, and decreased mortality rates, most notably in some of the most fragile populations, some of which are also more likely to encounter the criminal justice system (Western & Pettit, 2010). Therefore, if better mental health outcomes for individuals recently released from incarceration is the goal, research produced from the Oregon Experiment suggests that expanding eligibility and access to Medicaid will help obtain this result by improving utilization rates and health outcomes.

Reduces Incarceration Rates

Multiple researchers have determined that poor mental health contributes to heightened incarceration and recidivism rates (Wilson et al., 2011; Baillargeon et al., 2010; Frank & McGuire, 2010). Wilson et al. proposed research stating that mental illness results in higher recidivism and re-incarceration, which leads to increased cost (2011). By studying a population of roughly 20,000 people admitted to a large urban jail system in 2003, Wilson et al. mapped the recidivism patterns of those without mental illness and substance use disorders compared to

individuals with serious mental illness, substance abuse disorders, and dual diagnoses. The results confirmed that those with ill mental health were 50% more likely to be re-incarcerated (Wilson et al., 2011). A study conducted by Baillargeon et al. determined from a group of people released from the Texas prison system that individuals with serious mental illness were more likely than those without to return to incarceration multiple times; these numbers were substantially higher for those with dual diagnoses, which includes mental illness and substance abuse disorders (2010). Using data from the Texas prison study, Baillargeon et al. attribute mental illness with even higher recidivism rates than average, possibly due to unmet mental health treatment needs (2010). As we estimate the effects of mental health on incarceration rates, we must consider that in some cases negative mental health and a lack of treatment contributes to increased recidivism, while in other cases, issues that commonly exist alongside negative mental health, such as exposure to violence, poverty, or another outside factor could be contributing to heightened recidivism rates. To the extent that poor mental health and mental illness impact incarceration rates, expanded and enriched mental healthcare can reduce the prison population.

Researchers including Frank and McGuire utilized data from a New York State 6-month evaluation of 3,500 individuals who received court-ordered assisted outpatient treatment (AOT) to determine that rates of incarceration for this group decreased by 20% and arrests fell by 25%, while homelessness and psychiatric hospitalization rates decreased drastically as well (2011). Thus, Frank and McGuire link AOT and mental health treatment to both improving mental health and reducing crime (2011). Further, a study conducted by Morrissey et al. indicated that individuals with severe mental illness who had access to Medicaid upon release from prison accessed mental health resources faster and more often than those without access to Medicaid (Morrissey et al., 2007). The work by Morrissey et al. suggests that if Medicaid mental health

resources are available to individuals upon release from prison, they will be accessed and could contribute to decreased crime. If the results of such studies could be considered causal, the mental health and medical treatment accounts for the decrease in violent crime rates. In other words, expanding and enhancing Medicaid mental healthcare coverage to low-income populations and those recently released from incarceration could reduce violent crime and incarceration rates, and decrease the overall prison population.

Decreases Individual Financial Stressors

Expanding Medicaid to encompass more low-income individuals decreases financial pressure on the individual, leading to improved financial security and, thus, increased self-reported health due to fewer instances of stress and depression. The Medicaid expansion program nearly eliminated catastrophic out-of-pocket medical expenditures, defined as expenses more than 30% of income for recipients in Oregon (Baicker et al., 2013). Medical debt decreased by 13.28%, and the amount of out-of-pocket expenditures decreased by 15.3% (Baicker et al., 2013). The relief of individual financial pressure provided by insurance coverage helps mitigate the significant adverse effects on mental health from perceived financial distress (Selenko & Batinic, 2011). Therefore, the decreases in medical debt and large out-of-pocket expenditures improve mental health by creating more financial stability for the low-income community.

Additionally, data from Oregon indicates that Medicaid reduces by 40% the probability that an individual will have to borrow money or skip a payment on other crucial bills due to medical expenses (Baicker & Finkelstein, 2011). While this increased financial stability greatly benefits the individual, these effects are also felt by collections agencies and health care providers in the public sector as increased coverage correlates with a 25% drop in the probability that medical bills owed to a collection agency will go unpaid (Baicker & Finkelstein, 2011).

Thus, an increase in publicly funded health care for low-income individuals benefits both the individual and the health care provider, who now has an increased likelihood of receiving full payment for their services. The reduced financial pressure granted by Medicaid coverage also indirectly impacts health outcomes by reducing cases of depression and anxiety, leading to an overall increase in self-reported health outcomes.

Popular Arguments Against Eligibility and Access

(1) Costs

Cost is the most cited reason for limiting Medicaid access and eligibility on both an individual basis and a state-by-state basis as previous policy overhauls to expand Medicaid led to rising tax rates and insurance premiums for the general public. The Affordable Care Act (ACA) financed Medicaid expansion by increasing payroll taxes by .9% on individuals making more than $200,000 or couples married filing jointly earning more than $250,000 per year (Gruber, 2011). Although the specific tax rates implemented by the ACA are unique to this legislation, generally, taxes on individuals must increase to support a major overhaul of government benefit programs that improves and enhances healthcare coverage. While the amount that premiums have risen resulting from the ACA is a highly controversial topic and differs across sources, the Kaiser Family Foundation, a non-partisan resource, found that insurance rates rose by 4.4% in 2016 (other estimates yielded results of a 6% and 10% increase over four years) (Kaiser Family Foundation, 2016). Rising premiums reduce the financial autonomy of the taxpayer and hinder economic consumption. Although not all the increases in insurance rates were a direct result of the ACA, expanding required coverages and covering more people at a higher risk of needing payouts most likely accounted for a portion of the growing rates (Center et al., 2017). The specific tax rates and penalties enforced by the ACA might not necessarily resemble what

associated costs for all Medicaid expansion programs would look like; however, enriching Medicaid coverage will most likely result in an increased financial impact on individual taxpayers.

Given that Medicaid is a joint state-and-federal funded program, many substantial expansions in the past have been subsidized by the federal government as states are shielded from much of the bill (Gruber, 2011). However, because expansion programs are subject to adjustments as presidential administrations change, many state legislators oppose increasing benefits because of the risk of the repeal of federal expansion programs. If an expanded and enriched Medicaid program were to be repealed, state legislators would be "on the hook" to cover the full cost of the benefits in the future (Center et al., 2017). Removing mental health care and overall coverage in the wake of a changing federal budget is far more challenging than simply never providing the benefits to begin with.

Counterargument:

The increased total costs to society from premiums and taxes associated with expanding Medicaid pale in comparison to the estimated annual societal costs of mental disorders in North America, estimated at approximately $83.1 billion in 2003 (Beck, Emery, & Greenberg, 2005). Many of these losses result from decreases in productivity in the workplace, unemployment, and disability, which would not necessarily disappear with expanded or enhanced Medicaid but would be reduced due to marginal improvements on mental health in the population (Dewa & McDaid, 200). These costs are placed onto the public sector through governments, employers, workers, and their families (Dewa & McDaid, 200). Therefore, society will face a negative economic cost whether mental healthcare Medicaid resources are provided to low-income populations or are not due to either the taxpayer cost of providing healthcare or the cost of

untreated mental disorders on businesses and the public sector. Additionally, the increased cost of providing beds and meals to fund the prison system is far more expensive than paying for mental healthcare. However, if the cost of mental disorders on the public sector were nonexistent, we must consider if the health of the economy and the individuals who must pay those costs are worth more than the health of an individual who would suffer without care. Insofar as the costs of mental healthcare will be borne by society either directly or indirectly, would it not be better to pay to provide care and improve the mental health of an individual than to face an economic penalty through increased incarceration and reduced productivity while letting the mental health of the population suffer?

Currently, existing literature well summarizes what costs and expenses will look like in the short term, but less data is available surrounding what the long-term expenditures will look like (Baicker & Finkelstein, 2009). There is evidence to suggest that healthcare costs will decrease in the future if individuals access preventative care, receiving treatment earlier, rather than by racking up costly emergency room bills for conditions in dire circumstances that could easily be treated by routine care (Maciosek et al., 2010). Although upfront and current costs for expanding Medicaid mental health resources appear high, these costs should be viewed as an investment in bringing down future costs.

From a single taxpayer standpoint, under the ACA, individuals do not foot the majority of the bill required to expand Medicaid, the healthcare industry does. Most of the funding for current Medicaid expenditures originates from reductions in reimbursements to the insurance sector, hospitals, pharmaceutical companies, and medical device manufacturers (Gruber, 2011). These reductions can impact the quality of healthcare provided, which will be addressed later, reducing the tax burden on individuals. Considering Rawls' Theory of Justice, a rational person

would only accept a social structure that provides an equal distribution of rights and resources to all members of society. Thus, even if the economy is limited or costs are increased, a society that fails to provide mental healthcare to all members or solely provides this care through its' criminal justice system would not be accepted. While taxpayer costs are a highly controversial, partisan topic, the survival and wellbeing of uninsured individuals matter more than the loss of financial autonomy to the Rawlsian moral theory.

(2) Hurts quality of care

Another popular viewpoint against strengthening Medicaid through enhancing coverage to low-income communities holds that the increased number of newly insured individuals will crowd primary care physicians and emergency rooms. This crowding would lead to increased wait times, more costly fees, and a lower quality of care. As has occurred in the past, when a sizeable portion of the previously uninsured group of the public gains access to healthcare, creating a large sudden onset of new patients, primary care providers cannot accommodate the flood and will close their doors to new patients (Gooch, 2010). When primary care providers deny treatment to the newly insured, emergency room visits increase because patients are guaranteed to be treated without an appointment and are able to come in outside of regular business hours (Gooch, 2010). A rapidly increased percentage of insured individuals will limit access to primary care providers and increase wait times for both the newly insured and those previously insured.

Further, this belief also claims that any benefits of expanded care could be undermined by the quality of care including issues such as medical errors, the spread of infection in health care settings, and poor retention of patients, known as the cascade of care (Bloom, Khoury, & Subbaraman, 2018). The sudden addition of millions of newly insured Americans will require

either increased productivity from current medical professionals or an increase in medical personnel. Currently, overwork, stress, and fatigue of medical professionals are believed to cause 70% of medical errors; insofar as this statistic is accurate, medical errors will increase even further if greater productivity is required (Blendon et al., 2002) Expanding medical personnel on such short notice might lead to less trained, practiced, and qualified practitioners carrying out medical procedures which would lead to mistakes. Additionally, expansion to the pool of insured individuals will decrease the quality of care by influencing the spread of infections acquired in health care settings (Kaier, Mutters, & Frank, 2012). If medical facilities are unable to expand to accommodate the newly insured population and become more crowded and understaffed, the transmission of healthcare-acquired infections will rise due to decreases in employee hygiene compliance, more frequent movement of patients and staff between wards, and an overburdening of isolation facilities (Clements, Halton, & Graves, 2008). These infections account for roughly 37,000 lives lost per year in the European Union (Kaier, Mutters, & Frank, 2012). Increasing the number of insured individuals without expanding current medical facilities will lead to overall decreases in quality of care caused by overcrowding, undertrained personnel, and increased transmissions of infection.

Counterargument

The uninsured population currently needs access to many health resources, but either cannot access them or chooses not to access them due to high costs, lack of insurance, location, mistrust of doctors, and many other reasons. Medicaid coverage of more individuals and types of illness will not create more sickness but instead will allow individuals who have always needed access to resources to be able to receive them. While this might add to the wait times of the currently insured, from a Rawlsian perspective this argument is unjust because no human would

accept a social contract in which a basic need, such as healthcare, is distributed so that some individuals have lesser life prospects so that others can have greater. The uninsured population faces death and decreased life prospects without access to healthcare, while the currently insured will only feel the effects of expanded Medicaid through more crowded facilities and providers, and longer wait times. These effects result in an inconvenience that might lead to decreased quality of care for the currently insured, but would not be agreed upon behind the veil of ignorance due to the severely diminished capabilities imposed on those experiencing poverty from a lack of access to mental healthcare. Thus, this argument is not morally justifiable.

Many individuals oppose Medicaid expansion due to either the costs or the low quality of care; however, some literature suggests that quality of care and expenses are not positively correlated (Solberg et al., 2002; Jha et al., 2009). Nevertheless, conflicting literature also exists, indicating that the relationship between costs/efficiency and quality is not well understood (Burke & Ryan, 2014). Taking a conservative approach and assuming that higher costs are required to provide better quality care, taxes and the cost of Medicaid reimbursements to providers would have to increase to sufficiently refund health practitioners for their work. These reimbursements would help cover the cost of growing personnel and expanding facilities, which would mitigate the spread of infection due to hygiene and staffing deficiencies, and overcrowding. John Rawls' Theory of Justice suggests that these costs are required for a morally just society because merely providing poor healthcare to low-income populations reduces the life prospects of this community; therefore, healthcare must be provided regardless of income level, and that care must be high-quality to be considered morally just (Rawls, 13). Insofar as the purpose of Medicaid is to improve the health of communities rather than merely providing

healthcare, funding for such programs must rise to enhance the quality of care and make government-funded healthcare viable and worthwhile.

(3) Partisan argument/Constitutionality

An additional argument against expanding Medicaid originates from what is called "the partisan debate" in which American citizens feel that the government is becoming too involved in daily life and should not be providing healthcare (Lanford and Quadango, 2010). In addition to mandatory tax increases to improve Medicaid access, government expansion further into the field of healthcare requires both legal mandates and enforcement. Further, the Affordable Care Act enforced tax penalties on persons without health insurance, an order that has since been struck down as unconstitutional in the recent *Texas v US* Fifth Circuit Court of Appeals Case. The individual mandate requiring individuals to either obtain basic health insurance or pay a tax penalty was struck down by the Court as recent changes to the Tax Code eliminated the tax penalty and the very reason the ACA was upheld as constitutional by the Supreme Court in 2012. In addition to the striking of portions of these updated eligibility laws as they are deemed unconstitutional, federal Circuit Courts for years have argued that access to medical treatment is not a fundamental human right secured by the Constitution.

In the *Wideman v Shallowford Community Hospital* Court of Appeals Case, the question of the existence of a constitutional right to the access of essential medical care was posed. The decision of the case outlines the federal court's opinion by stating that "We can discern no general right, based upon either the Constitution or federal statutes, to the provision of medical treatment and services by a state or municipality." Thus, the state is under no legal obligation to provide medical treatment or services because the Constitution does not protect access to healthcare. The Court cites previous cases to assert further that "the Constitution is a charter of

negative rather than positive liberties" (Orentlicher, 2012). Therefore, the government cannot prevent an individual from accessing necessary health resources, but also is under no obligation to provide the means to pay for care if the individual cannot pay. Some individuals oppose the expansion of Medicaid given the unconstitutionality of sections of the ACA, a previous attempt to expand publicly funded healthcare benefits, and Circuit Court decisions arguing that access to health care is a privilege rather than a right.

Counterargument

Simply because the tax penalty portion of the ACA has been deemed unconstitutional does not mean that the judicial branch views expanding health care as against the Constitution. *Texas v US* solely opposes the federal mandate of individuals to have health insurance without a tax or enforceable requirement in place. Thus, the idea of expanding Medicaid is legal, but the current funding structure of the expansion is not under the current Tax Code. Under these circumstances, the expansion of eligibility for Medicaid should not be discredited as unconstitutional because this argument is factually incorrect.

Although health care is not technically considered a basic right according to the US Constitution and interpretations by courts of the law, we must ask ourselves whether it is just for an individual to die without access to crucial health resources. If society deems this to be unjust, should the state then have an obligation to interfere? While some individuals do not support the growth of government to intrude in daily life, increased insurance coverage is correlated with decreased mortality (Sommers, Baicker, & Epstein, 2012). Therefore, the price of reduced governmental presence in the healthcare field by retaining current levels of autonomy comes at the expense of human life. From a Rawlsian perspective, behind the veil of ignorance, a rational man would accept a broader government presence if it meant receiving access to healthcare

because better health increases an individual's capabilities and life prospects (Rawls, 10). Therefore, a rational person would accept greater political interference in day-to-day life to protect their own self-interest without knowledge of their policy beliefs or financial position within society. When individuals will die without access to crucial mental health resources, the government has a moral obligation to interfere, regardless of the individual's income level or prior criminal involvement.

Conclusion

Failure to provide access to mental health care treatment unjustly and disproportionately impacts low-income individuals and the formerly incarcerated. Although America is moving towards extending mental health resources based on relation to the FPL, this process must continue throughout the nation and include all individuals, regardless of their criminal record. Taxpayers must be willing to set aside their autonomy interests to allow for the well-being of the formerly incarcerated community to thrive. To promote the welfare and central capabilities of formerly incarcerated low-income individuals in the United States, in a dignifying manner, Medicaid or some other form of comprehensive mental health care ethically ought to be provided.

AJ's experience sheds light on the negative mental health consequences that surround release from incarceration. After finally receiving enrollment into Medicaid, almost two months out of prison, AJ was able to obtain medication and regularly scheduled doctor's appointments. His treatment plan allowed him to make ends meet as a construction worker and help provide for his sister, Kate. Without mental healthcare, AJ would have failed to reintegrate into society and would most likely have ended up back in prison. Eligibility for this crucial mental healthcare treatment was a necessity for AJ, returning him to his family, job, and life, that others with

similar backgrounds in states like Mississippi or South Dakota would not have the luxury to receive. AJ's transition demonstrates the impact of removing one of the many barriers that low-income formerly incarcerated individuals face and provides a model for services America should be providing nationwide.

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