Meeting the Mental Health Care Needs of the Realignment Population: Estimating Their Health Profiles and Eligibility for Medicaid Under Health Care Reform

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INTRODUCTION AND OVERVIEW

To help reduce the size of the prison population and close the revolving door for parole violators, California enacted through California Assembly Bill 109 and signed into law in April 2011 its Public Safety Realignment Plan. Realignment was implemented in October 2011 and fundamentally changed the state’s criminal justice (CJ) system. Under Realignment, non-serious, non-violent, and non-sex offenders no longer serve time in state prison nor are supervised by state parole when released. Instead, local counties have responsibility for managing, housing, supervising, and rehabilitating these low-level offenders. Under Realignment, two groups of offenders will be handled at the local level: (a) those that complete their prison terms and are then placed on Post-Release Community Supervision (PRCS); and (2) those who serve their imprisonment locally (jail with or without mandatory post release supervision) under the new Penal Code section 1170(h). Those who violate their terms of parole (except for those previously sentenced to a term of life) also are handled locally rather than being sent back to prison. The California Department of Corrections and Rehabilitation (CDCR) retained responsibility for parole supervision for offenders released on parole prior to October 1, 2011, and for violent and serious offenders, high-risk sex-offenders, mentally disordered offenders, and inmates paroled from a sentence of life, including three-strikes offenders (CDCR, “2011 Public Safety Realignment,” 2011).

To date, almost all ongoing research efforts on Realignment have focused on understanding its impact with respect to community corrections, the judicial system, and public safety—much less is known about their health care needs. For example, early work examined the approaches that counties took in their realignment plans (Abarbanel, McCray, Newhamm, & Snyder, 2013; Hopper, Dooley-Sammuli, & Evans, 2012). Research has also focused on the impact of realignment on crime rates and offender recidivism (Bird & Grattet, 2014; Lofstrom & Raphael, 2013b; Males, 2014). Others have focused on the impact of realignment on key criminal justice actors and agencies (Ball & Weisberg, 2014; Petersilia, 2014a, 2014b; Weisberg & Quan, 2014) as well as jail and prison populations (Lofstrom & Raphael, 2013a; Quan, Abarbanel, & Mukamal, 2014). Turner and colleagues have focused on the use of risk in realignment (Gerlinger & Turner, 2013; Turner & Gerlinger, 2013).

Background on Health Care Needs of California’s Prison and Parole Population

The health needs of U.S. prisoners and the important role health plays in successful reentry back to communities has been well-documented. Overall, the prison population tends to be sicker than the general U.S. population with a number of chronic health conditions such as hypertension or diabetes—conditions that require ongoing medical management. Prisoners also tend to have higher infectious disease rates. For instance, the U.S. prison population has 5 times the Hepatitis C rate of the general population—a major contributor to lung transplantations (Davis and Pacchiana, 2004). Especially high are their mental health and drug treatment needs with two-thirds meeting the diagnostic criteria for drug abuse and dependence. However, the
uncoordinated release of individuals from prison means there are few mechanisms to link them to health care upon return to local communities.

Davis et al.’s (2009) analysis of self-reported data for a sample of California prison inmates showed that they bear a high burden of chronic diseases like asthma and hypertension and infectious diseases like hepatitis and tuberculosis, conditions that require regular use of health care for effective management. Yet among those California inmates who reported a current medical issue, a substantial share report not having seen a physician since admission to prison.

The substance abuse treatment and mental health care needs of California prisoners are even more pronounced than their physical health care needs. More than three-quarters of California inmates reported having a substance abuse problem (including alcohol) (Davis et al., 2009). Yet among California inmates reporting substance abuse or dependence, only 39 percent reported receiving treatment since admission to prison, which is lower than that reported by state prisoners nationally.

Anecdotal evidence from California counties’ early experiences with Realignment suggests that the mental health care needs of the local custody and PRCS populations are more substantial than anticipated (Misczynski, 2012). Counties though tend to have incomplete information about the different realignment populations’ care needs and how they may vary. Because PRCS and 1170(h) offenders are expected to be younger, they will likely have fewer chronic health problems, but still are expected to have relatively high drug treatment and mental health care needs. For example, in Los Angeles County, between October 1, 2011 and September 30, 2012, about 44 percent (4,612) of the post-released supervised persons (PRCS and 1170(h) under managed supervision) were referred by probation to the Community Assessment Service Centers (CASCs) for a substance use disorder (SUD) (Marx and McCravey, 2012).

In general, county health services, mental health, and alcohol and drug programs only have visibility on certain segments of the realignment population—including those that either:

1. Are supervised by probation (PRCS and 1170(h)s with split sentences) and have had an assessment of treatment needs with a referral made to county or safety net clinics (though not all counties have done this type of assessment);
2. Seek care from one of the county clinics and self-identify as being part of the realignment population; or
3. Are a very small proportion of the prison population being released from state prison that have serious mental illness, in which case county mental health departments receive medical “packets” from CDCR with these individuals’ medical history so their care can be transitioned to the county.

**Opportunities Under the Affordable Care Act (ACA)**

The Patient Protection and Affordable Care Act (ACA) offers an historic opportunity to expand health insurance coverage for the criminal justice-involved population, improve access to mental health care and drug treatment, and to better manage their care. Under the ACA, Medicaid eligibility has been expanded to include all non-Medicare-eligible citizens and legal residents¹ under age 65 with incomes up to 133 percent² of the federal poverty level (FPL)

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¹That is, legal residents who have been in the country five years or longer.
²The ACA specifies that childless adults are eligible for Medicaid with modified adjusted gross income (AGI) at or below 133 percent of the FPL. However, the ACA also adds a 5 percentage-point deduction from the FPL, which
(Patient Protection and Affordable Care Act, Public Law 111-148). In addition, the ACA provides subsidies to purchase insurance for individuals below 400 percent of the FPL without coverage from their employers, and penalizes employers for not offering coverage.

The net effect of the ACA is that there will be more options available to low-income populations, either through an employer, the exchanges, or Medicaid. Importantly, expansion of Medicaid eligibility to include low-income, childless adults has opened up the possibility for many ex-offenders to become eligible for Medicaid (California’s Medicaid program is referred to as Medi-Cal); thus, removing a key barrier to access to care. In the long-run, there is the potential of reducing both health care costs (e.g., overutilization of emergency departments and hospitals) and criminal justice costs (e.g., reducing recidivism) and of improving health outcomes for the ex-offender population. At the same time, there are also some challenges. Expansion of Medicaid eligibility could lead to increased demand for health care safety net services that are already stretched thin, thus possibly impacting access to care given limited capacity at the county level. In addition, Disproportionate Share Hospital (DSH) payments\(^3\) are being cut, which means that fewer resources will be available for individuals who remain uninsured. Noncitizens will not necessarily qualify for Medicaid. Finally, under the ACA individuals can be penalized for not having health insurance which likely will include a portion of the reentry population.\(^4\) Combined, these changes and restrictions suggest that facilitating Medicaid enrollment for eligible ex-offenders and soon-to-be-released offenders will be important.

The success of ensuring that ex-offenders gain access to insurance via Medicaid or through premium tax credits for the exchange depends on the ability of California and its counties to leverage the provisions of the ACA. The types of information they need to do so include what is the size of the eligible ex-offender population and their expected demand for services, what are effective Medicaid enrollment strategies and mechanisms to cost effectively transition care from prison to community providers, and what incentives can be provided to relevant stakeholders (health and criminal justice) to effectively plan for this component of the Medicaid expansion population.

**Key Research Questions**

As noted, almost all ongoing research efforts on Realignment have focused on understanding its impact with respect to community corrections, the judicial system, and public safety; less so on understanding the health care needs of the Realignment population. To assist counties in leveraging health care reform’s provisions, an estimate of the proportion of the different populations under Realignment and state parolees who will be eligible for Medicaid and the health exchanges under health care reform is needed to inform state and local planning efforts. In addition, estimates of the self-reported mental health care needs and how they vary across these different populations would help counties better understand to how the health profiles are similar or different and implications for likely demand for services.

Our analysis addresses the following research questions:

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\(^3\) Disproportionate Share Hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, or other health insurance (ref: [http://www.hhs.gov/recovery/cms/dsh.html](http://www.hhs.gov/recovery/cms/dsh.html)).

\(^4\) Although penalties are waived for the lowest income groups (non-tax filers).
- What percentage of the state prison population, the parolee population, and the active Realigned supervised population will be eligible for Medicaid under health care reform?
- What is the mental health profile of the different Realignment populations, how do they vary, and what is their likely demand for services?

Methods

Overall Approach

Our approach involved three sets of analyses. First, we created the analytic sample approximating the different Realignment groups (prison, local custody, parole, PRCS) using a California sample of prison inmates from a national survey of inmates in state correctional facilities. Realignment groups were categorized using the current and prior offenses for each individual in the offender’s criminal history, plus mental health and other criteria to proxy Realignment groups (i.e., the non-non-nons).

Second, we used self-reported survey data on prisoner health care needs to estimate the health profile of the different populations affected by Realignment using a previously documented approach in Davis et al. (2009). This analysis allowed us to examine differences in the health profiles of the various Realignment groups.

Third, for each Realignment group, we then estimated the percentage of each group that would be eligible for Medicaid and for the tax credits to purchase health insurance on the health exchange under the ACA. To do so, we built upon a method first documented by Cuellar and Cheema (2012) and used data from the inmate survey (above) on income, marital status and household composition, criminal history, and release date, and data from the Current Population Survey (CPS) on income and length of U.S. residence to estimate Medicaid eligibility and eligibility for the tax credits for each of the offender groups.

Creating the Realignment Groups

To estimate the percentage of the prison group, the parolee group, and the active Realigned supervised groups (PRCS and local custody (1170(h)) that will be eligible for Medicaid under the ACA—we analyzed data on a sample of California prison inmates (n=1,757) from a national survey of inmates in state correctional facilities. Groupings representing the four possible groups created under Realignment were developed using data on inmates in the Bureau of Justice Statistics (BJS) 2004 Survey on Inmates in State Correctional Facilities (SISCF). The SISCF contains inmate self-reports of their criminal activity, background, and personal characteristics as well as self-reported data on health status. Although this survey is now a decade old, the 2004 version is the most current iteration of the survey. Also, importantly the SISCF survey pre-dates the 2011 implementation of Realignment in California and so allows us to simulate the different groups created under Realignment. Variables from the SISCF were selected to match the criteria associated with placement in the realignment groups of prison or local custody for those remaining in custody and parole and PRCS for those being held.

Analyses were done on inmates in the state prison sample; inmates incarcerated in the Federal system were excluded. Consideration was limited to those who committed their crimes in California. This included California residents who committed their crime in state (but not California residents who committed their crime in other states) plus non-California residents who

5 We require a “pre-realignment” sample of prisoners in order to approximate the formerly imprisoned felons who are now being handled locally. A “post-realignment” prison sample would not allow us to create a local jail group.
committed their crime in California. We included only those individuals currently sentenced to serve time, and dropped all individuals who were incarcerated for reasons other than under sentence (e.g. awaiting trial, held to testify, etc.). Finally, we made the decision to excluded persons in the inmate sample who were serving time only for parole violations. Parole violators, under realignment, are subject to up to 180 days of jail time for violations; however we determined these offenders would muddy the comparison between prison and 1170(h) offenders.

Indicators to reflect the population of individuals who would have been released were made at this point. Realignment affects two groups of convicted offenders, those who are incarcerated and those who are under supervision after release. This decision to use the entirety of the California inmate sample to represent the California inmate population was straightforward. Developing a sample of convicted individuals under supervision was only slightly more complex. As there is no survey of parolees as useful as the SISCF, we made the assumption that inmates who would be released under supervision next year would be similar to the population within one year of release this year. We could therefore choose to represent individuals in the released population using inmates within one year of release in the SISCF. While inmates within one year of release would be present in both the in-custody population and the released population this does not represent double counting as they represent different groups of people.

Variables were selected to match the criteria for deciding whether an individual would be placed under state control or local control for both the in-custody and released subsamples. The criteria for who will be kept under state control in the incarcerated population (i.e. prison) was different from the criteria for who will be kept under state control in the released population (i.e. parole), although the criteria are similar. In both cases, offenders with more serious and violent crimes, as well as offenders who are mentally disordered and likely to reoffend, were placed in state control, although there were some differences in how these criteria we applied.

Inmates in the released subsample were divided into a parole group (for more serious offenders) and a PRCS group (for lower-level offenders). There are four criteria for being placed in parole: being under a life sentence; currently serving for a serious or violent felony; being a high risk sex offender; or being mentally disordered.

To identify those who would have been serving a life sentence, we used a variable reflecting the flat sentence of life. Individuals that had been sentenced to life, even if they were eligible for release, would always be placed on parole and not PRCS.

To identify those who would be serving a term for a serious or violent felony, we matched the offense codes for current offenses in the SISCF to the offenses used under California Realignment guidelines. Inmates within one year of release with a current serious/violent offense/sex offense would be classified as “parolees,” whereas inmates with a current non-serious/non-violent/non-sex offense would be classified as PRCS. Inmates with no current or prior serious/violent/sex offense would be considered 1170(h) offenders. Serious offenses are defined in the California Penal code sections 1192.7(c) and 1192.8; violent offenses are enumerated in penal code 667.5(c). The survey data offense codes are divided into detailed offense descriptions within larger commonplace categories (e.g., murder, larceny/theft). We used the current offense in the survey data for the realignment offense and all the prior incarcerations and probation offenses to define an inmate’s history, thus allowing us to map realignment definitions with the inmate survey data. The offense codes used related to: murder and other homicides; kidnapping; rape; lewd act with children; forcible sodomy; armed robbery; aggravated assault (but not simple assault); assaulting a public officer blackmail/extortion/

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6 This approach has been used by Petersilia (1993), (Petersilia, 2003).
intimidation; violent offenses- other; and arson. Burglary was also included, but as a special case; only those burglaries at a residence were included, consistent with the distinction between first degree and second degree burglary in California law. Codes for thefts including firearm and selling drugs to a minor that are included in the California Realignment guidelines were not included as they are overbroad in the SISCF, as the offense codes in the SISCF do not distinguish at that level of detail and would catch all thefts and all selling of drugs. These offense codes were applied to all variables in the SISCF that referred to a current offense, as the SISCF records not only the controlling offense for a given offender but also lesser offenses under the hierarchy rule and offenses committed after being admitted (e.g. charged with a new crime while on probation or parole, escape, etc.).

To identify whether an individual was a high-risk sex offenders, we selected variables in the inmate survey that matched the Static 99 protocol, used by California to assess the risk of sexual recidivism in male inmates. The Static-99 comprises 10 items, the first seven apply for all inmates and the last three apply only when the victim is a child. These items include: youth of the offender (age 18-24); ever lived with an intimate partner for at least two years; non-sexual violence in the current conviction; prior convictions for non-sexual violence; prior sex offenses (including both charges and convictions); prior sentencing dates; and prior convictions for non-contact sexual offenses; and when the victim was a child, include: was the victim unrelated; was the victim a stranger; and was the victim male. Directly comparable variables in the SISCF were available for all of these items, with the exception of living with an intimate partner. For this item we approximated the variable using a combination of living with a spouse, boyfriend, or girlfriend in the month before their arrest and ever been married. The net effect of this approximation is unclear—while it does not include those who had been in a long-term unmarried relationship but were not at the time of the arrest, it does include people who had a short marriage or a short relationship right before arrest. However, as it is only one of several items on the protocol, which is itself only one determinant of whether an individual will be placed in parole, the overall effect of this assumption may be minimal. These ten items were summed to create raw scores; an individual is considered a high-risk sex offender if the number of raw score is four or greater.

The final factor leading to placement in the parole group was being mentally disordered. We operationalized this factor having ever been diagnosed with mania (including mania, manic-depression, or bipolar disorder) or psychotic disorders (including schizophrenia and other psychotic disorders) and had also been admitted to a mental hospital during their incarceration.

If an inmate were within one year of release and had been sentenced to life, or had committed a serious or violent offense, or would be considered high-risk sex offenders, or would be considered mentally disordered, then they were placed in the parole group. All other inmates within one year of release were placed in the PRCS group. The process for defining the state prison and local custody groups was similar to the process for defining the parole and PRCS groups but with a few distinctions. As above, inmates whose offenses were considered serious or violent were placed in the more serious category and kept in the state system, but for held inmates this applied not only for the current offense but for previous convictions as well. Also as above, inmates given life sentences and inmates considered mentally disordered were placed in the more serious group (state prison). The requirements for high-risk sex offenses and the Static 99 are not applied to the incarcerated population however.

Following this process, all inmates who committed crimes in California crimes were placed in either the prison group or local custody group, and those who were within 1 year of release
were also placed in either the parole or PRCS groups. For the analytic sample, this resulted in 842 inmates in the prison group and 572 inmates in the local custody group, and 176 inmates within 1 year of release in the parole group and 363 in the PRCS group. Inmates who did not respond to one or more of the variables used for identifying groups, or one or more of the variables of interest in health conditions (described in the next section), were dropped; 95 out of 1509 inmates (6%) were dropped for one of these reasons. Table 1 shows the categorization of the inmate survey sample by Realignment group, unweighted and weighted.

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<tr>
<th>In-Custody Groups</th>
<th>Released Groups</th>
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<tbody>
<tr>
<td></td>
<td>Unweighted</td>
</tr>
<tr>
<td>Prison</td>
<td>842</td>
</tr>
<tr>
<td>Local Custody</td>
<td>572</td>
</tr>
<tr>
<td>Total</td>
<td>1414</td>
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Additional analyses were done using a more constrained population of PRCS. The analytic described so far defines the population as released at the time of realignment; additional analyses were done to reflect the released population as it will be in the future. As the PRCS population will come from released prisoners and as the demographics of those who will serve time in prison inmates will change with the realignment, the subsample representing the future PRCS was drawn from those members of the PRCS sample that whose characteristics would also have sent them to prison.

**Analysis of health indicators to describe health profiles of each realignment group**

To estimate the mental health profiles of the different populations created under Realignment, we analyzed the self-reported health data from the California sample of the 2004 SISCF. To do so, we used a similar methodology as reported by Davis et al. (2009 and 2011) to understand how the different groups’ physical health and behavioral health needs vary and to create the health profiles for each of the four groups.

Mental health indicators included whether an inmate had ever been diagnosed with a mental health condition, specifically: depressive disorders; mania, including manic-depression and bipolar disorder; schizophrenia or another psychotic disorder; post-traumatic stress disorder; other anxiety disorders, such as a panic disorder; personality disorders such as antisocial or borderline personality disorders; and any other mental or emotional condition.

Substance abuse was considered in several ways. First, we considered abuse or dependence on drugs and/or alcohol. To estimate the reported prevalence of symptoms of substance abuse

<sup>7</sup>The number of inmates in the PRCS group reflects the number of inmates that would go into PRCS at the time of Realignment, but future PRCS populations will be smaller because many will be diverted to local custody and never serve time in prison. Of the 363 inmates in the PRCS group, only 42 would be in the future PRCS population (eligible for prison first and PRCS later) while the remaining 321 would initially be sent to local custody and would therefore never enter PRCS upon release.

<sup>8</sup>Similar to the previous footnote, the weighted population of PRCS here reflects the number that would go into PRCS at the time of Realignment, but future PRCS populations would be smaller. Of the 28,650 members of the weighted PRCS group, only 4,014 would be in the future PRCS population (eligible for both prison first and PRCS later) while 24,636 would initially be sent to local custody and would therefore never enter PRCS upon release.
and dependence, we used a similar methodology as that developed by the Bureau of Justice Statistics (BJS) (Mumola and Karberg, 2006) for the 2004 SISCF. Survey respondents were categorized as dependent on or abusing drugs and alcohol based on the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) criteria. The inmate survey has 6 questions related to alcohol abuse and 11 questions related to alcohol dependence and a similar set of similar 6 questions related to drug abuse and 11 questions related to drug dependence. For abuse, the selected variables related to: failure to fulfill major role obligations; frequent use in physically hazardous situations; frequent legal problems; and continued use despite persistent or recurrent social or interpersonal problems (variables v2033-v2038 for alcohol abuse, v2166-v2171 for drug abuse). For dependence, the selected variables related to: tolerance; withdrawal; use of ever larger amounts; persistent desire; involvement in chronic behavior to obtain the substance; reduction or abandonment of activities because of substance use; and use of substance despite physical or psychological problems caused or exacerbated by the substance (variables v2039-v2049 for alcohol dependence, v2172-v2182 for drug dependence).

Lastly, comorbid conditions are prevalent among the criminal justice-involved population. So we also created indicators that looked at comorbidity between mental health and drug abuse or dependence conditions.

We conducted descriptive analyses of the inmate survey reporting lifetime health problems. We made the following comparisons and assessed the statistical significance of any differences found among the four Realignment groups. Specifically, we compared the extent to which the different groups varied with regards to physical health, mental health, and substance abuse conditions. We compared the health condition of inmates that would remain under state jurisdiction (i.e. prison and parole) to those shifted to local jurisdiction (i.e. local custody and PRCS) to identify differences in state expenditures. We also compared the health condition of those in-custody (i.e. prison and local custody) to those who would be released (i.e. parole and PRCS) in a number of ways to identify characteristics of the released population. These comparisons were in all cases made using the final survey weights and we report statistically significant differences at the 95% confidence level (p<=0.05 level).

Analysis to Estimate Medicaid Eligibility and Eligibility for the Exchange

We estimated the proportion of each Realignment cohort that would be eligible under the ACA for Medicaid (those whose annual income was below 138% of the FPL) or eligible for federal tax credits to purchase private health insurance policies through insurance exchanges (i.e., those with annual incomes between 138% and below 400 percent of the FPL). To do so, we refined an approach first reported by Cuellar and Cheema (2012) in order to increase the accuracy of our estimates of the income of the persons in each Realignment category using the demographic and income information of each inmate in the SISCF.

Data Sources

We estimated inmates’ eligibility for Medicaid and the premium tax credit using data from the 2004 Survey of Inmates in State Correctional Facilities (SISCF), and the 2010 and 2011 American Community Survey (ACS). The SISCF is a nationally representative survey of inmates in state prisons conducted periodically by the Census Bureau for the Bureau of Justice Statistics. The most recent year for which data are available is 2004. SISCF has detailed information on state inmates’ current and past offenses, which allows us to create four subgroups of inmates under realignment. In addition, the SISCF contains data on inmates’ demographic
characteristics, family structure prior to arrest, pre-arrest employment and monthly income. The survey also asked inmates whom they anticipated to live with after release. By using these data in the SISCF we can construct a sample of inmates being released in the next 12 months.

Data on income in the SISCF are limited since it is reported as a range rather than a point estimate for each inmate. Therefore, in order to estimate inmates’ incomes we use the ACS which is a population survey administered by the Census Bureau that collects data on demographic, social, economic and housing characteristics from approximately 3 million individuals nationally. It includes 12 monthly independent samples, and asks about employment and income in the past 12 months prior to the month of the interview. Our intention was to estimate income for 2010 which is the year prior to the implementation of the ACS. Due to the sampling design and data collection process, some respondents in the 2010 ACS reported employment and income for all or part of the calendar year 2009. To overcome this issue, we produced two sets of estimates based on the 2010 ACS and the 2011 ACS, and took the simple average of these estimates for our final estimate.

Sample
We constructed an analytic sample of inmates that included those who reported California as either the state of residence or the state where the offense occurred, expected to be released within 12 months of the survey interview, were under sentence at the time of the interview, would be between 18 and 64 years old after release, and were not parole violators. We used an algorithm based on inmates’ offense and sentence history to categorize each inmate into one of the four groups under realignment – parole, prison, PRCS and local custody. Our final inmate sample consisted of 217 inmates in prison, 322 inmates in local custody, 364 inmates in PRCS, and 175 inmates in parole.

The 2010 and 2011 ACS data file for California contain data for 355,699 and 359,623 noninstitutionalized individuals. We excluded institutionalized individuals, because many of these individuals were incarcerated at the time of interview (and as a result were not earning income), whereas we were interested in estimating inmates’ post-release income distribution assuming they were not institutionalized that year.

Estimating Post-Release Income
Two key variables in determining eligibility for Medicaid and the premium tax credit are income and household size. The income variable in the SISCF is a categorical variable with broadly defined categories. About 7 percent of our final inmate sample did not report their pre-arrest income. Those who responded may not be able to accurately recall their pre-arrest income, as a substantial portion of inmates were arrested more than 5 years prior to the survey interview. Given these issues, we did not use the income data from the SISCF. Instead, we matched each inmate in the SICSF to the set of individuals with identical demographic characteristics and employment status in the ACS. We then calculated the proportion of the ACS sample that are eligible for Medicaid or the premium tax credits and then assigned these proportions to the SISCF sample of inmates.

A large body of research has documented the poor labor force experience of previously-incarcerated individuals. Employment and earning prospects for inmates tend to be limited even before conviction (Western 2002, Sabol 2007). The inmate population consists of a disproportionate share of racial and ethnic minorities with low levels of education – a group which suffers high rates of unemployment (Harlow 2003, Bureau of Labor Statistics 2013,
Western and Pettit 2010). For example, the jobless rate among African Americans with little schooling was 20.5 percent in 2013, close to double the national average. Further, unobserved individual circumstances associated with higher risks of crime and incarceration may also be related to higher risk of joblessness. Using administrative records, Sabol (2006) showed that less than 40 percent of offenders released from Ohio state prisons during 1999 and 2000 were employed in any quarter over the five quarters prior to prison admission. According to Lalonde and Cho (2008), among first-time female inmates entering the Illinois state prison system between 1995 and 2000, their quarterly employment rates average about 25 percent during the two to four pre-prison years.

There is also burgeoning evidence of adverse effects of incarceration on post-release labor market outcomes, likely through mechanisms of stigma, erosion of job skills, or weakening social contacts with family and friends who can connect inmates to job opportunities (Western et al. 2001). In their review of the literature, Western et al. (2001) concluded that having served in prison has a significant negative effect on earnings. This is consistent with newer research which continues to find a negative relationship between incarceration and earnings (Raphael 2007, Pettit and Lyons 2009). Several recent studies also found that incarceration or incarceration length is positively associated with employment in the short term, possibly due to participation in work release programs while in prison. Unfortunately, such effect was only transitory, as over time employment declined steadily to its pre-charges levels (Kling 2006, Lalonde and Cho 2008).

Overall, the evidence suggests that ex-prisoners have the same probability of being employed after incarceration as before incarceration, but their overall income declines. Although some may experience an increase in employment immediately after existing prison as a result of work programs, these “gains” from incarceration dissipate in the medium term. Based on this literature, we incorporated inmates’ employment status at arrest to reflect the weak attachment of inmates to the legitimate labor market prior to arrest. We also applied an “earning penalty” to the estimated income to account for the adverse effect of incarceration on inmates’ post-release economic wellbeing. Estimates of reduction in earnings associated with incarceration in the literature range from 10 percent to 40 percent (Western et al. 2001, Geller et al. 2006, Raphael 2007, The Pew Charity Trust 2010). The wide range of the estimate likely reflects the difference in study population and methods, as well as whether the reduction accounts for both loss in hourly wages and loss in hours and/or weeks worked. For our analysis we applied the most conservative estimate of a 40 percent reduction to total earnings.

In the absence of detailed income information in the ACS, we were unable to approximate the modified adjusted gross income (MAGI) as specified by the ACA for assessing eligibility for Medicaid and the premium tax credit. As a result, we used total income as a proxy for MAGI.

**Accounting for Household Size**

We determined Medicaid or premium tax credit eligibility based on the total income of members belonging to the same health insurance unit (HIU). Under the ACA, the Medicaid HIU and the premium tax credit HIU differ in their treatment of certain types of families, but are in general defined around the tax filing unit (Kaiser Family foundation 2011). We constructed inmates’ expected HIU according to their responses about whom they anticipated to live with after release. We excluded members who were not part of a nuclear family, a strategy largely similar to other analysis related to the ACA (Shadac 2012, Blavin et al 2012).
As shown in Table 2, the great majority of inmates in our sample will be in a HIU of one person upon release. About 20 percent of inmates expect to live with a spouse alone or a spouse and children. Because we do not have information about spousal or other family income, nor do we know the exact number of children living in these households, we placed these inmates into a HIU of 1. For inmates expecting to live with children but not their spouse, assigning them to a household of one can lead to underestimating the proportion of inmates eligible for Medicaid. It is less clear how it will affect our estimates for inmates anticipating to live with their spouses. Depending on the income of spouses, we may overestimate the proportion of inmates that are eligible for Medicaid and underestimate the proportion that are eligible for tax credits or those with incomes too great for both, or vice versa. However, for these inmates, there is a high probability that many will not be able to retain the family relationship due to elevated risk of divorce associated with incarceration. Western (2004) estimated that previously incarcerated White men are more than twice as likely to experience divorce or separation by the sixth year of marriage, compared to their counterparts that are never incarcerated. For Hispanic men, incarceration is estimated to increase the rate of divorce or separation from 30.1 percent to 43.4 percent. Thus, the extent to which we bias our estimates by placing these inmates into a HIU of one person is not clear.

Table 2. Anticipating Post-release HIU type (%), Unweighted

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<th>Prison</th>
<th>Local Custody</th>
<th>PRCS</th>
<th>Parole</th>
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<tbody>
<tr>
<td>Live by self</td>
<td>82.0</td>
<td>78.6</td>
<td>79.1</td>
<td>81.7</td>
</tr>
<tr>
<td>Live with spouse only</td>
<td>8.3</td>
<td>8.4</td>
<td>8.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Live with child(ren) only</td>
<td>6.5</td>
<td>7.5</td>
<td>6.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Live with spouse and child(ren)</td>
<td>3.2</td>
<td>5.6</td>
<td>5.2</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Accounting for Immigration Status

California does not require the five-year waiting period for lawfully present individuals to be eligible for full-service Medi-Cal (California’s Medicaid program). But undocumented immigrants are not eligible for either the full-service Medi-Cal or the premium tax credit. We did not have data on immigration status for each inmate in our sample. It is possible that the distribution of undocumented immigrants across different eligibility categories is uneven. However, failure to account for undocumented immigrants is likely to have a small impact on our estimates.

Analysis

For each inmate in our analytic sample, we identified individuals with identical age, sex, education, race/ethnicity, and employment status in the ACS. We applied the “earning penalty” to these individuals’ total income, and then calculated the weighted proportions of these individuals that are eligible for Medicaid or the premium tax credits based on the “penalized” total income as a percentage of the FPL. We repeated this process for every inmate in the sample, and took the average of these proportions across all inmates in our sample.
Results

Socio-demographic Characteristics of the Different Realignment Groups

In general, the Realignment groups are predominantly male. However, the local custody and PRCS groups tended to have more females than the prison or parole groups as expected (Table 3). The difference between the prison (95.1% male) and the local custody (90.3% male) groups was the only comparison though that was statistically significant with respect to gender.

A greater proportion of African-Americans (31.5%) was represented in the prison group compared to those in the local custody group (24.6%). A similar pattern was seen for the released population—28.9% of the parole group compared to 20.1% of the PRCS group was African-American. For each comparison, differences between groups were statistically significant at the 0.05 level.

The average age for inmates in each of the groups was approximately 35 years. Among the released groups, although the PRCS group tended to be younger than the parole group the difference between the two groups was not statistically significant. In looking at the age distribution within each group, although not shown, nearly twice as many individuals in the prison group (6.4%) were 55 years or older than individuals in the local custody group (3.0%) with this difference being statistically significant.

In terms of educational attainment, across the four groups approximately 6 out of 10 individuals had higher a high school degree or a GED.

California has a large foreign-born population. More than a quarter of Californians (27.2 percent) are foreign-born compared with 12.4 percent of the U.S. population (U.S. Census Bureau, 2008, Table 40). This difference is reflected in the inmate population. Between 11.1% and 16.8% self-reported as being foreign born (Table 3).

<table>
<thead>
<tr>
<th>Table 3. Socio-Demographic Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Race</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
</tr>
<tr>
<td>African-American (non-Hispanic)</td>
</tr>
<tr>
<td>Other race (non-Hispanic)</td>
</tr>
<tr>
<td>Age (mean)</td>
</tr>
<tr>
<td>Educational attainment (H.S. degree or GED)</td>
</tr>
<tr>
<td>Foreign born</td>
</tr>
</tbody>
</table>

Lifetime Prevalence of Mental Illness

The prevalence of mental illness in general tends to be higher among the criminal justice-involved population than in the general U.S. population. For example, according to the NCCHC (2002), among state prison inmates, the prevalence of schizophrenia and other psychotic disorders and bipolar disorder is more common among inmates than it is in the overall U.S. population.
In the SISFCF, inmates were asked whether they had ever been diagnosed with any of the mental health disorders listed in Table 4. For the in-custody groups, a higher percentage (30.4%) or 1 out of 3 individuals in the prison group reported having ever been diagnosed with a mental illness as compared to 18.0% of the local custody group. We found a similar difference in looking at the released groups: 38.2% of individuals in the parole group reported having ever been diagnosed with a mental illness as compared to 19.0% of the PRCS group.

The results for the different types of mental health disorders also indicate that for almost all of the individual disorders listed these differences between the prison and local custody groups and between the parole and PRCS groups hold up. This suggests that among those in-custody, the prison group tends to have a higher burden of mental illness than the local custody group. And among those in the released groups, the parole group tends to have a higher burden of mental illness than the PRCS group.

Table 4. Lifetime Mental Health Problems

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prison</th>
<th>Local Custody</th>
<th>Parole</th>
<th>PRCS</th>
<th>PRCS prs</th>
<th>PRCS no pris</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive disorder</td>
<td>22.3%</td>
<td>10.6%</td>
<td>30.3%</td>
<td>10.7%</td>
<td>5.5%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Manic-depression, bipolar disorder, or mania</td>
<td>13.1%</td>
<td>4.1%</td>
<td>27.6%</td>
<td>4.9%</td>
<td>0.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Schizophrenia or another psychotic disorder</td>
<td>8.1%</td>
<td>0.9%</td>
<td>12.6%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>7.4%</td>
<td>4.1%</td>
<td>10.9%</td>
<td>4.9%</td>
<td>4.1%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>10.2%</td>
<td>5.0%</td>
<td>18.0%</td>
<td>7.3%</td>
<td>4.1%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>9.0%</td>
<td>3.8%</td>
<td>11.8%</td>
<td>3.8%</td>
<td>0.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Other disorders</td>
<td>2.3%</td>
<td>1.7%</td>
<td>3.3%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Any mental health problem</strong></td>
<td>30.4%</td>
<td>18.0%</td>
<td>38.2%</td>
<td>19.0%</td>
<td>11.7%</td>
<td>20.2%</td>
</tr>
<tr>
<td><strong>Multiple mental health problems</strong></td>
<td>18.7%</td>
<td>7.3%</td>
<td>27.5%</td>
<td>7.6%</td>
<td>2.0%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Note: Any mental health problem is defined as ever been diagnosed with any of these mental health problems listed in the categories above (i.e. depressive disorder, mania or associated disorders, schizophrenia or other psychotic disorders, PTSD, other anxiety disorders, personality disorders, or other disorders). Multiple mental health problems is defined as being diagnosed with more than one of the disorders listed above.

Pink shading indicates difference between prison vs local custody groups is statistically significant at the 0.05 level. Gray shading indicates difference between parole vs PRCS groups is statistically significant at the 0.05 level.

**Drug Use, Abuse, and Dependence**

The SISC provides us with information on the self-reported use of alcohol and drugs by inmates. Between 51% - 60.2% of individuals met the diagnostic criteria for drug abuse and between 41.9% - 49.5% met the diagnostic criteria for drug dependence (Table 5). When we looked at the timing of the reported use of drugs, between 82.5% - 89.8% reported having used drugs in their lifetime and between 70.0% - 78.5% reported having used drugs regularly (once a week or more for a month).

Polysubstance use is defined as the regular use of more than one substance. Most of the prison group had a history of using one substance or another, with 71.4% of individuals reporting
having used drugs (except marijuana) or alcohol. When considering marijuana use as well, the rates of substance use were even higher.

Additionally, more than half of the inmates in the four Realignment groups that used drugs or alcohol, used more than one. Between 45.8% and 49.6% of individuals reported having had regularly used at least one drug and alcohol, while between 40.7% and 48.9% reported having used more than one illegal drug other than marijuana (Table 5).

In general, a greater percentage of the local custody (vs prison) and the PRCS (vs parole) groups reported regular use of drugs (except marijuana) or alcohol supporting the hypothesis that the drug treatment needs of those who are in custody at the local level or supervised at the local level are quite high.

### Table 5. Drug Use, Abuse, and Dependence

<table>
<thead>
<tr>
<th>Drug abuse/dependence</th>
<th>Prison</th>
<th>Local Custody</th>
<th>Parole</th>
<th>PRCS</th>
<th>PRCS pris</th>
<th>PRCS no pris</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug abuse</td>
<td>51.0%</td>
<td>55.5%</td>
<td>55.2%</td>
<td>60.2%</td>
<td>62.3%</td>
<td>59.9%</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>41.9%</td>
<td>47.1%</td>
<td>45.4%</td>
<td>49.5%</td>
<td>58.8%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Timing of use (any drug)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>82.5%</td>
<td>85.2%</td>
<td>85.7%</td>
<td>89.8%</td>
<td>96.5%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Regular use</td>
<td>70.0%</td>
<td>72.5%</td>
<td>75.6%</td>
<td>78.5%</td>
<td>90.9%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Polysubstance Use (regular use, lifetime)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs (except marijuana) or alcohol</td>
<td>71.4%</td>
<td>78.7%</td>
<td>77.2%</td>
<td>82.5%</td>
<td>86.0%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>45.8%</td>
<td>46.2%</td>
<td>51.7%</td>
<td>49.6%</td>
<td>50.4%</td>
<td>49.5%</td>
</tr>
<tr>
<td>More than one substance (except marijuana)</td>
<td>40.7%</td>
<td>45.4%</td>
<td>48.9%</td>
<td>47.8%</td>
<td>25.8%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Note: Polysubstance use refers to the regular use of more than one substance. Drugs (except for marijuana) or alcohol is the broadest category, having had regularly used at least one drug or alcohol, including the use of only drugs (except for marijuana) or only alcohol; this is not polysubstance use is included for the sake of comparison. Drugs and alcohol refers to having had regularly used both drugs (at least one) and alcohol. More than one substance (except alcohol) refers to having used multiple substances (including both alcohol and/or drugs except marijuana).

Pink shading indicates difference between prison vs local custody groups is statistically significant at the 0.05 level.

### Co-Occurring Mental Illness, and Substance Abuse Problems

The co-occurrence of substance use disorders and other mental disorders are common and have been studied extensively. With respect to co-morbid mental illness and substance abuse disorders, the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) survey estimated that 22 percent of individuals with a mood disorder and 19 percent of individuals with an anxiety disorder had a co-occurring drug-use disorder (Brady, Verduin, and Tolliver, 2007).

Co-occurring disorders in general are more difficult and expensive to treat and for those with co-occurring mental health and substance abuse disorders it is especially difficult for caseworkers and health providers to place these individuals into treatment programs. For example, drug treatment programs typically are not be set up to treat co-occurring serious mental illness, and similarly mental health treatment programs are often not equipped to address drug
abuse or dependence problems. This is particularly a challenge for parole or probation or county treatment providers trying to place the released population into programs.

Table 6 indicates that the level of comorbidity with respect to mental illness and drug abuse or dependence in our sample is substantial across all four Realignment groups. Both the state correctional system and local counties will have to find ways to address this level of need in the different Realignment groups. The results for co-occurring depression and drug abuse or dependence and anxiety and drug abuse or dependence showed between 2-3 times a greater number of individuals in the prison and parole groups reported comorbid depression or anxiety and drug abuse or dependence compared to the local custody and PRCS groups.

### Table 6. Results for Co-Occurring Physical Health, Mental Illness, and Substance Abuse Disorders

<table>
<thead>
<tr>
<th></th>
<th>Prison</th>
<th>Local Custody</th>
<th>Parole</th>
<th>PRCS</th>
<th>PRCS pris</th>
<th>PRCS no pris</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime chronic physical health problem and …</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>… any mental health disorder</td>
<td>16.7%</td>
<td>9.6%</td>
<td>24.2%</td>
<td>9.7%</td>
<td>4.8%</td>
<td>10.5%</td>
</tr>
<tr>
<td>… depression and/or anxiety</td>
<td>13.6%</td>
<td>7.1%</td>
<td>22.4%</td>
<td>7.6%</td>
<td>4.8%</td>
<td>8.1%</td>
</tr>
<tr>
<td>… schizophrenia and/or mania</td>
<td>9.6%</td>
<td>2.7%</td>
<td>18.5%</td>
<td>3.0%</td>
<td>0.7%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Mental health disorder and alcohol abuse or dependence</td>
<td>14.9%</td>
<td>8.3%</td>
<td>19.3%</td>
<td>8.4%</td>
<td>6.9%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Mental health disorder and drug abuse or dependence</td>
<td>19.4%</td>
<td>11.8%</td>
<td>29.7%</td>
<td>13.7%</td>
<td>8.2%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Depression and drug abuse or dependence</td>
<td>15.1%</td>
<td>6.3%</td>
<td>23.5%</td>
<td>7.7%</td>
<td>5.5%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Anxiety and drug abuse or dependence</td>
<td>6.5%</td>
<td>3.6%</td>
<td>14.0%</td>
<td>4.5%</td>
<td>0.7%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Note: Pink shading indicates difference between prison vs local custody groups is statistically significant at the 0.05 level. Gray shading indicates difference between parole vs PRCS groups is statistically significant at the 0.05 level.

### Estimates of Medicaid Eligibility and Eligibility for the Exchanges of the Different Realignment Groups

Within each of the different Realignment groups, we estimated the percentage of inmates who would be financially eligible for Medicaid and the premium tax credit. Inmates with income below 138% of FPL are considered financially eligible for Medicaid. We estimated that 65.1% of those on parole and 62.6% of those on PRCS would be eligible for Medicaid (Table 7). These estimates were consistent with our expectation that a majority of the released population would likely be eligible for Medicaid under the ACA.

Those with income between 139% and 400% FPL are financially eligible for the premium tax credits to purchase health insurance through the Exchange, as long as they are not offered insurance through their jobs. Since the majority of inmates are likely to have low-pay or part-time jobs or remain unemployed after they are released, we assumed that they would not have employer-sponsored health insurance after release and therefore, would be eligible for the premium tax credit (Schmitt and Warner, 2010; Holzer et al., 2003). Based only on income (and not whether they were employed in jobs that offered insurance), we estimated that 30.0% of the
parole cohort and 30.5% of the PRCS cohort would be eligible for a premium tax credit through the Marketplace (Table 7).

| Estimated Percent Eligible for Medicaid or the Premium Tax Credit for the Different Realignment Groups |
|-------------------------------------------------|--------|-------|------|------|
| | Prison | Local custody | PRCS | Parole |
| Medicaid (income up to 138% FPL) | 64.5 | 62.6 | 62.6 | 65.1 |
| | (1.91) | (1.8) | (1.67) | (2.12) |
| Premium tax credit (139 - 400% FPL) | 30 | 30.6 | 30.5 | 30 |
| | (1.5) | (1.33) | (1.23) | (1.7) |
| Income above 400% FPL | 5.49 | 6.78 | 6.89 | 4.94 |
| | (0.707) | (0.673) | (0.68) | (0.584) |

Standard errors in parentheses

While our focus is on the released groups (i.e., parole and PRCS) in this analysis, we also wanted to provide estimates of the Medicaid and tax credit eligible populations for those still in-custody to inform corrections officials’ planning about how to facilitate Medicaid enrollment for those still in-custody. We estimated that 64.5% of individuals in the prison group and 62.6% of individuals in the local custody group would be eligible for Medicaid upon release. For these two groups, based only on income, we also estimated that 30.0% of the prison group and 30.6% of the local custody group would be eligible for a premium tax credit through the Marketplace. As indicated in Table 7, across the different Realignment groups we estimated that less than 7 percent would have income above 400% of the FPL.

Discussion

In this paper, we have presented a methodology for estimating the percentage of the criminal justice-involved population eligible for Medicaid and for the health exchanges in California. Specifically, we were able to take advantage of the 2004 SISCF which allowed us to simulate the different groups created under Realignment and includes information that could be used to estimate Medicaid eligibility and to compare differences in the health profiles among the four Realignment groups.

We were able to build on and refine the methods first developed by Cuellar and Cheema (2012) to estimate Medicaid and tax credit eligibility for this population in two ways. First, the CPS likely overestimates the income of the prison population because of inherent differences in the earning potential of those persons who lead lives that lead to incarceration and those who do not. To account for this we included information on the income categories reported in the SISCF to create matching cohorts in the two surveys that more closely mirrored the actual income that would be earned by those being released from prison. In addition, we applied an empirically determined wage penalty to account for the impact that prison would likely have on the earning
potential of our sample. This wage penalty was much higher than the one used by Cuellar and Cheema. These refinements help ensure that we are estimating the income of our sample as efficiently as possible.

For the PRCS and parole groups, we estimated that between 62.6% and 65.1% would be eligible for Medicaid. This estimate is much closer to estimates we found in the literature of the uninsured rate of ex-prisoners that ranged from 57% to 85% (Heiser and Williams, 2008; Visher, LaVigne, and Travis, 2004; Mallik-Kane, 2005).

What do the mental health profile results tell us about the differences among the Realignment groups in terms of their likely demand for health care? Given the high rates of mental illness and drug abuse or dependence in the four cohorts and of co-occurring disorders, for the released groups (i.e., those on parole or PRCS) gaining access to insurance through Medicaid or through the health exchanges is an important step towards addressing their complex set of health care needs and improving access to care. Our analysis to estimate what percentage would be eligible for Medicaid under the ACA, indicated that approximately two-thirds of the released groups (i.e., those on parole or PRCS) would be eligible. This provides parole and probation with some guidance as to the level of eligibility for these two groups.

We also estimated what percentage of those in the prison and local custody groups would be eligible for Medicaid with our results suggesting that about two-thirds of these individuals would be eligible. For CDCR and county jails contemplating strategies for initiating the process of Medicaid enrollment, this provides them with an estimate of what percentage of the in-custody population might benefit from Medicaid screening and enrollment programs.

**Study Limitations**

We included in our analysis of the BJS inmate survey individuals who had committed their crimes in California and sentenced to state prison. We recognized that a small percentage were individuals who were residents of other states. We may not have created the right sample if non-California residents are not all adjudicated in California after release or if California residents who commit crimes in other states return to California upon release from prison. Because we were unable to predict who stays and who leaves we believe we have a good approximation of the group of offenders who would be returning to California communities and eligible for Medicaid under California’s rules.

Our analysis of Medicaid eligibility was unable to take into account the specific proportion of inmates that would take up either Medicaid or the Tax credit because data on take-up rates in this population after the implementation of the ACA are unavailable at this time.
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Western, Bruce, and Becky Pettit. “Incarceration & Social Inequality.” Daedalus 139, no. 3 (July 1, 2010): 8–19. doi:10.1162/DAED_a_00019.