

10-4-2017

The Economic Advantage of Preventative Health Care in Prisons

Sabeena Bali

Follow this and additional works at: <http://digitalcommons.law.scu.edu/lawreview>



Part of the [Law Commons](#)

Recommended Citation

Sabeena Bali, Comment, *The Economic Advantage of Preventative Health Care in Prisons*, 57 SANTA CLARA L. REV. 453 (2017).
Available at: <http://digitalcommons.law.scu.edu/lawreview/vol57/iss2/4>

This Comment is brought to you for free and open access by the Journals at Santa Clara Law Digital Commons. It has been accepted for inclusion in Santa Clara Law Review by an authorized editor of Santa Clara Law Digital Commons. For more information, please contact sculawlibrarian@gmail.com, pamjadi@scu.edu.

**THE ECONOMIC ADVANTAGE OF PREVENTATIVE
HEALTH CARE IN PRISONS**

Sabeena Bali*

Introduction	454
I. A Selective History of Health Care.....	456
A. Cruel and Unusual Punishment	456
B. Health Care in California Prisons	458
1. Overcrowding and Communicable Disease	459
2. Overcrowding and Non-Communicable Disease	460
C. Health Care Reform in the United States.....	462
1. Why the Affordable Care Act	462
2. The Individual Mandate Provision	465
3. The Medicaid Expansion Provision	466
II. The Constitutional and Economic Problem of a Sick Post- Prison Population Using Medicaid	468
III. A Cost-Effective Opportunity Drawn From the Public Health Literature	471
A. Evidence of the Cost-Effectiveness of Preventative Care in the General Population	471
B. Drawing from the Communicable Disease Literature	472
C. Drawing from the Non-Communicable Disease Literature	476
D. Recidivism and Health Care Economics	478
IV. Preventative Treatment Avoids a Sick Post-Prison Population ...	478
Conclusion.....	479

* B.A. Hampshire College, J.D. Santa Clara University. I am appreciative of Professor W. David Ball for his guidance with this writing and throughout law school. This project was catalyzed by conversation with the Boston Health Care for the Homeless Program, went on with help from the good people in Geneva, and came to a close with the scrutinous eyes of loved ones, especially Vinita Bali, at home in the San Francisco Bay Area. Thank you to everybody along the way.

INTRODUCTION

A prisoner is not always a prisoner. Latest government statistics report that, in United States federal and state correctional facilities, over half a million individuals finished their sentences and were released back into their communities.¹ In California, 69.9% of prisoners are not serving life sentences.²

Those leaving correctional facilities are often ill when they return home.³ In *Plata v. Brown*, the Supreme Court of the United States affirmed an order to reduce the California state prison population by 38,000 inmates, to remedy constitutionally inadequate health care.⁴ California has conceded that prisoners do not receive basic preventative care, or in graver instances, even care for serious illness.⁵ It follows, then, that individuals returning from correctional facilities may have physical and mental conditions that, if not exacerbated by unconstitutionally poor health care and overcrowding, may be exacerbated by the tough process of re-assimilation.⁶

Despite recent unsuccessful endeavors from the Trump administration to repeal and replace the Patient Protection and Affordable Care Act (hereinafter “Affordable Care Act” or simply “Act”),⁷ the Act continues—for the time being—to expand those eligible for Medicaid to include ex-prisoners who are within 133% of the federal poverty level.⁸ It also ensures that pre-existing conditions cannot be a basis for denial of coverage.⁹ The normal annual re-assimilation of sickly prisoners, or the release of sickly prisoners per *Plata*, will overwhelm health and human services, whose expenditures already use 31.5% of the California budget.¹⁰

This is not to disagree, in any way, with California’s expansions of Medicaid. Who we are as a society is marked by how we treat the poor and the condemned.¹¹ Like all people, prisoners—irrespective of

1. E. Ann Carson, *Prisoners in 2014*, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE (Sept. 2015), <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5387>.

2. *The Facts: Criminal Justice Facts, State-by-State Data*, THE SENTENCING PROJECT (2012), <http://www.sentencingproject.org/the-facts#map>.

3. See *Brown v. Plata*, 131 S. Ct. 1910 (2011).

4. *Id.* at 1928.

5. *Id.* at 1925–26.

6. *Id.* at 1923–26.

7. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).

8. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2015); 45 C.F.R. § 155.305 (2013).

9. 42 U.S.C. § 300gg (2015).

10. *Enacted Budget Detail, Welcome to California’s 2016-17 State Budget*, CAL. DEPT. OF FINANCE (June 30, 2016), <http://www.ebudget.ca.gov/2016-17/Enacted/agencies.html>.

11. Bryan Stevenson, *We Need to Talk about an Injustice*, TED (Feb. 2012),

socioeconomics or morality—are owed the basic human right to essential health services such as access to medicine, prevention, treatment, and rehabilitation.¹² Communities also reap the benefits of supporting the human right to health for all, in the form of safety: crime and recidivism are decreased.¹³

Of course, our Constitution guarantees this right for prisoners.¹⁴ But furthermore, it would also spare an avoidable and astronomical percentage of taxpayer dollars that could be spent elsewhere. In an era of scarcity, perhaps right- and left-wing politicians are most inclined to agree when progressive politics also serve the dual purpose of lightening the taxpayers' burden.¹⁵ This Comment proposes that preventative and early health care for prisoners should be provided because it would ultimately result in tax savings. Although taxpayers may be required to support a greater corrections budget to afford such care up-front, savings will ultimately be recuperated in the form of decreased Medicaid spending.

This Comment proceeds in four parts. Part I will begin with the history of the Eighth Amendment's prohibition on cruel and unusual punishment,¹⁶ health affairs in prisons,¹⁷ and health reform after the passage of the Affordable Care Act.¹⁸ Around the same time that the Supreme Court recognized that the Eighth Amendment's prohibition on cruel and unusual punishment is systematically violated via poor health care in prisons, the Obama administration's Affordable Care Act overhauled the health insurance landscape and expanded Medicaid. Part II outlines the problem of our sickly jailed and imprisoned

https://www.ted.com/talks/bryan_stevenson_we_need_to_talk_about_an_injustice.

12. For the recognition of the importance of universal health coverage in national systems, as well as the global commitment to the fundamental right of every human being to the highest attainable standard of health without distinction of race, religion, political belief, economic or social condition, *see* U.N. G.A. Res. A/67/L.36 (Dec. 12, 2012), the Const. of the World Health Org. (Apr. 7, 1948), the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment arts. 1, 2, 4, Dec. 10, 1984, 1465 U.N.T.S. 85, and the Int'l Covenant on Econ., Soc. & Cultural Rights, Dec. 16, 1966, Dec. 16, 1966, 993 U.N.T.S. 3.

13. Andrea A. Bainbridge, *The Affordable Care Act and Criminal Justice: Intersections and Implications*, U.S. DEPT. OF JUSTICE (July 2012), https://www.bja.gov/publications/aca-cj_whitepaper.pdf.

14. *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

15. *See generally* Hadar Aviram, *Humonetarianism: The New Correctional Discourse of Scarcity*, 7 HASTINGS RACE & POVERTY L.J. 1, 3 (2010). For a complete history and analysis of so-called “humonetarian” discourse on criminal justice, *see also* HADAR AVIRAM, *CHEAP ON CRIME: RECESSION-ERA POLITICS AND THE TRANSFORMATION OF AMERICAN PUNISHMENT* (2015).

16. *See* discussion *infra* Part I.A.

17. *See* discussion *infra* Part I.B.

18. *See* discussion *infra* Part I.C.

population as they return home, specifically the repercussion on Medicaid.¹⁹ The more unhealthy the Medicaid-using population is, the more taxpayer dollars will be required to care for them.²⁰ Part III finds an opportunity for savings from public health economics literature,²¹ looking at examples both from communicable²² and non-communicable diseases.²³ Part IV finally proposes that money be spent up-front in providing preventative care, and that Medicaid funding for prisoners be spent on preventative care as opposed to hospitalization.²⁴ Drawing from the public health economics literature, I argue that paying for preventative care is more economical than supporting a chronically ill population with government-funded Medicaid.²⁵

I. A SELECTIVE HISTORY OF HEALTHCARE

A. Cruel and Unusual Punishment

The Eighth Amendment of the United States Constitution states that “cruel and unusual punishments [shall not be] inflicted.”²⁶ It is applicable both to the federal government and to the states through the Fourteenth Amendment.²⁷ As with all the succinct clauses in our short Constitution, it is not accompanied by explanation, and precise definition is elusive.²⁸ Its principles date back to the Old Testament of the Bible,²⁹ and the precise phrasing was borrowed from the English Bill of Rights of 1689.³⁰

However, it has been suggested that the Framers reappropriated the phrase, because their dispositions were of course different than those of the British almost a century before them.³¹ During a state

19. See discussion *infra* Part II.

20. See *infra* note 170 and accompanying text.

21. See discussion *infra* Part III.

22. See discussion *infra* Part III.A.

23. See discussion *infra* Part III.B.

24. See discussion *infra* Part IV.

25. See discussion *infra* Part IV.

26. U.S. Const. amend. VIII.

27. U.S. Const. amend. XIV, § 1. See also *Robinson v. California*, 370 U.S. 660, 667 (1962).

28. *Furman v. Georgia*, 408 U.S. 238, 258 (1972) (Brennan, J., concurring) (per curiam).

29. Anthony F. Granucci, *Nor Cruel and Unusual Punishments Inflicted: The Original Meaning*, 57 CAL. L. REV. 839, 844 (1969).

30. *Trop v. Dulles*, 356 U.S. 86, 99–100 (1958). Jeremy Bentham was a prominent voice in the English jurisprudence on the purposes of punishment. See JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION (1988) (“punishment ought in no case to be more than . . . that quantity [that] is *needless*.”).

31. Granucci, *supra* note 29, at 860.

convention on the ratification of the Constitution, Mr. Abraham Holmes of Massachusetts suggested that the Framers' intent in using the clause was to limit Congress' power to prescribe punishment.³² This interpretation is supported by an argument made by Mr. Samuel Livermore of New Hampshire during debates of the First Congress on the adoption of the Bill of Rights:

[I]t is sometimes necessary to hang a man, villains often deserve whipping, and perhaps having their ears cut off; but are we in future to be prevented from inflicting these punishments because they are cruel? If a more lenient mode of corrective vice and deterring others from the commission of it could be invented, it would be very prudent in the Legislature to adopt it; but until we have some security that this will be done, we ought not to be restrained from making necessary laws by and declaration of this kind.³³

Accordingly, at a minimum, it is understood that the Eighth Amendment's Cruel and Unusual Punishments Clause prohibits torture or lingering death brought about by something "inhuman and barbarous," and more than the "mere extinguishment of life."³⁴ For example, atrocities such as being burned at the stake, crucified, or broken on a wheel have long been proscribed.³⁵

More recently, punitive methods beyond merely those that are draconian have been proscribed.³⁶ Embracing the notion of a living, not a dead, Constitution,³⁷ the Supreme Court has noted that the Eighth Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."³⁸ The concerns are the individual dignity inherent to human existence and the maintenance of civilized government.³⁹

Specifically regarding health care, *Estelle v. Gamble* held that deliberately withholding adequate health care for prisoners is also a

32. *Trop*, 356 U.S. at 258–59.

33. Granucci, *supra* note 29, at 842.

34. *In re Kemmler*, 136 U.S. 436, 447 (1890).

35. *Id.* at 446; *see also* *Wilkerson v. Utah*, 99 U.S. 130, 136 (1878).

36. *Estelle*, 429 U.S. at 102.

37. The Supreme Court is, however, compelled in a number of instances by the path most "deeply rooted in this Nation's history and tradition." *See, e.g.*, *Washington v. Glucksburg*, 521 U.S. 702, 720–21 (1997), *Moore v. City of East Cleveland*, 431 U.S. 494, 503–04 (1977), *Bowers v. Hardwick*, 478 U.S. 186, 191–92 (1986), *Lawrence v. Texas*, 539 U.S. 558, 598 (2003), *McDonald v. City of Chicago*, 561 U.S. 742, 767 (2010), *United States v. Windsor*, 133 S. Ct. 2675, 2706–07 (2013).

38. *Trop*, 356 U.S. at 86, 101.

39. *Id.* at 100–02.

violation of the Cruel and Unusual Punishments Clause.⁴⁰ Prisoners have no choice but to rely on prison authorities to have their basic human needs met.⁴¹ If these needs are ignored, at best, needless pain and suffering is inflicted.⁴² At worst, the result is the very same as “torture or lingering death.”⁴³

However, it has been suggested that the deliberate indifference standard set forth in *Estelle* is as amorphous and difficult to apply as cruel and unusual was.⁴⁴ At some point, possibly willful blindness or lack of means to rectify a known problem becomes deliberate indifference, despite the lack of deliberation or malicious intent.

B. Health Care in California Prisons

To remedy systematic violations of the Eighth Amendment, a three-judge district court is empowered to order a reduction of prisoners.⁴⁵ In *Brown v. Plata*, California was mandated to reduce its prison population by 38,000 prisoners, or in other words, from 200% down to 137.5% of its prisons’ design capacities.⁴⁶

The court suggested good-time credits.⁴⁷ Instead, California passed the Public Safety Realignment Act that sends low-level non-violent offenders to county jail rather than to state prisons.⁴⁸ In 2008, 107,042 prisoners were booked and 15,294 were released from California county jails on a monthly basis.⁴⁹ By 2011, only 88,551 prisoners were booked, but only 10,196 were released per month.⁵⁰ After the passage of the Public Safety Realignment Act, the state also planned to create 10,000 specialized medical and mental health beds,

40. *Estelle*, 429 U.S. at 104.

41. *Id.* at 103.

42. *Id.*

43. *Id.*

44. Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 947 (1992).

45. 18 U.S.C. § 3626(a) (2015).

46. *Plata*, 131 S. Ct. at 1910, 1923–24.

47. *Id.* at 1920.

48. A.B. 109, 2011–2012 Assemb., Reg. Sess. (Cal. 2011). See also Margo Schlanger, *Plata v. Brown and Realignment: Jails, Prisons, Courts, and Politics*, 48 HARV. C.R.-C.L. L. REV. 165, 165–67 (2013) to trace the legal and political causes and outcomes after the *Plata v. Brown* population order; see also W. David Ball, *Tough on Crime (on the State’s Dime): How Violent Crime Does Not Drive California Counties’ Incarceration Rates—And Why it Should*, 28 GA. ST. U. L. REV. 987, 990 (2012) for an analysis of the implications of redirecting offenders from state prisons to county jails.

49. Schlanger, *supra* note 48, at 206.

50. *Id.*

but halted this plan due to budgetary constraints.⁵¹

Some low-level non-violent prisoners are released, many prison sentences are served in jail under Realignment, and most sentences naturally come to an end. In 2014, 636,346 prisoners returned to their communities around the United States.⁵² Given that one prisoner dies every six to seven days⁵³ due to “extreme departures from the standard of care,”⁵⁴ prisoners are not likely to be in healthy condition at the time they are released. California prison wardens and health care managers have conceded that they fail to provide prisoners with adequate medical care.⁵⁵ Prisoners have elevated rates of chronic, untreated illness⁵⁶ due to “extreme departures from the standard of care.”⁵⁷

A primary cause of such poor prisoner health is overcrowding.⁵⁸ As the *Plata* court noted, California’s prisons have operated at approximately 200% of their design capacity for the past eleven years.⁵⁹ They are designed to house a population of just fewer than 80,000.⁶⁰ However, in 2007—the peak of overcrowding—California’s total prisoner population reached 176,059.⁶¹ Now, as of 2017, it is still at 131,084,⁶² which is approximately 164% of the California prison system’s design capacity.

1. Overcrowding and Communicable Disease

Overcrowding may contribute to the spread of communicable disease. It means that prisoners live in cramped accommodations that

51. Allen Hopper, James Austin, & Jolene Forman, *Shifting the Paradigm or Shifting the Problem? The Politics of California’s Criminal Justice Realignment*, 54 SANTA CLARA L. REV. 527, 546–48 (2014).

52. Carson, *supra* note 1.

53. *Plata*, 131 S. Ct. at 1927.

54. *Id.* at 1925.

55. *Id.* at 1940.

56. State Prison Health Care Spending: An Examination, PEW CHARITABLE TRUST AND THE JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION (July 2014), <http://www.pewtrusts.org/~media/assets/2014/07/stateprisonhealthcarespendingreport.pdf>.

57. *Plata*, 131 S. Ct. at 1925.

58. *Id.* at 1923.

59. *Id.* at 1923–24.

60. *Id.* at 1923.

61. William J. Sabol and Heather Couture, *Prison Inmates at Midyear 2007*, BUREAU OF JUSTICE STATISTICS BULLETIN, U.S. DEP’T OF JUSTICE (June 2008), <https://www.bjs.gov/content/pub/pdf/pim07.pdf>.

62. Weekly Report of Population as of Midnight July 12, 2017, CAL. DEP’T OF CORR. AND REHAB. (July 12, 2017), http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Weekly_Wed/TPOP1A/TPOP1Ad170712.pdf.

are not designed to house them, such as gymnasiums.⁶³ In one instance, fifty-four prisoners shared one single toilet.⁶⁴ Such conditions lead to risk of transmission of infectious agents.⁶⁵

Communicable diseases that are prevalent in prison populations include hepatitis B and C, HIV, methicillin-resistant staphylococcus aureus (MRSA), sexually transmitted diseases (syphilis, gonorrhea, and chlamydia), and airborne illnesses such as tuberculosis.⁶⁶ The rate of hepatitis C among inmates in 2006 was 17.4% compared to the national rate of less than 1%.⁶⁷ The rate of HIV/AIDS among prisoners is five times higher than the national rate.⁶⁸ In 1996, the National Commission on Correctional Health Care estimated that as many as 145,000 HIV-positive prisoners were released from federal or state prisons.⁶⁹ In 1997, there were between 465,000 and 595,000 cases of sexually transmitted diseases among recently released prisoners.⁷⁰ Finally, over 7% of prisoners test positive for tuberculosis.⁷¹ By some estimates, over half of the people in the country with tuberculosis had served time in a correctional facility that year.⁷²

2. Overcrowding and Non-Communicable Disease

Another result of overcrowding is inappropriate facilities, which may contribute to contraction of non-communicable disease. Contributory factors include lack of access or time for showering, lack of clean clothing, lack of access to outdoor recreation, leaky pipes and broken plumbing, and exposure to extreme heat or cold.⁷³ Due to an insufficient number of beds, suicidal prisoners may be kept “for their

63. *Plata*, 131 S. Ct. at 1924.

64. *Id.*

65. *Id.*

66. Maureen Mullen Dove, *Law and Fact of Health Care in Prisons*, 44 MD. BAR J. 4, 11 (2011).

67. *State Prison Health Care Spending: An Examination*, PEW CHARITABLE TRUST AND THE JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION (July 2014) (on file with the author).

68. *HIV Among Incarcerated Populations*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Mar. 14, 2017), <https://www.cdc.gov/hiv/group/correctional.html>.

69. *The Health Status of Soon-to-Be-Released Inmates: A Report to Congress, Vol. 1*, NAT'L COMMISSION ON CORRECTIONAL HEALTH CARE (Sept. 2004), http://www.ncchc.org/filebin/Health_Status_vol_1.pdf.

70. *Id.*

71. *Id.*

72. *Id.*

73. Mary Tiedeman, Daniel Ballon, Melinda Bird, & Peter Eliasberg, *2010 Interim Report on Conditions Inside Los Angeles County Jail*, ACLU OF S. CAL. AND ACLU NAT'L PRISON PROJECT, 12–13 (Sept. 9, 2010), <https://www.aclu.org/report/2010-interim-report-conditions-inside-los-angeles-county-jail>.

safety” for prolonged periods in telephone-booth-sized cages without toilets, standing in their own urine.⁷⁴ Lack of space, resources, or access to hygiene, then, possibly contributes to the prevalence of non-communicable disease such as diabetes, hypertension, and mental illness. The prevalence of diabetes in federal and state inmates is estimated to be 4.8%, with a further 18% diagnosed with pre-diabetic hypertension.⁷⁵ The suicide rate in California state prisons is 80% higher than the corresponding national average.⁷⁶

At times, overcrowding results in long wait times or the inability to be seen by a health care provider at all. This is best demonstrated by example. One prisoner presented with testicular pain and died because of a seventeen-month delay in a customary cancer work-up.⁷⁷ Another prisoner presented with severe abdominal pain and died because of a five-week delay in being referred to the necessary specialist.⁷⁸ A third prisoner presented with constant and extreme chest pain, and then died because of an eight-hour delay in evaluation by a doctor.⁷⁹

Prisons are unable to retain sufficient numbers of medical staff, maintain hygienic medical facilities, or obtain necessary medical equipment.⁸⁰ Vacancy rates at correctional facilities can be as high as 54.1% for psychiatrists, 25% for physicians, and 20% for surgeons.⁸¹ If an inmate requires referral, wait time can be as long as twelve months.⁸² The Supreme Court found that only 2 out of 316 inmates with pending referrals had an appointment within two weeks, and less than half had an appointment at all.⁸³ Perhaps the remote locations of most prisons, or ability to competitively compensate health care providers, may be to blame for insufficient staff.

Granted, some amount of prisoner illness is already present upon booking, but the findings in *Brown v. Plata* indicate that illness emerges or becomes exacerbated during incarceration.⁸⁴ Prisoners are already in poor health, and the process of leaving the system further

74. *Plata*, 131 S. Ct. at 1910.

75. Southern Poverty Law Center. *Prisoner Diabetes Handbook: A Guide to Managing Diabetes – for Prisoners, by Prisoners* (Jan. 2007), https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/publication/SPLCdiabetes8507.pdf.

76. *Id.*

77. *Id.* at 1925.

78. *Id.*

79. *Id.*

80. *Id.* at 1927.

81. *Plata*, 131 S. Ct. at 1932.

82. *Id.* at 1924.

83. *Id.* at 1933.

84. *Id.* at 1925.

deteriorates ex-prisoners' health. Ex-prisoners face the physically and mentally tough process of re-assimilation into their communities,⁸⁵ and often do so without health insurance coverage.⁸⁶ Medicaid benefits are suspended upon incarceration,⁸⁷ and prisoners who are enrolled often miss their renewal requirements during their incarceration.⁸⁸ For prisoners who wish to newly enroll, Medicaid procedures impose requirements that are difficult for people in prisons, who may not have access to their necessary documents and papers.

C. Health Care Reform in the United States

In *National Federation of Independent Businesses v. Sebelius*,⁸⁹ the Supreme Court upheld the Patient Protection and Affordable Care Act ("Affordable Care Act," or simply "Act"), a decision that has been called by some scholars the greatest re-distribution of wealth of our time.⁹⁰ Along with a shift in power and the rise of the Trump administration, some right-wing politicians have unsuccessfully attempted—and may continue to attempt—to repeal and replace the Affordable Care Act.⁹¹ Even if provisions of the Act are no longer part of United States law, each state may exercise its right to continue current coverage under Medicaid. So long as childless adults within a certain designation of the federal poverty line⁹² are covered, a significant effect of the Act still holds.

1. Why the Affordable Care Act

The Affordable Care Act was spurred both by lack of access to health care for many Americans and the resulting cost on others. When President Barack Obama assumed office in 2008, 46.3 million or 15.4% of Americans were not covered by health insurance.⁹³ Still, even those without insurance needed sudden care at times.⁹⁴ They

85. Alison Evans Cuellar & Jehanyeb Cheema, *As Roughly 700,000 Prisoners Are Released Annually, About Half Will Gain Health Coverage and Care Under Federal Laws*, 31 HEALTH AFFAIRS 931 (2012).

86. *Id.*

87. S.B. 1616, 2005-2006 S., Reg. Sess. (Cal. 2006).

88. Cuellar & Cheema, *supra* note 85; see also *Plata*, 131 S. Ct. at 1924-26.

89. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

90. Bradley W. Joondeph, *The Health Care Cases and the New Meaning of Commandeering*, 91 N.C. L. REV. 811, 813 (2012).

91. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).

92. See discussion *infra* Part I.C.3.

93. See Carmen DeNavas-Walt, Bernadette D. Proctor, & Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. CENSUS BUREAU (Sept. 2008), <https://www.census.gov/prod/2010pubs/p60-238.pdf>.

94. *Sebelius*, 132 S. Ct. at 2585 (2012).

went to hospitals and emergency rooms, which are required to stabilize patients and provide basic care regardless of ability to pay.⁹⁵

In a given year, over 60% of uninsured individuals visit an emergency room.⁹⁶ In 2008, health care providers absorbed \$43 billion of the \$116 billion in care they provided to uninsured individuals.⁹⁷ In order to be reimbursed for the remaining \$73 billion in unpaid hospital bills, health care providers passed on the burden to insurers by charging them more.⁹⁸ In turn, insurers passed on the burden to consumers in the form of higher premiums.⁹⁹

Ultimately, indigent patients' use of health facilities raised family insurance plan premiums by an average of over \$1,000 per year.¹⁰⁰ The higher premiums are raised, the less accessible insurance coverage becomes for indigent patients, and so the cycle continues.¹⁰¹ Also, when lower income populations do have insurance, it is likely through Medicaid,¹⁰² and the taxpayer is also billed. Perhaps this is why in 2009, Americans spent an estimated \$2.5 trillion on health care, the highest per capita amount in the world.¹⁰³

To resolve these problems, in 2010 Congress passed the Affordable Care Act.¹⁰⁴ It spans over 900 pages of the United States Code¹⁰⁵ and contains provisions such as the guaranteed-issue provision, which prohibits insurance companies from denying coverage to those with pre-existing conditions.¹⁰⁶ However, it is the individual mandate and Medicaid expansion provisions that have been the most controversial.¹⁰⁷ The individual mandate requires individuals to purchase a health insurance policy, or else pay a tax.¹⁰⁸ The Medicaid expansion requires Medicaid to cover all individuals who are at least within 133% of the federal poverty line.¹⁰⁹ By enrolling individuals

95. *Id.* (citing, *e.g.*, 42 U.S.C. § 1395dd (2015)).

96. *Id.* at 2611 (Ginsburg, J., dissenting).

97. *Id.*

98. *Id.* at 2585.

99. *Id.*

100. *Sebelius*, 132 S. Ct. (citing 42 U.S.C. § 18091(2)(F) (2015)).

101. *Id.* at 2611 (Ginsburg, J., dissenting).

102. In a conversation with a case manager at the Boston Health Care for the Homeless Program, I learned that 100% of her patients with insurance are on a plan through Medicaid.

103. *Health Policy Snapshot: How Does the ACA Control Health Care Costs?*, ROBERT WOOD JOHNSON FOUNDATION (July 2011), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71451.

104. *Sebelius*, 132 S. Ct. at 2580.

105. *Id.*

106. 42 U.S.C. § 300gg-3 (2015).

107. *Sebelius*, 132 S. Ct. at 2580–82.

108. *Id.* at 2577.

109. *Id.* at 2581–82.

whose premiums will likely be more than their health care costs, the Act intends to counter-balance the costs of forcing insurers to accept individuals with pre-existing conditions.¹¹⁰ Additionally, the tax on uninsured individuals is expected to garner about \$4 billion per year by 2017.¹¹¹

When the Affordable Care Act was passed, Congress' left- and right-wing politicians were (and continue to be) in notoriously antagonistic positions.¹¹² For the left wing, the Act was a milestone in health care and social welfare.¹¹³ The right wing, on the other hand, wasted no time in appealing to the courts to challenge the Act's constitutionality.¹¹⁴ However, they were in the position of wanting to repeal the entirety of the act—not just the individual mandate and Medicaid expansion provisions—while challenging the act on narrow enough grounds to leave intact the federal government's power to regulate, tax, and spend.¹¹⁵ These tools would enable the passage and maintenance of right-wing policies in a then-predominantly left-wing Congress.¹¹⁶

In order to understand the challenges to the Affordable Care Act, it is first necessary to set forth the notion of enumerated powers that governs the federal government. The Framers envisioned powerful states with a limited federal government, and wrote in the Tenth Amendment that “[t]he powers not delegated to the United States by the Constitution . . . are reserved to the States respectively, or to the people.”¹¹⁷ Because the Constitution grants eighteen powers to Congress,¹¹⁸ by negative inference, “[t]he enumeration presupposes something not enumerated.”¹¹⁹ If Congress were acting beyond the scope of its authority, then the Act should not have been enacted in the first place, even without violating the Bill of Rights or being prohibited elsewhere in the Constitution.¹²⁰ Challengers to the Act therefore argued that the individual mandate was beyond Congress' commerce

110. *Id.* at 2585.

111. *Id.* at 2594.

112. Jack M. Balkin, *The Court Affirms Our Social Contract*, THE ATLANTIC (June 29, 2012), <http://www.theatlantic.com/national/archive/2012/06/the-court-affirms-our-social-contract/259186/>.

113. *Id.*

114. *Id.*

115. *Id.*

116. *See id.*

117. U.S. Const. amend. X.

118. U.S. Const. art. I, § 8.

119. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2577 (2012) (citing *Gibbons v. Ogden*, 22 U.S. 1 (1824)).

120. *Id.* at 2577.

power,¹²¹ and that the Medicaid expansion was beyond its spending power.¹²²

In a 5-4 decision written by Chief Justice John Roberts, the Supreme Court held that the individual mandate was beyond Congress' commerce power but within its taxing power; further, although the Medicaid expansion was beyond Congress' spending power,¹²³ this provision was severable and did not render the entire Act unconstitutional.¹²⁴

2. *The Individual Mandate Provision*

The Court agreed that the individual mandate was beyond Congress' commerce power,¹²⁵ but found that it was within its taxing power.¹²⁶ The individual mandate requires individuals to purchase a health insurance policy with satisfactory "minimum essential" coverage.¹²⁷ Individuals may either obtain their policy through their employer, through a government program such as Medicaid or Medicare, or through a private company.¹²⁸ Undocumented aliens, prisoners, or low-income individuals who are not required to file annual taxes annually are exempt from the mandate.¹²⁹ Those who do not comply with the mandate must pay a "penalty" to the Internal Revenue Service.¹³⁰

The commerce power authorizes Congress to "regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."¹³¹ Although the commerce power has historically been construed broadly,¹³² the Court rejected the argument that mandating participation in a health insurance program affects interstate commerce by spreading the cost of covering those with pre-existing conditions across all premiums.¹³³ Rather, the Court stressed that the power to

121. U.S. Const. art. I, § 8, cl. 3.

122. U.S. Const. art. I, § 8, cl. 1.

123. *Sebelius*, 132 U.S. at 2608.

124. *Id.*

125. *Id.* at 2591.

126. *Id.* at 2601.

127. 26 U.S.C. § 5000A (2015).

128. 26 U.S.C. § 5000A(f) (2015).

129. 26 U.S.C. § 5000A(d)-(e) (2015).

130. 26 U.S.C. § 5000A(g)(1) (2015).

131. U.S. Const. art. I, § 8, cl. 3.

132. *See, e.g., Wickard v. Filburn*, 317 U.S. 111 (1942) (holding the commerce power to be broad enough to encapsulate activities that substantially affect interstate commerce in the aggregate). *See also Katzenbach v. McClung*, 379 U.S. 294 (1964) (using the expansive commerce power to prohibit racial discrimination before the passage of the Civil Rights Act of 1964).

133. *Sebelius*, 132 S. Ct. at 2585–86.

regulate does not equate to the power to create.¹³⁴

However, the failure of the Affordable Care Act to have been enacted pursuant to the commerce power was not fatal to the individual mandate. The taxing power authorizes Congress to “lay and collect Taxes.”¹³⁵ Although the Act says that noncompliance with the mandate results in a “penalty,” this repercussion bears sufficient similarities to be a “tax.”¹³⁶ Thus, under the taxing power, but not the commerce power, the individual mandate provision was found constitutional and upheld.

3. *The Medicaid Expansion Provision*

The Court held that it was beyond Congress’ enumerated powers to require states to enact the Medicaid expansion provision, though states may do so if they wish.¹³⁷ Medicaid is a social program that enrolls those with limited resources into a government health care plan.¹³⁸ Previously, Medicaid covered only pregnant women, the blind, the elderly, the disabled, unemployed parents who made less than 37% of the federal poverty level, or employed parents who made less than 63% of the federal poverty level.¹³⁹ The Affordable Care Act, on the other hand, wished to compel states to cover all individuals with incomes below 133% of the federal poverty level, including the never-before-used category of “childless adults.”¹⁴⁰ Although incarcerated individuals are not eligible for Medicaid, nowhere in the Act are ex-prisoners who have served their sentences excluded from eligibility.¹⁴¹

However, if states did not expand their Medicaid programs, they were threatened with the loss of all federal funds for Medicaid.¹⁴² The Spending Clause of the Constitution authorizes Congress to have the power to “provide for the . . . general Welfare of the United States.”¹⁴³ Congress may also engage in conditional spending, or giving federal funds to the states only if they partake in some desired action.¹⁴⁴ In *South Dakota v. Dole*, the Supreme Court said that the inducement could not be “so coercive as to pass the point at which ‘pressure turns

134. *Id.* at 2586.

135. U.S. Const. art. I, § 8, cl. 1.

136. *Sebelius*, 132 U.S. at 2594.

137. *Id.* at 2603.

138. *Id.* at 2605–06.

139. 42 U.S.C. § 1396a(a)(10) (amended 2010).

140. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2015).

141. 45 C.F.R. § 155.305 (2013).

142. *Sebelius*, 132 U.S. at 2601.

143. U.S. Const. art. I, § 8, cl. 1.

144. *College Savings Bank v. Florida Prepaid Postsecondary Ed. Expense Bd.*, 527 U.S. 666, 686 (1999).

into compulsion.’”¹⁴⁵

Here, however, the Court called the conditional spending “a gun to the head.”¹⁴⁶ The federal government threatened to withhold all of Medicaid funds unless the program was expanded.¹⁴⁷ Medicaid spending was over 20% of the states’ budgets, and the receipt of federal funds provided for between 50% to 83% of these expenditures.¹⁴⁸ Although states could choose whether or not to expand Medicaid, it would be beyond the spending power for the federal government to withhold Medicaid funding if states chose not to.¹⁴⁹ Inversely, given threats by the Trump administration to repeal and replace the Act, it might be seen as abuse of the spending power for the federal government to revoke all Medicaid funding if those states which chose to expand Medicaid *keep* their expansions.

The Affordable Care Act included a severability clause,¹⁵⁰ so although the Medicaid expansion was invalid and made only optional for the states, the other provisions such as the guaranteed-issue and individual mandate were left intact.

President Obama has said that 18 million Americans have gained health coverage and more than 90% of Americans have health insurance for the first time.¹⁵¹ Pursuant to the Affordable Care Act and its amendment, the Health Care and Education Reconciliation Act, thirty-one states, including California, have discretionarily chosen to expand their Medicaid programs.¹⁵² For the first time, Medicaid covers childless adults, or in other words nondisabled, nonelderly, low-income adults.¹⁵³

The Supreme Court and the State of California have agreed that poor health care in prisons violates the Eighth Amendment’s

145. *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)).

146. *Sebelius*, 132 S. Ct. at 2604.

147. 42 U.S.C. § 1396c (2015).

148. *Sebelius*, 132 S. Ct. at 2604 (citing Nat. Ass’n of State Budget Officers, Fiscal Year 2010 State Expenditure Report, p. 11, Table 5 (2011) and 42 U.S.C. § 1396d(b) (2015)).

149. *Sebelius*, 132 S. Ct. at 2607.

150. 42 U.S.C. § 1396c (2015).

151. Barack Obama, President of the United States, State of the Union (Jan. 12, 2016).

152. *Coverage Expansion as of July 2016*, MEDICAID, <https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf>.

153. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2015); see also *Where the States Stand on Medicaid Expansion*, ADVISORY BOARD (Jan. 13, 2016, 8:46 AM), <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap>.

prohibition on cruel and unusual punishment.¹⁵⁴ Beyond constitutional concerns, there are fiscal concerns, too. Under the Affordable Care Act, up to 129 million Americans with pre-existing conditions can no longer be denied coverage.¹⁵⁵ Ex-prisoners will be incentivized to enroll in a health care plan to avoid the tax on the uninsured¹⁵⁶ and will be eligible for Medicaid.¹⁵⁷ Given that the cost of funding this additional, unhealthy population will pass on to taxpayers, preventative care may be not only a basic constitutional and human right, but also a less costly expenditure in the long term.¹⁵⁸

II. THE CONSTITUTIONAL AND ECONOMIC PROBLEM OF A SICK POST-PRISON POPULATION USING MEDICAID

California state prisons are lethally overcrowded.¹⁵⁹ Though the purpose of punishment may be a matter of philosophical debate,¹⁶⁰ it is clear that—with the exception of the death penalty—the purpose is not to bring prisoners to a premature death during their incarceration. Prisoners rely on the state for their health care, as they cannot seek it for themselves.¹⁶¹ This care is not being given.¹⁶² However, appealing to constitutional and human rights interests is of little additional motivation. The state already concedes that its failure to provide health care violates the Eighth Amendment's prohibition on cruel and unusual punishment.¹⁶³ It is aware of the problem, but difficulty lies in financing the solution.¹⁶⁴

While the *Brown v. Plata* litigation has unfolded, so too has health care reform. The Affordable Care Act pushed for the expansion of Medicaid.¹⁶⁵ Though the Supreme Court ruled that states are not required to undertake the expansion, thirty-one states, including California,¹⁶⁶ have discretionarily done so anyways.¹⁶⁷ Childless adults earning less than 133% of the federal poverty level will be eligible for

154. See discussion *supra* Part I.A–B.

155. Obama, *supra* note 151.

156. See discussion *supra* Part I.C.1.

157. See discussion *supra* Part I.C.2.

158. See discussion *supra* Part I.C.3.

159. *Plata*, 131 S. Ct. at 1923.

160. See Bentham, *supra* note 30.

161. *Trop*, 356 U.S. at 103.

162. *Plata*, 131 S. Ct. at 1925.

163. Ball, *supra* note 48, at 990.

164. *Plata*, 131 S. Ct. at 1927.

165. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2015).

166. *Where the States Stand on Medicaid Expansion*, *supra* note 153.

167. See *Coverage Expansion*, *supra* note 152.

Medicaid.¹⁶⁸ In California, this means that up to 80% of inmates are eligible to enroll upon release.¹⁶⁹ Additionally, pre-existing conditions cannot be a basis for denial of coverage.¹⁷⁰

The more care a health insurance consumer needs, the more costly their policy is.¹⁷¹ In the case of Medicaid, these costs are passed on to the taxpayer through income tax withholdings.¹⁷² Already 18.9% of the California budget is spent on Medicaid, which amounted specifically to \$95.4 billion from 2015 to 2016.¹⁷³

California's prison inmates are sick and dying.¹⁷⁴ In overcrowded living conditions, there is a high risk of disease.¹⁷⁵ This is the population that is newly empowered to enroll in taxpayer-funded Medicaid. Researchers estimate that over 200,000 ex-prisoners per year are newly eligible to enroll in Medicaid.¹⁷⁶ It is projected that 33.6% of inmates released annually will now be eligible for Medicaid where they previously were not.¹⁷⁷ Local estimates are higher. In California, it is projected that 80% of individuals in jails are either enrolled or eligible for Medicaid.¹⁷⁸ These individuals are a particularly expensive addition to Medicaid given the nature of the health care they require.

On the other hand, not expanding Medicaid or failing to insure indigent populations is not a viable alternative. Even those without insurance need health care.¹⁷⁹ Ambulatory care and emergency rooms are often the only available care when latent need for care suddenly arises, and these places are required to stabilize patients and provide basic care regardless of ability to pay.¹⁸⁰ In a given year, over 60% of uninsured individuals visit an emergency room.¹⁸¹ In 2008, health care providers absorbed \$43 billion of the \$116 billion in care they provided

168. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2015).

169. Bainbridge, *supra* note 13, at 6.

170. 42 U.S.C. § 300gg (2015).

171. *Sebelius*, 132 S. Ct. 2566 (2012).

172. *Id.*

173. Edmund G. Brown Jr. Governor, State of California, 2015-16 Governor's Budget Summary, <http://www.ebudget.ca.gov/2015-16/pdf/BudgetSummary/FullBudgetSummary.pdf>.

174. See discussion *supra* Part I.B.

175. *Id.*

176. *Id.*

177. Bainbridge, *supra* note 13. As roughly 700,000 prisoners are released annually, about half will gain health coverage and care under federal laws.

178. *Id.* at 6.

179. *Sebelius*, 132 S. Ct. at 2585 (2012).

180. *Id.* (citing, *e.g.*, 42 U.S.C. § 1395dd (2015)).

181. *Id.* at 2611 (Ginsburg, J., dissenting).

to uninsured individuals.¹⁸² In order to be reimbursed for the remaining \$73 billion in unpaid hospital bills, health care providers passed on the burden to insurers by charging them more.¹⁸³ In turn, insurers passed on the burden to consumers in the form of higher premiums.¹⁸⁴

Ultimately, indigent patients' use of health facilities raised family insurance plan premiums by an average of over \$1,000 per year.¹⁸⁵ The higher premiums are raised, the less accessible insurance coverage becomes for indigent patients, and so the cycle continues.¹⁸⁶ Perhaps this contributed to the fact that, in 2008, Americans spent an estimated \$2.5 trillion on health care, the highest per capita amount in the world.¹⁸⁷ Indeed, a sick ex-prison population is expensive, but not expanding Medicaid per the Affordable Care Act is expensive as well.

Poor ex-prisoner health also indicates a likelihood of returning to prison, which increases costs in the criminal justice system and also burdens taxpayers' wallets. Studies show that continuous health care for ex-prisoners—particularly for substance use, addiction, and mental illness—reduces criminal behaviors.¹⁸⁸ Given that over two-thirds of prisoners who are released are re-arrested within three years,¹⁸⁹ any reduction in recidivism will alleviate the costs associated with the overburdened criminal justice system while improving safety in our communities.

Ex-prisoners should of course be included in the pool of those eligible for Medicaid, and with the Medicaid expansion and guaranteed-issue provisions,¹⁹⁰ they will be. But these individuals' inclusion need not be costly.

182. *Id.*

183. *Id.* at 2611.

184. *Id.*

185. *Sebelius*, 132 S. Ct. at 2611 (citing 42 U.S.C. § 18091(2)(F) (2015)).

186. *Id.* at 2611 (Ginsburg, J., dissenting).

187. See *Health Policy Snapshot: How Does the ACA Control Health Care Costs?*, *supra* note 103.

188. Bainbridge, *supra* note 13; see also Maureen McDonnell, Laura Brookes, Arthur Lurigio et al., *Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations*, CMTY. ORIENTED CORRECTIONAL HEALTH SERVICES (Jan. 2011) (on file with the author).

189. Matthew R. Durose, Alexia D. Cooper, and Howard N. Snyder. *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010 – Update*, BUREAU OF JUSTICE STATISTICS (April 22, 2012), <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=4986>.

190. This provision bars denial of coverage on the basis of pre-existing conditions.

III. A COST-EFFECTIVE OPPORTUNITY DRAWN FROM THE PUBLIC HEALTH LITERATURE

A premise of the Affordable Care Act is that healthy individuals use less insurance money for their health care than they pay into the insurance program through their premiums; conversely, unhealthy individuals use more money than they pay through premiums.¹⁹¹ Medicaid is a social program funded by the government rather than by premiums,¹⁹² but the premise remains that the healthier the consumer, the more costly and extensive treatment.¹⁹³ The difference is that the cost is absorbed across taxpayers.¹⁹⁴

The aim, then, should be to keep populations that are likely to use Medicaid, such as the post-prison population, as healthy as possible. Poor ex-prisoner health is an excessive burden on Medicaid, but evidence shows that preventative programs are cost-effective.¹⁹⁵ Implementation of preventative programs which even require initial investment would save taxpayer dollars in the long run. This is shown in the general population. Of particular concern amongst the ex-prison population are certain communicable diseases—hepatitis C and HIV/AIDS—and certain non-communicable diseases—diabetes.

A. Evidence of the Cost-Effectiveness of Preventative Care in the General Population

In the general population, many preventative measures are less costly than treatments for pre-existing conditions. The National Institute of Health recommends routine tests for blood pressure, blood sugar, breast, colon, and ovarian cancers, cholesterol, depression, HIV, osteoporosis, and sexually transmitted diseases.¹⁹⁶ Studies show that of these, at least vaccinations, screenings for colon and prostate cancers, screenings for depression, and preventative measures for HIV and sexually transmitted diseases are more cost-effective than their respective treatments.¹⁹⁷ As a more general model, health economists

191. *Sebelius*, 132 S. Ct. at 2580.

192. *Id.* at 2692 (Ginsburg, J., dissenting).

193. *Id.* at 2612.

194. *Id.* at 2692.

195. It bears noting that cost-effectiveness and cost-savings are different concepts; in determining the worth of a health intervention, cost-effectiveness more holistically takes into account the benefits to be gained, whereas cost-savings only takes into account whether the intervention is less expensive than the averted medical costs. See *The Health Status of Soon-to-Be-Released Inmates*, *supra* note 69, at 35.

196. *Preventative Health Care*, U.S. NAT'L LIBRARY OF MEDICINE: NAT'L INSTITUTES OF HEALTH, <https://www.nlm.nih.gov/medlineplus/ency/article/001921.htm>.

197. Cohen JT, Neumann PJ, Weinstein MC., *Does preventative care save money?*

have suggested that preventative care is more cost-effective than treatment when it is employed unambiguously, or in other words when an individual is at-risk for certain illnesses.¹⁹⁸ As noted in Part II, *supra*, prisoners are at-risk for a range of communicable and non-communicable diseases due to overcrowding.

B. Drawing from the Communicable Disease Literature

Prisoners are at-risk for several communicable diseases, including hepatitis B and C, HIV, methicillin-resistant staphylococcus aureus (MRSA), sexually transmitted diseases (syphilis, gonorrhea, and chlamydia), and airborne illnesses such as tuberculosis.¹⁹⁹ In particular, however, early treatment for hepatitis C, and preventative care such as counseling and testing for HIV, have been found to be extremely cost-effective.

Hepatitis C is a liver disease, and it is caused by a blood-borne virus which spreads through inadequate sterilization of medical equipment, unsafe injection practices, and the transfusion of unscreened blood and blood products.²⁰⁰ The complications of hepatitis C include cirrhosis, chronic or end-stage liver disease, and liver cancer, some of which require the need for liver transplants and all of which come with their own further costs.²⁰¹ The economic burden of hepatitis C-related diseases was \$6.5 billion in 2011.²⁰²

With the advent of a new drug called sofosbuvir, 90% of cases can be cured in twelve weeks.²⁰³ Gilead Sciences is the patent-holder of sofosbuvir and brands it Sovaldi,²⁰⁴ the manufacturing cost is \$200 for the twelve-week treatment, but it is sold at \$1,000 per pill.²⁰⁵ Gilead's

Health economics and the presidential candidates, 358 N. ENG. J. MED. 661 (2008).

198. Hey, JD & Patel, MS., *Prevention and Cure? Or: Is an Ounce of Prevention Worth a Pound of Cure?*, 2 J. OF HEALTH ECON. 119 (1983).

199. Maureen Mullen Dove, *Law and Fact of Health Care in Prisons*, 44 MD. BAR J. 4, 11 (2011).

200. *Hepatitis C Fact Sheet No. 164*, WORLD HEALTH ORGANIZATION (July 2015), <http://who.int/mediacentre/factsheets/fs164/en/>.

201. Beth Schwartzapfel, *Why Some Prisons are Spending Millions on a Pricey New Drug*, THE MARSHALL PROJECT (Feb. 22, 2016); Jagpreet Chhatwal, Fasiha Kanwal, Mark S. Roberts, & Michael A. Dunn, *Cost-Effectiveness and Budget Impact of Hepatitis C Virus Treatment with Sofosbuvir and Ledipasvir in the United States*, 162 ANNALS OF INTERNAL MEDICINE 397 (2015).

202. See Chhatwal et al., *supra* note 201.

203. Beth Schwartzapfel, *The \$33 Test in Prison That Could Save Countless Lives on the Outside*, THE MARSHALL PROJECT (Nov. 24, 2015).

204. See *Sovaldi* (2017), <http://www.sovaldi.com/> ("SOVALDI, the SOVALDI logo . . . are trademarks of Gilead Sciences, Inc., or its related companies.").

205. Chhatwal et al., *supra* note 201.

mark-up is \$83,800 per course of treatment.²⁰⁶ A large portion of those expected to use hepatitis C treatments use Medicaid, and therefore treatment with Sovaldi is expected to fall upon the government and taxpayers.²⁰⁷ Although Gilead's pricing of Sovaldi may be seen as a barrier to eradication of hepatitis C,²⁰⁸ despite its high price, Sovaldi may be less expensive than the comorbidities associated with chronic hepatitis C.

The theory that preventative and early care would be economically viable is more than merely conjectural. Treating hepatitis C has been proven to be cost-effective specifically in the prison population. An estimated 12% to 31% of the prison population is afflicted with chronic hepatitis C, compared with a national average just over 1%.²⁰⁹ Pre-emptively treating hepatitis C in its early stages proved to be more cost-effective than conducting liver biopsies or treating chronic liver fibrosis or failure.²¹⁰ By one estimate, \$760 million spent on liver transplants and other medical care could be averted over the next thirty years with the implementation of hepatitis C treatment.²¹¹ Eighty percent of these savings would occur in the general population.²¹² Treatment was cost-effective—even though it was not anticipated to be due to risky behaviors, high rates of reinfection, and high mortality rates inside and outside of prisons.²¹³ Perhaps this is why, despite the initial sticker shock of Sovaldi, California has increased its spending on hepatitis C in prisons from approximately \$10 million in 2014 to \$57.6 million in 2015, reflecting a 453.8% annual change in hepatitis C spending.²¹⁴ Other states are encouraged to follow California's lead.

Beyond the economic gains to be realized by early treatment of hepatitis C, a unique public health opportunity may be had. More than

206. See *id.* at n. 13. For a criticism of how Gilead and the pharmaceutical industry makes access to hepatitis C treatment inaccessible and hinders eradication of the spread of disease, see *Hepatitis C Fact Sheet No. 164*, *supra* note 200.

207. See Chhatwal et al., *supra* note 201.

208. *Id.*

209. Tan, JA, Joseph, TA, & Saab, Sammy, *Treating Hepatitis C in the Prison Population is Cost-Saving*, *HEPATOLOGY* 48(5) 1387, 1397–95 (2008).

210. *Id.*; see also Liu, Shan, Watcha, D, Holodniy, M, & Goldhaber-Fiebert, JD., *Sofosbuvir-Based Treatment Regimens for Chronic, Genotype 1 Hepatitis C Virus Infection in U.S. Incarcerated Populations: A Cost-Effectiveness Analysis*, *ANNALS OF INTERNAL MEDICINE* 161(8) 546–53 (2014).

211. Chhatwal et al., *supra* note 201.

212. *Id.*

213. Tan, JA, Joseph, TA, & Saab, Sammy, *supra* note 209, at 1391.

214. David Eugene Archer Sr. *Treatment Costs of Hep C for Inmates on the Rise*. San Quentin News, June 2016, at 4.

3 million Americans are chronically infected with hepatitis C.²¹⁵ One-third of them pass through the correctional system each year; during incarceration, infected prisoners expose thousands of daily prison visitors and the nation's 431,600 correctional employees.²¹⁶ After incarceration, ex-prisoners and those they encounter threaten the general population with the spread of disease. Therefore, treating hepatitis C has the additional benefit of reducing the spread of hepatitis C amongst the general population.²¹⁷ To ignore prisoners as a key population at risk for hepatitis C is to pass a critical public health opportunity to eradicate or limit the spread of disease.

Prisoners are also a key population for HIV prevention, meaning they are at high risk of infection and have lower access to treatment.²¹⁸ HIV is the human immunodeficiency virus, which targets the immune system and weakens people's defences against infection; in its most advanced stage HIV infection is AIDS, or acquired immunodeficiency syndrome.²¹⁹ It is spread through the exchange of bodily fluids such as blood, breast milk, semen, and vaginal secretions; for this reason, risk factors for infection include unsterile medical procedures, unprotected sex, sharing contaminated needles,²²⁰ or transmission from mother to child. Transmission is high in prisons due to the prevalence of sexual violence, dirty needles, and transmission from mother to child.²²¹ There is no cure for HIV/AIDS, but antiretroviral therapy can suppress viral replication at a lifetime treatment cost of between \$165,000 and \$267,000.²²²

A study evaluated the cost-efficiency and cost-savings of preventative care in prison populations, specifically counselling and testing.²²³ For every 10,000 prisoners offered counselling, approximately 5,000 accepted, and fifty infected prisoners were identified.²²⁴ The study conservatively assumed that infected prisoners

215. Chhatwal et al., *supra* note 201.

216. *Occupational Employment and Wages, May 2016: 33-3012 Correctional Officers and Jailers*, Occupational Employment Statistics, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/oes/current/oes333012.htm>.

217. *Id.*

218. *Consolidated Guidelines on HIV Testing and Services*, WORLD HEALTH ORGANIZATION (July 2015).

219. *HIV/AIDS Fact Sheet No. 360*, WORLD HEALTH ORGANIZATION (Nov. 2015), <http://www.who.int/mediacentre/factsheets/fs360/en/>.

220. *Id.*

221. *Id.*

222. See Beena Varghese & Thomas A. Peterman, *Cost-Effectiveness of HIV Counseling and Testing in U.S. Prisons*, 78 J. OF URBAN HEALTH 304, 308 (2001).

223. See *id.* at 305, 308.

224. *Id.* at 308.

who underwent counselling were 25% more likely to adopt safer behaviors, reducing their risk of transmission from 7% to 5.2%.²²⁵ Further, the preventative measure only cost \$78.17 per infected inmate—which included wage and time costs for administrators, counsellors, phlebotomists, and laboratory staff, the cost of serum collection kits, the enzyme immunoassay, Western blot tests, and controls, and ultimately saved \$563,834.²²⁶

Since 2010, California has done routine HIV testing for incoming inmates.²²⁷ Ninety-one percent are placed on drug therapy and 88% reach viral suppression.²²⁸ In the general population only 40% of those on drug therapy reach viral suppression.²²⁹ Other common harm reduction programs include the distribution of safe supplies such as clean needles and condoms.²³⁰ Although the distribution of clean needles in the general population has found great success,²³¹ it might be controversial and difficult to implement due to security risks to the prison population. However, a condom distribution program would be inexpensive and significantly safer to implement. Indeed, California and Vermont are the first two states to require that condoms be provided to inmates.²³² As a result of this policy, sexual activity did *not* increase, custody operations were not impeded, and HIV-positive prisoners were found more likely to use condoms than their HIV-negative counterparts.²³³ Other states are encouraged to follow California and Vermont's leads.

225. *Id.* at 307.

226. *Id.* at 307–08.

227. Kimberly D. Lucas, Valorie Eckert, Czarina N. Behrends, Charlotte Wheeler, Robin J. MacGowan, and Ranet C. Mohle-Boetani. *Evaluation of Routine HIV Opt-Out Screening and Continuum of Care Services Following Entry into Eight Prison Reception Centers – California, 2012*. 65 Morbidity and Mortality Weekly Report 178 (Feb. 26, 2016), <https://www.cdc.gov/mmwr/volumes/65/wr/mm6507a3.htm>.

228. *Id.*

229. *Id.*

230. Hands-on information on harm reduction programs and supplies has been gleaned by the author from volunteering with the HIV Education and Prevention Program of Alameda County (HEPPAC), colloquially known as *casa segura*, in Oakland, California. For an overview of harm reduction policy, issues, and links to local organizations such as HEPPAC, see Harm Reduction Coalition, <http://harmreduction.org>.

231. See Don C. Des Jarlais, *Editorial: Harm Reduction—A Framework for Incorporating Science into Drug Policy*, 85 AM. J. OF PUBLIC HEALTH 10 (1999).

232. A.B. 999, 2013-2014 Assemb., Reg. Sess. (Cal. 2013); see also *California Prisons Aim to Keep Sex between Inmates Safe, If Illegal*, NAT'L PUBLIC RADIO (Jan. 21, 2015), <http://www.npr.org/2015/01/21/378678167/california-prisons-aim-to-keep-sex-between-inmates-safe-if-illegal>.

233. Mary Sylla, Nina Harawa, & Olga Grinstead Reznick, *The First Condom Machine in a U.S. Jail: The Challenge of Harm Reduction in a Law and Order Environment*, 100 AM. J. OF PUBLIC HEALTH 982 (2010).

The logic from hepatitis C and HIV/AIDS can be extended to other communicable diseases. Implementation of these policies in prison has the unique potential to translate to better health outcomes in the general population, because of high levels of compliance—prisoners adhere to a strict schedule and have no place to avoid adherence to a health regimen—and because prisons contain key populations for many communicable diseases. While preventative care and early treatment for hepatitis C with Sovaldi may seem like an investment, they actually save taxpayer money by avoiding seriously ill ex-prisoners' use of Medicaid.

C. Drawing from the Non-Communicable Disease Literature

The same cost-effectiveness found for communicable diseases is also found for non-communicable diseases, such as type 2 diabetes.

Type 2 diabetes, or the body's ineffective use of insulin, leads to high blood glucose levels and can cause serious damage to the heart, blood vessels, eyes, kidneys, and nerves.²³⁴ These can rapidly lead to blindness, renal failure which requires round-the-clock kidney dialysis, end-stage renal disease, cardiovascular events such as stroke and congestive heart failure, and the need for amputation of limbs.²³⁵

Diabetes is one of the most common chronic illnesses among adults in the United States, affecting up to a quarter of the United States population according to the National Institutes of Health.²³⁶ It is costly, particularly if left untreated. It has been called a “catastrophic medical expenditure.”²³⁷ With a direct annual cost of \$827 billion, it imposes the largest economic burden on the global healthcare system and the wider global economy.²³⁸ The estimated costs as a result of diabetes complications can range from \$2,188 per year for congestive heart failure, to \$46,207 per year for end-stage renal disease, and even up to \$50,000 per year for stroke.²³⁹

As in the case of hepatitis C and HIV/AIDS, preventative treatment of diabetes has been found to be cost-effective in prisons as

234. *Global Report on Diabetes*, WORLD HEALTH ORGANIZATION 11 (2016), <http://www.who.int/diabetes/global-report/en/>.

235. *See id.* at 30.

236. *Diabetes in the U.S. Population*, National Institutes of Health (Sept. 21, 2015), <https://www.nih.gov/news-events/nih-research-matters/diabetes-us-population>.

237. *Global Report on Diabetes*, *supra* note 234, at 14.

238. *Id.* at 14.

239. Donna M. Tomlinson & Clyde B. Schechter, *Cost-Effectiveness Analysis of Annual Screening and Intensive Treatment for Hypertension and Diabetes Mellitus among Prisoners in the United States*, prepared for the Nat'l Commission on Correction Health Care, Chicago, IL 1, 150.

well.²⁴⁰ It is most frequently seen in people who are poor,²⁴¹ like many of those in the corrections system, though other risk factors include age, ethnicity, diet, and physical inactivity.²⁴² Early detection can avoid the severe outcomes of type 2 diabetes.²⁴³ A pre-diabetic individual can be detected early through blood pressure and blood sugar tests, which are simple and inexpensive to administer, and the disease can be avoided with a more regimented diet and other simple lifestyle measures.²⁴⁴ Adults can improve insulin sensitivity and glucose uptake with regular exercise and better diet—specifically, a diet which increases the consumption of fiber and reduces the consumption of unsaturated fats.²⁴⁵ The cost of using a sphygmomanometer to test blood pressure and drawing blood to test glucose levels is estimated to be \$131.71 per prisoner per year.²⁴⁶ Physical activity is free to implement, and diet might be simple to modify in prison cafeterias. Particularly because the prison population is conducive to high levels of patient compliance,²⁴⁷ researchers find that screening for diabetes in prisoners is highly cost-effective.²⁴⁸

Type 2 diabetes presents an interesting extrapolation from the hepatitis C and HIV/AIDS literature because the average public taxpayer might be more willing to support treatment. Less stigma is associated with it. Albeit, hepatitis C is uniquely compelling because curing it in the prison population can eradicate it altogether as an infectious disease. However, as a leading cause of death in the United States, type two diabetes affects far more Americans than hepatitis C does.²⁴⁹

Health programs which prevent, screen for, and treat communicable and non-communicable diseases early are cost-effective and, in several ways, worth the investment up-front. Based on the key populations in prisons, addressing these diseases will not only fulfill

240. *Id.* at 152, 154.

241. David Whiting, Nigel Unwin, & Gojka Roglic, *Diabetes: Equity and Social Determinants*, in EQUITY, SOCIAL DETERMINANTS AND PUBLIC HEALTH PROGRAMMES 77, 78 (Erik Blas & Anand Sivasankara Kurup eds., 2010).

242. *Id.* at 80–81, 86.

243. *Global Report on Diabetes*, *supra* note 234, at 48.

244. *Id.* at 51.

245. *Id.* at 36.

246. *See* Tomlinson & Schechter, *supra* note 239, at 141.

247. *Id.* at 141.

248. *Id.* at 153.

249. Leading Causes of Death, Centers for Disease Control (Sept. 30, 2015), <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>.

the constitutional duty to provide health care in prisons, but also ensure a healthier ex-prison, low-income population and healthier United States in general. In turn, this decreases spending on Medicaid.

D. Recidivism and Health Care Economics

It should briefly be noted that improving health in the prison population not only reduces costs through Medicaid, but also directly in the criminal justice system. This is particularly compelling incentive for wardens and correctional employees—state corrections departments should take on more economic burden, when savings are seen elsewhere in state budget from health and human services departments.

Studies show that continuous health care for ex-prisoners—particularly for substance use, addiction, and mental illness—reduce criminal behaviors.²⁵⁰ Given that over two-thirds of released prisoners are re-arrested within three years,²⁵¹ any reduction in recidivism will save significant costs that are spent on the criminal justice system. Thus, health care can provide taxpayer savings by way of reducing the burdened criminal justice system, while improving safety in our communities.

IV. PREVENTATIVE TREATMENT AVOIDS A SICK POST-PRISON
POPULATION

This Comment proposes early investment in health care. Providing preventative care for prisoners will result in a less sickly ex-prison population. The ex-prison population, after the Affordable Care Act, is (1) incentivized to obtain health insurance coverage once released home, and (2) newly eligible for Medicaid given the expansion to childless adults below 133% of the federal poverty line. Preventative care may require the allocation of additional funding to state corrections department budgets. However, state taxpayers will see this money recuperated from health and services departments, as preventative care has been evidenced to be more cost-effective than paying for sickly ex-prisoners' Medicaid.²⁵² Therefore, state governments would be more prudent to invest taxpayer money wisely, and individuals should encourage their elected representatives accordingly. This logic holds true regardless of political change to the Affordable Care Act, so long as states choose to extend Medicaid to

250. Bainbridge, *supra* note 13; *see also* Maureen McDonnell, Laura Brookes, Arthur Lurigio et al., *supra* note 188.

251. Reentry Trends in the U.S.: Recidivism, BUREAU OF JUSTICE STATISTICS (Jan. 15, 2016), <http://www.bjs.gov/content/reentry/recidivism.cfm>.

252. *See* discussion *supra* Part I.C.3.

childless adults.

Investing early is not only more cost-effective, but leads to better public health and community safety outcomes. Infectious diseases such as hepatitis C could be eradicated if key populations such as prisoners are treated.²⁵³ If prisoners released home are healthy, their rates of recidivism are lower,²⁵⁴ leading to safer communities and further taxpayer savings by way of a less burdened criminal justice system.

To realign incentive with what is cost-effective, these Medicaid dollars should be re-allocated. Medicaid should instead cover sofosbuvir for hepatitis C, screening programs, condoms, dirty needle exchange programs for HIV/AIDS,²⁵⁵ and nutrition programs in prison cafeterias. Encouragement of exercise should be free to implement, as time and space are already allotted for this.

CONCLUSION

Every day, prisoners are released from prisons in which they have received constitutionally inadequate health care.²⁵⁶ The federal and California state governments are aware of overcrowding in state prisons that is so severe that prisoners die from lack of access to health care.²⁵⁷ Out of disbelief that health care can be improved, the Supreme Court has ordered the reduction of the prison population by up to 46,000 inmates,²⁵⁸ though the jury is still out on whether realignment is successfully curing the problem.

In the meantime, prisoners that are released back into their communities now face a country in which health insurance is more available than ever before to low-income individuals.²⁵⁹ Childless adults—or those with no qualifications other than being below 133% of the federal poverty line—are newly eligible to enroll, despite having a criminal record.²⁶⁰ However, these individuals are in poor health and their presence in the Medicaid programs will be costly.²⁶¹

253. See discussion *supra* Part III.B.

254. Maureen McDonnell, Laura Brookes, Arthur Lurigio et al., *supra* note 188.

255. Needle exchange programs take a harm reduction approach to care and aim to combat stigma associated with responsible injection drug use. Programs will exchange dirty needles and replace them with clean ones, thus eliminating needles that have the potential to spread HIV, hepatitis, and other diseases. For more information, see HARM REDUCTION COALITION, harmreduction.org.

256. *Plata*, 131 S. Ct. at 1923–24.

257. *Id.*

258. See discussion *supra* Part II.

259. *Id.*

260. 42 U.S.C. § 18032(f)(1)(B) (2010).

261. See discussion *supra* Part I.B.

There are many reasons for which preventative care should be employed during incarceration, but an economical rhetoric appeals to both humanitarian and tough-on-crime politics. By paying for preventative and early health care in prisons, individuals will be healthier upon release, and require less taxpayer money in the long-term scheme.²⁶² This additional investment could be taken from the Medicaid funds already allocated to inmate hospitalization, which would be the secondary purpose of dual purpose of incentivizing prison officials to provide primary care.²⁶³ Last, a healthier post-prison population will reduce recidivism, which will decrease the burden on the criminal justice system and save taxpayer dollars as well.²⁶⁴

Since the early 1900s, we as a country have acknowledged that the ability to preserve one's own health is integral to the basic dignity of humankind, a concept rooted in the Eighth Amendment.²⁶⁵ It is a shame that we do not honor our philosophies in the way we treat the poor and condemned in our prisons. We cannot say that we cannot afford to do so. The Affordable Care Act brought about a restructuring of the health insurance system that allows taxpayers to invest money in the dignity of prisoners, while also saving money by not having to fund the maintenance of chronic illness.

With a wise approach to the tax system, both the politically left and right wings can be appeased and health care in the United States can be improved for all, equally.

262. See discussion *supra* Part IV.

263. *Id.*

264. See discussion *supra* Part III.D.

265. See *Trop*, 356 U.S. at 100.