

The Inmate Exception: A Medicaid Loophole with Serious Consequences

Elisabeth Poorman, MD, MPH

Dr. Poorman is a medical resident at Cambridge Health Alliance.

As a medical resident in Massachusetts, I'm fortunate to expect that my patients have access to health insurance regardless of their income. In most states, Medicaid eligibility is extremely restrictive; living below the federal poverty line is enough to qualify patients in only a handful of states. This is about to change in the majority of the country with the Affordable Care Act (ACA) and its expansion of Medicaid to adults living below 138% of the federal poverty level. Now, the impoverished will have access to basic health coverage.

But a loophole in the original Medicaid law was preserved—a clause known as the “Inmate Exception” that bans people in jail or prison from receiving Medicaid.¹ During incarceration, the county or state government (or private company) takes over care, providing some basic medical services. With these disruptions in coverage, many chronic medical issues fall through the cracks, and few jails or prisons connect people to care when they re-enter the community.

Many states have even interpreted the Inmate Exception as an opportunity to shrink their Medicaid rolls, with official policies to disenroll jail inmates upon incarceration, even if they haven't been charged with a crime. Although they have access to emergency medical care while incarcerated, when they leave their previous Medicaid is not automatically reinstated despite the fact their qualification still stands. This is particularly dangerous because in the first two weeks after release, parolees are at 12 times the risk of death of the general population.²

For patients with chronic medical conditions, just being picked up and spending a night in jail can be a dangerous proposition, as they leave without medications, follow up, or coverage. The Affordable Care Act does not address this issue. Although the Medicaid expansion will insure more people, they will have a tough time staying insured. This is a bureaucratic nightmare, with the potential for unnecessary harm, hospitalizations, cost, and mortality.³

Incarceration is a fact of life for millions of people every year, especially in poor communities and communities of color. A third of black men who are born in 2001 will be imprisoned during their lifetime, and my preliminary findings suggests that those who qualify for Medicaid by income status are twice as likely to be incarcerated than those with higher incomes over a 12-month period. Upon release, access to primary care or medications for chronic diseases is not a foregone conclusion. This has ripple effects across families and entire communities, with loved ones left to care for sick relatives now without insurance who are often sicker when they leave jail or prison than when they entered. Caring for patients from these communities means we cannot ignore incarceration and the harm caused by the Inmate Exception.

Does this affect your practice? Using data from the Bureau of Justice Statistics, I estimate that just over 5 million Americans who would otherwise qualify for Medicaid will potentially lose it because they will be incarcerated in the next 12 months. That translates to 60 out of 1,000 Medicaid patients on your

panel losing their insurance in a 12-month period and then waiting months to be re-enrolled.

Sitting across from my sickest, poorest, and most socially complex patients, I often feel overwhelmed. The medical knowledge that my fellow interns and I are so hungry to learn often feels pointless. What medication is affordable for this patient? What medication will the patient tolerate and actually use? After I am able to make some headway on these complex issues and after months of visits, the needle moves a little bit forward, and these tiny positive changes are a source of great joy. But this progress relies on continuity and consistency and continuity and consistency are impossible when many of my patients frequently lose their insurance. I implore SGIM to take this on as an issue. We must take a stand on behalf of our most marginalized patients. Together, we can raise our collective voice and demand an end to the Inmate Exception.

References

1. Social Security Act Amendments of 1965, Pub. L. No. 97, (April 9, 1965).
2. Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison—a high risk of death for former inmates. *N Engl J Med* 2007; 356(5):536.
3. Sommers BD, Graves JA, Swartz K, Rosenbaum S. Medicaid and marketplace eligibility changes will occur often in all states; policy options can ease impact. *Health Affairs* 2014; 33(4):700-7.