Filling the Gap: The Importance of Medicaid Continuity for Former Inmates

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Despite no federal law mandating Medicaid termination for prisoners, 90 percent of states have implemented policies that withdraw inmates' enrollment upon incarceration. This leaves a medically and psychiatrically vulnerable population uninsured during the months following release, a time period during which former inmates have been shown to have an increased risk of medical problems and death. We believe it is of critical importance for the 10 million Americans who cycle in and out of corrections each year, as well as the communities they return to, that Medicaid be suspended rather than terminated during incarceration.

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Mr. J. is a 53-year-old African-American male with long-standing HIV/AIDS, hepatitis C, addiction, diabetes, and schizophrenia who presented to the hospital complaining of polyuria, polydipsia, confusion, and weakness and was found to have a blood glucose of 765, ketonuria, and an anion gap of 17. This was his sixth visit to the emergency room for hyperglycemia in the 6 weeks since his release from Rhode Island's prison. Mr. J. was admitted with a diagnosis of diabetic ketoacidosis and treated with insulin and hydration. He was seen twice by the endocrinology consult team and restarted on his anti-retroviral regimen. He was discharged 4 days later, homeless and uninsured, with instructions to take daily anti-retrovirals, anti-psychotics, and insulin, and to follow-up with the endocrinologists, a community mental health center, and his HIV doctor, all of which would likely not be possible for him.

Mr. J. is one of the million people with severe mental illness who pass through the correctional system each year, and like many with psychiatric and substance use issues, he has spent most of his adult life cycling in and out of correctional facilities for predominantly non-violent offenses.[1,2] After his most recent incarceration, however, Mr. J. faced two new problems. His mother, who had always looked after him and offered him a place to live, had died during his time in prison. In addition, his Medicaid coverage had been terminated, leaving him unable to pay for insulin, which in turn resulted in multiple emergency room visits and his eventual hospitalization. Ironically, Mr. J.'s HIV status granted him more coverage than many former inmates, thanks to Project Bridge, a program funded by the Ryan White CARE (Comprehensive AIDS Resources Emergencies) Act to provide intensive case management and free HIV care to the recently incarcerated.[3] With resources such as Project Bridge, Rhode Island's prisons are considered among the best for medical care and pre-release practices,[4] and yet even so Mr. J.'s health was virtually unmanageable without Medicaid assistance to cover his crucial diabetic and psychiatric medications.

Mr. J's case highlights the critical importance of continuity in Medicaid enrollment upon release from prison. Each year the US releases more than 10 million people from the nation's correctional facilities.[5] Re-entry into the community for former inmates is a vulnerable time, marked by difficulties adjusting, increased drug use, and a 12-fold increased risk of death in the first 2 weeks after release.[6] Prisoners with mental illness are a particularly vulnerable population, and having Medicaid at the time of release is a distinct advantage, leading to increased access to and utilization of services, as well as decreased drug use and re-incarceration.[1,5] Without Medicaid, the recently incarcerated are forced to rely on emergency rooms for medical care, shifting the burden of cost to hospitals as well as local city and state agencies.[7,8] In addition, releasing inmates without medical coverage is a public health hazard that can contribute to increased spread of infectious diseases. Each year, 33% of all hepatitis C infected persons pass through the correctional system, as do 25% of HIV-positive Americans and 40% of active tuberculosis cases.[9] In addition, infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) and influenza are commonly spread within correctional facilities.[10] The increased prevalence of communicable diseases within prisons, combined with lack of medical coverage and access to treatment upon release, is a dangerous convergence that promotes the spread of infection within the community. This increased prevalence of disease disproportionately affects racial and ethnic minorities given the demographic make-up of correctional populations, and the communities to which former inmates are returning: as of 2005, six out of ten inmates were minorities, and 4.7% of the African-American male population in the US was incarcerated.[11] Clearly the racial divide in prisons means that Medicaid termination policies for inmates will disproportionately affect minorities, particularly African Americans. The US already has a shocking racial discrepancy in health, with American blacks experiencing 4.3 to 4.5 million premature deaths relative to whites between 1940 and 1999.[12] Lack of medical coverage for former inmates will only worsen this problem.

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Since its creation in the 1960s, Medicaid has prohibited the use of federal funds to cover medical, mental health, or substance use treatment costs incurred by inmates in jails and prisons.[7] Medicaid law does not, however, require that states terminate recipients' enrollment while incarcerated, so an inmate could theoretically leave prison and immediately resume coverage. Unfortunately federal rules establish only the minimum requirements, and states have the freedom to enact tougher regulations, including mandatory termination upon incarceration.[13] Despite a statement issued by the Secretary of Health and Human Services urging resumption of Medicaid coverage immediately upon release, most states interpret the law in the strictest sense. According to a survey of Medicaid directors, 90 percent of states have implemented policies that withdraw inmates' enrollment upon incarceration, leaving them to potentially face months of reenrollment paperwork and bureaucracy upon release before they can get any medical coverage.[14]

One of the most troubling aspects of the process of Medicaid termination is the manner in which incarcerated recipients are reported. On August 22, 1996, federal welfare reform legislation authorized the Social Security Administration (SSA) to sign reporting contracts with correctional facilities.[15] In an effort to eliminate spending on incarcerated individuals, the SSA offered incentive payments of up to $400 per inmate reported who is receiving Social Security Income (SSI) or Social Security Disability Income (SSDI).[14] Given that the majority of people qualify for Medicaid because they are eligible for SSI benefits, inmates most frequently lose their Medicaid benefits once their SSI is suspended following notification by the jail or prison. Since correctional facilities receive more money the sooner they report SSI recipients who have been incarcerated ($400 within 30 days versus $200 within 90 days), this termination of Medicaid benefits most often occurs within 1 month. This not only affects sentenced inmates in prisons, but also many of those awaiting trial in jails, who may eventually be found innocent. In contrast to the monetary incentive to report incarceration, correctional facilities receive no reward for reporting release of SSI recipients, despite the fact that legally those incarcerated less than 1 year should maintain their SSI eligibility.[13] According to a report by the General Accounting Office, as of 1999, 3,115 correctional facilities had signed these reporting agreements with the SSA, with a total of 39,137 benefits suspended.[15]

Medicaid, the single largest payer for mental health services,[16] is a crucial resource for the 16% of inmates reporting current mental illness, as well as for the additional 14% reporting past psychiatric treatment.[17] This termination policy therefore delivers the greatest impact to the mentally ill who were recently incarcerated. In addition to the substantial need for health insurance, this vulnerable population is less equipped to deal with the complicated re-enrollment process and most likely to be dis-enrolled given their longer duration of incarceration.[18] Following release, former inmates must fill out paperwork for both SSI and Medicaid, as well as visit offices for each to meet with representatives to determine eligibility, a process that can take up to 3 months.[7,14] This is likely to be particularly difficult for the severely mentally ill, who often are struggling with addiction, lack of transportation, and homelessness, in addition to having significant difficulties with interpersonal skills. Even for those who eventually regain coverage, the 3-month lag time without coverage is a significant medical and financial liability. The risk of dying for former inmates is sharply increased in the 2 weeks immediately following release, with drug overdose, cardiovascular disease, homicide, and suicide as the leading causes of death.[6] Not only does the period of being uninsured during the enrollment process miss this critical 2-week window, but also lapses in coverage in general lead to worse health outcomes. The "unstably insured," or people who go for periods of time without coverage, experience worse outcomes and more hospitalizations than the continuously insured, even after regaining coverage.[19,20]

Mr. J. has finally regained his Medicaid coverage, and as a result both his diabetes and psychiatric needs are under careful management. As is true for nearly all Medicaid recipients, the medical conditions that made him eligible initially did not resolve during his incarceration. And yet it took several months for him to get re-enrolled, during which time he faced tremendous, and potentially fatal, health risks; cost the hospital thousands of dollars; and received suboptimal care. This situation could have been prevented had his Medicaid enrollment been suspended rather than terminated, as is now the policy in New York. The Medicaid Suspension Legislation, passed in July of 2007, requires New York State to suspend Medicaid for people entering prisons and jails with prior Medicaid enrollment and permits immediate reinstatement upon release.[21] In addition, New York passed the Assembly Bill 10864 earlier this year, requiring the institution of pilot projects in each state correctional facility where staff will file Medicaid applications for inmates before they are released from prison to ensure immediate access to health coverage and allow a seamless transition into community care.[22] Policy changes such as these set an example for other states to follow. With the US now leading the world in the number of incarcerated and the length of sentences,[23] the issue of ensuring health care coverage by preventing Medicaid termination is of critical importance not just to the nearly 10 million individuals who cycle in and out of correctional facilities each year, but to the communities and health-care systems to which they return.

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