The Medicaid Inmate Exception Rule: A Major Barrier to Adolescent and Youth Mental Health Improvement Efforts

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Introduction

In the United States, there are over 48,000 youth confined away from their homes after encounters with the law. Most of these youth are held in detention centers, long-term secure facilities, and adult prisons and jails.[1] Currently, it is estimated that two-thirds of detained adolescents have a mental illness, which is over three times the prevalence of teen mental illness in the general population.[2] When an adolescent is incarcerated, mental health services are not expanded. Instead, both Medicaid and the Children's Health Insurance Program (CHIP) are typically retracted for that individual due to an "inmate exception rule."[3]

The implications of this rule are widespread because incarcerated youth are more likely to rely on federal health insurance programs for their coverage.[4] Imprisoned adolescents may lose access to any long-term treatments they had previously been receiving and may have trouble re-enrolling in insurance after their release. In addition, this rule eliminates some health care quality standards and increases financial burden on state and local taxpayers. The purpose of this policy brief is to integrate historical context with relevant present-day stakeholders, analyze current policies, and recommend policy measures to improve mental health for adolescents who are impacted by the inmate exception rule both during and after their incarceration.

Background

Origin of the Inmate Exception Rule

The Social Security Act explicitly prevents federal funding through programs such as Medicaid and CHIP from assisting any "inmate of a public institution."[5] Typically, Medicaid and CHIP are jointly financed by both the federal government and states. Under the inmate exception rule, the burden for covering inmates' health costs falls completely to states and counties. A 2014 survey of 42 state prison systems revealed that in about two-thirds of systems, when an individual receiving Medicaid is incarcerated, they are completely removed from their health insurance program.[6]

Health Care While Incarcerated

The National Commission on Correctional Health Care (NCCHC) sets standards for youth and adolescent medical care. Standards include meeting urgent health needs, testing for communicable diseases, and providing physical, mental, and oral health screenings.[7] Despite these standards, 2004 data demonstrated that less than half of facilities were in adherence.[8]

The incarcerated juvenile population has acute needs for mental health care. However, facilities serving these youth are underprepared to adequately meet their needs. In 2002, only 53% of facilities had in-house mental health professionals to care for youth. Further, 60% of programs providing substance abuse counseling lack professionals specifically trained in this type of treatment.[9]

Health Implications of the Rule

The inmate exception rule has an outsized impact on incarcerated youth. A 2015 study exploring the connections between social disadvantage and criminality chronicles a "poverty trap," where forms of disadvantage such as poverty, lack of family structure,

and illness are interconnected.[10] Low-income people and members of racial and ethnic minorities are also more likely to be incarcerated.[11,12] Therefore, federal programs like Medicaid and CHIP are especially essential as forms of health coverage for youth and adolescents even prior to incarceration.

In addition, youth may face obstacles re-enrolling in health insurance programs after they are released. One study found that only 23% of young men incarcerated in New York had re-enrolled in Medicaid after their release from jail, despite having eligible incomes for the program.[13]

Systemic Implications of the Rule
Clearly, youth prisons are home to high concentrations of mental illness. Tasking these institutions with the financing of care precludes major efforts to focus on rehabilitation, which one may argue is the primary purpose of incarceration.

Stakeholders impacted by the inmate exception rule are not limited to jails, prisons, and incarcerated youth themselves. If an adolescent does not re-enroll in a health insurance program after release, they may not receive preventive services or mental health treatments. Instead, they may present in severe condition to an emergency department setting, where costs to the overall healthcare system are high.

Furthermore, providing care has benefits both to the individual receiving them and the prison system as a whole. A 2016 study found that incarcerated adolescents receiving mental health treatments had lower recidivism rates.[2]

In addition, since the Medicaid inmate exception rule limits funding from the federal government, states and counties need to take on larger costs, which may influence the quality of the health services received by incarcerated youth and adolescents. Care providers reimbursed by Medicaid are required to adhere to several quality and reporting standards.[14] Health care provision in a jail or prison context that is not subject to the oversight that all other federally-funded facilities must undergo places adolescents and youth with mental illness in critical situations where there is no federal external confirmation that their care needs are being appropriately met.

Policy Efforts
The Affordable Care Act (ACA) allowed states to expand Medicaid coverage to 138% of the federal poverty line and also created markets for individuals to be able to purchase their own health insurance plans. In addition, the ACA allowed individuals waiting for their depositions in court to receive coverage via the individual markets. However, the ACA did not make the same allowance for Medicaid enrollment.[15]

Currently, the Trump Administration has touted their commitment to reforming the United States' criminal justice system. However, the Administration's simultaneous support for Medicaid work requirements makes it more difficult for low income people to get health insurance, especially when they are first released from jail or prison.

Policy Recommendations

During Incarceration:

- *Increase NCCHC Facility Oversight*

Ensure that facilities housing juveniles are adhering to recommended standards by **tying institutional funding to National Commission on Correctional Health Care compliance.** This would help make up for the lapse in coverage caused by the inmate

exception rule while an individual is incarcerated.

After Incarceration:

- *Pause Coverage, Don't Rescind*

Instead of completely removing youth and adolescents from CHIP or Medicaid when they become incarcerated, the federal government could **mandate that their enrollment must be put on hiatus**. This administrative change would allow adolescents' previous health records to remain intact and would mean that they would not have to re-enroll in health insurance programs after leaving jail or prison.

- *Ensure A Smooth Transition*

Help youth, adolescents, and their families navigate the insurance system by **partnering with health-focused public agencies**. Youth and adolescents would receive assistance in filling out applications as their release date approaches and would get clear information about why health insurance is important in managing their particular mental illness.

Emphasize continuity of care by having health counselors work with mentally ill adolescents to ease the transition from incarceration to public living. Connect youth and families with community resources.

An intervention pairing health experts with an incarcerated population is found in New York City. In this case, the Department of Health and Mental Hygiene oversees health care provision for inmates instead of a law enforcement agency.[16]

- *Repeal the Inmate Exception*

By passing **new legislation at the federal level** to repeal the inmate exception, states will receive federal funds to support their incarcerated populations. Health care in jails and prisons will be subject to the same quality standards as care delivered in other settings.

Additionally, youth and adolescents with mental illness will have better access to treatments, which, as described in a previous section, reduces the likelihood that they will end up back in jail or prison.

Conclusion

It is exceedingly evident that there are many problems associated with the United States' policy to restrict federal Medicaid and CHIP funding for incarcerated youth.

Of course, if youth and adolescents were not incarcerated in the first place, mental health outcomes may improve. However, preventing juvenile incarceration proves complex because of the multifaceted approach required to address socioeconomic factors that are the most directly implicated in the incarceration of youth and adolescents in the United States.

The current divisive political climate may hinder any intervention, as strong bipartisan support would be required to reform and add onto some of the most contentious and expensive programs that are currently offered.

Overall, the United States needs to address mental illness among its incarcerated youth and adolescents. An outdated Medicaid and CHIP inmate exception rule harms families by removing youth and adolescents from health insurance programs. Incarcerated young people already have high rates of mental illness, are increasingly dependent on federal programs for coverage, and receive substandard care while held inside facilities.

Additional Resources

1. National Association of Counties Guide to Medicaid Inmate Exclusion Policy: https://www.sheriffs.org/sites/default/files/NACo%20Medicaid%20and%20Jails%20One-Pager_wNSA.pdf

2. Legislator Guide to Medicaid for Juvenile Justice-Involved Children: https://www.ncsl.org/documents/cj/jjguidebook-medicaid.pdf

3. Federal Children's Health Insurance Program Website: https://www.medicaid.gov/chip/index.html

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