The Hidden Death Penalty: Access to Cancer Diagnostics and Medicaid/Medicare in Prisons

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ABSTRACT

Cancer is the leading cause of inmate death in state and federal prisons in the United States.[1] This paper examines the systematic barriers to cancer diagnostics within prisons, including the lack of access to regular screenings and the exclusion of incarcerated individuals from Medicaid and Medicare under the Federal Inmate Exclusion Policy (MIEP).[2] These shortcomings contribute to delayed diagnoses, higher rates of late-stage cancers, and preventable deaths, violating constitutional protections against cruel and unusual punishment as established in Estelle v. Gamble*.[3] Moreover, untreated cancers result in increased healthcare costs upon prisoner release, burdening the public health system.[4] This paper proposes two key solutions: repealing MIEP to extend Medicaid and Medicare coverage to prisons, and implementing regular cancer screening programs. Together, these measures aim to reduce cancer mortality, improve prisoner health outcomes, and ensure compliance with constitutional standards while mitigating long-term public health costs.*

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[1] *Incarceration Associated with Higher Cancer Mortality, Yale Study Shows*, YALE SCH. MED. (Sept. 16, 2022), https://medicine.yale.edu/news-article/incarceration-associated-with-higher-cancer-mortality-yale-study-shows/.

[2] *See generally infra* Part II (discussing lack of access to cancer diagnostics and Medicare and Medicaid in prisons).

[3] *See generally infra* Part III (discussing harms produced by the access issues in prisons).

[4] *See infra* Part II.C (discussing increased public healthcare costs).

INTRODUCTION

A prison sentence in the United States[5] not only deprives individuals of their liberty and freedom, but also stands to pose a profound threat to their physical health. Despite the various safety risks that prisoners face living behind bars,[6] cancer remains the leading cause of mortality among the incarcerated population in state and federal prisons.[7] This reality stems, in part, from the lack of access to cancer diagnostic care and the exclusion of prisoners from Medicare and Medicaid coverage. Across correctional facilities nationwide, these access issues result in death—instead of release—marking the end of many sentences.[8] In addition to increased mortalities, lack of access to diagnostics and insurance for prisoners increases public health costs and violates the constitutional principles announced in *Estelle v. Gamble*.[9] With over two million people incarcerated in the United States,[10] this healthcare disparity demands attention and reform.

This paper explores the cancer healthcare disparity plaguing the United States prison system, and in turn, the American public health system at large. Part I discusses the lack of access to cancer diagnostic care and Medicaid and Medicare coverage in prisons. Part II then explores the harms produced by this access problem, including increased prisoner mortality, increased public health costs, and unvindicated constitutional rights. Finally, Part III proposes a repeal of the Federal Medicaid and Medicare Inmate Exclusion Policy, alongside an increase in regular screening procedures, as potential solutions to ameliorate these unresolved harms. To note, available data on healthcare and cancer outcomes in prison are limited, largely acquired through just a handful of comprehensive studies, personal stories, and

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[5] When discussing incarcerated populations, this paper is referring exclusively to prisoners in state and federal correctional facilities in the United States.

[6] E. Ann Carson, *Mortality in State and Federal Prisons, 2001–2019 — Statistical Tables*, BUREAU OF JUST. STAT., (Dec. 2021), https://bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf (discussing causes of death in prisons).

[7] *Incarceration Associated with Higher Cancer Mortality, Yale Study Shows*, *supra* note 1; Christopher R. Manz, Varshini S. Odayar & Deborah Schrag, *Disparities in Cancer Prevalence, Incidence, and Mortality for Incarcerated and Formerly Incarcerated Patients: A Scoping Review*, 10 CANCER MED. 7277, 7286 (2021); Lisa V. Puglisi, Tyler N.A. Winkelman, Cary P. Gross & Emily A. Wang, *Cancer Prevalence Among Adults with Criminal Justice Involvement from a National Survey*, 35 J. GEN. INTERN. MED. 967, 968 (2019) (finding that "lung cancer, cervical cancer, and alcohol-related cancers are significantly more common among Americans with a history of criminal justice involvement compared with the general population").

[8] *See, e.g.*, PENAL REFORM INT'L, DEATHS IN PRISON (Dec. 2022), https://cdn.penalreform.org/wp-content/uploads/2022/12/Deaths-in-prison-briefing.pdf.

[9] In *Estelle v. Gamble*, the Supreme Court held that deliberate indifference to a prisoner's medical needs violates the Eighth Amendment's prohibition against cruel and unusual punishment. *See* Estelle v. Gamble, 429 U.S. 97, 104–05 (1976). For a more in-depth discussion on this case, see *infra* Part II.B (discussing constitutional violations and increased litigation as a harm generated by the lack of access to diagnostics and Medicare and Medicaid in prisons).

[10] JOHN D. CARL & MARY D. LOOMAN, A COUNTRY CALLED PRISON: MASS INCARCERATION AND THE MAKING OF A NEW NATION 13 (2d ed. 2024); *see also* Carson, *supra* note 6.

litigation.[11] The paucity of research on cancer in prisons has resulted in data gaps that prevent a comprehensive understanding of this problem.[12] This paper explores the issue to the extent that it is currently researched.

I. ACCESS TO DIAGNOSTICS AND MEDICAID/MEDICARE COVERAGE

While cancer claims countless lives each year, there are several proven ways to reduce its deadly impact.[13] Two critical measures—regular screenings to detect cancer at an early stage and health insurance to cover these services—are areas where prisons fall short.

A. Lack of Access to Diagnostic Care

In a personal submission to the *Prison Journalism Project*, Kevin Connell, a prisoner in Virginia, penned, "[e]arly diagnosis is the most critical element in achieving positive cancer outcomes, which is perhaps why I've seen so few happy endings in [twenty-five] years of incarceration."[14] Connell's testimony underscores the grim truths of cancer diagnostics in prisons.[15] This reality is fueled by a troubling paradox: incarcerated individuals are at a higher risk of developing cancer,[16] yet they are significantly less likely to receive the early diagnoses needed to save their lives.[17]

1. Higher Cancer Incidence Rates in the Incarcerated Population

Incarcerated individuals have a twenty-two percent higher likelihood of cancer incidence when compared to the general population.[18] This is largely

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[11] *The Impact of Incarceration on Cancer Outcomes*, UNIV. FLA. COLL. MED., https://radonc.med.ufl.edu/researchlabs/current-radiation-oncology-research-at-uf/the-impact-of-incarceration-on-cancer-outcomes/ (last visited Nov. 20, 2024) [hereinafter UF COLL. MED.].

[12] *See generally* Manz, Odayar & Schrag, *supra* note 7 (reviewing the twenty available studies regarding cancer incidence in United States jails and prisons).

[13] AM. CANCER SOC'Y, CANCER FACTS AND FIGURES 2021, https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf.

[14] Kevin A. Connell, *The Cancer Sign That's Everywhere in Prison*, PRISON JOURNALISM PROJECT (July 11, 2024), https://prisonjournalismproject.org/2024/07/11/cancer-in-prison.

[15] To note, there is little—if any—data on the differences in cancer care between public and private, maximum and minimum security, and co-ed and all-women's prisons. However, this paper addresses the prison system at large with data encompassing all types of prisons.

[16] *See* Manz, Odayar & Schrag, *supra* note 7, at 7278.

[17] *See, e.g.*, Hassan Aziz, Ruth L. Ackah, Amy Whitson, Bridget Oppong, Samilia Obeng-Gyasi, Carrie Sims & Timothy M. Pawlik, *Cancer Care in the Incarcerated Population: Barriers to Quality Care and Opportunities for Improvement*, 156 JAMA SURGERY 964, 968 (2021) ("Incarcerated patients commonly present to oncology clinics with advanced stages of cancer and a history of prolonged signs and symptoms."); Lisa Puglisi, Alexandra A. Halberstam, Jenerius Aminawung, Colleen Gallagher, Lou Gonsalves, Dena Schulman-Green, Hsiu-Ju Lin, Rajni Metha, Sophia Mun, Oluwadamilola T. Oladeru, Cary Gross & Emily A. Wang, *Incarceration and Cancer-Related Outcomes (ICRO) Study Protocol: Using a Mixed-Methods Approach to Investigate the Role of Incarceration on Cancer Incidence, Mortality and Quality of Care*, 2021 BMJ OPEN 1, 3 (2021).

[18] *See* Manz, Odayar & Schrag, *supra* note 7, at 7278.

attributed to the prevalence of key cancer risk factors and the overrepresentation of low-income and minority groups within prisons.

With respect to the key risk factors, individuals in the criminal justice system have higher rates of smoking (82%) and substance abuse (67%) when compared to the general population.[19] These behaviors significantly increase cancer risk, with, for example, smoking accounting for twenty percent of U.S. cancers[20] and excessive alcohol consumption raising risks for stomach, pancreatic, and prostate cancers. [21] Additionally, the prison population struggles at high rates with cancer-causing conditions including hepatitis C, HIV, AIDS, obesity, and chronic stress.[22]

In conjunction with these risk factors, the demographics of prisons are already vulnerable to negative cancer outcomes. Incarcerated populations are "largely drawn from the most disadvantaged part of the nation's population: . . . disproportionately minority, and poorly educated."[23] Black Americans are incarcerated at nearly five times the rate of whites, and Latinx Americans are incarcerated at nearly 1.5 times the rate of whites. [24] Moreover, people earning "less than 150 percent of the federal poverty level are [fifteen] times more likely to be charged with a felony." [25] While discussing the health disparities that exist within those populations is beyond the scope of this paper, it suffices to state that in the United States, racial

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[19] Cyrus Ahalt, Timothy Buisker, Janet Myers & Brie Williams, *Smoking and Smoking Cessation Among Criminal Justice-Involved Older Adults*, 12 TOBACCO USE INSIGHTS 1, 1–3 (2019). One study which assessed nearly 19,000 prisoners across ten counties identified 1/4 of the population as having a former or current alcohol or drug use disorder. *See* Seena Fazel, Isabel A. Yoon & Adrian J. Hayes, *Substance Use Disorders in Prisoners: An Updated Systematic Review and Meta-Regression Analysis in Recently Incarcerated Men and Women*, 112 ADDICTION 1725, 1733 (2017).

[20] *How Smoking Tobacco Affects Your Cancer Risk*, AM. CANCER SOC'Y 1 https://www.cancer.org/content/dam/CRC/PDF/Public/8345.00.pdf (last updated Nov. 19, 2024).

[21] *Alcohol and Cancer*, CTR. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/cancer/risk-factors/alcohol.html (last updated Jan. 29, 2025).

[22] *See* UF COLL. MED., *supra* note 11; Emily Hoff, Andrea Warden, Ruby Taylor & Ank E. Nijhawan, *Hepatitis C Epidemiology in a Large Urban Jail: A Changing Demographic*, 138 PUB. HEALTH REPS. 248, 248 (2022) (noting that "[n]early 1 in 3 people with hepatitis C virus (HCV) infection pass through the criminal justice system annually.").

[23] THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES (Jeremy Travis, Bruce Western & Steve Redburn, eds. 2014). Another study noted that the United States prison population is "disproportionate[ly] of ethnic and racial backgrounds, [and] often originate from . . . vulnerable socio-economic regions." UF COLL. MED., *supra* note 11.

[24] ASHLEY NELLIS, SENT. PROJECT, THE COLOR OF JUSTICE: RACIAL AND ETHNIC DISPARITY IN STATE PRISONS 5 (Oct. 13, 2021), https://www.sentencingproject.org/app/uploads/2022/08/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf ("In 12 states, more than half the prison population is Black: Alabama, Delaware, Georgia, Illinois, Louisiana, Maryland, Michigan, Mississippi, New Jersey, North Carolina, South Carolina, and Virginia.").

[25] Tara O'Neill Hayes & Margaret Barnhorst, *Incarceration and Poverty in the United States*, AM. ACTION F. (June 30, 2020), https://www.americanactionforum.org/research/incarceration-and-poverty-in-the-united-states/.

minorities[26] and low-income individuals[27] experience higher rates of death from cancer regardless of incarceration status, largely due to their limited access to health insurance, primary care, and cancer preventative resources.[28]

With known cancer risk factors and vulnerable populations confined within prisons, the higher rates of cancer incidence within this population are unsurprising. Nevertheless, this population's likelihood of receiving a life-saving diagnosis remains low.

2. Incarcerated Populations are Less Likely to Receive Early Diagnosis Due to Delayed or Unavailable Screenings

The World Health Organization (WHO) recommends no more than one month between symptom presentation and diagnosis for cancer cases.[29] This guidance reflects the well-known understanding that the earlier cancer is detected, the more likely someone is to survive.[30] Prisons, however, are grossly underperforming on WHO's target as screenings are limited and "cancer is diagnosed at more advanced stages" within the incarcerated population.[31]

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[26] *Cancer Disparities in the Black Community*, AM. CANCER SOC'Y, https://www.cancer.org/about-us/what-we-do/health-equity/cancer-disparities-in-the-black-community.html (last visited Dec. 11, 2024) ("African Americans have a higher cancer burden and face greater obstacles to cancer prevention, detection, treatment, and survival. In fact, Black people have the highest death rate and shortest survival of any racial/ethnic group for most cancers in the U.S."); *Cancer and African American People*, CTR. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/cancer/health-equity/african-american.html (last visited Dec. 11, 2024) ("Black people have the highest death rate for cancer overall.").

[27] *See generally* Joseph M. Unger, Anna B. Moseley, Christabel K. Cheung, Raymond U. Osarogiagbon, Banu Symington, Scott D. Ramsey & Dawn L. Hershman, *Persistent Disparity: Socioeconomic Deprivation and Cancer Outcomes in Patients Treated in Clinical Trials*, 39 J. CLINICAL ONCOLOGY 1339, 1339 (2017); Hayes & Barnhorst, *supra* note 25.

[28] Valentina A. Zavala, Paige M. Bracci, John M. Carethers, Luis Carvajal-Carmona, Nicole B. Coggins, Marcia R. Cruz-Correa, Melissa Davis, Adam J. de Smith, Julie Dutil, Jane C. Figueiredo, Rena Fox, Kristi D. Graves, Scarlett Lin Gomez, Andrea Llera, Susan L. Neuhausen, Lisa Newman, Tung Nguyen, Julie R. Palmer, Nynikka R. Palmer, Eliseo J. Pérez-Stable, Sorbarikor Piawah, Erik J. Rodriquez, María Carolina Sanabria-Salas, Stephanie L. Schmit, Silvia J. Serrano-Gomez, Mariana C. Stern, Jeffrey Weitzel, Jun J. Yang, Jovanny Zabaleta, Elad Ziv & Laura Fejerman, *Cancer Health Disparities in Racial/Ethnic Minorities in the United States*, BRIT. J. CANCER 315, 316–18 (2021).

[29] PATRICIA H. DAVID, OFF. CORRECTIONS OMBUDS, OCO INVESTIGATION OF DELAYED CANCER DIAGNOSIS AND MANAGEMENT 15 (Jan. 14, 2021), https://oco.wa.gov/sites/default/files/Delayed%20Cancer%20Diagnosis%20and%20Management%20Final%20with%20DOC%20Response.pdf (citing WORLD HEALTH ORGANIZATION, GUIDE TO CANCER EARLY DIAGNOSIS (Feb. 16, 2017), https://iris.who.int/bitstream/handle/10665/254500/9789241511940-eng.pdf).

[30] Jennifer T. Loud & Jeanne Murphy, *Cancer Screening and Early Detection*, 33 SEMINARS ONCOLOGY NURSING 121, 128 (2017) ("Cancer screening recommendations have been shown to significantly decrease the mortality from certain cancers (i[.]e[.], cervical and colorectal), while more modestly decreasing mortality of others.").

[31] Oluwadamilola T. Oladeru, Jenerius A. Aminawung, Hsiu-Ju Lin, Lou Gonsalves, Lisa Puglisi, Sophia Mun, Colleen Gallagher, Pamela Soulos, Cary P. Gross & Emily A. Wang, *Incarceration Status and Cancer Mortality: A Population Based Study*, 17 PLOS ONE, no. 9, 2022, at 1, 2.

Timely access to cancer screenings in prisons is a largely unexplored area.[32] Available data, however, reveal access to regular screenings—or access to screenings at all—are largely uncommon,[33] but variable depending on the correctional facility.[34] According to one study, 13.9% of federal prisoners and 20.1% of state prisoners had received no medical examinations since their incarceration.[35] More specifically, for breast cancer, some studies report zero percent of women receiving mammograms[36] during their incarceration, while others report up to fifty percent receiving screenings.[37] These statistics stand in sharp contrast to the American Cancer Society's recommendation that women over the age of forty-five should get mammograms annually.[38] With respect to colorectal cancer, the American Cancer Society similarly recommends regular screenings starting at age forty-five.[39] However, one study found that "only [twenty-percent] of [incarcerated] male patients were up to date with . . . screening."[40] Other cancers, including lung and hepatocellular carcinoma, currently have no studies specifically assessing screening frequencies in correctional facilities. However, the negative outcomes for these types of cancers in prisons indicate that screening procedures are poor.[41] For example, the Yale School of Medicine explored screenings in Connecticut prisons and found that, despite the lack of reporting on screening frequency, it was clear based on the high rates of cancer mortality that the inmates were "under-screened and under-detected."[42]

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[32] *See e.g.*, Christopher R. Manz, Varishini S. Odayar & Deborah Schrag, *Cancer Screening Rates and Outcomes for Justice-Involved Individuals: A Scoping Review*, 29 J. CORR. HEALTH CARE 220, 222 tbl. 1 (2023); Oladeru, Aminawung, Lin, Gonsalves, Puglisi, Mun, Gallagher, Soulos, Gross & Wang, *supra* note 31, at 2.

[33] *See* UF COLL. MED., *supra* note 11; Andrew P. Wilper, Steffie Woolhandler, Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor & David U. Himmelstein, *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 670 (2009).

[34] *See* Aziz, Ackah, Whitson, Oppong, Obeng-Gyasi, Sims & Pawlik, *supra* note 17, at 966 (noting that screening access is "heavily dependent on (1) the state in which the individual is incarcerated, (2) the length of incarceration, and (3) arrangements for health care . . . and follow-up made by each individual correctional institution").

[35] It can be inferred from this data that "no medical examinations" include no cancer screenings. *See id.* at 968.

[36] Yoshiko Iwai, Alice Yunzi L. Yu, Samantha M. Thomas, Tyler Jones, Kelly E. Westbrook, Andrea K. Knittel & Oluwadamilola M. Fayanju, *Examining Inequities Associated with Incarceration Among Breast Cancer Patients*, 13 CANCER MED., May 15, 2024, at 2.

[37] Manz, Odayar & Schrag, *supra* note 32, at 225.

[38] *American Cancer Society Guidelines for the Early Detection of Cancer*, AM. CANCER SOC'Y, https://www.cancer.org/cancer/screening/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html (last visited Dec. 14, 2024).

[39] *Id.*

[40] Manz, Odayar & Schrag, *supra* note 32, at 227.

[41] Jingxuan Zhao, Sandhya Kajeepeta, Christopher R. Manz, Xuesong Han, Leticia M. Nogueira, Zhiyuan Zheng, Qinjin Fan, Kewei Sylvia Shi, Fumiko Chino & K. Robin Yabroff, *County-Level Jail and State-Level Prison Incarceration and Cancer Mortality in the United States*, 117 J. NAT'L CANCER INST. 157 (2024) (finding high mortality rates for lung and liver cancers in state prisons).

[42] Ilana B. Richman, Pamela R. Soulos, Hsiu-ju Lin, Jenerius A. Aminawung, Oluwadamiloa Oladeru, Lisa B. Puglisi, Emily A. Wang & Cary P. Gross, *Incarceration and Screen-Detectable Cancer*

Once, or if, cancer is detected in inmates following a screening, the disease has typically entered a later stage which worsens survival rates.[43] In a study on Connecticut prisons, 58.8% of prisoners were diagnosed at a metastasized stage compared to 31.9% in the never incarcerated group.[44] Results overall identified nearly two-thirds of prison patients already had regional spread at the time of diagnosis.[45] Furthermore, the Office of the Corrections Ombuds (OCO) conducted an investigation of state prison inmates in Seattle, Washington[46] which revealed an average of 6.5 months for prisoners to be diagnosed with cancer after the presentation of initial symptoms.[47] Some, however, reported diagnoses up to seventeen months after symptom onset.[48] Importantly, these late-stage diagnoses are occurring with cancers that have effective screening options,[49] namely, cervical, lung, colorectal, and liver cancers.[50] One study examined the differences in diagnostics for cancer tumor staging in prisoners versus non-prisoners.[51] For colorectal cancer, the tumors of prisoners were diagnosed at a ninety-two percent worsened stage than non-prisoners; for liver cancer, there was a twenty-one percent differential.[52]

Cervical cancer offers another stark example of this diagnostic disparity. In the general population, cervical cancer is considered highly treatable. About 12,000 women in the United States each year are diagnosed with cervical cancer, and approximately ninety-two percent of those women

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Diagnosis Among Adults in Connecticut, 116 J. NAT'L CANCER INST. 485, 485 (2023); Sujata Srinivasan, *Connecticut Prisons Likely Under-Screen, Under-Diagnose Cancer, Study Finds*, CT MIRROR (Dec. 6, 2023, 8:00 AM), https://ctmirror.org/2023/12/06/ct-prisons-cancer-screening-yale-school-medicine/.

[43] Isabella Backman, *How Incarceration Raises Risk of Cancer Diagnosis and Death—Even After Release*, YALE SCH. MED. (Mar. 17, 2023), https://medicine.yale.edu/news-article/how-incarceration-raises-risk-of-cancer-diagnosis-and-deatheven-after-release/; Manz, Odayar & Schrag, *supra* note 7.

[44] Oladeru, Aminawung, Lin, Gonsalves, Puglisi, Mun, Gallagher, Soulos, Gross & Wang, *supra* note 31, at 7.

[45] *Id.*

[46] *See* DAVID, *supra* note 29.

[47] Jim Brunner, *Investigation Finds More Deadly Delays in Cancer Diagnosis and Treatment at Washington State Prisons*, SEATTLE TIMES (Mar. 30, 2021, 10:27 AM), https://www.seattletimes.com/seattle-news/law-justice/investigation-finds-more-deadly-delays-in-cancer-diagnosis-and-treatment-at-washington-state-prisons/.

[48] *Id.* One individual studied, Michael Boswell, pleaded for months to receive treatment for a bleeding lesion on his back. The staff, however, consistently told him the lesion was benign. Months later, he received an aggressive skin cancer diagnosis. Boswell died only a month later at age 37. Boswell had a known family history of cancer and overt symptoms, but the delayed care for an initially treatable condition still culminated in his death. Boswell's experience was not idiosyncratic in Monroe Correctional Facility—the OCO report identified many other similarly situated prisoners, with some not getting diagnoses until 17 months after symptom presentation. *Id.*

[49] *See generally* Manz, Odayar & Schrag, *supra* note 32.

[50] *Id.*

[51] *See generally* Kathryn I. Sunthankar, Kevin N. Griffith, Stephanie D. Talutis, Amy K. Rosen, David B. McAneny, Matthew H. Kulke, Jennifer F. Tseng & Teviah E. Sachs, *Cancer Stage at Presentation for Incarcerated Patients at a Single Urban Tertiary Care Center*, 15 PLOS ONE 1 (2020).

[52] *Id.* at 7 tbl.2.

survive.[53] Incarcerated women, however, are largely immune from these success rates.[54] First, they are disproportionately affected by cervical cancer, with an estimated risk of four to five times higher than that of women in the general population.[55] Yet, according to a recent survey, only thirty-six percent of prisons offered onsite colposcopy, and even fewer (9%) offered on-site procedures like excision treatments.[56] Furthermore, follow-up of abnormal pap smear results is often delayed.[57] A twelve-month study conducted in the Ohio prison system found that out of 170 abnormal pap smear results among the incarcerated women, only 24.4% of those abnormalities received any follow-up.[58]

As stated by the American Cancer Fund, "[e]arly detection saves lives."[59] Consequently, the failure of prisons to provide timely screenings operates, effectively, as a death sentence for many inmates. Even where screenings are available, however, the limited access to Medicare and Medicaid for prisoners poses another barrier to access.

B. Medicaid and Medicare Inmate Exclusion Policy

The Social Security Act of 1965 prohibits federal Medicaid and Medicare funding for the care of "inmate[s] of a public institution," except where an inmate is "a patient of a medical institution" for twenty-four hours or longer.[60] In other words, when a prisoner receives healthcare within their correctional facility, they are exempt from using Medicaid or Medicare to

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[53] *Cervical Cancer Statistics*, CTR. DISEASE CONTROL & PREVENTION (June 13, 2024), https://www.cdc.gov/cervical-cancer/statistics/index.html. ("Each year in the United States, about 11,500 new cases of cervical cancer are diagnosed and about 4,000 women die of this cancer.").

[54] Alexa N. Kanbergs, Mackenzie W. Sullivan, Morgan Maner, Lauren Brinkley-Rubinstein, Annekathryn Goodman, Michelle Davis & Sarah Feldman, *Cervical Cancer Screening and Follow-Up Practices in U.S. Prisons*, 64 AM. J. PREVENTATIVE MED. 244, 246–48 (2023); Ingrid A. Binswanger, Shane Mueller, C. Brendan Clark & Karen L. Cropsey, *Risk Factors for Cervical Cancer in Criminal Justice Settings*, 20 J. WOMEN'S HEALTH 1839, 1841–44 (2011); Amanda Emerson, Marissa Dogan, Elizabeth Hawes, Kiana Wilson, Sofia Mildrum Chana, Patricia J. Kelly, Megan Comfort & Megha Ramaswamy, *Cervical Cancer Screening Barriers and Facilitators from the Perspectives of Women with a History of Criminal-Legal System Involvement and Substance Use*, 12 HEALTH & JUST., no. 9, 2024, at 1, 1–12.

[55] Kanbergs, Sullivan, Maner, Brinkley-Rubinstein, Goodman, Davis & Feldman, *supra* note 54, at 247; Emerson, Dogan, Hawes, Wilson, Chana, Kelly, Comfort & Ramaswamy, *supra* note 54.

[56] Kanbergs, Sullivan, Maner, Brinkley-Rubinstein, Goodman, Davis & Feldman, *supra* note 54, at 247; Emerson, Dogan, Hawes, Wilson, Chana, Kelly, Comfort & Ramaswamy, *supra* note 54.

[57] Kanbergs, Sullivan, Maner, Brinkley-Rubinstein, Goodman, Davis & Feldman, *supra* note 54, at 247; Emerson, Dogan, Hawes, Wilson, Chana, Kelly, Comfort & Ramaswamy, *supra* note 54.

[58] Abnormal pap smear results are indicative of potential cervical cancer. *See HPV and Pap Test Results: Next Steps After an Abnormal Cervical Cancer Screening Test*, NAT'L CANCER INST. (June 6, 2024), https://www.cancer.gov/types/cervical/screening/abnormal-hpv-pap-test-results.

[59] *Early Detection, Early Prevention*, AM. CANCER FUND, https://americancancerfund.org/early-detection-early-prevention/ (last visited Dec. 14, 2024).

[60] This policy is known as the Medicaid/Medicare Inmate Exclusion Policy. 42 U.S.C. § 1396d(a)(32)(A) (2006).

pay for those services.[61] However, if a prisoner goes to a hospital, they may be permitted.[62] This exclusion policy is particularly significant because a large segment of the prison population would be eligible for—and benefit from—access to this health insurance.

Medicaid is designed to provide healthcare to the nation's "most economically disadvantaged populations."[63] Yet prisons, which incarcerate some of the poorest people in this nation,[64] are excluded from its coverage. Well over half of prisoners are impoverished, compared to the national poverty rate of 11.8%.[65] A study conducted by the Prison Policy Initiative found that seventy-two percent of women and fifty-seven percent of men were earning less than $22,000 per year prior to incarceration.[66] And, even for those who were not in poverty before prison, incarceration virtually eliminates income potential.[67] The average minimum wage for incarcerated workers is 86 cents.[68] While Medicaid eligibility varies depending on state and household size, the American Journal of Preventative Medicine estimates that, at least for states participating in Medicaid expansion, eighty to ninety percent of the incarcerated population would qualify for Medicaid.[69] With respect to Medicare, the purpose is to provide coverage to individuals aged sixty-five or older.[70] Yet, the prison population, which is aging prolifically, is exempt from this care. Presently, about three percent of the prison population is over age sixty-five.[71] However, between 2007 and 2010, the number of "prisoners age[d] 65 and older grew at a rate 94 times

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[61] *See* Alysse G. Wurcel, Katharine London, Erika L. Crable, Nicholas Cocchi, Peter J. Koutoujian & Tyler N.A. Winkelman, *Medicaid Inmate Exclusion Policy and Infectious Diseases Care for Justice-Involved Populations*, (Mar. 14, 2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10986832/pdf/23-0742.pdf.

[62] *Id.*

[63] *Medicaid 101*, MACPAC, https://www.macpac.gov/medicaid-101/ (last visited Dec. 10, 2024).

[64] *See* Hayes & Barnhorst, *supra* note 25.

[65] *Id.*

[66] Bernadette Rabuy & Daniel Kopf, *Prisons of Poverty: Uncovering the Pre-Incarceration Incomes of the Imprisoned*, PRISON POL'Y INITIATIVE (July 9, 2015), https://www.prisonpolicy.org/reports/income.html; *See* Hayes & Barnhorst, *supra* note 25.

[67] Amanda Y. Agan & Michael D. Makowsky, *The Minimum Wage, EITC, and Criminal Recidivism*, 58 J. HUM. RESOURCES 1712, 1713 (2023).

[68] Wendy Sawyer, *How Much Do Incarcerated People Earn in Each State*, PRISON POL'Y INITIATIVE (Apr. 10, 2017), https://www.prisonpolicy.org/blog/2017/04/10/wages/.

[69] Alexander Testa & Lauren C. Porter, *Previous Incarceration, Health Insurance, and the Affordable Care Act in the U.S.*, 65 AM. J. PREVENTIVE MED. 1034, 1034 (2023).

[70] *Introduction to Medicare*, CTRS. FOR MEDICAID & MEDICARE SERVS. (Apr. 3, 2023), https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefits-and-recovery-overview/medicare-secondary-payer/downloads/introduction-to-medicare.pdf.

[71] This value comes from the most recent report from the Department of Justice on the age demographic in prisons. *See* LAUREN G. BEATTY & TRACY L. SNELL, U.S. DEP'T. OF JUST., PROFILE OF PRISON INMATES, 2016, (Dec. 2021), https://bjs.ojp.gov/content/pub/pdf/ppi16.pdf.

the overall prison population."[72] NPR reports that "by one measure, about [one] third of all prisoners will be considered geriatric by 2030."[73]

With a large sum of the prison population eligible for this insurance, such services would be instrumental to improving healthcare access. Without this access, however, most prisons provide medical care through contracted healthcare providers.[74] Prisoners then are responsible for, often cost-prohibitive, co-pays. For example, the Prison Policy Initiative reports that in West Virginia prisons, "a single visit to the doctor would cost almost an entire month's pay for an incarcerated person."[75] With Medicaid and Medicare available, however, most preventative and screening services are covered.[76] Medicare Part A generally covers cancer treatment you receive as an inpatient, while Part B "covers many medically necessary cancer-related services . . . on an outpatient basis."[77] Similarly, Medicaid generally covers most of cancer treatment care.[78]

Although MIEP permits prisoners to use Medicaid or Medicare when hospitalized in an outside facility for over twenty-four hours, this provision proves mostly futile.[79] Due to security concerns and transportation challenges, "access to true emergency care [is often] delayed."[80] An inmate who is ill cannot dial 911 or reach out to their primary care provider—instead, they must convince a prison guard that they are in need of treatment and then see in-house medical personnel to decide whether further treatment is needed.[81] Although not reviewed in the available data on prison healthcare, personal testimonies reveal that the system described above often results in prisoners not receiving outside medical care.[82] This is bolstered by

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[72] *Report Examines Trends in U.S. Aging Prison Population*, NAT'L COMM'N ON CORRECTIONAL HEALTH CARE (2010), https://www.ncchc.org/aging-prison-population/.

[73] Meg Anderson, *The U.S. Prison Population is Rapidly Graying. Prisons Aren't Built for What's Coming*, NPR (Mar. 11, 2024, 5:12 AM), https://www.npr.org/2024/03/11/1234655082/prison-elderly-aging-geriatric-population-care.

[74] *See generally* Roger Watson, Anne Stimpson & Tony Hostick, *Prison Healthcare: A Review of the Literature*, 41 INT'L J. NURSING STUDS. 119, 121 (2004).

[75] Wendy Sawyer, *The Steep Cost of Medical Co-pays in Prison Puts Health at Risk*, PRISON POL'Y INITIATIVE (Apr. 9, 2017), https://www.prisonpolicy.org/blog/2017/04/19/copays/.

[76] *See Medicare Coverage for Cancer Prevention and Early Detection*, AM. CANCER SOC'Y, https://www.cancer.org/cancer/financial-insurance-matters/understanding-health-insurance/government-funded-programs/medicare/medicare-coverage-for-cancer-prevention-and-early-detection.html (last updated Feb. 13, 2025); *What is a Medicaid Co-Pay?*, FREEDOM CARE, https://freedomcare.com/medicaid-copay/ (last visited Dec. 14, 2024).

[77] *Medicare & Medicaid*, FORCE, https://www.facingourrisk.org/support/insurance-paying-for-care/treatment/medicare-and-medicaid (last visited Apr. 12, 2025).

[78] *Medicaid and Cancer Care Access: Policy Brief*, AM. SOC'Y OF CLINICAL ONCOLOGY (Aug. 2022) https://web.archive.org/web/20240517170225/https://society.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2022-Medicaid-Cancer-Access.pdf (last visited Dec. 14, 2024).

[79] *See infra* Part II (explaining the story of Ferdinand Dix as one example).

[80] Marc Shalit & Matthew R. Lewin, *Medical Care of Prisoners in the USA*, 364 MED., CRIME & PUNISHMENT 34, 34 (2004).

[81] *Id.*

[82] *See, e.g.*, Sam McCann, *Health Care Behind Bars: Missed Appointments, No Standards, and High Costs*, VERA (June 29, 2022), https://www.vera.org/news/health-care-behind-bars-missed-appointments-no-standards-and-high-costs.

research that reveals the high rates of missed medical appointments within prisons. For example, the New York Department of Corrections reported over 1,000 missed medical appointments in December 2021 alone.[83] On Rikers Island, there were 11,789 missed medical appointments in April 2022.[84]

The Medicare/Medicaid Inmate Exclusion Policy (MIEP) imposes significant barriers to prison healthcare access, leaving prisoners with few options, most of which are prohibitively expensive. Eliminating MIEP could make a material difference in the delivery of prison healthcare, which is further discussed in Part III.

II. THE HARM

Ferdinand Dix was sentenced to serve six years in an Arizona state prison.[85] He did not make it out alive.[86] For over two years, Dix complained to prison officials of a chronic cough, shortness of breath, and other alarming symptoms.[87] As his complaints and suffering were disregarded, lung cancer metastasized to his liver, lymph nodes, and other major organs.[88] His body soon became "infested with tumors," and his abdomen bloated to the size "of a full-term pregnant woman" because of a mass "four times [the size] of a normal liver."[89] Still, prison officials delayed examination.[90] Eventually, and unsurprisingly, Dix fell into an unresponsive state.[91] Only then, the prison transported him to an outside hospital where he died a few weeks later.[92] Dix's mother filed a lawsuit over the matter, claiming that but for the prisoner's failure to provide appropriate diagnostic and treatment care, her son would still be alive.[93]

The story of Ferdinand Dix is far from unique—across the United States, the lack of access to timely cancer diagnostics and health insurance as discussed in Part I results in a myriad of harms. This Part will explore such harms including (1) increased mortalities; (2) litigation over constitutional violations; and (3) increased healthcare costs.

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[83] *Id.*

[84] *Id.*

[85] *Survivors of Prison Violence — Arizona*, BLOGSPOT (Feb. 22, 2012), https://azprisonsurvivors.blogspot.com/2012/02/aspc-tucson-deaths-in-custody-ferdinand.html; Victoria Bekiempis, *Don't Get Cancer if You're in Prison*, NEWSWEEK MAG. (July 22, 2015, 9:54 AM), https://www.newsweek.com/2015/07/31/dont-get-cancer-if-youre-prison-356010.html; Molly Rothschild, Note, *Cruel and Unusual Prison Healthcare: A Look at the Arizona Class Action Litigation of* Parsons v. Ryan *and Systemic Deficiencies of Private Health Services in Prison*, 61 ARIZ. L. REV. 945, 946–48 (2019).

[86] *See Survivors of Prison Violence — Arizona*, *supra* note 85.

[87] *Id.*

[88] *Id.*

[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] *See Survivors of Prison Violence — Arizona*, *supra* note 85.

[93] *Id.*; Complaint at 8, Wallace v. Ariz. Dep't Corr., No. 2:12-cv-00302 (D. Ariz. Feb. 16, 2012), ECF No. 3.

A. Increased Morality Among Prisoners

Each year someone spends incarcerated in the United States decreases their life expectancy by two years.[94] Cancer is the leading contributor to this stark reality, accounting for approximately thirty percent of all deaths in state and federal prisons.[95] Several studies, however, consider this statistic a gross underrepresentation of reality.[96] While the exact value of cancer mortalities in prison remains uncertain, these deaths are undoubtedly on the rise. In 2018, the Bureau of Justice Statistics reported that the mortality rate for cancer in state prisons was the highest since 2001.[97] Another study revealed that between 2004 and 2016, prison cancer mortalities rose by fifty-nine percent.[98]

Cancer survival rates are lower for those incarcerated. One comprehensive study reviewed sixteen prison systems and identified that "[i]ncarcerated patients with cancer have a 92% higher 5-year mortality than the general population."[99] Similar studies on individual prisons have variable results, but the data remains bleak. For example, in a 2022 study of Connecticut prisons, the overall five-year survival rate for screenable cancers was 67.4% for those diagnosed while incarcerated, and 85.2% among those never incarcerated.[100] These results varied depending on the type of cancer. With respect to breast cancer, the "five-year survival rate was lowest for incarcerated patients (60%), compared to those . . . never incarcerated (89.5%)."[101] In a similar Texas study, there was a "four-fold higher death rate from hepatocellular carcinoma compared to the rest of the United States population."

These lowered survival rates render cancer the leading cause of death in prisons, outsizing mortalities caused by suicide, homicide, heart disease, and alcohol- and drug-related illnesses.[102] One study found that between 2000 and 2018, cancer accounted for 16,277 total mortalities within

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[94] *See* McCann, *supra* note 82; Emily Widra, *Incarceration Shortens Life Expectancy*, PRISON POL'Y INITIATIVE (June 26, 2017), https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/.

[95] *Incarceration Associated with High Risk of Mortality, Yale Study Shows*, *supra* note 1.

[96] CAROLINE ISAACS, DEATH YARDS: CONTINUING PROBLEMS WITH ARIZONA'S CORRECTIONAL HEALTH CARE 13–15 (Oct. 2013), https://afscarizona.org/wp-content/uploads/2014/03/death-yards-continuing-problems-with-arizonas-correctional-health-care-2013.pdf (explaining death reporting systems in prisons to highlight that "natural causes" deaths reported—if investigated further—would likely reveal people dying of cancer that went undiagnosed).

[97] Aziz, Ackah, Whitson, Oppong, Obeng-Gyasi, Sims & Pawlik, *supra* note 17, at 965.

[98] Manz, Odayar & Schrag, *supra* note 7, at 7278.

[99] Christopher Manz, Brett Nava-Coulter, Emma Voligny & Alexi A. Wright, *Cancer Care Delivery in Prisons: From Barriers to Best Practices*, 20 JCO ONCOLOGY PRAC. 49, 49 (2024).

[100] Oladeru, Aminawung, Lin, Gonsalves, Puglisi, Mun, Gallagher, Soulos, Gross & Wang, *supra* note 31, at 5.

[101] *Id.*

[102] Jessica L. Adler & Weiwei Chen, *Jail Conditions And Mortality: Death Rates Associated With Turnover, Jail Size, And Population Characteristics*, 42 HEALTH AFFS. 849, 852–53 (2023); *Mortality: Death and Dying*, PRISON POL'Y INITIATIVE, https://www.prisonpolicy.org/visuals/mortality.html (last visited Dec. 14, 2024) (outlining death causes in prison).

correctional facilities.[103] Another study reported that higher incarceration rates in state prisons were associated with higher overall state mortality rates.[104]

This great volume of deaths, importantly to note, are far from peaceful. NPR reviewed court and medical records and conducted interviews with the families and lawyers of prisoners who died of cancer during incarceration.[105] Of the findings across prisons, one commonality emerged: their final weeks were marked by extreme pain and suffering.[106] Joseph Guadagnoli, incarcerated in West Virginia, died of cancer after complaining of symptoms for months. On December 1, he submitted a sick call request stating, "I cannot breathe . . . I have been asking for [help for] seven months."[107] In another case, Michael Bougher, a California prisoner, fainted over five times before doctors discovered a brain tumor the size of an egg.[108] Many other prisoners endured such prolonged suffering, reporting unaddressed symptoms of severe stomach pain, nausea, migraines, muscle cramps, and shortness of breath.[109]

The increased likelihood of death from cancer in prison is a direct consequence of the failure to provide adequate access to care and insurance.[110] This reality runs afoul to the constitutional right prisoners have to receive adequate healthcare, which has culminated in a litany of litigation.

B. Rights Not Vindicated: Expensive Litigation and Persistent Constitutional Violations

The lack of access to regular cancer screenings and appropriate health insurance presents a constitutional violation. In *Estelle v. Gamble*, the Supreme Court held that "deliberate indifference" to the medical needs of prisoners violates the Eighth Amendment's protection against "cruel and unusual punishment," imposing a constitutional duty on the government to provide adequate medical care to those it incarcerates.[111] In its ruling, the Court emphasized that denying medical care to prisoners leads to unnecessary suffering that is incompatible with "contemporary standards of decency."[112] In 1993, the Court extended *Gamble*, ruling that prisons must not only address inmates' immediate health concerns, but also avoid creating

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[103] Manz, Odayar & Schrag, *supra* note 7, at 7280.

[104] *New Study Finds Higher County-Level Jail and State-Level Prison Incarceration Rates Associated With Higher County- and State-Level Cancer Mortality Rates*, AM. CANCER SOC'Y (Sept. 17, 2024), https://pressroom.cancer.org/study-incarceration-rates-cancer.

[105] Meg Anderson, *1 in 4 Inmate Deaths Happens in the Same Federal Prison. Why?*, NPR (Sept. 23, 2023, 6:00 AM), https://www.npr.org/2023/09/23/1200626103/federal-prison-deaths-butner-medical-center-sick-inmates.

[106] *Id.*

[107] *Id.*

[108] *Id.*

[109] *Id.*

[110] *See supra* Part I (discussing access issues).

[111] Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

[112] *Id.* at 103.

conditions that "risk . . . serious damage" to their *future* health.[113] Then, in 1964, *Cooper v. Pate* held that prisoners could challenge the legality of prison conditions in federal court.[114]

Unsurprisingly, the coupling of *Cooper* and the constitutional duties emanating from *Gamble* have been the foothold of much prison healthcare litigation.[115] For deaths marked by ignored medical complaints, missed doctor appointments, and severe pain and suffering, *Gamble* would ostensibly set a clear path forward.[116] However, litigation has proven to be a "diminished [avenue]" for vindication,[117] as prisons continue to fall short of their responsibilities despite reprimands.[118] Most cases on the issue result in either ineffective settlements or injunctions.[119] For example, in 2012, the ACLU sued the Arizona State Prison system over its failure to provide "basic health care and minimally adequate condition[s]" to its inmates.[120] The suit was settled in 2014 upon the prison system's "promise" to improve conditions.[121] However, in the following seven years, preventable suffering and deaths persisted.[122] The lawsuit then was re-filed where a federal judge then issued a "thorough and sweeping injunction . . . requiring the Arizona Department of Corrections . . . to make 'substantial' changes to ensure medical care reaches constitutional standards."[123] Time will tell whether the injunction will be upheld, but history suggests its likely failure. In *Parsons v. Ryan*, prisoners of the Arizona Department of Corrections (ADC) filed a class action lawsuit claiming that the prisons put them at "substantial risk of

[113] Helling v. McKinney, 509 U.S. 25, 35 (1993).

[114] Cooper v. Pate, 378 U.S. 546, 546 (1964) (per curiam).

[115] *See* Rothschild, *supra* note 85, at 950.

[116] The argument is that, where correctional facilities ignore complaints of medical symptoms and access to screenings and treatments are limited, the prison is failing to protect the future and current health of their inmates.

[117] Rothschild, *supra* note 85, at 971.

[118] *See* Rothschild, *supra* note 85.

[119] Tori Collins, *When Fines Don't Go Far Enough: The Failure of Prison Settlements and Proposals for More Effective Enforcement Methods*, 76 MAINE L. REV. 132, 1423–46 (2024) ("[T]here is little motivation to comply with a settlement when it is not the actors within prisons, but the state or federal department overseeing them that is held responsible. As one commentator notes, 'settlement agreements—just like remedies stipulated by a final [] judgment—depend on a [government's] willingness to commit to the terms of its agreement.' Though trial courts can choose to impose imprisonment on high-ranking officials who have been held in contempt, they are often hesitant to do so." (alterations in original) (footnotes omitted)).

[120] Jensen v. Thornell, No. CV-12-00601, Order and Permanent Injunction (D. Ariz. Apr. 7, 2023); Corene Kendrick & Maria Morris, *Federal Judge Finds Arizona's Prison Health Care is "Plainly Grossly Inadequate" and Unconstitutional*, ACLU (Jul. 8, 2022), https://www.aclu.org/news/prisoners-rights/federal-judge-finds-arizonas-prison-health-care-is-plainly-grossly-inadequate-and-unconstitutional; *see also* Jensen v. Thornell, ACLU, https://www.aclu.org/cases/jensen-v-thornell?document=parsons-v-ryan-rebuttal-declaration-eldon-vail-attachments (last updated Apr. 7, 2023) (reporting on the *Jensen* case).

[121] Jensen v. Thornell, ACLU, *supra* note 120.

[122] *Id.*

[123] *Id.*

unnecessary pain and suffering . . . and death."[124] The case resulted in a $4.9 million settlement with a stipulation between parties that the ADC would be monitored for compliance.[125] However, the monitoring was unsuccessful, and eventually the court removed the monitoring requirement noting that it was "'ill-advised' for the ADC to continue 'defending its noncompliance.'"[126] *Parsons* showcases how prisons often side-step court-orders because "due to their closed environments, largely hidden from public view, [prisons] create a space where abuse is . . . likely to go unnoticed and unaccounted for."[127]

The line of Supreme Court cases addressing prison healthcare outlines specific standards that are plainly being unmet. The result has been a flood of litigation, but little material change. Consequently, the rights of prisoners to receive healthcare remains largely unvindicated.

C. Increased Healthcare Costs

This prison cancer problem is, in fact, not just a prison problem. While prisons spend an estimated $8.1 billion on health care services each fiscal year,[128] many expenses are pushed down the line for the public health system to incur. Ninety-five percent of prisoners eventually get released,[129] and studies establish that this post-release period is a highly vulnerable time for their health.[130] 1 in 70 are hospitalized within the first week of leaving their correctional facility, and 1 in 12 are hospitalized within 90 days.[131] Essentially, people are leaving prison sicker than when they entered, and healthcare providers are thus faced with the added challenge of treating individuals whose health has worsened due to inadequate care while incarcerated. Cancer, specifically, is a leading cause of mortality shortly after release[132] as those diagnosed with cancer within the first-year post-incarceration are often already in advanced, terminal stages of the illness.[133]

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[124] Maria Polletta, *Arizona Governor Picks Federal Bureau of Prisons Official David Shinn to Lead State Corrections Agency*, ARIZ. CENT. (Oct. 7, 2019, 5:58 PM), https://www.azcentral.com/story/news/politics/arizona/2019/0/07/david-shinn-appointeddirector-arizona-department-corrections/3900413002/; *See* Rothschild, *supra* note 85, at 956.

[125] *See* Rothschild, *supra* note 85, at 961–62.

[126] *Id.* (citing Jacques Billeaud, *Expert Picked in Lawsuit Over Inmates' Health Care in Arizona*, WASH. TIMES (Dec. 6, 2018, 4:39 PM)).

[127] *See* Rothschild, *supra* note 85, at 965.

[128] PEW CHARITABLE TR., PRISON HEALTH CARE: COSTS AND QUALITY (Oct. 18, 2017), https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

[129] Timothy Hughes & Doris James Wilson, *Reentry Trends in the United States*, BUREAU OF JUST. STATS. (Apr. 14, 2004), https://bjs.ojp.gov/content/pub/pdf/reentry.pdf.

[130] Backman, *supra* note 43.

[131] *Id*.

[132] Oladeru, Aminawung, Lin, Gonsalves, Puglisi, Mun, Gallagher, Soulos, Gross & Wang, *supra* note 31; Megha Ramaswamsy, Christopher Manz, Fiona Kouyoumdijan, Noel Vest, Lisa Puglisi, Emily Wang, Chelsea Salyer, Beverly Osei, Nick Zaller & Timothy R. Rebbeck, *Cancer Equity for Those Impacted by Mass Incarceration*, 115 J. NAT'L CANCER INST. 1128, 1128–130 (2023).

[133] *See supra* notes 42–58 and accompanying text.

This is largely attributed to the fact that, while in prisons, individuals are not getting screened.[134]

These delays in cancer diagnoses and treatment significantly increases healthcare costs. For example, treating breast cancer averages $82,121 in stages one and two, but rises to $129,387 in stage three.[135] Similarly, cervical cancer, a common diagnosis during the post-release period,[136] costs approximately $15,722 in its early stages, but escalates to over $52,539 in its terminal stages.[137] These late-stage costs are transferred to the public health system when prisoners are released, but could be avoided if addressed earlier on.

III. PROPOSED SOLUTIONS

To address the access issues and associated harms outlined above, this paper proposes two solutions. First, it advocates for the repeal of the Federal Medicaid and Medicare Inmate Exclusion Policy to enable these services to be utilized within correctional facilities. Second, it recommends the implementation of regular screenings within prisons. Together, these measures aim to improve health outcomes and mitigate the challenges faced by incarcerated individuals.

A. Repeal Medicaid/Medicare Inmate Exclusion Policy to Allow Such Services in Prisons

Pursuant to the Social Security Act of 1965, incarcerated people are excluded from Medicaid and Medicare coverage, except for hospital stays longer than twenty-four hours.[138] The Medicaid/Medicare Inmate Exclusion Policy (MIEP) is predicated on the idea that "carceral systems are traditionally a state concern"[139] and that inmates constitute the "undeserving poor" and thus should be shut-out from government benefits.[140] These

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[134] Backman, *supra* note 43.

[135] Erin L. Boyle, *What's the Average Cost of Breast Cancer Treatment?*, HEALTH CENT. (Sept. 10, 2024), https://www.healthcentral.com/patientpower/breast-cancer/cost-of-treatment.

[136] Backman, *supra* note 43.

[137] Ning Liu, Nicole Mittmann, Peter C. Coyte, Rebecca Hancock-Howard, Soo Jin Seung & Craig C. Earle. *Phase-Specific Healthcare Costs of Cervical Cancer: Estimates from a Population-Based Study*, AM. J. OBSTETRICS & GYNECOLOGY 615 (2016).

[138] 42 U.S.C. § 1396d(a)(32)(A) (2006); Wurcel, London, Crable, Cocchi, Koutoujian & Winkelman, *supra* note 61, at 95.

[139] Kim Herbert, *Improving Healthcare Quality and Access for People Experiencing Incarceration Through Repealing the Medicaid Inmate Exclusion Policy*, GEO. J. POVERTY L. & POL'Y, Feb. 5, 2024, https://www.law.georgetown.edu/poverty-journal/blog/improving-healthcare-quality-and-access-for-people-experiencing-incarceration-through-repealing-the-medicaid-inmate-exclusion-policy/; *see also* Mira Edmonds, *The Reincorporation of Prisoners into the Body Politic: Eliminating the Medicaid Inmate Exclusion Policy*, 28 GEO. J. ON POVERTY L. & POL'Y 279, 285 (2021).

[140] Nicole Huberfeld, *Federalism in Health Care Reform*, *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197, 203, 205 (Ezra Rosser ed. 2019); Edmonds, *supra* note 139, at 286

aforementioned purposes of MIEP are not being realized as (1) the post-release period creates higher costs for the public health system when prisoners are not cared for during incarceration,[141] and (2) the concept of prisoners as "undeserving poor" directly contradicts the principles announced in *Estelle v. Gamble*.[142] Repealing MIEP to allow Medicaid and Medicare services to cover carceral facilities offers a viable solution for fostering a healthier, and less costly prison population.

1. The Federal Government Should Repeal MIEP

Repealing MIEP is, in fact, a more appropriate path towards achieving the legislation's intended purpose of saving federal Medicaid funds.[143] Furthermore, a repeal would help ensure that correctional facilities remain in compliance with constitutional principles as prisoners would no longer be considered *un*-deserving poor.

The primary purpose of MIEP was that federal Medicaid Funds should "not be used to finance care for institutionalized individuals who have traditionally been the responsibility of State and local governments."[144] This goal is fundamentally flawed, as MIEP balloons healthcare costs during the post-prison-release period for both state and federal governments. As discussed in Part I.C., to manage healthcare costs, correctional facilities "charge prisoners unaffordable co-pays . . . and offer low-quality care that inadequately follows established clinical guidelines," including regular cancer screenings.[145] This lack of care frequently results in individuals re-entering society sicker, and consequently, more expensive to treat.[146] In other words, the expenses that MIEP aims to mitigate (*i.e.*, costs of prisoners while they are incarcerated) are merely deferred until release when prisoners re-enroll in Medicaid and Medicare. It is predicted that if MIEP is repealed,

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(first citing LESLIE ACOCA, JESSICA STEPHENS & AMANDA VAN VLEET, HEALTH COVERAGE AND CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM: THE ROLE OF MEDICAID AND CHIP 13 (2014); and then citing COMMITTEE ON ECONOMIC SECURITY, OLD AGE SECURITY STAFF REPORT (Jan. 1935) (including a survey of state old age assistance laws and their focus on ensuring that "recipients of relief are 'deserving' citizens" and may have formed the basis for the inmate exclusion in 1935 Social Security Act)).

[141] *See supra* Part I.C (discussing increased public healthcare costs).

[142] *See supra* Part II.B (discussing *Estelle v. Gamble* and its progeny).

[143] 50 Fed. Reg. 13196 (Apr. 3, 1985) ("As explained in the preamble to the NPRM, we decided to change our regulations and ensure that Medicaid funds are not used to finance care for institutionalized individuals who have traditionally been the responsibility of State and local governments."); *see also* Herbert, *supra* note 139; *see also* Edmonds, *supra* note 139.

[144] 50 Fed. Reg. 13196 (Apr. 3, 1985) ("As explained in the preamble to the NPRM, we decided to change our regulations and ensure that Medicaid funds are not used to finance care for institutionalized individuals who have traditionally been the responsibility of State and local governments."); *see also* Herbert, *supra* note 139; *see also* Edmonds, *supra* note 139.

[145] *See* Sarah Wang, *Prison Health Care is Broken Under the Medicaid Inmate Exclusion Policy*, HARV. L. PETRIE-FLOM CTR. (Jan. 26, 2022), https://blog.petrieflom.law.harvard.edu/2022/01/26/medicaid-inmate-exclusion-policy/.

[146] *See* discussion *supra* Part II.C and footnotes 136–38 (discussing costs of cancer treatment depending on stage).

Medicaid expansion states could save $4.7 billion each year.[147] The current high-cost reality is likely to be exacerbated with the bipartisan passage of the Consolidated Appropriations Act of 2024 (CAA), which "requires states to suspend, rather than terminate,[148] Medicaid coverage when people are incarcerated."[149] With the passage, starting in 2026, newly released inmates will automatically be re-enrolled in Medicaid and Medicare,[150] and will likely utilize its services immediately to front the costs of their worsened illnesses.[151]

Furthermore, a repeal of MIEP would help bring correctional facilities into compliance with constitutional obligations and likely reduce litigation. *Estelle v. Gamble* "affirmed that incarcerated individuals have the constitutional right to health care."[152] Yet, the current prison healthcare system—in part because of MIEP—is falling short of that obligation.[153] MIEP reflects a Medicaid principle that government-issued benefits belong "only to those deemed worthy, or *deserving* poor."[154] Because of the crimes prisoners have committed, they are categorized—in the government's eyes—as *un*-deserving, and shut out from benefits.[155] Consequently, prison systems have to look elsewhere for healthcare delivery which typically results in privatizing healthcare and contracting with or outsourcing to providers.[156] This system is expensive,[157] which dissuades prisons from utilizing healthcare. However, if Medicaid and Medicare were available in prisons, correctional facilities could "offset[] [their healthcare] costs with the federal assistance provided."[158]Also, federal prisons would be able to tap into Medicaid's negotiation power "which can reduce healthcare costs by

[147] *See* Wang, *supra* note 145, at 4.

[148] Prior to the passage of the Consolidated Appropriations Act, prisoners were automatically disenrolled from Medicaid upon incarceration. So, when they were released, they were without insurance until they re-applied and re-enrolled. This new legislation will ensure that upon release prisoners are automatically re-enrolled. *See* Sarah E. Wakeman, Margaret E. McKinney & Josiah D. Rich, *Filling the Gap: The Importance of Medicaid Continuity for Former Inmates*, 24 J. GEN. INTERNAL MED. 860, 860 (2009).

[149] Consolidated Appropriations Act, 2024, Pub. L. No. 118–42, 138 Stat., 25, 407; John Sawyer, Vikki Wachino, Silicia Lomax & Margot Cronin-Furman, *New Bipartisan Legislation Uses Changes to Medicaid Policy to Help Support Healthy Transitions Between Corrections and Community*, COMMONWEALTH FUND (Mar. 14, 2024), https://www.commonwealthfund.org/blog/2024/new-bipartisan-legislation-uses-changes-medicaid-policy-help-support-healthy-transitions [hereinafter COMMONWEALTH FUND].

[150] Provided that they are eligible.

[151] COMMONWEALTH FUND, *supra* note 149.

[152] Wang, *supra* note 145, at 3; *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976).

[153] *See supra* Part I.B (discussing MIEP) and Part II.B (discussing constitutional violations).

[154] Elenore Wade, *The Undeserving Poor and the Marketization of Medicaid*, 72 BUFF. L. REV. 875, 877 (forthcoming 2025).

[155] *See* Edmonds, *supra* note 139, at 282–83.

[156] *See* Sabeena Bali, Comment, *The Economic Advantage of Preventative Health Care in Prisons*, 453 SANTA CLARA L. REV. 453, 461, 469 (2017).

[157] Departments of Corrections collectively spent $8.1 billion on prison health care services for incarcerated individuals in fiscal year 2015. *See* PEW CHARITABLE TR., *supra* note 128.

[158] S*ee* Bali, *supra* note 156, at 471.

lowering beneficiary rates." [159] Through these payment and coverage systems, Medicaid "encourages using cost-effective services such as preventative care . . . chart[ing] a path for more funding to preventative care programs in carceral institutions."[160] Such improvements would better equip prisons to respond to medical concerns, decreasing the risk that prisoners suffer and die from preventable or treatable cancers in violation of *Gamble*.

Repealing MIEP will, of course, require some political will. However, with the passage of the CAA, it seems that Congress may be moving in the right direction. This passage reflects a congressional interest to "improve access to health care at re-entry . . . [and] improve both health and safety outcomes for people and communities."[161]

2. Avenues to Getting Medicaid/Medicare Services into Prisons

Once MIEP is repealed, the next step to this solution will be getting Medicare and Medicaid services into prisons. This could happen in three primary ways: (1) prisons can become Medicaid and Medicare providers; (2) prisons can do fee-for-service billing through Medicaid and Medicare; or (3) prisons can contract with Medicaid and Medicare managed care organizations.

Prisons could first consider becoming Medicare and Medicaid providers. Provider requirements vary by state,[162] but once a prison becomes enrolled, the institutions can contract with providers and bill them on a fee-for-service basis. [163] Alternatively, prisons could forgo the provider enrollment process, and instead offer Medicaid benefits through either a fee-for-service (FFS) basis or through managed care plans.[164] With respect to managed care plans, prisons would enroll eligible prisoners in a plan,[165] then providers from that plan could enter the prison and provide services to enrollees.[166] Such managed care systems "provide[] states with some control and predictability over future costs," give "greater accountability for outcomes[,] and can better support systematic efforts to measure [and] monitor performance, access, and quality."[167]

Regardless of the path chosen, repealing MIEP would result in the cost of prison healthcare not falling wholly on correctional facility budgets, and

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[159] *See* Herbert, *supra* note 139.

[160] *Id.*

[161] COMMONWEALTH FUND, *supra* note 149, at 2.

[162] 42 C.F.R § 455(B)&(E) (2024); CTRS. FOR MEDICAID MEDICARE SERVS., MEDICAID PROVIDER ENROLLMENT REQUIREMENTS, https://www.cms.gov/files/document/mpe-faqs082616pdf (last visited Dec. 16, 2024).

[163] CTR. FOR MEDICAID AND MEDICARE SERVS., s*upra* note 162.

[164] *Provider Payment and Delivery Systems*, MACPAC, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/ (last visited Dec. 16, 2024).

[165] *Enrollment Process for Medicaid Managed Care*, MACPAC (last visited Apr. 12, 2025), https://www.macpac.gov/topic/managed-care/?post_type=subtopic.

[166] *Id.*

[167] *Id.*

instead, "enable[] states to offer more comprehensive coverage to more people." Additionally, the Center for Medicaid and Medicare Services (CMS) "sets quality standards to which institutions accessing federal funds must adhere." Although the National Commission on Correctional Health Care sets accreditation standards for carceral facilities, compliance is optional.[168] Ultimately, healthcare funded by Medicaid and CMS standards would incentivize and make it easier for prisons to actually provide the quality care that is currently lacking.

B. Increase Regular Screenings

It is well-established that prisoners have higher rates of cancer incidence,[169] and that early cancer detection saves lives.[170] Yet in prison, "early cancer symptoms are often missed altogether or misdiagnosed" because of the current system of "rushed discretionary screenings" or no screenings at all.[171] Following a repeal of MIEP, the next crucial step for prisons is to eliminate discretionary-only screenings and adopt regular inmate cancer screenings in-line with recommendations by the American Cancer Society.[172]

Evidence suggests the effectiveness of prisons increasing screening programs. For instance, Connecticut prisons faced criticism after researchers observed "a trend toward diagnosis of late-stage cancers in the post-incarceration period," [173] which was attributed to the lack of regular screenings during incarceration. In response, Connecticut introduced a prison on-site colon cancer screening program.[174] The program has garnered "national attention," with results showing that nearly half of the participants "were found to have pre-cancerous polyps" that were able to be addressed.[175] Without this increased screening, the prisoners with polyps may have faced the same fate of so many before them who missed an early diagnosis. Connecticut's approach represents a step in the right direction and offers a strong model for other carceral facilities across the nation.

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[168] Currently, only seventeen percent of United States prisons and jails are accredited. *See Facility Accreditation*, NAT'L COMM'N ON CORR. HEALTH CARE, https://www.ncchc.org/accreditation (last visited Dec. 14, 2024); McCann, *supra* note 82.

[169] *See* Manz, Odayar & Schrag, *supra* note 7, at 7278.

[170] *See* DAVID, *supra* note 29.

[171] *See* Aziz, Ackah, Whitson, Oppong, Obeng-Gyasi, Sims & Pawlik, *supra* note 17, at 968.

[172] *American Cancer Society Guidelines for the Early Detection of Cancer*, AM. CANCER SOC'Y, https://www.cancer.org/cancer/screening/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html (last visited Dec. 16, 2024).

[173] Sujata Srinivasan, *Study Raises Questions About Cancer Screening in Prisons*, CONN. PUB. RADIO (Dec. 1, 2023, 1:36 PM), https://www.ctpublic.org/news/2023-12-01/connecticut-prisons-likely-under-screen-under-diagnose-cancer-study-finds.

[174] Sujata Srinivasan, *A Program to Screen for Colon Cancers in CT prisons is Attracting National Attention*, CONN. PUB. RADIO (May 10, 2024, 3:04 PM), https://www.ctpublic.org/2024-05-10/a-program-to-screen-for-colon-cancers-in-ct-prisons-is-attracting-national-attention.

[175] *Id.*

Interesting new data also reveals that prisoners would be responsive to the availability of screenings. One study found an overall 69% willingness to be screened—88% of the female sample were willing to be tested while incarcerated and 56% of the sample was willing to undergo a colonoscopy.[176] The study concluded by finding that "the correctional population may be an excellent group to target for screening efforts."[177] Similarly, a study conducted by the World Health Organization in Europe found that "many people living in prisons are strongly willing to be screened for cancer."[178] If this data proves universally true, increasing screenings would be viable for early diagnosis, and in turn, lower mortalities and lower costs.

With a repeal of MIEP, increasing regular screenings would be easier and less expensive with the entry of Medicare and Medicaid providers into the institutions. Ultimately, prisons must prioritize screening their inmates in order to thwart the cancer that is plaguing the population.

CONCLUSION

In a nation grappling with widespread healthcare challenges,[179] it is unsurprising that the needs of incarcerated individuals have received low priority.[180] However, these prison healthcare disparities should no longer remain in the shadows. Of the limited research on health outcomes in prison, it is well-established that access to cancer diagnostics and health insurance are limited. Consequently, cancer is the leading cause of mortality among the incarcerated population, public health costs are increasing, and prisoner's rights are being violated and left unvindicated. Two viable solutions to this issue are repealing MIEP and increasing regular screenings in carceral facilities. While there remains a lot of work to be done to improve the health of this hidden population, this paper proposes a promising way to start enacting change.

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[176] Ingrid Binswanger, Mary C. White, Eliseo J. Pérez-Stable, Joe Goldenson & Jacqueline Peterson Tulsky, *Cancer Screening Among Jail Inmates: Frequency, Knowledge, and Willingness*, 95 AM. J. PUB. HEALTH 1781, 1781, 1783–84 (2005).

[177] *Id.* at 1785.

[178] Although WHO is based on European prisons, many studies suggest that European prisons are dealing with the same challenges as American prisons. *Prisons Can Bring Health to Vulnerable People*, WHO (July 18, 2022, 8:40 AM), https://www.who.int/europe/news-room/17-07-2022-protecting-prisoners-from-cancer--new-who-report-explains-how-to-fight-health-inequities.

[179] Christopher J.L. Murray, Sandeep Kulkarni & Majid Ezzati, *Eight Americas: New Perspectives on U.S. Health Disparities*, 29 AM. J. PREVENTATIVE MED. 4 (2005) (exploring "the consistent gap in all measures of mortality, particularly between black and white Americans, as well as in "insurance coverage, access and utilization of care" and quality of care).

[180] E. Bernadette McKinney, *Hard Time and Health Care: The Squeeze on Medicine Behind Bars*, 10 AM. MED. ASS'N. J. ETH. 116, 117–18 (2008).