Inmate Health Care

The Impact on Virginia’s Health Care System

This article concentrates on inmate health care needs of local and regional jails, not the state-run prison system.

Prior to 2003, responsibility for inmates’ health needs was largely a gray area. While it was widely agreed that sheriffs and jails were not responsible for health problems that arose before they took charge of an inmate, law enforcement officers still had to ensure that health care was provided for everyone in their custody.

It took one significant incident to shed light on a problem that plagues the entire system. While incarcerated, an inmate in Southwest Virginia had all of his teeth removed and dentures fitted. It should have been clear that this inmate’s poor dental health was a pre-existing condition, but the local sheriff was stuck with the bill.

In 2003, Delegate Benny Keister and Senator Phil Puckett introduced legislation to correct the situation and codify common practice. The legislation stated that sheriffs, jail superintendents or localities were not required “to pay for the medical treatment of an inmate for any injury, illness or condition that existed prior to the inmate’s commitment to a local or regional facility, except that medical treatment shall not be withheld for any communicable diseases, serious medical needs or life threatening conditions.”

However, there were still several questions without answers: What is considered a “pre-existing” condition? Are injuries received during apprehension “pre-existing”? What about diseases
contracted from other inmates? Where does self-pay end and sheriff-pay begin?

What did become clear was that the 2003 legislation allowed some sheriffs to pay for less inmate care than in years past by establishing a more specific minimum standard-of-care that they could fall back on. At the same time, some local corrections officers were now required to provide inmate access to certain minimum levels of care. While the most expensive procedures and services might no longer be covered by jails, the 2003 legislation was effective in guaranteeing inmates health care access.

**Inmate Settings**

Virginia has three primary institutions for incarceration: state prisons, regional jails and local jails. In general, state prisons confine anyone convicted of a felony. Those convicted of a “lesser” felony (Class 5 or 6) can be confined in a local or regional jail.2

On the surface, there is little difference between a regional or local jail. By definition, local jails are operated within the jurisdiction of one locality while regional jails operate within the jurisdiction of three localities.3 Regional jails may contract with private vendors to operate a regional jail.4

In most areas with high “demand,” jails contract directly with hospitals to provide inmate health care. The inmates’ needs dictate the rates at which service is provided. Some local jails have even contracted directly with preferred provider organizations (PPOs) to ensure that not only are their inmates’ health care costs paid but also that access to various services is guaranteed. Hospitals and jails negotiate payments for health care based on the unique needs of their circumstances.

**The Inmate Patient**

Inmate patients present several challenges that do not exist with the “average” patient. They typically are more violent, and drug and alcohol dependencies are more common in inmates. Instances of infectious disease such as HIV, AIDS, tuberculosis and Hepatitis C are more prevalent as is mental illness such as schizophrenia.4 In 1999, more than 300,000 state and local jail inmates nationwide were diagnosed with “severe mental problems.”5 Care for these patients ranged between five and 43 percent of jail health care costs.

While some inmates have some of the most expensive ailments to treat upon incarceration, other inmates contract them while in the custody of the state or locality. Due to the close quarters in correctional facilities and interaction of inmates with each other and public safety personnel, communicable diseases must be treated in order to avoid near epidemic rates of spreading. The cost of preventing the spread of communicable diseases, though it could be charged to inmates, is immediately born by the state, the locality or the hospital.

Further complicating the situation is the need to guard inmate patients from themselves, each other and, while being treated at community medical facilities, the general public.

David Fuller, chief executive officer of Southampton Memorial Hospital in Franklin, one of three secure hospital facilities in the Commonwealth, describes inmate health care:

> The same rights pertain to the inmate population as any routine patient. However, the routine patient presented to a hospital does not come with handcuffs and leg irons and is not accompanied by an “armed” chaperone. The added measures (for inmates) are necessary to ensure the total safety of the patient population being served and contribute to the high costs of medical care for inmates. Simply stated, no other population of patients we serve requires the security measures and the associated costs.

With all of these factors combined, the cost to treat inmate patients is more than the cost to treat the average patient. Despite this, some jails have felt that the rates they pay are too high.

**Virginia’s Costs**

Jails have actually proven to be quite adept at saving money on inmate health care. In addition to contracting with PPOs (and in some cases HMOs), jails and other correctional institutions have explored telemedicine, generic-only prescription plans and utilization review programs in order to determine which services are clinically appropriate and which are not.

As a result of these cost-saving practices, the average cost per inmate per day has decreased significantly since 1998. Between 1998-2006, inmate health care costs per capita decreased by 12 percent to $5.39 per inmate per day. This is a reduction of 72 cents per prisoner since 1998.

Despite decreases in cost per prisoner, more money is being spent on inmate health care overall. In 2006, inmate health care accounted for 8.9 percent of Virginia regional and local jails’ operating expenses – a 127 percent increase since 1998. During the same period, 1998-2006, jails’ budgets have doubled. Jail medical costs were the single largest

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**Prevalence of Infectious, Chronic and Mental Diseases in Inmate Populations Compared to Average Hospital Patient**

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<tr>
<th>Disease</th>
<th>Comparison</th>
<th>Cost Factor</th>
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<td>Active Tuberculosis</td>
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<td>Hepatitis C</td>
<td>↑ 9-10 X</td>
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<td>HIV Infection</td>
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<td>Asthma</td>
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<td>Schizophrenia or Other Psychotic Disorders</td>
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<td>Bipolar Disorder</td>
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<td>Major Depression</td>
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increase percentage-wise during the time frame. This is most likely attributable to the increase in inmate responsible days, from over 5.9 million in 1998 to over 9.8 million in 2006 (a 65.7 percent increase). However, as a percentage of total operating costs since 1998, inmate health care costs remain relatively unchanged. While total medical costs have doubled, so too have jails’ operating budgets.

**Funding Inmate Health Care**
The one relative factor in jails’ budgets that has changed in the last decade is how jail budgets are funded. Taking into account federal and other funding, from 1998 to 2006 the local share of jail funding grew from 40 percent to approximately 45 percent while the state share of jail funding shrank from approximately 52 percent to 44 percent.

Localities are forced to fund more of their jail budgets than ever before. Localities provide countless essential services with limited resources and just a handful of revenue streams. In a “Dillon Rule” state such as Virginia, localities can do only that which the state explicitly empowers them to do. Fairfax County, for example, cannot impose taxes without first receiving authority from the General Assembly. While the Compensation Board directs state funding to the localities to augment their revenue streams, local budgets in general are more sparse and less flexible than those of other levels of government.

Further complicating matters is that costs are rarely covered by Medicaid. The inmate population tends to be more indigent than a non-inmate patient. If not incarcerated, many inmates would qualify for Medicaid or other health care programs. However, the Centers for Medicare & Medicaid Services (CMS) ruled in 2002 that most health care for inmates in state and local correctional facilities was a non-reimbursable cost. CMS’ interpretation:

_Inmates of correctional facilities are wards of the State. As such, the State is obligated to cover their basic economic needs (food, housing and medical care) because failure to do so would be in violation of the eight amendment of the Constitution. Therefore, because these indi-

viduals have a source of third party coverage, they are not uninsured_.

Between rising overall health care costs for jails and localities, a greater share of jail funding coming directly from localities and an inability to have health care costs reimbursed by federal or state programs, there is a growing potential for unpaid bills and bad debt. In an informal survey of its members in 2007, VHHA found that capping inmate costs at Medicaid rates would result in millions of dollars of additional hospital losses in facilities or systems that serve large numbers of inmate patients.

This new responsibility for inmate health care becomes a new drain on already tight budgets. As a result, two solutions discussed below have gained popularity.

**The Legislative “Solution”**
During both the 2007 and 2008 General Assembly Sessions, legislation was introduced to limit sheriffs’ costs to Medicaid rates or below. Introduced largely as a way to realize savings for both state and local budgets, ultimately the measure would shift costs from governments to hospitals and would inevitably result in greater amounts of bad debt or charity care. The legislation failed both years.

As costs for inmate health care are not reimbursable by Medicaid, capping inmate health costs at Medicaid rates, Medicare rates or any other rate is arbitrary and is not reflective of sound public or fiscal policy, especially considering that the uniqueness of the inmate population adds costs not typical for other patients.

**Private Health Care for Inmates**
Private, prison-specific health care providers contract directly with local and regional jails to provide basic health care. If an inmate needs more complex services, the inmate is referred to a local hospital or specialist. Some of these private providers have successfully lobbied for legislation similar to that described above in other states in an effort to increase their own profits. Specifically, they sought to cap the prisoner reimbursement rates they would have to pay hospitals at a rate lower than they had contracted with the jails. The “savings” would go directly into the companies’ profits while the hospitals would be left with under-compensated costs.

At least three known private, prison-specific health care providers have contracted with Virginia jails. While the savings to the local and regional jails from these contracts can be significant, private contractors do little to ensure that inmates receive the same quality of health care that they would receive outside of incarceration. The contractors also do little to alleviate the uncompensated costs to hospitals of caring for inmates.

Dr. Ray E. Moseley, associate professor of Bioethics, Law and Medical Professionalism at the University of Florida outlines the popularity of third party, private prison contractors:
Some say privatized [correctional health care] is more efficient, but the data out there that I’ve seen is not good on that. It’s less efficient. There’s no clear-cut savings. We want to weigh the benefits and consequences of long-term versus short-term. You might save money by cutting corners in jail in the short term but might add cost to another segment of the health care system.

De-arresting Inmates
In all states, regardless of the presence of a cap on inmate costs, one trend continues: furloughing or “de-arresting” prisoners.

“When you’re in jail, you’re being punished by being incarcerated. Your punishment isn’t supposed to be exacerbated by the fact that you’re ill. You shouldn’t suffer more because of your illness, because the punishment is not that your medical condition won’t be taken care of.” – Dr. Ray E. Moseley, associate professor of Bioethics, Law and Medical Professionalism at the University of Florida

It has been reported throughout Virginia and the United States that inmates are released from police custody on the doorsteps of hospitals, treated and then re-arrested upon their discharge. Police will stand guard at a patient’s door, waiting to pick them up as soon as care has been administered. In one instance a pedophile was de-arrested in order to receive emergency care at the local hospital.

De-arresting occurs when a patient is brought to a medical facility by the police before he has been booked. After an inmate has been booked, he can be medically furloughed by a magistrate. Both of these provisions in the law had specific intentions: to ensure that adequate health care was available to inmates. However, as the widespread tales would suggest, the law is being exploited so that jail costs are kept to a minimum and these unrecoverable costs are shifted to hospitals.

VHHA’s Position
VHHA and its membership opposes capping rates that hospitals may charge in the care of local, regional or state inmates. The multitude of complicating factors, including but not limited to security, surrounding the treatment of inmates leads to increased costs compared to the non-inmate patient. Capping rates below those determined fair and adequate by the free market would burden hospitals attempting to care for inmates effectively and affect the overall condition of patients and exacerbate communication of disease among inmate populations. Local, regional and state detention centers have effectively negotiated contracts with local hospitals in order to ensure that their inmates receive quality health care in a timely manner. VHHA urges the continuation of these contractual negotiations that guarantee that inmates receive the best possible health care.

Footnotes
1. § 53.1-126, Code of Virginia
2. § 18.2-15, Code of Virginia
3. § 53.1-81, Code of Virginia
4. § 53.1-82, Code of Virginia
5. Corrections Health Care Costs, Council of State Governments
6. Corrections Health Care Costs, Council of State Governments
8. Department of Health and Human Services Memorandum, “Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia’s Department of Medical Assistance Services to the Medical College of Virginia Hospitals for the Fiscal Years Ending in June 30, 1997, and June 30, 1998 (A-03-01-00222), April 18, 2003, pg. 9