



Issue Brief - 2012

OREGON DEPARTMENT OF CORRECTIONS

Inmate Co-Pays for Healthcare

Background

The Oregon Department of Corrections (DOC) uses a co-pay system for specific healthcare services. This method increases patient responsibility and decreases non-essential visits without limiting access to care.

In the 2009-11 biennium, \$513,299 was collected through the inmate medical co-pay process.

DOC requires that inmates financially participate in the following:

Eye exams (refractory, not medical)

- Co-pay required:
 - Eye-glass exams
- Inmate pays in full:
 - Elective procedures

Items that will become the inmate's property

- Inmate pays in full:
 - Eyeglasses
 - Dentures
 - Prosthetics

Non-Essential Self Care Items

- Inmates pay in full:
 - Medicated shampoos
 - Fiber supplements
 - Non-therapeutic vitamin or mineral supplements

Arguments for Universal Co-Pay¹

Proponents of universal co-payment argue that cost-sharing on the part of inmates should also apply to medical sick calls. With the cost of inmate medical care placing a significant strain on corrections financial resources, they believe that co-pays are necessary for the following reasons:

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- Reduced sick call participation. Sick call can be (and is) abused by some inmates, placing a strain on available resources.
- Inmates who can spend money on commissary candy or toiletries should be able to pay for medical care with the same funds.
- It will reduce frivolous requests for medical attention.
- It reduces security issues by reducing inmate movements.
- It instills a sense of fiscal responsibility and forces the inmate to make mature choices on how to spend money.

Concerns Related to Universal Co-Pay

A number of issues exist with the universal application of a co-pay system, to include legal/tort exposure, challenges to purported revenue offsets and actual savings, lack of evidence that co-pays reduce abuse of the sick-call process and concerns with the belief that paying medical fees positively influences inmates' level of maturity and their understanding of personal responsibility.

¹ "Charging Inmates a Fee for Health Care Services," National Commission on Correctional Health Care (NCCHC) Board of Directors Position Statement, reviewed October 2005.
<http://www.ncchc.org/resources/statements/healthfees.html>

Legal Concerns

Oregon Administrative Rule (OAR) 291-124-085 does allow, but not mandate, DOC to collect a user co-pay or fee. Despite this, the primary Federal and State legal question that remains (associated with charging inmates a user fee for health services) is whether the fee serves to deny inmates access to needed care. According to Federal case law, a system of charging inmates for medical care that meets constitutional standards, must at a minimum: (1) deliver care to indigents without regard to ability to pay; (2) in all cases, provide care first with payment assessed thereafter; and (3) have sufficient exemptions from imposition of charges to meet the requirements of *Estelle v. Gamble* (1976) that care for serious conditions not be denied through “deliberate indifference.” Federal Courts have also ruled that, under considerations of Due Process, inmate patients must be provided with a meaningful opportunity to contest the applications of these fees since they affect their inmate accounts – and that any fees for health care charged must be appropriate to the monies earned and available to the inmates. This is generally accepted to be no higher than in the \$2-\$10 range.

Correctional co-pay systems need to fulfill Federal Court legal concerns as briefly outlined above and this creates the following constraints on the process:

- The assessment of an appointment charge should be made after the fact.
- The health care provider should be removed from the operation of collecting the fee.
- Charges should be small and not compounded when a patient is seen by more than one provider for the same circumstance (which requires tracking).
- No inmate should be denied care because of a record of nonpayment or current inability to pay for currently needed care.
- In general, the following visits are **excluded** from actual collection of fees:
 - chronic disease
 - emergency care
 - mental health
 - multiple visits from the same circumstance

- referrals to specialists
- work clearances & injuries
- assault related exams and injuries
- institution-created visits such as, intake physical, TB screening, etc.
- court demanded tests or services, and
- indigent inmates.
- Co-payment should not affect or lower medication costs, hospital costs, specialist referrals, tests, or procedures. All of these are ordered by professional medical staff based on the evaluation of the patient and thus are presumably important and necessary.
- The system should allow for a minimum balance in the inmate’s account, or provide another mechanism permitting the inmate to have access to necessary hygiene items (shampoo, shaving accessories, etc.) and over-the-counter medications.
- The facility should have a grievance system in place that accurately tracks complaints regarding the program. Grievances should be reviewed periodically, and a consistently high rate of grievances should draw attention to the need to work with staff to address specific problems that may have accompanied the fee-for-service program.

Even if all the criteria above are met and the courts are reflecting decisions that benefit the defendants (corrections departments), states are still incurring the cost of defending against litigation.

In addition, such a system requires tracking, adjudicating, accounting and an appeals work-load coupled with low fees and multiple exemptions. If implemented, DOC would need to build a systemic solution that currently doesn’t exist.

Revenue Concerns

In the private sector, a common co-pay is \$15-\$30. This can generate enough revenue in a private business to result in net income, but in a corrections environment, a co-pay amount must be much less.

In cases concerning inmate co-pay that have gone to court, these courts have held that if there is a co-pay, it must be limited to an amount reasonable

given the overall income of inmates, should not be applied to the indigent or the mentally ill. Generally, “reasonable” inmate co-pays have been determined to range from \$2-\$10.²

In a study conducted by DOC accounting, with the current paper process, administering a co-pay system, assessing, collecting, and addressing exceptions and appeals, each transaction would cost DOC an estimated \$3-\$5, and only a portion of transactions would be collected.

The Executive Office of Public Safety and Security found that after surveying the Massachusetts Sheriffs and DOC, additional fees would increase the cost to taxpayers by creating a cost associated with implementing the fees.³

Corrections Department surveys show that revenue generated by collected fees is generally low in most correctional systems. For example, Kansas collected \$42,000 in \$2 co-pays for a 16-month period.⁴ Maryland raised \$40,000 in co-payment fees over an 8 month period.⁵ If implemented, and DOC collection rates were comparable to Washington DOC (\$3 co-pays), DOC might collect in the range of an additional \$50,000 per year with implementation of a fee for visit program. Review of other correctional systems revealed revenues generated less than 1% of their Health Services budgets.⁶

Cost Savings Concerns

Evidence from correctional system studies demonstrates that, when initially implemented, charging a fee for health care visits decreases the number of health care visits. Despite the drop in visits, co-pay systems do not seem to lower overall health care costs:

² “Charging Inmates a Fee for Health Care Services”, NCHC

³ “Inmate Fees as a Source of Revenue,” Executive Office of Public Safety and Security report, July 2011

⁴ “PSC2: Require Prisoners to Pay for Some Health Care Services”, Window on State Government, Texas Comptroller of Public Accounts

⁵ “PCS2: Require Prisoners...”, Texas Comptroller

⁶ “PCS2: Require Prisoners...”, Texas Comptroller

A recent community based study shows, “Co-payments (even \$2 or \$3) per service tends to decrease the use of essential as well as other health care and can trigger the subsequent use of more expensive care such as emergency rooms or hospitalization.”⁷

This study has not been replicated in a correctional environment, but the dynamics are the same.

In addition, any cost savings projections must be offset by the cost to defend “access to care” litigation in the courts.

More Cost Savings Concerns

The main portion of health care cost comes beyond the initial visit. As a result:

Co-pay would not affect or lower medication costs, hospital costs, specialist referrals, tests or procedures. All of these are ordered by professional medical staff based on the evaluation of the patient and thus are presumably important and necessary.

Co-pay would not lower emergency care usage, and is likely to increase emergency care usage.⁸

Mental health treatment costs would not change. Mental illness presents a special set of problems for the charging of fees. Typically, the key to successful treatment is regularity of follow-up and faithful compliance with prescribed medication. Although achieving good treatment compliance by mentally ill patients is a significant challenge, the work only increases when an additional burden, a co-payment, is placed on the patient. Often, even more than the patient himself or herself, correctional systems bear the burden of untreated or under-treated mental illness and the occurrence of unacceptable behavior patterns. Therefore, it is in the prison’s own best interest to facilitate and encourage early intervention and regular treatment rather than impose any unnecessary barriers to a patient’s treatment.

⁷ Center on Budget and Policy Priorities, May 31, 2005, “The Effect of Increase Cost-Sharing in Medicaid”

⁸ Center on Budget and Policy Priorities, May 31, 2005.

Co-payment for chronic illness visits, whether medical or psychiatric, is not legally or operationally defensible. On-going treatment for diabetes, asthma, epilepsy, mental illness, hypertension, and other conditions represent necessary care. Early and consistent quality care reduces the incidence of expensive complications later.

Many Health Services visits, such as: intake physicals, TB screening, work clearance, or work injury are policy-generated and a co-pay could not be charged.

In both 2008 and 2009, the top 30 percent of the [un-incarcerated] population accounted for nearly 89 percent of the healthcare expenditures.⁹ This statistic is representative of the incarcerated population as well. The remaining inmate population uses Health Services at a rate comparable to healthy community individuals (about 3 visits per year). Some of these high users are very sick individuals, whereas some may actually be overusing the system. If we want to decrease “frivolous” or “abusive” visits, triage on a case-by-case basis is more cost effective than implementing system-wide co-payment plans.

Inmate “Responsibility” Concerns

In essence, a co-pay system for sick call is asking the least medically sophisticated person (the patient) to make the first important medical decision with limited information. Rather than encouraging early access, evaluation and further decision making done by qualified medical personnel, the inmate may opt out of care to avoid the co-pay.

Also, fee programs stratify the population into two classes of inmates – those who have enough money for both health care and commissary items and those who have to choose between the two. By their very nature, the inmate population is not known for having made good decisions in the past.

⁹ “The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009”, Stephen B. Cohen, PhD & William Yu, Agency for Healthcare Research and Quality.

Conclusion

DOC Health Services uses targeted inmate medical co-pays in an effort to reinforce personal responsibility and glean benefit where possible without incurring the potential administrative cost and legal consequences of a universal co-payment program.



**The mission of the
Oregon Department of Corrections
is to promote public safety by
holding offenders accountable for their
actions and reducing the risk of future
criminal behavior.**



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