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The Honorable Strom Thurmond
Chairman, Subcommittee on Criminal Justice Oversight
Committee on the Judiciary
United States Senate

Subject: Federal Prisons: Responses to Questions Related to Containing Health Care Costs for an Increasing Inmate Population

Dear Mr. Chairman:

On April 6, 2000, we testified at an oversight hearing the Subcommittee held on inmate health care costs of the federal Bureau of Prisons (BOP).[1] This letter responds to your request of May 22, 2000, in which you and Senator Patrick Leahy, Ranking Minority Member, Senate Committee on the Judiciary, raised additional questions about BOP's efforts to contain the costs of providing health care to inmates. To respond to these questions, we drew upon the information we developed in preparing for the hearing and performed additional work in May 2000 in accordance with generally accepted government auditing standards. Because our work was based primarily on publicly available reports and testimonies, including our own previously published reports, we did not seek agency comment on a draft of this letter. Our responses to your questions (1 through 4) and to Senator Leahy's questions (5 and 6) follow.

Question 1. Do you think that prisoner abuse of health care, such as inmates using medical visits to get out of work or other duties, is a significant problem, and would you expect a copay requirement to help reduce any such abuse?

In our testimony, we reported that the Congressional Budget Office (CBO) had looked at this question and reported that, where similar prisoner copayment programs were adopted in 36 states or local jurisdictions, prison medical facilities experienced average reductions in sick call visits of 16 percent to 50 percent. Although we are not aware of any formal study by BOP or others, we received anecdotal information from BOP health care officials that frivolous visits to medical units do occur in BOP and that some reduction in this kind of abuse could be

[1] Federal Prisons: Containing Health Care Costs for an Increasing Inmate Population (GAO/T-GGD-00-112, Apr. 6, 2000).

anticipated if some additional charge were levied. However, we were not provided with an estimate of the magnitude of the anticipated reduction.

Question 2. Does it appear that states have benefited from a copay requirement?

As noted in response to the previous question, CBO has reported that after adopting copayment requirements, 36 state or local jurisdictions experienced reductions in the number of sick call visits. These reductions ranged from a low of 16 percent to a high of 50 percent.

Question 3. It appears that personnel salaries are the primary category for health care costs. Have recent BOP initiatives, such as restructuring staff to depend less on highly paid physicians for routine duties, helped reduce staff costs in recent years?

One BOP official told us that, as a result of our 1994 report,[2] BOP began examining the utilization of its health care staff to allow for more efficient operations. One result the BOP official cited was a restructuring initiative that focused on using qualified, lower-salaried medical personnel instead of more highly paid physicians and physicians' assistants for certain routine duties. BOP attributed annual savings of about $5.5 million to this initiative. We also testified that BOP medical personnel salaries—on a macro level—have decreased steadily from a peak of $1,399 per inmate in fiscal year 1996 to $1,225 in fiscal year 1999. We testified that Public Health Service (PHS) associated costs, largely composed of PHS salaries, have dropped from $378 per inmate in fiscal year 1997 to $367 in fiscal year 1999. A BOP Health Services Division official was quite confident that the downward slope in per inmate medical personnel salaries and PHS associated costs was due to the staff restructuring initiative and other related cost-cutting initiatives. However, BOP officials were concerned that the savings from these economy and efficiency measures will eventually bottom out.

BOP officials said they expect overall medical costs to continue to rise in future years for several reasons:

- Projections of the number of inmates incarcerated in federal facilities show continued increases.
- Felony inmates transferred to BOP from the District of Columbia Department of Corrections generally have disproportionately more medical needs than other BOP inmates.
- BOP is receiving increasing numbers of long-term, nonreturnable detainees from the Immigration and Naturalization Service (INS).
- BOP's expenditures for pharmaceuticals likely will rise due to the increasing prevalence of illnesses such as HIV and hepatitis.

Question 4. You noted during your oral testimony that many inmates are staying in medical referral centers for long periods due to serious medical conditions. Do you think it may be more cost effective for BOP to have an intermediate care medical facility for inmates needing long-term care?

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[2] Bureau of Prisons Health Care: Inmates' Access to Health Care Is Limited by Lack of Clinical Staff (GAO/HEHS-94-36, Feb. 10, 1994).

Most evidence indicates that an intermediate care facility could have advantages for BOP, although a thorough cost-benefit study might still need to be conducted to consider the various forms that such a facility could take. Medical costs at BOP's medical referral centers are higher on a per inmate basis than medical costs at standard prisons. Based on BOP data, the estimated medical costs on a per inmate basis at a medical referral center are about $16,000 per year, whereas medical costs at a standard prison are less than $2,500 per year.

In terms of inmate access to medical care, BOP officials told us that it is important that there be a regular turnover of patients in medical referral center hospital beds—based on the medical needs of the patients. They told us that increasing numbers of chronically ill inmates with long sentences are being sent to medical referral centers because the inmates' medical conditions cannot be treated appropriately at a standard prison. For these inmates, the medical referral center is the end of the line. This means that fewer and fewer hospital beds are turning over. It also means that new patients from standard prisons may have to wait for the next available medical referral center hospital bed to be freed up. For example, at one medical referral center we toured, we learned that the waiting list of new patients for the next available bed is gradually getting longer.

Anecdotally, we were told that BOP already has enough chronically ill inmates to fill an intermediate care medical facility of 400 beds. This type of facility would have the added benefit of freeing up more expensive medical referral center beds presently occupied by inmates who have little chance of returning to their home prison. Nonetheless, a cost-benefit study could determine, for instance, whether the per inmate cost of constructing an intermediate care medical facility would be more or less than competing alternatives, such as contracting for a privatized nursing home environment or renovating an existing building at a medical referral center just for the chronically ill.

Question 5. In your written statement, you indicated that CBO has estimated that the Federal Prisoner Health Care Copayment Act of 1999 would generate annual revenues of $1 million and "would be helpful to BOP's efforts to control medical costs." Under section 4048(g) of this legislation, fees collected from inmates subject to an order of restitution shall be paid to victims in accordance with the order. Seventy-five percent of all other fees collected would be deposited into the Federal Crime Victim's Fund and the remainder would be used to cover the administrative expenses incurred in carrying out this Act. With legislative mandates on the use of copayment fees, how would the Federal Prisoner Health Care Copayment Act of 1999 significantly contribute to reducing health care costs?

We testified that a May 1999 CBO analysis of the proposed $2 health care service fee estimated that BOP might generate additional revenue of about $1 million in fiscal year 2000. However, BOP endorses the proposed fee primarily as a means to reduce unnecessary or frivolous medical visits—that is, BOP does not view the proposed fee primarily as a revenue generator.

BOP has suggested that the proposed legislation be modified to mandate that 100 percent of collected fees go to the Crime Victims Fund. According to one official, BOP might send a check each quarter to the fund—a procedure that would help to minimize administrative

expenses. BOP suggested this alternative because an administrative process is already in place that could be modified at little or no cost to include tracking collected fees. However, the cost of distributing restitution checks to victims is another matter since no administrative process or supporting staff structure currently exists. One BOP official told us that the number of checks could be enormous, the amount of each check would be small, and the administrative cost of establishing and maintaining a process (to make sure victims received the appropriate checks) would be an additional expense. This official also opined that victims might react negatively to receiving checks of such small amounts repeatedly over the years.

CBO has looked at this question of unnecessary or frivolous medical visits. CBO reported that where similar prisoner copayment programs were adopted in 36 states or local jurisdictions, prison medical facilities experienced average reductions in sick call visits of 16 percent to 50 percent. We received anecdotal information from BOP health care officials that frivolous visits to medical units do occur in BOP and that some reduction in this kind of abuse can be anticipated if additional charges are levied. However, we have not independently verified the magnitude of such a reduction.

Neither BOP nor we believe that the primary benefit of the copayment proposal is to generate revenue. Rather, its primary benefit would be to reduce unnecessary or frivolous medical visits and the burden that such visits place on BOP medical staff. Given the projected increase in the prison population through 2006, it appears the demands on BOP's health care system will increase.

Question 6. Have the administrative initiatives that BOP put into place over the last several years to contain inmate health care costs and increase efficiency of services been taken into account by your estimate? Have the facts or assumptions on which you based your estimate of $1 million changed?

The estimates of increased efficiency of services by virtue of administrative initiatives BOP has undertaken over the last several years are BOP estimates. The $1 million estimate of anticipated revenue generated by a prisoner copayment provision is CBO's estimate. We referred to the CBO estimate in our testimony because we did not want to duplicate that work. Also, given the short time in which we conducted our review, we did not attempt to independently verify the estimates and do not know whether the facts and assumptions used by CBO have changed.

BOP officials believe that savings or benefits from the economy and efficiency initiatives BOP has implemented will eventually bottom out and they expect that inmate health care costs will rise given

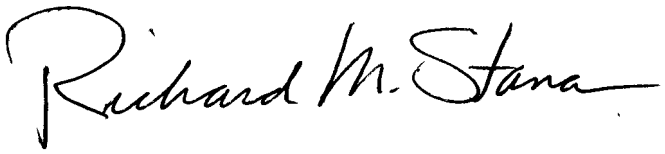
- the pressures from a growing prison population;
- transfers of inmates to BOP from the District of Columbia Department of Corrections—inmates who generally have disproportionately more medical needs than other BOP inmates;
- the increase in numbers of long-term, nonreturnable detainees from INS; and
- the growth in expenditures for pharmaceuticals because of the increasing prevalence of illnesses such as HIV and hepatitis.

We believe it is time to consider additional measures for containing BOP medical costs. The copayment provision is one alternative to consider—not because it is a revenue generator, but rather because such a provision can be expected to reduce the demand on medical services by reducing the number of unnecessary or frivolous medical visits by inmates.

As agreed with your office, we plan no further distribution of this letter until 30 days after its issuance, unless you publicly release its contents earlier. We will then send copies of this letter to Senator Charles E. Schumer, the Subcommittee's Ranking Minority Member; Senator Orrin G. Hatch, Chairman, and Senator Patrick Leahy, Ranking Minority Member, Senate Committee on the Judiciary; and Representative Henry J. Hyde, Chairman, and Representative John Conyers, Jr., Ranking Minority Member, House Committee on the Judiciary. Copies will also be made available to others upon request.

If you or your staff need additional information, please call me on (202) 512-8777.

Sincerely yours,



Richard M. Stana
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