



## Eliminating Financial Assessments for Health Care Services During Incarceration

### Position Statement

The National Commission on Correctional Health Care is opposed to charging or causing assessment of fees, copays, or any other monetary assessments or creating or causing other disincentives that may restrict people's access to health care. NCCHC further encourages correctional health leadership to advocate against local mandates, internal policies, and informal culture that restrict access to care.

### Discussion

NCCHC supports unobstructed access to health care for people who are incarcerated. Access to health care among incarcerated people is a constitutional right<sup>1</sup>. Access to health care facilitates health and supports reentry and community integration after incarceration<sup>2</sup>. It is well-documented that fee-for-service and co-payment programs restrict people's access to care<sup>3-8</sup>. Fees for care compel individuals to make care-seeking decisions regarding their symptoms that they are not qualified to make (for example, does my chest pain, fever, or cough warrant me paying a fee?).

NCCHC recognizes that lack of access to health care remains among the most significant characteristics of jail, prison, and juvenile correctional systems in the United States. People who have been incarcerated have higher morbidity and mortality<sup>9,10</sup> from treatable serious medical and mental health conditions in large part because of social determinants of health, including lifelong inequities in access to health care and services. Black, indigenous, and other people of color (BIPOC) are overrepresented in carceral settings, and people with incarceration histories primarily come from and return to the communities with the greatest health and socioeconomic disparities. Consequently, health care fees have disparate impact on the BIPOC community and foster health and socioeconomic inequities for individuals and their families<sup>11-20</sup>.

Contrary to NCCHC's position, and contrary to sound medical practice as stated by the American Medical Association, some jurisdictions mandate financial assessments such as fees for service or co-payments<sup>19</sup>. Evidence suggests that such mandates discourage both essential and less critical health care, with adverse effects on people's health<sup>20-23</sup>. A randomized study showed that removal of court fees reduced recidivism<sup>24</sup>. Similar effects are likely with correctional health care fees. Where such practices still exist in correctional facilities, aggregate data regarding health care utilization should be shared publicly to demonstrate that such practices do not impact utilization. Such data should include, at minimum, utilization by service type (primary care, specialty services, mental health services including substance use treatment, hospital transfers, and telehealth visits) and by age, race, ethnicity, and zip code. The purpose of the utilization review is to document any disproportionate impact and prevent harms that

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may be caused to people with the greatest socioeconomic disparities and overrepresentation in the correctional population.

## **Guidelines**

NCCHC's mission is to improve the quality of health care in jails, prisons, and juvenile confinement facilities. Given the potential adverse impact on care, NCCHC is opposed to charging fees for health care. However, we recognize that such practices exist and offer guidance to mitigate barriers that fees impose. To ensure health services are available to all regardless of ability to pay and to promote health equity, the following guidelines are strongly recommended:

1. Health care professionals have no role associated with any fee from patients.
2. No charges should be assessed for the following:
  - a) Receiving screening (medical, dental, and mental health) or any required follow-up to the screening
  - b) The health assessments required by facility policy
  - c) Chronic care or other staff-initiated care, including follow-up and referral visits
  - d) Acute care, including any costs related to emergency care and trauma care
  - e) Infirmity care or hospitalization
  - f) Pregnancy and postpartum care
  - g) Laboratory and diagnostic services
  - h) Prescription medications to maintain health
  - i) Diagnosis and treatment of contagious disease
  - j) Mental health care, including substance use disorder treatment
  - k) Preventive health care
3. No one should be denied care because of a record of nonpayment or current inability to pay.
4. Before initiating a financial assessment protocol and at least annually thereafter, administrators should:
  - a) Conduct a cost–benefit analysis to determine the financial need for the financial assessment and the expenses resulting from its administration. Such an analysis should consider not only operational costs, including the administrative burden of collecting and tracking fees, but also costs incurred by the community, such as health care costs associated with gaps in care and the long-term consequences of failure to provide preventive measures and timely health care to avoid more significant, life-threatening, and costly outcomes.
  - b) Weigh factors related to adverse outcomes on the individual, the institution, and the community when access to care is limited.
  - c) Examine its management of systems for sick call and triage, use of emergency services, and other aspects of the health care system for efficiency and efficacy to establish baseline usage and be prepared to document the impact of the financial assessment protocols.

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5. Before and after the implementation of financial assessments, administrators should track facility-specific utilization by diagnosis, the incidence of disease, and all other health problems.
  - a) Population health indicators should be maintained and regularly reviewed as part of ongoing quality assurance, including disease prevalence, adverse events, time from admission to diagnosis, onset of serious medical issues, and frequency of encounters appropriate to the patient's presenting issues.
  - b) Any indication that infection levels or other adverse outcome indicators, as well as incidents of delayed diagnosis and treatment of serious medical problems, are either on par with or lower than the levels before implementation should be treated as indicators that the program is hindering access to needed care.
6. Details of the financial assessment protocols should be communicated to all people upon admission, as well as to staff, and all written and oral communications should clearly state that access to care will not be denied regardless of ability to pay.
  - a) Only certain nonessential services initiated by the patient should be considered for a financial assessment (fee, other charges, or administrative action).
  - b) All facility staff should have working knowledge of the situations that will or will not be subject to a financial assessment as well as administrative procedures necessary to request a visit with a health care professional.
  - c) Facilities should frequently conduct anonymous surveys of people who are incarcerated to assess access to and quality of health care services.
7. All financial assessments should be made after health care services are rendered.
8. Financial assessments should be small and not compounded when a patient is seen by more than one health care professional for the same circumstance.
9. No one should be denied care because of a record of nonpayment or current inability to pay.
10. Financial assessments should not encroach on access to necessary hygiene items (e.g., shampoo, shaving accessories, menstrual supplies) and over-the-counter medications and should allow for a minimum balance in a commissary account or other means for such essentials of daily living.
11. The facility should have a grievance system that accurately tracks complaints about financial assessments.

**Adopted by the National Commission on Correctional Health Care Board of Directors**

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**October 2005 — reaffirmed**

**October 2012 — reaffirmed with revision**

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