

A POUND OF FLESH: HOW MEDICAL COPAYMENTS IN PRISON COST INMATES THEIR HEALTH AND SET THEM UP FOR REOFFENSE

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INTRODUCTION	256
I. THE COSTS OF MASS INCARCERATION: EXPENSE-SHIFTING AND THE RESULTING HARM TO PRISONER HEALTH.....	259
A. <i>The War on Drugs and the Costly Rise of Mass Incarceration</i>	260
B. <i>Justifications for Medical Copayments in Prison</i> ...	263
1. Justification: Copayments Raise Revenue.....	263
2. Justification: Copayments Deter Frivolous Medical Claims	267
3. Justification: Copayments Teach Inmates a Lesson	271
II. JUDICIAL AND LEGISLATIVE ACQUIESCENCE TO THE DEPRIVATION OF MEDICAL CARE AS PUNISHMENT.....	273
A. <i>Prison Health Care Under the Eighth Amendment</i>	273
B. <i>Judicial Deference to the “Legitimate Penological Purpose”: Setting the Bar Impossibly Low</i>	275
C. <i>Disenfranchisement of Prisoners as a Limit to Political Participation in the Criminal Justice Sphere</i>	276

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III. POLICY RECOMMENDATIONS: ALTERNATIVE SOLUTIONS TO THE MEDICAL CO-PAY PROBLEM	278
A. <i>Judicial Solutions</i>	278
B. <i>Political Solutions</i>	279
CONCLUSION.....	282

“[T]hey had come to regard insolvency as the normal state of mankind, and the payment of debts as a disease that occasionally broke out.”¹

INTRODUCTION

Brad seldom talks about the time he spent in prison.² Even while he was incarcerated, he generally steered our email and telephone conversations to topics in my life and the outside world—how my high school volleyball season was going, where I wanted to go to college, or how the Packers’ season was shaping up. Since being out of prison, my brother has recounted some of the alarming details regarding the harsh conditions of his punishment. Of the many grim stories he relayed, I was most struck by the manner in which his prison facility commodified the health of inmates.

Although Brad’s facility housed, on average, over 1,300 inmates, he informed me that there was no full-time nursing staff available to provide medical care at any given time. Inmates could fill out a request to be seen by medical providers, but they could only be seen at specific hours on certain days when medical staff—employed by a private healthcare contracting company, not the government—were on site. Whenever an inmate did get examined by medical staff, the prison facility deducted a copayment of five dollars out of the inmate’s commissary account—the prisoner’s fund to pay for toiletries, extra clothing, food, stationary, stamps, over-the-counter medication, and any other essentials or incidentals an inmate might need. Funds in commissary accounts come from any money contributed by an inmate’s family and “wages” earned by the inmate at their job.

At Brad’s facility, inmates were required to have jobs. During his time there, he worked both in the kitchen and in the

1. CHARLES DICKENS, *LITTLE DORRIT* 68 (1857).

2. Telephone Interview with Brad Thompson, Former Inmate, Federal Correctional Institution, Schuylkill (Oct. 28, 2019). The account of the prison conditions described in the Introduction come from this interview unless otherwise noted.

recreational yard, cleaning up the grounds and wiping down the exercise equipment. At each job, he worked about twenty-five hours per week for a maximum wage of just forty dollars per month. Even though he made double the starting rate for prison employees, Brad made only forty cents per hour. Brad would have had to work twelve and a half hours at the highest pay rate he received to afford the five-dollar copayment. And if an inmate did *not* take part in the correctional facility's exploitative labor system, they risked getting sent to the "Hole"—solitary confinement.³

In Brad's experience, access to medical care while in the Hole was even more limited. Prison medical staff visited the solitary cells only once or twice per week, sliding medical request forms under the cell doors. Brad also described how prescription medications were passed out only sporadically while in the Hole, if at all. On multiple occasions, he failed to receive his medication for up to a week at a time while in the Hole, even though the same staff passed out his prescription medication daily while he was in the general population. On one occasion, this neglect forced Brad into withdrawals, leaving him isolated, hallucinating, and terrified in solitary confinement.

The horrors underlying the American prison system are convenient to ignore for people who have never been affected by them. The facts concerning prison conditions and practices can be unpleasant and disconcerting, but with current policies and jurisprudence so entrenched in deference to correctional facilities and maintenance of the status quo, it is also frustrating for many who hope to institute change. This general acceptance of the brutal conditions in American prisons also reflects the lack

3. It has been nearly a decade since United Nations Special Rapporteur on Torture, Juan E. Méndez, reported that solitary confinement should be banned as a "punishment or extortion technique," as it is "contrary to rehabilitation, the aim of the penitentiary system." Méndez explained, "Considering the severe mental pain or suffering solitary confinement may cause, it can amount to torture or cruel, inhuman or degrading treatment or punishment when used as punishment, during pre-trial detention, indefinitely or for a prolonged period, for persons with mental disabilities or juveniles." See *Solitary Confinement Should Be Banned in Most Cases, UN Expert Says*, UN NEWS (Oct. 18 2011), <https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says> [https://perma.cc/8V49-C9LN]. In 2018, it was estimated that 61,000 people were subject to solitary confinement in American correctional facilities. See Joshua Manson, *How Many People Are in Solitary Confinement Today?* SOLITARY WATCH (Jan. 4, 2019), <https://solitarywatch.org/2019/01/04/how-many-people-are-in-solitary-today> [https://perma.cc/82HX-YYTE].

of quality, comprehensive statistical studies on prisoner wages and expenses, prison healthcare facilities, the use of solitary confinement, the benefits of charging fees to inmates as a revenue raising strategy, and countless other aspects of the American criminal justice system.⁴ It seems that America as a whole, from the general public to the legislatures and courts, prefers to forget about its incarcerated population rather than solve the issues underlying crime in America.

The attitude of acquiescence in legislatures and courts has permitted the American prison system to develop a practice of exploiting the health of its incarcerated population as an additional and excessive form of punishment. This article focuses on a practice widely used in prisons—the imposition of medical copayments—which contributes to the current culture of endangering the physical and mental health of incarcerated persons, all in the name of cost cutting and prisoner control. The problem of medical copayments could be solved by both the courts, which could recognize that the practice serves no legitimate penological interest, and the states themselves, which could pursue other avenues for funding medical costs for prisoners or look to affordable treatment options external to incarceration facilities.

Part I offers some historical context behind the development of mass incarceration as accepted government policy and the resulting budgetary problems that gave rise to the imposition of copayments on the inmates themselves, then continues with explanations and refutations of three major justifications posited by prison policymakers for charging medical copayments. Part II introduces the current judicial state of the provision of prison health care and the concept of judicial deference to the decisions of prison officials, then proceeds with a discussion of legislative silence on the shifting of incarceration costs from governments to their incarcerated populations and the associated problems with such a policy. Part III offers potential solutions to help minimize fees charged to those behind bars, while also suggesting large scale changes that would help to contain the costs of incarceration that currently burden the American government at all levels. This article concludes that it is both possible and realistic for the American system to strike a balance between the needs

4. Ryan Cooper, *American Prisons' Cruel and Unusual Health Care*, WEEK (Apr. 19, 2017), <https://theweek.com/articles/692864/american-prisons-cruel-unusual-health-care> [<https://perma.cc/5DQW-WMU3>].

for administrative efficiency in prisons and prisoner health, safety, and rehabilitation.

I. THE COSTS OF MASS INCARCERATION: EXPENSE-SHIFTING AND THE RESULTING HARM TO PRISONER HEALTH

Medical copayments are but one of many types of fines and fees imposed on incarcerated persons in order to raise revenue and shift the costs of incarceration from the government to the accused and convicted.⁵ In the medical context specifically, per-visit fees are also intended to reduce prisoner demand for services and disincentivize malingering inmates from seeking unnecessary care.⁶ This Section first offers context by exploring the historical link between the rise of mass incarceration and the use of medical copayments in correctional facilities. It then continues with an examination of the theoretical rationales offered by proponents of medical copayment charges in prisons and jails and concludes with respective discussions of how and why each rationale fails in practice.

5. For an overview of the causes and consequences of inmate fees and jail debt, see LAUREN BROOKE EISEN, CHARGING INMATES PERPETUATES MASS INCARCERATION 1–2 (2015) (“Every aspect of the criminal justice process has become ripe for charging a fee. In fact, an estimated 10 million people owe more than \$50 billion in debt resulting from their involvement in the criminal justice system. In the last few decades, additional fees have proliferated, such as charges for police transport, case filing, felony surcharges, electronic monitoring, drug testing, and sex offender registration. Unlike fines, whose purpose is to punish, and restitution, which is intended to compensate victims of crimes for their loss, user fees are intended to raise revenue Although this policy is alarming, less widely understood but equally troubling is the reality that these incarceration fees perpetuate our nation’s addiction to incarceration Some individuals are leaving jails and prisons with a mountain of debt, much of it stemming from the fees they incurred behind bars, where a short telephone call home can cost as much as \$20. These former inmates can face aggressive collection tactics, including additional fines, driver’s license suspension, or, in some cases, re-incarceration. Often, former inmates must depend on family members to pay the bills or are forced to prioritize criminal justice debt over other pressing needs such as feeding, clothing, and housing family members who are reliant on their income This debt can create a barrier to successful reentry.”).

6. Michelle Andrews, *Even in Prison, Health Care Often Comes with a Copay*, NPR (Sept. 30, 2015), <https://www.npr.org/sections/health-shots/2015/09/30/444451967/even-in-prison-health-care-often-comes-with-a-copay> [<https://perma.cc/F5JW-4ZXQ>].

A. *The War on Drugs and the Costly Rise of Mass Incarceration*

We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.

– John Ehrlichman, Chief Domestic Advisor to President Nixon⁷

The history of charging fees associated with prosecution and incarceration to inmates is relatively recent and inextricably tied to the history of mass incarceration. In response to rising crime rates and drug use in the late 1960s,⁸ President Nixon declared a “war on drugs” in June 1971.⁹ This declaration set the stage for the expansion of the tough-on-crime regime and the explosion of mass incarceration during the Reagan Administration.¹⁰ The public policy trends nurtured by the Reagan Administration led to the implementation of harsh laws¹¹ intended to limit judicial discretion in criminal sentencing:¹² three-strikes laws, mandatory minimum sentences laws concerning nonviolent drug offenses,¹³ and laws reducing opportunities for

7. Tom LoBianco, *Report: Aide Says Nixon's War on Drugs Targeted Blacks, Hippies*, CNN (Mar. 24, 2016), <https://www.cnn.com/2016/03/23/politics/john-ehrichman-richard-nixon-drug-war-blacks-hippie/index.html> [<https://perma.cc/9DLN-HZ97>].

8. Editorial, *End Mass Incarceration Now*, N.Y. TIMES (May 24, 2014) [hereinafter *End Mass Incarceration*], https://www.nytimes.com/2014/05/25/opinion/sunday/end-mass-incarceration-now.html?_r=0 [<https://perma.cc/69SQ-EWKZ>].

9. *A Brief History of the Drug War*, DRUG POLY ALLIANCE [hereinafter *Drug War*], <http://www.drugpolicy.org/issues/brief-history-drug-war> (last visited July 21, 2020) [<https://perma.cc/BSY2-Q3YJ>].

10. James Cullen, *The History of Mass Incarceration*, BRENNAN CTR. FOR JUST. (July 20, 2018), <https://www.brennancenter.org/our-work/analysis-opinion/history-mass-incarceration> [<https://perma.cc/UYC9-K5VZ>].

11. *Drug War*, *supra* note 9.

12. Kim Marie Thorburn, *Health Care in Correctional Facilities*, 163 W. J. MED. 560, 560 (1995).

13. *End Mass Incarceration*, *supra* note 8.

parole.¹⁴ The natural effect of these new draconian laws was to nearly double the nation's total prison population during the time President Reagan was in office—from 329,000 in 1980 to 627,000 in 1988.¹⁵

The mass incarceration phenomenon gained further momentum in the mid-1990s with the passage of the 1994 Crime Bill.¹⁶ Though President Clinton campaigned under the promise to implement more robust drug treatment programs,¹⁷ his Administration turned the drug war into a partisan competition.¹⁸ Under Clinton, the Democratic Party sought to outdo Republicans in the criminal penalty sphere by offering the states extra federal funding for prisons, encouraging the passage of truth-in-sentencing laws, making almost sixty more crimes punishable by the death penalty, and allowing more flexibility to try juveniles as adults.¹⁹ As a result, the incarcerated population in the United States continued its steep ascent: while the national population grew from about 226,000,000 in 1980 to about 323,000,000 in 2016 (approximately a 43 percent increase), the incarcerated population grew from 501,886 to 2,246,100 in the same time span. This prison boom, from the start of Reagan's presidency through the end of Obama's, represents an almost 350 percent increase in incarcerated persons.²⁰

Predictably, the massive increase in the incarcerated population brought about a corresponding surge in the cost of

14. *Criminal Justice Facts*, SENT'G PROJECT, <https://www.sentencingproject.org/criminal-justice-facts/> (last visited July 21, 2019) [<https://perma.cc/KSQ3-NUQW>].

15. Cullen, *supra* note 10.

16. Udi Ofer, *How the 1994 Crime Bill Fed the Mass Incarceration Crisis*, ACLU (June 4, 2019), <https://www.aclu.org/blog/smart-justice/mass-incarceration/how-1994-crime-bill-fed-mass-incarceration-crisis> [<https://perma.cc/WS8U-VVT3>].

17. *Drug War*, *supra* note 9.

18. Ofer, *supra* note 16.

19. *Id.*

20. The incarcerated population in the United States peaked in 2008, leveled off, and declined slightly during the Obama Administration due to some successful policy changes in the substance control sphere. However, the little momentum that has been built is in danger of reversal due to the Trump Administration's revival of drug war rhetoric, hearkening back to Reagan-era attitudes. See *Drug War*, *supra* note 9; Cullen, *supra* note 10; Eli Rosenberg, *Trump Is 'Most Excited' About Death Penalty for Drug Dealers. Rights Groups Say It's a Terrible Idea*, WASH. POST (Feb. 15, 2019), <https://www.washingtonpost.com/politics/2019/02/15/trump-again-praises-strongmen-who-execute-drug-dealers-rights-groups-say-its-terrible-idea/> [<http://perma.cc/YV6A-DDU6>]. Additionally, the slight reduction in the incarcerated population has not brought a corresponding decline in state expenditures on corrections. See *Criminal Justice Facts*, *supra* note 14, at 2.

housing, feeding, and providing medical care for that population. States' budgets grew tighter as their prison populations bloated, and voters balked at increases in taxes to support the burgeoning costs of funding an ever-expanding criminal justice system—costs that exploded from \$35 billion in 1982 to a staggering \$265 billion in 2012.²¹ Efforts to save taxpayer dollars resulted in the rise of privatization within the criminal justice sector, from private probation companies²² to private healthcare contractors.²³ These efforts also resulted in fees charged directly to those who found themselves within the criminal justice system at all levels. In most states, the accused may be charged for the services of public defenders, those on probation or parole may bear the costs of electronic monitoring devices, and those in jails and prisons can be charged for costs of room and board, meals, clothing, internet and telephone use, and, of course, for medical expenses.²⁴

The collection of fees charged to those entangled in the criminal justice system is a topic that critically lacks current and ample research.²⁵ Presently, at least thirty-five states authorize medical copayments or other fees for medical expenses at correctional facilities; the practice is expressly permitted by the Federal Bureau of Prisons,²⁶ and shows little sign of slowing or changing in the near future.²⁷ Policymakers and representatives of the Department of Corrections offer three main justifications for continuing the practice of charging incarcerated persons copayments to receive medical care. First, they claim that charging copayments to the beneficiaries of prison medical services alleviates the costs of providing those services. Second, prison policymakers and officials argue that requiring incarcerated persons to pay to receive medical care reduces the demand for medical services and discourages malingering inmates from using precious healthcare resources on frivolous medical visits.

21. EISEN, *supra* note 5, at 2.

22. *Id.*

23. Dan Weiss, *Privatization and Its Discontents: The Troubling Record of Privatized Prison Health Care*, 86 COLO. L. REV. 725, 747 (2015).

24. EISEN, *supra* note 5, at 3.

25. *Id.*

26. Andrews, *supra* note 6.

27. In June 2018, Illinois policymakers stopped charging medical copayments in the state prisons, but so far the trend has not caught on in other states. *See* Derek Gilna, *Illinois Ends Medical Co-Pays for Prisoners, but DOC Healthcare Criticized*, PRISON LEGAL NEWS (Jan. 8, 2019), <https://www.prisonlegalnews.org/news/2019/jan/8/illinois-ends-medical-co-pays-prisoners-doc-healthcare-criticized/> [https://perma.cc/4EL3-V3XA].

Finally, prison officials assert that charging inmates copayments prepares them for success in the real world, because, as one department spokesman put it, “charging copays . . . teaches prisoners lessons about budgeting money, which is useful when they are released.”²⁸ The following subsections explain and invalidate each of these justifications in turn.

B. Justifications for Medical Copayments in Prison

This Section presents three common justifications put forward in support of charging prisoners medical copayments: first, that medical copayments raise revenue to help cover the costs of providing medical care in prisons; second, that charging copayments reduces the demand for medical services and discourages frivolous medical claims; and third, that charging inmates copayments, among other fees, teaches them lessons in money management. The following subsections describe these rationales and explain why each fails in practice.

1. Justification: Copayments Raise Revenue

Charging inmates fees to help cover the costs of incarceration might seem a sensible solution to the massive financial burden on local governments that came with the rise of mass incarceration. Charging fees to inmates is certainly a popular policy, both among policymakers and taxpayers.²⁹ Many jurisdictions view charging inmates fees as necessary to offset the staggering costs of incarcerating so many.³⁰ At the same time, politicians and sheriffs promote the practice of charging inmates as a tax-savings measure to garner support from voters.³¹ One Nevada sheriff proposed charging inmates six dollars per day for meals, ten dollars for each doctor visit, and a five-dollar booking fee into

28. Michael Ollove, *No Escaping Medical Copayments, Even in Prison*, PEW CHARITABLE TR. (July 22, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/07/22/no-escaping-medical-copayments-even-in-prison> [https://perma.cc/43PN-FUJ4].

29. EISEN, *supra* note 5, at 5.

30. Lauren-Brook Eisen, *Paying for Your Time: How Charging Inmates Fees Behind Bars May Violate the Excessive Fines Clause*, BRENNAN CTR. FOR JUST. (July 31, 2014), <https://www.brennancenter.org/our-work/research-reports/paying-your-time-how-charging-inmates-fees-behind-bars-may-violate> [https://perma.cc/N3JV-W78G].

31. *Id.*

the jail.³² The sheriff pitched this proposal to the county commission as one that would “save county taxpayers millions of dollars a year,” and the commission approved.³³ Unfortunately, his hypothesis of saving taxpayers millions within his county alone simply by charging inmates for medical services is highly unlikely.

In reality, revenue from prisoner copayments contribute negligible amounts to correctional healthcare budgets. Many jurisdictions actually expend more resources trying to collect this revenue than they actually recover. To illustrate, Pennsylvania spent approximately \$248 million on correctional healthcare in 2014 while collecting only \$373,000 in copayments, recovering less than two-tenths of one percent of its costs from its incarcerated population.³⁴ Similarly, in the same year, Virginia spent \$160 million while collecting only \$500,000—about three-tenths of one percent of its expenditures.³⁵ California likewise collected about \$500,000—but spent about \$2.2 *billion*, recovering just a few hundredths of one percent of its expenses from inmates.³⁶ Thus, rather than relieving any appreciable pressure on perpetually strapped state budgets, revenue from inmate copayments makes no considerable contribution to prison healthcare budgets.

Additionally, an estimated 80 percent of incarcerated people are indigent prior to their incarceration.³⁷ One 2015 study found that incarcerated people between the ages of twenty-seven and forty-two earned “a median annual income of \$19,185 prior to their incarceration, which is 41 percent less than non-incarcerated people of similar ages.”³⁸ Thus, it is completely unrealistic and inequitable to expect that this population and their families could bear the burden of funding the necessities and incidentals

32. Associated Press, *Nevada County's Plan to Charge Inmates for Jail Meals Draws Lawsuit Threat*, FOX NEWS (Feb. 8, 2014), <https://www.foxnews.com/us/nevada-countys-plan-to-charge-inmates-for-jail-meals-draws-lawsuit-threat> [https://perma.cc/CS5A-T86P].

33. *Id.*

34. Ollove, *supra* note 28.

35. *Id.*

36. *Id.*

37. Andrews, *supra* note 6.

38. 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> [https://perma.cc/4JN9-AGJ4].

of the incarcerated family member's prison stay, though families often still contribute what they can.³⁹

Despite this, prisons will go to great lengths to charge inmates for medical and other services, ensuring that the debt follows them even after they reintegrate into society by using collection agencies.⁴⁰ These efforts are often nothing but a waste of government time and resources because “low-income people are no more likely to pay their fees when collection agencies are used.”⁴¹ In fact, “[s]ome counties have found that administrative costs are greater than what they have collected from jail fees.”⁴² A few counties have reassessed their fee collection programs as administrative expenses surpass revenue; others pursue collection but only collect actual revenues “as low as 6 percent of the fees assessed.”⁴³ Others struggle to maintain sufficient staff to adequately monitor and collect assessed fees.⁴⁴ Therefore, although governments and correctional facilities rationalize the collection of copayments by contending that it raises revenue to cover the costs of prison medical care, the practice makes no discernible dent in amounts expended for healthcare in prisons and actually costs some jurisdictions more than they save. It serves as a cost-prohibitive measure, even where the charges may not seem unreasonably expensive on their face.

The County of San Francisco has recently reexamined its reliance on criminal justice fees, looking far beyond the copayment context to the broader issue of administrative fees in the criminal justice system. After extensive research, community engagement, and legislative debate, the County forgave \$32 million worth of debt related to criminal justice administrative fees imposed on people exiting the criminal justice system.⁴⁵

The County first formed a coalition to develop an understanding of what types of fees were being charged, what impact these fees had on the County's revenue, and the corresponding burden of debt that the fees imposed on individuals within the

39. Andrews, *supra* note 6 (“Prisoners don’t have money; they’re getting \$20 a month from their family If they deplete that for medical care, they don’t have money for underwear, soap or food.”).

40. EISEN, *supra* note 5, at 4.

41. *Id.*

42. *Id.* at 5.

43. *Id.*

44. *Id.*

45. See THE FIN. JUSTICE PROJECT, CRIMINAL JUSTICE ADMINISTRATIVE FEES: HIGH PAIN FOR PEOPLE, LOW GAIN FOR GOVERNMENT 1 (2018), <https://sftreasurer.org/high-pain-low-gain> [<https://perma.cc/3AVP-ZPMG>].

criminal justice system.⁴⁶ It found that the substantial fees imposed were not generating revenue on a meaningful scale; in fact, over a six-year period, it had recouped only about 17 percent of the \$57 million in criminal justice administrative fees it had assessed.⁴⁷ What is more, over half of the fees imposed had revenue projections so low that they were not even included in the County's budget forecast.⁴⁸ At the same time, the fees were imposing a substantial burden on people exiting the criminal justice system, the majority of whom were low-income individuals who could not afford to pay them.⁴⁹ The coalition's report noted:

The vast majority of people exiting jail or prison are unemployed, have unstable housing, have no steady source of income, and find work difficult or nearly impossible to obtain after release Paying these fees can make it hard for someone to pay their rent or day to day expenses Research shows that the fees can push individuals into underground economies and can result in individuals turning to criminal activity to pay their debts.⁵⁰

Thus, the coalition determined that these administrative fees are "counterproductive, ineffective and anemic sources of revenue."⁵¹ In total, San Francisco County estimated that the elimination of criminal justice administrative fees would cause about \$1 million per year in lost revenue while lifting \$32 million in debt off of tens of thousands of individuals and determined that the benefits of eliminating the debt far outweighed the foregone revenue.⁵² The coalition's report noted that forgiving this debt would not only ease the burden of living expenses and help facilitate successful re-entry for ex-inmates but also save the county valuable time and resources that it would otherwise have spent trying to collect these fees.⁵³ In effect, San Francisco County has shown that when a local government actually collects and analyzes data regarding administrative fees (including medical copayments) associated with the criminal justice system

46. *Id.*

47. *Id.* at 1, 6.

48. *Id.* at 6.

49. *Id.* at 9.

50. *Id.* (quotation taken from the Executive Summary).

51. *Id.*

52. *Id.* at 6.

53. *Id.* at 10.

and incarceration, the revenue-raising rationales behind administrative fees can quickly break down.

2. Justification: Copayments Deter Frivolous Medical Claims

In addition to erroneously contending that medical copayments in prison raise revenue, prison officials also rationalize the imposition of medical copayments by insisting that they reduce the demand for medical services. Correctional employees are constantly wary of inmates who might be “malingering”—purposely presenting false or overexaggerated medical symptoms.⁵⁴ Prison policymakers argue that, by deterring frivolous medical claims, copayment policies save prisons money on over-the-counter medications and medical supplies that would otherwise be requested by malingering inmates.⁵⁵ Reducing frivolous medical requests would also allow medical staff to spend more time and resources on inmates with more serious medical conditions.⁵⁶

While malingering may be a legitimate concern for facilities with limited resources,⁵⁷ “[i]ncarcerated individuals . . . are disproportionately affected by chronic health conditions, mental illness, and substance abuse.”⁵⁸ Despite this, inmates “tend to receive inadequate health care before, during, and after incarceration or detention, further exacerbating their disadvantage.”⁵⁹ One study reported that approximately 68 percent of jail inmates, 20 percent of state prison inmates, and 14 percent of federal prison inmates had not received a medical exam

54. Lorry Schoenly, *He's Faking It: How to Spot Inmates' Invented Illnesses*, CORRECTIONS1 (Sept. 30, 2017), <https://www.correctionsone.com/correctional-healthcare/articles/hes-faking-it-how-to-spot-inmates-invented-illnesses-dx3GtdjSL9acMbxn/> [<https://perma.cc/73YD-C3RE>]. This article defines “malingering” and provides a list of potential motivations behind it—namely, avoiding criminal responsibility, receiving a reduced sentence, transferring to a better location (i.e., a hospital or mental health unit), receiving lighter work duty, obtaining contraband such as narcotics or psychotropics, or receiving a number of other perks like better shoes or a lower bunk.

55. Eisen, *supra* note 30.

56. *Id.*

57. See EISEN, *supra* note 5, at 5.

58. AM. ACAD. OF FAM. PHYSICIANS, INCARCERATION AND HEALTH: A FAMILY MEDICINE PERSPECTIVE (2017) <https://www.aafp.org/about/policies/all/incarceration.html> [<https://perma.cc/DQJ8-RLMX>].

59. *Id.*

since the start of their incarceration.⁶⁰ Additionally, of inmates who were taking prescription medication “for an active medical problem routinely requiring medication,” about 21 percent of federal, 24 percent of state, and 36 percent of jail inmates stopped taking the medication following their incarceration.⁶¹ At least part of this deficit for necessary services can be attributed to the copayment system which disincentivizes incarcerated persons from seeking needed medical care.⁶²

While a five-dollar copayment might seem affordable—a bargain, even—to those unfamiliar with the prison system, it is important to be mindful of proportionality in the context of correctional facilities. Inmates typically earn between fourteen and sixty-three cents per hour at correctional facility jobs.⁶³ A 2017 study found that fourteen states charge medical copayments that would equate to charging minimum wage workers in the “free” community over \$200.⁶⁴ By way of example, if medical providers charged minimum wage earners \$200, \$500, or over \$1,000 for every visit,⁶⁵ those people would be more likely to allow their health to deteriorate before they paid one week, two weeks, or even a full month of wages to see a doctor. Communicable illness would further compound the problem by risking the health of others due to that person’s reasonable determination to pay for groceries, rent, or childcare rather than seek medical care that month.

Incarcerated people face choices like these regularly, except that they are forced to choose between needed medical attention, hygiene products, over-the-counter medicine, telephone charges to communicate with loved ones, extra sets of clothing and undergarments, or simply to not become further entrenched in debt due to the countless fees that come along with a prison or jail

60. Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 669 (2009).

61. *Id.*

62. Andrews, *supra* note 6. (“But fees, even small ones, may not only deter prisoners from making requests for care that prison officials consider frivolous, they may also deter necessary care to keep chronic conditions in check . . .”).

63. Wendy Sawyer, *How Much Do Incarcerated People Earn in Each State?*, PRISON POLY INITIATIVE (Apr. 10, 2017), <https://www.prisonpolicy.org/blog/2017/04/10/wages/> [https://perma.cc/9UNV-YNP8].

64. Wendy Sawyer, *The Steep Cost of Medical Co-Pays in Prison Puts Health at Risk*, PRISON POLY INITIATIVE (Apr. 19, 2017), <https://www.prisonpolicy.org/blog/2017/04/19/copays/> [https://perma.cc/TW94-YT7D].

65. *Id.*

sentence.⁶⁶ One ex-inmate, Pete, describes his experience of being sick in jail yet not seeking medical attention for fear of the resulting fee:

And so I go back to jail, and by the time I left I owed \$261 to the jail. OK? Do you know when I went in I owed \$11. I stayed there one week, and by the time I checked out I owed \$261, and I didn't see the doctor; I didn't dare see the doctor even though I needed medication and I had withdrawals from being on lithium . . . because that would cost me another \$10 for the doctor visit. And I still racked up \$261.⁶⁷

For Pete, a seemingly affordable ten-dollar copayment was a cost-prohibitive measure which disincentivized him from seeking necessary medical attention for painful withdrawals.

Copayments deterring prisoners from seeking necessary care causes problems for the afflicted individual. This problem compounds when an inmate has a communicable illness and chooses not to seek care due to copayment costs. When a sick inmate does not seek medical care, disease can spread through the entire correctional facility to other inmates, staff, and visitors.⁶⁸ In such crowded and close quarters, the risk of spreading infectious diseases is especially high,⁶⁹ and policies designed to discourage inmates from utilizing prison medical services “ignore . . . the importance of preventive care in correctional facilities.”⁷⁰

Nearly all incarcerated people will at some point be released⁷¹—a fact that is often overlooked in the context of the American prison system.⁷² When prisoners go without hygiene

66. *Id.*

67. Alexes Harris et al., *Drawing Blood from Stones: Legal Debt and Social Inequality in the Contemporary United States*, 115 AM. J. SOC. 1753, 1783–84 (2010).

68. Wanda Bertram, *Momentum is Building to End Medical Co-Pays in Prisons and Jails*, PRISON POL'Y INITIATIVE (Aug. 8, 2019), <https://www.prisonpolicy.org/blog/2019/08/08/copays-update/> [<https://perma.cc/G33R-J5YP>].

69. Ollove, *supra* note 28.

70. Mark Lopez & Kara Chayriques, *Billing Prisoners for Medical Care Blocks Access*, PRISON LEGAL NEWS (Nov. 15, 1995), <https://www.prisonlegalnews.org/news/1995/nov/15/billing-prisoners-for-medical-care-blocks-access/> [<https://perma.cc/ER7Z-VUQX>].

71. As of 2016, only 53,290 out of nearly 2.2 million incarcerated people in the United States were serving life without parole sentences. See THE SENTENCING PROJECT, FACT SHEET: TRENDS IN U.S. CORRECTIONS 8 (2019).

72. Cooper, *supra* note 4.

items or medical treatment in efforts to contain the amount of debt they accrue behind bars, they increase the risk of contracting and spreading communicable illnesses.⁷³ This endangers not only others within the correctional facility, but also their communities and the general public when inmates reintegrate without seeking medical attention for a communicable disease.⁷⁴ While purporting to reduce demand for medical services, medical copayments in the prison context serve to undermine the important policies underlying preventative care.

Encouragingly, some states are reexamining the validity of medical copayments as a supposed deterrent of frivolous medical claims. Within the last few years, three states have made significant progress in either eliminating or drastically reducing prison medical copayments, largely due to the growing understanding that copayments tend to deter patients from seeking necessary care.⁷⁵ While Texas stopped short of eliminating prison copayments altogether, it passed legislation to drastically reduce its notorious \$100 fee with a \$13.55 fee per medical visit.⁷⁶ Illinois eliminated its five-dollar copayment in July of 2019 after a study reported that more than 60 percent of prisoners avoided seeking healthcare because of the copayment.⁷⁷ In addition, the California Department of Corrections and Rehabilitation announced an end to the five-dollar copayment, noting that “copayments may hinder patients from seeking care for health issues which, without early detection and intervention, may become exacerbated, resulting in decreased treatment efficacy and/or increased treatment cost,” and stated that an approach dedicated to preventative care “can prove to be fiscally prudent.”⁷⁸

73. Bertram, *supra* note 68.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*; *Eliminating Medical Co-Pays for Prisoners*, JOHN HOWARD ASS'N, <https://www.thejha.org/success-stories/eliminating-medical-co-pays-for-prisoners> (last visited Sept. 9, 2020) [<https://perma.cc/UN5V-TYVY>].

78. CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION ELIMINATES INMATE COPAYMENTS FOR HEALTHCARE SERVICES, CAL. DEP'T OF CORR. & REHAB. (Feb. 21, 2019), <https://www.cdcr.ca.gov/news/2019/02/21/california-department-of-corrections-and-rehabilitation-eliminates-inmate-copayments-for-health-care-services/> [<https://perma.cc/LXR6-4RYS>]; Bertram, *supra* note 68.

3. Justification: Copayments Teach Inmates a Lesson

They're giving them money to buy treats with, to buy commissaries, all these extras in the jail, and the county is saying, "No, wait a minute. You have a debt to society that you're gonna pay before you buy those Twinkies."

– Paul Ray, Utah State Representative⁷⁹

Some spokespeople for correctional facilities claim that charging medical copayments “teaches prisoners lessons about budgeting money, which is useful when they are released,”⁸⁰ and that copayments “instill a sense of responsibility and force prisoners to make mature choices regarding how they spend their money.”⁸¹ One official described charging prisoners fees and fines as part of a “two-fold responsibility” to taxpayers: “[o]ne is to collect as much as we can in terms of user fees from the inmates at the prison. The other is to attempt to rehabilitate the prisoners so that they are not a future burden yet again on the taxpayers. You do that by teaching them financial responsibility.”⁸²

This overtly paternalistic rationale fails to take into account the wage differential discussed above⁸³ and the fact that many people leave jail or prison with large amounts of debt.⁸⁴ The reality is that charging inmates fines and fees in amounts so grossly disproportionate to any paltry income they might earn while behind bars in no way prepares them for a fiscally independent life outside prison walls. Overwhelming evidence suggests instead that criminal justice debt and indigency upon release from prison seriously impede a person’s ability to successfully reenter society, impairing their ability to maintain housing and employment, apply for public benefits, and pay child support.⁸⁵ For example, several states suspend driver’s licenses for missed debt payments, which can cause people to miss work or lead to another conviction for driving with a suspended

79. EISEN, *supra* note 5, at 5.

80. Ollove, *supra* note 28.

81. Lopez & Chayriques, *supra* note 70.

82. Eisen, *supra* note 30.

83. See discussion *supra* Section I.B.2.

84. EISEN, *supra* note 5, at 1.

85. ALICIA BANNON ET AL., CRIMINAL JUSTICE DEBT: A BARRIER TO REENTRY 27–29 (2010).

license.⁸⁶ Further, although prison officials might believe that the imposition of fees on inmates will ensure that they do not become “a future burden yet again”⁸⁷ on taxpayers, failure to pay criminal justice debt can lead to probation or parole revocation and reincarceration in several states.⁸⁸

Additionally, the burden to fund commissary accounts often falls on inmates’ families⁸⁹ because incarcerated people, 80 percent of whom are indigent,⁹⁰ often cannot afford the necessities of prison life on a wage of perhaps a couple of dollars per day.⁹¹ Predictably, shifting these expenses onto inmates’ families disproportionately harms poor families.⁹² One ex-inmate says he was allowed to “become an asset to society” since his release largely “because he stayed in touch with family and priests even when he was in solitary confinement. When inmates can’t afford to maintain contact with the outside world . . . they are less equipped to transition smoothly to civilian life.”⁹³ But for indigent families, the ability to stay connected with an incarcerated loved one can force difficult choices. “It’s a wife that has three children at home, and her husband is in jail, so now she has a choice: Do I send money to him so he can afford to stay in touch with the kids, or do I feed the kids?”⁹⁴ In this way, fees charged in prison in the name of teaching inmates financial responsibility harm more than the individual inmate and can inhibit an

86. *Id.* at 2.

87. Eisen, *supra* note 30.

88. BANNON ET AL., *supra* note 85, at 2; *see also* Harris et al., *supra* note 67, at 1783–84.

89. For an overview of how the prison industry shifts costs of incarceration to the families of inmates, see Daniel Wagner, *Prison Bankers Cash in on Captive Customers*, CTR. FOR PUB. INTEGRITY (Nov. 11, 2014), <https://publicintegrity.org/business/prison-bankers-cash-in-on-captive-customers> [<https://perma.cc/3ZTD-RUMM>] (“Negative account balances discourage cash-strapped people from helping relatives, says Linda Dolan, 58, a manager for a defense contractor in California. Last year, when her son was sentenced to 20 days in jail in St. Lucie County, Florida, for reckless driving, Linda wanted to buy him a second pair of underwear and socks. But the county’s intake fee and daily ‘rent’ already had put the account about \$70 in the red. Linda and her husband both were out of work and couldn’t afford to pay \$100 for a pair of underwear. ‘If relatives are putting money on somebody’s books while they’re an inmate, it’s to help them buy necessities,’ Linda says. ‘I didn’t think it was right that the county was stealing the money.’”).

90. Andrews, *supra* note 6.

91. *See* discussion *supra* Section I.B.2.

92. Wagner, *supra* note 89.

93. *Id.*

94. *Id.*

inmate's ability to reintegrate smoothly not only into society as a whole but also into their own family.

II. JUDICIAL AND LEGISLATIVE ACQUIESCENCE TO THE DEPRIVATION OF MEDICAL CARE AS PUNISHMENT

The minimum constitutional standards for the quality of prison health care were set forth by the Supreme Court in *Estelle v. Gamble*.⁹⁵ Under that pivotal case, prisoners have a right under the Eighth Amendment to be free from inadequate medical care rising to the level of “deliberate indifference” on the part of the medical provider.⁹⁶ This Section first provides a summary of the basic framework under which prisoners may currently bring Eighth Amendment claims and the standard that must be met to state a claim for constitutionally deficient health care. It continues with an examination of the current treatment of challenges to medical copayments by courts, followed by a discussion of prisoners' and ex-prisoners' denial of a remedy under the political process.

A. Prison Health Care Under the Eighth Amendment

Although the American criminal justice system deprives incarcerated people of their health, prisoners are constitutionally guaranteed a minimum standard of health care under the Eighth Amendment of the Constitution.⁹⁷ In *Estelle*, the Supreme Court found that the Eighth Amendment's prohibition against “cruel and unusual punishment”⁹⁸ protects prisoners from instances in which prison officials or medical providers act or fail to act in a manner “sufficiently harmful to evidence deliberate indifference to serious medical needs.”⁹⁹ The Court wrote that the Eighth Amendment “proscribes more than physically barbarous punishments” and instead “embodies ‘broad and idealistic concepts of dignity, civilized standards, humanity, and decency’” against which penal measures must be evaluated.¹⁰⁰ These standards proscribe punishments “which ‘involve the

95. 429 U.S. 97 (1976).

96. *See id.* at 105–06.

97. *Id.*

98. U.S. CONST. amend. VIII.

99. *Estelle*, 429 U.S. at 106.

100. *Id.* at 102 (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)).

unnecessary and wanton infliction of pain.”¹⁰¹ Thus, the *Estelle* Court determined that, in the prison context, some denials of medical care “may result in pain and suffering which no one suggests would serve any penological purpose[,]” which “is inconsistent with contemporary standards of decency” in violation of the Eighth Amendment.¹⁰²

But, under *Estelle*, not every claim of inadequate treatment violates the Eighth Amendment.¹⁰³ Negligence alone, or “an inadvertent failure to provide adequate medical care[,]” does not rise to an Eighth Amendment violation, as it “cannot be said to constitute ‘an unnecessary and wanton infliction of pain.’”¹⁰⁴ In addition, “[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner.”¹⁰⁵ Thus, only acts or omissions rising to the level of “deliberate indifference” may serve as the basis for a prisoner’s claim under the Eighth Amendment.¹⁰⁶

Since *Estelle*, the Court has further distilled the deliberate indifference standard for adequate medical treatment of prisoners under the Eighth Amendment to include both an objective and subjective component.¹⁰⁷ A prisoner must show that their medical condition necessitating care was “sufficiently serious” to satisfy the objective component.¹⁰⁸ To satisfy the subjective component, the prisoner must establish that the actor that caused the deprivation possessed a sufficiently culpable state of mind by fulfilling a two-part test: first, the prisoner must show that the prison official was aware that the inmate faced a substantial risk of harm, and second, that the official disregarded that risk “by failing to take reasonable measures to abate it.”¹⁰⁹

The subjective prong of the deliberate indifference test makes the standard very difficult to meet in practice.¹¹⁰ A prison medical provider may claim to have not denied *all* medical

101. *Id.* at 103 (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

102. *Id.*

103. *Id.* at 105.

104. *Id.*

105. *Id.* at 106.

106. *Id.*

107. *See, e.g.*, *Rhodes v. Chapman*, 452 U.S. 337 (1981); *Wilson v. Seiter*, 501 U.S. 294 (1991).

108. *Wilson*, 501 U.S. at 298.

109. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

110. Joel H. Thompson, *Today’s Deliberate Indifference: Providing Attention Without Providing Treatment to Prisoners with Serious Medical Needs*, 45 HARV. C.R.–C.L. L. REV. 635, 650 (2010).

treatment, or that they at least provided some care, and courts will generally defer to the medical judgment as a matter of policy.¹¹¹ This judicial deference to prisons and prison officials is a common and recurring premise used to justify the denial of relief to prisoners bringing Eighth Amendment claims for all sorts of issues within the prison health care context—including medical copayments.

B. Judicial Deference to the “Legitimate Penological Purpose”: Setting the Bar Impossibly Low

While prisoners are guaranteed a right to medical care under *Estelle*, nowhere in the Court’s decision does it say that prison medical care must be provided to prisoners free of charge. Additionally, courts will find no equal protection violation so long as the prison regulation in question is “reasonably related to a legitimate penological interest.”¹¹²

For instance, in *Tillman v. Lebanon County Correctional Facility*, the Third Circuit Court of Appeals agreed with the county defendants that “teaching fiscal responsibility and deterring sick-call abuse,” the purported purposes of charging inmates fees for medical care, “were obviously reasonably related to legitimate penological interests.”¹¹³ The Supreme Court has also “counsel[ed] a policy of judicial restraint” in the context of prison administration¹¹⁴ because “[r]unning a prison is . . . peculiarly within the province of the legislative and executive branches of government.”¹¹⁵ Thus, so long as prison officials can come up with some kind of justification to show that there is a “legitimate penological interest” for the imposition of incarceration fees on prisoners, the courts will generally uphold such fees.¹¹⁶ Because the courts defer to the judgment of prison

111. *Id.* (citing *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (1976)).

112. *Tillman v. Lebanon Cty. Corr. Facility*, 221 F.3d 410, 416 (3rd Cir. 2000).

113. *Id.* at 419.

114. *Turner v. Safley*, 482 U.S. 78, 85 (1987).

115. *Id.* at 84–85.

116. *Tillman*, 221 F.3d at 416; *see also* *Waters v. Bass*, 304 F. Supp. 2d 802 (E.D. Va. 2004) (stating that per-diem prison room and board fees are reasonably related to legitimate penological interests of reducing expenses to taxpayers and engendering fiscal responsibility in inmates); *Heim v. Dauphin Cty. Prison*, No. 3:CV-10-1656, 2013 WL 183777 (M.D. Pa. May 1, 2013) (stating that room and board fees are reasonably related to legitimate purpose of partially reimbursing the prison for housing and treatment services to inmates); *Gardner v. Wilson*, 959 F. Supp. 1124 (C.D. Cal. 1997) (upholding medical copayments as reasonably related to legitimate

policymakers regarding the imposition of penal medical fees, those seeking a remedy might next turn to the political process—but they will likely find significant obstacles to relief there as well.

C. Disenfranchisement of Prisoners as a Limit to Political Participation in the Criminal Justice Sphere

While judicial deference to legislative and executive decisions is an important aspect of a majoritarian government, “deferential judicial review . . . is built on a tenuous foundation when applied to judicial review of legislative or executive branch policymaking in the criminal justice context.”¹¹⁷ By deferring to the other branches of government in the realm of criminal justice, the court assumes that the aggrieved may turn to the political process to implement policy change.

However, most inmates face substantial impediments to political participation, primarily in the form of felon disenfranchisement laws that are currently in place in forty-eight states.¹¹⁸ A 2016 study estimated that 6.1 million people were disenfranchised as a result of a felony conviction.¹¹⁹ This figure represents approximately two and one-half percent of the total voting-age population in the United States that is completely

penological interest of assuring that inmates do not abuse access to medical services); *Reynolds v. Wagner*, 936 F. Supp. 1216 (E.D. Pa. 1996) (upholding medical copayments as reasonably related to legitimate penological interest of instilling reasonable decision making powers in inmates); *Johnson v. Dep’t of Pub. Safety & Corr. Servs.*, 885 F. Supp. 817 (D. Md. 1995) (stating that copayments are related to the legitimate penological interest of promoting inmate responsibility and efficient use of medical resources).

117. Weiss, *supra* note 23, at 779.

118. Currently, only Maine and Vermont have rejected disenfranchisement laws for people with criminal convictions, even for people who are currently incarcerated. Fifteen states restore voting rights automatically after release from prison, twenty states extend disenfranchisement to include probation and/or parole, nine permanently disenfranchise those with certain criminal convictions, and Iowa and Kentucky permanently disenfranchise anyone with a felony conviction. See *Criminal Justice Disenfranchisement Laws Across the United States*, BRENNAN CTR. FOR JUST. (May 30, 2019), <https://www.brennancenter.org/our-work/research-reports/criminal-disenfranchisement-laws-across-united-states> [https://perma.cc/KY8X-VZJT].

119. THE SENTENCING PROJECT, 6 MILLION LOST VOTERS: STATE-LEVEL ESTIMATES OF FELONY DISENFRANCHISEMENT, 2016, at 3 (2016), <https://www.sentencingproject.org/wp-content/uploads/2016/10/6-Million-Lost-Voters.pdf> [https://perma.cc/73VE-NC9Y].

excluded from political participation.¹²⁰ Although the judicial deference granted to legislatures and prison officials in the criminal justice context is grounded in the idea of the political accountability of the other branches, that justification fails where those branches are not directly accountable to the populations that their policies affect.

The discussion of felon disenfranchisement raises an important question: how might political participation by the disenfranchised population meaningfully change the political tide? Some experts posit that “felon disenfranchisement has provided a small but clear advantage to Republican candidates in every presidential and senatorial election from 1972 to 2000.”¹²¹ The 2000 presidential election serves as the most notable and illustrative example of the potential voting power of disenfranchised felons. The famous presidential race, in which Al Gore won a plurality of the popular vote but narrowly lost to George W. Bush in the Electoral College, came down to just 537 votes in Florida.¹²² At the time of the election, there were approximately 827,000 disenfranchised felons in Florida; according to researchers,¹²³ if voter turnout among felons and inmates was just 13.6 percent, Gore would still have received enough votes to have won Florida (by a margin of over 30,000 votes) and the presidential election.¹²⁴ Thus, at least at the margins, empowering the currently disenfranchised to vote could provide the power to swing close elections.

Though they could make a substantial difference if allowed to fully participate in the political process, disenfranchised inmates and ex-inmates are too often unable to vote for policies or politicians that would benefit them. But even though the governmental processes have so far failed this vulnerable, disenfranchised population, there are viable solutions that could benefit both the prisoners directly affected by prison policy and policymakers seeking to preserve state budgets and shift costs away from taxpayers.

120. *Id.*

121. Christopher Uggen & Jeff Manza, *Democratic Contraction? Political Consequences of Felon Disenfranchisement in the United States*, 67 AM. SOC. REV. 777, 787 (2002).

122. *Id.* at 793.

123. For Uggen and Manza’s methodology in estimating how the disenfranchised population would vote, see *id.* at 782–87.

124. *Id.* at 792.

III. POLICY RECOMMENDATIONS: ALTERNATIVE SOLUTIONS TO THE MEDICAL CO-PAY PROBLEM

Although medical copayments as a policy have failed to strike a balance between prisons' legitimate need for efficiency and their incarcerated population's need for comprehensive and available medical care, many viable alternatives exist that would help build a more equitable system. This Section begins by examining some potential solutions that could come from the courts and concludes with a discussion of potential avenues of relief through local and state legislatures.

A. *Judicial Solutions*

Estelle made clear that prisoners have a right to adequate medical care during incarceration. State and local governments responded by providing care, but at a cost to the prisoners. Courts have thus far allowed these fees, finding no constitutional violations where prisons can allege some "legitimate penological interest" in imposing the fees.¹²⁵ For decades, courts have found purported interests such as "teaching fiscal responsibility and deterring sick-call abuse" to be sufficiently legitimate to grant judicial deference.¹²⁶ Thus, for plaintiffs challenging prison fees as unconstitutional, arguments under either the Equal Protection Clause or the Cruel and Unusual Punishment Clause of the Eighth Amendment are likely to be dead ends.

Some experts believe that a new, creative litigation strategy under the Excessive Fines Clause of the Eighth Amendment could provide a viable challenge to inmate fees charged in prisons.¹²⁷ The Excessive Fines Clause remained in obscurity for decades, with the Supreme Court declaring as recently as 1998 that it "has had little occasion to interpret, and has never actually applied, the Excessive Fines Clause."¹²⁸ The Constitution itself is silent on how to determine whether a particular fine is "excessive" under this clause.¹²⁹ Existing jurisprudence on the Excessive Fines Clause is sparse, and what does exist has dealt

125. See *Tillman v. Lebanon Cty. Corr. Facility*, 221 F.3d 410, 419 (3rd Cir. 2000).

126. *Id.*

127. Eisen, *supra* note 30.

128. *United States v. Bajakajian*, 524 U.S. 321, 327 (1998).

129. Eisen, *supra* note 30.

primarily with forfeiture cases.¹³⁰ In *United States v. Bajakajian*, Justice Thomas, writing for the majority, declared that “the touchstone of the constitutional inquiry under the Excessive Fines Clause is the principle of proportionality: The amount of the forfeiture must bear some relationship to the gravity of the offense that it is designed to punish.”¹³¹ Some experts posit that this holding could be applied in cases challenging fees charged to prisoners.¹³² Taken together with *Tillman*, which left open the possibility that fees might under some circumstances be considered “fines” under the Excessive Fines Clause if classified as punitive,¹³³ “creative litigants could possibly bring specific challenges in cases where an inmate’s fees are significantly more than the legally permissible statutory fine for the inmate’s crime,” which would cause the fees to violate Justice Thomas’s principle of proportionality.¹³⁴

While this litigation strategy might succeed in challenging the most egregious cases of excessive prison fees, it is not likely to abolish the existence of prison fees and copayments altogether. The most promising avenue to achieve meaningful change for all inmates would likely be through legislation and the political process.

B. Political Solutions

On the political end, one solution is for states to pursue Medicaid financing for eligible prisoners. Although Medicaid does not typically apply to prisoners, “Medicaid can reimburse states up to a percentage for care delivered outside of prisons.”¹³⁵ In this way, federal expansion of Medicaid coverage to prisoners would allow state and local governments to shift some of the costs of providing quality healthcare to the federal government rather than to the incarcerated population, relieving some pressure on state budgets and lessening any incentives to cut corners

130. *Id.*

131. *Bajakajian*, 524 U.S. at 335.

132. Eisen, *supra* note 30.

133. *Tillman v. Lebanon Cty. Corr. Facility*, 221 F.3d 410, 420 (3rd Cir. 2000).

134. Eisen, *supra* note 30.

135. Jordan Andrews, *The Current State of Public and Private Prison Healthcare*, WHARTON PUB. POL’Y INITIATIVE (Feb. 24, 2017), <https://publicpolicy.wharton.upenn.edu/live/news/1736-the-current-state-of-public-and-private-prison/for-students/blog/news.php> [<https://perma.cc/KW82-5E8X>].

on health care costs.¹³⁶ At the same time, states could secure quality external health care for inmates with more complex or chronic health problems who would most benefit from regular visits to specialists. This would be especially beneficial to prisoners who were on Medicaid prior to their incarceration since they are already low income and especially vulnerable to medical and financial issues.

Medical and geriatric parole are related solutions that also involve care delivered outside of prison walls. The rise of mass incarceration has not only brought more people into the prison system but has also kept them there longer.¹³⁷ The end result is an unprecedented aging of the prison population.¹³⁸ A practical response to the aging phenomenon within prisons might be to expand the use of medical parole, which is the authorization of certain inmates with specified severe medical conditions to be eligible for parole.¹³⁹ Another viable option would be geriatric parole, which allows for the consideration of release of inmates once they reach a statutorily specified age.¹⁴⁰ Medical parole is available in forty-five states, and geriatric parole in seventeen states, for inmates who meet certain eligibility or age requirements.¹⁴¹

In practice, these programs can be administratively undercut by prison officials, making it nearly impossible to even apply for medical or geriatric parole in certain states. One 2017 study found that “[t]he impact of these [medical parole] policies remains limited because so many people are ineligible, the criteria for release are so restrictive, and the process for approval is so burdensome.”¹⁴² For example, the Massachusetts legislature passed a law in 2018 approving a program to release

136. *Id.*

137. See Carrie Abner, *Graying Prisons: States Face Challenges of an Aging Inmate Population*, ST. NEWS, Nov.–Dec. 2006, at 8, 9, <http://www.csg.org/knowledge-center/docs/sn0611GrayingPrisons.pdf> [<https://perma.cc/77JU-R29C>].

138. *Id.*

139. *State Medical and Geriatric Parole Laws*, NCSL (Aug. 27, 2018), <http://www.ncsl.org/research/civil-and-criminal-justice/state-medical-and-geriatric-parole-laws.aspx> [<https://perma.cc/86SM-XBUY>].

140. *Id.*

141. *Id.*

142. Gal Tziperman Lotan, *In First Year of Medical Parole, Just Four Inmates Granted Reprieve*, BOS. GLOBE (July 15, 2019, 7:08 PM), <https://www.boston.com/metro/2019/07/15/first-year-medical-parole-just-four-inmates-granted-r-eprieve/cHf9pcDys4lB1uIToRiW9K/story.html> [<https://perma.cc/AF5P-8GBE>].

incapacitated or terminally ill prisoners.¹⁴³ But in the first year of the law's implementation, only four inmates actually received medical parole.¹⁴⁴ State lawmakers and inmates alike blame state prison officials, who, under the statute, are supposed to "provide inmates a medical parole plan and a diagnosis from a physician."¹⁴⁵ Instead, prison officials have essentially shifted those burdens to inmates, while rejecting filed applications for minor administrative reasons such as a doctor's signature that is not notarized.¹⁴⁶ One state senator who helped author the criminal justice bill permitting medical parole had hopes that more people would be released under the program, explaining that Massachusetts "shouldn't be warehousing people who are no longer physically capable of posing a threat to society, and instead should be getting them out to a nursing home or hospice where they can get better care at lower cost to the state."¹⁴⁷

Notwithstanding prison officials' reluctance to take advantage of cost-saving medical and geriatric parole programs, research shows that crime peaks during the teenage years and starts to decline when people are in their mid-twenties, and subsequently drops sharply as adults age into their thirties and forties.¹⁴⁸ Recidivism rates drop dramatically as prisoners age, resulting in sentencing practices that are highly inefficient, counterproductive, and costly.¹⁴⁹ States would be well-advised to take advantage of medical and geriatric release policies as a measure to make space in their perpetually bloated prisons and save on the costs of housing, feeding, and providing medical care for a population with inherently higher medical costs than younger inmates¹⁵⁰—all while keeping recidivism rates and community safety risks to a minimum. Perhaps legislators and policymakers fear that releasing convicted offenders before completion of their full sentence will show that they are not as "tough on crime" as some of their constituents would like. But if that is the case, we must recall that the tactic of imposing harsh sentences for more offenses and allowing less discretion in

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Criminal Justice Facts*, *supra* note 14.

149. *Id.*

150. Abner, *supra* note 137, at 10.

sentencing landed the United States in its current mess of mass incarceration in the first place.¹⁵¹

State and local governments could also look beyond the medical copayment context to the broader issue of administrative fees in the criminal justice system, as demonstrated by the County of San Francisco.¹⁵² If more jurisdictions would engage in the same type of thorough cost-benefit analyses, those efforts would pay off by saving time and resources as well as providing their formerly incarcerated populations with added resources to provide for themselves and more opportunities to avoid recidivism.

CONCLUSION

As a matter of policy, fees assessed to inmates for medical services which purport to raise revenue, reduce demand for services, or teach prisoners how to manage money are not justifiable on any of those claimed grounds. In reality, they serve only to perpetuate the cycle of incarceration and further punish prisoners beyond their imposed sentences by threatening their health, financial stability, and future freedom beyond the completion of their sentence. Is a thirty-day sentence truly only a thirty-day sentence when it comes with years of debt and interest to be paid off afterwards, and potentially two months more of incarceration if the offender fails to pay on time?¹⁵³ How much “truth” can there be in a system that locks people back up for failing to pay an eleven-dollar debt and releases them a week later, but now with a \$261 balance to pay back?¹⁵⁴ If prison sentences are to be completely truthful, perhaps the judge who

151. See discussion *supra* Section I.A.

152. THE FIN. JUSTICE PROJECT, *supra* note 45.

153. Brief for American Civil Liberties Union of Washington and Washington Association of Criminal Defense Lawyers as Amici Curiae Supporting Petitioner at 4, *Washington v. Nason*, 233 P.3d 848 (Wash. 2010) (No. 82333-2), 2010 WL 631307. In this case, a prosecutor argued that an ex-prisoner, James Nason, was willfully violating the conditions of his sentence by failing to keep up with his payments post-incarceration. The payments related back to an incident that took place seven years before, when Mr. Nason was eighteen years old. He was originally sentenced to thirty days of confinement. At the time he failed to pay, he was homeless, unemployed, and sleeping in his car. His only income was \$152 per month in food stamps. Despite this, the judge agreed with the prosecutor that Mr. Nason’s actions evidenced willful nonpayment and violation of a court order. As a result, he was sentenced to sixty days in jail. *See id.* at 3–4.

154. See *Harris et al.*, *supra* note 67.

sentenced Brad should have expressly informed him that his sentence would come along with forced labor for a few meager dollars per day, no meaningful avenue by which to seek addiction or mental health support, the punitive descent into withdrawals during solitary confinement, and a PTSD diagnosis.¹⁵⁵ In the pursuit of “truth” in sentencing, perhaps all who our society chooses to incarcerate should be warned that, whatever temporary period they are assigned to be locked up, their sentence likely does not end there. The physical and mental toll can last a lifetime, as can the financial burden carrying the risk of reincarceration in the event of nonpayment of prison debt.

Despite the abysmally flawed prison system in America, Brad is doing well a few years post incarceration. He is employed, sober, and has worked his way through treatment and accountability programs.¹⁵⁶ He enjoys being outdoors and riding a motorcycle again, and he is looking forward to purchasing a house and focusing on his family.¹⁵⁷ But Brad is building a good life today in spite of the system that so gravely mistreated him—a system that currently favors administrative convenience over prisoner health; quick, unsustainable sources of revenue over the development of maintainable solutions; and compelled indebtedness in the name of teaching a “lesson” over real preparation for financial independence outside prison walls.

Although Brad has shown that it is possible to beat the odds, it is unrealistic to expect all of the millions of people who go through the prison system in the United States to be able to rebuild a successful life from scratch immediately after release. By holding prisons answerable for their inefficient, cost-prohibitive policies, the American judicial system could incentivize prison officials and policymakers to formulate meaningful rationales behind their policies rather than justifying abusive practices with any excuse they know will inevitably receive judicial deference. Through medical and geriatric parole programs, jurisdictions could take advantage of cost-saving opportunities to send prisoners to outside facilities to receive care, while legislatures at both the state and federal levels could expand those programs and simplify their implementation.

Quite simply, the competing interests in this dynamic do not need to be mutually exclusive. We do not need to choose between

155. *See supra* note 2.

156. *Id.*

157. *Id.*

either security and administrative efficiency within our prisons or prisoner health, safety, and rehabilitation. It is not too late to merge the goals of each end, to continue elevating the concerns of the average citizen and taxpayer, and to simultaneously give voice to the quiet struggles of the imprisoned.