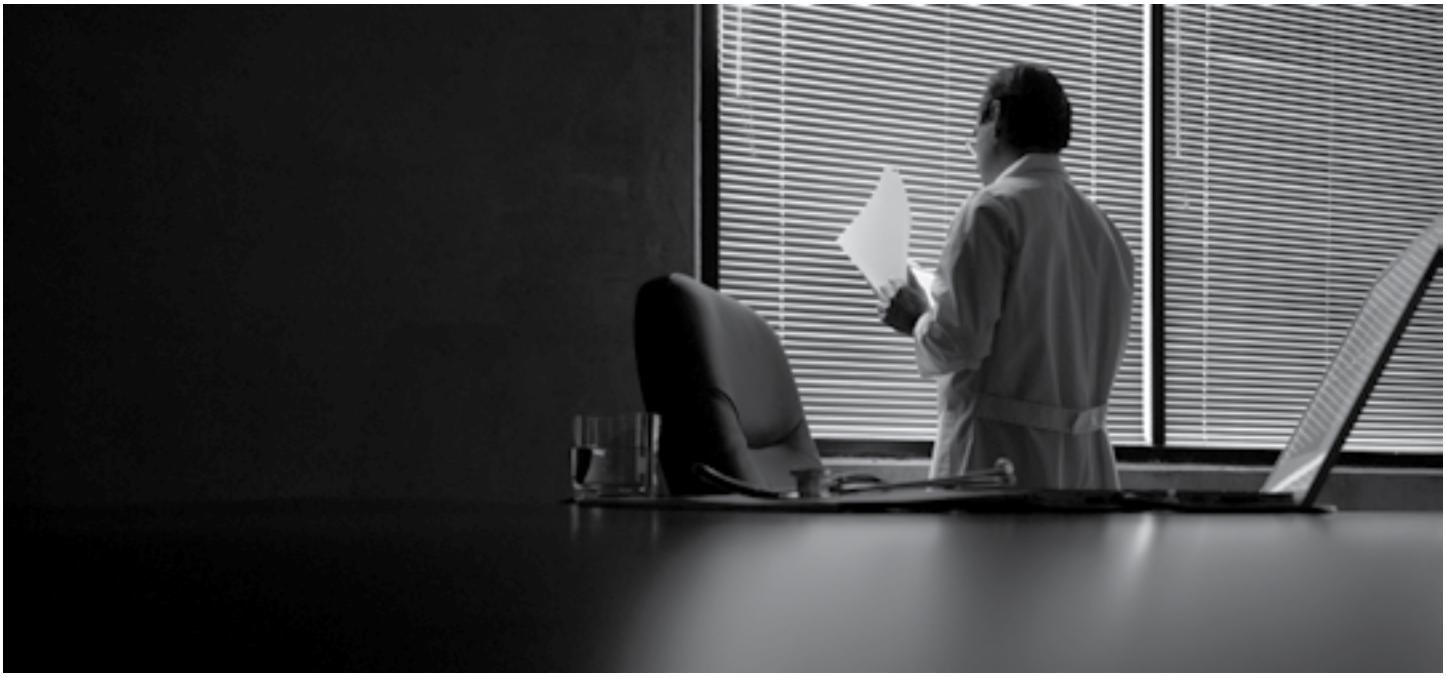
A report from The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation | July 2014



THE PEW CHARITABLE TRUSTS | MacArthur Foundation

State Prison Health Care Spending

An examination

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes. For additional information, visit www.pewtrusts.org.

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The report benefited from the insights and expertise of two external reviewers: Warren J. Ferguson, M.D., chairman of the board of directors of the Academic Consortium on Criminal Justice Health and professor and vice chair of the Department of Family Medicine and Community Health at the University of Massachusetts Medical School; and Brie Williams, M.D., M.S., associate professor of medicine at the University of California, San Francisco, and associate director of the university's Program for the Aging Century. These experts provided feedback and guidance at critical stages in the project. Although they have screened the report for accuracy, neither they nor their organizations necessarily endorse its findings or conclusions.

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Overview

Health care and corrections have emerged as fiscal pressure points for states in recent years as rapid spending growth in each area has competed for scarce revenue. Not surprisingly, the intersection of these two spheres—health care for prison inmates—also has experienced a ramp-up, reaching nearly $8 billion in 2011.

Under the landmark 1976 Estelle v. Gamble decision, the U.S. Supreme Court affirmed that prisoners have a constitutional right to adequate medical attention and concluded that the Eighth Amendment is violated when corrections officials display "deliberate indifference" to an inmate's medical needs.[1] The manner in which states manage prison health care services that meet these legal requirements affects not only inmates' health, but also the public's health and safety and taxpayers' total corrections bill. Effectively treating inmates' physical and mental illnesses, including substance use disorders, improves their well-being and can reduce the likelihood that they will commit new crimes or violate probation once released.[2]

The State Health Care Spending Project previously examined cost data from 44 states* and found that prison health care spending increased dramatically from fiscal year 2001 to 2008. However, new data from a survey of budget and finance staff officials in each state's department of corrections, administered by The Pew Charitable Trusts and the Vera Institute of Justice, show that some states may be reversing this trend.

This report examines the factors driving costs by analyzing new data on all 50 states' prison health care spending from fiscal 2007 to 2011.† It also describes a variety of promising strategies that states are using to manage spending, including the use of telehealth technology, improved management of health services contractors, Medicaid financing, and medical or geriatric parole.

The project's analysis of the survey data yielded the following findings:

- Correctional health care spending rose in 41 states from fiscal 2007 to 2011, with median growth of 13 percent, after adjusting for inflation.
- Per-inmate health care spending also rose in 39 states over the period, with a median growth of 10 percent.
- In a majority of states, however, total spending and per-inmate spending peaked before fiscal 2011. Nationwide, prison health care spending totaled $7.7 billion in fiscal 2011, down from a peak of $8.2 billion in fiscal 2009. The downturn in spending was due, in part, to a reduction in state prison populations.
- From fiscal 2007 to 2011, the share of older inmates—who typically require more expensive care—rose in all but two of the 42 states that submitted prisoner age data.‡ Not surprisingly, states where older inmates represented a relatively large share of the total prisoner population tended to incur higher per-inmate health care spending.

As states work to manage prison health care expenditures, a downturn in spending was a positive development as long as it did not come at the expense of access to quality care. But states continue to face a variety of challenges that threaten to drive costs back up. Chief among these is a steadily aging prison population.

Data from the survey can provide state decision-makers with information to assess both their own state's

* The source of these data was the Bureau of Justice Statistics.

† States' fiscal years differ. (See Appendix A: Methodology.)

‡ Project researchers partnered with the Association of State Correctional Administrators to survey state officials on the share of state inmates who were age 55 or older in each year from fiscal 2007 to 2011.

spending—over time and compared with other states—as well as cost-containment initiatives underway from fiscal 2007 to 2011. Officials in all 50 states were willing to respond to the survey and supply spending information, which is a strong indication of their eagerness to make peer comparisons and address spending in a data-driven fashion.

The State Health Care Spending 50-State Study Report Series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, is examining seven key areas of state health care spending—Medicaid, the Children's Health Insurance Program, substance abuse treatment, mental health services, prison health care, and both active and retired state government employee health insurance. The project will provide a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research will highlight those variations and some of the key factors driving them. The project is concurrently releasing state-by-state data on 20 key health indicators to complement the programmatic spending analysis. For more information, see http://www.pewtrusts.org/healthcarespending.


PhotoAlto via Getty Images

Spending trends

In fiscal 2011, states spent a total of $7.7 billion on correctional health care—likely about a fifth* of overall prison expenditures. Most states' spending increased from fiscal 2007 to 2011, with median growth of 13 percent across the country, after adjusting for inflation.† During the same time period, states experienced moderate growth in their per-inmate spending, which rose by a median of 10 percent. (See Figure 1.)

However, spending was down from an inflation-adjusted peak of $8.2 billion in fiscal 2009, with California's decrease of $441 million from fiscal 2009 to 2011 accounting for most of this decline. Total spending peaked in 34 states (see Figure 2) and per-inmate spending peaked in 37 states prior to 2011, most commonly in 2009 and 2010.

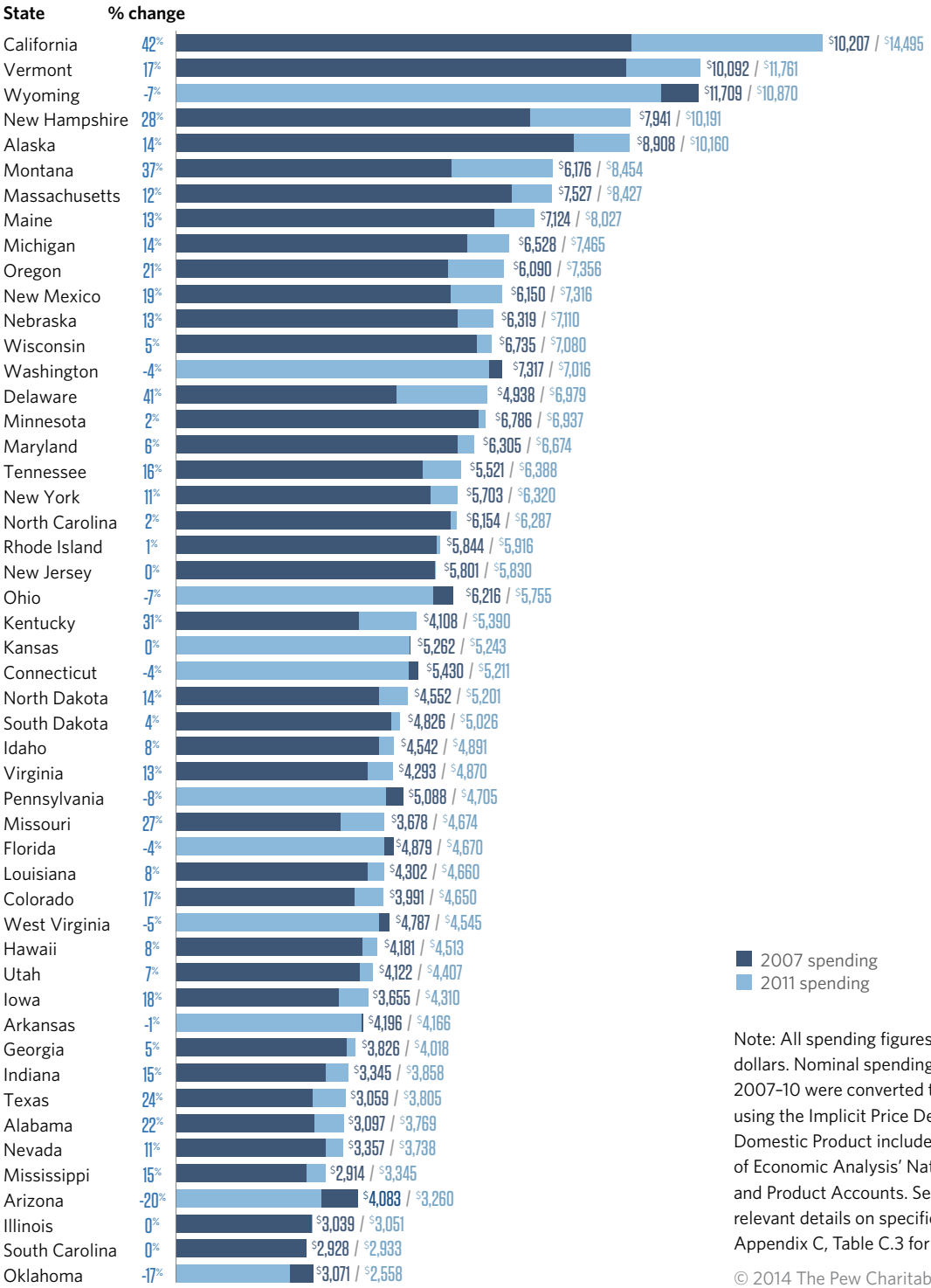
* In 2010, the most recent year for which total state prison expenditures were available as of the writing of this report, totaled $38.6 billion in nominal dollars. States' prison health care spending—$ 7.7 billion—represented 20 percent of this total. Prison health care likely represented a similar percentage in 2011. Tracey Kyckelhahn and Tara Martin, "Justice Expenditure and Employment Extracts, 2010—Preliminary," Bureau of Justice Statistics, July 2013, http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4679.

† Data for fiscal 2007 to 2010 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

Figure 1

Per-Inmate Spending on Prison Health Care Grew by a Median of 10% Over 5 Years, Peaking in 37 States Before 2011

Change by state, 2007–11

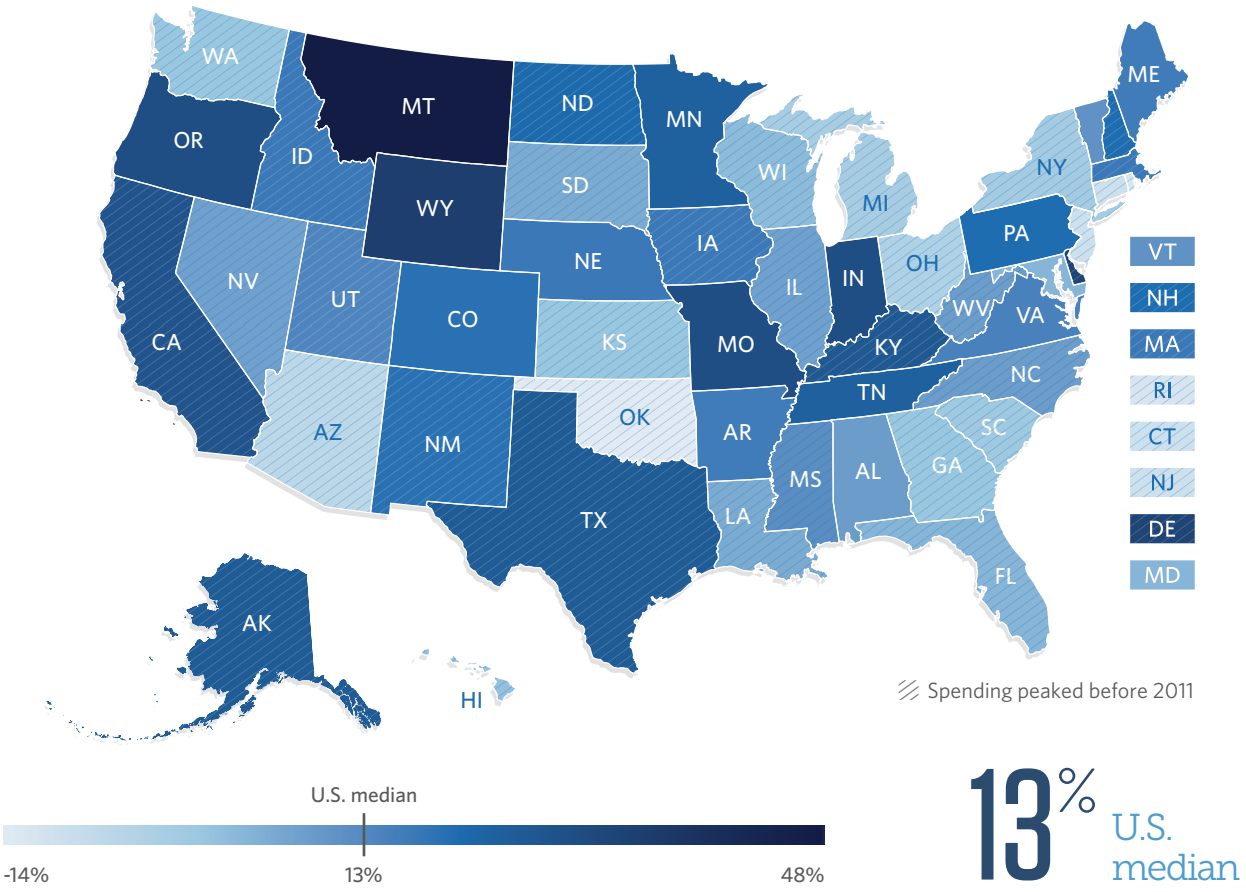


Note: All spending figures are in 2011 dollars. Nominal spending data for fiscal 2007–10 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts. See Appendix B for relevant details on specific state data. See Appendix C, Table C.3 for the data.

Figure 2

Total Spending on Prison Health Care Grew by a Median of 13% Over 5 Years, Peaking in 34 States Before 2011

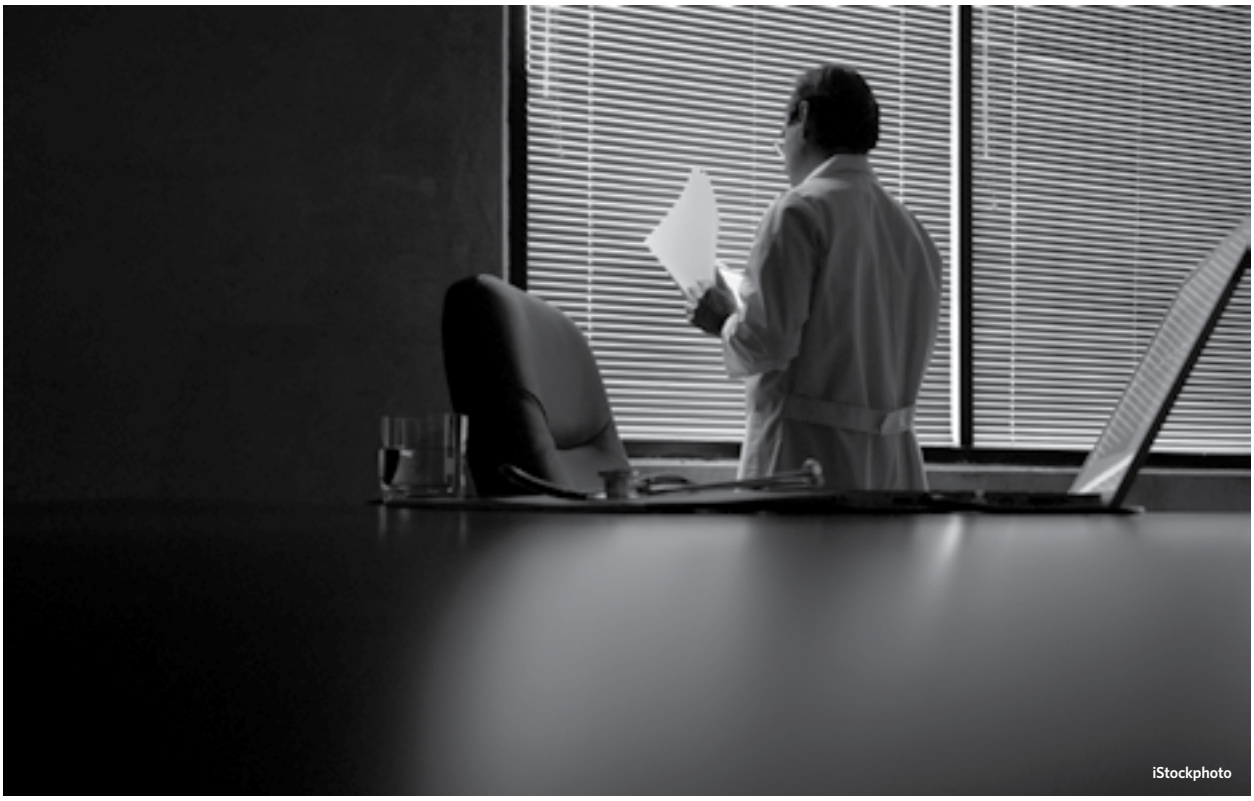
Change by state, 2007–11



Note: All spending figures are in 2011 dollars. Nominal spending data for fiscal 2007–10 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts. See Appendix C, Table C.1 for the data.

A Note on Making State-to-State Spending Comparisons

A variety of factors affect interstate spending comparisons, such as variation in the age and health status of correctional populations, regional differences in prices of health care providers, and disparities in care quality and health outcomes. Because of the range of variables that influence spending and the absence of measured outcomes, higher spending is not necessarily an indication of waste, and lower spending is not necessarily a sign of efficiency.



Distribution of spending

To gain greater insight into how states spend their correctional health care dollars and to provide detailed information to policymakers for comparison purposes, the survey broke down spending into major components: administration, medical care, dental care, mental health care, pharmaceuticals, hospitalization, and substance abuse treatment.* As in the health care system writ large, the collection and analysis of such disaggregated spending and health outcome data are necessary for the effective management of correctional health care, including the successful implementation and evaluation of cost-containment strategies. According to a group of correctional health care researchers and practitioners coordinated by the Division of Geriatrics at the University of California, San Francisco, reliable and timely outcome and cost data are particularly important for optimizing care quality and value—that is, achieving desired health outcomes at sustainable costs—for inmates age 55 and older because of the high cost of their care and their unique needs.[3]

Nearly all states provided data for one or more of the spending categories for each year, with only 10 states† doing so for all spending categories for each year requested. Among those 10, the largest component of correctional health care spending from fiscal 2007 to 2011 was general medical care—doctors, nurses, physician assistants, and medical supplies—followed by on-site and off-site hospitalization, pharmaceuticals, and mental health care. (See Figure 3.) This distribution of funds stayed relatively stable over the five years.

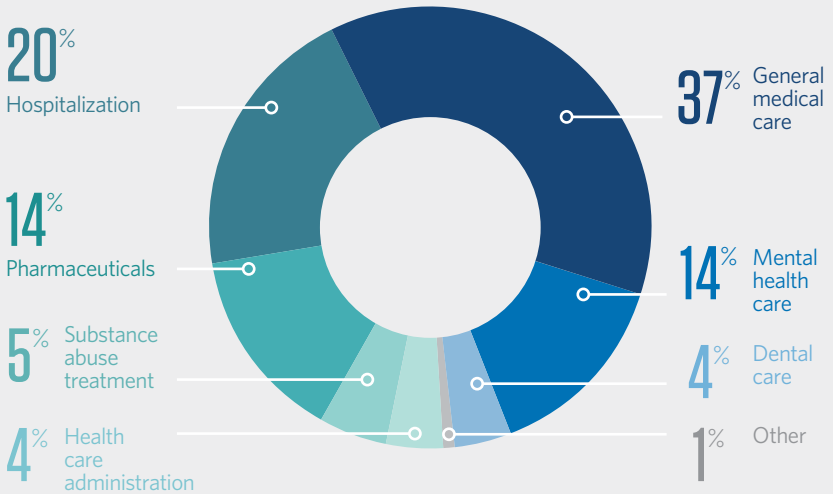
* Some states do not normally include substance abuse treatment in their official calculation of correctional health care spending.

† The 10 states included Florida, Illinois, Minnesota, Nebraska, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, and Washington.

Figure 3

General Medical Care Was the Largest Component of Prison Health Care Spending

Average distribution of funds by category for 10 states, 2007–11



Note: These averages are limited to the 10 states that submitted complete disaggregated spending data: Florida, Illinois, Minnesota, Nebraska, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, and Washington. The averages were determined by summing each spending component in each of the 10 states and calculating each component's share of total spending among all 10 states in that year. The percentage represented by each category was then averaged across the 5 years.

Data and accounting limitations

The large number of states that did not submit complete disaggregated spending data for correctional health care may suggest that many could be hampered in their efforts to manage spending if their budgeting and accounting systems do not provide a deep level of granularity.

Some states have improved their data capabilities, including expanding their work to capture spending in finer detail. In 2010, for example, the South Carolina Department of Corrections converted its accounting system to one that consolidated more than 70 state agencies into a single, statewide enterprise system for finance, materials management, and payroll that allows the corrections department to collect more detailed information on health care costs.[4] Similarly, in 2006, New Hampshire changed its accounting methods to comprehensively capture correctional health care related costs that had been excluded from prior analyses.[5]

Beyond accounting system limitations, data capabilities may be limited when contractors provide correctional health care—and, in some cases, all correctional services. In such cases, the state typically pays a negotiated daily rate and does not require that specific spending items be reported. Even so, several states provided health care spending figures for inmates in private prisons, demonstrating that these data can be obtained.

States that look to for-profit companies, outside partners, and/or other state entities such as public university medical centers to fulfill all or part of their prison medical, dental, and mental health care needs would benefit by ensuring that contractors meet clearly specified goals for quality and cost. Some states, for example, have gained more control over spending on outsourced correctional health care by attaching performance standards and tracking systems to their contracts.[6]

Spending drivers

The size, age, and health status of inmate populations are the primary determinants of states' total correctional health care spending. In addition to the number of state prisoners, several factors characteristic of most state corrections systems can affect the delivery of health care and drive costs on a per-inmate basis. These include:

- The distance of prisons from hospitals and other providers.
- The prevalence of infectious and chronic diseases, mental illness, and substance use disorder among inmates.
- An aging inmate population.

Trends in prison populations

The significant growth in correctional health care spending from fiscal 2001 to 2008 reflected, in part, a concurrent rise in prison populations nationally. During that time period, the number of sentenced prisoners in correctional institutions increased by 15 percent, from 1.34 million to 1.54 million.[7] A multidecade trend, the number of Americans in prison nearly tripled from 1987 to 2007 and continued growing until 2009.[8] Tougher sentencing laws and more restrictive probation and parole policies that put more people in prison for longer stays drove much of the increase.[9] More recently, however, many states have begun to review and modify their corrections and sentencing policies.

The correctional health care spending downturn in 2010 and 2011 resulted, in part, from a reduction in state prison populations. According to the survey, states' average daily inmate population reached its apex in 2009 and then began to fall. This trend aligns with periodic counts from the Bureau of Justice Statistics that also showed the number of inmates in state prisons declining for the third straight year in 2012.[10]

Location, staffing, and inmate transportation

For remote prisons far from the population centers where most medical professionals tend to work, states may need to provide higher-than-average compensation to attract and retain medical staff, or they may incur considerable overtime and temporary-worker costs if their recruitment efforts fall short. Expenses add up quickly when inmates must travel long distances to see specialists or stay overnight in hospitals. The Legislative Analyst's Office in California, for example, reported that medically related guarding and transportation costs for one inmate can exceed $2,000 per day.[11]

Prevalence of disease and mental illness

Inmates have a higher incidence of chronic and infectious diseases, such as AIDS and hepatitis C, and mental illness than that of the general population.[12] These costly conditions, many of which are present prior to incarceration, place a significant burden on state correctional budgets, which assume the entire cost of care.

In 2010, roughly 65 percent of incarcerated adults in prisons or jails met the medical criteria for an alcohol or drug use disorder,[13] and inmates were seven times likelier than individuals in the community to have such a condition. One-third suffered from mental illness, and one-quarter had a co-occurring mental illness and substance use disorder.

Estimates of the prevalence of hepatitis C in prisons vary across the country, indicating regional differences in high-risk behaviors such as intravenous drug use. A survey of state correctional department medical directors and health administrators placed the national rate of hepatitis C among inmates at 17.4 percent in 2006.[14] By way of comparison, roughly 1 percent of all U.S. residents have chronic hepatitis C infection.[15] More conservative research estimates the prevalence of hepatitis C among prisoners at seven times that of the population outside prison walls.[16] The cost implications behind these numbers could become more significant for some states in the years ahead if they elect to make use of expensive new prescription drugs recently approved by the U.S. Food and Drug Administration to care for those with chronic hepatitis C infection.[17]

Older inmates, greater expense

As the number of inmates who have grown old behind bars dramatically increased, so did the health care costs required to treat them. From 1999 to 2012, the number of state and federal prisoners age 55 or older—a common definition of "older" prisoners—increased 204 percent, from 43,300 to 131,500. During the same period, the number of inmates younger than 55 grew much more slowly: up 9 percent, from 1.26 million to 1.38 million.[18] (See Figure 4.) The graying of American prisons stems from the use of longer sentences as a public safety strategy and an increase in admissions of older inmates to prison.[19]

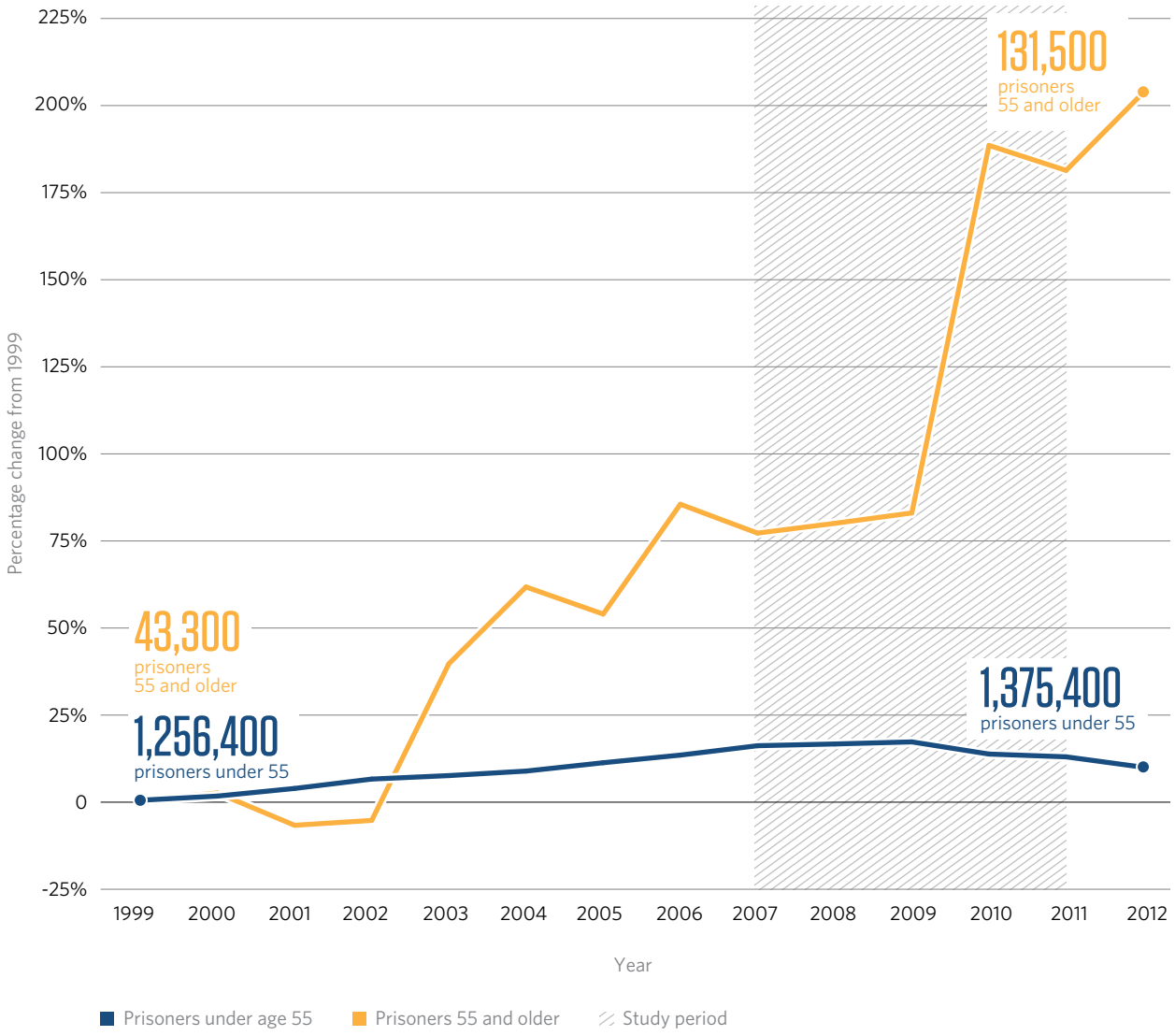
Like senior citizens outside prison walls, older inmates are more susceptible to chronic medical and mental conditions, including dementia, impaired mobility, and loss of hearing and vision. In prisons, these ailments necessitate increased staffing levels, more officer training, and special housing—all of which create additional health and nonhealth expenses. Medical experts say inmates typically experience the effects of age sooner than people outside prison because of issues such as substance use disorder, inadequate preventive and primary care prior to incarceration, and stress linked to the isolation and sometimes-violent environment of prison life.[20]

The older inmate population has a substantial impact on prison budgets. Estimates of the increased cost vary. The National Institute of Corrections pegged the annual cost of incarcerating prisoners age 55 and older with chronic and terminal illnesses at, on average, two to three times that of the expense for all other inmates, particularly younger ones.[21] More recently, other researchers have found that the cost differential may be wider.[22]

Figure 4

The Number of State and Federal Prisoners Age 55 and Older Increased by 204%, 1999–2012

Percentage change in sentenced prison populations by age group



Note: The Bureau of Justice Statistics estimates the age distribution of prisoners using data from the Federal Justice Statistics Program and statistics that states voluntarily submit to the National Corrections Reporting Program. State participation in this program has varied, which may have caused year-to-year fluctuations in the bureau's national estimates but this does not affect long-term trend comparisons. From 2009-10, the number of states submitting data increased substantially, which might have contributed to the year-over-year increase in the national estimate between those years.

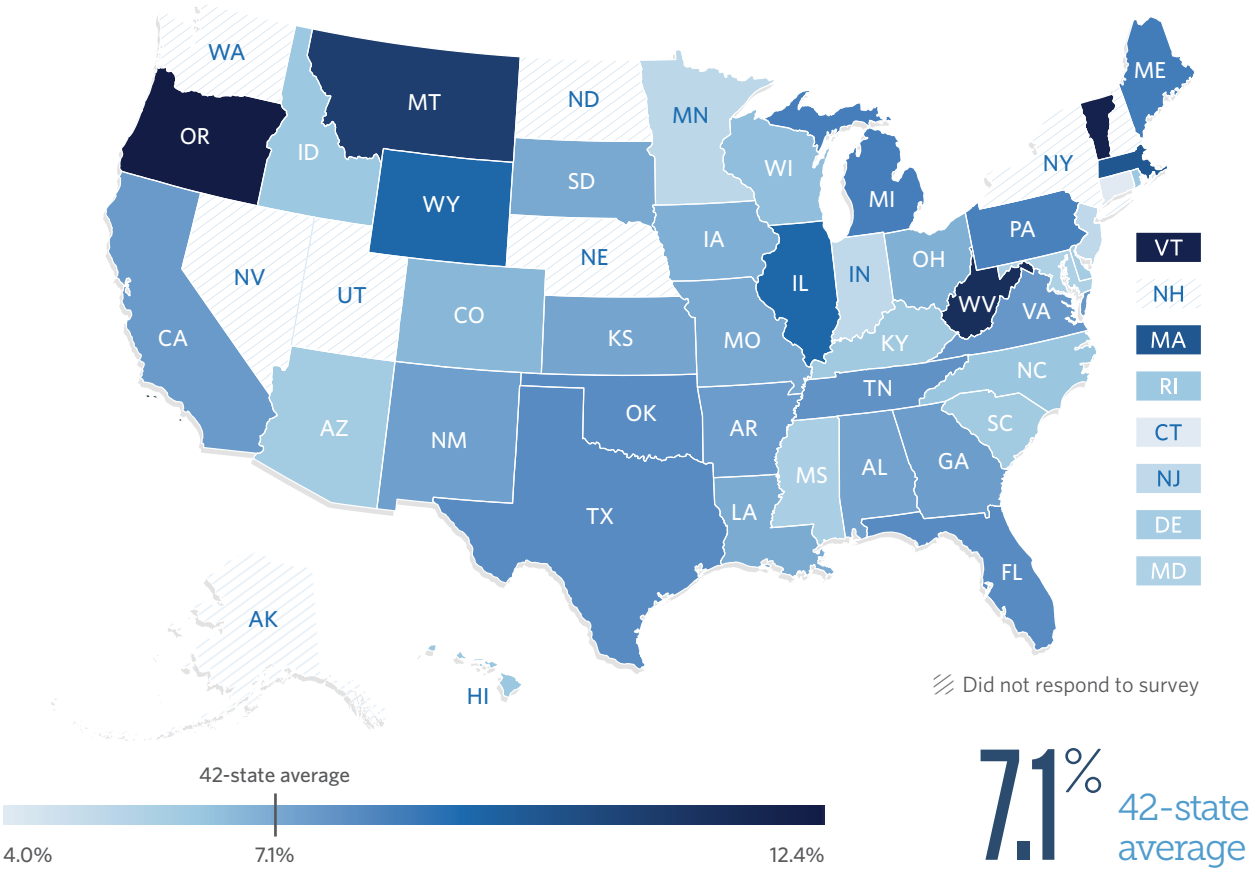
Source: U.S. Department of Justice, Bureau of Justice Statistics

To better understand trends in inmate age on a state-by-state level, Pew researchers partnered with the Association of State Correctional Administrators to survey state officials on the share of state inmates who were age 55 or older in each year from fiscal 2007 to 2011.* During this period, the share of older prisoners increased in all but two (Hawaii and Mississippi) of the 42 states that provided data. The average proportion of older inmates increased from 6.2 percent of all inmates to 8.2 percent. The proportion in fiscal 2011 ranged from less than 6 percent in New Jersey, Minnesota, Indiana, Hawaii, and Connecticut to more than 13 percent in Oregon, Vermont, and West Virginia. (See Figure 5.)

Figure 5

The Share of Older Inmates in State Prison Populations Varied Throughout the Country

Percentage of inmates age 55 and older by state, 2007–11 average



Note: Data for Idaho were not available for fiscal 2007; the average is from 2008–11. Data were not available for any years in 8 states: Alaska, Nebraska, New Hampshire, Nevada, New York, North Dakota, Utah, and Washington. See Appendix C, Table C.4 for the data.

Source: Association of State Correctional Administrators

* Researchers asked survey respondents to submit the percentage of pretrial and sentenced inmates age 55 or older under the custody of state departments of corrections in adult correctional institutions and private prisons for fiscal 2007 through 2011. Respondents were asked to exclude inmates in the custody of local jails unless the corrections system in their state is a combined jail-prison system (sometimes called a "unified" system).

By comparing data between the primary survey of this report and the secondary survey focusing on the number of older inmates, project researchers found evidence of a relationship between the relative size of a state's older inmate population and its spending per inmate, though testing the causal relationship was beyond the scope of the research. States where older inmates represented a relatively large share of the total population from fiscal 2007 to 2011 tended to have higher per-inmate spending. For instance, median per-inmate spending over the study period was 37 percent higher among the 10 states with the largest share of inmates 55 and older than the 10 states with the smallest share of older inmates. (See Figure 6.) This relationship between older inmates and health care spending suggests that the share of a state's prison population represented by older inmates may be one factor among several that influences trends in per-inmate spending over time.

Figure 6

Median Per-inmate Health Care Spending Was Higher in States Where Older Inmates Represented a Greater Share of Prison Populations

Per-inmate health care spending in states with the highest and lowest percentage of inmates age 55 and over, 2007–11 average

Bottom 10		
	Average share of prisoners age 55 and older, 2007-11	Average health care spending per inmate, 2007-11
Connecticut	4.0%	$5,437
Indiana	5.0%	$3,529
New Jersey	5.0%	$5,886
Minnesota	5.1%	$6,994
Maryland	5.5%	$6,140
Mississippi	5.6%	$3,238
Delaware	5.7%	$6,317
Arizona	5.8%	$4,050
South Carolina	5.8%	$2,976
Kentucky	5.9%	$4,955
Median	**5.6%**	**$5,196**

Top 10		
	Average share of prisoners age 55 and older, 2007-11	Average health care spending per inmate, 2007-11
Pennsylvania	7.9%	$4,870
Michigan	8.0%	$7,103
Maine	8.0%	$7,182
Illinois	8.8%	$3,162
Wyoming	8.8%	$11,532
Massachusetts	9.4%	$8,507
Montana	10.5%	$7,952
West Virginia	11.2%	$4,709
Vermont	11.9%	$11,015
Oregon	12.4%	$6,727
Median	**9.1%**	**$7,142**

Note: Each state's percentage of prisoners age 55 and older and per-inmate health care spending were averaged from 2007-11. All spending figures are in 2011 dollars. Nominal spending data for fiscal 2007–10 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts. See Appendix C, Tables C.3 and C.4 for the data.

Source: Pew survey, Association of State Correctional Administrators

Cost-containment strategies

As state policymakers feel the strain of correctional health care costs on their budgets and look ahead to their aging prison population, corrections officials are pursuing ways to rein in expenses without sacrificing the quality of care or public safety. Strategies being explored include using telehealth technologies, outsourcing prison health care, enrolling prisoners in Medicaid, and paroling older and/or ill inmates. Each of these strategies was discussed in detail in the project's October 2013 report, *Managing Prison Health Care Spending*.

Telehealth

Teleheath refers to the use of electronic information and telecommunications technologies to support, among other things, long-distance health care services. This strategy can help improve prisoners' access to primary care doctors and specialists while reducing transportation and guarding expenses. Additional public safety benefits can be realized as well because inmates will likely need fewer trips off the prison grounds for medical care.

Advances in outsourcing care

Many states look to outside partners to provide all or part of their prison health care services at lower costs while maintaining or improving the quality of care. Effective management and oversight—for example, attaching performance standards and tracking systems to contracts or monitoring the timeliness and effectiveness of prisoners' treatment—are critical to the success of these partnerships.

Medicaid financing

A number of states have made a concerted effort to enroll eligible prisoners in Medicaid so that the program can be billed for qualifying health services, which are limited to the care delivered outside of prison, such as at an off-site hospital or nursing home, when the inmate has been admitted for more than 24 hours.

States can obtain federal Medicaid reimbursement that covers at least 50 percent of enrolled prisoners' inpatient hospitalization costs. They may save additional dollars because Medicaid typically pays the lowest provider rates of any payor in a state.

States expanding their Medicaid eligibility under the Affordable Care Act may reap the largest savings. Most inmates, as nondisabled adults without dependent children, will only become eligible for coverage of inpatient costs under this expansion. The federal government will initially reimburse 100 percent of the cost of covered services for all newly eligible enrollees, including inmates. The federal matching rate will gradually decrease to 90 percent by 2020.

States may also assist eligible inmates leaving the prison with their enrollment in Medicaid or new health insurance marketplaces, helping to preserve the continuity of health care treatments between prison and the community.

Medical or geriatric parole

Many states have adopted medical or geriatric parole policies that allow for the release of older, terminally ill, or incapacitated inmates who meet certain requirements. Because of the high cost of incarcerating older prisoners with chronic or terminal illnesses, granting medical or geriatric parole when appropriate can achieve notable savings, even if the state retains financial responsibility for parolees' health care costs outside prison.

In practice, however, states have released relatively few people. Key barriers include narrow eligibility criteria, complicated applications, lengthy review processes, difficulty in assessing medical suitability, and a shortage of nursing home spaces for such offenders. Because many older and infirm prisoners were convicted of violent crimes or sentenced under habitual-offender laws, opposition among policymakers and the public to the concept of medical or geriatric parole has proved to be another significant obstacle.

Conclusion

Correctional health care spending poses a fiscal challenge to state lawmakers, though evidence indicates that spending peaked at the end of the last decade. The situation posed by these expenses may be particularly acute in states where older inmates represent a relatively large proportion of the prison population.

Corrections officials will be better positioned to manage their systems effectively with access to rigorous, disaggregated spending and health outcomes data that can be used to identify cost drivers and to evaluate the value and impact of cost-containment initiatives. Moving forward, four strategies—telehealth, outsourcing care, Medicaid financing for eligible inmates, and appropriate use of medical or geriatric parole—among others, provide promising opportunities for states to save taxpayer dollars and maintain or improve the quality of inmate care while protecting public safety. Tracking future spending trends, particularly in the context of the Affordable Care Act's Medicaid expansion, will be critical in these efforts.

Appendix A: Methodology

Spending survey

Pew conducted a survey of states' correctional health care spending in partnership with the Vera Institute of Justice. Pew based its methodology on one used by the Bureau of Justice Statistics, or BJS, for a similar analysis of data from fiscal 2001 and 2008.[23] Minor differences between the methods are described below.

State correctional health care expenses for fiscal 2007 to 2011 were first identified and tallied through an analysis of the U.S. Census Survey of State Government Finances.[24] State-specific data were then shared with budget and finance staff officials in each state's department of corrections, who were asked to verify their accuracy, make any necessary corrections, and provide—if possible—a detailed breakout on the component costs of correctional health care.

Pew consulted a panel of advisers and five pilot states to review the project definition of health care and the survey instrument. The advisers were Michael Fine, M.D., director of the Rhode Island Department of Health and former medical program director of the Rhode Island Department of Corrections; B. Jaye Anno, Ph.D., co-founder of the National Commission on Correctional Health Care and owner of Consultants in Correctional Care; and Don Specter, director of the Prison Law Office. The pilot states were California, Louisiana, Missouri, Rhode Island, and Washington.

Pew sought to capture each state's correctional health care spending—provided by state employees and/or contracted providers—including expenses for health care administration, medical care, dental care, mental health care, substance abuse treatment, pharmaceuticals, and hospitalization. These data include correctional health care costs for inmates in the custody of private prisons, when states could provide this information. States pay for the care and custody of inmates in private prisons through a negotiated daily rate, and the specific costs of health care cannot always be disaggregated from this rate. Nine states contracting with private prisons were able to provide information about health care costs for those inmates: Arizona, Colorado, Georgia, Hawaii, Indiana, Mississippi, New Mexico, Oklahoma, and Texas. Twelve states that contract with private prisons were unable to provide information about health care expenditures for those inmates: Alabama, Alaska, California, Florida, Idaho, Kentucky, Louisiana, Montana, Ohio, Tennessee, Vermont, and Virginia. Inmates in private prisons in these 12 states are excluded from the average daily population and thus not factored into the average cost per inmate.

Substance abuse treatment is not included in some states' official calculation of correctional health care because it is categorized as rehabilitative programming. It is included in this analysis when states could provide information about these costs. Eleven states were unable to provide five years of data for substance abuse treatment costs: Alabama, Arkansas, California, Georgia, Hawaii, Mississippi, North Dakota, Vermont, Virginia, West Virginia, and Wisconsin. Thus the total cost of health care in these states is marginally underreported.

The costs of inmates in the jurisdiction of state corrections departments but in the custody of local jails are excluded from this analysis except in the six states with a unified structure in which the state operates jails and prisons: Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont.

Data are reported for each state's fiscal year that ended in the year surveyed. For example, data for "fiscal 2008" is the state fiscal year that ended in calendar year 2008. Some states describe fiscal years differently. For instance, Pennsylvania describes the fiscal year that ends in 2008 as fiscal 2007 to 2008.

Once data for all 50 states were collected, researchers investigated the results of outlier states where (a) total nominal spending declined from 2007 to 2011, and (b) per-inmate spending increased dramatically relative to other states.

Data for fiscal 2007 to 2010 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

Adjustments from BJS's methodology

Pew reported fiscal 2008 correctional health care spending data in its October 2013 report, *Managing Prison Health Care Spending*, based on BJS's analysis. Nominal total spending data for fiscal 2008 in Pew's survey may differ from those reported in BJS's study because of minor adjustments Pew made to the bureau's methodology.

State spending for correctional health care provided to inmates in the custody of private prisons was included in Pew's survey.

Pew's definition of correctional health care included substance abuse treatment, and state officials were specifically asked to capture these data in their tally. Some states do not include substance abuse treatment in their official calculation of correctional health care, and these costs may be excluded for those states in BJS's analysis.

Pew calculated the average cost per inmate by dividing total spending by the average daily inmate population. The BJS divided total costs by a snapshot count of the inmate population at the end of the year.

Pew queried the amount of each component cost of health care: health care administration, medical care, dental care, mental health care, substance abuse treatment, pharmaceuticals, and hospitalization. The BJS tallied aggregate correctional health care spending. Pew did not specifically ask for capital outlays, which BJS did.

Pew uses a different index to adjust historical state spending for inflation. Data for fiscal 2007 to 2010 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts. The BJS used the State and Local Consumption Expenditures and Gross Investment price index also included in the National Income and Product Accounts.

Age demographic survey

Pew partnered with the Association of State Correctional Administrators to survey its members regarding the share of their inmates age 55 and older. Survey respondents were asked to submit the percentage of pretrial and sentenced inmates age 55 or older under the custody of state departments of corrections in adult correctional institutions and private prisons for fiscal 2007 through 2011. Inmates in the custody of local jails were excluded unless the corrections system in the state is a combined jail-prison system (sometimes called a "unified" system).

Appendix B: State data notes

Alabama: Correctional health care costs exclude the cost of health care administration.

California: Correctional health care costs exclude the cost of inpatient psychiatric care, which is provided by the California Department of State Hospitals.

Colorado: Most correctional health care costs for inmates in private prisons are provided by the state corrections department. A small portion of health care costs for inmates in private prisons, such as expenses for basic care, are provided by the private prison but are excluded from the state total because this amount could not be obtained by the state.

Idaho: Correctional health care costs exclude a portion of the cost of substance abuse and mental health services.

Iowa: Correctional health care costs exclude the cost of hospitalization, which is provided by the University of Iowa Hospitals and Clinics.

Kansas: Official state reports of correctional health care exclude the cost of substance abuse treatment services. The state' total correctional health care costs, excluding substance abuse, are: $42,527,240 (2007), $44,409,217 (2008), $46,027,669 (2009), $46,350,047 (2010), and $46,384,321 (2011).

Massachusetts: Correctional health care costs include those for substance abuse treatment for detoxification and maintenance medications, but exclude the cost of counseling services.

Michigan: Correctional health care costs include the cost of substance abuse treatment, which is not included in the state's official reports of correctional health care costs.

New York: Correctional health care costs exclude mental health services provided by the New York State Office of Mental Health.

North Carolina: Correctional health care costs exclude those of health care administration because they are comingled with the administrative expenses of all other agencies.

Appendix C: State prison health care spending and population data

Table C.1

Total correctional health care spending (thousands)

State	2007	2008	2009	2010	2011	Real change in spending, 2007-11	Real spending peaked before 2011
United States	$6,798,873	$7,722,955	$8,204,873	$7,847,256	$7,679,772	13%	Yes
Alabama	$89,057	$92,465	$94,206	$96,215	$97,266	9%	No
Alaska	$31,108	$32,014	$33,424	$43,050	$38,963	25%	Yes
Arizona	$138,223	$158,454	$161,691	$138,273	$129,627	-6%	Yes
Arkansas	$57,741	$58,325	$60,136	$65,268	$66,888	16%	No
California	$1,688,342	$2,277,690	$2,577,835	$2,218,926	$2,137,045	27%	Yes
Colorado	$85,725	$93,611	$98,457	$99,331	$102,355	19%	No
Connecticut	$108,414	$115,581	$111,361	$101,652	$97,774	-10%	Yes
Delaware	$34,987	$45,213	$46,983	$45,315	$46,094	32%	Yes
Florida	$409,646	$443,595	$416,244	$427,795	$424,592	4%	Yes
Georgia	$206,094	$229,106	$215,069	$207,282	$208,103	1%	Yes
Hawaii	$23,573	$24,350	$26,335	$22,569	$23,934	2%	Yes
Idaho	$21,515	$24,034	$25,086	$25,542	$25,232	17%	Yes
Illinois	$133,878	$139,612	$145,458	$145,983	$144,039	8%	Yes
Indiana	$80,289	$84,838	$90,561	$93,894	$103,396	29%	No
Iowa	$32,365	$38,013	$39,681	$37,429	$38,001	17%	Yes
Kansas	$46,144	$47,590	$48,618	$48,004	$46,738	1%	Yes
Kentucky	$49,933	$59,279	$61,226	$65,587	$62,972	26%	Yes
Louisiana	$69,459	$78,186	$83,605	$78,602	$73,362	6%	Yes
Maine	$14,676	$14,195	$14,939	$15,798	$17,049	16%	No
Maryland	$142,071	$121,166	$130,873	$145,852	$147,856	4%	No
Massachusetts	$81,567	$100,606	$102,357	$96,261	$95,348	17%	Yes
Michigan	$335,525	$340,223	$352,120	$343,538	$330,400	-2%	Yes
Minnesota	$51,950	$55,350	$59,778	$61,509	$63,880	23%	No
Mississippi	$57,775	$66,743	$66,262	$69,299	$64,575	12%	Yes
Missouri	$110,545	$127,086	$132,805	$138,756	$142,988	29%	No
Montana	$19,721	$26,883	$27,315	$28,866	$29,284	48%	No
Nebraska	$27,709	$28,620	$29,453	$31,498	$32,363	17%	No
Nevada	$43,016	$44,411	$49,782	$48,539	$46,593	8%	Yes
New Hampshire	$19,586	$26,884	$24,913	$24,817	$23,564	20%	Yes

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State	2007	2008	2009	2010	2011	Real change in spending, 2007-11	Real spending peaked before 2011
New Jersey	$158,019	$159,238	$150,122	$151,170	$141,752	-10%	Yes
New Mexico	$41,036	$52,418	$53,533	$55,391	$48,790	19%	Yes
New York	$363,460	$377,928	$386,396	$372,454	$360,567	-1%	Yes
North Carolina	$233,169	$253,454	$276,005	$274,532	$255,125	9%	Yes
North Dakota	$5,248	$5,555	$6,514	$6,681	$6,350	21%	Yes
Ohio	$287,087	$281,926	$303,040	$301,032	$279,716	-3%	Yes
Oklahoma	$73,293	$73,545	$68,002	$64,353	$62,692	-14%	Yes
Oregon	$80,778	$82,648	$100,872	$93,662	$103,836	29%	No
Pennsylvania	$218,758	$231,421	$241,122	$254,647	$262,024	20%	No
Rhode Island	$22,038	$22,633	$22,155	$19,819	$19,364	-12%	Yes
South Carolina	$68,633	$69,213	$75,944	$71,705	$68,520	0%	Yes
South Dakota	$16,467	$16,738	$17,536	$18,054	$17,487	6%	Yes
Tennessee	$77,488	$82,744	$88,599	$90,985	$95,090	23%	No
Texas	$464,354	$505,633	$555,101	$583,760	$581,555	25%	Yes
Utah	$25,968	$28,481	$31,571	$30,094	$29,529	14%	Yes
Vermont	$16,340	$16,175	$17,279	$18,064	$18,077	11%	No
Virginia	$130,003	$142,427	$143,099	$149,298	$149,850	15%	No
Washington	$117,865	$140,581	$143,222	$128,503	$119,253	1%	Yes
West Virginia	$21,291	$20,669	$25,074	$24,931	$23,150	9%	Yes
Wisconsin	$151,546	$148,519	$156,868	$153,093	$156,060	3%	Yes
Wyoming	$15,397	$16,888	$16,243	$19,582	$20,707	34%	No

Note: All spending figures are in 2011 dollars. Nominal spending data for fiscal 2007–10 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

Table C.2

Average daily prison population

State	2007	2008	2009	2010	2011	Change in average daily population, 2007-11	Average daily population peaked before 2011
United States	1,265,239	1,268,096	1,278,759	1,271,416	1,270,036	0%	Yes
Alabama	28,760	25,523	26,179	25,841	25,806	-10%	Yes
Alaska	3,492	3,707	3,534	3,753	3,835	10%	No
Arizona	33,856	34,658	35,649	36,394	39,764	17%	No
Arkansas	13,762	14,402	14,529	15,136	16,057	17%	No
California	165,406	154,483	157,219	152,799	147,438	-11%	Yes
Colorado	21,479	22,138	22,551	22,254	22,011	2%	Yes
Connecticut	19,965	20,633	19,662	19,264	18,762	-6%	Yes
Delaware	7,086	7,171	7,048	6,764	6,605	-7%	Yes
Florida	83,965	87,035	90,417	91,574	90,927	8%	Yes
Georgia	53,864	54,629	54,767	53,704	51,794	-4%	Yes
Hawaii	5,638	5,520	5,461	5,258	5,303	-6%	Yes
Idaho	4,737	4,861	4,919	5,000	5,159	9%	No
Illinois	44,049	43,992	44,310	44,742	47,212	7%	No
Indiana	23,999	24,903	26,017	26,417	26,800	12%	No
Iowa	8,856	8,765	8,712	8,384	8,816	0%	Yes
Kansas	8,770	8,651	8,473	8,575	8,914	2%	No
Kentucky	12,154	12,205	12,101	12,234	11,684	-4%	Yes
Louisiana	16,147	16,205	16,586	15,849	15,742	-3%	Yes
Maine	2,060	2,149	2,177	2,167	2,124	3%	Yes
Maryland	22,532	22,943	22,778	21,786	22,155	-2%	Yes
Massachusetts	10,837	11,181	11,325	11,267	11,315	4%	Yes
Michigan	51,397	50,577	48,435	45,652	44,262	-14%	Yes
Minnesota	7,655	7,720	8,230	9,024	9,209	20%	No
Mississippi	19,824	20,553	20,788	19,812	19,305	-3%	Yes
Missouri	30,053	29,988	30,255	30,447	30,595	2%	No
Montana	3,193	3,199	3,309	3,408	3,464	8%	No
Nebraska	4,385	4,387	4,400	4,462	4,552	4%	No
Nevada	12,813	12,992	12,818	12,529	12,466	-3%	Yes
New Hampshire	2,467	2,481	2,490	2,445	2,312	-6%	Yes
New Jersey	27,238	26,787	25,923	24,928	24,316	-11%	Yes
New Mexico	6,672	6,459	6,363	6,671	6,669	0%	Yes

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State	2007	2008	2009	2010	2011	Change in average daily population, 2007-11	Average daily population peaked before 2011
New York	63,728	63,538	61,457	59,237	57,054	-10%	Yes
North Carolina	37,886	38,684	40,108	40,426	40,581	7%	No
North Dakota	1,153	1,162	1,180	1,198	1,221	6%	No
Ohio	46,187	47,683	48,726	48,796	48,602	5%	Yes
Oklahoma	23,867	24,309	24,391	24,549	24,511	3%	Yes
Oregon	13,264	13,766	13,620	13,819	14,116	6%	No
Pennsylvania	42,998	46,028	50,622	53,416	55,696	30%	No
Rhode Island	3,771	3,860	3,773	3,502	3,273	-13%	Yes
South Carolina	23,437	23,958	24,081	24,105	23,358	0%	Yes
South Dakota	3,412	3,373	3,428	3,496	3,479	2%	Yes
Tennessee	14,035	14,095	14,103	14,640	14,885	6%	No
Texas	151,814	151,713	150,570	151,227	152,841	1%	No
Utah	6,300	6,389	6,321	6,338	6,700	6%	No
Vermont	1,619	1,545	1,552	1,555	1,537	-5%	Yes
Virginia	30,286	32,060	32,078	30,337	30,772	2%	Yes
Washington	16,108	16,280	16,564	16,995	16,997	6%	No
West Virginia	4,448	4,917	4,940	5,052	5,093	15%	No
Wisconsin	22,500	22,627	22,294	22,325	22,042	-2%	Yes
Wyoming	1,315	1,212	1,526	1,864	1,905	45%	No

Table C.3

Per-inmate correctional health care spending

State	2007	2008	2009	2010	2011	Real change in spending, 2007-11	Real per-inmate spending peaked before 2011
United States	$5,374	$6,090	$6,416	$6,172	$6,047	13%	Yes
Alabama	$3,097	$3,623	$3,599	$3,723	$3,769	22%	No
Alaska	$8,908	$8,636	$9,458	$11,471	$10,160	14%	Yes
Arizona	$4,083	$4,572	$4,536	$3,799	$3,260	-20%	Yes
Arkansas	$4,196	$4,050	$4,139	$4,312	$4,166	-1%	Yes
California	$10,207	$14,744	$16,396	$14,522	$14,495	42%	Yes
Colorado	$3,991	$4,229	$4,366	$4,464	$4,650	17%	No
Connecticut	$5,430	$5,602	$5,664	$5,277	$5,211	-4%	Yes
Delaware	$4,938	$6,305	$6,666	$6,699	$6,979	41%	No
Florida	$4,879	$5,097	$4,604	$4,672	$4,670	-4%	Yes
Georgia	$3,826	$4,194	$3,927	$3,860	$4,018	5%	Yes
Hawaii	$4,181	$4,411	$4,822	$4,292	$4,513	8%	Yes
Idaho	$4,542	$4,944	$5,100	$5,108	$4,891	8%	Yes
Illinois	$3,039	$3,174	$3,283	$3,263	$3,051	0%	Yes
Indiana	$3,345	$3,407	$3,481	$3,554	$3,858	15%	No
Iowa	$3,655	$4,337	$4,555	$4,464	$4,310	18%	Yes
Kansas	$5,262	$5,501	$5,738	$5,598	$5,243	0%	Yes
Kentucky	$4,108	$4,857	$5,060	$5,361	$5,390	31%	No
Louisiana	$4,302	$4,825	$5,041	$4,959	$4,660	8%	Yes
Maine	$7,124	$6,605	$6,862	$7,290	$8,027	13%	No
Maryland	$6,305	$5,281	$5,746	$6,695	$6,674	6%	Yes
Massachusetts	$7,527	$8,998	$9,038	$8,544	$8,427	12%	Yes
Michigan	$6,528	$6,727	$7,270	$7,525	$7,465	14%	Yes
Minnesota	$6,786	$7,170	$7,263	$6,816	$6,937	2%	Yes
Mississippi	$2,914	$3,247	$3,188	$3,498	$3,345	15%	Yes
Missouri	$3,678	$4,238	$4,390	$4,557	$4,674	27%	No
Montana	$6,176	$8,404	$8,255	$8,470	$8,454	37%	Yes
Nebraska	$6,319	$6,524	$6,694	$7,059	$7,110	13%	No
Nevada	$3,357	$3,418	$3,884	$3,874	$3,738	11%	Yes
New Hampshire	$7,941	$10,836	$10,004	$10,150	$10,191	28%	Yes
New Jersey	$5,801	$5,945	$5,791	$6,064	$5,830	0%	Yes
New Mexico	$6,150	$8,115	$8,413	$8,303	$7,316	19%	Yes

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State	2007	2008	2009	2010	2011	Real change in spending, 2007-11	Real per-inmate spending peaked before 2011
New York	$5,703	$5,948	$6,287	$6,288	$6,320	11%	No
North Carolina	$6,154	$6,552	$6,882	$6,791	$6,287	2%	Yes
North Dakota	$4,552	$4,781	$5,520	$5,577	$5,201	14%	Yes
Ohio	$6,216	$5,913	$6,219	$6,169	$5,755	-7%	Yes
Oklahoma	$3,071	$3,025	$2,788	$2,621	$2,558	-17%	Yes
Oregon	$6,090	$6,004	$7,406	$6,778	$7,356	21%	Yes
Pennsylvania	$5,088	$5,028	$4,763	$4,767	$4,705	-8%	Yes
Rhode Island	$5,844	$5,864	$5,872	$5,659	$5,916	1%	No
South Carolina	$2,928	$2,889	$3,154	$2,975	$2,933	0%	Yes
South Dakota	$4,826	$4,962	$5,116	$5,164	$5,026	4%	Yes
Tennessee	$5,521	$5,870	$6,282	$6,215	$6,388	16%	No
Texas	$3,059	$3,333	$3,687	$3,860	$3,805	24%	Yes
Utah	$4,122	$4,458	$4,995	$4,748	$4,407	7%	Yes
Vermont	$10,092	$10,469	$11,133	$11,616	$11,761	17%	No
Virginia	$4,293	$4,443	$4,461	$4,921	$4,870	13%	Yes
Washington	$7,317	$8,635	$8,646	$7,561	$7,016	-4%	Yes
West Virginia	$4,787	$4,204	$5,076	$4,935	$4,545	-5%	Yes
Wisconsin	$6,735	$6,564	$7,036	$6,858	$7,080	5%	No
Wyoming	$11,709	$13,934	$10,644	$10,505	$10,870	-7%	Yes

Note: All spending figures are in 2011 dollars. Nominal spending data for fiscal 2007–10 were converted to 2011 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

Table C.4

Percentage of inmates age 55 and older

State	2007	2008	2009	2010	2011	2007-11 average	Percentage change, 2007-11
42-state average	6.24%	6.63%	7.12%	7.55%	8.21%	7.15%	33%
Alabama	6.30%	6.70%	6.70%	7.20%	7.90%	6.96%	25%
Arizona	5.00%	5.20%	5.70%	6.30%	6.80%	5.80%	36%
Arkansas	5.80%	6.50%	7.40%	7.60%	8.20%	7.10%	41%
California	5.70%	6.40%	7.10%	7.90%	8.80%	7.18%	54%
Colorado	5.30%	5.70%	6.30%	7.00%	7.70%	6.40%	45%
Connecticut	3.29%	3.56%	3.99%	4.52%	4.76%	4.02%	45%
Delaware	4.83%	5.07%	5.59%	6.16%	7.07%	5.74%	46%
Florida	7.00%	7.00%	7.00%	8.00%	9.00%	7.60%	29%
Georgia	6.30%	6.76%	6.93%	7.50%	7.91%	7.08%	26%
Hawaii	6.00%	6.04%	6.04%	6.06%	5.96%	6.02%	-1%
Idaho	N/A	5.40%	5.80%	6.20%	6.50%	5.98%	20%
Illinois	8.00%	8.00%	9.00%	9.00%	10.00%	8.80%	25%
Indiana	4.32%	4.75%	4.89%	5.18%	5.61%	4.95%	30%
Iowa	5.30%	6.30%	6.80%	7.10%	7.50%	6.60%	42%
Kansas	5.80%	6.60%	6.70%	7.10%	8.20%	6.88%	41%
Kentucky	5.27%	5.54%	5.80%	6.38%	6.28%	5.85%	19%
Louisiana	5.61%	6.03%	6.77%	7.21%	7.96%	6.72%	42%
Maine	6.57%	7.56%	8.69%	8.43%	8.95%	8.04%	36%
Maryland	5.00%	4.50%	5.00%	6.00%	7.00%	5.50%	40%
Massachusetts	8.48%	8.76%	9.42%	9.93%	10.41%	9.40%	23%
Michigan	7.00%	8.00%	8.00%	8.00%	9.00%	8.00%	29%
Minnesota	4.40%	5.00%	5.20%	5.20%	5.70%	5.10%	30%
Mississippi	6.00%	5.00%	5.00%	6.00%	6.00%	5.60%	0%
Missouri	5.93%	6.66%	7.16%	6.78%	7.54%	6.81%	27%
Montana	9.00%	9.50%	10.20%	11.20%	12.70%	10.52%	41%
New Jersey	4.15%	4.59%	5.00%	5.45%	5.81%	5.00%	40%
New Mexico	6.10%	6.60%	7.30%	7.20%	8.00%	7.04%	31%
North Carolina	5.26%	5.60%	6.06%	6.38%	6.99%	6.06%	33%
Ohio	5.86%	6.26%	6.53%	6.80%	7.48%	6.59%	28%
Oklahoma	6.60%	7.00%	7.30%	8.10%	8.80%	7.56%	33%
Oregon	10.67%	11.80%	12.69%	12.82%	13.83%	12.36%	30%
Pennsylvania	7.30%	7.40%	7.70%	8.30%	8.90%	7.92%	22%
Rhode Island	5.10%	5.60%	6.20%	6.30%	6.70%	5.98%	31%

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State	2007	2008	2009	2010	2011	2007-11 average	Percentage change, 2007-11
South Carolina	4.80%	5.10%	5.80%	6.40%	7.00%	5.82%	46%
South Dakota	6.00%	6.00%	7.00%	7.00%	8.00%	6.80%	33%
Tennessee	6.34%	6.95%	7.61%	7.86%	8.25%	7.40%	30%
Texas	6.60%	7.00%	7.60%	8.10%	8.70%	7.60%	32%
Vermont	10.10%	10.40%	12.30%	12.90%	13.70%	11.88%	36%
Virginia	6.10%	6.50%	7.10%	8.00%	8.60%	7.26%	41%
West Virginia	9.30%	10.90%	11.10%	11.60%	13.20%	11.22%	42%
Wisconsin	5.20%	5.70%	6.10%	6.80%	7.50%	6.26%	44%
Wyoming	8.00%	8.50%	8.30%	9.30%	9.90%	8.80%	24%

Note: Prison population age data for Idaho were not available for fiscal 2007; the average is from 2008–11. Data were not available for any years in 8 states: Alaska, Nebraska, New Hampshire, Nevada, New York, North Dakota, Utah, and Washington.

Source: Pew survey; Association of State Correctional Administrators

Endnotes

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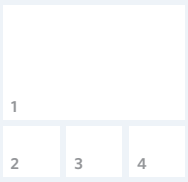

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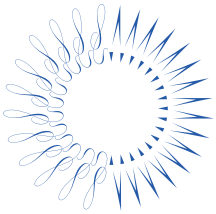

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