

ENHANCING CORRECTIONAL HEALTH CARE: AN ADMINISTRATIVE APPROACH TO ELEVATING STANDARDS AND ACCESS

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Walter Jordan, a 67-year-old man incarcerated in Arizona, died in “excruciating needless pain” from a cancer that could have been treated if he received timely medical attention.¹ Nine days before his death, he sent a handwritten plea titled “Notice of Impending Death” to a federal court, warning that delays in his treatment left him with little time to live.²

Antonio Arnez Smith, a 45-year-old incarcerated man in Alabama, faced similar neglect.³ By the time he was granted medical furlough, he was severely emaciated, in extreme pain, and covered in bed sores.⁴ Smith’s condition had deteriorated to the point that he could not lift his head.⁵ He died just four days after his release, leaving his family questioning why he had not been provided earlier medical intervention.⁶

George Hawkins, Jr., a person with whom the author personally communicated, endured months of untreated dental pain in a Virginia prison.⁷ Despite following every proper step—seeking medical attention, documenting his suffering, and filing grievances—his condition worsened.⁸ By the time he was finally treated, his teeth were beyond repair and required extraction, a preventable outcome of prolonged neglect.⁹

Access to adequate health care in prisons remains a persistent challenge, often turning manageable conditions into life-threatening situations. These cases highlight systemic gaps in prison health care that lead to unnecessary suffering. Part I of this Note examines the constitutional and statutory framework governing inmates’ right to medical care and the historical evolution of correctional health standards. Part II analyzes the structural and systemic

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1. David Fathi, *How Poor Health Care Turned Walter Jordan’s Prison Sentence Into a Death Sentence*, ACLU (Jan. 11, 2018), <https://www.aclu.org/news/prisoners-rights/how-poor-health-care-turned-walter-jordans> [https://perma.cc/G2R6-S3UJ].

2. *Id.*

3. *Family Says Alabama Prison Failed to Provide Care for Dying Man*, EQUAL JUST. INITIATIVE (Dec. 14, 2023), <https://eji.org/news/antonio-arnez-smith-family-says-alabama-prison-failed-to-provide-care-for-dying-man/> [https://perma.cc/684K-8L58].

4. *Id.*

5. *Id.*

6. *Id.*

7. *Hawkins v. Allen*, 743 F.Supp.3d 765, 769–772 (E.D. Va. Aug. 5, 2024).

8. *Id.* at 771–72.

9. *Id.*

failures that persist under that framework, including chronic understaffing, inadequate oversight, and the public health consequences of incarceration. Part III examines the role of private health care contractors and the regulatory gaps that allow substandard care to persist despite constitutional mandates. Part IV proposes a comprehensive reform agenda grounded in administrative law, arguing that state legislatures and correctional agencies must mandate accreditation, expand technology-driven care delivery, and restructure financial incentives to align contractor behavior with the constitutional obligation to provide adequate health care. Part V concludes.

Correctional health care reform is not merely a matter of prison administration; it is a matter of public health infrastructure. State policymakers must move beyond reactive constitutional compliance and adopt administrative mandates that institutionalize accountability, transparency, and evidence-based care. Doing so protects not only incarcerated individuals, but also the communities to which they return.

I. INTRODUCTION

There are four basic purposes of criminal punishment: deterrence, incapacitation, just punishment, and rehabilitation.¹⁰ Among these objectives, rehabilitation is distinct in its focus on changing behaviors to reduce recidivism.¹¹ While the primary legal justification for providing medical care in correctional facilities stems from constitutional protections rather than rehabilitative goals, access to adequate health care can support rehabilitation by addressing physical and mental health conditions that might otherwise hinder reintegration into society.¹² “The U.S. Constitution requires [all] prison officials to provide all state and federal prisoners as well as pretrial detainees . . . with adequate medical care.”¹³ Yet, state and federal prisons have long struggled to provide sufficient medical care, resulting in preventable deaths that receive little scrutiny.¹⁴

In its 1976 decision, *Estelle v. Gamble*, the Supreme Court held that “deliberate indifference to serious medical needs” constitutes “cruel and unusual

10. U.S. SENT’G GUIDELINES MANUAL §1A1.2 (U.S. SENT’G COMM’N 2024).

11. See DORIS LAYTON MACKENZIE, SENTENCING AND CORRECTIONS IN THE 21ST CENTURY: SETTING THE STAGE FOR THE FUTURE 1 (2001), <https://www.ojp.gov/pdffiles1/nij/grants/189089.pdf> [<https://perma.cc/TD7J-4YCL>] (defining rehabilitation as the modification of offender behavior and thinking to prevent future crime).

12. Danielle Wallace & Xia Wang, *Does in-prison physical and mental health impact recidivism?*, 11 SSM POP. HEALTH 1, 1–2 (2020), <https://doi.org/10.1016/j.ssmph.2020.100569> [<https://perma.cc/KE4K-XRA6>].

13. COLUM. HUM. RIGHTS L. REV., A JAILHOUSE LAWS. MANUAL, YOUR RIGHT TO ADEQUATE MEDICAL CARE 706 (13th ed. 2024), <https://jlm.law.columbia.edu/files/2017/05/35.-Ch.-23.pdf> [<https://perma.cc/B8KB-QQ5T>].

14. *Prison Health Care Crisis Mounts as Incarcerated Population Age*, EQUAL JUST. INST. (May 14, 2024), <https://eji.org/news/prison-health-care-crisis-mounts-as-incarcerated-population-ages/> [<https://perma.cc/D6PH-6K48>] [hereinafter EJI].

punishment” under the Eighth Amendment.¹⁵ However, subsequent cases, such as *Farmer v. Brennan* (1994), have underscored that “deliberate indifference” requires a subjective recklessness standard: prison officials must be shown to have been aware of and consciously disregarded substantial risk to inmate health.¹⁶ Therefore, mere negligence is insufficient to meet this high burden.¹⁷

This Note examines how deficiencies in correctional health care persist under current legal and regulatory frameworks and proposes a comprehensive approach to enhance health care standards. While cases like those of Walter Jordan, Antonio Arnez Smith, and George Hawkins illustrate the human cost of systemic failures, the proposed framework emphasizes legislative reforms, accreditation mandates, and technology-driven solutions that transcend the challenging standard set by *Estelle*. This Note focuses on prisons rather than jails, as prisons hold individuals for longer periods, which provides a greater opportunity to implement systemic health care improvements and rehabilitative policies. By exploring constitutional and statutory shortcomings, analyzing the role of private health care providers, and focusing on public health and ethical obligations, this Note seeks to balance inmates’ health care rights with the practical realities of correctional facilities.

II. UNDERSTANDING HEALTH CARE IN CORRECTIONAL SETTINGS

This section explores the current state of health care in U.S. prisons by examining its evolution and the legal foundations that shape it today. By exploring these aspects, this section uncovers the challenges and opportunities in providing adequate health care to incarcerated individuals, as well as the broader implications for justice and public health.

A. Contemporary State of Health Care Delivery in U.S. Prisons

“Health care behind bars is bad even in the best scenarios.”¹⁸ With an aging prison population, the strain on these already failing systems continues to grow.¹⁹ Studies have shown that a fifty-nine-year-old in prison has the same morbidity rate as a non-incarcerated seventy-five-year-old, with earlier onset cognitive decline and higher mortality rates.²⁰ Many so-called “natural deaths” in prison have been linked to medical neglect rather than aging itself.²¹

Access to medical care in prisons is severely limited, in part due to the

15. *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

16. *See* 511 U.S. 825, 837–41 (1994).

17. *Id.* at 835.

18. EJI, *supra* note 14.

19. *Id.*

20. Farah Acher Kaikow et al., *Caring for the Rapidly Aging Incarcerated Population: The Role of Policy*, 49 J. GERONTOLOGICAL NURSING 7, 7–11 (2023); EJI, *supra* note 14.

21. *Id.*

exclusion of incarcerated individuals from Medicaid coverage.²² Additionally, prison medical personnel often face ethical and operational conflicts, where institutional policies sometimes override patients' health needs.²³ In some cases, this means clearing individuals for punitive measures, like solitary confinement, despite its well-documented adverse health effects.²⁴

1. Oversight and Accreditation Efforts

Organizations such as the National Commission on Correctional Health Care ("NCCHC") have established standards for correctional health care in an effort to improve oversight and accountability.²⁵ These standards address: governance and administration; health promotion, safety, and disease prevention; personnel and training; ancillary health care services; patient care and treatment; special needs and services, and medical-legal issues.²⁶ The NCCHC also offers a Certified Correctional Health Professional ("CCHP") certification for health care professionals working in correctional facilities.²⁷ In 2017, the NCCHC expanded access to its CCHP certification through nationwide computer-based testing sites.²⁸ The CCHP credential signifies a provider's mastery of NCCHC standards and commitment to quality patient care in correctional settings.²⁹ While accreditation establishes essential guidelines for correctional health care, the integration of innovative technologies, such as telemedicine and electronic health records ("EHR"), has become a crucial component in improving health care access and continuity for incarcerated individuals.

22. Sam McCann, *Health Care Behind Bars: Missed Appointments, No Standards, and High Costs*, VERA (June 29, 2022), <https://www.vera.org/news/health-care-behind-bars-missed-appointments-no-standards-and-high-costs> [https://perma.cc/XNM8-JXER].

23. *Id.*

24. *Id.*

25. Wendy Habert, *Standards for Health Services in Juvenile Detention & Confinement Facilities: What's New?*, NAT'L COMM'N ON CORR. HEALTH CARE (2022), <https://www.ncchc.org/wp-content/uploads/2022-Standards-for-Health-Services-Whats-New.pdf> [https://perma.cc/XNM8-JXER].

26. *Standards for Health Services in Jails/Prisons*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://www.ncchc.org/jails-and-prisons/> [https://perma.cc/2PGB-J2H6] (last visited Mar. 16, 2026).

27. *Certification as a Talent Management Strategy*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://ncchc.org/certification-as-a-talent-management-strategy/> [https://perma.cc/5MZQ-MY4] (last visited May 28, 2026).

28. *NCCHC Historical Time Line*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://www.ncchc.org/historical-time-line/> [https://perma.cc/9XS2-WVNF] (last visited Mar. 16, 2026) [hereinafter NCCHC Time Line].

29. *Id.*

2. Role of Telemedicine and Electronic Health Records (EHR)

a. Telemedicine

Telehealth serves as an alternative approach to conventional care across a range of health care disciplines, particularly for populations with limited access to health care services, such as those in rural and remote communities.³⁰ The term “telehealth” refers to the delivery of health services at a distance using information and communication technologies, encompassing patient and professional education, health care administration, and clinical services.³¹ Telemedicine, a subset of telehealth, specifically involves remote clinical care.³² It can operate in two primary forms: synchronous (real-time consultations using videoconferencing) and asynchronous (technologies that allow medical data, such as images and diagnostic test results, to be reviewed later).³³

Within correctional facilities, telemedicine has emerged as a viable solution for improving health care access, particularly in overcoming logistical and security barriers to in-person consultations.³⁴ Studies show that telehealth can be as effective as conventional care, offering benefits such as reduced transportation costs, improved access to specialists, and more timely medical interventions.³⁵ It provides remote consultations with medical professionals and is utilized for both routine and urgent care.³⁶ Research dating back to the 1990s demonstrated the effectiveness of telemedicine in correctional settings, and by 2011, it had been widely adopted across the United States, especially in rural or isolated areas.³⁷

Despite these benefits, telehealth implementation in prisons faces significant challenges. Many facilities struggle with technological limitations, inconsistent internet connectivity, and concerns about patient confidentiality.³⁸

30. *Telehealth and Health Information Technology in Rural Healthcare*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/telehealth-health-it> [https://perma.cc/SBK4-CBCR] (last visited Mar. 16, 2026) [hereinafter RHlhub].

31. Esther Jie Tian et al., *The impacts of and outcomes from telehealth delivered in prisons: A systematic review*, 16 PLOS ONE 1, 3 (2021).

32. *Id.*

33. *Id.*

34. RHlhub, *supra* note 30.

35. Tian et al., *supra* note 31, at 4, 11.

36. Aaron Timm, *The Role of Wearable Technology in Advancing Inmate Healthcare*, CORRECTIONAL NEWS (Aug. 5, 2024), <https://correctionalnews.com/2024/08/05/the-role-of-wearable-technology-in-advancing-inmate-healthcare/> [https://perma.cc/5H92-A8XZ].

37. PETER L. NACCI ET AL., NAT'L INST. OF JUST., IMPLEMENTING TELEMEDICINE IN CORRECTIONAL FACILITIES 16 (2002), <https://www.ojp.gov/pdffiles1/nij/190310.pdf> [https://perma.cc/Z3RF-TN4K]; KARISHMA A. CHARI ET AL., NAT'L CTR. FOR HEALTH STATS., PUB. NO. 96, NATIONAL SURVEY OF PRISON HEALTH CARE: SELECTED FINDINGS (2016), <https://www.cdc.gov/nchs/data/nhsr/nhsr096.pdf> [https://perma.cc/26W8-VWQ6].

38. RHlhub, *supra* note 30; Sarah Wurzburg, *Three Things to Know About Implementing Telehealth in Correctional Facilities*, COUNCIL OF STATE GOV'TS (Apr. 12, 2021),

Institutional hesitancy, inadequate infrastructure, and restrictive security protocols further limit its effectiveness.³⁹ Additionally, the success of virtual consultations depends on the willingness of both medical providers and incarcerated individuals to engage with telehealth systems.⁴⁰ While telehealth is not a complete replacement for in-person care, optimizing its use—through improved training, standardized procedures, and stronger institutional support—could help bridge critical gaps in correctional health care and ensure more equitable access to medical treatment.

b. Electronic Health Records (EHR)

The evolution of medical records in correctional health care reflects broader technological advancements in health care technology and standards. Historically, prisons relied on paper-based records, with physical files stored in cabinets and lab results manually attached to patient charts.⁴¹ However, the shift to EHRs has revolutionized correctional health care by improving accessibility, efficiency, and continuity of care.⁴² The NCCHC has supported this transition by updating its standards to emphasize the use of EHRs, ensuring compliance with privacy, security, and confidentiality regulations.⁴³ EHRs offer several advantages in correctional settings, including improved care coordination, reduced redundant testing, and better documentation.⁴⁴ While patient portals are widely available in free-world health care systems, incarcerated individuals often lack access to their own medical records, creating barriers to continuity of care upon release.⁴⁵

Despite these benefits, several challenges hinder the full implementation of EHRs in correctional facilities. A case study of the New York City jail system illustrates both the advantages and difficulties of adopting EHRs.⁴⁶ One major challenge is correctional institutions' reluctance to invest in health information infrastructure, largely due to concerns over legal liability, security risks, and financial constraints.⁴⁷ Furthermore, interoperability issues, specifically the ability of jail-based EHRs to integrate with external health care systems, remain

<https://csgjusticecenter.org/2021/04/12/three-things-to-know-about-implementing-telehealth-in-correctional-facilities/> [https://perma.cc/H36Y-C8JU].

39. Tian et al., *supra* note 31 (finding that implementation of prison telehealth is constrained by security restrictions, resource limitations, and local contextual barriers).

40. Wurzburg, *supra* note 38.

41. Pauline Marcussen, *A Brief History of Medical Records in Corrections*, NAT'L COMM'N ON CORR. HEALTH CARE (Sep. 15, 2023), <https://www.ncchc.org/a-brief-history-of-medical-records-in-corrections/> [https://perma.cc/U8LY-PFDR].

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.*

46. Michelle Martelle et al., *Meaningful Use of an Electronic Health Record in the New York City Jail System*, 105 AM. J. PUB. HEALTH 1752, 1752–54 (2015).

47. *Id.*

a significant barrier because they impede seamless tracking. Studies highlight that the lack of data sharing between jail and community health systems contributes to poor continuity of care, increased risk of recidivism, and preventable adverse health outcomes among formerly incarcerated individuals.⁴⁸

To fully leverage the benefits of EHRs in correctional health care, institutions must address security concerns, improve health information exchange, and ensure that incarcerated individuals have better access to their medical records upon release. Interoperability improvements between jail health systems and community providers have been shown to enhance reentry outcomes, reduce hospitalizations, and facilitate better care coordination.⁴⁹ Balancing security protocols with the need for effective, continuous health care is crucial to enhancing the quality of correctional health care.

3. The Consequences of Inadequate Prison Health Care

The failures of prison health care extend beyond incarceration and affect individuals post-release as well.⁵⁰ Studies indicate that incarceration significantly exacerbates health risks.⁵¹ For instance, cancer mortality rates are higher among incarcerated individuals compared to the general population, and formerly incarcerated individuals face an elevated risk of hospitalization and death from heart disease.⁵² Most critically, within the first two weeks of release, the risk of death is more than twelve times higher than that of non-incarcerated individuals.⁵³ These alarming health disparities highlight the longstanding deficiencies in correctional health care. To fully understand the challenges facing incarcerated individuals today, it is essential to examine the historical evolution of prison health care and the policies that have shaped its development.

B. Historical Evolution of Correctional Health Care Standards

Eighth Amendment prison litigation was largely absent before the 1960s

48. Geoffrey Glowallaa & Vignesh Subbianb, *Data Sharing between Jail and Community Health Systems: Missing Links and Lessons for Re-entry Success*, 290 MEDINFO 47, 47 (2021).

49. *Id.*

50. Leah Wang, *Chronic Punishment: The unmet health needs of people in state prisons*, PRISON POL'Y INITIATIVE (June 2022), <https://www.prisonpolicy.org/reports/chronicpunishment.html#insurance> [<https://perma.cc/V2DA-WNXE>].

51. *See infra* notes 52–53.

52. Wang, *supra* note 50; Christopher R. Manz, Varshini S Odayar & Deborah Schrag, *Disparities in cancer prevalence, incidence, and mortality for incarcerated and formerly incarcerated patients: A scoping review*, 10 CANCER MED. 7277 (2021); Emily Wang et al., *Cardiovascular Disease in Incarcerated Populations*, 69 J AM. COLL. CARDIOLOGY 2968, 2970 (2017).

53. Wang, *supra* note 50; Ingrid A. Binswanger et al., *Release from Prison — A High Risk of Death for Former Inmates*, 356 N ENG. J. MED. 157, 161 (2007).

due to several key legal barriers.⁵⁴ Prior to *Robinson v. California*, the Eighth Amendment did not apply to the states, meaning state prisoners could not challenge their conditions under federal constitutional law.⁵⁵ Additionally, *Monroe v. Pape* expanded the scope of 42 U.S.C. § 1983, allowing individuals to sue state officials for constitutional violations.⁵⁶ Lastly, *Cooper v. Pate* marked a shift in federal court involvement, permitting prisoners to bring constitutional claims against state prison officials, whereas earlier federal courts had generally deferred to state prison management.⁵⁷ These rulings dismantled the legal barriers that prevented prisoners from pursuing Eighth Amendment claims, setting the stage for a wave of prison litigation in subsequent decades.⁵⁸ However, the systematic deficiencies remained, especially with the Social Security Act (“SSA”) Amendments of 1965, which created Medicare and Medicaid but explicitly prohibited these federal programs from subsidizing health care in jails and prisons.⁵⁹ This omission was significant because it exempted correctional health care systems from quality oversight mandates.⁶⁰ Early anecdotal and scientific evidence studies found that incarcerated individuals often entered correctional facilities in poor health and that prisons lacked adequate health care to address their medical needs.⁶¹ As research on correctional health care began emerging around 1970, many early reports were often based on anecdotal evidence rather than experimental data.⁶² Moreover, the few studies that attempted to field-test issues in prison health care delivery were plagued by methodological flaws.⁶³ Despite these shortcomings, these studies consistently highlighted key findings: incarcerated individuals suffered from higher rates of chronic illnesses, substance use disorders, and mental health conditions compared to the general population.⁶⁴ Additionally, many facilities lacked even basic medical services, and the conditions within prisons and jails often exacerbated existing health problems. Although imperfect, these early studies were instrumental in exposing systemic deficiencies and shaping future discussions on prison health care reform.⁶⁵

54. *Eighth Amendment Prison Litigation*, FED. JUST. CTR., <https://www.fjc.gov/history/spotlight-judicial-history/eighth-amendment-prison-litigation> [https://perma.cc/GUP7-3ASW] (last visited Mar. 16, 2026) [hereinafter FJC].

55. *Robison v. California*, 370 U.S. 660 (1962); see FJC, *supra* note 54.

56. *Monroe v. Pape*, 365 U.S. 167, 167 (1961); see FJC, *supra* note 54.

57. *Cooper v. Pate*, 378 U.S. 546, 546 (1964); see FJC, *supra* note 54.

58. FJC, *supra* note 54.

59. James René Jolin et al., *Correctional Healthcare — an Engine of Health Inequity*, 38 J. GEN INTERN MED. 216, 216–18 (2022).

60. *Id.*

61. B. JAYE ANNO, NAT’L INST. OF CORR., CORRECTIONAL HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM 10–11 (2001), <https://s3.amazonaws.com/static.nicic.gov/Library/017521.pdf> [https://perma.cc/SBW6-QC6D].

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

In the early 1970s, prominent organizations such as the American Public Health Association (“APHA”), the American Bar Association (“ABA”), and the American Medical Association (“AMA”) began advocating for improved prison health care standards.⁶⁶ Recognizing the growing urgency of these issues, the American Civil Liberties Union (“ACLU”) launched its National Prison Project in 1972 to address systemic deficiencies in correctional health care.⁶⁷ Two years later, the Commission on Accreditation for Corrections (“CAC”), the official accrediting body of the American Correctional Association (“ACA”), was established to promote accountability and quality in correctional facilities.⁶⁸ The CAC brought together a diverse group of professionals across various fields, including adult and juvenile corrections, probation, parole, and correctional health services.⁶⁹

After the Supreme Court’s decision in *Estelle v. Gamble*, efforts to reform correctional health care gained traction.⁷⁰ In 1977, the AMA held its first National Conference on Improved Medical Care and Health Services, now known as the National Conference on Correctional Health Care.⁷¹ This event set the stage for the publication of the AMA’s first set of health standards for prisons and juvenile confinement institutions in 1979.⁷² By 1983, the National Commission on Correctional Health Care (“NCCHC”) was established to develop standards and accreditation policies, further solidifying the foundation for improved correctional health care.⁷³ Later, in 1989, the Journal of Correctional Health Care was introduced, providing a peer-reviewed platform to advance research and best practices in this field.⁷⁴

C. Constitutional and Legislative Foundations of Prison Health Care

1. The Constitutional Basis for Prison Health Care

The Eighth Amendment of the U.S. Constitution prohibits cruel and unusual punishment, a principle that extends to the medical care of incarcerated

66. Susan Reverby, *Can There Be Acceptable Prison Health Care? Looking Back on the 1970s*, 134 PUB. HEALTH REP. 89, 90 (2019).

67. *American Civil Liberties Union (National Prison Project)*, BARBARA MCDOWELL SOC. JUST. CTR. (2011), <https://www.mcdowellsocialjusticecenter.org/grantees/american-civil-liberties-union> [<https://perma.cc/RCX8-NK5N>].

68. *Commission on Accreditation for Corrections*, AM. CORR. ASS’N, <https://www.aca.org/certifications-and-accreditation/commission-on-accreditation> [<https://perma.cc/2835-XF6D>] (last visited Mar. 16, 2026) [hereinafter CAC].

69. *Id.*

70. William J. Rold, *Thirty Years After Estelle v. Gamble: A Legal Retrospective*, 14 J. CORR. HEALTH CARE 11, 17–18 (2008).

71. NCCHC Time Line, *supra* note 28.

72. *Id.*

73. *Id.*; *About us*, NAT’L COMM’N ON CORR. HEALTH CARE, <https://ncchc.org/about-us/> [<https://perma.cc/UZK7-DJK6>] (last visited May 28, 2026).

74. Reverby, *supra* note 66.

individuals.⁷⁵ The Supreme Court first addressed this issue *Estelle v. Gamble*, a landmark case that set the constitutional standard for prison health care.⁷⁶ In *Estelle*, the Court ruled that deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment under the Eighth Amendment.⁷⁷ However, the Court distinguished between medical malpractice and constitutional violations, emphasizing that negligence alone does not meet the constitutional threshold for an Eighth Amendment violation.⁷⁸

J.W. Gamble, an inmate of the Texas Department of Corrections, filed a lawsuit under 42 U.S.C. § 1983⁷⁹ arguing that prison officials violated his constitutional rights by providing inadequate medical care following an injury sustained during prison labor.⁸⁰ While the Court acknowledged that prisoners have a constitutional right to medical care, it found that Gamble's treatment did not rise to the level of deliberate indifference because medical personnel saw him multiple times.⁸¹ Justice Thurgood Marshall, writing for the majority, reaffirmed that the Eighth Amendment embodies "broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . .," against which penal measures must be evaluated.⁸² The Court relied on this reasoning to explain why prison health care must meet evolving standards of decency.⁸³ However, the ruling carefully limited the scope of constitutional claims, making it clear that not every instance of inadequate medical treatment constitutes an Eighth Amendment violation.⁸⁴

For a claim to succeed, an inmate must prove more than an accident, medical negligence, or an inadvertent failure to provide care.⁸⁵ The Court clarified that an accident, even if it causes suffering, does not constitute cruel and unusual punishment.⁸⁶ Likewise, an unintentional failure to provide medical care, no matter how harmful, does not meet the standard of "wanton infliction of unnecessary pain."⁸⁷ Medical malpractice claims are governed by state law, rather than the Eighth Amendment.⁸⁸ Thus, a complaint about a physician's negligence in diagnosing or treating a medical condition is not a valid claim of

75. U.S. CONST. amend. VIII; Gabriel B Eber, *Using the Constitution to Improve Prisoner Health*, 99 AM. J. PUB. HEALTH 1541, 1541–42 (2009), <https://pmc.ncbi.nlm.nih.gov/articles/PMC2724445/> [<https://perma.cc/W6TP-RNLN>].

76. Rold, *supra* note 70, at 13.

77. *Estelle v. Gamble*, 429 U.S. 97, 116 (1976).

78. *Id.* at 106.

79. The Civil Rights Act of 1871; *see infra* Part II.C.2.

80. *Estelle*, 429 U.S. at 98.

81. *Id.* at 97.

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

83. *Id.* at 102 (citing *Troop v. Dulles*, 356 U.S. 86, 101 (1958)).

84. *Id.* at 105.

85. *Id.* at 105–06.

86. *Id.* at 105.

87. *Id.* at 105–06.

88. *Id.* at 97.

medical mistreatment under the Eighth Amendment.⁸⁹ This distinction underscores why proving a Constitutional violation in the context of prison health care is particularly challenging. A prisoner must demonstrate that officials were aware of a serious medical need and deliberately failed to address it.

Another significant decision that broadens the scope of Eighth Amendment prison claims is *Helling v. McKinney*.⁹⁰ The Supreme Court held that McKinney could base his Eighth Amendment claim on the potential future health risks of exposure to environmental tobacco smoke.⁹¹ This ruling was pivotal in establishing that prison officials have a constitutional duty to address not only immediate health concerns but also conditions that pose a substantial risk of serious harm over time.⁹² By recognizing the importance of preventative measures, *Helling* reinforced the principle that deliberate disregard for an inmate's long-term well-being can constitute cruel and unusual punishment under the Eighth Amendment.

2. Statutory Barriers and Prisoners' Rights Litigation

Despite the constitutional protections recognized in *Estelle*, statutory barriers continue to complicate prisoners' ability to bring Eighth Amendment claims.⁹³ One of the primary legal mechanisms for asserting such claims is 42 U.S.C. § 1983, a statute originally enacted as part of the Ku Klux Klan Act of 1871 to combat racial violence and state-sanctioned civil rights violations during Reconstruction.⁹⁴ However, for much of the 20th century, § 1983 remained largely dormant as a tool for litigation against state officials. This changed with *Monroe*, in which the Supreme Court broadly interpreted the phrase "under color of state law" to include abuses of authority by public officials, even when their actions were not explicitly authorized by state law.⁹⁵ This ruling expanded access to federal courts for plaintiffs alleging constitutional violations by state actors, including prison commissioners and wardens.⁹⁶ Yet, despite this broader interpretation, prevailing on a § 1983 claim remains challenging, as plaintiffs must demonstrate that a state official deprived them of a constitutional right and substantiate their claim with specific factual evidence rather than conclusory allegations.⁹⁷

89. *Id.* at 106.

90. *Helling v. McKinney*, 509 U.S. 25 (1993).

91. *Id.*

92. *See id.*

93. Andrea Fenster & Margo Schlanger, *Slamming the Courthouse Door: 25 years of evidence for repealing the Prison Litigation Reform Act*, PRISON POL'Y INITIATIVE (Apr. 26, 2021), https://www.prisonpolicy.org/reports/PLRA_25.html [<https://perma.cc/9TKT-VM9H>].

94. FJC, *supra* note 54.

95. *Monroe v. Pape*, 365 U.S. 167 (1961).

96. *Id.*

97. *Jolly v. Klein*, 923 F. Supp. 931, 943 (S.D. Tex. 1996).

Congress first authorized federal oversight of prison conditions through the Civil Rights of Institutionalized Persons Act (“CRIPA”), which allows the Attorney General to bring civil actions against state institutions exhibiting a pattern or practice of egregious constitutional violations.⁹⁸ However, individual prisoners do not have a private right of action under CRIPA; instead, they must rely on 42 U.S.C. § 1983 for personal claims.⁹⁹ In 1996, Congress imposed significant restrictions on prisoner lawsuits by enacting the Prison Litigation Reform Act (“PLRA”), fundamentally altering how incarcerated individuals can bring constitutional claims.¹⁰⁰ The PLRA governs civil actions filed by incarcerated individuals regarding prison conditions. The Act imposes several procedural “constraints designed to prevent sportive filings in federal court.”¹⁰¹

Courts are required to conduct an early screening of prisoner complaints, dismissing those deemed “frivolous, malicious, or [that] fail to state a claim upon which relief may be granted.”¹⁰² Additionally, prisoners must fully exhaust all available administrative remedies before filing a federal lawsuit.¹⁰³ Even when grievances are ignored or delayed by prison officials, prisoners may still be required to navigate the full appeals process before their claims are considered properly exhausted.¹⁰⁴ Further, the statute imposes a physical injury requirement, barring claims for mental or emotional harm unless the prisoner can demonstrate a prior showing of physical injury or the commission of a sexual act—a restriction that significantly limits recovery for claims involving psychological trauma.¹⁰⁵

Another problematic provision of the PLRA relates to attorney’s fees.¹⁰⁶ The statute caps attorney compensation at 150% of the monetary judgment awarded, which can result in drastically low fees even in cases where a prisoner prevails on a meritorious constitutional claim.¹⁰⁷ This provision creates a disincentive for attorneys to take on prisoner rights cases, effectively reducing access to legal representation for incarcerated individuals wishing to challenge

98. *Amdt8.4.7 Conditions of Confinement*, CONST. ANNOTATED, https://constitution.congress.gov/browse/essay/amdt8-4-7/ALDE_00000966/ [<https://perma.cc/ZH7Y-A57L>] (last visited Mar. 9, 2025) [hereinafter *Constitution Annotated*]; 42 U.S.C. § 1997 et seq.

99. 42 U.S.C. § 1997e(a).

100. *Constitution Annotated*, *supra* note 98; 42 U.S.C. § 1997e.

101. *Skinner v. Switzer* 562 U.S. 521, 535 (2011); 42 U.S.C. § 1997e.

102. 28 U.S.C. § 1915A.

103. 42 U.S.C. § 1997e(a).

104. COLUMBIA HUM. RIGHTS L. REV., A JAILHOUSE LAWYER’S MANUAL ch. 14 (13th ed. 2024), <https://jlm.law.columbia.edu/a-jailhouse-lawyers-manual-13th-edition/> [<https://perma.cc/UEF3-EMSY>].

105. *See* 42 U.S.C. § 1997e(e); Haleigh Hoskins, *Access Denied: Amending the Prison Litigation Reform Act’s Administrative Remedy and Physical Injury Provisions for Cases of Sexual Assault*, CONG. BLACK CAUCUS FOUND., <https://www.cbcfinc.org/capstones/criminal-justice-reform/access-denied-amending-the-prison-litigation-reform-acts-administrative-remedy-and-physical-injury-provisions-for-cases-of-sexual-assault/> [<https://perma.cc/N5UA-GEZ6>] (last visited Mar. 16, 2026).

106. *See* Fenster & Schlanger, *supra* note 93; 42 U.S.C. § 1997e(d).

107. Fenster & Schlanger, *supra* note 93.

unconstitutional conditions.¹⁰⁸ In 2020, incarcerated civil rights plaintiffs were represented by counsel in only 7.6% of their cases, compared to 89.8% of civil cases not involving incarceration.¹⁰⁹

D. Indiana's Constitutional and Statutory Standards

While the Eighth Amendment and federal statutes like 42 U.S.C. § 1983 and the PLRA establish the constitutional and procedural framework for prison health care claims, state law plays a crucial role in defining correctional health care standards. In Indiana, these standards are shaped by both the state constitution and statutory regulations, which dictate how health care policies are implemented within correctional facilities.

Similar to the Eighth Amendment, Article I, § 16 of the Indiana Constitution states that “cruel and unusual punishments shall not be inflicted.”¹¹⁰ Indiana further refines its approach through Indiana Code § 11-12-4-1, which sets minimum requirements for prison health care, facility security, and public safety.¹¹¹ This statute emphasizes flexibility, allowing regulations to accommodate local needs while maintaining consistency with statewide correctional health care policies.¹¹² The Indiana Department of Health and the Fire Prevention and Building Safety Commission oversee the development and enforcement of these standards.¹¹³

In addition to statutory law, the Indiana Administrative Code (“IAC”) provides further specificity. Section 210 IAC 3-1-11 outlines health care standards for the Indiana Department of Correction (“IDOC”), while 210 IAC 7 governs offender health co-payment policies.¹¹⁴ These regulations help structure health care delivery within Indiana prisons, but modernizing procedures and integrating new technologies, such as electronic medical records or telehealth services, could further enhance compliance and improve health care outcomes for incarcerated individuals.

The case of *Stafford v. Carter* exemplifies the challenges of aligning correctional health care practices with both federal constitutional standards and Indiana’s statutory and regulatory framework.¹¹⁵ In this case, incarcerated individuals with chronic Hepatitis C Virus (“HCV”) alleged that IDOC and its

108. *Id.*

109. *Id.* (noting that all data were collected by Professor Margo Schlanger; prison and jail population data were obtained from the Bureau of Justice Statistics; court filing and outcome data were derived from the Federal Judicial Center’s Integrated Database; and court order coverage data were based on Bureau of Justice Statistics prison and jail censuses conducted periodically since 1983).

110. IND. CONST. art. 1, § 16.

111. IND. CODE § 11-12-4-1(a)(3) (2025).

112. IND. CODE § 11-12-4-1(b).

113. *Id.*

114. 210 IND. ADMIN. CODE 3-1-11 (2025); 210 IND. ADMIN. CODE 7 (2025).

115. See *Stafford v. Carter*, No. 1:17-cv-00289-JMS-MJD, 2018 WL 361639 (S.D. Ind. Sep. 13, 2018).

contracted medical providers systematically denied them access to life-saving direct-acting antiviral (“DAA”) drugs, violating their Eighth Amendment rights and state constitutional protections against cruel and unusual punishment.¹¹⁶ The court certified a class of all current and future IDOC inmates diagnosed with chronic HCV, allowing the plaintiffs to challenge IDOC’s policies on a systemic level.¹¹⁷ This case underscores the importance of ensuring that Indiana’s correctional health care policies not only meet minimum statutory requirements but also adhere to evolving medical standards and constitutional protections.

By aligning correctional health care practices with both Indiana statutes and administrative regulations, Indiana could strengthen its system while maintaining consistency with evolving legal and medical standards. Cases like *Stafford v. Carter* highlight the need for ongoing oversight and reform to ensure that incarcerated individuals receive adequate and timely medical care.

III. STRUCTURAL FAILURES AND REFORM IN CORRECTIONAL HEALTH CARE

A. Systemic Health Challenges in Correctional Settings

1. COVID-19

The COVID-19 pandemic exposed major weaknesses in prison health care by demonstrating the disproportionate impact of infectious diseases on incarcerated individuals, highlighting systemic vulnerabilities in correctional health care.¹¹⁸ Between April 2020 and April 2021, the mortality rate inside American jails was nearly 2.5 times the broader population.¹¹⁹ However, inconsistent reporting and data collection make it difficult to assess the full extent of the crisis.¹²⁰ These disparities reflect a broader lack of oversight and accountability in correctional health care, further perpetuating these inequalities.¹²¹ The pandemic also exacerbated resource shortages in correctional facilities, many of which were unable to handle the sharp surge in critically ill patients, leading to delays or denials of medical treatment.¹²² Chronic disease management suffered, with reports indicating that more than 50% of surveyed countries experienced disruptions in essential health care services, including

116. *Id.* at *1.

117. *Id.*

118. *COVID-19 in Prisons and Jails*, PRISON POL’Y INITIATIVE (July 2024), <https://www.prisonpolicy.org/virus/> [<https://perma.cc/VK6T-36Q4>].

119. Jolin et al., *supra* note 59, at 216 (citing Marquez N, Ward et al., *COVID-19 Incidence and Mortality in Federal and State Prisons Compared with the US Population*, 326 JAMA 1865, 1865–1867 (2021)).

120. *Id.*

121. *Id.*

122. Abdul Rahman Jazieh, *COVID-19 Pandemic as a Catalyst for Healthcare Transformation: Finding the Silver Lining in a Global Catastrophe*, 3 GLOB. J. ON QUALITY & SAFETY IN HEALTHCARE 117, 117 (2020).

treatments for hypertension, diabetes, and/or cardiovascular conditions.¹²³ While the pandemic devastated correctional health care systems, it also prompted calls for reform, highlighting the urgent need for preventive health care models, improved infection control, and better integration of prison health services with broader public health frameworks.¹²⁴

2. Social Determinants of Health (SDOH) and Incarceration

Incarceration is deeply connected to broader public health and social inequities. The health challenges begin before imprisonment and persist after release.¹²⁵ Preexisting health disparities, combined with the stressors and environmental conditions of incarceration, contribute to poorer health outcomes among incarcerated populations.¹²⁶ Additionally, the social and economic consequences of incarceration—such as employment barriers, housing instability, and lack of post-release medical care—create long-term public health concerns that extend beyond prison walls.¹²⁷ The Social Determinants of Health (“SDOH”) framework helps explain how socioeconomic instability, limited health care access, and marginalized backgrounds contribute to the health disparities seen in incarcerated populations.¹²⁸ By viewing incarceration itself as a social determinant of health, policymakers and health care providers can better understand the structural changes needed to improve health outcomes in correctional settings.

According to the World Health Organization (“WHO”), social determinants of health are the non-medical factors that influence health outcomes.¹²⁹ These factors include “the conditions in which people are born, grow, live, work, and age.”¹³⁰ The five key areas of SDOH are health care access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment.¹³¹

Incarceration itself has been considered a social determinant of health, as it

123. *Id.*

124. See generally *id.*; Newton E. Kendig et al., *Infection Prevention and Control in Correctional Setting*, 30 EMERGING INFECTIOUS DISEASES S88, S88, S91 (2024).

125. Louise Reagan et al., *Health equity for people living in correctional facilities: Addressing bias, stigma, and dehumanization*, 47 RSCH. NURS. & HEALTH 359, 359 (2024).

126. *Id.* at 359–60.

127. ROBERT WOODS FOUND., MASS INCARCERATION THREATENS HEALTH EQUITY IN AMERICA 3 (2019), <https://www.rwjf.org/en/insights/our-research/2019/01/mass-incarceration-threatens-health-equity-in-america.html> [<https://perma.cc/FX8Y-6Y93>]; Dora M. Dumont et al., *Public Health and the Epidemic of Incarceration*, 33 ANNU. REV. PUB. HEALTH 325, 331–34 (2012).

128. Shivani Nishar et al., “It’s a revolving door”: understanding the social determinants of mental health as experienced by formerly incarcerated people, 11 HEALTH JUST. 1, 1, 3–5 (2023).

129. *Social Determinants of Health (SDOH)*, U.S. CTRS. FOR DISEASE CTRL. & PREVENTION (Jan. 17, 2024), <https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html> [<https://perma.cc/B2GG-7JQD>].

130. *Id.*

131. *Id.*

disrupts nearly every aspect of an individual's social and economic stability.¹³² Incarcerated individuals disproportionately come from marginalized communities with existing social and structural inequities, which incarceration often exacerbates.¹³³ Limited resources and the isolating nature of prison life can lead to deteriorated health over time.¹³⁴ Moreover, the stigma of incarceration reinforces these structural inequities during reentry, creating additional barriers to employment, housing stability, and post-release health care.¹³⁵ Addressing incarceration as a social determinant of health requires systemic reforms that extend beyond the prison walls. Adopting holistic, cross-sector public health approaches to criminal justice policy, improving access to health care, and addressing the structural inequities that lead to incarceration are essential to mitigating their long-term impact on individual and community health.¹³⁶

3. *Consequences of Underfunded Medical Services*

Correctional health care has long been viewed as a paradox—facilities are expected to provide meaningful medical services, yet the very nature of incarceration often undermines health.¹³⁷ As one scholar explains, “Understanding the connection between prisons and health requires us to hold both of these ideas at the same time: prisons can undermine health and provide meaningful health care services, and they operate in an environment that insists on both.”¹³⁸

Structural deficiencies in prison health care systems increase this tension, leading to long waits for care, missed appointments, and inadequate treatment.¹³⁹ In some facilities, chronic understaffing and the absence of consistent administrative leadership further strain medical services, with reports of nurses working extended shifts and insufficient personnel to ensure continuity of care.¹⁴⁰ This systemic neglect fundamentally contrasts the rehabilitative mission of

132. Lauren Brinkley-Rubinstein & David H. Cloud, *Mass Incarceration as a Social-Structural Driver of Health Inequities: A Supplement to AJPH*, 110 AM. J. PUB. HEALTH S14, S14-15 (2020).

133. *Id.*

134. Lauren Brinkley-Rubinstein, *Incarceration as a catalyst for worsening health*, 1 HEALTH JUST. 1, 5, 7–8 (2013).

135. Brinkley-Rubinstein & Cloud, *supra* note 132.

136. STEVE OLSON & KAREN M. ANDERSON, THE EFFECTS OF INCARCERATION AND REENTRY ON COMMUNITY HEALTH AND WELL-BEING: PROCEEDINGS OF A WORKSHOP ch. 3 (2020), <https://www.nationalacademies.org/read/25471/chapter/4> [<https://perma.cc/MZW3-597Y>].

137. Jason Schnittker, Michael Massoglia & Christopher Uggen, *The ‘Paradox’ of Receiving Health Care in Prison*, UNIV. OF PENN. (Jan. 6, 2023), <https://penntoday.upenn.edu/news/Penn-sociologist-Jason-Schnittker-paradox-receiving-health-care-prison> [<https://perma.cc/XUZ8-59XR>].

138. *Id.*

139. McCann, *supra* note 22.

140. *Overworked and Understaffed Nurses at JCCC: A Resident’s Point of View*, MO. PRISON REFORM (June 12, 2024), <https://moprisisonreform.org/overworked-and-understaffed-nurses-at-jccc-a-residents-point-of-view/> [<https://perma.cc/KM8J-2YY8>].

correctional institutions. Prisons are intended to prepare individuals for reintegration in society, yet conditions behind bars frequently contribute to chronic illness, worsen mental health, and are associated with reduced life expectancy.¹⁴¹ This poses a broader public health challenge, as individuals returning to their communities often do so in worse health, increasing burdens on social services and health care systems.

Research indicates that continuity of health care during and after incarceration plays an important role in recidivism reduction.¹⁴² When treatment initiated in prison is continued after release—through mechanisms such as Medicaid enrollment, medication continuity, and provider linkages—the public health and recidivism-reduction benefits of correctional health programs are preserved.¹⁴³ Conversely, when care is disrupted at the point of reentry, those benefits may be undermined, increasing instability and adverse outcomes that complicate reintegration.¹⁴⁴

Addressing these issues requires systemic reforms that prioritize health and wellness within correctional facilities. Administrative solutions, such as improved funding allocation, accreditation standards, and expanded health care services, could help extend life expectancy among incarcerated individuals while ensuring they reenter society in better health, ready to contribute as productive members of their communities.

B. Legal and Policy Barriers to Effective Health Care

1. Administrative Law's Role in Shaping Prison Health Care Standards

Administrative law serves as the backbone for establishing and regulating health care standards in correctional facilities by defining rules that provide systemic guidelines supplementing constitutional protections.¹⁴⁵ Unlike the reactive nature of Eighth Amendment claims, administrative regulations proactively address the delivery and quality of care, emphasizing consistency and efficiency across correctional systems.¹⁴⁶ Sub-regulatory policies, such as agency manuals, guidance documents, and policy statements, further shape these standards by interpreting and implementing broader regulatory mandates

141. Nazish Dholakia, *Mass Incarceration Is a Public Health Crisis*, VERA (June 17, 2025) <https://www.vera.org/news/mass-incarceration-is-a-public-health-crisis> [<https://perma.cc/9TX4-6HZW>].

142. Matt McKillop, *After Prison Protects Investments and Progress*, PEW CHARITABLE TRS. (June 22, 2018), <https://www.pew.org/en/research-and-analysis/articles/2018/06/22/health-care-continuity-after-prison-protects-investments-and-progress> [<https://perma.cc/C98S-9X9F>].

143. *Id.*

144. *Id.*

145. See *Administrative Law*, LEGAL INFO. INST. CORNELL L. SCH., https://www.law.cornell.edu/wex/administrative_law [<https://perma.cc/NA3T-K766>] (last visited Mar. 16, 2026).

146. Rold, *supra* note 70, at 18 (noting that the prospect of litigation prompted corrections officials to develop professional standards proactively, rather than waiting to be sued).

without undergoing the full rulemaking process.¹⁴⁷ Accreditation standards and policy guidance often function to standardize procedures and clarify expectations, even where they are not legally binding.¹⁴⁸ Their flexibility enables agencies to adapt to evolving challenges while maintaining oversight that aligns with constitutional and statutory requirements.

Under the doctrine of *Chevron* deference, courts historically deferred to an agency's reasonable interpretation of ambiguous statutes, recognizing that agencies possess subject-matter expertise in their respective fields.¹⁴⁹ This principle allowed agencies, including those overseeing correctional health care, to establish and implement standards without excessive judicial interference. However, the recent limitation of *Chevron* deference raises questions about the extent of discretion prison medical providers and regulatory agencies now have in setting health care standards.¹⁵⁰ Without *Chevron*, courts are more likely to scrutinize agency decisions, requiring a clearer statutory basis for administrative rules. This shift increases the burden on agencies to ensure that correctional health care policies are explicitly authorized by legislation, making them more vulnerable to legal challenges if they lack clear congressional backing. For example, Indiana Administrative Code § 210-3-1-11 outlines specific health care standards for the Department of Correction, ensuring that medical services provided to incarcerated individuals align with state-mandated requirements.¹⁵¹ The Indiana Department of Correction's Health Service Policy, outlined in Policy 01-02-101, establishes additional guidelines to safeguard the mental and physical health of incarcerated individuals.¹⁵² These policies emphasize that care must be tailored to address serious medical conditions, prioritizing medically necessary treatment to prevent loss of life, disability, or significant pain.¹⁵³ The policy further mandates the use of clinical judgment by licensed medical professionals, with the Chief Medical Officer holding ultimate clinical authority.¹⁵⁴ By setting clear standards within Indiana's regulatory framework, these policies reinforce the state's responsibility to provide constitutionally

147. Hannah L. Cross & Lester J. Perling, *The Return of Subregulatory Guidance Reliance*, NELSON MULLINS (Sep. 7, 2021), https://www.nelsonmullins.com/insights/blogs/healthcare_essentials/regulatory_compliance/the-return-of-subregulatory-guidance-reliance [https://perma.cc/53ZB-LK5R].

148. *Policies and Procedures*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://ncchc.org/q-a/policies-and-procedures/> [https://perma.cc/H7RR-2GAK] (last visited May 28, 2026).

149. *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 865 (1984); Michael R. Blumenthal et al., *The End of Chevron Deference: What Does It Mean, and What Comes Next?*, AM. BAR ASS'N. (Aug. 16, 2024), https://www.americanbar.org/groups/business_law/resources/business-law-today/2024-august/end-chevron-deference-what-does-it-mean-what-comes-next/ [https://perma.cc/BDV5-QX82].

150. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024).

151. *See* 210 IND. ADMIN. CODE 3-1-11 (2025).

152. *See* IND. DEP'T OF CORR., POL'Y & ADMIN. PROC. MANUAL OF POL'YS & PROCS., 01-02-101 (Apr. 1, 2022), <https://www.in.gov/idoc/files/01-02-101-Health-Services-4-1-2022.pdf> [https://perma.cc/ALL2-J7QG] [hereinafter *Indiana Health Services Policy*].

153. *Id.*

154. *Id.*

adequate health care while maintaining state-level administrative oversight.¹⁵⁵ Administrative regulations in correctional health care also interface with accreditation standards set by organizations like the NCCHC, further emphasizing the collaborative role of administrative frameworks in raising the quality of inmate health care.¹⁵⁶ Moving forward, administrative solutions must carefully balance flexibility, cost-efficiency, and accountability to ensure that regulations are both effective and legally defensible in a post-*Chevron* landscape.

However, administrative policies are only as effective as the resources available to implement them. Recent federal decisions, such as the hiring freeze imposed by the Trump administration, have exacerbated chronic staffing shortages within the Bureau of Prisons, leading to severe gaps in medical care.¹⁵⁷ At FMC Devens, a federal medical center, 24% of Health Services positions remain vacant, and 39% of Psychology Services roles are unfilled.¹⁵⁸ Such shortages limit access to necessary medical treatment, undermining the very administrative safeguards designed to ensure adequate health care. These deficiencies highlight the fragile balance between administrative oversight and resource allocation, raising concerns about the sustainability of correctional health care policies in the face of bureaucratic and political shifts.

2. Privatization's Negative Impact on Correctional Health Care

The privatization of correctional health care has raised serious concerns about quality, accountability, and financial incentives. Many state and local governments contract private companies to provide medical services in prisons and jails, often prioritizing cost-saving measures over patient care. This model has led to issues such as understaffing, inadequate medical treatment, and avoidable deaths. Additionally, private health care providers often operate with limited oversight, and indemnification clauses shield government entities from legal liability, reducing incentives for meaningful reform.

a. Challenges in privatized health care

Incarcerated individuals have no say in who provides their medical care, as

155. *Id.*

156. See *Standards: A framework for quality*, NAT'L COMM'N ON CORR. HEALTH CARE, <https://ncchc.org/standards/> [<https://perma.cc/H6GW-9RA4>] (last visited Mar. 16, 2026).

157. Walter Pavlo, *Sweeping Changes for the Bureau of Prisons Under the Trump Administration*, PRISONOLOGY (Jan. 23, 2025), <https://www.prisonology.com/blog/sweeping-changes-for-the-bureau-of-prisons-under-the-trump-administration> [<https://perma.cc/Rf8D-FKSV>].

158. *Id.* (citing Press Release, U.S. Dep't of Just. Off. of the Inspector Gen., DOJ OIG Releases an Inspection of the BOP's Federal Medical Center Devens (Dec. 11, 2024), <https://oig.justice.gov/news/doj-oig-releases-inspection-bops-federal-medical-center-devens> [<https://perma.cc/RXB3-WF7A>]).

health care services are determined entirely by contracts between private companies and state or local governments.¹⁵⁹ These contracting decisions are often driven by budgetary considerations rather than care quality, and because contracts frequently shield government entities from legal liability, officials have little incentive to address patient or worker complaints when renewing them.¹⁶⁰

In 2015, only seventeen states had self-operated correctional health care systems, and thirty-two states contracted at least a portion of their health services to an outside vendor.¹⁶¹ Correctional health care in the U.S. is a multibillion-dollar industry dominated by a handful of large companies, including private equity-owned Wellpath and YesCare (f/k/a Corizon Health).¹⁶² The dominance of private equity-owned firms in the market significantly limits the options available to local governments when selecting providers for correctional health care services.¹⁶³ Private equity's dominance in prison and jail health care services can be traced back to the industry's shift toward privatization in the 1970s.¹⁶⁴ By 2009, approximately 40% of correctional health care, amounting to \$3 billion annually, was managed by private companies.¹⁶⁵ One of the main reasons that prisons and jails turn to private health care providers is to limit legal liability.¹⁶⁶ This structure is often implemented through indemnification provisions that make the health care company responsible for costs, expenses, and liabilities associated with correctional health care, requiring it to compensate care-related costs and liabilities incurred by its government-entity client.¹⁶⁷ While state administrative regulations set standards for correctional health care, private contractors may not always be subject to the same requirements, particularly if contracts lack enforcement mechanisms or oversight provisions.¹⁶⁸ This regulatory gap allows private providers to operate with varying levels of accountability. In Kansas and Missouri alone, Corizon held nearly \$2 billion in contracts, yet Missouri's contract contained no performance penalties or bonuses, and the state collected

159. Michael Fenne, *Privatized prison healthcare seeks profit at patients' expense*, PRIV. EQUITY STAKEHOLDER PROJECT (Oct. 17, 2023), <https://pestakeholder.org/news/privatized-prison-healthcare-seeks-profit-at-patients-expense/> [https://perma.cc/QJ7P-9NY5].

160. *Id.*

161. PEW CHARITABLE TRS., *STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE: HOW STATES SET UP AND FINANCE OFF-SITE CARE FOR INCARCERATED INDIVIDUALS 4* (July 2018), https://www.pewtrusts.org/-/media/assets/2018/07/prisons-and-hospital-care_report.pdf [https://perma.cc/D4UE-RJGV].

162. Fenne, *supra* note 159.

163. *Id.*

164. Reverby, *supra* note 66.

165. Fenne, *supra* note 159.

166. *Id.*

167. Fenne, *supra* note 159.

168. Jolin et al., *supra* note 59; Jason Szep et al., *Dying Inside The Hidden Crisis in America's Jails Part Two*, REUTERS (Oct. 26, 2020), <https://www.reuters.com/investigates/special-report/usa-jails-privatization/> [https://perma.cc/8WTB-DMT2].

no data on inmate health outcomes, leaving legislators with little ability to evaluate the contractor's performance.¹⁶⁹ Contracts with private providers often lack quantified standards for care, such as staffing requirements or protocols governing hospitalization decisions.¹⁷⁰ The structure of these arrangements has drawn criticism for allowing government officials to deflect responsibility onto private contractors, further complicating efforts to ensure consistent health care standards across facilities.¹⁷¹

b. Financial incentives and service cuts

The structure of private correctional health care contracts creates powerful financial incentives that can work against patient care. The primary objective of a private equity-owned company is profit maximization, and one of the principal mechanisms for achieving that goal is cost reduction.¹⁷² This dynamic is particularly evident in correctional health care, where most contracting states rely on capitated payment models that provide fixed per-person rates regardless of the volume or intensity of care delivered.¹⁷³ Under a capitated structure, vendors receive a fixed payment per individual and bear financial risk when costs exceed that amount; when spending falls below the rate, contractors retain the difference.¹⁷⁴ This model places a premium on economizing and requires states to be vigilant in oversight to ensure that savings are not the product of poor or inadequate care.¹⁷⁵

One documented consequence of cost-driven management is understaffing. A CNN investigation found that amid a corporate focus on growth and cost containment, Correct Care Solutions, which now operates as Wellpath, repeatedly relied on undertrained workers, provided minimal training, and left facilities short-staffed across dozens of states.¹⁷⁶ A former nurse at a Washington State facility described a medical unit where patient requests went unanswered and medication errors occurred due to chronic understaffing; these were conditions she attributed directly to the company's cost-cutting culture.¹⁷⁷ The investigation concluded that these failures contributed to substandard care and

169. Andy Marso, *What is \$2 billion buying Kansas and Missouri in prison health care? Few people know*, THE STAR (Jan. 21, 2018), <https://www.kansascity.com/news/politics-government/article195673934.html> [<https://perma.cc/QV47-D7PA>].

170. Szep et al., *supra* note 168.

171. *Id.*; Marso, *supra* note 169.

172. Fenne, *supra* note 159.

173. PEW CHARITABLE TRS., PRISON HEALTH CARE: COSTS AND QUALITY 12 (Oct. 2017), https://www.pewtrusts.org/~media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf [<https://perma.cc/DK2F-R38C>].

174. *Id.* at 12–13.

175. *Id.* at 13.

176. Blake Ellis & Melanie Hicken, *CNN Investigates: 'Help me before it's too late'*, CNN (June 25, 2019), <https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs/> [<https://perma.cc/8YFL-UF6B>].

177. *Id.*

preventable deaths.¹⁷⁸

Private contractors have also reduced costs by assigning workers to perform tasks beyond the scope of their training and licensure.¹⁷⁹ In 2015, Corizon Health entered into a settlement following the death of an inmate under its care, agreeing to stop using licensed vocational nurses to perform the work of registered nurses.¹⁸⁰ Attorneys in the case estimated that for every licensed vocational nurse deployed in a registered nurse role, Corizon saved approximately 35% in labor costs.¹⁸¹

c. Accountability and political influence

The relationship between private correctional health care companies and the public officials who award their contracts has drawn scrutiny from journalists, watchdog organizations, and federal prosecutors.¹⁸² From 2008 to 2016, Corizon Health held a contract with Alameda County, California worth more than \$264 million, which the Board of Supervisors renewed three times without a competitive bidding process, each time on the recommendation of the county sheriff.¹⁸³ During that same period, public disclosure records show that Corizon donated more than \$110,000 to the sheriff's reelection campaigns.¹⁸⁴ It was his single largest campaign donor in each year the company contributed, a pattern watchdogs argued created at minimum the appearance of a conflict of interest.¹⁸⁵ Wellpath has similarly made political contributions to sheriff campaigns across multiple states, including Louisiana, Texas, Georgia, and others, through its political action committee.¹⁸⁶ The most egregious example of this dynamic resulted in a federal criminal conviction. In February 2022, Gerard Boyle, founder of Correct Care Solutions, was sentenced to three years in federal prison after pleading guilty to a twelve-year bribery scheme involving cash, gifts, travel, and campaign contributions exchanged for contract extensions and inside

178. *Id.*

179. Dan Levine, *Prison health provider agrees to changes in California*, REUTERS (Feb. 10, 2015), <https://www.reuters.com/article/us-usa-prison-settlement-idUSKBN0LE2KT20150210> [<https://perma.cc/Z6JB-P83S>].

180. *Id.*

181. *Id.*

182. MICHAEL FENNE, PRIVATE EQUITY FIRMS REBRAND PRISON HEALTHCARE COMPANIES, BUT CARE ISSUES CONTINUE 17–21 (Priv. Equity Stakeholder Project, 2022), https://pestakeholder.org/wp-content/uploads/2022/11/Wellpath_HIG_12-2022.pdf [<https://perma.cc/FGR2-PF3E>].

183. Simon Aponte, 2 *Investigates: Jail medical company Corizon loses Alameda Co. contract*, FOX2KTVU (Aug. 5, 2016), <https://www.ktvu.com/news/2-investigates-jail-medical-company-corizon-loses-alameda-co-contract> [<https://perma.cc/DZ6U-N9HP>].

184. Simon Aponte, 2 *Investigates: Questions Surround Jail Contractor's Donations to Sheriff's Campaign*, FOX2KTVU (Sep. 4, 2015), <https://www.ktvu.com/news/2-investigates-questions-surround-jail-contractors-donations-to-sheriffs-campaign> [<https://perma.cc/FE3T-XULU>].

185. *Id.*

186. FENNE, *supra* note 182, at 17–21.

bidding information worth more than \$3 million per year.¹⁸⁷

IV. A FRAMEWORK FOR REFORM: MANDATORY ACCREDITATION, ENFORCEABLE STANDARDS, AND PUBLIC ALTERNATIVES

A. Privatization, Accreditation, and the Path to Reform

The structural failures and accountability deficits documented in Part III make clear that litigation alone cannot drive meaningful reform. Critics of privatized correctional health care have argued that the structure of private contracting can distort incentives away from patient care and toward cost containment and liability management.¹⁸⁸ Regardless of the specific company involved, the profit motive in private correctional health care has been associated with service reductions and staffing constraints that raise concerns about care quality.¹⁸⁹

Indiana illustrates the continuing reliance on private contractors. In July 2021, Centurion Health began a four-year contract with the Indiana Department of Administration to provide comprehensive physical health, mental health, transitional health, and related support services to approximately 25,000 incarcerated individuals across twenty-one state facilities.¹⁹⁰

By contrast, several jurisdictions have shifted toward publicly administered models. In 2015, New York City declined to renew its private contract with Corizon and transferred management of correctional health services to the public Health and Hospitals Corporation, citing direct public accountability, improved oversight, and continuity of care as central goals.¹⁹¹ Los Angeles County similarly operates correctional health services through its Department

187. Fenne, *supra* note 159; *see also* Press Release, U.S. Dep't of Just., U.S. Att'y's Off., E.D. Va., CEO Sentenced for Bribing Former Norfolk Sheriff (Feb. 25, 2022), <https://www.justice.gov/usao-edva/pr/ceo-sentenced-bribing-former-norfolk-sheriff-0> [<https://perma.cc/G69L-F6WZ>].

188. Fenne, *supra* note 159.

189. *Id.*

190. *Centurion Health Provides Correctional Health for Indiana Department of Correction*, CENTURION (July 12, 2021), <https://teamcenturion.com/newsroom/centurion-to-partner-with-indiana-doc-to-provide-comprehensive-healthcare-services/> [<https://perma.cc/FSU3-FC3U>] (noting that the four-year contract included two two-year renewal options).

191. Press Release, NYC Health and Hospitals, Health and Hospitals Corporation To Run City Correctional Health Service (June 10, 2015), <https://nychealthandhospitals-appservice-east-us.azurewebsites.net/pressrelease/health-and-hospitals-corporation-to-run-city-correctional-health-service/> [<https://perma.cc/72K6-EUES>] [hereinafter NYC Health Services Press Release] (archived version confirms transfer of correctional health management from Corizon to the public Health and Hospitals Corporation); *Correctional Health Services*, NYC HEALTH & HOSPS., <https://www.nychealthandhospitals.org/correctional-health-services/> [<https://perma.cc/8S36-7DL5>] (last visited May 29, 2026) (describing the public correctional health division established in 2016 after the city declined to renew its contract with private provider Corizon).

of Health Services.¹⁹² Other jurisdictions rely on community- or university-based models to deliver correctional health care.¹⁹³

Accreditation of correctional health care facilities in the United States remains voluntary, unevenly distributed, and legally unenforceable as a minimum standard of care.¹⁹⁴ Two primary bodies offer accreditation in this space. The American Correctional Association, through its Commission on Accreditation for Corrections, accredits more than 1,300 facilities across the United States and internationally under its general operational standards.¹⁹⁵ The NCCHC offers a separate program focused specifically on health care quality, and its standards have been recognized by courts as among the most rigorous benchmarks for constitutionally adequate correctional health care; further, these standards have documented benefits, including reduced liability exposure, enhanced patient safety, continuous quality improvement, and greater public accountability.¹⁹⁶ Yet no federal law mandates that correctional facilities obtain health care-specific accreditation, leaving care quality to vary significantly from one facility to another.¹⁹⁷

Indiana provides a telling example of how this regulatory gap operates in practice; its continued reliance on private health care contractors, in the absence of health care-specific accreditation requirements or enforceable contract performance standards, reflects the broader structural deficiencies this Note seeks to address.¹⁹⁸ While IDOC policy directs staff to consider NCCHC standards when developing health care directives, neither Indiana statute nor administrative regulation requires facilities to obtain NCCHC accreditation.¹⁹⁹

192. *Correctional Health Services (CHS)*, L.A. CNTY. DEPT. OF HEALTH SERVS., <https://dhs.lacounty.gov/correctional-health-services/our-services/correctional-health-services/> [https://perma.cc/GL46-ZAZP] (last visited May. 29, 2026) (describing Los Angeles County's publicly operated Correctional Health Services division within the Department of Health Services) [hereinafter LA Correctional Health Care Services].

193. See, e.g., *University Correctional Health Care*, RUTGERS UNIV. BEHAV. HEALTH CARE, <https://ubhc.rutgers.edu/clinical/uchc/overview.xml> [https://perma.cc/BA6T-TKK8] (last visited May 29, 2026) (describing a university-based correctional healthcare program emphasizing clinical excellence, compassionate care, and health equity); see also *Unity Health Care Awarded DOC Inmate Comprehensive Medical Services Contract*, CISION PR NEWswire (Apr. 16, 2019), <https://www.prnewswire.com/news-releases/unity-health-care-awarded-doc-inmate-comprehensive-medical-services-contract-300832653.html> [https://perma.cc/88ZE-4TP7].

194. McCann, *supra* note 22.

195. CAC, *supra* note 68.

196. Thomas J. Weber & Tommy Williams, *The Many Benefits of Accreditation*, NAT'L COMM'N ON CORR. HEALTH CARE (June 20, 2024), <https://www.ncchc.org/the-many-benefits-of-accreditation/> [https://perma.cc/M79G-MUFY].

197. McCann, *supra* note 22.

198. See IND. CODE § 11-12-4-1 (2025) (setting minimum health care requirements for IDOC without mandating accreditation); 210 IND. ADMIN. CODE 3-1-11 (2025) (outlining health care standards for IDOC without requiring NCCHC or equivalent health care-specific accreditation).

199. Indiana Health Services Policy, *supra* note 152, at 3, 7–8 (directing staff to “take into consideration” ACA and NCCHC standards when preparing health care directives but imposing no accreditation requirement).

As a result, compliance with those standards remains aspirational rather than legally enforceable. Although some IDOC facilities hold general operational accreditation through the American Correctional Association, the documented pattern of care failures across successive private contractors in Indiana underscores that facility-level ACA accreditation alone is insufficient to ensure health care quality.²⁰⁰ The experiences of New York City and Los Angeles County suggest that publicly administered models may offer greater structural accountability, though the relative effectiveness of public versus private models depends heavily on oversight, funding, and institutional commitment.²⁰¹ Because constitutional litigation is reactive, durable reform must come through proactive administrative mandates. Even where full public administration is not politically or fiscally feasible, state legislatures must, at minimum, mandate health care-specific accreditation, enforce measurable contract performance standards, and restructure financial incentives to reduce contractors' incentives to limit or deny necessary care.²⁰² Indiana, which already benefits from a robust medical school infrastructure through Indiana University School of Medicine, might consider exploring a university-affiliated model similar to those operating in New Jersey and other states as a longer-term alternative to exclusive reliance on private contractors.²⁰³

B. Technology-Driven Health Care Innovations

1. Mandating Telehealth Expansion in Correctional Facilities

Telehealth has emerged as an important tool in correctional health care, improving access to medical services and reducing certain operational costs.²⁰⁴ By minimizing the need for resource-intensive transfers to external medical facilities, telehealth enhances both security and efficiency while ensuring incarcerated individuals receive timely care.²⁰⁵ Research indicates that telehealth implementation can reduce offsite transports and facilitate improved monitoring

200. Press Release, Ind. Dep't of Corr., National Organization Recommends Indiana Prison for Reaccreditation (Sep. 18, 2018), <https://www.in.gov/idoc/files/National-Organization-Recommends-Indiana-Prison-for-Reaccreditation.pdf> [<https://perma.cc/A547-WWYS>].

201. NYC Health Services Press Release, *supra* note 191; LA Correctional Health Care Services, *supra* note 192.

202. *See* Marso, *supra* note 168; *see also* Pew Charitable Trs., *supra* note 173.

203. *See e.g.*, *University Correctional Health Care*, *supra* note 193; *see also* *Student Outreach Clinic*, IND. UNIV. SCH. OF MED., <https://medicine.iu.edu/indianapolis/service-learning/outreach-clinic> [<https://perma.cc/45H2-724M>] (last visited May 29, 2026).

204. *See supra* notes 36–39 and accompanying text; *see also* Saif Khairat et al., *Assessment of Stakeholder Perceptions and Cost of Implementing a Telemedicine Specialty Program at Correctional Facilities in North Carolina*, 27 PERMANENTE J. 49, 49 (June 2023).

205. *Telehealth in Correctional Facilities (2025)*, NAT'L COMM. ON CORR. HEALTHCARE, <https://ncchc.org/position-statements/telehealth-in-correctional-facilities-2025/> [<https://perma.cc/4VFP-VCTD>] (last visited May 29, 2026).

of chronic conditions.²⁰⁶ Beyond correctional settings, telehealth technologies have become widely adopted for their cost-effectiveness and ability to expand health care access.²⁰⁷ The documented cost savings from technology-driven delivery further strengthen the case for mandated integration. For example, a statewide specialty care telemedicine program in North Carolina's prison system reduced health care expenses by \$416,020 within the first six months and projected net savings of over \$1.1 million within the first year.²⁰⁸ Because constitutional litigation does not compel modernization and administrative policy currently treats telehealth as optional, leaving its implementation to institutional discretion, states must mandate baseline telehealth integration as part of health care-specific accreditation requirements.²⁰⁹

2. Requiring EHR Adoption to Improve Care Continuity

A well-integrated EHR system could alleviate inefficiencies in correctional health care by streamlining medical data management and improving continuity of care before, during, and after incarceration.²¹⁰ Currently, many correctional facilities still rely on manual recordkeeping despite the fact that records must be retained for up to twenty years after a patient's release—a long-term administrative obligation that electronic systems are better designed to manage.²¹¹

For more than a decade, EHR technology has become a cornerstone of health care in the United States, offering transformative benefits such as improved care continuity, adherence to evidence-based practices, and reduced medical errors.²¹² The Centers for Medicare and Medicaid Services ("CMS") have advanced these objectives through its Medicaid and Medicare EHR Incentive Program, commonly referred to as meaningful use ("MU").²¹³ This program provides financial incentives to health care providers to adopt, implement, or upgrade to certified EHR systems and demonstrate their effective

206. *Id.*

207. Shilpa N. Gajarawala & Jessica N. Pelkowski, *Telehealth Benefits and Barriers*, 17 J. NURSE PRACS. 218, 218 (2020).

208. Khairat et al., *supra* note 204.

209. Telehealth in Correctional Facilities (2025), *supra* note 205.

210. DANIEL SALAZAR, JR., NAVAL POSTGRADUATE SCH., THE AMERICAN CORRECTIONAL HEALTHCARE SYSTEM IS AILING: TECHNOLOGY INNOVATION AS A PRESCRIPTION FOR PENAL SYSTEM HEALTHCARE DELIVERY 82–83 (June 2022), <https://calhoun.nps.edu/server/api/core/bitstreams/53632e26-5c5e-42b5-b1a2-c0976539dce5/content> [https://perma.cc/N96N-5J8J].

211. *EHRs and Data Archiving for Correctional Health*, HARMONY HEALTHCARE IT, <https://www.harmonyhit.com/ehrs-and-data-archiving-for-correctional-health/> [https://perma.cc/P6SJ-56LK] (last visited Mar. 9, 2025).

212. See Michelle Martelle et al., *Meaningful Use of an Electronic Health Record in the New York City Jail System*, 105 AM. J. PUB. HEALTH 1752 (Sep. 2015).

213. *Id.* at 1752.

use in improving patient outcomes.²¹⁴ Notably, a 2012 regulatory amendment extended eligibility under this program to correctional health providers, meaning that states operating publicly administered correctional health systems may already be positioned to participate.²¹⁵ Extending similar incentive structures more broadly to correctional facilities, including those operated through private contractors, could reduce disparities in care between incarcerated populations and the general public.²¹⁶ Because constitutional litigation does not compel technological modernization and existing policy leaves EHR adoption to institutional discretion, states must mandate baseline EHR integration as part of health care-specific accreditation requirements, with federal incentive funding serving as the mechanism to accelerate compliance.

3. *Wearable Technology as a Supplement to Systemic Reform*

Recent innovations in wearable technology have introduced new opportunities for real-time health monitoring in correctional settings, with some correctional facilities adopting biometric wristbands and remote monitoring systems capable of tracking heart rate, blood oxygen levels, skin temperature, and location data.²¹⁷ Some facilities have moved beyond general surveillance tools toward clinically oriented applications. For example, a Florida county jail is piloting Vivalink's mobile cardiac monitoring solution to address the needs of an inmate population frequently presenting with cardiac complaints that its on-site infirmary lacked the equipment to assess.²¹⁸ These technologies hold genuine potential as continuous vital sign monitoring can reduce the likelihood of undetected medical emergencies and enable faster responses to acute health crises.²¹⁹ However, implementation has been uneven and, in some cases, counterproductive. The Fulton County Jail spent \$7.4 million on a biometric wristband system that was ultimately described as a failure, in part because the same facility lacked a full-time health care provider, which illustrates that wearable technology cannot substitute for adequate staffing and basic care infrastructure.²²⁰ Additionally, the data privacy implications of biometric wearables in correctional settings remain largely unresolved, as it is unclear whether all correctional technology contractors handle protected health

214. *Id.*

215. *Id.*

216. See *Ending Mass Incarceration: The Need for Federal Incentives*, EQUAL JUST. INITIATIVE (Jan. 29, 2016), <https://eji.org/news/need-federal-incentives-to-end-mass-incarceration/> [https://perma.cc/Q6H7-4LBQ].

217. Danielle Dorchester, *Wristwatched: A New Frontier of Health Monitoring in Prisons*, ELEC. PRIV. INFO. CTR. (Aug. 22, 2024), <https://epic.org/wristwatched-a-new-frontier-of-health-monitoring-in-prisons/> [https://perma.cc/FDK9-SLPQ].

218. Timm, *supra* note 36.

219. *Id.*

220. Dorchester, *supra* note 217.

information in full compliance with HIPAA.²²¹ HIPAA's Privacy Rule applies to incarcerated individuals and extends to health care services provided both inside correctional facilities and at outside providers, which means correctional technology contractors that collect or process protected health information are subject to its requirements regardless of how they characterize their products.²²² Additionally, liability for any breaches could be assigned to the company providing the EHR services, ensuring accountability and compliance with both legal and ethical obligations. Accordingly, states that authorize or fund wearable health monitoring programs in correctional facilities must establish clear regulatory frameworks governing data use, patient consent, and HIPAA compliance. Further, they must ensure that technology deployment supplements—rather than substitutes for—adequately staffed and accredited health care programs.

C. Financial and Legislative Reforms

Private contractors currently face a structural financial disincentive to provide timely medical care because, under capitated contract models, they bear responsibility for external hospital costs, which means that every avoidable hospitalization reduces their profit margin.²²³ States should shift financial responsibility for external hospital costs to the state rather than the private contractor, removing the profit-based incentive to delay or deny care and aligning the contractor's financial interests with better patient outcomes.²²⁴

Indiana illustrates both the scale of the problem and the feasibility of reform. Indiana has an incarceration rate of 721 per 100,000 people, higher than any independent democratic country, with approximately 46,000 residents currently behind bars.²²⁵ Yet Indiana's Medicaid program already serves nearly two million residents, meaning that expanding state-supported health care frameworks to cover the costs of care for its incarcerated population would represent a marginal increase in the state's existing health care infrastructure relative to the population it already serves.²²⁶

Strategic investment in technology would further reduce long-term costs by

221. *Id.*

222. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.); 45 C.F.R. § 164.512(k)(5) (2024); Caitlin Anthoney, *Does HIPAA apply to incarcerated individuals?*, PAUBOX (Apr. 8, 2024), <https://www.paubox.com/blog/does-hipaa-apply-to-incarcerated-individuals> [https://perma.cc/NNG3-58DX].

223. PEW CHARITABLE TRS., *supra* note 173, at 12–13.

224. PEW CHARITABLE TRS., *supra* note 161.

225. *Indiana Profile*, PRISON POL'Y INITIATIVE, <https://www.prisonpolicy.org/profiles/IN.html> [https://perma.cc/2XQV-7DX7] (last visited May 29, 2026).

226. Whitney Downard, *Medicaid rolls higher than pre-pandemic enrollment as unwinding continues*, IND. CAP. CHRON. (May 15, 2024), <https://indianacapitalchronicle.com/2024/05/15/medicaid-rolls-higher-than-pre-pandemic-enrollment-as-unwinding-concludes/> [https://perma.cc/T853-FPUT]; Indiana Profile, *supra* note 225.

shifting the system from reactive to preventive care. Wearable health monitors currently being piloted in correctional facilities across the country provide real-time tracking of vitals, alerting staff to abnormal readings, medication reactions, or signs of distress before conditions escalate into costly emergencies.²²⁷ EHR integration similarly reduces duplicative testing and ensures continuity of care across transfers and reentry.²²⁸ While initial implementation requires investment, the North Carolina telemedicine data already discussed demonstrates that technology-driven solutions generate measurable net savings within the first year of deployment.²²⁹ A state-supported financial model combined with technology-driven early detection would lower overall health care costs, improve medical outcomes, and reduce the public health burden that falls on communities when incarcerated individuals reenter society with unmet medical needs.

V. CONCLUSION

The cases of Walter Jordan, Antonio Arnez Smith, and George Hawkins are not anomalies. They are the predictable product of a system that has long treated constitutional minimums as a ceiling rather than a floor. The Eighth Amendment's deliberate indifference standard was never designed to guarantee adequate health care; it was designed to prohibit the worst abuses. The gap between that constitutional floor and genuinely adequate care is where the failures documented throughout this Note have accumulated, and it is precisely the gap that administrative law must fill.

This Note has argued that durable reform requires more than litigation. It requires state legislatures to mandate health care-specific accreditation through bodies like NCCHC, enforce measurable contract performance standards with real consequences for noncompliance, and restructure the financial incentives that currently reward private contractors for denying care. It requires investment in telehealth, EHR systems, and wearable monitoring technology, not as substitutes for adequate staffing and accreditation, but as tools to extend the reach and consistency of care within facilities that already meet minimum standards. And it requires states like Indiana, which incarcerates its residents at a rate higher than any independent democratic country on earth, to reckon honestly with the gap between the aspirational language of its administrative policies and the documented failures of its contracted health care providers.

The path forward is not without obstacles. Political resistance, fiscal constraints, and the deeply embedded profit incentives of the private correctional health care industry will not yield easily to reform. But the framework proposed here does not require the abolition of private contracting

227. Bobeth Yates, *Fulton County Jail starts to use wristbands to monitor inmates' health*, 11ALIVE (Sep. 22, 2023), <https://www.11alive.com/article/news/local/fulton-county-jail-wristbands-inmate-safety/85-025b12b7-a7f3-480e-8b6f-b715c9851106> [https://perma.cc/4Z23-3UC4].

228. *See supra* notes 212–13 and accompanying text.

229. *See supra* note 210 and accompanying text.

or a wholesale restructuring of state correctional systems. It requires accountability: mandatory accreditation, enforceable standards, transparent oversight, and a financial model that stops rewarding contractors for the very failures the system was designed to prevent.

By addressing these issues, society upholds basic human dignity, reduces the public health burden that follows incarcerated individuals into their communities upon release, and builds a correctional system that prepares people to reenter society in better health, not worse.