Hepatitis C
Screening and Treatment
In U.S. Prisons:
The Big Picture

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Incarceration and Hepatitis C in the United States

• Number of people in prisons and jails = 2.3 million

• Number of people in federal prisons and state prisons = 1.6 million

• Number of people incarcerated in federal prisons = 210,567 (13 percent)

• Number of people incarcerated in state prisons = 1.4 million (87 percent)

• Estimated number of incarcerated people with hepatitis C = 30 percent

Guidelines for HCV Screening and Treatment

- **AASLD/IDSA guidelines:**
  - Screen everyone who has ever been incarcerated
  - Treat everyone who has chronic hepatitis C

- **Federal Bureau of Prisons (BOP) guidelines:**
  - Opt-out screening of all sentenced inmates; those with a history of high-risk behavior; or upon inmate request
  - Treatment is based on disease severity: high priority (advanced fibrosis or cirrhosis); intermediate priority (F2); and low priority (F0 to F1)
  - Inmates with ongoing high-risk behaviors may be excluded
  - Apply only to federal prisons (only 13 percent of incarcerated people)

- **State prison guidelines:** vary by state

Most State Prisoners Are Not Tested and Not Treated

*Health Affairs* study (October 2016):

- 32 of 41 states reporting data (65 percent) do not perform routine opt-out testing of inmates
  - Main criteria for testing: abnormal labs, HIV, or reported substance use
- Only 17 of 41 states reporting data (35 percent) perform routine opt-out testing
- 10 percent of state prisoners were known to have hepatitis C (949 of 106,266 prisoners in 41 states)
- Less than one percent (0.89 percent) of those known to have hepatitis C were receiving some type of treatment
- States reporting financial data spent a median $76,085 on Solvadi and a median $63,509 on Harvoni

State Prisons Have Few Options for Obtaining Drug Discounts

- The BOP receives at least a 24 percent discount on HCV drugs
- State prisons are ineligible for discounts under the Federal 340B Drug Pricing Program
- Other current avenues for obtaining lower prices:
  - Direct negotiations with pharmaceutical companies – 66 percent (29/44) of states were attempting this method
  - Partnering with FQHCs, which are eligible for 340B, to provide health care to prisoners at reduced costs – 36 percent of states were pursuing discounts via this method
  - Pooled procurement with other state correctional agencies to buy in bulk for a lower price – 30 percent of states were attempting this method
  - No strategy: Idaho and Michigan

Even Prisons Must Follow the Law (theoretically)

We’ve got to know the law to change the law...

- Prisoners have a legal right to adequate medical care
- State correctional agencies’ “deliberate indifference” to the serious medical needs of prisoners may constitute cruel and unusual punishment under the Eighth Amendment (Estelle v. Gamble)
- “Deliberate indifference” to circumstances “sure or very likely to cause” illness or suffering could violate the Eighth Amendment (Helling v. McKinney)
- Bolsters the argument for early treatment of hepatitis C
- To show “deliberate indifference”: prisoners must show that corrections officials were aware of facts from which they can infer that there is a “substantial risk of serious harm,” must draw that inference, and must fail to take “reasonable steps” to reduce that substantial risk (Farmer v. Brennan)
The Legal Standards Leave Something to be Desired (see quote)

“Never forget that everything Hitler did in Germany was legal.” – Martin Luther King, Jr.

- The Farmer standard makes it more difficult for a prisoner to show deliberate indifference
  - Courts may vary in their interpretations of “substantial” and “reasonable”
  - The Farmer standard creates a disincentive for prisons to test inmates
    - If prisoners are not screened, then how can a prison official know of and disregard an “excessive risk” to the prisoner’s health?
  - If prisons screen inmates, they have an obligation to treat – otherwise they could face a legal claim based on deliberate indifference
  - Courts have ruled that budgetary concerns may excuse a prison’s failure to provide medical care under certain circumstances (Peralta v. Dillard)
Litigation Moves Slowly Forward

- **Paszko v. O’Brien**: class action lawsuit alleging that Massachusetts Dept of Corrections violates the Eighth Amendment by delaying and denying treatment and testing
  - Treatment protocol is based on disease severity, length of stay, disciplinary reports
  - Testing is often not performed to evaluate disease severity
  - Plaintiff Emilian Paszko died on March 14, 2016

- **Chimenti v. Pennsylvania Department of Corrections**: class action lawsuit alleging that Pennsylvania Dept of Corrections violates the Eighth Amendment by denying any kind of HCV treatment, not just DAAs
  - Plaintiff Salvatore Chimenti has advanced cirrhosis
  - Plaintiff Daniel Leyva was told by a prison doctor that the newest treatments “cost too much”
  - An estimated 20 percent of Pennsylvania’s prison population has hepatitis C

- **Abu-Jamal v. Kerestes**: alleged that the Pennsylvania DOC violated the Eighth Amendment by denying treatment
  - Judge denied motion for preliminary injunction because the plaintiff named the wrong defendants, BUT found that the Pennsylvania DOC’s treatment protocol violates the Eighth Amendment and is therefore unconstitutional
Policy Proposals Are Needed to Complement Litigation

• Litigation is costly and can succeed only so far
  • Decisions can be appealed, injunctions can be lifted, relief can be denied, and one court’s decision does not often set lasting precedent
• Federal policy proposals: thinking big
  • Enact a federal statute modeled after PREA, geared to eliminate HCV in prisons
  • Create funding incentives for states to implement opt-out screening and/or to expand coverage of inmates
  • Enable state prisons to negotiate lower prices directly through the Federal 340B program
  • Enable state prisons to be eligible for “best price” drug rebates (pharma company may enter into rebate agreement with a state prison in exchange for that state prison’s coverage of the company’s drugs)
  • Authorize the HHS to negotiate bulk prices for HCV meds and then distribute them to state prisons (the Vaccines for Children model)
  • Expand Medicaid to cover the last 30 days of each inmate’s stay (to facilitate continuity of care)
Medicaid and Reentry

Investigation by The Marshall Project and Kaiser Health News, Dec. 6, 2016:

• 19 states have no formal procedure to enroll prisoners in Medicaid before they reenter the community.

• Of the 31 states that opted into the Medicaid expansion, most have not created large-scale enrollment programs or operate smaller programs that cover only certain categories of prisoners.

• Example: Minnesota is an expansion state, but will provide assistance only to prisoners eligible for special release planning programs.
  • Result: fewer than 1,000 of the 6,800 inmates released last year applied for Medicaid.

• Example: Indiana’s Medicaid agency considers ex-prisoners in work release programs to be incarcerated, thus does not cover them.
  • And yet: Indiana’s DOC considers these ex-prisoners free, thus making them ineligible for prison health care.

Takeaways

- Although prisoners have a legal right to medical care, access to HCV treatment is limited.
- Screening is not often performed, especially in state prisons.
- State prisons, which house most inmates, lack formal methods for obtaining discounts on costly HCV medications.
- Litigation, though important, is time-consuming, expensive, and can extend only so far.
- We must explore federal policy proposals despite the political environment.
- States can also act on their own, and devote a bigger chunk of their budget to HCV screening and treatment access in prisons.
- With at least 10 million people cycling in and out of prisons and jails each year, screening, treatment, continuity of care are crucial.
“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Martin Luther King, Jr.

Questions, answers, thoughts…

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