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OVERSIGHT OF THE FEDERAL BUREAU OF PRISONS

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BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE OVERSIGHT

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

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OVERSIGHT OF THE FEDERAL BUREAU OF PRISONS

THURSDAY, APRIL 6, 2000

U.S. SENATE,
SUBCOMMITTEE ON CRIMINAL JUSTICE OVERSIGHT,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 3:04 p.m., in room SD–226, Dirksen Senate Office Building, Hon. Strom Thurmond (chairman of the subcommittee) presiding.

Alson present: Senator Sessions.

OPENING STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Senator THURMOND. The committee will come to order.

I am pleased to hold this oversight hearing today regarding the Federal Bureau of Prisons. I have always believed that we must be tough on crime, and maintaining dangerous criminals in prison is a key component in the war against crime. One of the primary reasons that crime is on the decline is that we are putting more serious offenders in prison and keeping them there for longer periods of time.

One of the greatest challenges facing the Bureau of Prisons today is its duty to house an ever increasing inmate population. The number of prisoners has doubled since 1990, and is expected to rise by an additional 50 percent in the next 7 years. Today, prisoners are being added at a rate of at least 1,000 per month.

Keeping the growing inmate population productively occupied is essential. Boredom and idleness, especially in our currently overcrowded prisons, can be dangerous. Last year, this subcommittee held a hearing on Federal Prison Industries that highlighted the central importance of this work program to the effective management and safe control of Federal inmates. This program teaches job skills to inmates, and studies continually show that participants are more likely to find and hold jobs after their release and are less likely to commit other crimes.

I think this year we should make every effort to reform this program without endangering its success. We can eliminate the legal preference that Prison Industries has to make products for the Federal Government if we also allow it to compete in the commercial market. Also, we should encourage Prison Industries to produce items that are currently made in foreign countries and not in the United States. Reforms such as these should further minimize its impact on the private sector.

With the constant rise in inmates, the Bureau is doing a good job in controlling the cost of medical care for prisoners. While national trends show health care costs rising annually, the Bureau's costs have actually decreased for the last 3 years in a row. This is based on various initiatives that the Bureau has implemented, including staff reorganizations, bulk purchasing, and telemedicine.

Moreover, as the General Accounting Office notes, the Congress should permit the Bureau to charge a small co-pay for inmates when they receive non-emergency care, as many States already do. This would help discourage frivolous health care visits, thereby freeing medical staff for needy inmates. Also, the Bureau should be able to cap inmate hospital payments at the Medicare rate.

A recent DOJ Inspector General report raises concerns about inmate use of telephone calls to continue their criminal activity while incarcerated, including crimes like drug trafficking and fraud. In 1995, the Department of Justice settled a prisoner lawsuit regarding phone use on terms generous to the prisoners.

Currently, most inmates are allowed to make as many telephone calls as they are able to pay for, or as many collect calls as people outside will accept. The case demonstrates that while the current Justice Department often encourages settlement agreements in various areas of the law, these settlements are not always in the best interest of all parties involved.

While inmates should be able to maintain contact with their families and communities, the Bureau must balance these needs against the public interest in preventing inmate crime. The Bureau is taking steps to address this issue. It must work diligently to prevent prisoners from committing crime from behind bars.

I want to thank the witnesses who are present, especially the Director of the Bureau. Dr. Sawyer has one of the toughest jobs in the Federal Government, and I wish to commend her for her hard work and dedication. I look forward to discussing these important issues today.

I will now introduce Dr. Kathleen Hawk Sawyer, the Director of the Federal Bureau of Prisons, of the Department of Justice. She has 24 years of management and training experience in the Bureau of Prisons and currently oversees the operation of 95 Federal institutions.

How are you doing?

Ms. SAWYER. Just fine, sir.

Senator THURMOND. She holds a bachelor's degree from Wheeling Jesuit College, in West Virginia, and both a master's degree and doctorate degree from West Virginia University.

We will now turn to Director Sawyer.

STATEMENT OF KATHLEEN HAWK SAWYER, DIRECTOR, FEDERAL BUREAU OF PRISONS, WASHINGTON, DC

Ms. SAWYER. Good afternoon. I am certainly pleased to appear before you today, and I want to start by thanking you, Mr. Chairman, for your tremendous support of the Bureau of Prisons, and I thank you for that throughout the years that we have worked with you.

The Bureau continues to effectively meet our mission. As you indicated, our 31,000 outstanding and dedicated staff manage over

140,000 inmates in 95 of our own Federal prisons, as well as contract facilities around the country. During fiscal year 1999, the Bureau experienced its second consecutive year of record-breaking growth. We grew by 11,300 inmates last year alone, and we anticipate that by 2007 the Bureau of Prisons population will reach 205,000 inmates. That is a growth of nearly 50 percent over today's numbers.

Crowding in our facilities is 34 percent over-capacity systemwide. At medium- and high-security facilities, crowding levels are even more dangerous, with 55-percent crowding at medium-security and 51-percent crowding at high-security. We must reduce this crowding at each facility for the safety of staff, inmates, and the communities surrounding us.

With the resources Congress has already provided, we are making significant progress in this regard. We have 22 new prisons that are funded or partially funded, and in the fiscal year 2001 budget we are seeking funding and advanced appropriations for nine additional new prisons.

In addition to absorbing our own rapidly increasing Federal inmate population, the Bureau has begun assuming responsibility for the sentenced felons from the DC. Department of Corrections, as required by the National Capital Revitalization Act. Thus far, we have absorbed 2,300 sentenced felons, and we will be absorbing the remainder of the inmates by the end of 2001. Absorbing these inmates is going to be a great challenge for the Bureau because, as I indicated, our facilities are extremely crowded already and the new bed capacity to absorb the DC. inmates will not be constructed before the deadline date of December 2001.

You may recall that in the preliminary drafts of the Revitalization Act, the Lorton closure date was supposed to have been 2003, which was consistent with the dates by which we would get the new institutions built. However, when enacted, the date for closure had been changed to 2001, which means we will be absorbing the remainder of the inmates by the end of 2001 without sufficient bed capacity on line.

The Bureau is committing to providing inmates with programs to help them make the most of their time in custody, as well as to reenter the community successfully. Our programs include drug treatment, education, vocational training, and work skills training. We operate residential treatment programs for substance abuse for nearly 30 percent of the Federal inmate population who have serious substance histories.

An interim report researching our success in our drug treatment programs shows that, 6 months after release, 73 percent of the inmates who completed our program are less likely to be arrested and 44 percent are less likely to test positive for any substance abuse. Last year, nearly 6,000 inmates completed their General Education Degree, the GED, and thousands of others completed a variety of additional education and vocational training programs.

As I have testified on previous occasions, and as you mentioned, Mr. Chairman, Federal Prison Industries is our most important program, and it is a cost-effective program. It is entirely self-sustaining and operates without any appropriated funds. It provides

significant training for inmates that has been demonstrated to reduce recidivism.

For many years now, as you indicated, some members of the business and organized labor communities have voiced strong concerns with the mandatory source preference, that it gives us an unfair advantage in the Federal marketplace. Should we lose mandatory source status, we would clearly need alternative authorities, as you indicated, such as being able to make products for the commercial market and being able to make products that are currently made offshore.

Recently, the General Accounting Office conducted an audit of our health care, and as you indicated, Mr. Chairman, it was determined that our health care costs have been steadily going down as nationwide health care costs have been increasing. GAO noted several of the initiatives that contributed to this savings. They also highlighted the two legislative proposals that you mentioned in your comments, Mr. Chairman, about the inmate copayment and the Medicare rate caps. And it would certainly improve our ability to provide cost-effective health care in the Bureau if both of these legislative initiatives would be successful.

In August 1999, the Office of the Inspector General completed an audit on our inmate telephone system. The report identified some significant problems that have occurred over the years with inmates abusing their phone privileges, and we have been working diligently to improve both the inmate telephone system and our monitoring to address the shortcomings of the program.

Our goal is to maintain reasonable access by inmates to phones to support healthy family and community ties which assist in successful return to the community, but at the same time we must control for any abuses of phone privileges. The dramatic growth that we have experienced in the Bureau over the last several years and the huge numbers of new staff coming in have outpaced our traditional methods of preventing phone abuses. We must now look to new technologies that are now available for us to enable us to control phone abuses, and the new technology will be installed in all Bureau of Prisons facilities by November of this year.

I am very proud of the Bureau of Prisons staff and the job that they do each and every day. Despite our record-setting population growth, the Bureau has maintained its outstanding level of performance.

I would like to conclude again, Mr. Chairman, by thanking you and the members of the subcommittee for your wonderful support of the Bureau of Prisons throughout the years. This concludes my prepared comments and I would be happy to take any questions you might have.

Senator THURMOND. Thank you very much. I want to compliment you on your fine record.

Ms. SAWYER. Thank you, Mr. Chairman.

Senator THURMOND. I have heard so many nice things about you. You are not only nice looking, but you are a very efficient woman.

Ms. SAWYER. Thank you, Mr. Chairman.

Senator THURMOND. Director Sawyer, your budget for the new fiscal year requests about $2 billion in new funding to construct or complete construction of 17 new prisons over the next 3 years. Is

this new funding, including advanced appropriations, critical to help you control overcrowding?

Ms. SAWYER. It is absolutely critical, Mr. Chairman. As I indicated, our crowding levels are really at very dangerous proportions, especially at our medium and high security levels, which are the most dangerous inmates in our system. We desperately need to have more prison beds coming on line. We are trying to build them as fast as we can to get the beds on line quickly. We appreciate the great support and resources we receive from the Congress, and we desperately need each and every one of those beds we are requesting.

Senator THURMOND. Director Sawyer, the GAO review of health care costs in the Bureau of Prisons shows that unlike the national trend, your per-capita health care costs are declining. What do you credit as the primary reason you have been able to keep per-capita inmate medical costs under control?

Ms. SAWYER. Well, we have been watching our costs very carefully, Mr. Chairman, looking for every way possible to bring those costs down, and we have identified a number of things that have had a great impact on our costs. One was reorganizing or changing the way we staff our health care operations.

We used to be very reliant on physicians and mid-level practitioners, physician assistants. We find that by spreading the health care resources a little differently, by bringing in more registered nurses and licensed practical nurses and other staff to do the lesser skilled work, frees up, then, the physicians and physician assistants to do what they are trained to do, and that is provide medical care, but at much less cost to the taxpayer.

We have entered into a number of cooperative agreements with the Veterans Administration and the veterans hospitals. We share some contracts with them. We do laboratory work together. We have a cooperative agreement with them, or a contract on our pharmaceuticals that we are able to achieve at a much lesser cost through the VA.

Telemedicine has been a great boon for us, and I think we have only just begun to see the benefits of telemedicine because that not only saves us money in terms of the amount that we spend for the consultant medical staff, but it saves us the cost of transporting an inmate downtown to a local hospital. We are able to do it using the technology of teleconferencing, telemedicine. We are getting wonderful results there and significant cost savings. So there are a number of different strategies that have resulted in our cost savings.

Senator THURMOND. Director Sawyer, as you are well aware, the inmate population continues to grow and it is aging. Also, more and more inmates have serious health conditions such as AIDS. Will problems such as these make it harder to keep health care costs under control in the future?

Ms. SAWYER. Well, I think it is specifically because we envisioned both of these things coming our way, an aging population as well as the many infectious diseases that come into our institutions—HIV, hepatitis, tuberculosis. That is exactly why we took such an aggressive approach to reducing our costs because we need to be able to keep those costs down to a reasonable level and still meet

the medical needs of both the aging population and the many infectious diseases that come our way.

Senator THURMOND. Director Sawyer, do you think it is a problem today that too many inmates seek medical care when it is not needed, and would requiring prisoners to make a modest co-pay for non-emergency care help prevent prisoner abuse of health care privileges?

Ms. SAWYER. Yes, we do, Mr. Chairman. We have done a lot of tracking and counting the numbers in our institutions. We believe that about 25 to 35 percent of those inmates who come to sick call really don't need to come to sick call. They are trying to get off a day of work or get out of a school class and not have to attend. They really don't need to be utilizing the very expensive medical resources that we have available. We believe the medical co-pay requirements where the inmates would have to pay just a nominal amount for, again, non-emergency situations would reduce the abuses of sick call.

Senator THURMOND. Director Sawyer, the GAO review of health care costs concludes that the Bureau could save money if it could pay hospitals at Medicare rates, especially if benchmarking efforts were expanded. Do you agree that these appear to be promising methods to help BOP control medical costs in the future?

Ms. SAWYER. Yes, we agree that both of those are promising initiatives. We are very much hoping to someday achieve approval of the legislation that would allow us to have Medicare rates capped by the outside hospitals. We believe it would save up to 50 percent of what we are currently paying now on health care costs out in the local hospitals.

The benchmarking is a very promising thing, and we are teaching all of our staff around the system how to do benchmarking when they are developing new medical contracts. It is very promising in some locations, especially the inner city and some other areas around the country. We are a little wary of it in some of the smaller, more remote communities where we are located because communities that have a larger poor population get offsets by Medicare. There are multipliers that actually increase the costs somewhat. So we want to look at it a little carefully in terms of some of our remote institutions to make sure there truly will be a cost savings utilizing the benchmarking approach in some of those locations.

Senator THURMOND. Director Sawyer, the August 1999 report of the Inspector General raises concerns about inmates using telephones to continue criminal activity from behind prison walls, such as drug trafficking. Are you concerned about this issue, and what steps have you taken to respond?

Ms. SAWYER. We are very concerned about this issue, Mr. Chairman, and our concern for this was what led us to be looking to utilize the new technologies that exist today to get much better control over inmate access.

We have been trying to put into place a new technology phone system for the last several years and we ran into some serious glitches both in terms of some protests to our contracts as well as some litigation which delayed our ability to put in the new system.

During that same time period, though, as GAO noted, we were growing dramatically and we had a lot of brand new staff coming in, and our own practices and procedures and our policies fell short in terms of being able to be sure that we identified all the inmates who were going to attempt to continue illegal activities in the institutions.

So we are now very clearly targeting getting that new technology in place by November of this year. Since the GAO report, we have implemented a lot of new practices and procedures and oversight and monitoring to make sure that we do control any inmate who attempts to abuse our phone systems.

Senator THURMOND. Director Sawyer, I understand from the IG report that some BOP facilities limit prisoner phone calls to 15 minutes each. Do you think that all BOP facilities should limit the length and total number of calls that a prisoner can make on a weekly or monthly basis?

Ms. SAWYER. Yes, Mr. Chairman. We believe, as GAO does, that one of the ways to get better control over abuses is to limit access to calls. Again, we have already cut back access in our institutions currently, shutting down the phone systems during the daytime when inmates are supposed to be working, and shutting all the phones off later in the evening as the evening comes to an end.

Our plan is with the new phone system, we have it installed now in 40-some institutions, and that will automatically cut you off after a 15-minute phone call and it will restrict how long you have to wait before you can make another phone call. Again, the new technology coming is going to give us some wonderful benefits.

With the 140,000 inmates that we have in our system and 90-some institutions, it is hard to keep controls on these things manually anymore because we are so big, and the new technology will just give us tremendous new capabilities, including cutting an inmate off after a 15-minute call.

Senator THURMOND. Director Sawyer, what is the status of implementing ITS–II, your new telephone monitoring system, in all facilities, and what effect will it have on curbing inmate telephone abuses?

Ms. SAWYER. Currently, 42 of our 95 institutions are already fully installed with the ITS–II system. The remainder of the institutions will be completed by November of this year, 7 months away. It will do a number of things for us. It will identify every inmate using the telephone with a PIN number. We will know exactly which inmate is on the phone. We will know which numbers they are calling because it can restrict you to just 10 approved numbers by us.

It cuts you off after 15 minutes. It controls how frequently you can use the phones, so it controls the inmate access. But the other thing it does is it allows us to do a lot of cross-referencing to really target abuses. We can tell how much time over the course of a week or a month you may be trying to utilize the phone. If you are using it excessively, obviously you are probably up to no good, and we can target your calls and monitor them even more carefully.

We can cross-reference numbers to determine whether or not multiple inmates are trying to call the same numbers which may suggest illegal activity going on there, or at least something that

is not appropriate. They will be able to cross-reference numbers with any numbers that law enforcement officials have that they know are known drug connections. And if our inmates are utilizing any of those numbers, we can pull it up quickly through the new technology. There is just a wealth of capabilities that this new system will provide for us, and again it will be fully operational by November of this year.

Senator THURMOND. Director Sawyer, is Prison Industries better than other prison work programs to teach inmates skills they need when they are released and to help prevent recidivism?

Ms. SAWYER. Absolutely, Mr. Chairman. We believe that the Prison Industries program is the best possible way to teach good work skills and develop good work habits, and research backs us up with that fact. Traditional vocational training programs teach the skill, but there is not sufficient live work then for the inmates to be able to do to develop the proper kinds of work habits and really make those skills reality for them.

The Prison Industries program enables us to do both teach the skills, develop the good work habits, and also give them real work over an extended period of time to really hone their skills so that by the time they are released, they are very ready to go back into law-abiding society and have good employment.

Senator THURMOND. Director Sawyer, assuming that Congress eliminated the mandatory source preference for Prison Industries regarding the Federal Government but did not give Prison Industries the authority to sell products in the private sector, what impact would this have on Prison Industries?

Ms. SAWYER. We believe it would have a serious impact upon Prison Industries. We don't know exactly the volume that it will have, but we know that if we lose the mandatory source, we will lose some sales in some of the traditional markets that we have been involved in historically.

That is exactly why, as you indicated in your opening comments, Mr. Chairman, should we lose mandatory source, we must have some new opportunities open to us, some new authorities that will allow us to sell to some other markets in order to keep an adequate number of inmates employed in Prison Industries.

Senator THURMOND. Director Sawyer, if Prison Industries were permitted to make products for sale in the commercial market and paid comparable wages similar to State prison work programs, would Prison Industries be able over time to eliminate the mandatory source preference that it now has in the Federal market?

Ms. SAWYER. We believe that that is one vehicle that would help us certainly reduce our reliance on mandatory source. Being able to sell in the commercial market and pay prevailing or minimum wage is a program that is available to State facilities right now, State correctional systems. It is called the Prison Industries Enhancement program, PIE program, and we believe that that would help us to achieve the kinds of sales levels that we need.

The other area that would be helpful, as you referenced earlier, is being able to make products that are currently being manufactured offshore and then brought back and sold in this country. If we could have access to the commercial market for those kinds of

products also, we believe the combination of the two would significantly reduce our need for mandatory source.

Senator THURMOND. Director Sawyer, do you think it would be beneficial for the Bureau of Prisons and for American companies if Prison Industries were allowed to make products that are currently made by foreign labor outside of the United States?

Ms. SAWYER. Yes, we certainly do, Mr. Chairman. We think that is a wonderful opportunity for us because those jobs have already left this country. We wouldn't be harming the domestic labor market at all, but it would give good work to our inmates and develop good work skills.

Senator THURMOND. Director Sawyer, on the issue of inmate telephone calls, it seems that one way to deter prisoner abuse of phones is to provide tough, consistent punishment for inmates who abuse their telephone privileges. What is the Bureau's policy for the discipline of these inmates?

Ms. SAWYER. We agree exactly with that point, Mr. Chairman, and it was one of the issues raised by the Inspector General's office also. Our disciplinary response to inmates in the past had not been as tough as we could make it, so we have made some significant changes in that regard giving a lot more teeth to the disciplinary action that will occur for those inmates who abuse our phone systems.

Senator THURMOND. Director Sawyer, are three-way calls a significant problem, and will the ITS–II telephone system help prohibit inmates from making three-way calls?

Ms. SAWYER. Yes, Mr. Chairman, three-way calls are very difficult for us, and unfortunately the ITS system in and of itself will not resolve that problem for us. There is currently no technology out there that can clearly identify and clearly eradicate three-way calls. We continue to work with the technology experts in the field of telecommunications and as soon as they land on anything that is usable in terms of three-way calls, we will include that into the ITS system. But currently there is nothing that is fail-safe that would identify for us three-way calls.

Senator THURMOND. Director Sawyer, I believe that completes the questions I had in mind. Do you have anything else you want to say?

Ms. SAWYER. No, sir. Again, I just thank you for your support of the Bureau of Prisons.

Senator THURMOND. Thank you again for your good work.

Ms. SAWYER. Thank you, sir.

[The prepared statement of Ms. Sawyer follows:]

PREPARED STATEMENT OF KATHLEEN HAWK SAWYER

Mr. Chairman and Members of the Subcommittee: I am pleased to appear before you today to discuss the operations of the Federal Bureau of Prisons (BOP). Let me begin by thanking you, Chairman Thurmond, Ranking Minority Member Senator Schumer, and other members of the Subcommittee for your strong support of the BOP. I look forward to continuing our work with you and the members of the Subcommittee.

The BOP continues to meet effectively our mission to protect society by confining offenders in facilities that are safe, humane, cost-efficient, and appropriately secure, and that provide work and other self-improvement opportunities to assist offenders in becoming law-abiding citizens. Through their dedication and outstanding con-

tributions, over 31,000 BOP staff manage over 140,000 inmates in 95 institutions and contract confinement facilities throughout the country.

POPULATION GROWTH AND RESOURCES

During fiscal year 1999, the BOP experienced its second consecutive year of record breaking inmate population increases. In fiscal year 1998, the population increased by more than 10,000, and in fiscal year 1999, the increase was over 11,300. By fiscal year 2007, we anticipate a Federal inmate population of approximately 205,000. That is growth of nearly 50 percent over the current level.

Overcrowding in BOP facilities is 34 percent over capacity system wide. At medium and high security facilities overcrowding levels are at even more dangerous proportions, 55 percent at medium security facilities and 51 percent at high security facilities. We must reduce overcrowding at those facilities for the security of staff, inmates, and the surrounding communities. With the resources Congress has already provided, we are making substantial progress with 22 new prisons funded. However, we need to do more. In the fiscal year 2001 budget request we seek funding and advanced appropriations to fund 9 new prisons over the next three years. Advanced appropriations, coupled with design-build contracting, will enable the BOP to build the new facilities more quickly and at less cost.

DISTRICT OF COLUMBIA (DC) FELONS

In addition to absorbing the rapidly increasing federal inmate population, the BOP has begun assuming responsibility for sentenced felons from the District of Columbia (DC), as required by the National Capital Revitalization and Self-Government Improvement Act of 1997 (the "DC Revitalization Act"). The BOP also continues to move forward on the Revitalization Act requirement to privatize confinement for at least 2,000 DC sentenced felons. Environmental and legal challenges have delayed our efforts to transfer the inmates to privately operated prisons, but we have accepted almost 2,300 DC sentenced felons from the DC Department of Corrections facilities for placement into facilities operated by or under contract with the BOP. Over 900 of these inmates are currently housed in a facility operated by the Virginia Department of Corrections.

During fiscal year 2000, the BOP will accept on an on-going basis from the DC Department of Corrections, minimum and low security male sentenced felons, female sentenced felons, and sentenced Youth Rehabilitation Act (YRA) offenders. The inmates to be accepted include both new Superior Court commitments and those confined in the DC Department of Corrections (or facilities under contract with the Department of Corrections). We will continue to accept, on a case-by-case basis, special management cases, as well as inmates with chronic medical problems who can be housed in the general population of a BOP minimum or low security facility. Further, despite severe overcrowding at our penitentiaries and medium security facilities, we have agreed to take up to five maximum custody inmates per month who have shown by their behavior that they are incapable of functioning in an open inmate population. Also, contingent upon BOP capacity, transfer of additional mental health/medical cases will be accomplished.

Absorbing the DC sentenced felons into the BOP presents an extraordinary challenge. BOP facilities are extremely overcrowded, and the new prison facilities being constructed to absorb DC felons will not be ready until after the transfer deadline of December 31, 2001. In the preliminary drafts of the Revitalization Act, the Lorton closure date was 2003, consistent with BOP estimates for construction completion of new facilities. However, when enacted, the date for closure was 2001, and thus we are not in the best position to absorb these inmates. We are, nevertheless, committed to meeting the requirement of the act and receiving all inmates by the end of 2001.

Finally, we continue to seek a modification to the 50 percent privatization requirement in the DC Revitalization Act. This charge is necessary because nearly two-thirds of the D.C. Code sentenced felons are classified as medium and high security under our classification system. Consequently, to meet the 50 percent requirement in the Revitalization Act, the BOP would have to place more than 2,000 medium and high security offenders in contract prisons. Consistent with the Administration's position that the private sector has not yet established a sufficient track record in housing these offenders, the BOP believes it would present a significant risk to public safety if the higher security D.C. offenders were to be placed in privately operated prisons. Accordingly, we are seeking language to provide us with the same discretion that we have with other federal inmates to determine which D.C. felons can appropriately be placed in private facilities, consistent with the safety of staff and inmates and the surrounding community.

INMATE PROGRAMS

The BOP takes its mission very seriously and is very committed to providing inmates with programs designed to help them make the most of their time in custody and successfully reenter the community upon release. We provide a variety of correctional programs that further these objectives, including drug treatment, education, vocational and work skills training.

Residential drug abuse treatment

The BOP operates residential drug treatment programs for the nearly 30 percent of the federal inmate population who have histories of substance abuse. Residential programs (where inmates live in housing units devoted to drug treatment activities) are the most significant component of the drug treatment process. Through our 44 residential drug abuse treatment programs we provide treatment to all eligible offenders with substantiated histories of moderate to serious drug abuse. Nearly 50,000 inmates have completed this program since 1990. An interim report from an ongoing evaluation of BOP residential drug abuse treatment programs showed that individuals who had been released to the community for a minimum of six months after completing residential treatment were 73 percent less likely to be arrested for a new offense and 44 percent less likely to test positive for drug use, as compared to similar inmates who did not complete the program.

Education and vocational programs

Last year nearly 6,000 inmates completed their General Education Degree (GED) and thousands of others completed a variety of additional education programs, as well as vocational training programs. Through these programs, inmates gain knowledge and skills that help them become gainfully employed upon release and avoid new criminal conduct. These programs have been shown by BOP research to significantly reduce recidivism. I will address the value of work skills programs in more detail below in the context of Federal Prison Industries.

Life skills programs

In recent years the BOP has developed a host of new programs intended to assist inmates make a better adjustment to prison life, to help those who had been involved with gangs adapt to independent functioning as inmates in prison and as citizens after release to the community, and help those inmates with deficiencies in life skills improve their functions while being incarcerated and upon release. The programs are designed to bring about a significant increase in the quantity and quality of interactions between staff and inmates. The goal of these interactions is to increase the likelihood that staff will have a positive influence over the inmates, as well as a greater opportunity to prevent illicit inmate behavior. They also emphasize the development of positive, pro-social values and behaviors that will enable inmates to manage better their lives in the institution and upon return to the community; all are designed to teach individual responsibility, respect for the law and authority, and pro-social coping and interacting skills.

We remain committed to self-improvement programs for inmates and their significance to our overall mission despite the substantial overcrowding and the additional strain that it puts on our staff in providing programs.

FEDERAL PRISON INDUSTRIES

As I have testified on previous occasions, Federal Prison Industries (FPI) is the BOP's most important and cost-effective correctional program. FPI, which is entirely self-sustaining and operates without any appropriated funds, provides an important inmate program at no cost to the taxpayers. FPI's mission is to: (1) employ, instill good work habits in, and provide skills training to as many inmates as possible; (2) contribute to the safety and security of federal prisons by keeping inmates constructively occupied; (3) produce market-priced, quality good for Federal Government customers; (4) operate in a self-sustaining manner; and (5) minimize its impact on private business and labor. FPI employs nearly 21,000 inmates, representing approximately 25 percent of the sentenced, medically eligible, federal inmate population. Inmates employed by FPI learn marketable job skills, develop a strong work ethic, and are less likely to engage in prison misconduct.

In addition, inmate employment in FPI reduces recidivism and thereby increases public safety. A comprehensive study conducted by the BOP demonstrated that FPI is an important rehabilitation tool that provides inmates an opportunity to develop work ethics and skills that can be used upon release from prison. Inmates employed by FPI were found to be 24 percent more likely, upon release, to become employed and remain crime-free for as long as 12 years after release.

The FPI program also contributes significantly to the safety and security of the BOP's correctional facilities. FPI keeps inmates productively occupied and reduces inmate idleness and the violence and other misconduct associated with it. In recent years, FPI's role as a correctional program has become even more important as the inmate population and institution overcrowding have increased substantially. The FPI programs are essential to the security of communities in which they are located, the Federal Prison System, its staff, and inmates.

For many years now, some members of the business and organized labor communities have voiced strong concerns that the mandatory source preference gives FPI an unfair competitive advantage in the federal market place. The debate has intensified in recent years as the number of inmates employed in FPI has increased with a corresponding increase in output of goods and services. The increases are drive by the past two decades bi-partisan federal criminal justice policy of putting more people in prison for longer periods of time. There is now an ongoing dialogue between interested Members of Congress, FPI, private business, and organized labor that we hope can achieve a solution that will simultaneously satisfy the legitimate concerns and competing issues of all interested parties.

Should FPI now forgo its mandatory source status, as an offset for sales and inmate job assignments that would be lost as a result, the BOP clearly needs alternative opportunities in order to maintain current inmate employment levels in industries.

We believe there is broad-based consensus for several principles, which should guide the development of these opportunities:

- Private businesses should be allowed to compete for federal business.
- Federal customers should have more discretion in procuring products.
- EPI should operate in a manner that minimizes any adverse impact on domestic companies and workers.
- EPI should employ inmates and provide job skills training to provide for secure prison management by reducing inmate idleness and to reduce recidivism by prisoners who are released to the community.
- EPI should operate in a self-sustaining manner.

MEDICAL ISSUES

Chronic health care costs

The number of inmates over 50 years old confined in BOP facilities is gradually increasing. While it is true that the aging inmate population has inordinate needs for health care, we have found that younger inmates who have a history of high risk behaviors are also prone to significant health concerns (e.g., HIV, hepatitis). Specifically, many of our elderly inmates have no significant health care needs, and are appropriately housed based upon their security levels in our general population facilities. The bulk of our health care costs emanate from our Medical Referral Centers (essentially prison hospitals), which house some elderly offenders, but also house large numbers of younger offenders suffering from chronic, debilitating diseases that result from the lifestyle as they have led.

Infectious disease

Large urban correctional systems, like the District of Columbia system, have consistently reported higher rates of drug use among their inmates, a behavior strongly linked to blood borne pathogen infections, such as HIV and hepatitis B and C. For example, studies of the felon population at the DC Jail have shown HIV infection rates of 8–10 percent, while the prevalence of HIV infections in the BOP inmate population has been steady at 1 percent over the past decade (based upon our random seroprevalence studies and clinical observations, we can estimate that our seroconversion rate is extremely low). Accordingly, we expect that our health care costs will rise as a result of absorbing the DC Code offenders, since treating HIV-infected inmates is very expensive; medical care averages $20,000 per year per HIV-infected inmate, compared to just over $3,200 per year per non-infected inmate.

General Accounting Office audit of BOP health care costs

From July, 1999 to February, 2000, the General Accounting Office (GAO) conducted an audit of the BOP's inmate health care costs. GAO found that inmate health care costs rose from 1990 to 1996, but declined thereafter. In comparison, nationwide health care costs rose continuously from 1990 to 1998. They further noted that several BOP health care cost-containment initiatives are beginning to produce savings.

GAO also highlighted the BOP's support for two legislative initiatives that could improve inmate health by increasing efficiency and potentially reducing medical costs, while maintaining the quality of inmate health care. First, H.R. 1349 and S.

704 are companion bills that provide the BOP the authority to charge non-indigent inmates a minimal copayment fee for health care visits. These bills seek to decrease health care visits scheduled by inmates who do not have genuine medical concerns, but sign up for "sick call" to avoid required activities (e.g., work assignments, education classes). The Department strongly supports these bills, and believes they would provide a significant tool to assist BOP medical staff to more appropriately spend time evaluating and treating inmates with legitimate medical needs. Additionally, we believe these bills would further our efforts to help inmates understand the importance of personal responsibility.

A Medicare rate-based cap on payments to hospitals that treat federal inmates, similar to that already granted to the Department of Defense and the Department of Veterans Affairs, might produce substantial health care savings without decreasing the quality of health care inmates receive. Our analysis of a small sample of BOP inmate health care billings to outside hospitals revealed that the Medicare rate cap provision would have saved the BOP almost 50 percent of the total hospital bills included in the sample.

INMATE TELEPHONE USE

From February, 1998 to August, 1999, the Office of the Inspector General (OIG) conducted an audit of the BOP's inmate telephone system (the results of the audit were published in a report entitled "Criminal Calls: A Review of the Bureau of Prisons' Management of Inmate Telephone Privileges"). The report identified some significant problems that have occurred over the years with inmates abusing their phone privileges. We have been working diligently to improve both the inmate telephone system and our monitoring to address the shortcomings in the program. The systems in place today are significantly better than in past years. The systems and operating procedures, and monitoring capabilities planned for the future are the best available in the field of corrections, and I believe the BOP has repeatedly assumed a national leadership role in the development of inmate telephone monitoring hardware, software, and investigative strategies.

The BOP recognizes the importance of inmates maintaining close family ties, through visits, written correspondence, or telephone calls, in order to assist with their successful reentry to society following release from prison. Unlike many smaller state correctional systems that generally house inmates relatively close to home, the federal system must sometimes house inmates far from their families. As a result, social visits may occur less frequently, greatly increasing the importance of inmate telephone contact with family members. The BOP has provided inmates with access to collect call telephones for many years, and as a matter of security we have recorded all non-attorney calls and have randomly monitored non-attorney conversations. However, as our population has grown dramatically since the late-1980's, our traditional mechanisms to prevent inmate telephone abuses have been outpaced by population growth. Therefore, we have had to turn to new and improved technologies to prevent abuses.

As part of our technological advancement, in the early 1990s the BOP began developing a new telephone system that would provide inmates with debit calling and would enhance our monitoring capacity. While implementation of these technological advances has been delayed by litigation and contracting difficulties, we are now making substantial progress installing our most recent generation debit calling telephone system (ITS–II), and we hoe to have it installed in all federal prisons by November 2000. This new system will allow the BOP to significantly increase control of every inmate's calling privileges. The system can provide staff with numerous reports to assist in monitoring inmates and determine which inmates may be attempting to abuse telephone privileges. Additionally, the system links together all BOP facilities for information sharing among staff about inmate phone usage, and makes this information readily available to our headquarters.

In the OIG report, it was recommended that the BOP make changes in four broad areas: increased telephone monitoring, increased discipline of telephone abusers, proactive telephone restrictions for certain inmates, and detection and deterrence of inmate use of telephones for criminal activity involving the community. We have taken actions in all of these areas.

• We are revising training protocols and tracking systems to enhance proactive monitoring of inmate telephone calls. This will allow us to increase surveillance of inmates who are more likely to abuse the telephones and to better understand some of their often coded conversations. We have established a target date of June 30, 2000, for implementation of this initiative.

• We are developing a national contract to install state-of-the-art recording equipment in our institutions, and we are reviewing the potential for use of technologies

that enhance detection of three-way calling and other prohibited practices. We are conducting a pilot test of new technology and anticipate completion and assessment of the pilot data by December 31, 2000.

• On December 1, 1999, we modified our institution misconduct policy to reflect new offense codes for engaging in coded conversations, with loss of telephone privileges as one of the available sanctions. However, prior to implementation of these changes, our union (AFGE) notified us that, in accordance with the Master Agreement, they intend to negotiate this policy change. We are unable to provide a target date at this time, but we are hopeful these changes can be implemented very soon.

• On January 5, 2000, the BOP implemented the recommendation to use the Security Threat Group (STG) "telephone abuse" category more frequently and set better standards for its use. This will allow BOP staff to increase and enhance overall institution monitoring of targeted inmates.

• We have modified our inmate classification procedures to permit proactive restrictions upon inmate telephone privileges.

CONCLUSION

I am very proud of the BOP staff and the job they do each and every day. Despite our record setting population growth, evidenced by the net increase of 1,800 new inmates in the BOP last month alone, we see indications of our effective prison management. For example, over the past 5 years we have had substantial decreases in both inmate suicides and inmate misconduct, including assaults. However, such successes cannot be expected to continue in the face of the dramatic population increases and record setting overcrowding we project will occur in the next several years. Without the resources we have requested to bring additional bed space capacity on line, our record of service may be in jeopardy.

The BOP's mission involves myriad program and policy issues; today I have touched on just a few key topics. I'd like to thank you, Mr. Chairman. and Members of the Subcommittee for the opportunity to provide an update on the operations of the Bureau of Prisons. This concludes my prepared remarks, and I would be pleased to answer any questions you may have.

Senator THURMOND. Our next witness is Richard Stana, Associate Director for Administration of Justice Issues at the General Accounting Office. Mr. Stana, who has been with the GAO for 24 years, has a master's degree from Kent State University. He will present the findings of GAO regarding containing health care costs for an increasing inmate population.

Our final witness is Glenn Fine, Director of the Special Investigations and Review Unit of the Justice Department's Office of Inspector General. He has been with the IG's office for 5 years and received an undergraduate and a law degree from Harvard. He will discuss the IG report, Criminal Calls: A Review of the Bureau of Prisons' Management of Inmate Telephone Privileges.

I would ask that you please limit your opening statements to no more than 5 minutes. Your written testimony will be placed in the record, without objection.

We will start with Mr. Stana.

PANEL CONSISTING OF RICHARD M. STANA, ASSOCIATE DIRECTOR, ADMINISTRATION OF JUSTICE ISSUES, GENERAL GOVERNMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC; AND GLENN A. FINE, DIRECTOR, SPECIAL INVESTIGATIONS AND REVIEW UNIT, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

STATEMENT OF RICHARD M. STANA

Mr. STANA. Thank you, Mr. Chairman. I am pleased to be here today to discuss the results of our review which we did at your request of the Bureau of Prisons' efforts to contain rising inmate health care costs.

As you know, the inmate population in the Federal prison system is growing at a dramatic rate. Over the last 3 years, roughly 1,000 inmates were added to the Federal prison population each month, and BOP projects it will have almost 200,000 inmates by fiscal

year-end 2006. That is about 50 percent more than it has today. This population growth——

Senator THURMOND. Did you say 1,000 a month?

Mr. STANA. One thousand a month.

Senator THURMOND. Increase?

Mr. STANA. Yes, sir.

This population growth, along with the effect of mandatory minimum sentencing for drug-related crimes and the aging of the inmate population, has placed unprecedented demands on BOP's health care system. My prepared statement discusses in detail the trends in BOP's health care costs, the various initiatives BOP has undertaken to address these trends, and some options for controlling rising costs.

In my oral statement, I would like to highlight two main points. First, BOP's overall health care costs are on the rise on an overall basis. They increased by about 170 percent during the 1990's. Population increases aside, the three major cost drivers are salaries of BOP medical personnel, the cost of community hospital services, and salaries and relocation expenses of Public Health Service personnel.

However, BOP health care costs look much differently when analyzed on a per-capita basis rather than an overall basis. Adjusted for inflation, per-capita costs rose steadily, from about $3,000 in 1990 to a high of about $3,700 in fiscal year 1996, then decreased these past 3 years to about $3,250 per inmate in fiscal 1999. In contrast, the nation's per-capita health care costs rose continuously during the 1990's, to about $4,140 per capita in 1999.

In part, this recent downward trend is a result of many cost containment initiatives that Director Sawyer mentioned in her statement. Among these are medical staffing restructuring, obtaining discounts through quantity or bulk purchases, leveraging resources through cooperative efforts with other Government entities, centrally pre-certifying inmates for surgery before they are sent to community hospitals, using telemedicine, and even privatizing services at selected facilities. Collectively, BOP reports that these initiatives are saving millions of dollars each year.

My other point focuses on the next steps toward controlling BOP's health care costs. Two of these steps are embodied in legislative provisions. One provision would authorize the Director of BOP to assess and collect a fee of not less than $2 for certain health care visits requested by an inmate. CBO estimates this provision would generate annual revenues of about $1 billion, but by law these revenues would go to the victims of crime and not to BOP. Rather than being a revenue generator, the value to BOP is to reduce the number of unnecessary medical visits and free up limited resources for the inmates who need them the most.

The second legislative provision would allow BOP to emulate Medicare's prospective payment rates which vary with each hospital. These Medicare rates would become a cap to BOP's payments to community hospitals for services provided. This is significant because about one-fourth of BOP's total health care costs are for contracted services with community hospitals. CBO estimates that this provision would save BOP about $6 million annually. We believe

that both legislative provisions would be helpful to BOP's efforts to control medical costs.

Another step is one BOP could take without legislative action. Given its increasing reliance on community hospitals, BOP needs to negotiate more cost-effective contracts. BOP's South Central Region recently began using an innovative approach called benchmarking to identify best value among competing proposed contracts.

Specifically, the region required bidders to use a common or standard benchmark rate—that is, the Medicare Federal rate—and to separately show a proposed percentage markup or discount to that benchmark rate. This not only makes it easier to compare bids, but it also allows for more accurate payment for services rendered.

According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. We are recommending that BOP take steps to test the benchmarking approach in other regions and, if the test validates its cost-effectiveness, implement it BOP-wide.

Mr. Chairman, this concludes my oral statement. I would be happy to answer any questions you have.

Senator THURMOND. Mr. Stana, your report shows that the Bureau of Prisons is saving money with its private contract with the local medical university in Beaumont, Texas. Do you think it could be beneficial in the future for the Bureau to look for partnerships with other teaching medical centers as a way to control costs?

Mr. STANA. Well, there is a lot of merit in this proposal. They are saving about $4 per inmate per day on this contract, but I also ought to say at the same time that it is not clear that this contract and the costs that are connected with it would necessarily be able to be duplicated in other locations, for a number of reasons.

The long-term care is passed on to BOP and the contractor himself has said that they could no longer do it for this amount of money. So while the concept is a good one, I am not so sure that the exact features of the Beaumont contract could be duplicated.

Senator THURMOND. Excuse me. I want Mr. Fine to make his opening statement.

[The prepared statement of Mr. Stana follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Criminal Justice Oversight
Committee on the Judiciary
U.S. Senate

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FEDERAL PRISONS

Containing Health Care Costs for an Increasing Inmate Population

Statement of Richard M. Stana, Associate Director
Administration of Justice Issues
General Government Division

GAO/T-GGD-00-112

Summary

Containing Health Care Costs For An Increasing Inmate Population

In conjunction with a rising federal inmate population, the Bureau of Prisons' (BOP) health care costs (not adjusted for inflation) for treating prisoners increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent. Adjusted for inflation, BOP's per capita inmate health care costs increased from $3,001 in fiscal year 1990 to a high of $3,703 in fiscal year 1996. However, per capita costs steadily decreased in subsequent fiscal years, declining to $3,242 in 1999. By way of comparison, the nation's per capita health care costs (adjusted for inflation) rose continuously during fiscal years 1990 through 1999.

Since the early 1990s, BOP has attempted to increase the efficiency and economy of health care delivery to prisoners through various cost-containment initiatives, such as restructuring medical staffing, obtaining discounts through quantity or bulk purchases, leveraging resources through cooperative efforts with other governmental entities, and even privatizing medical services at selected facilities. BOP reports that some of these efforts are starting to produce savings, as indicated by the decrease in per capita inmate health care costs from 1997 through 1999.

To further control medical costs, BOP has proposed two legislative provisions. One—a prisoner copayment provision—would authorize the Director of BOP to assess and collect a fee of not less than $2 for each health care visit requested by a prisoner. BOP officials expect that this copayment provision would serve primarily to reduce the number of unnecessary medical visits. The Congressional Budget Office (CBO) has concluded that this provision would also generate annual revenues of about $1 million. The second provision would build on the federal government's extensive experience in establishing payment rates for inpatient hospital services through Medicare's prospective payment system. That is, Medicare's prospective rates, which vary to reflect expected patient-care costs, could be adapted to serve as caps to BOP's payments to community hospitals for services provided to federal prisoners. The CBO has estimated that this legislative provision would save BOP about $6 million annually. Although we did not fully evaluate the advantages and disadvantages of these two legislative provisions, we believe that they would be helpful to BOP's efforts to control medical costs.

In addition, we identified an administrative option whereby BOP might achieve further savings by negotiating more cost-effective contracts with community hospitals that provide medical care for inmates. In late 1999, to provide a basis for identifying best value among competing proposed

contracts, one of BOP's six regions—the South Central Region—began using an innovative "benchmarking" approach. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. We are recommending that BOP (1) take steps to test the benchmarking approach and (2) if results validate the cost effectiveness of this approach, implement it BOP-wide.

Statement

Federal Prisons: Containing Health Care Costs for an Increasing Inmate Population

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our review of health care costs at the federal Bureau of Prisons (BOP). We undertook this work at the request of, and as agreed with the Subcommittee. We focused our work primarily on identifying (1) trends in BOP health care costs from fiscal year 1990 through fiscal year 1999, (2) BOP initiatives to contain rising medical costs, and (3) legislative and administrative options for helping to contain health care costs.

My statement is based on our analyses of BOP statistics and reports and on interviews with officials in BOP's central office and six regional offices and officials with the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which administers the Medicare program. We performed our work from July 1999 to March 2000 in accordance with generally accepted government auditing standards. Regarding the various cost-containment initiatives or proposals discussed in this statement, we did not independently verify the savings estimates made by BOP and the Congressional Budget Office (CBO). Attachment I presents additional details about our scope and methodology in addressing the objectives.

In this statement, I make the following points:

- In conjunction with a rising federal inmate population, BOP's health care costs (not adjusted for inflation) increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent. Adjusted for inflation,[1] BOP's per capita inmate health care costs increased from $3,001 in fiscal year 1990 to a high of $3,703 in fiscal year 1996. The per capita costs steadily decreased in subsequent fiscal years, declining to $3,242 in fiscal year 1999. In contrast, the nation's per capita health care costs (adjusted for inflation) rose continuously during fiscal years 1990 through 1999.

- Since the early 1990s, BOP has attempted to increase the efficiency and economy of health care delivery to prisoners through various cost-containment initiatives, such as restructuring medical staffing, obtaining discounts through quantity or bulk purchases, leveraging resources through cooperative efforts with other governmental entities, and even

[1] Throughout this statement, when we present health care cost data adjusted for inflation, we used the gross domestic product (GDP) price index, with 1998 as the base year.

privatizing medical services at selected facilities. BOP reports that some of these efforts are starting to produce savings.

- To further control medical costs, BOP has proposed two legislative provisions. One—a prisoner copayment provision—would authorize the Director of BOP to assess and collect a fee of not less than $2 for each health care visit requested by a prisoner. BOP officials expect that a copayment provision would serve primarily to reduce the number of unnecessary medical visits. CBO's analysis also concluded that a copayment provision would reduce the number of unnecessary medical visits and would generate annual revenues of about $1 million. The second legislative provision would establish a Medicare-based cap on payments to community hospitals that treat inmates. CBO has estimated that this legislative provision would save BOP about $6 million annually. We believe that these two legislative provisions would be helpful to BOP's efforts to control medical costs.

- Finally, we identified an administrative option whereby BOP might achieve further savings by negotiating more cost-effective contracts with community hospitals that provide medical care for inmates. In late 1999, to provide a basis for identifying best value among competing proposed contracts, one of BOP's six regions—the South Central Region—began using an innovative "benchmarking" approach. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. We are recommending that BOP (1) take steps to test the benchmarking approach in other regions and (2) if results validate the cost effectiveness of this approach, implement it BOP-wide.

Background

BOP's responsibility for maintaining the federal prisoner population includes providing health care for all inmates in its custody. According to BOP's Health Services Manual, the health care mission of BOP is to provide the necessary medical, dental, and mental health services to inmates by a professional staff, consistent with acceptable community standards. BOP uses various medical care arrangements to provide health services to inmates. These arrangements include BOP's use of both internal and external health care providers.

Internally, each of BOP's 98 facilities has an on-site health service unit to provide routine, ambulatory medical care. For instance, these units are to provide care for moderate and severe illnesses, including hypertension and diabetes mellitus, as well as care for patients with HIV infection and AIDS.

A medical professional is to be either on-site or available for 24-hour continuous duty to handle medical problems that may occur during or after normal working hours.[2] According to a BOP official, inmate sick call is to be conducted on a weekly schedule at each facility, with urgent care services available at all times. If an inmate is found to have a health problem beyond the capabilities of the health service unit, BOP medical personnel are to refer the inmate to one of seven medical referral centers or, alternatively, to an outside community care provider (hospital).

To round out BOP's internal health care network, the seven medical referral centers provide hospital and other specialized services to inmates. According to a BOP Health Services Division official, the medical referral centers originally were intended to provide all of BOP's medical needs. However, despite still performing some major medical procedures (such as treatment for chronic diseases and mental illness), the centers have evolved to focus on postsurgical recovery and aftercare for inmates who have received medical treatment from outside community care providers. The change in focus was due to rapid changes in medical technology and procedures, in addition to the limited capacities of the medical centers.

BOP's health service units and medical referral centers are staffed by a combination of Public Health Service (PHS) and BOP health care employees, consisting of physicians, dentists, physician assistants/nurse practitioners, nurses, pharmacists, psychiatrists, psychologists, and laboratory and x-ray personnel. The Joint Commission on Accreditation of Healthcare Organizations has accredited all of BOP's health service units and medical referral centers.

In certain instances, BOP's internal resources cannot fully meet inmates' medical needs. If an inmate requires special medical expertise that is not available internally, BOP personnel are to seek it from an external medical provider. In addition, according to a BOP official, a continual rise in BOP's inmate population caused six of the seven[3] medical referral centers to exceed their rated capacities for patients during 1999, and this situation will likely continue in view of the projected rising prison population. For these reasons, in future years, according to a BOP official, community medical providers can be expected to play a larger role in meeting the health care needs of a growing and aging inmate population—and, in turn,

[2] In some BOP facilities, after hours care may be provided by the local community hospital.

[3] According to a BOP official, the seventh medical referral center (Ft. Devens, MA) was in the process of opening during the time of our review and, therefore, was not operating at full capacity.

this trend will increase the importance of negotiating cost-effective contracts.

Generally, secure transportation and guard escort services are required for prisoners referred from BOP facilities to community providers. Costs for transportation and guards represent additional health care expenses borne by BOP in obtaining community-based medical services for inmates. However, according to a BOP official, in some cases the community providers can visit and treat inmates inside BOP's facilities, which eliminates the need for secure transportation and guard escorts.

Trends in Health Care Costs

In conjunction with a rising federal inmate population, BOP's health care costs increased during the 1990s. According to BOP data, the federal inmate population increased from 64,936 at fiscal year-end 1990 to 133,689 at fiscal year-end 1999. Further, BOP officials estimate that the total federal inmate population will reach approximately 198,700 by fiscal year-end 2006.[4]

BOP data show that the number of inmates 46 years of age and older increased each year from 1995 to 1999. For example, the number of inmates between the ages of 46 and 50 rose from 7,937 in 1995 to 9,854 in 1999, an increase of 24 percent. Inmates 66 years of age and older rose from 881 in 1995 to 1,225 in 1999, an increase of 39 percent. A BOP official attributed the "aging" of the inmate population, in part, to changes in sentencing laws that are intended as get tough on crime measures—laws involving, for example, mandatory minimum sentences and repeat offender provisions. According to the BOP official, older inmates place greater demands on the health care system than do younger inmates.

BOP's health care costs (not adjusted for inflation) increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent.[5] However, BOP's health care costs as a percentage of total operational costs were fairly stable, averaging 13 percent annually during this period.

During fiscal years 1990 through 1999, BOP's cumulative health care costs for inmates totaled about $2.7 billion. For this 10-year period, table 1 shows the following:

[4] Attachment II presents more information about BOP inmate population trends.

[5] These figures represent operational costs. BOP categorizes its costs as operational costs (primarily salaries and other operating expenses) and capital costs (building and construction expenditures).

- Almost three-fourths of BOP's cumulative health care costs involved three categories: BOP medical personnel salaries (38 percent), community provider services (24 percent), and PHS associated costs (10 percent). Four other categories (at 5 to 8 percent each) accounted for the remainder of the cumulative costs.
- Per capita inmate health care costs (adjusted for inflation) increased from 1990 to 1999 in all of the categories except two (community provider services and miscellaneous).

Table 1: BOP Health Care Costs by Category, Fiscal Years 1990 Through 1999

Cost category	Percentage of cumulative health care costs (1990-99)	Per capita health care costs (1990)[a]	Per capita health care costs (1999)	Percentage change in per capita health care costs from 1990 to 1999
BOP medical personnel salaries	38%	$1,066	$1,225	+14.9%
Community provider services	24	741	728	-1.8
PHS associated costs	10	336	367	+9.2
Supplies	8	289	307	+6.2
Consultants	8	255	281	+10.2
Guard escort services	7	155	198	+27.7
Miscellaneous[b]	5	159	135	-15.1
Total	**100%**	**$3,001**	**$3,241**	**+8.0%**

[a]Per capita costs for 1990 are adjusted to 1999 dollars using the GDP price index.

[b]The miscellaneous category includes headquarters expenses, equipment purchases, HIV testing, transportation charges (including airlift costs), printing costs, and interest.

Source: Developed by GAO based on BOP data.

On the other hand, it must be recognized that the limited or point-to-point (1990 and 1999) comparisons in table 1 are insufficiently detailed to show trends for the intervening years. BOP's per capita inmate health care costs, adjusted for inflation, were $3,001 in fiscal year 1990, increased to a high of $3,703 in fiscal year 1996, and then decreased annually to $3,242 in fiscal year 1999. In contrast to the decrease in BOP's per capita health care costs in recent years, national per capita health care costs—that is, data for all adults and children in the United States—show a steady increase annually during fiscal years 1990 to 1999. Adjusted for inflation, national per capita health care costs progressively increased from $3,059 in 1990 to $3,970 in 1998 and to $4,140 (estimated) in fiscal year 1999.

Per capita data for selected BOP cost categories (adjusted for inflation) show the following:

- BOP medical personnel salaries: Per capita costs decreased steadily from a peak of $1,399 in 1996 to $1,225 in 1999.

- Community provider services: Per capita costs decreased from a high of $952 in 1993 to $728 in 1999.
- PHS associated costs: Per capita costs were $378 in 1997 and $379 in 1998, and then decreased to $367 in 1999.
- Guard escort services: Per capita costs decreased from $289 in 1995 to $198 in 1999.

Overall medical costs, however, are likely to continue to rise in future years, according to BOP officials. In explaining this anticipated trend, the officials noted the following reasons:

- Projections of the number of inmates incarcerated in federal facilities show continued increases.
- Felony inmates transferred to BOP from the District of Columbia Department of Corrections generally have disproportionately more medical needs than other BOP inmates.
- From the Immigration and Naturalization Service (INS), BOP is receiving increasing numbers of long-term, nonreturnable detainees.
- BOP's expenditures for pharmaceuticals likely will rise due to the increasing prevalence of illnesses such as HIV and hepatitis.

Attachments III and IV present more information about trends in BOP's health care costs.

Cost-Containment Initiatives

A BOP Health Services Division official stated that the recent downward trend in per capita inmate health care costs was due to implementation of various cost-containment initiatives. In the last several years, BOP has put into place a number of initiatives to address health care costs. In response to our inquiries, BOP officials identified a total of 23 ongoing and/or planned cost-containment initiatives. We grouped these initiatives into five categories: (1) cooperative efforts with other federal agencies to acquire medical services, equipment, and supplies; (2) other acquisition-related initiatives involving BOP only; (3) staffing-related initiatives; (4) initiatives concerning the delivery of services; and (5) health care privatization and other initiatives. Examples of initiatives in each category are discussed in the following sections.[6] As indicated, BOP has reported that some of the ongoing initiatives have resulted in cost savings.

Cooperative Acquisitions

BOP has various cooperative initiatives—either ongoing or planned—with the Department of Defense (DOD), the General Services Administration, the U.S. Marshals Service (USMS), and/or the Department of Veterans

[6] Attachment V lists all of the 23 ongoing and/or planned initiatives.

Affairs (VA). The purpose of BOP's cooperative efforts with other agencies is to save money through bulk purchasing and resource sharing. In 1993, for example, VA began including BOP in contracts to obtain discounts on high-volume purchases of pharmaceuticals. As a result of this effort, BOP has cited average annual savings of approximately $760,000. One example of resource sharing is a pilot project that began in the New York City area in 1998. Under the terms of an interagency agreement, VA physicians work in medical specialty clinics at BOP facilities to treat both BOP and USMS prisoners.

Other Acquisition-Related Initiatives

An example of another type of acquisition-related initiative is a precertification program that BOP began in 1995. That is, precertification is required before inmates are sent to community providers for inpatient surgery, other inpatient hospitalization services, or outpatient surgery. In the precertification process, BOP headquarters officials, including both policy and medical personnel, are to review and approve community-provided medical treatment being requested by BOP field personnel. According to a BOP official, it appears that precertification has led to field institutions recommending treatment only for those cases deemed to be medically necessary or medically indicated. As a result of this initiative, BOP reported savings of $785,000 in 1998.

Staffing-Related Initiatives

Regarding staffing initiatives, in 1994, wardens at some BOP prisons began eliminating 24-hour medical staff coverage, if emergency care was readily available in the community. BOP reports that this initiative has generated cost savings averaging about $1.6 million per year. A BOP official acknowledged that this initiative was implemented as a result of our 1994 report on inmate health care.[7]

Also, partly as a result of our 1994 report, BOP began restructuring its health care staff to allow for more efficient operations. For example, one staffing initiative focused on using qualified, lower-salaried medical personnel—instead of more highly paid physicians and physicians' assistants—for certain nonprimary health care duties, such as routine laboratory and pharmacy services. According to BOP, this initiative has generated annual savings of about $5.5 million.

A BOP Health Services Division official added that both the reductions in 24-hour medical staff coverage and staff restructuring caused the downward trend in BOP's health care salary costs since 1997. Also,

[7]Bureau of Prisons Health Care: Inmates' Access to Health Care Is Limited by Lack of Clinical Staff (GAO/HEHS-94-36, Feb. 10, 1994).

according to this official, the restructuring initiative has had a positive effect on BOP's second highest health care cost category (after salaries)—community provider services. That is, restructuring has reduced the number of trips to community medical providers by emphasizing the proper roles of BOP's own internal medical staff. For example, the number of occurrences of community hospitalization decreased from 5,247 in fiscal year 1997 to 5,166 in 1999. The annual number of inmate inpatient days in community hospitals also decreased over the last 5 years, from 23,257 in fiscal year 1995 to 23,107 in fiscal year 1999. The official added that the reduced number of trips to community medical providers—a result of BOP's restructuring initiative—has also resulted in reduced guard escort costs.

Delivery of Services Initiatives

In 1996, BOP began a telemedicine initiative that involves using video teleconferencing to exchange health information and provide health care services. BOP's stated goals for this program are to reduce costs, improve access to medically necessary resources, and enhance security, while delivering quality medical care to the inmate population.

In 1999, Abt Associates, Inc., performed an evaluation of this initiative and concluded that telemedicine was a widely accepted and viable cost-containment strategy.[8] Based upon the demonstration project and additional research, BOP personnel presented a proposal, in March 1999, to the BOP executive staff to implement telemedicine throughout BOP. The executive staff approved the proposal. As of November 1999, BOP had eight facilities equipped with telemedicine, with plans to add the technology to all facilities by the end of calendar year 2000.

According to a BOP official, the success of the telemedicine initiative partly accounts for the downward trend in the costs of guard escort services. As previously mentioned, BOP's per capita costs for guard escort services decreased from $286 in fiscal year 1995 to $199 in fiscal year 1998.

Privatization Initiative

BOP has an ongoing privatization project, among other health care cost-containment initiatives. Specifically, in response to a Senate Appropriations Committee report, BOP is experimenting with the delivery of health services through privatization at its facilities located in Beaumont, TX. The University of Texas Medical Branch (UTMB) is

[8] Telemedicine Can Reduce Correctional Health Care Costs: An Evaluation of a Prison Telemedicine Network (NCJ 175040), March 1999, prepared by Abt Associates, Inc., for the Joint Program Steering Group, Office of Science and Technology, National Institute of Justice.

providing all the health services for four separate prison facilities located in Beaumont.

Under the terms of its contract with BOP, UTMB was to provide medical services at the rate of $5.12 per inmate, per day in fiscal year 1998. In comparison, BOP's overall per inmate rate was $9.21 a day during the same time period. Thus, the contract rate for the Beaumont facilities seemingly represented daily savings of $4.09 per inmate, when compared with the rest of BOP.

However, according to BOP officials, the Beaumont pilot was not fully operational until the middle of fiscal year 1998, and the first full year of data for the pilot was not completed until fairly recently, that is, the end of fiscal 1999. Therefore, BOP does not expect a detailed evaluation of the Beaumont project to be completed until June 2001. BOP's Beaumont evaluation plan notes that the evaluation will include comparisons with other correctional programs to show whether privatization at Beaumont offers better value for the taxpayer, while providing the required quality of care. Also, BOP officials told us that replication of the Beaumont privatization model is a concern, particularly with respect to remote locations that do not have access to major community medical centers or teaching medical centers.

BOP Proposals for Legislation

BOP has proposed two legislative provisions to help further control health care costs. One provision would authorize the Director of BOP to assess and collect a prisoner copayment. Another provision would establish a Medicare-based cap on payments to community hospitals that treat inmates.

Proposal For Prisoner Health Care Visit Copayment

Requiring federal prisoners to help defray the cost of their health care by paying even a nominal fee for medical visits could help BOP control health care costs. Recognizing the potential for cost savings, the Senate passed S. 704 on May 27, 1999, authorizing the Director of BOP to assess and collect a fee of not less than $2 for certain health care visits requested by a prisoner. The Senate referred S. 704 to the House. A similar bill (H.R. 1349) has been introduced in the House in March 1999, and hearings were held September 30, 1999. As of March 9, 2000, there had been no further action in the House on this bill.

BOP Expects More Efficient Use of Medical Resources With a Copayment Fee Set at $2 Per Visit

If the legislation passes, BOP anticipates setting the copayment fee at $2 per visit[a], excluding indigent inmates who are unable to pay. According to BOP, a copayment fee can be expected to result in more efficient use of medical resources. Specifically, BOP anticipates the copayment fee of $2 per visit will result in more efficient use of medical resources by (1) reinforcing BOP's efforts to teach prisoners personal responsibility, (2) reducing the wait-time of genuinely ill prisoners to receive medical attention, (3) diverting fewer valuable staff hours unnecessarily, and (4) allowing medical staff to more appropriately spend their time evaluating and treating those prisoners who have legitimate medical needs.

In short, BOP anticipates that a copayment provision will discourage frivolous demands on finite medical resources—such as the practice of prisoners signing up for sick call to avoid required activities. While BOP anticipates that a copayment provision will not generate a net gain in revenue, BOP still endorses such a provision for the several previously mentioned reasons.

CBO Estimates Additional Revenue of $1 Million From Prisoner Copayments in the First Year

A May 1999 CBO analysis of the proposed $2 health care service fee estimated that BOP might generate additional revenue of at least $1 million in fiscal year 2000. CBO projected that the potential savings would increase annually in subsequent years as initial fixed or start-up costs were recovered, but also noted that actual savings would be realized only to the extent that appropriations were reduced.

Under the Senate version of the proposed copayment legislation, all fees collected from prisoners subject to restitution orders would be paid to victims. In the remaining cases, 75 percent of the fees collected would be deposited into the Crime Victims Fund, and the other 25 percent would be available to the Attorney General to help defray BOP's costs of administering a copayment fee provision and making appropriate distributions of collections. CBO estimated that administrative costs would be about $170,000 annually. BOP has suggested that the proposed legislation be modified to mandate that 100 percent of collected fees go to the Crime Victims Fund.

CBO has noted that a copayment provision would discourage some prisoners from unnecessary health care visits, perhaps reducing overall visits by up to 25 percent. CBO based its projection on the results of similar prisoner copayment programs that have been adopted in 36 states

[a] BOP supports copay fee exemptions for emergency visits, mental health visits, obstetric care, scheduled physical exams, and chronic care visits.

or local jurisdictions. The states and localities using prisoner copayment fees have, according to CBO, realized average reductions in sick call visits of 16 to 50 percent.

Proposal for Medicare Rate Cap on Hospital Payments

According to BOP, inmate health care costs could be further controlled by building on the federal government's extensive experience in establishing payment rates for inpatient hospital services through Medicare's prospective payment system.[10] That is, Medicare's rates, which vary to reflect expected patient-care costs, could be adapted as caps to BOP's payments to community hospitals for services provided to federal prisoners. A BOP official told us that no appreciable costs would be incurred in implementing a Medicare-based cap for BOP's payments to community hospitals.

In this regard, BOP (with HCFA assistance) has drafted legislative language, that is currently included in the administration's draft crime bill as the "Prisoner Medical Payment Efficiency Act of 1999." Under the proposed legislation, community hospitals that choose to treat BOP inmates would be required to accept payment rates as prescribed in regulations to be issued by the Attorney General and the HHS Secretary—payments that would be tied to the Medicare program's rate structure. BOP's National Health Care Systems Administrator explained that the language is intended only to ensure that those hospitals that agree to treat federal prisoners do so at the rates specified by the Attorney General and HHS Secretary.

As of early March 2000, the administration's draft crime bill had not been introduced in Congress. However, what follows, is our presentation of cost-benefit and other perspectives on the Medicare-based cap proposal.

CBO and BOP Have Estimated That Substantial Savings Would Result From a Cap Based on Medicare Rates

In September 1999, CBO analyzed the Medicare-based cap proposal[11] and estimated that the proposal would save about $6 million annually, assuming appropriations were reduced accordingly. CBO concluded that the annual savings would result from contracts that could be negotiated using Medicare rates. More specifically, CBO arrived at the $6 million-savings estimate by considering the following information:

[10] The prospective payment system is the mechanism by which the Medicare program calculates payments to hospitals for services rendered, at predetermined rates, specific to patient diagnoses.

[11] CBO's analysis involved a preliminary review of section 6508 ("Medicare Rate Enforcement Mechanism") of S. 899, which contained a proposal similar to that in the administration's draft crime bill.

- In 1998, BOP spent $82 million under contracts with community hospitals that treated federal prisoners.
- Of this total, about $30 million (or 37 percent) involved services provided under contracts that were "not negotiated" because of factors such as company or hospital location, underwriting issues, or one-bidder-only responses to BOP's solicitations.
- Approximately 20 percent of the $30 million resulted from nonnegotiated contracts that had prices higher than applicable Medicare rates.

Thus, CBO concluded that bringing the nonnegotiated contracts' costs in line with Medicare rates would save about $6 million annually, which is an amount equal to 20 percent of $30 million. By design, CBO's methodology (a broad overview or "macro" approach) was intended to provide an order-of-magnitude estimate of savings that could be expected from having a Medicare-based cap on BOP payments to community hospitals.

In addition, BOP recently analyzed a nonprojectable sample of actual billings received by BOP from community hospitals and concluded that a Medicare-based cap would generate substantial savings. In its analysis, BOP summarized actual cost data from the nonprojectable sample (217 of 3,362) of hospital bills received for the prisoners' care in 1998. Then, for this sample, BOP calculated what the medical care would have cost at applicable Medicare rates. A comparison[12] of the actual billings and the constructed Medicare-based rates showed that BOP paid about $1.3 million for services that would have cost about $662,000 at Medicare rates—representing lost potential savings for BOP of nearly 50 percent.

HCFA Supports a Medicare-Based Rate Cap for BOP

BOP collaborated with HCFA—the Medicare program administrator—in developing the legislative proposal to use a Medicare-based cap to better control federal prisoners' health care costs. According to HHS' Legislative Affairs Office, HCFA officials were closely involved in developing the legislative language and fully support BOP's efforts. Both HHS and BOP officials noted that the proposed legislative language requires further collaboration by the Attorney General and the HHS Secretary to establish implementing regulations. The process of establishing regulations, according to BOP officials, would allow for the consideration of special circumstances or interests, such as the continued stability of the Medicare program, the potential impact on rural hospitals, and possible extraordinary expenses for prisoners' medical care.

[12] Attachment VI presents more details on BOP's sample analysis.

DOD and VA Already Use Medicare Rates in Paying for Civilian Hospital Care

Under existing provisions[13] of the Medicare statutes, community hospitals that agree to treat DOD and VA civilian beneficiaries are required to accept certain payment rates. These rates are prescribed by regulations[14] required by the federal Medicare statutes and issued by the Secretary of HHS and the Secretaries of DOD and VA, respectively. As a result, DOD and VA are paying community hospitals for medical care for civilian beneficiaries based on Medicare rates. BOP patterned its legislative proposal on these existing provisions for DOD and VA. Regarding the period before DOD began using Medicare-based rates in its health care program for civilian military dependents,[15] we reported that DOD's medical reimbursement rates were significantly higher—50 percent higher on average—than those for similar services under the Medicare program.[16]

Recent Legislation Reflects the Use of a Medicare-Based Rate Cap on Payments to Hospitals

In November 1999, Congress passed legislation establishing a Medicare/Medicaid-based cap on health care payments to community hospitals for treating prisoners under the custody of USMS and the Immigration and Naturalization Service (INS), both of which are component agencies of the Department of Justice, as is BOP. The legislation was enacted as part of the Department of Justice's fiscal year 2000 appropriation (P.L. 106-113). Language included in the appropriation amended title 18 of the U.S. Code to limit the amount that the Attorney General can pay for certain federal prisoners' heath care, stating that:

"Payment for costs incurred for the provision of health care items and services for individuals in the custody of the United States Marshals Service and the Immigration and Naturalization Service shall not exceed the lesser of the amount that would be paid for the provision of similar health care items and services under—(A) the Medicare program ...or (B) the Medicaid program..." 18 U.S.C. 4006.

Attachment VII presents more information about this legislation and USMS efforts to contain costs for health care provided to detainees.

Contracting for Health Care Services Could Be Improved

Irrespective of whether the legislative proposals suggested by BOP are enacted, another option for controlling health care costs involves negotiating more reasonably priced contracts with community providers (hospitals). In this regard, to help identify best value among competing

[13] 42 U.S.C. section 1395cc (a)(1)(J),(L).

[14] DOD and VA regulations, respectively, are located at 32 C.F.R. 199.14 and 38 C.F.R. 17.55.

[15] The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is DOD's medical program for active duty dependents and retirees and their dependents.

[16] Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians (GAO/HEHS 98-80, Feb. 26, 1998).

bidders, one of BOP's six regions (the South Central Region) recently began using a benchmarking approach in contract solicitations. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. Thus, wider testing and use of the benchmarking approach—throughout all six of BOP's regions—might produce even greater cost savings.

Current Pricing Structures Not Adequate for Identifying Best Value

At the time of our review, BOP had 112 contracts with community hospitals to supplement its health service units and medical referral centers. Typically, a contract had a 5-year term consisting of a base year and 4 option years. BOP's costs under these contracts totaled about $82 million in fiscal year 1998.

Of BOP's 112 contracts with community hospitals, about 63 percent had pricing structures based on nonbenchmarked Medicare rates, about 23 percent had pricing structures based on fee schedules, and the remaining 14 percent were based on per diem rates or other pricing structures. BOP officials acknowledged that current contract-solicitation practices—as reflected in the pricing structures of competing contract proposals and the resulting contracts—generally have not provided an adequate basis for BOP to identify the lowest price for medical treatment. To illustrate the lack of price comparability among bids, BOP officials noted the following:

- Contract proposals that use nonbenchmarked Medicare rates: Under general practices, each applicable bidder has proposed that its contract be based on its own unique Medicare rate. Because these rates are unique to the respective hospital, this type of pricing proposal does not lend itself to the easy comparing of hospitals—not even to the comparing of hospitals located in the same urban and/or rural geographic area. For example, regarding viral meningitis treatment provided by five hospitals in the El Paso, Texas, area—after adjusting or otherwise identifying the specifically applicable Medicare factors—BOP found that the Medicare rates had a variance among the five hospitals of almost 43 percent, ranging from a low of about $7,000 to a high of about $10,000.
- Contract proposals that use fee schedules: Fee schedules are exceedingly difficult to use for comparative purposes. For instance, a fee schedule can be quite voluminous, with hundreds of pages and thousands of individual line items. In fact, it is not unusual for the printed pages of a fee schedule to be several inches thick. Moreover, comparison difficulties are further compounded in that fee schedules tend to change frequently. For these reasons, when contract competitions have been based on fee schedules, BOP generally has been unable to adequately identify the lowest-priced

and highest-priced bidders. Rather, BOP has tried to compare randomly selected line items, but comparison results have not been projectable to entire fee schedules.

- Contract proposals with a mixture of rate structures: In responding to a given solicitation, some community hospitals may bid their own unique Medicare rate, and other hospitals may bid with fee schedules. BOP's experience is that comparing these bids is very difficult. Thus, as a general practice, BOP has tended to automatically select a Medicare-rate bidder without determining whether such selection offered the best value.

In summary, BOP had 112 contracts with community hospitals at the time of our review. However, BOP officials readily acknowledged that—given the difficulties in comparing rate structures in competing bids—BOP cannot readily determine whether or not these contracts represent best values.

One Region Reported Savings Based on a New Contracting Approach

Community medical providers can be expected to play an even larger role in the future to meet the health care needs of a growing and aging inmate population—and, in turn, this trend would increase the importance of negotiating cost-effective contracts.

Recently, to provide a basis for identifying best value among competing proposed contracts, one of BOP's six regions—the South Central Region—began using an innovative "benchmarking" approach. Specifically, in soliciting contracts, the region required bidders to use a common or standard benchmark rate—that is, the "Medicare federal rate" for relevant Medicare diagnosis-related groups (DRG)—and to separately show (if applicable) a proposed percentage markup or percentage discount to that benchmark rate.

While South Central Region officials are convinced the benchmarking approach solves BOP's difficulties in comparing prices among bids, the officials acknowledge that data are not available to demonstrate agencywide that price reductions would result in every renegotiated contract that uses the benchmarking approach. Such data could take years to accumulate.

As of January 2000, BOP's South Central Region had used the benchmarking approach twice. Based on this experience, the region undertook a price analysis comparing (1) the region's most recently awarded contract based on the benchmarking approach, and (2) another contract recently awarded under BOP's traditional approach. The region reported estimated cost savings of about 32 percent annually from the

contract awarded under the benchmarking approach compared with the contract negotiated under BOP's traditional approach. According to regional office contracting officials, if the benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone.

Possible Opportunity for BOP-wide Savings

In November 1999, after a series of meetings with South Central Region officials, we contacted BOP's other five regional offices to obtain views on the benchmarking approach. Contracting officials in all five regions told us that the benchmarking approach has merit and that they may consider using it in the future.

In addition, contracting officials at BOP headquarters commented that use of the benchmarking approach for contracting is best viewed as a supplement to, rather than a replacement for, BOP's efforts to obtain legislation placing a Medicare-based cap on payments to community hospitals for treating inmates. The officials noted, for instance, that benchmark contracting is a bottom-up approach designed to encourage competition—and, in turn, stimulate price reductions—whereas the legislative cap proposal is a top-down approach to set a maximum payment amount.

Nonetheless, under BOP's decentralized management structure for contracting, BOP headquarters officials told us that they would prefer to obtain full "buy-in" from each of the regions before implementing a benchmarking approach agencywide. South Central Region officials acknowledged that sufficient data are not available to demonstrate that price reductions would result from using the benchmarking approach to renegotiate every contract. However, South Central Region officials are convinced that the benchmarking approach solves BOP's difficulties in comparing prices among bidders and, thus, should be a preferred contracting approach. Although BOP currently has no plans to implement the benchmarking approach agencywide, headquarters officials told us that a training seminar on this approach is to be provided to representatives of all regional contracting offices by summer 2000.

Each year—given the typical terms of its contracts (a base year, plus 4 option years)—BOP is to review each of its contracts for price reasonableness and decide whether to exercise the option or to solicit a new contract. According to South Central Region officials, wider use of the benchmarking approach may help to make these decisions and realize significant cost savings. BOP headquarters officials noted, however, that the cost effectiveness of the benchmarking approach should be further

validated before deciding whether to implement this approach throughout the agency.

Conclusions

BOP's inmate population was 133,689 at fiscal year-end 1999, more than double the number at fiscal year-end 1990. In conjunction with an aging and growing inmate population, BOP's health care costs increased during this decade, to a cumulative total of $2.7 billion during fiscal years 1990 through 1999. In recent years, however, available data show some signs of a positive trend. For example, BOP's per capita inmate health care costs (adjusted for inflation) decreased in 1997, 1998, and 1999. A BOP official attributed the recent downward trend to various cost-containment initiatives, such as working with other federal agencies to leverage available resources, restructuring health care staff to allow for more efficient operations, and making greater use of telemedicine technology.

In the future, BOP anticipates that the federal prison population will continue to age and to grow, reaching an estimated 198,700 inmates by fiscal year-end 2006. To help further control medical costs, BOP has proposed two legislative provisions. One provision would authorize the Director of BOP to assess and collect nominal fees for certain health care visits requested by a prisoner. According to CBO, 36 states or local jurisdictions already have such a provision. BOP endorses a fee provision as a means of using limited medical resources more efficiently. BOP anticipates that a fee provision would not generate an increase in net revenue, even though CBO has estimated that a $2 fee would generate savings of at least $1 million in fiscal year 2000 and that future years would show even greater savings as initial fixed or start-up costs were recovered. However, CBO also noted that actual savings would be realized only to the extent that appropriations were reduced.

The second proposed legislative provision would establish a Medicare-based cap on payments to community hospitals that treat BOP prisoners. CBO has estimated that this legislative provision would save about $6 million annually. The Medicare program's administrator, HCFA, supports BOP's efforts to secure passage of this legislative provision. Two other federal agencies, DOD and VA, already have statutory authority to use Medicare rates in paying for civilian hospital care. Moreover, legislation enacted in November 1999 utilized a Medicare/Medicaid-based rate cap for community hospitals that treat prisoners under the custody of USMS and INS.

In our opinion, these two legislative provisions seem to be steps in the right direction. That is, we think that these provisions would be helpful to BOP's efforts to control medical costs.

An administrative option whereby BOP might achieve further savings involves focusing on contract negotiations, that is, negotiating more cost-effective contracts with community hospitals that provide medical care for inmates. In 1999, to provide a basis for identifying best value among competing proposed contracts, one of BOP's six regions, the South Central Region, began requiring bidders to use a common or standard baseline rate (the Medicare federal rate for relevant DRGs) and to separately show, if applicable, a proposed percentage markup or percentage discount to that rate. According to regional office contracting officials, based on actual experience with two recent contracts, if this benchmarking approach were applied to all contracts in the South Central Region, the estimated savings would be about $5.6 million annually in this one region alone. Thus, by not implementing the benchmarking approach agencywide, BOP may be foregoing an opportunity to save potentially millions of dollars annually in health care costs.

Recommendation to the Attorney General

We recommend that the Attorney General require the BOP Director to test the benchmark contracting approach currently being used in BOP's South Central Region. If test results validate the cost effectiveness of the benchmark contracting approach, the BOP Director should require its implementation for health care contracts throughout BOP.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions that you or other Members of the Subcommittee may have.

Contacts and Acknowledgements

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Attachment I

Objectives, Scope, and Methodology

Objectives

At the request of the Chairman, Subcommittee on Criminal Justice Oversight, Senate Committee on the Judiciary, our objectives were to identify (1) trends in the federal Bureau of Prisons (BOP) health care costs from fiscal year 1990 through 1999, (2) BOP initiatives to contain rising medical costs, and (3) legislative and administrative options for helping to contain health care costs.

Scope and Methodology

Initially, to obtain an overview understanding, we reviewed various reports, studies, and articles about correctional health care costs and related issues. These documents included the most recent health services evaluation reports completed (in 1997, 1998, or 1999) by BOP's Program Review Division—that is, reports evaluating health services at BOP's medical referral centers.

Also, we obtained (1) overall statistics on the BOP inmate population and health care expenditures, (2) descriptive information about BOP's cost-containment initiatives and claimed savings, and (3) general data about applicable hospital payment rates under the Medicare program and rates in BOP's contracts with community hospitals. We discussed the sources of data with applicable agency officials, and we worked with the officials to reconcile any mathematical or other discrepancies that we identified in the data.

The following four sections discuss more specifically the scope and methodology of our work in addressing the respective objectives.

Cost Trends

To identify trends in BOP health care costs since fiscal year 1990, we obtained BOP inmate population data and health care cost information from BOP's Administration Division. For example, the Administration Division provided us data showing the actual growth and/or the projected growth of the federal inmate population for fiscal years 1990 through 2006. To provide a relative perspective of BOP's health care costs, we calculated these costs as a percentage of the agency's total operational costs for fiscal years 1990 through 1999.

Also, using data provided by BOP's Administration Division, we calculated the annual changes in BOP's health care cost categories (salaries, supplies, etc.) during fiscal years 1990 through 1999. To determine and discuss the reasons for changes or trends in the various cost categories, we interviewed the Administrator of BOP's National Health Systems.

Further, for comparative purposes, we obtained national health care cost data from the Health Care Financing Administration's (HCFA) Office of the

Actuary. Using HCFA and BOP data, respectively, we calculated per capita annual health care costs for both the nation and BOP for fiscal years 1990 through 1999. Using the standard gross domestic product (GDP) price index, we adjusted all per capita costs for inflation. That is, we adjusted all per capita cost data to 1999 dollars, using the GDP price index.

Cost-Containment Efforts

To identify BOP's initiatives for containing health care costs, we interviewed officials at BOP headquarters and BOP's six regional offices. In so doing, we obtained information about ongoing as well as planned initiatives. We reviewed documents on BOP's health care contracting practices and on BOP's pilot project involving privatization of the delivery of health care services at the prison complex in Beaumont, TX. In addition, we reviewed a November 1996 report—prepared by the Department of Justice's Office of the Inspector General—on inmate health care costs.[1]

We contacted the U.S. Marshals Service (USMS) to obtain information about a cooperative or joint (BOP and USMS) initiative to contain health care costs. We interviewed relevant USMS headquarters officials and reviewed relevant documentation, including a 1994 Department of Justice report on medical services for USMS detainees.[2]

We did not independently verify the savings cited by BOP regarding its various cost-containment efforts. Further, we did not analyze or confirm the relationship between the trends in BOP's per capita health care costs and BOP's cost-containment initiatives.

Legislative Options

As suggested by the requester's office, we focused on two BOP proposals—one calls for establishing a prisoner copayment requirement for medical service, and the other calls for establishing a Medicare-based cap on payments to community hospitals that treat inmates. We discussed these proposals with Department of Justice, BOP, USMS, and HCFA officials in Washington, D.C. We also interviewed a representative of the American Hospital Association in Washington, D.C.

Prisoner Copayments

Regarding a possible requirement for prisoner copayments, we reviewed relevant legislative bills—S. 704 and H.R. 1349—that were introduced in the 106th Congress. Also, we reviewed the Congressional Budget Office's (CBO) analysis of a copayment provision.

[1] Inspection of Inmate Health Care Costs in the Bureau of Prisons, Report Number I-97-01, November 1996.

[2] Management Report: Review of the U.S. Marshals Service Detainee Medical Services, Department of Justice, Justice Management Division, December 1994.

Cap on BOP Payments to Community Hospitals

We obtained the views of HCFA and BOP officials on the merits of a legislative proposal—included in the administration's draft crime bill—to establish a Medicare rate cap on BOP payments to community hospitals that treat inmates. In addition, we reviewed a Department of Justice policy options paper[3] on the advantages and disadvantages of such a cap. Further, regarding estimates of cost savings calculated by CBO and BOP, we contacted applicable staff of the respective agencies to discuss the methodology and data sources used to make the estimates.

BOP's Health Care Contracts With Community Hospitals

To obtain a general overview of BOP contracting, we reviewed BOP's Acquisition Policy Manual and excerpts from the Federal Acquisition Regulations related to solicitations, and we discussed contracting practices with responsible BOP officials at headquarters and the six regional offices.

Regarding a benchmark contracting approach used by BOP's South Central Region, we discussed this approach with regional contracting officials and also reviewed relevant documents. For example, we reviewed the region's first benchmark solicitation package, which led to a health care contract being awarded in September 1999 for the newly opened Federal Detention Center in Houston, Texas.

Also, the region's contracting officer provided us a briefing on the benchmark contracting approach, including its advantages in comparing bid prices and its potential for achieving price reductions. Further, regional office contracting staff provided us a detailed analysis comparing the prices of two health care contracts recently negotiated by the region. One contract was awarded under the benchmark approach, and the other was awarded under BOP's traditional approach. According to BOP regional office officials, this was a reasonably designed comparison in that

- both contracts were awarded within 14 months of each other,
- the estimated amount for each contract was in the range of $25 million to $30 million,
- the same contractors bid in both solicitations,
- the BOP facilities involved in both solicitations were medical referral centers, and
- the BOP facilities were located in the same city (Fort Worth, TX).

[3] Legislative Options – Medicare Rates for Detainee Health Services, Department of Justice, Justice Management Division, December 1996.

We discussed with BOP staff the methodology and data sources used to make the analysis, and we examined the supporting documentation.

To understand the difficulties BOP has experienced in trying to compare price proposals under BOP's traditional approach to medical care solicitations, we reviewed examples of actual bid proposals—some based on hospital fee schedules and some based on Medicare rates. Also, we obtained the views of contracting officials in the South Central Region.

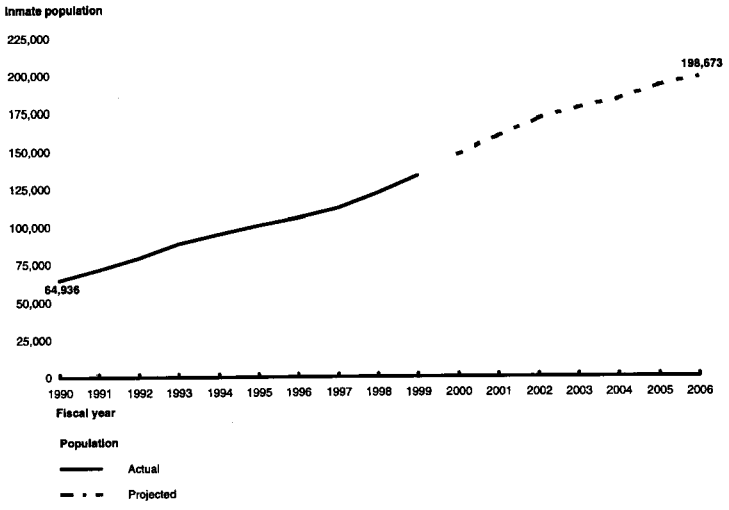
To obtain a broader spectrum of views on the benchmark contracting approach and on BOP's traditional contracting approach for health care, we interviewed BOP contracting officials from headquarters and from the agency's six regional offices. From BOP headquarters, we obtained cost data that compared medical payments under BOP's traditional health care contracts to Medicare rates. From each of BOP's six regional offices, we obtained data on the rates or pricing structures in the respective region's contracts with community hospitals.

Attachment II

BOP Inmate Population Trends

As figure II.1 shows, the federal inmate population steadily increased during the 1990s. According to BOP officials, the primary cause of the population growth in recent years has been the number of federal drug case convictions. Moreover, this population growth appears likely to continue through fiscal year 2006.

Figure II.1: BOP Inmate Population Growth, Fiscal Years 1990-1999, and BOP Projected Inmate Population Growth, Fiscal Years 2000-2006



Source: BOP data.

Table II.1 shows the specific numbers that constitute the trend line in figure II.1.

According to BOP officials, in addition to the impact from the continuing prosecution of drug cases, the projected inmate population will increase because of two other factors:

- Projected increases during fiscal years 2000 through 2002 are due, in part, to BOP's congressionally mandated assimilation of approximately 7,200 District of Columbia inmates.[1]
- Projected increases during fiscal years 2003 through 2006 include the anticipated transfer of about 4,000 inmates from the Immigration and Naturalization Service detention.

Table II.1: Actual Inmate Population, Fiscal Years 1990-1999, and Projected Inmate Population, Fiscal Years 2000-2006

Fiscal year	Inmate population	Number change from previous year	Percent change from previous year
1990	64,936	—	—
1991	71,508	6,572	10%
1992	79,678	8,170	11%
1993	88,565	8,887	11%
1994	95,162	6,597	7%
1995	100,973	5,811	6%
1996	105,432	4,459	4%
1997	112,289	6,857	7%
1998	122,316	10,027	9%
1999	133,689	11,373	9%
2000	147,674[a]	13,985	10%
2001	159,859[a]	12,185	8%
2002	171,223[a]	11,364	7%
2003	177,890[a]	6,667	4%
2004	183,846[a]	5,956	3%
2005	193,254[a]	9,408	5%
2006	198,673[a]	5,419	3%

[a]Projected population at end of fiscal year.

Source: BOP data.

[1]The National Capital Revitalization and Self-Government Improvement Act of 1997 (enacted as title XI of the Balanced Budget Act of 1997, P.L. 105-33) requires the transition of both male and female D.C. felony offenders to BOP.

Attachment III

Health Care Cost Trends

BOP categorizes its costs as operational costs (primarily salaries and other operating expenses) and capital costs (building and construction expenditures). This attachment presents information about BOP's operational costs regarding health care for inmates.

Health Care Costs Compared With Total Operational Costs

As table III.1 shows for fiscal years 1990 through 1999, BOP's health care costs as a percentage of total operational costs were fairly stable throughout the 10-year period, averaging 13 percent annually. However, in conjunction with a rising federal inmate population in the 1990s, BOP's inmate health care costs increased annually during this decade. Overall, BOP's health care costs (not adjusted for inflation) increased from $137.6 million in fiscal year 1990 to $372.1 million in fiscal year 1999, an average annual increase of about 8.6 percent. Nonetheless, as indicated in table III.1, this increase has not been disproportionate to the trend in BOP's total operational costs. That is, as previously mentioned, BOP's health care costs as a percentage of total operational costs were fairly stable, averaging 13 percent annually during fiscal years 1990 through 1999.

Table III.1: BOP's Health Care Costs and Total Operational Costs, Fiscal Years 1990-1999 (Dollars in Millions)

Fiscal year	Health care costs	All other operational costs	Total operational costs	Health care as a percentage of total operational costs
1990	$137.6	$1,008.6	$1,146.2	12%
1991	174.4	1,185.7	1,360.1	13
1992	211.1	1,347.4	1,558.5	14
1993	235.7	1,566.7	1,802.4	13
1994	262.4	1,742.3	2,004.7	13
1995	300.8	2,021.5	2,322.3	13
1996	327.1	2,135.6	2,462.7	13
1997	341.3	2,247.6	2,588.9	13
1998	354.7	2,414.8	2,769.5	13
1999	372.1	2,495.5	2,867.6	13

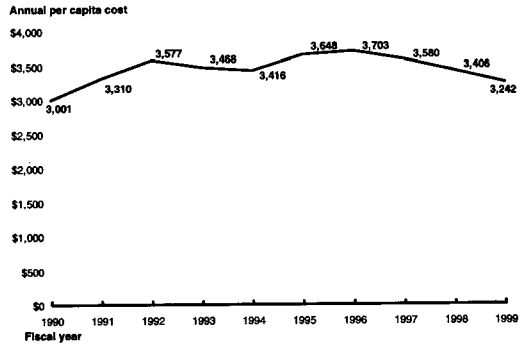
Note: All dollar amounts are in then-year dollars (i.e. not adjusted for inflation).

Source: Developed by GAO based on BOP data.

Per Capita Health Care Costs Adjusted for Inflation

For fiscal years 1990 through 1999, figure III.1 shows the trend in BOP's per capita inmate health care costs adjusted for inflation, using 1999 as the base year. As shown, the per capita costs increased from $3,001 in 1990 to a peak of $3,703 in 1996, and then decreased to $3,242 in 1999.

Figure III.1: Annual Per Capita Cost of Inmate Health Care, Adjusted for Inflation, Fiscal Years 1990-1999



Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.

Source: BOP data.

For fiscal years 1990 through 1999, figure III.2 compares national per capita health care costs with BOP's per capita health care costs, adjusted for inflation. In contract to the continuing upward trend in national per capita health care costs through 1999, BOP's per capita health care costs decreased in 1997, 1998, and 1999.

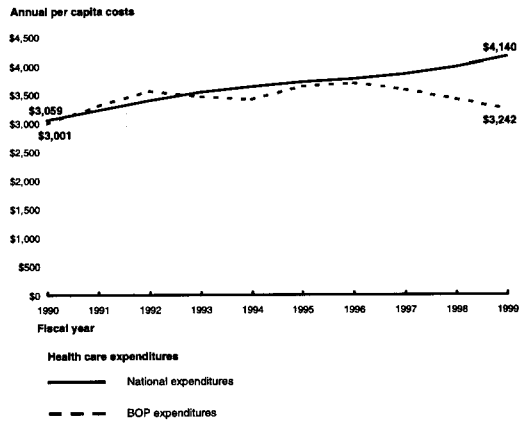


Figure III.2: Comparison of Annual Per Capita Health Care Cost for the United. States and BOP, Adjusted for Inflation, Fiscal Years 1990-1999

Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.
Sources: Developed by GAO based on data from BOP and HCFA.

Overall medical costs, however, are likely to continue to rise in future years, according to BOP officials. In explaining this anticipated trend, the officials noted the following reasons:

- Projections of the number of inmates incarcerated in federal facilities show continued increases.
- Felony inmates transferred to BOP from the District of Columbia Department of Corrections generally have disproportionately more medical needs than other BOP inmates.
- From the Immigration and Naturalization Service (INS), BOP is receiving increasing numbers of long-term, nonreturnable detainees.
- BOP's expenditures for pharmaceuticals likely will rise due to the increasing prevalence of illnesses such as HIV and hepatitis.

Attachment IV

Health Care Cost Categories

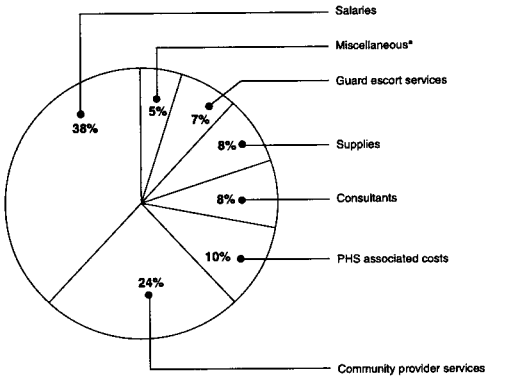
This attachment presents information about trends in BOP's costs of providing health care for inmates during fiscal years 1990 through 1999. For this 10-year period, the information presented covers BOP's cumulative or total health care costs, as well as the various categories or components of the total costs.

Cumulative Health Care Costs

BOP's cumulative health care costs for inmates totaled about $2.7 billion during fiscal years 1990 through 1999. Of these total cumulative costs, figure IV.1 shows that

- 38 percent pertained to salaries of on-site medical personnel;
- 24 percent consisted of contract payments to physicians and hospitals for medical services inmates received outside the prison facility (community provider services);
- 10 percent was for compensation of Public Health Service medical employees (PHS associated costs);
- 8 percent involved purchases of small equipment items and drugs (supplies);
- 8 percent involved payments to physicians who contracted with BOP to treat inmates inside the prisons (consultants);
- 7 percent primarily involved overtime payments to guards who escorted inmates being transported to outside medical facilities (guard escort services); and
- 5 percent involved payments for various miscellaneous items, including airlift costs, headquarters expenses, and equipment purchases.

Figure IV.1: BOP Cost Categories for Inmate Health Care Expenditures, Fiscal Years 1990-1999



*This category includes headquarters expenses, equipment purchases, HIV testing, transportation charges (including airlift costs), printing costs, and interest.

Source: Developed by GAO based on BOP data.

Trends in Major Health Care Cost Categories

As figure IV.1 shows, BOP's three largest health care cost categories are salaries, community provider services, and PHS associated costs. For each of these categories, figure IV.2 shows BOP's per capita costs (adjusted for inflation) during fiscal years 1990 through 1999.

As figure IV.2 shows, per capita salary costs for in-house medical personnel increased during most of this 10-year period. A BOP official attributed the rise to the high cost of in-house medical personnel. The official noted, for example, that a physician's compensation can easily exceed $100,000 annually.

The most recent years reflect a decrease in per capita salary costs. Specifically, this cost component peaked at $1,399 in fiscal year 1996, then steadily decreased annually declining to $1,225 in fiscal year 1999. According to BOP officials, these decreases can be attributed to various cost-containment initiatives implemented by BOP.[1] A BOP official cited,

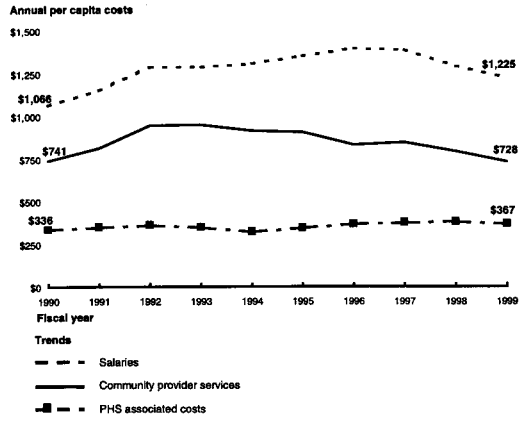
[1] Attachment V lists BOP's cost-containment initiatives.

for example, a staff-restructuring initiative that involved using lower-paid but qualified staff rather than higher-paid physicians to perform certain routine services, such as laboratory, pharmacy, and x-ray duties.

Regarding the per capita costs of community provider services, figure IV.2 shows that 1993 was the peak year during the 10-year period. These per capita costs decreased from $952 in fiscal year 1993 to $728 in fiscal year 1999. According to a BOP official, the policy has been to return the inmates as quickly as possible from external hospital facilities so that BOP could perform the rehabilitative and recuperative services in prison hospitals.

Figure IV.2 shows that PHS associated per capita costs increased gradually from $322 in fiscal year 1994 to $367 in fiscal year 1996, leveled off at $378 in fiscal year 1997 and $379 in fiscal year 1998, and then decreased to $367 in fiscal year 1999. A BOP official told us that this trend was due to high retention rates and increased tenure for PHS personnel.

Figure IV.2: Trends in Annual Per Capita Inmate Health Care Costs for Salaries, Community Provider Services, and PHS Associated Costs, Fiscal Years 1990-1999



Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.

Source: Developed by GAO based on BOP data.

Trends in Other Health Care Cost Categories

In addition to the three major cost categories discussed above, BOP's other health care cost categories are (1) supplies, (2) consultants, (3) guard escort service, and (4) miscellaneous. For fiscal years 1990 through 1999, figure IV.3 shows the per capita costs for the first three categories and for equipment, which is a component of the fourth category (miscellaneous). For recent years, the reasons for changes in per capita are discussed below.

Per capita supply costs increased steadily from $262 in fiscal year 1996 to $307 in fiscal year 1999. According to a BOP official, supply costs began increasing in 1996 primarily due to bulk purchases for 10 prisons that opened in fiscal years 1997 and 1998. The official indicated that another contributing factor was the purchase of expensive drugs for treating inmates infected with AIDS or hepatitis C. For example, the drug Interferon, which is used to treat hepatitis C, costs $11,000 annually per inmate patient according to a BOP official. Further, as discussed below, the official noted that BOP made an accounting change in 1995 whereby more items thereafter were classified as "supplies" and not "equipment."

As figure IV.3 shows, per capita consultant costs rose steadily, from $212 in fiscal year 1994 to $320 in fiscal year 1998, before decreasing to $281 in fiscal year 1999. A BOP official said prison wardens were encouraged to use consultants (i.e., contract physicians) to treat inmates inside the prisons because this arrangement was less expensive than paying salaries and benefits for additional BOP or PHS personnel. A BOP official also said that efficiencies were gained by having contract physicians come to BOP facilities and treat multiple inmates on-site, as opposed to transporting the inmates to outside medical facilities.

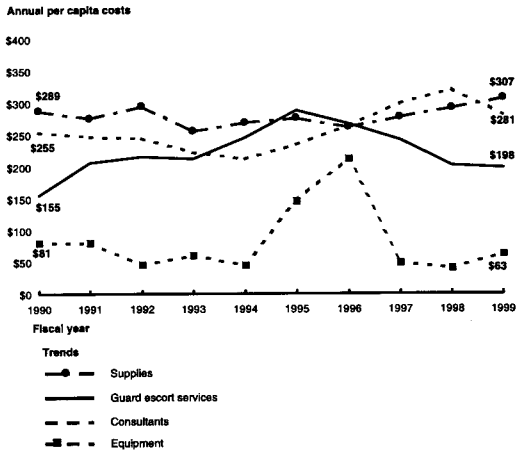
In contrast to increased consultant costs, per capita guard escort service costs progressively decreased from a high of $289 in fiscal year 1995 to $198 in fiscal year 1999. As indicated above, a reason for this trend is that more emphasis was placed on providing on-site treatment (e.g., by having contract physicians come to the prisons), which lessened the demand for guard escort services.

The miscellaneous category of BOP's health care costs include HIV testing, airlift costs, headquarters expenses, and equipment. Of the four categories shown in figure IV.3, per capita equipment costs reflect the widest fluctuation, particularly over the period from fiscal year 1994 to fiscal year 1999. These costs rose to $146 in fiscal year 1995, peaked at $212 in fiscal

year 1996, dropped to $49 in fiscal year 1997 and $40 in fiscal year 1998, and then increased to $63 in fiscal year 1999. According to a BOP official, per capita equipment costs likely increased in 1995 and 1996 as a result of advance purchases of equipment for 10 new prisons that BOP opened in fiscal years 1997 and 1998. Regarding the sharp decline in per capita equipment costs after 1996, a BOP official noted that an accounting change raised the dollar threshold for the equipment category to $25,000, which resulted in many items thereafter being classified as supplies.

A BOP official said he anticipated that all four cost categories would continue their current trends in the future; that is, supply and consultant per capita costs probably would continue to increase, while guard escort service and equipment per capita costs probably would continue to decrease.

Figure IV.3: Trends in Inmate Per Capita Health Care Costs for Consultants, Supplies, Guard Escort Service, and Equipment, Fiscal Years 1990-1999



Note: All data are adjusted to fiscal year 1999 dollars, using the GDP price index.
Source: Developed by GAO based on BOP data.

Attachment V

Summary of BOP Health Care Cost-Containment Initiatives by Type

BOP has implemented or is planning to implement various health care cost containment initiatives. BOP has 23 initiatives that are either currently ongoing or are in the planning stages.[1] As shown in table V.1, these initiatives fall into five categories: (1) cooperative acquisition efforts with other agencies, (2) other acquisition efforts, (3) staffing reforms, (4) delivery of services, and (5) others. The dollar savings shown are BOP's figures, either realized or estimated cost savings. We did not verify any savings reported by BOP on specific initiatives. In addition, where applicable, the year shown in parentheses indicates when BOP implemented the particular health care cost-containment initiative.

Table V.1: Health Care Cost-Containment Initiatives

Initiatives	Description
Cooperative acquisitions	
Pharmacy prime vendor (1993)	BOP "piggybacks" on Department of Veterans Affairs (VA) pharmaceutical contracts. The savings realized by BOP are through bulk purchases on these contracts. BOP cites average annual savings of approximately $760,000.
Federal resource sharing	BOP has existing contracts with VA for various local services at the facility level, such as lab services, telemedicine where VA facilities are involved, HIV tests, etc.
U.S. Marshals Service New York Managed Care Network Pilot Project (1998)	An interagency agreement between USMS and the VA hospitals in Manhattan and Brooklyn calls for VA physicians to come inside the BOP facilities to provide medical specialty clinics. The use of the two VA hospitals for outpatient appointments and medical tests saves time and money and enhances prisoner security, while reducing the number of outside locations for prisoner medical appointments.
Consolidation Pilot Project with the U.S. Marshals Service	In response to a congressionally mandated Department of Justice study, BOP will be consolidating outside medical services for both BOP and USMS prisoners housed in BOP facilities. This project is to begin in early calendar year 2000 at three BOP pilot sites in New York City, Miami, and Oklahoma City. Under this project, according to USMS, BOP physicians will order outside care, when needed, for USMS prisoners. BOP will also pay for the medical and transportation expenses. Initially, BOP will enter into an agreement with the USMS to be reimbursed for its prisoners' medical-related expenses. After 2001, BOP will be requesting budget increases from Congress to cover the expenses of the USMS prisoners.
Mandatory national contracts	BOP piggybacks on VA contracts for various generic drugs not included in the "Pharmacy Prime Vendor" initiative discussed above. BOP estimated annual savings of $770,000 in 1998 that would have been realized had this initiative been in place. As of December 1999, BOP was beginning to award some of these contracts.
Medical equipment	BOP intends to require Central Office approval of purchases of medical equipment, valued at $1,000 or more, while taking advantage of bulk purchasing with VA, the Department of Defense, and the General Services Administration. This initiative is in its formative stages and has yet to be developed.
Other acquisition-related initiatives	
Precertification (1995)	Under this initiative, before inmates are sent to community providers for inpatient surgery, other inpatient hospitalization service, or outpatient surgery, precertification is required. In the precertification process, BOP headquarters officials, including policy and medical personnel, are to review and approve BOP field institutions' requests that inmates be treated by community providers. BOP cites savings of about $785,000 in 1998.

[1] BOP expects many of the initiatives in the planning stages to be reviewed by BOP's executive staff in the spring of 2000. At that time, the staff will either approve or reject the proposals.

Attachment V
Summary of BOP Health Care Cost-Containment Initiatives by Type

Initiatives	Description
Pharmacy over-the-counter (1994)	By allowing inmates to purchase drugs over-the-counter (OTC) with their own funds, BOP has experienced savings in pharmaceuticals. BOP expects this project will also reduce the number of inmate sick calls. A BOP official from the Health Services Division stated that savings from this initiative were approximately $1.2 million for fiscal year 1999. He added that, as of October 1999, BOP had 36 OTC drugs available to prisoners. BOP will continue to add drugs to the OTC program to increase savings further. Also, BOP is considering adding vending machines to this initiative, which would allow inmates access to some OTC drugs 24-hours a day, 7 days a week. Currently, inmates can purchase OTC drugs only one time a week at the commissary.
Pharmacy national formulary initiative (1992)	BOP officials determine the most cost-effective mix of drugs they will authorize. BOP's emphasis is on generics and limiting medical personnel from prescribing newer, more expensive drugs when the old ones are effective. BOP officials could not provide any overall cost savings for this initiative.
Laboratory	BOP will perform a cost-benefit analysis of the options for obtaining laboratory services. These options include (1) keeping all laboratory services in-house, (2) contracting out all laboratory services, or (3) engaging in resource sharing for laboratory services with another agency, such as VA. This initiative is in its formative stages and has yet to be fully developed.
Staffing-related initiatives	
Elimination of 24-hour medical staff (1994)	Prison wardens at some facilities have eliminated 24-hour medical staff coverage as long as emergency care was readily available in the community. The individual prison wardens make these decisions. BOP is reemphasizing this initiative by stressing to wardens that they should plan for this change, if feasible, at their respective facilities. BOP expects this initiative will continue to lower staff costs and estimates that its cost savings have averaged $1.6 million annually.
Medical staff restructuring (1994)	BOP has utilized lower-paid medical personnel to perform certain services they are qualified to perform, instead of having more highly paid physicians' assistants or other medical personnel perform the same services. BOP estimates an annual savings of $5.5 million from this initiative.
Staffing ("provider teams")	This effort focuses on the right mix of staff ("health care provider teams") at each facility to provide the best care in the most efficient and economical manner. Specifically, within the provider teams, the same medical professionals see the same inmates on an ongoing basis, resulting in a degree of familiarity with their conditions. This improves efficiency through continuity of care. Provider teams will oversee the delivery of health services during inmate sick call, in addition to dental and mental health services. This initiative is in its formative stages and has yet to be fully developed.
Delivery of services initiatives	
Telemedicine (1996)	Telecommunications technologies exchange health information and provide health care services across geographic, time, social, and cultural barriers. The technology, as applied in BOP, involves video teleconferencing, modified with the addition of peripheral devices to produce images of diagnostic quality. As of November 1999, telemedicine was utilized at eight BOP facilities. During calendar year 2000, BOP expects to equip all of its remaining facilities with telemedicine. This initiative helps avoid guard escort costs for outside medical trips.
Levels of care	BOP will place inmates already incarcerated with special medical needs at facilities that have staff and funding to address their specific conditions, thereby eliminating duplicated health care resources at numerous facilities. Savings will be realized BOP-wide through more efficient health care operations and savings on staff costs. Some facilities may increase their costs, while others will decrease theirs. This initiative is still in the planning stages.
Scope of services	BOP will make decisions on the scope of services to be provided to inmates. A BOP official stated that this initiative is linked to the aforementioned staffing initiative on health care provider teams and concerns the types of services the teams will perform. This initiative has yet to be fully developed.
Pharmacy	BOP plans to explore options for restructuring pharmacy services, including consolidating staff for multiple facilities in the same location. This initiative is in its formative stages and has yet to be fully developed.

Attachment V
Summary of BOP Health Care Cost-Containment Initiatives by Type

Initiatives	Description
Other Initiatives	
Beaumont Privatization Project (1998)	This project involves the privatization of the entire health care operation at BOP's facilities in Beaumont, TX. The project has been fully operational since the middle of fiscal year 1998. As of October 1999, no results of this project had been reported to BOP's executive staff. BOP expects an evaluation report on this project by June 2001.
Health promotion and disease prevention	A three-person team will actively seek ways to keep inmates healthy by encouraging healthy lifestyles. This initiative will help prevent health care costs from rising through preventative means. BOP has not done an impact assessment.
Combined 325/350 Project (FY 1997)	BOP will combine funds for inside (code "350) and outside (code "325") medical care at the facility level, thereby increasing local wardens' authority and responsibility in the fiscal management of health care and requiring them to manage health care within a budget. BOP could not provide any estimated cost savings from this initiative.
Special program needs of physically disabled, chronically and terminally, and geriatric offenders	Under this ongoing initiative, BOP screens inmates when they enter the prison system to determine the best and most cost-effective arrangements for their care. All inmates entering into the system are screened for disabilities, and appropriate assignments are made for these inmates. Certain medical problems can be staff intensive (ventilator patients, for example), and BOP must do proper planning to provide the best care for the inmate in the most cost-effective manner. BOP could not provide any estimated cost savings from this initiative.
Automation of medical records	Automation of medical records is planned for the second quarter of fiscal year 2000. Currently, all medical records are kept manually. No one in BOP can immediately access medical records; therefore, efficiency is adversely impacted. According to BOP, this effort is not likey to be completed in the next 2 or 3 years. This initiative is in its formative stages and has yet to be fully developed.
Decentralized training	BOP plans to decentralize review and approval authority for local medical training from BOP's Central Office to the field. The plan was to be implemented at the beginning of fiscal year 2000. By doing this, BOP is putting the responsibility on the local wardens to make the most cost-effective decisions on continuing education training for their medical personnel. BOP expects this effort to eliminate at least two staff positions in the Central Office, that is, staff who have been responsible for reviewing and approving requests from wardens for local training.

Source: Developed by GAO based on BOP data.

In addition to the 23 initiatives presented in table V.1, our statement discusses the following:

- BOP has proposed two legislative provisions to further control medical costs. One provision—a prisoner copayment provision—would authorize the Director of BOP to assess and collect a fee of not less than $2 for each health care visit requested by a prisoner. The second provision would establish a Medicare-based cap on payments to community hospitals that treat inmates.
- Also, we identified an administrative option whereby BOP could achieve further savings by negotiating more cost-effective contracts with community hospitals that provide medical care for inmates.

Attachment VI

BOP Inmate Care In Community Hospitals In 1998: Sample Data Comparing Actual Billings To Constructed Medicare-Based Billings

This attachment compares (1) data that BOP collected on actual hospital billings received for prisoners' care in community hospitals in 1998 with (2) data developed by BOP on what Medicare-based billings would have been. BOP's analysis was based on a nonprojectable sample of 217 inpatient billings, about 7 percent of the bills that BOP received for various hospital services across the country in calendar year 1998. The sampled billings covered 55 hospital discharge classifications or DRGs. For each of the 55 DRGs, table VI.1 presents the actual hospital billings to BOP from the 7-percent sample, the constructed Medicare-based billings, and the billing differences. The data are arrayed by billing differences, beginning with the largest difference.

BOP's analysis found that actual hospital billings exceeded the constructed Medicare-based billings for 50 of the 55 DRGs. Overall, the comparative analysis showed that BOP paid about $1.3 million (actual hospital billings) for services that would have cost about half that amount ($662,000) at Medicare rates.

BOP used HCFA's online, Internet personal computer software program, PPS PC Pricer-1998,[1] to calculate what the billings would have been at the relevant Medicare rates for the services provided by the hospitals. We did not review the actual hospital bills in BOP's sample and did not verify BOP's Medicare billing calculations.

Table VI.1: BOP Inmate Care In Community Hospitals In 1998: Sample Data (Grouped by DRG) Comparing Actual Billings with Constructed Medicare-Based Billings

DRG	DRG description	Actual hospital billing to BOP	Constructed Medicare-based billing	Billing difference
145	Other Circulatory System Diagnosis Without Complications	$114,713	$29,286	$85,427
203	Malignancy of Hepatobiliary System or Pancreas	97,211	31,885	65,326
175	G.I. Hemorrhage Without Complications	77,296	16,351	60,945
143	Chest Pain	47,472	14,883	32,589
208	Disorders of the Biliary Tract Without Complications	36,321	6,450	29,871
14	Specific Cerebrovascular Disorders Except TIA	48,122	22,591	25,531
198	Cholecystectomy Except Laparoscope Without C.D.E. Without Complications	$48,431	$24,594	$23,837

[1]The PPS PC Pricer software calculates the amount that a hospital is to be paid for each patient discharged in a particular hospital discharge classification or DRG. Software updates are released quarterly during the fiscal year. BOP used the 1998 version in developing its constructed Medicare billings.

Attachment VI
BOP Inmate Care In Community Hospitals In 1998: Sample Data Comparing Actual Billings To Constructed Medicare-Based Billings

DRG	DRG description	Actual hospital billing to BOP	Constructed Medicare-based billing	Billing difference
503	Knee Procedure Without PDX of Infection	30,043	9,377	20,666
231	Local Excision & Removal of Int Fix Devices Except Hip & Femur	28,707	8,268	20,439
395	Red Blood Cell Disorders Age >17	23,119	5,140	17,979
165	Appendectomy With Complicated Principal Diag Without Complications	27,907	10,463	17,444
122	Circulatory Disorders With AMI Without C.V. Comp Disch Alive	21,370	3,957	17,413
280	Trauma To The Skin, Subcut Tiss & Breast Age >17 With Complications	19,202	2,257	16,945
127	Heart Failure & Shock	29,128	13,611	15,517
209	Major Joint & Limb Reattachment Procedures of Lower Extremity	28,166	12,904	15,262
489	HIV With Major Related Condition	18,118	4,995	13,123
232	Arthroscopy	21,043	7,925	13,118
160	Hernia Procedures Except Inguinal & Femoral Age >17 Without Complications	17,553	5,911	11,642
158	Anal & Stomal Procedures Without Complications	15,469	4,240	11,229
290	Thyroid Procedures	16,811	6,122	10,689
189	Other Digestive System Diagnoses Age >17 Without Complications	27,088	16,769	10,319
53	Sinus & Mastoid Procedures Age >17	17,067	7,730	9,337
124	Circulatory Disorders Except AMI, With Card Cath & Complex Diag	12,957	3,752	9,205
135	Cardiac Congenital/Valvular Disorders Age >17 Without Complications	21,192	12,005	9,187
281	Trauma to the Skin Subcut Tiss & Breast Age >17 Without Complications	12,132	3,335	8,797
153	Minor Small/Large Bowel Procedures Without Complications	15,099	6,394	8,705
449	Poisoning & Toxic Effects of Drugs Age >17 With Complications	11,774	3,279	8,495
275	Malignant Breast Disorders Without Complications	14,458	6,141	8,317
174	G. I. Hemorrhage With Complications	13,856	5,588	8,268
138	Cardiac Arrhythmia & Conduction Disorders With Complications	23,117	15,133	7,984
125	Circulatory Disorders Except AMI, With Card Cath Without Complex Diag	14,377	6,805	7,572
162	Inguinal & Femoral Hernia Procedures Age >17 Without Complications	11,328	3,990	7,338
136	Cardiac Congenital & Valvular Disorders Age >17 Without Complications	14,673	7,553	7,120
335	Major Male Pelvic Procedures Without Complications	14,430	7,637	6,793
306	Prostatectomy With Complications	14,248	8,388	5,860
256	Other Musculoskeletal System & Connective Tissue Diagnoses	$20,219	$14,772	$5,447

Attachment VI
BOP Inmate Care In Community Hospitals In 1998: Sample Data Comparing Actual Billings To Constructed Medicare-Based Billings

DRG	DRG description	Actual hospital billing to BOP	Constructed Medicare-based billing	Billing difference
270	Other Skin Subcut Tiss & Breast Proc Without Complications	11,341	6,151	5,190
415	O.R. Procedure for Infectious & Parasitic Diseases	19,092	14,376	4,716
316	Renal Failure	14,142	10,268	3,874
7	Periph & Cranial Nerve & Other Nerv Syst Proc Without Complications	11,654	7,835	3,819
416	Septicema Age >17	11,543	7,853	3,690
197	Cholecystectomy Except Laparoscope Without C.D.E. No Complications	16,864	13,346	3,518
76	Other Resp System O.R. Procedures With Complications	27,833	24,335	3,498
243	Medical Back Problems	12,193	9,314	2,879
120	Other Circulatory System O.R. Procedures	17,346	14,613	2,733
172	Digestive Malignancy With Complications	12,723	10,654	2,069
142	Syncope & Collapse Without Complications	21,159	19,102	2,057
188	Other Digestive System Diagnoses Age >17 With Complications	11,480	9,572	1,908
369	Menstrual & Other Female Reproductive System Disorders	14,988	13,912	1,076
183	Esophagitis Gastroent/Misc Digest Disorders Age >17 No Complications	13,480	12,893	587
171	Other Digestive System O.R. Procedures Without Complications	15,854	16,296	(442)
423	Other Infectious & Parasitic Diseases Diagnoses	16,051	17,630	(1,579)
75	Major Chest Procedures	21,952	23,700	(1,748)
148	Major Small/Large Bowel Procedures With Complications	31,087	33,099	(2,012)
107	Coronary Bypass Without Cardiac Cath	11,500	26,540	(15,040)
Total		**$1,336,499**	**$661,969**	**$674,529**

Note: All billing amounts are rounded to the nearest dollar.

Source: Developed by GAO based on BOP data.

Attachment VII

U.S. Marshals Service: Efforts to Contain Costs for Health Care Provided to Detainees

Background

The U.S. Marshals Service (USMS), a component agency of the Department of Justice, is responsible for housing federal pre-trial detainees, who are remanded to its custody until sentenced and designated to a BOP facility to serve time. In fiscal year 1999, USMS maintained an average monthly population of 32,119 pre-trial detainees and housed about 70 percent of the detainees in local jails under contractual arrangements whereby USMS paid per diem rates for bed space. The remaining 30 percent of USMS detainees were housed in BOP detention centers.

Health Care Delivery and Cost

USMS' responsibility for maintaining detainees includes covering the cost of their health care. USMS is different from BOP in two aspects of health care: delivery and coverage. Unlike BOP, USMS does not provide medical care directly to its detainees. Instead it is entirely dependent upon the provision of such services from medical staff in local, state, and federal facilities that house USMS prisoners or from community hospitals. Another difference between BOP and USMS is the average length of stay. For an individual held by USMS, custody can range from a matter of days to as long as a year. Since confinement is relatively short, USMS' health care policy is limited to reasonable and medically necessary care and does not extend to elective or preventative health care. By contrast, since BOP prisoners are confined for longer periods, BOP practices preventative health care.

For the 70 percent of USMS detainees housed in jails, delivery of medical services varies widely. Generally speaking, USMS detainees held in local jails normally receive the same medical care that the local jails provide to other inmates. The expenses for medical services provided within local jails are incorporated in the per diem rate charged. USMS is billed directly by community medical care providers for the cost of medical services provided outside the jails. Larger county jails may have enhanced medical services as a part of their infrastructure and may use county staff and facilities. In these situations, the county may provide more comprehensive medical services, including inside care, transportation and guard services for community hospital care, and bill review and payment. USMS would in such situations reimburse the county for outside care. Smaller jails provide medical care on an as needed basis by local professionals. The diversity in health care delivery by county jails complicates efforts by USMS to manage a medical program and to take proactive steps to contain costs.

As with detainees in jails, the USMS detainees in BOP centers have access to the same medical services and staff provided by BOP to its prisoners. These medical services are provided by Public Health Service staff in clinic-type facilities on site to treat routine medical problems at no cost to

USMS. Instead these services are funded as part of the BOP institution's operating costs. When USMS detainees need medical treatment outside a BOP facility, USMS is charged the rate contracted by BOP with the outside facility (community hospital). Physicians' fees are billed separately, usually at full cost. Further, regarding instances when USMS detainees need medical treatment in community hospitals, secure transportation and guard escort services are required. These costs are also paid by USMS.

The business practice for USMS has been to pay all outside medical bills at the full price rather than at a reduced rate. The Justice Department reported in a 1996 review[1] that USMS did not know how to get price discounts, interpret medical bills, or price them properly at Medicare rates even if the vendor agreed to Medicare prices. USMS also lacked professional medical staff with the technical expertise to develop medical care policy, determine medical necessity, or assist field staff when medical care issues arose.

In addition to USMS' business practice of paying at full price, both the size of the detainee population and the cost of outside medical treatment have been increasing. As a result, the need for medical care outside secured facilities has become a significant expense to USMS and in fiscal year 1998 totaled $25 million, an increase of over 30 percent since 1993.

Cost-Containment Initiatives

In the mid-1990s, USMS began developing a formal Prisoner Medical Services Program in order to contain increasing medical costs for a rapidly growing prisoner population. One example of how this program has contained medical costs is a pilot project in New York City. The objective of the project was to reduce medical costs to Medicare rates by creating a managed care network. In implementing this project, USMS established a managed care network of local hospitals and physicians' associations that agreed to charge Medicare rates. USMS' network also gained access to secured hospital beds at Medicaid rates.

A related aspect of the New York City pilot project is guard service. USMS obtained county jail security guard service at only $130 per day. Prior to this, if a USMS detainee had to be hospitalized, two contract hospital guards on a 24-hour schedule would cost the USMS about $1,000 per day. USMS reports that this pilot project in the New York City area saved $15 million in prisoner medical care costs covering approximately a 4-year period (February 1996 to December 1999).

[1] Justice Performance Review, New York City Managed Care Network, U.S. Department of Justice, February 1996.

USMS also developed an in-house prototype medical claims system that helped in processing medical claims while at the same time collecting vital program data to help USMS identify cost trends. At the time of our review, USMS was surveying its 1998 medical diagnoses to establish a profile of medical need and was working with the VA to obtain managed care services through the Veterans Integrated Service Networks (VISN).

VISNs offer medical services and support, such as medical contracts, diagnostics, and laboratory services, throughout the nation. For example, USMS negotiated an interagency service agreement with a VISN in New York City to provide medical specialty clinics inside federal detention facilities in Manhattan and Brooklyn to reduce outside prisoner medical trips that were costly and represented a prisoner security risk to the local population. The VISN also provided USMS with outpatient services at its hospitals in New York City at Medicare rates that reduce USMS' medical costs.

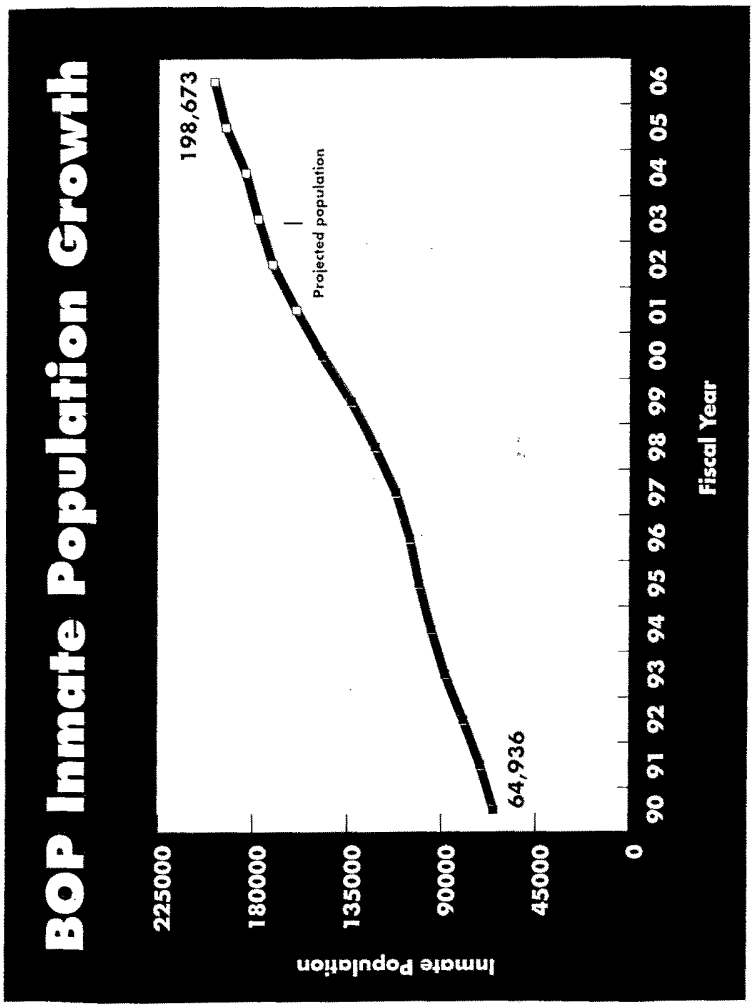
Legislative Cap on Costs

In 1999, recognizing the need to reduce the cost of health services still further, USMS and the Immigration and Naturalization Service (INS) coordinated with the Health Care Financing Administration (HCFA) to develop proposed legislative language setting a maximum amount that USMS and INS would pay for community medical care. That proposed cap was based on using the Medicare rate structure. In November 1999, Congress passed legislation establishing such a cap on future health care payments made by the USMS and INS. The legislation was enacted as part of the Department of Justice's fiscal year 2000 appropriation.[2] Language included in the appropriation amended Section 4006 of Title 18, U.S. Code, to limit the amount that the Attorney General can pay for certain federal prisoners' heath care, stating that:

"Payment for costs incurred for the provision of health care items and services for individuals in the custody of the United States Marshals Service and the Immigration and Naturalization Service shall not exceed the lesser of the amount that would be paid for the provision of similar health care items and services under—(A) the Medicare program ...or (B) the Medicaid program..." 18 U.S.C. 4006.

[2] P.L. 106-113 (Nov. 29, 1999).

For the Record



STATEMENT OF GLENN A. FINE

Mr. FINE. Mr. Chairman, Senator Sessions, thank you for inviting me to testify before the subcommittee about a special investigation conducted by the Department of Justice Office of the Inspector General regarding telephone abuse by Federal prison inmates.

My name is Glenn Fine and I am the Director of the Special Investigations and Review Unit, the unit of the Office of the Inspector General which conducts sensitive or complex investigations of Department programs and personnel.

In August 1999, we issued a special report entitled "Criminal Calls: A Review of the Bureau of Prisons' Management of Inmate Telephone Privileges." This special investigation attempted to identify the scope of the problem of telephone abuse by Federal prison inmates, look at the Bureau of Prisons' response to that problem, and offer recommendations to address the issue.

The review was conceived of and conducted by a team of OIG employees, led by an OIG attorney, Tamara Kessler, an OIG inspector, Adrian Flave, and an OIG investigator, Jeff Long. Our 122-page report, which has been provided to the subcommittee and which is available on our Web site, contains a detailed description of our findings.

Because my written statement has been submitted and will be admitted to the record, I will briefly try and describe our report, the structure of our review, the major findings of our review, and the recommendations that we made.

At the outset of the review, we attempted to determine the scope of the problem. However, we quickly learned that the Bureau of Prisons had little information on this issue. Neither BOP headquarters nor Bureau of Prisons facilities throughout the country keep statistics on cases in which Federal prison inmates are accused of committing crimes from prison using telephones.

We therefore attempted to independently assess this problem by sending out questionnaires to 94 U.S. attorneys' offices, to the FBI, and to the DEA asking them to identify prosecutions and investigations they had conducted involving Federal inmates' use of telephones. We also surveyed BOP facilities and conducted site visits of nine BOP facilities to interview the staff that was responsible for monitoring inmate calls and to ask them about the pattern of inmate calls.

In addition, we examined some high-profile prosecutions of inmates who had been convicted of committing crimes using prison telephones. We also interviewed one inmate, Rayful Edmond, a notorious drug dealer who had been convicted of drug trafficking both outside prison and inside prison, to ask him about his experience using the telephones.

What did we find? Well, our surveys, case examinations, document reviews and interviews painted a very troubling picture of the scope and seriousness of the problem of Federal inmates using prison telephones to engage in criminal activity We believed that it was a significant problem.

For example, responses to our survey to the U.S. attorneys' offices revealed over 100 cases in which they had prosecuted Federal inmates for committing crimes behind bars using prison telephones, and in approximately 10 of them there were murder cases,

there were drug trafficking cases, there were fraud cases. We also found additional investigations by the FBI and the DEA, and in few of these cases was the criminal activity detected by the Bureau of Prisons.

FBI agents and Federal prosecutors whom we interviewed also told us that they believed that the BOP made insufficient effort to target telephone calls and to refer the evidence of criminal conduct for investigation. Many of the BOP monitors and employees we talked to believed that a significant percentage of the calls made by inmates were not for legitimate purposes, such as maintaining ties to their family and community, but were for illegitimate purposes.

We also found that very few of the calls that were made were monitored. Virtually every call made by a prison inmate is taped, but less than 4 percent of them, only about 3.5 percent of them, are ever listened to by Bureau of Prisons officers or monitors.

Another finding was that we found during our site visits that the BOP staff that was responsible for monitoring telephone calls was insufficiently trained, and that monitoring equipment often was not working. We saw that some officers who were assigned the duties of monitoring as collateral duties performed their duties in a perfunctory way and not sufficiently.

In our case studies, we saw many cases in which prison inmates who had been convicted of using prison telephones to commit crimes were not targeted even after they had been convicted for monitoring and still enjoyed full telephone privileges, and that was despite some calls and requests by prosecutors or judges to keep track of these inmates. Rayful Edmond was one of them. He told us that, in his experience, he used the telephones virtually every day—he called on it all day long—to arrange drug deals outside of prison; that he on 50 or 60 occasions used telephones to have drugs introduced in prisons. He participated in telephone conference calls to Colombia.

And, Senator Thurmond, that is Colombia, South America, you will be glad to know, not Columbia, SC.

Senator THURMOND. I hope so.

Mr. FINE. He said he knew that most of his calls were not listened to and he didn't fear that any restrictions would be placed on him even if he were found out. He had little concern about that.

Based on our review, we made recommendations to deal with this issue in four areas. First, we said and we recommended that the BOP should increase the percentage of inmate telephone calls it monitors if it expects to make any headway in the problem of inmate telephone abuse.

Second, we believe that the BOP should more consistently discipline telephone abusers. Third, the BOP should restrict and target telephone privileges proactively for those inmates who have a history of telephone abuse or a likelihood of telephone abuse. And, fourth, the BOP should emphasize the responsibility of its officers to detect and deter crimes by inmates using telephones.

In response to our report, the BOP has acknowledged its shortcomings and has stated that it is working diligently to improve its monitoring program. The Director told you that, and we have seen a response by them. However, to determine whether the changes

in the BOP procedures have been effective to adequately address these issues, we plan to conduct a 1-year-after review, approximately 1 year after we completed our initial report, to review the Bureau of Prisons procedures and the changes that it made to determine whether they are effective in protecting the public and to correcting inmate telephone abuse.

In conclusion, Mr. Chairman and Senator Sessions, permitting inmates access to prison telephones and protecting the public against crimes facilitated through the use of prison telephones present a complex balancing of interests. The BOP has told us that its main mission of its monitoring program was to detect internal activity that could undermine the security of its institutions. It has also told us that it wants to allow prison telephone calls to promote ties to the family and community of the inmates. Those are both critical and legitimate objectives.

We also believe, however, that it is critical that the BOP focus on preventing inmates from using prison telephones to commit crimes outside of prison that affect those outside the institution as well. We believe that the BOP should aggressively implement changes such as the ones we recommended to address the serious problem of inmate telephone abuse.

That concludes my oral testimony and I would be glad to answer any questions that you have.

[The prepared statement of Mr. Fine follows:]

PREPARED STATEMENT OF GLENN A. FINE

Mr. Chairman, Senator Schumer, and Members of the Subcommittee on Criminal Justice Oversight:

I. INTRODUCTION

I appreciate the opportunity to appear before the Subcommittee to discuss the work of the Office of the Inspector General (OIG) with respect to our oversight of the Federal Bureau of Prisons (BOP). Specifically, I appear before this panel today to discuss a special investigation conducted by the OIG and issued in August 1999 entitled, "Criminal Calls: A Review of The Bureau of Prisons' Management of Inmate Telephone Privileges." This special review sought to identify the scope of the problem of telephone abuse by BOP inmates, assess the BOP's response to the problem, and offer recommendations to address this serious issue.

Telephone privileges for BOP inmates have increased dramatically since the 1970s when inmates were permitted one telephone call every three months and that call was placed by BOP staff. Now, most BOP inmates are allowed to make as many telephone calls as they are able to pay for or as many collect calls as people outside prison will accept. The BOP provides inmates access to telephones on the grounds that it furthers important correctional objectives, such as maintaining inmates' ties to their families. However, BOP's responsibilities extend beyond those objectives. Permitting inmates virtually unlimited access to telephones comes at the cost of allowing inmates the ability to commit serious criminal activity using prison telephones. Often those crimes extend beyond the prison. Even though the BOP records all inmate calls, except prearranged calls between inmates and their attorneys, we found that the BOP listens to few such calls—approximately 3.5 percent of the tens of thousands of calls made daily by federal inmates.

Our review found that federal inmates using prison telephones to commit serious crimes while incarcerated—including murder, drug trafficking, and fraud—is a significant problem. Although the BOP has been aware of the problem for many years, we concluded that it had taken insufficient steps to address the abuse of prison telephones by inmates. The BOP failed to respond adequately, partly because of the fear of litigation if it made changes to inmate telephone privileges, partly because of its misplaced reliance that new technology will provide solutions, and partly because of its apparent belief that inmates primarily use the telephone to maintain family relationships and community ties.

We concluded that the BOP needs to squarely address what appears to be significant inmate abuse of prison telephones and take immediate and meaningful actions to correct the problem. Technology alone will not solve the problem of inmate telephone abuse without aggressive intervention by BOP officials. We believe that unless the BOP places some meaningful restrictions on inmate telephone privileges, steps up its monitoring of inmate calls, disciplines telephone abuses more consistently, and devotes more effort to detecting and deterring prison telephone abuse, the significant problem of inmates using prison telephones to commit crimes will persist.

II. THE OIG REVIEW

At the outset of our review, we attempted to determine the scope of the problem of inmates' abuse of prison telephones. However, we learned that the BOP had a paucity of information on this issue. Neither BOP headquarters in Washington, D.C., nor BOP facilities across the country keep statistics of cases in which inmates are accused of committing crimes from prison using the telephone. Although the BOP maintains statistics on violations of prison regulations, this data is not sufficiently specific to identify which cases involve the use of telephones. Several BOP officials acknowledged to us that their limited statistics do not represent the overall number of telephone violations because many violations are resolved informally or not pursued administratively when criminal charges are brought.

Given the limited information available from the BOP, we attempted to independently identify the scope of inmate telephone abuse through a questionnaire we sent to all 94 United States Attorneys' Offices (USAOs). In the questionnaire, we asked the USAOs to identify any cases they prosecuted involving crimes committed by inmates using telephones in BOP facilities. We sent a similar questionnaire to the Federal Bureau of Investigation (FBI) and Drug Enforcement Administration (DEA) headquarters, for distribution to all FBI and DEA field offices, asking them to identify investigations they conducted involving federal inmates' use of prison telephones to commit crimes. In response to our requests, we received information from 72 USAOs, 16 FBI field offices, and 11 DEA field offices. Because these organizations do not index cases according to whether they took place in prison or involved the use of telephones, their responses to our questionnaires were based on the recollection of the people who filled them out rather than on any comprehensive statistical review, and they undoubtedly do not represent the total universe of such cases.

We also sent a questionnaire to the 66 BOP facilities that use the Inmate Telephone System (ITS), a telephone system employed by the BOP that can store and analyze data about inmate telephone calls better than the older telephone system used in 27 other BOP facilities. In this survey, we sought information about the volume of inmate calls and each institution's monitoring practices, staffing, equipment, and other policies related to the detection of telephone abuse by inmates.

We also visited nine BOP facilities to interview staff responsible for the institution's security and inmate telephone monitoring operations. These nine facilities represent institutions with different security levels and different physical layouts, two factors that affect the methods of monitoring the use of prison telephones. We visited four penitentiaries, three medium-security facilities, and two low-security institutions.

In addition, we examined prosecutions of several high-profile inmates who were convicted of committing crimes from inside a BOP facility. We looked at these cases to determine what steps, if any, the BOP had taken to prevent these inmates from using the telephones to continue their criminal activities while they were incarcerated. We also interviewed one of these inmates, Rayful Edmond III, about his experience using prison telephones to commit crimes.

In total, we interviewed more than 70 BOP employees and approximately 20 other persons in the Department of Justice. We examined numerous documents, including BOP program statements on inmate telephone usage, the case law on inmate rights to telephone access, and the litigation and settlement agreement in a large class action lawsuit brought by inmates against BOP regarding the telephone system.

III. FINDINGS

Our interviews, case examinations, data collection, and document review paint a troubling picture of the scope and seriousness of inmate use of prison telephones to engage in criminal activity. Our 122-page report, which has been provided to the Subcommittee and which is also available on the OIG's website at "www.usdoj.gov/oig," contains a detailed description of our findings. For purpose of this statement, I will summarize our major findings.

We determined that inmate abuse of prison telephones appears to be significant. For example, responses to our survey to the USAOs revealed more than 100 cases recently prosecuted by those offices involving inmates' use of prison telephones to commit criminal acts. Eleven of these cases involved prosecutions for murder or attempted murder arranged by inmates over prison telephones. In one case, an inmate used prison telephones to attempt to arrange the murder of two witnesses and a judge and to pay for the execution with illegal firearms. One inmate directed a fraudulent employment matching service scheme using prison telephones that involved approximately $1.6 million. Another inmate used prison telephones to swindle trucking companies out of more than $100,000.

The FBI field offices that responded to our questionnaire reported that they conducted 44 investigations between 1996 and 1998 involving prison inmates using telephones to commit crimes. The DEA reported investigating 12 cases at BOP facilities in the recent past in which federal inmates had used prison telephones to commit crimes. In none of the DEA cases was the criminal activity detected by the BOP.

FBI agents who handled many cases of prison crimes told us that they believed that the BOP makes little effort to target inmate telephone calls and to refer evidence of criminal conduct to the FBI for investigation. Similarly, a federal prosecutor from the Los Angeles USAO, who works mostly on prosecutions involving crime in prisons, said that the prison telephones to commit crimes is rarely detected by the BOP.

Rayful Edmond, a notorious Washington D.C. drug dealer who used prison telephones at USP Lewisburg to run an international drug organization, told the OIG that he talked on the telephone "all day long" and made arrangements for drug deals on the telephone almost every day, including participating in conference calls to Columbia. He estimated that he arranged to have drugs brought into prison 50 or 60 times. He claimed that almost half of Lewisburg inmates were involved in bringing drugs into the institution and that most of these drug deals were arranged over prison telephones. Edmond said that he has little concern about conducting drug deals using prison telephones because he knew that most calls were not being monitored. He said he also believed that even if he were caught abusing his telephones privileges, at worst he would receive a light punishment or a restriction of his privileges for a short period of time.

Our survey determined that most inmate calls from prison are never listened to by BOP employees. Only 3.5 percent of the tens of thousands of calls made every day from BOP facilities were monitored. Our survey also found that even though inmate telephones were available an average of 18 hours per day, the institutions had staff assigned to listen to telephone calls an average of only 14 hours on weekdays and 12 hours on weekends. Our survey also indicated that 16 of the 66 BOP institutions using ITS assign staff to listen to inmate telephone calls less than 50 percent of the time that the telephones are operational. While all calls are recorded and can be listened to later, we found that this occurred rarely.

Some inmates use prison telephones excessively. Fifteen inmates at the nine institutions we visited spent more than 66 hours each on the telephone during a one-month period. This equates to more than two hours per day, on average, that these inmates spent talking on the telephone. However, none of the institutions had done anything about this excessive telephone use or was even aware of it.

During our visits to the nine institutions, we also found that the BOP staff responsible for monitoring inmate telephone calls were not sufficiently trained on the telephone monitoring equipment or monitoring procedures. For example, we did not talk to any telephone monitor who had received anything other than on-the-job training. We found no BOP telephone monitors who had received formal instruction on the best way to monitor inmate telephone calls; how to recognize suspicious activities or coded inmate language; which inmates should be monitored; or how to detect three-way calls, which are prohibited under BOP regulations. We also found that many BOP facilities make little or no effort to monitor telephone use by high-risk inmates. In addition, we saw that some correctional officers who are assigned collateral duties of monitoring inmate calls do so in a perfunctory way, often monitoring fewer calls than they are required by their post orders. During our site visits, we also saw that some of the equipment used to monitor calls was broken and no one had placed an order for it to be repaired.

In addition to our surveys and site visits, we examined several high-profile prosecutions of inmates who were convicted of conducting their crimes from inside a BOP facility. We looked at their cases to determine the response of the BOP in each case and what, if anything, it could have done differently to detect the criminal activity. These cases provided stark examples of the BOP's failure to adequately mon-

itor inmate telephone use. In addition to the case of Rayful Edmond, we reviewed the following cases:

• Anthony Jones, a drug dealer in Baltimore, MD, was convicted of being a felon in possession of a firearm and was incarcerated at a BOP facility in Allenwood, PA. While incarcerated, Jones became aware of an ongoing grand jury investigation into his drug activities and used prison telephones to order his associates outside prison to murder two witnesses he suspected had testified against him. One of the witnesses was killed and the other was shot several times. As a result, in May 1998 Jones was convicted of murder and attempted murder, and he received a sentence of life imprisonment without parole. Yet, even after these convictions, Jones retained full telephone privileges and the BOP failed to take any measures to monitor his telephone calls. Only after the OIG questioned the BOP about Jones' telephone access in connection with this review did the BOP move to restrict his telephone privileges in July 1998.

• Jose Naranjo was convicted of conspiracy to distribute cocaine in 1979. While serving a 12-year sentence in Otisville, NY, he used the prison telephones to participate in a conspiracy to import cocaine from Colombia, South America to North Carolina. Even after his conviction for that crime, he continued to enjoy full telephone privileges. After being transferred to Petersburg, VA, he engaged in other conspiracies to distribute cocaine, and in 1995 was again convicted of drug distribution offenses that he had committed using prison telephones. After Naranjo's sentencing, the federal prosecutor wrote to the BOP to urge it to prohibit Naranjo from using prison telephones. However, during our review in 1998, we were surprised to learn that Naranjo's telephone privileges had been restored and that the BOP was making no special effort to monitor his calls.

• Oreste Abbamonte was convicted of using prison telephones at Lewisburg, PA, to orchestrate the distribution of multiple kilograms of heroin. After this conviction, federal prosecutors wrote a letter to the BOP stating that Abbamonte's access to prison telephones had enabled him to commit drug crimes while incarcerated. When Abbamonte was sentenced, the court specifically recommended that he be confined to the BOP's highest security facility with limited telephone privileges.

Despite these recommendations, the BOP placed no restrictions on Abbamonte's telephone use, and his drug trafficking using prison telephones continued. While in a BOP facility in Leavenworth, KS, Abbamonte again used prison telephones to conspire to purchase cocaine, and he was convicted in 1992 for this offense. When we reviewed Abbamonte's BOP files in 1998, we were again surprised to find that his telephone privileges were not limited in any way despite the prosecutor's letter, the court's specific request, and his repeated use of the prison telephones to commit crimes.

Several BOP officials told us they believed that a new generation of telephone equipment planned for installation in all BOP institutions during the next two years will detect many cases of inmate telephone abuse. However, no new technology—including ITS II, the BOP's new inmate telephone system—will solve the problem of inmate telephone abuse without aggressive intervention by BOP officials. Implementation of a new inmate telephone system is not the "cure all" that some BOP officials apparently are counting on. In fact, given the lack of understanding and failure to use some of the security features that already exist in the BOP telephone system, the new system could have little impact on BOP's efforts to detect telephone abuse by inmates unless the BOP makes a more sustained effort to use the new technology aggressively to detect and deter telephone abuse.

IV. RECOMMENDATIONS

Based on our review, we recommended that the BOP take steps to curb prison telephone abuse in four ways. First, the BOP must increase the percentage of inmate telephone calls it monitors if it expects to make any headway on the problem of inmate telephone abuse. While additional resources will be helpful in this regard, because of the high volume of inmate calls the only realistic solution is to reduce the number of calls so that BOP staff assigned to this task can monitor a greater percentage of calls. Towards this end, we made various recommendations, including that the BOP impose limits on all inmates' telephone privileges, set a significantly higher goal for monitoring inmate calls and then calculate the resources needed to meet this goal, have telephone monitors on duty at all times that prison telephones are available to inmates, do a better job identifying inmates with a high probability of abusing their telephone privileges, and institute a plan to monitor these inmates' calls proactively.

Second, the BOP must increase and more consistently discipline telephone abusers. During our review, we found various cases in which inmates retained full tele-

phone privileges even after they were convicted of a crime involving use of prison telephones. We recommend that the BOP develop and enforce policies to ensure that administrative action is quickly taken against inmates who abuse their telephone privileges, particularly those inmates convicted of crimes stemming from their use of prison telephones. The BOP also should develop and implement policies that mandate restriction of telephone privileges as the preferred sanction for inmate telephone abuse. Subsequent violations of BOP telephone policies should result in increased sanctions that include loss of all telephone privileges. Inmates who commit crimes using prison telephones also should have their privileges revoked.

Third, the BOP should restrict telephone privileges proactively for inmates who have a history of telephone abuse or a likelihood of abuse. This would mean that some inmates simply would not have telephone privileges because of their previous behavior using the telephones in prison. As an additional safeguard to deter potential criminal conduct, the Department of Justice should educate prosecutors about the availability of court orders restricting an inmate's telephone privileges in racketeering and drug cases. The Department also should consider seeking legislation to permit similar court orders in all cases in which the government can make a showing that the defendant should not be entitled to telephone privileges because of a prior history of telephone abuse.

Moreover, the Department should emphasize to USAOs the need to inform BOP of inmates who pose special risks of committing serious crimes while incarcerated, as outlined in a letter from the Attorney General on May 7, 1998. As of the fall of 1998, the BOP had received only two such notifications. These notifications are critical because they fill gaps in BOPs' knowledge about the inmates' history and put the BOP on notice of the risk posed by certain inmates. In light of the BOP's failure to properly monitor high-risk inmates after either court order or notice from prosecutors, we recommend that a reporting system be established to assure USAOs that the BOP has taken proper measures after such a notification.

Fourth, the BOP should emphasize the responsibility of its officers to detect and deter crimes by inmates using BOP phones. Our review found that Special Investigator Supervisor (SIS) officers at BOP institutions spend far too little time detecting and deterring criminal conduct committed by inmates using prison telephones. The SIS's mission should be expanded to include a more substantial focus on the detection of crimes by inmates in BOP custody. This could be accomplished through additional training for SIS staff, greater communication between the SIS and other law enforcement agencies, and better intelligence-gathering on inmates. In addition, the BOP should revise its procedures to require SIS staff to ensure that the numbers listed on an inmate's telephone calling list are investigated prior to approval of those lists, especially with high-risk inmates.

V. OIG FOLLOW-UP REVIEW

In response to our report, the BOP acknowledged the shortcomings of its telephone monitoring efforts and stated that it has been working diligently to improve its monitoring program. However, the BOP contested whether there was widespread abuse of prison telephones by inmates, arguing that the 100-plus cases of inmates recently prosecuted for telephone abuse cited in the OIG report were only a small percentage of the total number of inmates in BOP custody. We found this argument unconvincing. Our surveys identified serious cases of criminal activities. In addition, our interviews of BOP correctional officers, law enforcement officers, prosecutors, and Rayful Edmond, as well as our case studies of how the BOP failed to monitor the telephone calls of inmates who had been convicted of committing serious crimes with prison telephones, indicate that the problem is significant. Moreover, we believe that the absence of reported cases is attributable, in large measure, to the fact that the BOP does not monitor prison calls adequately and does not even compile statistics on prison telephone abuse. As a result, the reported cases we collected in our survey appear to be, as one FBI agent who investigated such cases phrased it, "the tip of the iceberg."

In its response the BOP concurred with many of the reform recommendations we made, including imposing limits on telephone privileges. It disagreed with several of the recommendations, however, such as whether the BOP should monitor a higher percentage of inmate calls, whether there should be a telephone monitor on duty at all times prison telephones are available to inmates, or whether SIS officers should focus more of their attention on the detection of crimes by inmates in BOP custody.

To determine whether the BOP's procedures and proposed changes in response to our report adequately address these issues, the OIG plans to conduct a "year-later" follow-up review of the BOP's management of inmate telephone privileges. We in-

tend to use a variety of techniques, including surveys, interviews, site visits, data analysis, and document review, to assess whether BOP has made improvements in its efforts to curb inmates' abuse of telephone privileges.

In conclusion, permitting inmates access to prison telephones and protecting the public against crimes facilitated through use of prison telephones present a complex balancing of interests. Our review highlighted the serious nature of inmate abuse of prison telephones, including murders and drug deals arranged using BOP telephones. Our review also led us to conclude that the current inmate call monitoring system is ineffective. Our interviews of telephone monitors left us with the impression that they are overwhelmed and not adequately trained. The low number of crimes or administrative violations detected and the high number of crimes likely being committed should indicate to the BOP that major changes are needed. We believe that, in light of our report, the BOP should aggressively implement changes to address the serious problem of inmate telephone abuse.

Senator THURMOND. Senator Sessions.

Senator SESSIONS. Thank you, Mr. Chairman.

Well, on the telephones, do the Federal prisons themselves make a profit by selling the phone to a private contractor, and do they have an incentive to allow more calls to be made? That was true in Alabama prisons, I know, and actually they were paying for it because the prisoners had to call collect to their mama or their wife, who didn't have the money to pay for the calls. But they couldn't turn them down when they called collect and ended up with big fees, higher than normal telephone fees, and the contractors and the prison both were making money off of the deal.

Mr. FINE. Senator Sessions, in this case the contractor and the Bureau of Prisons do get a share of the profits that are made from inmate telephone calls. I think the problems in the State institutions that I have read about are significantly different in that there are exorbitant rates charged to inmates using the telephones.

In the Bureau of Prisons, the rates that are charged are approximately 15 to 31 cents for debit calls. For local calls, it is 50 cents, a flat fee, and for collect calls it is the standard collect charge, whatever that may be. A portion of the profits go to the contractor and a significant portion of the profits do go to the Bureau of Prisons.

Senator SESSIONS. So the more calls that are made, the more they make. What do they use that for the coffee fund or——

Mr. FINE. Well, they use that for the inmate trust fund. There is currently an issue whether they can use that money to monitor telephone calls. The money that is used has to go in the inmate trust fund for the benefit of the inmates, and there is an open question whether that could be applied to monitoring efforts. We believe that it should be, and there may be sort of a need for clarifying legislation to make it clear to the Bureau of Prisons that they can use that money to more proactively and aggressively monitor the inmates' calls.

Senator SESSIONS. Well, several of the former public officials or public officials who were involved in this are now themselves in the bastille in Alabama for these manipulations of telephone toll calls. And I thought it was really bad. Some of that investigation began when I was attorney general.

Do you think that the fact that the prison makes some money out of it could cause them to be less aggressive in containing the calls?

Mr. FINE. Well, that is a possibility.

Senator SESSIONS. Well, you know, I guess that is the answer. My next question is did you have any occasion to examine the nature of these contracts to make an opinion about the wisdom of those contracts? I thought they were rather bizarre because there was big money being made. Once they set the system up, the owners sit back in their homes and the money just comes in. Every time some prisoner calls their mother collect, the chink goes into that cash register of the businessman, and I wonder why the Federal prison system couldn't run that itself, or get the major phone companies to do it.

Mr. FINE. We did not examine the contracts and the arrangements that had been made between the Bureau of Prisons and the telephone companies. What we were mostly focusing on in this was their efforts to monitor and prevent criminal calls from behind bars. We found a significant problem there. But you raise a serious issue; there is not question about that.

Senator SESSIONS. And is it basically done on a collect call basis?

Mr. FINE. No. It is on a debit basis in most institutions, with the option of having collect calls. They can make debit calls. They get a phone access code and if they have money in their commissary account, they can use that phone access code to make a direct debit call. If they don't have sufficient money in their commissary account, they can use the phones to make collect calls to their families.

Senator SESSIONS. One hundred seventeen prosecutions is significant of people in prison abusing the phones. One of the great prosecutors I have ever known, Broward Segrist, in Montgomery, years ago prosecuted some 30 prisoners who were using the prison phones to conduct fraud, and I remember him telling me, they said, well, you know, it is just worthless; a lot of these guys got 20 years in jail. We have got a trial, it will be a holiday for them. They get another year and there is nothing you can do to them. But he said he felt so strongly about it that it was wrong that he was not going to turn away and listen to the prison people and the experts who said they shouldn't be prosecuted.

I would assume, based on my personal experience, that a lot of cases of significance have not been prosecuted for that very reason, and actually gone to trial and been convicted because the U.S. attorney's office has a lot of demands on it. It is going to prosecute a $1,000 fraud when the guy has already got 10 more years to serve in jail, and he might escape during the prosecution. So it is a burdensome thing to prosecute. So, that indicates to me that you have a bigger problem than a lot of people would suggest.

Have you seen any computer fraud? Has there been any access by prisoners to computers in a way that has led to fraudulent activity?

Mr. FINE. No, not in this survey. What we did was we surveyed the U.S. attorneys' offices, and they did not have—everyone did not have indexes of these cases and records of these cases. What it really was was whoever got our survey from memory remembering the cases that involved prison telephones.

So I agree with you. We believe that those numbers were the tip of the iceberg, and the fact that there were that many prosecutions indicates that there is much, much more criminality going on be-

hind bars and only some of them get prosecuted. Of the cases that we were referred, I don't believe there were any computer frauds that were noted in response to our survey.

Senator SESSIONS. I had a neighbor in Mobile, AL, that talked to me about receiving—two people I knew in town received a call saying their child had been either in an accident or arrested, and that this person had been asked to call on their behalf and they needed to fax so much money to this address. And these people were terrified. They didn't know whether their child had been injured or had been arrested. Eventually, it turned out to be a prison call scam.

Is that the kind of thing we are talking about?

Mr. FINE. That is the kind of thing we are talking about. We are talking about those kinds of frauds where prisoners have virtually unlimited access to the phone and can commit these fraudulent schemes. We saw one case, for example, where there was a prisoner behind bars in Federal custody who committed a fraud by claiming he was a headhunter, claiming there was an employment matching service. Send me some money and I will get you a job. The person who sent the money had no idea that they were sending money to a prisoner behind bars. That is the kind of thing that can happen, and the thing that you just described as well.

Senator SESSIONS. Well, many of these are quite devious and sociopathic, and it is why we have controls on the use of their phones.

Do you uncover any need for legislation, or did you think for the most part the problems could be solved by regulations within the prison?

Mr. FINE. We believe for the most part the problem can be solved by the Bureau of Prisons by aggressively intervening, by aggressively using the technology that they have and monitoring inmate calls more aggressively, by restricting the number of calls to a reasonable level. We saw some cases where there was an absolutely incredible amount of telephone calls being made by single prisoners that the Bureau of Prisons was not aware of or was not even doing anything about. So the tools are in place.

There is a little bit of legislation that we suggested around the edges; one, for example, making it clear that the Bureau of Prisons can use the profits from the telephone system to monitor telephone calls, that that is part of the overall system, and that that would be used for the benefit of the inmates; that is, providing a secure system could use that money.

In addition, judges can restrict privileges for inmates if it is a drug offense or a racketeering offense, and we looked into and recommended that there be some consideration of expanding the types of crimes where judges can actively restrict the privileges of inmates. But in response to your question, by and large the tools are there and we have recommended that the Bureau of Prisons aggressively use those tools.

Senator SESSIONS. I would think they ought to look at the whole idea of this contracting out this phone business. I am not sure that is healthy. Maybe in the early days, only a few people knew how to put a system in like that that could work to do the collect calls or however they managed it. But I think we are probably beyond

that now. Mainstream companies probably could do it, and it provides an opportunity to create a cash cow for a contractor who really is not doing any work. Once he gets the system set up, it just basically runs itself and the money clinks in every week.

Mr. Chairman, I did want to ask a little later some questions about health care issues, but I have taken too much time. I apologize.

Senator THURMOND. Mr. Stana, do you believe that the benchmark contracting initiative and a cap on hospital charges at Medicare rates has the potential to significantly help contain costs?

Mr. STANA. Yes, I do, Mr. Chairman. The initiatives that are currently being implemented by the Bureau of Prisons have been very helpful, but they can only go so far. They have gotten the Bureau down to the levels they are from 3 years ago, but there is going to be a sort of a diminishing return to how much more you can expect from those initiatives.

Now, what you get with a Medicare cap is you have the hospitals using a system that they fully understand. It is the Federal system. There are predetermined rates that are set by HCFA, with a little bit of room that would be made in the legislative proposal for any other special needs brought about by taking care of inmates. And you would know exactly what you had. You would have more of a basis for confidence that you are getting one of the best values for the money.

With the benchmark, you have something completely different. What you have with the benchmark rate is not using the Medicare care, per se. You are using the Federal Medicare rate, which is the base rate before each individual hospital gets to add their own circumstances and cost features into that rate, and this is significant.

Of the five hospitals in the El Paso area, for example, there was a 40-percent difference in the Medicare rate among the hospitals for the same procedure. So by using the benchmark rate, what you are telling the hospitals is this is the rate I want you to benchmark your bid at; let me know the percentage above that rate or below that rate you are going to bid at. Now, both of these rates could be complementary, with the Medicare cap being at the upper end and the benchmark rate being something perhaps below that, so that they could work in tandem.

Senator THURMOND. Mr. Stana, what do you predict will be the primary health care cost issues that the BOP will face in the future?

Mr. STANA. Well, I think there are many issues that they face in the future, but I would boil it down to three. The first one is contracts. Right now, about a third of their costs are made through contracting, and they need to have the confidence that they are getting the best possible contracts. And we think the Medicare cap and the benchmarking procedure would go a long way to making sure that they are getting the smart contracting procedures.

The second thing is caring for special-needs populations. Director Sawyer mentioned the problem of the aging inmate population. In fact, I just last week visited two Federal medical centers in Fort Worth, TX, Carswell for women and Fort Worth for men, and what I saw is a number of elderly inmates who are not really appropriately placed in the general population, but being that there is

no intermediary care, were placed in the Federal medical center, taking up a hospital bed, which is very expensive care.

Right now, I believe the Bureau estimates that they have virtually enough inmates, or will very soon, to open a separate facility that would, in essence, be nursing care. And this is a challenge that is going to exacerbate as the aging of the population proceeds.

The third thing is pharmaceuticals. They spend a lot of money on psychotropic drugs for mentally ill inmates, cocktails for HIV inmates. For example, the normal prisoner's health care cost is about $3,250. For an AIDS patient, it is about $20,000, and the hepatitis drugs the same thing.

Senator SESSIONS. Twenty thousand for whom?

Mr. STANA. Twenty thousand for an AIDS patient.

Senator SESSIONS. And $3,500 for——

Mr. STANA. And $3,250 for the average BOP inmate health care cost.

For hepatitis C, it is $14,000 for medications there, and care, for an average hepatitis patient. Again, the average for BOP-wide is $3,250.

Senator SESSIONS. A year?

Mr. STANA. A year.

As times goes on, as you get more and more AIDS patients and hepatitis C, which they are just beginning to test for, and mentally ill inmates in the system, health care costs are going to go up, and we need to be sure that we can get on top of these issues.

Senator THURMOND. Mr. Stana, the Bureau of Prisons is faced with a sharply rising prison population which increases Government expenses in all areas, including health care costs. In this time of growth, is it important for the BOP to make cost containment measures a top priority not only in the medical care area but other areas as well?

Mr. STANA. It is critical that they have cost containment strategies for all areas of their operations. In the early 1990's, we did a number of reports dealing with the construction program and the population management programs that the Bureau had at that time, and that is when we were dealing with a population base of about 50 to 60,000 inmates. As you know, we are more than double that today.

I would think that they would focus their cost containment areas in a handful of areas where there may be some payback. One is reexamining the design capacities, how they are designing their prisons to enable the use of double-bunking where appropriate instead of having each inmate have a separate cell. Of course, you can't do that at the more advanced security levels, but at the mediums and below, you may be able to take advantage of that in a greater way.

The second thing is construction costs. When we compared construction costs of the Federal prisons to State and local prisons a number of years ago, we found that the Federal prisons were far more expensive. In part, that is because they build a more substantial building, but in part they didn't take advantage of common use areas and they gave each inmate, on average, more square footage.

Another area that we would like to reexamine sometime is their use of halfway houses. We found a lot of excess capacity going unused in the halfway house system, when there were inmates that

could be appropriately placed there and they could be housed there at much less expense.

Finally, privatization. Of course, we have the Taft experiment going now and we don't know how that is faring yet. There is not enough experience there, but I think we ought to look to the private sector to do more and more just as they are doing in the health care system.

Senator THURMOND. Mr. Fine, what steps has the Bureau taken in response to your IG report to make inmate abuses of phone privileges more of a priority?

Mr. FINE. We have been generally pleased with their response. They have acknowledged the shortcomings and have stated they have diligently attempted to address the issue. They are implementing the new inmate telephone system, the new technology, at many different institutions. They have told us that they have entered many more inmates in categories of inmate telephone abuse, and that they will look at them more targeted and more proactively.

They have sent out a monitoring guide to the officers and the investigators in the field. They have made the use of coded language in telephone calls a more severe disciplinary offense. They are attempting to increase the discipline levels for some of the offenses. So they have told us they have taken significant steps to address the problem of inmate telephone abuse.

What we intend to do, however, is, as I stated before, go back in a year after our report to see whether those policy changes and procedural changes have had an effect. In the past, we have seen a disconnect to some extent from the policies that are at the headquarters level to what we saw in the field, and we think it is important that those policies are implemented throughout the Bureau of Prisons so that they will have the intended effect.

Senator THURMOND. Mr. Fine, at the time of your report inmates were provided almost unlimited telephone privileges. What restrictions on inmate telephone calls do you think are appropriate?

Mr. FINE. Well, we know that the Bureau of Prisons had a wardens' working group a few years ago that looked at this issue and suggested that 300 minutes a month would be an appropriate restriction. That seems to us to be reasonable. We didn't state the exact number of minutes that should be the maximum, but we do think that there should be a restriction on the number of minutes. Otherwise, the Bureau of Prisons won't be able to get a handle on the problem of inmates using the telephones excessively and using them excessively to conduct criminal activities. So we have recommended to the Bureau of Prisons that they look at this issue and put in a reasonable restriction such as that.

Senator THURMOND. Mr. Fine, do you think that the settlement that the Department of Justice recently made in the *Washington* v. *Reno* litigation was more generous for prisoners than the law required, and has the settlement deterred efforts within BOP to restrict telephone privileges?

Mr. FINE. It has restricted efforts to some extent. The main problem with that settlement agreement, in our view, was that the litigation and the settlement agreement delayed the implementation of needed changes. It delayed to some extent the new technology,

the new inmate telephone system, and it also has created a mind set within the Bureau of Prisons that they are hesitant to make changes in the inmate telephone privileges and hesitant to make changes in the current system, when the actual settlement agreement, in our belief, wouldn't prevent that from happening.

For example, the settlement agreement states that inmates should be allowed 120 minutes of collect calling per month and 60 minutes of debit calling per month. That, in our view, is not an onerous restriction because the wardens' working group and sort of in our view, any restriction would be a higher level. But that settlement agreement has prevented the BOP from looking at this issue and making changes while the settlement agreement is in effect, and we think that the fear of litigation and the fear of the settlement agreement shouldn't hold up the needed changes.

Senator THURMOND. Mr. Fine, should the Department of Justice try to get the court to amend the consent decree on terms more favorable to BOP if the decree impedes efforts to restrict telephone abuse?

Mr. FINE. I would say yes. If it does restrict the efforts to restrict telephone use, then the Department of Justice should clearly look at that settlement agreement. However, in our talking to the Federal programs attorneys and the Bureau of Prisons attorneys, their view is that the settlement agreement would not restrict efforts as long as the Bureau of Prisons could make the case, and we believe that they can, that restrictions are necessary for the security and good order of the institution and to protect the public.

That is a provision in the settlement agreement, and as long as the case can be made and the Bureau of Prisons makes that case, the settlement agreement should not restrict their efforts to impose significant controls on inmate telephone use.

Senator THURMOND. Mr. Fine, your report notes that in 1998 the Attorney General sent a memorandum to U.S. attorneys encouraging them to inform the Bureau of Prisons of incoming inmates who posed a special risk of committing crimes while in prison. Do you think the Department of Justice needs to do more to encourage U.S. attorneys to warn BOP about these new inmates?

Mr. FINE. Yes, we do think they should. We think that memo was a good step. When that memo was issued in May 1998, we looked at it, and in the fall of 1998 there had only been two referrals to the Bureau of Prisons to look at inmates who exhibited a likelihood of continuing their criminal activities. In August 1999, there were six. We are told currently there has only been about 17 referrals. We believe that there should be more referrals, and the Department of Justice and both the U.S. attorneys' offices as well as the law enforcement agencies should make an effort to notify the Bureau of Prisons about inmates of greatest concern.

Senator THURMOND. Mr. Fine, is it important to limit prisoner use of telephones to hours when telephone monitors are on duty?

Mr. FINE. We think that is an important restriction that should be made. I know the Bureau of Prisons disagrees with that. They believe that monitors should only be on duty at the times of the highest usage. The problem we found is that although almost all inmate telephone calls are taped, if they are not listened to live, they are rarely listened to. And we believe that the live monitoring

is the most effective monitoring that occurs; that the alerts can be noted and listened to. And we believe that there should be monitors on duty at the time of telephone usage.

Senator THURMOND. I want to thank you gentlemen for being here and for your testimony. I have got another engagement and I have got to go.

Senator, can you take over now?

Senator SESSIONS. Yes, I can. Thank you, Mr. Chairman. I just have a few questions I would pursue.

It is difficult to overestimate the problems that come from these consent settlements. Every warden, when asked to do something about phones, is going to say, well, there is a lawsuit and they have got a consent settlement and the judge will put me in jail if I do anything. So it is just an excuse for doing nothing.

I really believe that the Bureau of Prisons needs to assert the fact that they represent the United States of America with regard to housing prisoners, and not lawyers and a judge in a back room in a courthouse somewhere trying to monitor the telephone system. I really think we have gone too far on that, and I hope that out of this will come a determination to conduct reform across the board.

Mr. Stana, with regard to the aging population, I assume that was not part of your analysis precisely, but anecdotally or otherwise did you form any opinions or develop any concerns about increasing health care costs coming from an aging prison population?

Mr. STANA. Well, aside from the obvious cost of maintaining an elderly patient, what we found is that the Bureau's system of health care really isn't flexible enough right now to provide a gradation of care as inmates move along in their care needs.

In the private sector—you and I have parents and uncles or whatever—if you need a little more help, you can go into assisted living. If you need a little more than that, you can go into a nursing home. If you need a lot of care, there is a hospital. You know, there is a gradation of care.

Well, with the Federal prison system, if you can't maintain yourself or be maintained in the general population, given your security level, your option is to go to the Federal medical centers. That is very costly. I just came back from the Federal medical centers last week and one impression I came away with is there are an awful lot of elderly inmates who are using up bed space.

Senator SESSIONS [presiding]. Hospital-style bed space?

Mr. STANA. Hospital-style. It is questionable whether they needed that intensity of care, but there is nowhere else to put them. So I think what the Bureau needs to do, and I think they are thinking along these lines, is to create an option, almost a nursing home, if you will, to care for these elderly inmates.

Senator SESSIONS. And you believe that would be not only more appropriate, but less expensive in the long run?

Mr. STANA. Well, like I say, it frees up hospital beds for inmates who need hospital-style care. That is what the private sector does and that is what the Bureau of Prisons is eventually going to have to do.

Senator SESSIONS. To your knowledge, are there any proposals now about how to deal with elderly prisoners who maybe have

reached a point in their life when they cease to be dangerous? I don't think we can say that about every prisoner, but there are some probably that that could be said about, people who have contracted a terminal illness or something like that. Is there sufficient ability for the prison system to transfer them to some sort of work camp or outside facility, or even on a home detention basis?

Mr. STANA. I met an inmate last week who was terminally ill with cancer. She had maybe 2 months to live, and the Bureau was working with her on a compassionate release so she could go home and essentially die with her family. The problem is not many inmates who serve long sentences have a support network once they leave the prison. Their relatives disown them or they just aren't there.

So by releasing the inmate to get care other than in a prison, the question is where do you release them to, and would the private sector care, either nursing homes or other types of assisted living, be willing to take on inmates who are there under those circumstances.

Senator SESSIONS. Not an easy question to deal with.

Mr. STANA. No.

Senator SESSIONS. What trends did you see in pharmaceutical drugs? Has that been going up steadily?

Mr. STANA. Well, they have, but through bulk purchasing and cooperative agreements with other governmental agencies, they have really got a bit of a handle on that. The issue here is what are they going to do with the inmate population as they see it coming. You know, they are testing more for hepatitis, hepatitis B and C, and so they are finding more cases of that, and that is a very expensive treatment. It is a form of blood poisoning.

The same with AIDS patients. There is only 1 percent of the BOP inmate population that has HIV or AIDS, but about 8 to 10 percent of the District of Columbia inmates that are being transferred into the Federal system have the AIDS virus. So it is very expensive care. Psychotropic drugs, as I mentioned before, are very expensive, you know, the anti-depressants, schizophrenia drugs, and so on. And you have to provide this level of care.

Now, what the Bureau does attempt to do in discerning what type of care to give to which inmates is try to discern who needs life-saving care, who needs the kind of care that would essentially leave them with a lifelong condition, like a bad hip and they just can't get along without it. They may provide that.

Then there is a sort of a gray area on a case-by-case basis of if a person has a hernia, well, can they live with it? Well, if they can, they won't do it. If they can't live with it, then they will; they will provide the care. And then there is a fourth category that is dental caps and removing tattoos, things like that that are most of the time dismissed out of hand. But I have got to say my own observation would be if they are going to err, they are going to err on the side of providing the care rather than withholding care from an inmate in need.

I have one thing I wanted to mention. You were having an exchange with Mr. Fine a second ago and you asked about computer security in prisons. We did a report and issued it last summer on the controls on inmates who do prison work programs that gives

them access to personal information. It is mostly in the State systems where the State department of corrections may be under contract with the health bureaus or the driver's license bureaus to transfer files on computers.

The real key we found there is good supervisory controls over the inmates, making sure that they are controlled when they go in, they are working in a controlled environment while they are working, and there are some controls to see what they are taking out of the facility with them.

We found a relative handful of cases where an inmate read a medical file and discovered that it was a relative and they called the relative and it resulted in an embarrassing situation. Or they got a credit card number somehow or a driver's license and they proceeded to get a credit card and it was Eddie Bauer for the cell block, you know. But it was rather rare. In fact, we expected to find more of it, and we owe it to the kinds of controls that they have in prison work programs. The programs that did not have the controls really were at risk.

Senator SESSIONS. Well, everything is risk. You hire somebody off the street and they can violate privacy or steal. I am generally of the view and would be supportive of more effort to make prisoners work, to have them work. The prisoners benefit from it, the prison benefits from it, the taxpayers benefit from it. Violence in the prison goes down when prisoners are working. There is just a more pleasant circumstance. So I think we can't be intimidated just because somebody might escape. Well, they are about to be released in 9 months anyway, free and clear, you know. I think we have got to pursue the effort of work and employment.

The numbers on health care costs look fairly good to me over the decade. I mean, they have more than doubled, tripled, probably, but we also have almost twice as many.

Mr. STANA. Well, that is it. The biggest cost driver is the population increase. We mentioned earlier that the net increase is about 1,000 inmates a month. Well, what that does is that commits the Bureau of Prisons to about $3 million more in health care costs each year just by the fact that they are coming in the door with the average health care costs. You do the math and it is $3 million more a year just by simple population growth. But they have taken steps and they are bringing it down on a per-capita basis.

Senator SESSIONS. Well, Federal prison does not segregate AIDS patients, is that correct?

Mr. STANA. I am not clear on that. I think if they present a danger, they would, but I don't know if they would do that on a routine basis.

Senator SESSIONS. The State of Alabama has segregated AIDS patients, won that at the supreme court level, and believes that even if it is just one, two, three, four, five cases that are eliminated in transmissions of disease, that is a benefit to the prisoner as well as to the taxpayer.

Mr. STANA. Yes. My understanding is they do not segregate them.

Senator SESSIONS. I don't think they do.

What about hepatitis C? That is easily transmitted.

Mr. STANA. My understanding is they do not, but I think one thing that they are trying to do, or at least it is a proposal they are thinking about is trying to bring patients with like needs together in the same situation so they can treat everyone and maybe come up with a cost saving that way.

For example, the medical center at Fort Worth has a specialty in wounds treatment. The medical center in Springfield has kidney dialysis. By doing that, you bring people with like illnesses together and maybe get some savings that way.

Senator SESSIONS. And they have always had mental hospitals.

Mr. STANA. They have always had those things, yes.

Senator SESSIONS. Thank you very much for your testimony. I believe that the prison system is a necessary evil, if you want to say it that way. I don't believe anyone can deny that our tendency in recent years to lock up for longer periods of time repeat, habitual, dangerous offenders has saved people from being murdered and has reduced crime in America. It is a big factor in it. We are doing a better job. We are not where we need to be, but we are doing a better job of identifying those who need longer periods in prison and seeing that they get it.

That does mean that we have got costs that occur from that, and we need to keep them as low as possible. The taxpayers do not need to be paying more than they have to take care of a person's health care, or they shouldn't be subjected to crime because they want to give a prisoner the right to use a phone whenever they reasonably can allow them to use that phone.

Before we dismiss, I will put Senator Leahy's statement into the record. He is the ranking member of this committee.

[The prepared statement of Senator Leahy follows:]

PREPARED STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

As we renew are discussion of the issues facing our prisons, I would like to address an aspect of the prison privatization that poses a serious threat to public safety and deserves immediate congressional action—the interstate transportation of prisoners.

Last year, the escape of convicted child murderer Kyle Bell from a private prison transport bus should have served as a wake-up call, to the Congress and to the country. Kyle Bell slipped off a TransCorp. America bus on October 13, while the bus was stopped in New Mexico for gas. Apparently, he picked the locks on his handcuffs and leg irons, pushed his way out of a rooftop vent, hid out of sight of the guards who traveled with the bus, and then slipped to the ground as it pulled away. He was wearing his own street clothes and shoes. The TransCorp guards did not notice that Bell was missing until nine hours later, and then delayed notifying New Mexico authorities. Bell was a fugitive for three months before his capture in January of this year.

Kyle Bell's escape is not an isolated case. In recent years, there have been several escapes by violent criminals when vans broke down or guards fell asleep on duty. Just last week, James Prestridge, a convicted murderer, escaped in Chula Vista, California, while he was being transported from Nevada to North Dakota by a private company called Extradition International. According to the Los Angeles Times, the van was stopped at a rest area when Prestridge overpowered two guards, took one officer's gun, and escaped with another violent offender who was being transported by the same van. They remain at large today.

In addition to these disturbing incidents, there have also been an alarming number of traffic accidents in which prisoners were seriously injured or killed because drivers were tired, inattentive or poorly trained. Privatization of prisons and prisoner transportation services may seem cost efficient, but public safety must come first.

This is why I joined Senator Dorgan in introducing S. 1898, The Interstate Transportation of Dangerous Criminals Act. This bill requires the Attorney General to set minimum standards for private prison transport companies, including standards on employee training and restrictions on the number of hours that employees can be on duty during a given time period. A violation is punishable by a $10,000 fine, plus restitution for the cost of re-capturing any violent prisoner who escapes as the result of such violation. This should create a healthy incentive for companies to abide by the regulations and operate responsibly.

I would also like to take this opportunity to urge House action on S. 704, the Federal Health Care Copayment Act, which was introduced by Senators Kyl, Abraham, Ashcroft, Cleland, Dorgan, Grassley, Hatch, Inouye, Johnson, Lincoln, Sessions and Thurmond. Senator Johnson brought this issue of medical copayments for prisoners' health care to my attention last year. My own state of Vermont does not have a copayment requirement for prisoners' health care so I appreciated the Senator from South Dakota sharing with me the problems he has seen in his State.

After some initial reservations, I was glad to help move this bill out of Committee after it was improved during markup. It passed the Senate by unanimous consent on May 27, 1999, more than 11 months ago, but has still not been acted upon in the House. This is legislation that has the support of the Bureau of Prisons and of the U.S. Marshals Service.

In my view, a critical part of this bill is its protection against prisoners being refused treatment based on an inability to pay. In particular, I am glad the Senate accepted my amendment to make clear that copayment requirements should not apply to prisoner health care visits initiated and approved by custodial staff, including staff referrals and staff-approved follow-up treatment for a chronic illness. The goal of the bill is to deter prisoners from seeking unnecessary health care, not to prevent them from seeking health care when they need it.

In addition, the version passed by the Senate excluded visits for emergency services, prenatal care, diagnosis or treatment of contagious diseases, mental health care and substance abuse treatment from the copayment requirement. Copayment requirements should not prevent prisoners from receiving emergency and critical health care.

I would like to thank the witnesses for being here today and welcome their comments. We will hear today whether the Federal Health Care Copayment Act is still needed, or whether the Bureau of Prisons has been able to make administrative adjustments despite the lack of authority that measure would have provided.

Senator SESSIONS. Is there anything else either one of you would like to add at this time?

Mr. STANA. No.

Mr. FINE. No. Thank you for inviting us to testify on this subject.

Senator SESSIONS. Thank you for your reports and your work. I think it will be helpful to the Bureau and to all of us as we attempt to operate a better and less expensive system.

So we will leave the record open now for a week for additional materials anyone may want to submit, and the hearing is adjourned at this time.

[Whereupon, at 4:21 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS AND ANSWERS

RESPONSES OF MS. KATHLEEN HAWK SAWYER TO QUESTIONS FROM SENATOR THURMOND

Question 1. Director Sawyer, what steps are you taking to proactively limit some inmates' telephone use based on their classification when they enter a facility rather than waiting until crimes are committed?

Answer. The BOP has developed a Public Safety Factor (PSF) for Serious Telephone Abuse and is incorporating it into the classification policy. PSFs, which can be applied during an inmate's initial classification or during their incarceration, are entered for inmates who require increased security measures to ensure the protection of society. Inmates with a PSF for Serious Telephone Abuse will have restrictions placed on their telephone use, and any telephone calls they are permitted to make will be live monitored. The Warden must permit inmates who have had their telephone privileges limited to place at least one telephone call per month. The PSF will be entered if any one of the following criteria applies:

- The PSI reveals the inmate was involved in criminal activity facilitated by the telephone;
- Federal law enforcement officials or a U.S. Attorney's Office notifies the BOP of a significant concern and need to monitor an inmate's telephone calls;
- The inmate is convicted of a criminal act directly related to telephone usage;
- The inmate has been found guilty of a 100 or 200 level incident report code for telephone abuse; such as using the inmate telephones to further criminal activity, or attempting to circumvent telephone monitoring procedures by placing a third party call or talking in code or;
- The Special Investigative Supervisor's (SIS) Office has reasonable suspicion and/or documented intelligence supporting telephone abuse.

Question 2. Director Sawyer, many of the changes that the Inspector General has recommended to curb phone abuse were derived from a 1997 Warden's Working Group on telephone abuse. Are you reviewing the Working Group's findings further subsequent to the Inspector General Report?

Answer. Yes. In November 1997, the BOP's Executive Staff reviewed the Wardens' Inmate Telephone Work Group Report and approved 9 of the 14 recommendations. In December 1999, we adopted four more recommendations of the Work Group (see below).

- After the Inmate Telephone System II (ITS–II) is installed in all of our facilities, we will have the technology in place to individually limit each inmate's calls to a prescribed number of calls or a total of minutes per day, week, or month, Although we continue to consider this and other means of limiting access as warranted, any significant changes to inmates' access to the telephones risks action by the Court who presided over the *Washington* v. *Reno* case. In January, 2000, the BOP requested of the Federal Programs Branch, Civil Division, Department of Justice, (the branch that represented the BOP in the *Washington* v. *Reno* case), an assessment of the litigation risks associated with further restrictions to limit inmate telephone access. The Civil Division opined that there would be a risk of reopening litigation if inmate telephone privileges were further restricted.
- Inmate telephone access has been restricted during normal inmate working hours (Monday through Friday, 7:30 a.m. until 10:30 a.m. and 12:30 p.m. until after the 4:00 p.m. inmate count). Institutions with ITS have the capability of allow-

ing limited telephone access during restricted hours to accommodate inmates who do not work standard institution shifts (e.g., evening or weekend Food Service workers).

- We have established the following guidelines to assist Disciplinary Hearing Officers (DHO) in imposing meaningful sanctions for inmates found guilty of abusing telephone privileges: 1st offense: 6 to 18 months loss of telephone privileges; 2nd offense: 18 to 36 months loss of telephone privileges; and 3rd offense: 5 years to duration of sentence loss of telephone privileges. When the sanction falls below the suggested range due to mitigating factors, the DHOs document in writing the reason for the departure.
- As discussed in question one above, we have developed a Public Safety Factor for limiting an inmate's social telephone calls as a matter of classification.

Question 3. Director Sawyer, if the 1995 settlement of the *Washington* v. *Reno* lawsuit causes problems for your efforts to control inmate phone use, should the Department of Justice consider reopening the settlement agreement pursuant to the Prison Litigation Reform Act?

Answer. The terms of the settlement agreement are set to expire in 2002. Under the Prison Litigation Reform Act, it is possible to seek modification of a consent decree by returning to the original judge. Given Judge Wilhoit's very strong feelings regarding this case, the BOP has concerns that further review of the case could precipitate additional, more onerous burdens rather than amelioration of the current, restrictive terms. The DOJ has similarly opined that there would be a risk of reopening litigation if inmate telephone privileges were further restricted (see Question 2). Accordingly, we have no plans to seek modifications.

Question 4. Director Sawyer, the Inspector General has recommended that the Bureau institute certain minimum administrative punishment, including loss of phone privileges, for certain types of phone abuse. Are you considering this suggestion?

Answer. Rather than developing mandatory sanctions for inmate misconduct, the BOP prefers to develop suggested ranges of sanctions that provide the Disciplinary Hearing Officers (DHO) with discretion in sanctioning inmate case. We have recently implemented a suggested sanction range for abuse of telephones (see Question (2). This strategy of providing DHOs some discretion in sanctions was successfully implemented several years ago by providing suggested ranges to DHOs for sanctioning inmates found to have introduced drugs into the institution through social visiting. The result was that DHOs imposed greater sanctions, and the introduction of drugs through the visiting room was reduced.

Question 5. Director Sawyer, is the Bureau increasing the involvement of Intelligence Section (SIS) officers in reviewing telephone crime?

Answer. Yes. We have taken action to improve our telephone system and monitoring efforts as follows:

- FBI staff are included in all SIS training sessions in an effort to improve the quality and effectiveness of our investigative operations as they relate to telephone monitoring.
- We created 24 additional intelligence positions at facilities located in metropolitan areas to work with inter-city crime task forces in identifying criminal acts and trends. Staff in these positions work as liaisons with law enforcement agencies to gain information about outside illegal activities, including targeting activities taking place through telephone communications. Two of the positions are assigned to FBI Headquarters and help ensure the BOP is aware of inmates coming into our custody who may pose unique security concerns.
- We prepared and distributed an Inmate Monitoring field Guide for Wardens and SIS staff. This guide gives very detailed instructions for staff regarding proper procedures to detect and deter telephone abuse. Moreover, we are developing a computerized tutorial training program for telephone monitoring which will be available to all BOP staff.

Additionally, the BOP is taking the following steps to support the agency-wide goal of enhanced telephone monitoring:

- We added a category for inmate telephone abusers in our computerized inmate database, thereby assisting staff in the identification and monitoring of those inmates who have or are likely to abuse their telephone privileges.
- Many of our facilities have recently instituted additional telephone monitoring stations that allow a higher percentage of telephone calls to be monitored.
- We have almost completed installation throughout the BOP of ITS–II, an enhanced telephone system that allows the BOP to significantly restrict every inmate's calling privileges. The system can be programmed to alert staff every

time a high risk inmate makes a telephone call. ITS–II can provide staff with numerous reports to monitor and determine which inmates may be attempting to abuse telephone privileges. It also "links" all BOP facilities and our headquarters together for information sharing of inmate telephone use information. The system allows the BOP to tag and target specific inmates who display a propensity to commit fraudulent or criminal activity over the telephone. In addition, the ITS–II system allows the BOP to restrict an inmate's calling capabilities to specific time periods, specific telephones, specified number of calls per day, specified number of minutes per day, period of time prior to placing another call, or no calls.

- We have added two new offense codes to the inmate discipline policy; a 100-level offense code for utilizing the telephone to continue criminal enterprises and a 200-level offense code for noncriminal use of the telephone. Additionally, we have made the use of coded language by inmates over the telephone a disciplinary violation in all circumstances.

Question 6. Director Sawyer, are you working to make telephone monitors in each facility a permanent position?

Answer. We expect to have permanent telephone monitor posts in place in all facilities by December, 2000. The posts will be rotated among qualified staff. This allows each monitor to become familiar with the process, yet avoids the "staleness" that can occur with a permanent assignment.

Question 7. Director Sawyer, the Bureau must always be alert to criminal activity within prison, and telephone abuse by inmates is one aspect of this issue. What is the status of implementing National Strategic Planning Objective 5.11?

Answer. National Strategic Planning Objective 5.11 was most recently revised with a greater emphasis on telephone initiatives. Action plans include some of the Office of Inspector General recommendations and approved BOP Executive Staff decisions. The current action plans, approved by the Executive Staff in March 2000, will be completed by early 2001. At that time, new actions plans will be developed and submitted to the Executive Staff for their approval.

Question 8. Director Sawyer, guard escort services for inmates who need transportation to medical facilities is one cost that has decreased considerably in recent years, down by an average of almost $100 per inmate. Have your efforts to expand telemedicine been an important reason for this decline?

Answer. As of June 9, 2000, twenty institutions will have telehealth equipment installed, and the equipment will be fully operational at ten institutions. The program appears very promising as a health care cost reduction initiative that, importantly, allows us to maintain the community standard of care for inmates. However, because of the relative newness of the program, further study is required before we can comfortably ascertain definitive cost benefits. A large part of the cost savings the BOP has realized results from the increased use of "in-house" medical visits by community specialists. By coming to the institution, physicians are able to examine multiple inmates in one visit, and the BOP does not incur transportation or escort guard costs. The BOP continues to seek innovative, cost-effective strategies for providing the community standard of medical care to our inmate population.

Question 9. Director Sawyer, in your statement you said that one of the major concerns facing the BOP is the number of inmates who have AIDS and hepatitis C and require additional care, along with an inmate population which is aging. Do you feel that the BOP should have an intermediate care medical facility that can offer assistance for those inmates who do not require full hospital services but need more medical assistance than the general inmate population?

Answer. The BOP is planning to develop enhanced care facilities that would house many of the chronic care inmates that are currently housed at Medical Referral Centers. These inmates do not require the intensive level of health care services available at the Medical Referral Centers, but do require more health care than most inmates in our general population facilities (e.g., uncontrolled diabetes, HIV infection requiring multiple medications, hepatitis C). By developing a multi-tiered health care delivery system, to include Medical Referral Centers, enhanced care facilities, and general population institutions, the BOP can match the appropriate level of health care resources to the appropriate inmate population.

Question 10. Director Sawyer, are inmates with infectious diseases such as HIV segregated from other inmates? Please explain.

Answer. All BOP staff and inmates are educated regarding appropriate precautions to prevent transmission of infectious diseases. These precautions include "universal precautions" (i.e. assuming all blood and body fluids are infected) and educating staff and inmates about how infectious diseases are spread and how they are best prevented. As such, inmates with infectious diseases such as HIV or hepa-

titis are housed in general population with other inmates, as these diseases are not spread by casual contact. We segregate sick inmates as necessary to provide appropriate medical treatment and prevent transmission of diseases that spread through casual contact (i.e., tuberculosis).

Question 11. Director Sawyer, is it a problem that inmates will use the fact that they have or may have an infectious disease as a weapon against staff or inmates, and if so, what type of punishment does this type of conduct receive?

Answer. The BOP views any assault as a serious incident, regardless of the means used to carry it out. Over the past five years the assault rate in the BOP has decreased by almost 30 percent, due in part to the efforts of our staff to effectively communicate with the inmate population. Ordinarily, inmates who engage in assaultive behavior toward staff are charged with a Greatest Severity Prohibited Act offense code, regardless of whether or not the inmate committed the assault with the intent to infect staff with an infectious disease. If the charge is sustained following the inmate's administrative hearing, any of the following sanctions may be imposed: loss of good conduct time, disciplinary transfer, disciplinary segregation up to 60 days, and loss of privileges (i.e., visiting, telephone, commissary).

Question 12. Director Sawyer, the Federal inmate population has more than doubled since 1990, and about 1,000 offenders are being added to your custody each month. Is managing the rising number of inmates the primary challenge that your agency faces today.

Answer. Managing the increasing number of inmates in a safe and secure manner and adding sufficient prison capacity are the two largest challenges we face. During FY 1999, the BOP experienced its second consecutive year of record breaking population increases when the total inmate population increased by more than 11,300. The BOP projects that inmate population growth this year will set another record, with projected growth of approximately 12,500 inmates. By Fiscal Year (FY) 2008, we anticipate a federal inmate population of approximately 209,000, nearly 50 percent above the current population level. To meet this growth, we currently have 32 prison facilities in some stage of planning, design or construction, though some are contingent on the advanced appropriations requested in our FY 2001 budget. These requests are currently under consideration by Congress.

RESPONSES OF MS. KATHLEEN HAWK SAWYER TO QUESTIONS FROM SENATOR LEAHY

Question 1. You testified about a number of successful administrative initiatives that the Bureau of Prisons has put into place over the last several years to contain inmate health care costs and increase efficiency of services. Indeed, BOP's per capita inmate health care costs have decreased steadily since 1997. In light of this trend, is the Federal Health Care Copayment Act still necessary, in your opinion? If yes, please provide a detailed explanation of your response.

Answer. The BOP views inmate health care copayments as a valuable tool in our overall strategy to encourage inmates to use available services in an appropriate manner and to teach them personal responsibility. While this will undoubtably reduce medical costs somewhat as some inmates decide not to seek unnecessary medical treatment, this is not the primary purpose of the bill. Inmates will not be charged copayments for prenatal visits, chronic care clinics, food handler's examinations, psychiatric assessments, or intake physicals. They will only be charged for appointments they initiate. None of the revenue generated by this bill will be made available to the BOP.

Question 2. The Inspector General's report on the management of inmate telephone privileges recommends legislation explicitly to authorize the Bureau of Prisons to use proceeds from the inmate telephone system to pay for monitoring inmate calls. Mr. Glenn Fine, Director of the Special Investigation and Review Unit of the Office of the Inspector General, indicated in his testimony that all such proceeds are required to go to the Inmate Trust Fund. When was the Inmate Trust Fund established and for what specific purpose? What are the current requirements for using funds from the Inmate Trust Fund? What specific operations, programs or other expenditures are currently funded by the Inmate Trust Fund?

Answer. The inmate Deposit Fund was established in 1930 by the Department of Justice (Circular No. 2126, "Rules Governing the Control of Prisoners Funds, at the Several Penal Institutions") to maintain inmates' monies while they were incarcerated and to authorize the establishment of an inmate commissary at each federal correctional institution. The existence and operations of prison Commissaries was recognized and approved by Congress in 1932 with the passage of the Department of Justice's 1933 appropriation bill. In 1934, Congress designated the "funds of Fed-

eral prisoners" and "Commissary funds" as "Trust Funds". All monies accruing to these funds were to be appropriated and dispersed in compliance with the Trust.

By the terms of the Trust Fund, profits may be used to provide programs that benefit all inmates, and may not be used for the personal benefit of individual inmates. Profits may not be used to purchase items ordinarily procured from funds appropriated by Congress for care of prisoners. Additionally, a September 26, 1994, Sixth Circuit Court of Appeals ruling in *Washington* v. *Reno* upheld a prohibition against the BOP using inmate commissary trust funds to pay for inmate telephone system components with a primary purpose of institution security.

Some examples of items purchased with trust Fund profits are:

- Recreation/arts and crafts operating costs, activities, and supplies including contracts, supplies, and equipment related to fulfilling the mission of the BOP's Recreation program (Staff salaries, benefits, travel and training are not funded through the Trust Fund, but are funded only through Salaries and Expenses (S&E) appropriations)
- Advanced Occupational Education (AOE) programs that may lead to an associate degree. All inmates, with appropriate academic prerequisites, are eligible to participate in AOE programs.
- Other Inmate Programs, including Artists in Residence; Inmate Placement; and Beckley Responsibilities and Values Enhancement Programming (Staff salaries, benefits, travel and training are not funded only through S&E appropriations)
- Educational items such as self-help videos, library books
- Commissary merchandise for inmate purchase
- Inmate Performance Pay (pay for satisfactory completion of inmate work assignment tasks)
- Commissary and ITS computer systems, property, and operating supplies (freezers, safes, shelving, etc.)
- Salaries and benefits for Trust Fund employees

RESPONSES OF RICHARD M. STANA TO QUESTIONS FROM SENATOR THURMOND

Question 1. Do you think that prisoner abuse of health care, such as inmates using medical visits to get out of work or other duties, is a significant problem, and would you expect a copay requirement to help reduce any such abuse?

Answer. In our testimony, we reported that the Congressional Budget Office (CBO) had looked at this question and reported that, where similar prisoner copayment programs were adopted in 36 states or local jurisdictions, prison medical facilities experienced average reductions in sick call visits of 16 percent to 50 percent. Although we are not aware of any formal study by BOP or others, we received anecdotal information from BOP health care officials that frivolous visits to medical units do occur in BOP and that some reduction in this kind of abuse could be anticipated if some additional charge were levied. However, we were not provided with an estimate of the magnitude of the anticipated reduction.

Question 2. Does it appear that states have benefited from a copay requirement?

Answer. As noted in response to the previous question, CBO has reported that after adopting copayment requirements, 36 states or local jurisdictions experienced reductions in the number of sick call visits. These reductions ranged from a low of 16 percent to a high of 50 percent.

Question 3. It appears that personnel salaries are the primary category for health care costs. Have recent BOP initiatives, such as restructuring staff to depend less on highly paid physicians for routine duties, helped reduce staff costs in recent years?

Answer. One BOP official told us that, as a result of our 1994 report, BOP began examining the utilization of its health care staff to allow for more efficient operations. One result the BOP official cited was a restructuring initiative that focused on using qualified, lower-salaried medical personnel instead of more highly paid physicians and physicians' assistants for certain routine duties. BOP attributed annual savings of about $5.5 million to this initiative. We also testified that BOP medical personnel salaries—on a macro level—have decreased steadily from a peak of $1,399 per inmate in fiscal year 1996 to $1,225 in fiscal year 1999. We testified that Public Health Service (PHS) associated costs, largely composed of PHS salaries, have dropped from $378 per inmate in fiscal year 1997 to $367 in fiscal year 1999. A BOP Health Services Division official was quite confident that the downward slope in per inmate medical personnel salaries and PHS associated costs was due to the staff restructuring initiative and other related cost-cutting initiatives. How-

ever, BOP officials were concerned that the savings from these economy and efficiency measures will eventually bottom out.

BOP officials said they expect overall medical costs to continue to rise in future years for several reasons:

- Projections of the number of inmates incarcerated in federal facilities show continued increases.
- Felony inmates transferred to BOP from the District of Columbia Department of Corrections generally have disproportionately more medical needs than other BOP inmates.
- BOP is receiving increasing numbers of long-term, nonreturnable detainees from the Immigration and Naturalization Service (INS).
- BOP's expenditures for pharmaceuticals likely will rise due to the increasing prevalence of illnesses such as HIV and hepatitis.

Question 4. You noted during your oral testimony that many inmates are staying in medical referral centers for long periods due to serious medical conditions. Do you think it may be more cost effective for BOP to have an intermediate care medical facility for inmates needing long-term care?

Answer. Most evidence indicates that an intermediate care facility could have advantages for BOP, although a thorough cost-benefit study might still need to be conducted to consider the various forms that such a facility could take. Medical costs at BOP's medical referral centers are higher on a per inmate basis than medical costs at standard prisons. Based on BOP data, the estimated medical costs on a per inmate basis at a medical referral center are about $16,000 per year, whereas medical costs at a standard prison are less than $2,500 per year.

In terms of inmate access to medical care, BOP officials told us that it is important that there be a regular turnover of patients in medical referral center hospital beds—based on the medical needs of the patients. They told us that increasing numbers of chronically ill inmates with long sentences are being sent to medical referral centers because the inmates' medical conditions cannot be treated approximately at a standard prison. For these inmates, the medical referral center is the end of the line. This means that fewer and fewer hospital beds are turning over. It also means that new patients from standard prisons may have to wait for the next available medical referral center hospital bed to be freed up. For example, at one medical referral center we toured, we learned that the waiting list of new patients for the next available bed is gradually getting longer.

Anecdotally, we were told that BOP already has enough chronically ill inmates to fill an intermediate care medical facility of 400 beds. The type of facility would have the added benefit of freeing up more expensive medical referral center beds presently occupied by inmates who have little chance of returning to their home prison. Nonetheless, a cost-benefit study could determine, for instance, whether the per inmate cost of constructing an intermediate care medical facility would be more or less than competing alternatives, such as contracting for a privatized nursing home environment, or renovating an existing building at a medical referral center just for the chronically ill.

RESPONSES OF RICHARD M. STANA TO QUESTIONS FROM SENATOR LEAHY

Question 1.—In your written statement, you indicated that CBO has estimated that the Federal Prisoner Health Care Copayment Act of 1999 would generate annual revenues of $1 million and "would be helpful to BOP's efforts to control medical costs." Under section 4048(g) of this legislation, fees collected from inmates subject to an order of restitution shall be paid to victims in accordance with the order. Seventy-five percent of all other fees collected would be deposited into the Federal Crime Victim's Fund and all the remainder would be used to cover the administrative expenses incurred in carrying out this Act. With legislative mandates on the use of copayment fees, how would the Federal Prisoner Health Care Copayment Act of 1999 significantly contribute to reducing health care costs?

Answer. We testified that a May 1999 CBO analysis of the proposed $2 health care system fee estimated that BOP might generate additional revenue of about $1 million in fiscal year 2000. However, BOP enforces the proposed fee primarily as a means to reduce unnecessary or frivolous medical visits—that is, BOP does not view the proposed fee primarily as a revenue generator.

BOP has suggested that the proposed legislation be modified to mandate that 100 percent of collected fees go to the Crime Victims Fund. According to one official, BOP might send a check each quarter to the fund—a procedure that would help to minimize administrative expenses. BOP suggested this alternative because an ad-

ministrative process is already in place that could be modified at little or no cost to include tracking collected fees. However, the cost of distributing restitution checks to victims is another matter since no administrative process or supporting staff structure currently exists. One BOP official told us that the number of checks could be enormous, the amount of each check would be small, and the administrative cost of establishing and maintaining a process (to make sure victims received the appropriate checks) would be an additional expense. This official also opined that victims might react negatively to receiving checks of such small amounts repeatedly over the years.

CBO has looked at this question of unnecessary or frivolous medical visits. CBO reported that where similar prisoner copayment programs were adopted in 36 states or local jurisdictions, prison medical facilities experienced average reductions in sick call visits of 16 percent to 50 percent. We received anecdotal information from BOP health care officials that frivolous visits to medical units do occur in BOP and that some reduction in this kind of abuse can be anticipated if additional charges are levied. However, we have not independently verified the magnitude of such a reduction.

Neither BOP nor we believe that the primary benefit of the copayment proposal to generate revenue. Rather, its primary benefit would be to reduce unnecessary or frivolous medical visits and the burden population through 2006, it appears the demands on BOP's health care system will increase.

Question 2. Have the administrative initiatives that BOP put into place over the last several years to contain inmate health care costs and increase efficiency of services been taken into account by your estimate? Have the facts or assumptions on which you based your estimate of $1 million changed?

Answer. The estimates of increased efficiency of services by virtue of administrative initiatives BOP has undertaken over the last several years are BOP estimates. The $1 million estimate of anticipated revenue generated by a prison copayment provisions is CBO's estimate. We referred to the CBO estimate in our testimony because we did not want to duplicate that work. Also, given the short time in which we conducted our review, we did not attempt to independently verify the estimates and do not know whether the facts and assumptions used by CBO have changed.

BOP officials believe that savings or benefits from the economy and efficiency initiatives BOP has implemented will eventually bottom out and they expect that inmate health care costs will rise given

- the pressures from a growing prison population;
- transfers of inmates to BOP from the District of Columbia Department of Corrections—inmates who generally have disproportionately more medical needs than other BOP inmates;
- the increase in numbers of long-term, nonreturnable detainees from INS; and
- the growth in expenditures for pharmaceuticals because of the increasing prevalence of illnesses such as HIV and hepatitis.

We believe it is time to consider additional measures for containing BOP medical costs. The copayment provision is one alternative to consider—not because it is a revenue generator, but rather because such a provision can be expected to reduce the demand on medical services by reducing the number of unnecessary or frivolous medical visits by inmates.

RESPONSES OF GLENN A. FINE TO QUESTIONS FROM SENATOR THURMOND

Question 1. Mr. Fine, do you think that prisoner use of coded language on the telephone to disguise criminals activity is a problem, and is it important for the BOP telephone monitors to be trained in detecting coded language?

Answer. Yes. Use of coded language by federal inmates is a serious problem and BOP telephone monitors need better training to identify such language that may disguise serious criminal activity. We believe it is very important for BOP telephone monitors to receive additional training regarding detecting criminal conversations on the telephone, including the use of coded language. In addition, as we suggest in recommendation number 12 in our report:

> The BOP should examine the possibility of making use of coded language by inmates over the telephone a disciplinary violation in certain circumstances. Such a rule would allow the BOP to restrict or suspend an inmate's telephone privileges when an SIS officer finds an inmate engaging in suspicious coded conversations. As a model, the BOP should look to its existing correspondence regulations that contain a provision allowing wardens to reject correspondence that contains a code.

Question 2. Mr. Fine, I understand that inmates are limited to twenty telephone numbers that they can have on their list to call at any one time. Does the Bureau need to do more to review the listed numbers that high-risk inmates may call to verify whether these numbers have connections to criminal activity?

Answer. Yes. Our investigation revealed that the BOP does an inadequate job reviewing the telephone numbers submitted by inmates for inclusion on their personal calling lists—especially inmates that should be considered high-risk for telephone abuse. As we point out in our report, inmates at most BOP institutions with the ITS system have unlimited calling privileges to contact up to a maximum of 30 individuals on an approved telephone list. Inmates prepare their proposed telephone lists during their admission and orientation process at a new BOP facility.

Inmates may submit on their list telephone numbers for any person they choose, with the understanding that all calls are subject to monitoring. Inmates are required to pledge that any calls made from the institution will be made for a purpose allowable under BOP policy or institution guidelines.

Normally, telephone numbers requested by the inmates are approved without review. When inmates request persons other than immediate family members or persons already on their visiting list, BOP staff are required to notify those persons in writing to afford them an opportunity to object to being placed on an inmate's telephone list. Other than this notification, however, the BOP conducts no screening of these individuals placed on an inmate's telephone list.

ADDITIONAL SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF HON. BYRON L. DORGAN, A U.S. SENATOR FROM THE STATE OF NORTH DAKOTA

Mr. Chairman and members of the Subcommittee, thank you for holding this oversight hearing today, and for the opportunity to submit this statement.

One of the duties that the Federal Bureau of Prisons (FBOP) is charged with is transporting federal inmates. It is a duty that the FBOP has carried out with the utmost care and responsibility.

At the state and local level, law enforcement agencies are responsible for the movement of their own prisoners. Although they can contract with he United States Marshals Service to move prisoners, states are increasingly turning to private companies to perform this service.

These companies transfer prisoners from state to state, often taking long, circuitous routes all over the country. Prisoners are dropped off and picked up at numerous stops along the way. These trips can last for weeks, requiring the guards to take constant breaks to eat, sleep, refuel, etc.

Mr. Chairman, the simple fact is that many of the companies have proven themselves inept when it comes to keeping prisoners in custody. Since 1996, at least 26 prisoners have escaped while being transported by a private company. Many of these escapees were violent offenders—murderers, rapists, sexual molester, armed robbers, and so forth. In this same time frame, FBOP has not lost a single prisoner. In fact, its been almost 10 years since someone escaped while being transported by FBOP.

It leads me to wonder what has caused these companies to fail where FBOP has been so successful. In my judgement, the answer is simple: FBOP has to live up to certain established standards, ranging from the hiring and training of personnel to the types of restraints used when transporting prisoners. Amazingly, there are currently no such standards that apply to private companies that haul violent prisoners around the country.

There are standards that govern how we transport toxic waste, because we want to make sure it's handled properly to prevent a risk to the public. But there are no standards governing how violent criminals should be handled when they are transported—and believe me, the public is very much at risk.

As I said earlier, there have been many escapes from private prisoner transport companies. Just last month, a convicted murderer serving a life sentence without parole escaped during a rest stop in Chula Vista, California. A convicted armed robber escaped with him, and they are still on the loose today. I want to share with you the details of this escape and some others that have taken place in the past few years. I think they will shock you, as they did me.

• March 25, 2000—Convicted murderer James Prestridge and convicted robber John Doran escaped while being transported form Nevada to out-of-state facilities. During a restroom break, the two convicts overpowered a guard, taking his gun, his keys, and his clothes. They then returned to the van transporting them and overpowered the other guard, *who was taking a nap.* After locking the two guards in the back of the van with the other prisoners, the inmates sped off, abandoning the van just north of the Mexican border. Prestridge was serving a life sentence without parole for first degree murder. Both inmates are still at large.

• January 22, 2000—three prisoners escaped while the van transporting them stopped at a convenience store for a restroom break. While the two guards weren't looking, two inmates jumped into the front seat, *where the keys had been left in the ignition.* The inmates sped off down the highway, leaving the two guards helpless on the side of the road. Luckily, shortly after the escape the van spun out of control and slammed into a dirt embankment, preventing the prisoners from completing their escape.

• October 13, 1999—Convicted child molester and murderer Kyle Bell was being transported to a prison in Oregon. The transport van traveled from North Dakota to Nashville, Tennessee and across the south central plains, until reaching Santa Rosa, New Mexico, where it stopped to refuel. While tow of the four guards refueled the bus and shopped at the truck stop, the two guards left behind to supervise the prisoners *slept in the front seat.* Using a key hidden in his shoe, Kyle Bell undid his handcuffs and shackles, and escaped through the roof ventilation hatch. After resuming its journey, *the van traveled for nine hours before the guards discovered Bell was missing.* And then it was another two hours before they notified law enforcement officials that here was a convicted killer loose in the area.

• July 24, 1999—Two men convicted of murder escaped from a van while being transported from Tennessee to Virginia. The two guards went into a fast food restaurant to get breakfast for the convicts, but then they returned did not notice that the convicts had freed themselves from their leg irons, possible with a smuggled key. While one guard went back into the restaurant, the other stood watch outside the van. *But he forgot to lock the van door.* The inmates kicked it open and fled. One was caught after 45 minutes. The other stole a car, but was apprehended eight hours later.

• July 30, 1997—Convicted rapist and kidnapper Dennis Glick escaped from a van while being transported from Salt Lake City to Pine Bluffs, Arkansas. While still in the van, Glick grabbed a gun from a guard *who has fallen asleep.* He took seven prisoners, a guard and a local rancher hostage and led 60 law enforcement officials on an all-night chase across Colorado. He was recaptured the next morning.

• November 30, 1997—Whatley Rolene, being transported from New Mexico to Massachusetts, was able to remove his cuffs and grab a shotgun while one guard was inside a gas station and other *slept in the front seat.* He later surrendered after a showdown with the Colorado State Patrol and a local Sheriff's Department.

• December 4, 1997—11 inmates escaped after overpowering a guard in the van transporting them. Among the escapees were convicted child molester Charles E. Dugger and convicted felon (and former jail escapee) Homer Land. Apparently, the escapees shed their shackles either by picking the locks or using a key. The one guard in the van had opened the van doors to ventilate it while the other guard was inside a fast food restaurant. *The guard in the van had been on the job less than a month.*

Dugger and the others were apprehended shortly after, but Homer Land forced his way into the home of a couple in Owatonna, MN, and held them hostage for 15 hours. He later forced them to drive him to Minneapolis, where they escaped while Land went into a store to buy cigarettes. Land was later apprehended in Chicago on a bus headed to Alabama.

• August 28, 1996—A husband-and-wife team of guards showed up at an Iowa State prison to transport six inmates, five of them convicted murderers, from Iowa to New Mexico. When the Iowa prison warden saw that there were only two guards to transport six dangerous inmates, he reportedly responded "You've got to be kidding me." Despite his concerns, the warden released the prisoners to the custody of the guards when told the transport company had a contract.

Despite explicit instructions not to stop anywhere but county jails or state prisons until reaching their destination, the husband and wife decided to stop at a rest stop in Texas. During the stop, the inmates slipped out of their handcuffs and leg irons and overpowered the couple. The six inmates stole the van and led police on a high-speed chase before being captured. The escape was reported to local authorities not by the husband and wife, but by a tourist that witnessed the incident.

These escapes all have one thing in common—they are fraught with errors and missteps by employees who are either inadequately trained or lack good supervision. Clearly, something needs to be done before more harm is wreaked upon an unsuspecting public; before more murderers, rapists, and child molesters escape while being transported by people who have to meet no standards and follow no common procedures.

That is why I have introduced, along with Senators Ashcroft and Leahy, the Interstate Transportation of Dangerous Criminals Act. I call the bill Jeanna's Bill, after the 11-year old girl who was brutally murdered in North Dakota by Kyle Bell.

This legislation requires the Attorney General to develop a set of minimum standards that private prisoner transport companies must follow if they want to continue hauling murderers and rapists across the country. The standards must include some basic common-sense provisions, such as employee background checks, minimum training standards, minimum standards for restraints, and a requirement that if a violent prisoner escapes while in transport, the company must immediately notify law enforcement.

These standards are not onerous—in fact, they can be no stricter than those the federal government uses when transporting federal prisoners. Rather, they provide a minimum level of safety and common sense to an industry that so far has lacked both.

Finally, the bill would also establish civil penalties for companies that violate these standards. And if a company's failure to follow the requirements results in an escape, then the company can be held liable for the costs incurred by state and local law enforcement agencies involved in the search. State and local governments do not spend millions of dollars to apprehend, try, and incarcerate violent criminals just so a private company can lose them again. If private prisoner transport companies are made liable for these costs, perhaps fewer violent convicts will escape.

No American should ever have to pull the family station wagon up to a gas pump only to find that the van next to them is full of convicted murderers whose only supervision is someone with one-week's training who may well be asleep. Nothing in this bill requires a degree in criminology. It is just common sense, and we need to make absolutely sure that private transport companies start to show some.

Senator Leahy and I have asked Chairman Hatch for a full committee hearing on our bill, and I am hopeful that one will be scheduled soon. In the meantime, I encourage you to support this bill. The Federal Bureau of Prisons is accountable for its actions, as evidence by this hearing today. But there is no oversight when it comes to these private companies. I hope you'll help me change that by supporting this important legislation.

PREPARED STATEMENT OF HON. TIM JOHNSON, A U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA

I want to thank Subcommittee Chairman Thurmond and Ranking Member Schumer for allowing me to share some thoughts on Federal prisoner health care costs and the Bureau of Prisons. As you know, Senator Kyl and I introduced last year a bill to require federal prisoners to pay a nominal fee when they initiate certain visits for medical attention. Fees collected from prisoners will either be paid as restitution to victims or be deposited into the Federal Crime Victims' Fund. My state of South Dakota is one of 34 states that have implemented state-wide prisoner health care copayment programs. The Department of Justice supports extending this prisoner health care copayment program to federal prisoners in an attempt to reduce unnecessary medical procedures and ensure that adequate health care services are available for prisoners who need them.

My interest in the prisoner health care copayment issue came from discussions I had in South Dakota with a number of law enforcement officials and US Marshal Lyle Swenson about the equitable treatment between pre-sentencing federal prisoners housed in county jails and the county prisoners residing in those same facilities. Currently, country prisoners in South Dakota are subject to state and local laws allowing the collection of a health care copayment, while Marshals Service prisoners are not, thereby allowing federal prisoners to abuse health care resources at great cost to state and local law enforcement.

As our legislation moved through the Judiciary Committee and Senate last year, we had the opportunity to work on specific concerns raised by South Dakota law enforcement officials and the US Marshalls service. I sincerely appreciate Senator Kyl's willingness to incorporate my language into the Federal Prisoner Health Care Copayment Act that allows state and local facilities to collect health care copayment fees when housing pre-sentencing federal prisoners.

I also worked with Senator Kyl and members of the Judiciary Committee to include sufficient flexibility in the Kyl-Johnson bill for the Bureau of Prisons and local facilities contracting with the Marshals Service to maintain preventive-health priorities. The Kyl-Johnson bill prohibits the refusal of treatment for financial reasons for appropriate preventive care. I am pleased this provision was included to preempt long term, and subsequently more costly, health problems among prisoners.

The goal of the Kyl-Johnson Federal Prisoner Health Care Copayment Act is not about generating revenue for the federal, state, and local prison systems. Instead, current prisoner health care copayment programs in 34 states illustrate the success in reducing the number of frivolous health visits and strain on valuable health care resources. The Kyl-Johnson bill will ensure that adequate health care is available to those prisoners who need it, with out/straining budgets of taxpayers.

I am pleased the Senate passed the Kyl-Johnson Federal Prisoner Health Care Copayment Act last year, and I am hopeful that the House will act on this legislation before the end of this session. A companion bill, sponsored by Representative Salmon, has bipartisan support and is now waiting action by the House Judiciary Committee. I look forward to working with members of the House on this important

piece of legislation, and I once again thank Chairman Thurmond, Ranking Member Schumer, and Members of the Subcommittee for giving me the opportunity to discuss this issue with you today.

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