Correctional Healthcare Requires Clearer Legal Standards

By **Susanne Moore** (August 19, 2026)


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The correctional healthcare industry is in danger due to unchecked legal actions based on unclear legal standards. This matters because the incarcerated population consists of fathers, husbands, mothers, wives, sisters, brothers, children who previously were free citizens of our communities, and most will someday return to live and work again in our communities.

Just as importantly, the tens of thousands of skilled healthcare professionals who serve this demographic deserve a stable and predictable legal environment in which to do so. It benefits all of us to provide effective medical and mental healthcare during incarceration, leading to community reentry with a greater chance of long-term success. There is a gap in the law that is jeopardizing this, and there is a fix.

A nurse in a community hospital who delays seeing a patient by 30 minutes faces a state malpractice claim evaluated against the standard of care for that setting. A nurse in a county jail who delays seeing a patient by 30 minutes because no officer was available for escort or because there was a lockdown faces a federal claim for deliberate indifference under Title 42 of the U.S. Code, Section 1983, evaluated against no defined standard, with no cap on punitive damages, and with plaintiff fees shifted to the defendant under Section 1988.

The resulting litigation exposure due to this undefined standard is increasingly making correctional healthcare financially unsustainable.

For example, YesCare Corp., one of the largest correctional healthcare providers in the country, **filed** for Chapter 11 bankruptcy on May 8 in the U.S. Bankruptcy Court for the Middle District of Florida after a $307.6 million Michigan jury verdict based on patient care deliberate indifference and the loss of roughly 80% of YesCare's revenue as states terminated contracts.

More than $17 million in payroll went unpaid. While the court **approved** a deal for a Chapter 11 trustee to take over administration of its insolvency case on July 30, many employees, including YesCare's former staff working in the Alabama prisons, still have not been paid.

At the same time, law firms began withdrawing from their cases in pending Section 1983 litigation because the company could not pay their bills, leaving individual clinicians to find and fund their own defense.

These types of events are destabilizing the workforce needed to provide correctional healthcare. YesCare is not an isolated case.

Wellpath Holdings, once the nation's largest private correctional healthcare provider, filed for Chapter 11 in late 2024 with $644 million in debt and more than 1,500 outstanding lawsuits, and Armor Correctional Health liquidated in 2024.

A declaration filed in Wellpath Inc.'s bankruptcy makes the connection explicit:

Wellpath also faced a short-term increase in professional liability insurance expenses, primarily driven by case settlements associated with terminated contracts and the lack of available third-party liability insurance. For example, in 2023, approximately 70% of all executed settlements related to incidents that allegedly occurred prior to 2018 … with cash settlements totaling approximately $110,000,000 between 2019 and 2023.[1]

Similarly, David Goldwasser, YesCare's chief restructuring officer, told the bankruptcy court that one of the "principal factors necessitating the commencement of these Chapter 11 Cases was the extraordinary financial and operational burden imposed by extensive litigation involving the Debtors," and that the $307 million Jackson verdict "has had an immediate and materially adverse effect on the Debtors' business operations, liquidity position, access to counterparties, and overall financial condition."[2]

The same pattern appeared in the bankruptcy of Tehum Care Services Inc. By the end of 2021, according to its chief restructuring officer, the company's "financial position had worsened in recent years due to revenue declines, margin compression, and deteriorating liquidity; it was operating in a significant negative working capital position due to its debt obligations; and it faced increased exposure to professional liability claims (indeed, hundreds) to the tune of an estimated $88 million."[3]

A major factor contributing to these post-litigation bankruptcies in the industry is a legal

framework that has never defined the standard against which correctional providers are measured.

Under the Eighth Amendment of the U.S. Constitution, as interpreted by the U.S. Supreme Court in Estelle v. Gamble in 1976, "deliberate indifference" to the serious medical needs of prisoners constitutes cruel and unusual punishment actionable under Section 1983.

For nearly 50 years, this phrase has been the foundation of federal civil rights claims against correctional healthcare providers. Yet neither Congress, the Supreme Court, nor any regulatory body has ever established objective, clinically grounded criteria for what constitutes compliant care in a correctional setting, nor what conduct crosses the line into deliberate indifference.

In community healthcare the Joint Commission sets accreditation standards for hospitals, and compliance is deemed by federal law to satisfy Medicare and Medicaid conditions of participation; in a malpractice case, the standard of care is defined by the community medical profession and established through expert testimony. Providers know what is expected of them.

Correctional healthcare offers no equivalent, and as a result, individual correctional healthcare providers are unable to obtain professional liability insurance covering deliberate indifference, the cause of action they will most often be sued for in this setting.

The solution to protecting our healthcare workers so that they can safely deliver constitutionally required correctional healthcare is feasible. It can be achieved with executive direction of existing law providing a starting point.

In July 2024, the bipartisan Federal Prison Oversight Act passed 392 to 2 in the U.S. House of Representatives and unanimously in the Senate, establishing a new inspections regime for the U.S. Bureau of Prisons' 122 facilities, including risk-based assessments of healthcare access.

It was well intentioned, but it needs to go a step further. The FPOA created oversight without defining what compliance looks like, and it applies only to federal facilities. This leaves out the thousands of state prisons and local jails where the vast majority of incarcerated healthcare is delivered.

The president can draft an executive order directing the Bureau of Prisons to develop clear

standards for constitutionally adequate care in partnership with the American Correctional Association, whose performance-based standards the U.S. Department of Justice already uses under the Civil Rights of Institutionalized Persons Act.

This is not a novel mechanism. It is the correctional analog to one that community healthcare already relies on: When a hospital meets Joint Commission accreditation, federal law deems it to have satisfied Medicare and Medicaid conditions of participation. A recognized accreditor's standards become the operative benchmark.

Correctional healthcare can work the same way. For the clinician, it means knowing what compliant care looks like before a lawsuit defines it in hindsight.

With a benchmark in place, the attorney general can advance a litigation position that a correctional healthcare provider in compliance with those standards benefits from a rebuttable presumption against deliberate indifference.

This is not a shield for bad actors. Plaintiffs would retain the ability to overcome the presumption with evidence of actual indifference; what changes is that providers would finally have a concrete benchmark for compliance, and juries would have an objective reference point in place of an undefined constitutional phrase. A defined line protects the clinician who met the standard and exposes the one who ignored it.

States can then be encouraged to adopt parallel standards and to require correctional-specific expert testimony on standard of care. This is important because delivering healthcare inside a correctional facility bears no resemblance to practicing in a hospital.

In a maximum security environment, a nurse may have to wear a stab-resistant vest and carry a spit shield. Seeing a patient requires an officer escort through a facility designed to restrict movement.

When a medical emergency occurs at 2 a.m. on the far side of a 3,000-bed facility, response time is dictated by security protocols, not clinical urgency.

Safety and security are the primary mission of any correctional institution, and healthcare has to operate within that framework. Standard of care expert testimony grounded in the custody environment would accurately measure provider conduct against the conditions in which it actually occurs.

The effect of these steps is cumulative. Once compliant care is defined and presumptively protective, the exposure that drove insurers out of this market becomes quantifiable, litigation outcomes become more predictable and therefore more manageable, and clinicians can keep doing this work.

That is what ultimately reaches the patient who will one day return to the community, because care that is constitutional and that supports a successful reentry depends on there being enough professionals willing and able to provide it.

Defining the standard is necessary to ensure that a functioning system can uphold incarcerated people's constitutional right to healthcare, and so that the people who depend on that care are not left without anyone to provide it.

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[1] Declaration of Timothy J. Dragelin as Chief Restructuring Officer and Chief Financial Officer of Wellpath Holdings, Inc. and Certain of Its Affiliates and Subsidiaries in Support of the Debtors' Chapter 11 Proceedings and First Day Pleadings ¶¶ 48–49, In re Wellpath Holdings, Inc., No. 24-90533 (ARP) (Bankr. S.D. Tex. Nov. 12, 2024), ECF No. 20.

[2] Declaration of David Goldwasser in Support of the Debtors' Chapter 11 Petitions and First Day Relief ¶¶ 19, 21, In re CHS FL, LLC, No. 26-bk-01087 (Bankr. M.D. Fla. May 10, 2026), ECF No. 25.

[3] Declaration of Russell A. Perry in Support of Debtor's Emergency Motion for Entry of Interim and Final Orders ¶ 6, In re Tehum Care Services, Inc., No. 23-90086 (CML) (Bankr. S.D. Tex. Mar. 15, 2023), ECF No. 186.