THE UNITED STATES JUSTICE-INVOLVED POPULATION & TOBACCO USE

Notes to Reader: References to tobacco in this issue brief refer to commercial tobacco and not the sacred and traditional tobacco that may be used for ceremonial or medicinal purposes by some Tribal communities. ***For definitions of key terms, please refer to the glossary on page nine.***

This issue brief was developed to highlight challenges that impact the justice-involved population's access to tobacco cessation treatments and outline options to address some of those challenges. It has been updated to include recent guidance from the Centers for Medicare and Medicaid Services (CMS) and new policies passed as part of the 2024 Consolidated Appropriations Act. Both give states new opportunities to improve access to care and tobacco cessation coverage. The following topics will be covered:

- An overview of health inequities experienced by the justice-involved population, as they relate to tobacco use and smoking in particular.
- A brief background on tobacco cessation treatment and access to healthcare in U.S. correctional facilities.
- Opportunities for states to increase access to tobacco use treatment and improve healthcare for the justice-involved population.

INTRODUCTION

The United States leads the world with the largest percentage of citizens who are incarcerated in jails or prisons. Approximately 1.8 million people in the U.S. are incarcerated in federal and state prisons or local jails.[1] Black and Hispanic individuals are disproportionately imprisoned.[2] Black men are six times more likely to be incarcerated than non-Hispanic white men due to various policies throughout the history of the U.S. that have had an unequal impact on Black individuals in America.[3, 4, 5] Though Black individuals make up less than 14% of the United States population, they comprise 35% of the population in jail, and while Hispanic individuals make up 19% of the United States population, they comprise nearly 30% of the population in federal prison.[6, 7, 8]

A significant public health problem impacting individuals in U.S. jails and prisons is cigarette smoking.[9] The smoking prevalence is over four times higher among the justice-involved population than the general population.[10] Between 50% and 80% of individuals who are incarcerated smoke cigarettes,[11] versus 11.5% of the overall US adult population.[12]

Many states have passed laws implementing smokefree policies in correctional facilities. It is important to note that there is no federal mandate requiring smokefree policies in local and state correctional facilities, so those decisions are entirely up to the locality or state. Smoking in federal prisons is, however, prohibited as of 2015.[13] These smokefree policies protect the health of incarcerated individuals in addition to helping those who work in these facilities by both reducing smoking and the exposure to secondhand smoke. Given that smoking is associated with several chronic health outcomes, these smokefree policies also help in reducing the cost of additional medical care for prison employees and individuals who are incarcerated.[14]

Still, certain challenges disproportionately affect the justice-involved population and increase their tobacco use risk. Individuals who have been incarcerated are more likely to experience inequities related to behavioral and physical health outcomes.[15, 16] Characteristics commonly found among the justice-involved population include substance use disorders (SUD), mental health conditions, poverty and lower education status.[17] These can all contribute to an increased risk of using tobacco products. Individuals who are currently, or were formerly, incarcerated are also more likely to have chronic health conditions such as high blood pressure and diabetes. These diagnoses can be caused, as well as further exacerbated, by continued tobacco use – specifically, smoking. Intensified by the lack of resources and social support upon release, adults who were previously incarcerated are more likely to engage in risky behaviors and experience substantial social stressors, such as unemployment, housing insecurity, lack of a support system and alcohol and substance abuse.[18] These challenges can be overwhelming, resulting in fewer quit-attempts and more individuals that were formerly incarcerated to continue their tobacco addiction or relapse.[19]

Comprehensive Tobacco Cessation Benefit

Seven FDA-approved medications:

- NRT gum
- NRT patch
- NRT lozenge
- NRT inhaler
- NRT nasal spray
- Bupropion
- Varenicline

Three forms of counseling:

- Individual
- Group
- Phone

The tobacco industry's intentional and predatory marketing tactics targeting the Black community have created large health disparities associated with menthol cigarette use, as well as death and disease caused by tobacco use. More than 80% of Black individuals who smoke in America use menthol cigarettes[20], which have been found to increase both the likelihood of becoming addicted and the degree of addiction.[21] Evidence indicates that individuals who smoke menthol cigarettes are less likely than those who smoke non-menthol cigarettes to successfully quit smoking, despite having a higher urge to end their tobacco dependence.[22] Furthermore, due to the number of Black men incarcerated in the U.S., the number of Black males who smoke is higher than the number of non-Black individuals who smoke in prisons or jails.[23]

It is well-established that most individuals who smoke want to quit, including individuals in jails and prisons.[24] Quitting smoking reduces the risk of premature death and can add as much as a decade to life expectancy. It also reduces the risk for many adverse health effects, including cancer, chronic obstructive pulmonary disease and negative reproductive health outcomes. The seven Food and Drug Administration (FDA) approved cessation medications and behavioral counseling are not only cost-effective cessation strategies, but also increase the likelihood of successfully quitting smoking, particularly when used in combination.[25] Evidence suggests that cessation counseling and behavioral interventions in correctional facilities show similar effectiveness to those interventions among the general population.[26] When considering cessation methods, it is important to note that e-cigarettes are not approved cessation treatments; they are commercial tobacco products. The FDA has not found any e-cigarette to be safe and effective in helping people who smoke to quit. Moreover,

secondhand e-cigarette emissions also pose risks.[27] Ensuring persons who are incarcerated have access to a comprehensive cessation benefit including all seven FDA-approved medications and three forms of counseling during their incarceration and upon their release, is a necessary step in saving lives.

HEALTHCARE IN PRISONS & JAILS

Individuals who are incarcerated tend to have more illnesses than the general population, and federal law protects their right to receive medical care while incarcerated.[28] However, under the provision of a federal law known as the "inmate exclusion," Medicaid has been barred from covering the healthcare costs of anyone committed to a jail, prison, detention center or other correctional facility regardless of the amount of time they are incarcerated.* As a result, some states terminate Medicaid coverage for people when they are incarcerated. To regain coverage upon release, individuals must then go through the Medicaid application process again. This can leave gaps in healthcare coverage. This coverage exclusion is relevant because evidence shows that coverage for comprehensive smoking cessation treatment increases the rate of successful quitting.[29] Many states opt to suspend, rather than terminate, Medicaid coverage so that it can resume upon release and improve continuity of care.

Healthcare Delivery Models in Correctional Facilities

- **Direct services model:** states deliver health services directly through state funded entities, such as the Department of Corrections, a public health system or public hospital.
- **Contracted model:** states contract with private third-party vendors to deliver the health services.
- **Hybrid model:** states use a combination of outsourced vendors and corrections and other staff.
- **University model:** states partner with their university health systems to provide health services to persons who are incarcerated.

Correctional facilities are required to provide healthcare services to individuals who are incarcerated, though healthcare delivery models vary across the United States. Ultimately, depending on whether a person is in jail or prison, either the state or a locality is responsible for the care. States tend to be responsible for the healthcare costs of individuals who are incarcerated in state prisons and localities are financially responsible for individuals who are incarcerated in county jails.† During Fiscal Year 2015, states spent approximately $8.1 billion on healthcare in correctional facilities and the median healthcare expense per incarcerated individual was $5,720.[30]

Regardless of how healthcare is delivered to the justice-involved population, data shows that many persons who are incarcerated go without the necessary healthcare they require. A study found that among individuals who are incarcerated with chronic medical problems, 14% in a federal facility, 20% in a state facility and 68% in a local jail did not receive a medical exam while incarcerated.[31]

* There is an exception to the "inmate exclusion" law for individuals in correctional facilities that are treated in a medical institution outside the jail or prison for 24 hours or more.
† In some smaller states, such as Vermont and Hawaii, prison and jails are combined. This can change who is financially responsible for the healthcare costs of persons who are incarcerated.

For individuals who are incarcerated, access to tobacco cessation services also varies. In the past, U.S. prisons and jails provided tobacco cessation services to persons who are incarcerated and correctional staff through commissaries or medical personnel. Services could range from educational information, counseling, classes and/or tobacco cessation medications.[32] However, as correctional facilities are implementing smokefree indoor and outdoor policies, some facilities have reduced the availability of cessation services and aids.[33] This was the case in California's prisons, which have eliminated all commercial tobacco products from the grounds, including nicotine replacement therapy products.[34] Prison officials within tobacco-free facilities question the need for cessation aids since individuals who are incarcerated and staff would not have exposure to tobacco products on the grounds.[35] Because many individuals entering correctional facilities have a history of commercial tobacco use, it is important that cessation treatments and services be accessible and available to help this population quit and to maintain their abstinence from tobacco.

ENSURING A SMOOTH TRANSITION

Ninety-five percent of all persons in state prisons will eventually return to the community.[36] Of those who quit tobacco during incarceration, up to 90% relapse upon community reentry.[37] Having appropriate healthcare and treatment services available is vital for a successful transition when reintegrating into their communities. Ensuring that people previously incarcerated can access the care they need immediately upon release can help prevent reoffending and a return to jail or prison. There is a subset of the justice-involved population that flows in and out of correctional facilities which severely disrupts their care. When individuals formerly incarcerated can achieve their health potential, it increases their chances of finding work, obtaining adequate housing and staying out of prison. This is particularly true for persons who are incarcerated and have mental health conditions or substance use disorders.

Most people in the U.S. have employer-sponsored health insurance. It is important to recognize the various systemic barriers in place that make it difficult for persons formerly incarcerated to successfully gain employment. The lack of employment adds to the challenge of obtaining health insurance and subsequently having access to routine healthcare services. Approximately 80% of persons formerly incarcerated are uninsured.[38] Without having proper health coverage, individuals who have been released from incarceration do not have the ability to get the medications, preventive care services, including tobacco use screening they may have been receiving when in jail or prison. The lack of health insurance among this population can cause a financial burden for states as they often end up paying for expensive healthcare or social service needs, which could often have been avoided with adequate cessation coverage.

Persons who are incarcerated are also barred from using the marketplace (healthcare.gov) to purchase private health insurance, except for those pending disposition (refers to an individual who has been charged with a crime but is waiting for the outcome of the charges). This would include the following situations:

- Individuals who have been arrested, but are not yet convicted of a crime; and
- Individuals who have been convicted of a crime but are waiting for their sentencing.[39]

It is important to note that insurers, however, tend to have their own limitations approved by state insurance commissioners.

Before the Patient Protection and Affordable Care Act (ACA), most individuals leaving jail or prison did not qualify for standard Medicaid[‡] because the coverage was very limited in the populations it served. As of November 2023, 40 states and DC have expanded Medicaid[§] to all adults with incomes below 138% of the federal poverty level or $2,859 per month for a family of three in 2023.[40, 41] This has created an opportunity to provide coverage to even more individuals as most people who are incarcerated in states with Medicaid Expansion would be otherwise eligible for Medicaid coverage.[42] New York and Colorado estimate that 80% and 90% of their prison populations, respectively, would likely be eligible for coverage through expansion.[43] This improves individuals' access to tobacco cessation services including medications and counseling. Although only 19 states provide a comprehensive cessation benefit for their Medicaid enrollees, all states provide some cessation services which is an improvement from pre-ACA times.[44] Additionally, Medicaid expansion programs are required by the ACA to provide a comprehensive tobacco cessation benefit without cost-sharing as part of their preventive services.[45]

In 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) was passed by Congress. This Act directed CMS to issue guidance on how states can use reentry section 1115 demonstration waivers to improve healthcare transitions for individuals who are incarcerated and returning to the community.[46]

In April of 2023, CMS released this guidance. It outlined how a reentry section 1115 demonstration waiver could allow Medicaid coverage of healthcare costs for individuals who are incarcerated but otherwise eligible for Medicaid, between 30-90 days before release. Under this guidance, the minimum benefits states would have to provide as part of this waiver include:

1. Case management;
2. Medication assisted treatment with counseling for substance use disorders; and
3. Thirty-day supply of all prescribed medication upon release from a correctional facility.

Other optional benefits may be added as well.[47,]

North Carolina's Work

North Carolina's pending 1115 waiver includes Medicaid coverage for tobacco cessation pre-release services as an additional benefit.

These services will be phased into the program, in addition to mandatory services.

These waivers allow states to ensure Medicaid coverage of comprehensive tobacco cessation treatment is provided for otherwise eligible individuals who are incarcerated and transitioning to the community. Covered Medicaid services could include case management that connects individuals to tobacco cessation treatment, provision of medications and counseling to address tobacco use prior to release and a thirty-day supply of prescribed tobacco cessation medications upon release. As most individuals who are incarcerated in states with Medicaid expansion would be

[‡] Standard Medicaid is a federal-state partnership that provides health coverage to many low-income families, including parents, children, elderly individuals, people with disabilities and pregnant women. The program is administered by the states, has federally mandated requirements and is funded jointly by the states and federal government.

[§] Medicaid expansion covers all individuals up to 138% of the Federal Poverty Level. It is funded jointly by the federal government and states, with the federal government paying for approximately 90% of the program.

eligible for Medicaid coverage, these waivers could help the justice-involved population quit for good.[48]

North Carolina has already submitted a waiver to CMS that includes coverage of tobacco cessation treatments for this population, and as of February 2024 it is pending approval from CMS.[49]

Some states are establishing data exchanges between correctional facilities and state Medicaid agencies.[50] States rely on the data exchanges to alert Medicaid-managed care plans and providers when individuals are being released from correctional facilities to ensure they are reached out to for their healthcare needs. Other states require their Medicaid-managed care plans to conduct "in-reach" into correctional facilities. This means a clinician will meet with a person who is incarcerated prior to their release in order to assess their physical and behavioral health status and develop a post-release care plan.

Ohio's Work

Ohio's Department of Rehabilitation and Correction works with the state's Department of Medicaid to help individuals who are incarcerated obtain a Medicaid managed care plan at least 90-100 days before their release. When released, they have a care coordinator to help them find a primary care provider, make and confirm appointments and learn about urgent care, healthcare specialists and transportation benefits.

Another strategy some states have implemented is developing programs that begin the Medicaid application process early.[51] These efforts require communication and coordination between the Department of Corrections and the state Medicaid program to make certain that once individuals are no longer incarcerated, they have Medicaid coverage. CMS' April 2023 guidance on reentry section 1115 demonstration waivers says that states using these waivers should begin this process no later than 45 days prior to release. This will help ensure access to pre-release services.[52] States can receive Medicaid funding to improve data exchanges through reentry section 1115 demonstration waivers as well. This can include funding for systems to support enrollment in Medicaid and case management for those enrolled in Medicaid.[53]

Alabama's Work

Alabama passed Medicaid suspension legislation in 2017. When the state terminates Medicaid coverage upon incarceration, the state loses the ability to shift the costs to the federal government. Alabama chose to pass this law to reduce prison medical costs to the state and to help people with behavioral health conditions from going in and out of the jail/prison system.

SUSPENDING MEDICAID COVERAGE

In 2024, the Consolidated Appropriations Act passed by Congress requires states to suspend, rather than terminate, Medicaid coverage for individuals upon incarceration.[54] This provision will go into effect on January 1, 2026; however, states have the option to suspend Medicaid coverage now. Forty states and DC have already taken this approach when working to improve continuity of care for individuals released from correctional facilities. They have adopted policies that suspend, rather than terminate, Medicaid for people

during incarceration.[55] When Medicaid is suspended by states, coverage and services restart once an individual is released from jail or prison.[**]

States have chosen to use this method for several reasons, including:

1. Avoiding the long reapplication process, which can take anywhere from 45 to 90 days. This often leaves formerly incarcerated individuals without healthcare services while waiting to be re-enrolled.

2. Saving on administrative costs related to the Medicaid reapplication and eligibility determination process.

Suspension, rather than termination, of coverage for individuals who are incarcerated is also a condition of approval for reentry section 1115 demonstration waivers.[56] This approach is beneficial for individuals detained, especially those in jails. At least 4.9 million people are arrested and jailed each year and at least one in four of these individuals are booked into a jail more than once during the same year. Analysis shows that repeat arrests are related to race, poverty and behavioral health conditions – all of which can contribute to and exacerbate a person's commercial tobacco use.[57] Approximately two-thirds of those detained in jails are there prior to their trial. Many of these individuals are simply held because they cannot afford their bail or have just been arrested and will be released within a few days.[58] Terminating Medicaid coverage for short stays in jail affects a large proportion of the justice-involved population and slows the speed at which they can be connected to the care that they need, including access to a comprehensive cessation benefit.

Finally, the 2024 Consolidated Appropriations Act directs the Secretary of Health and Human Services (HHS) to provide funding and guidance to states working to improve continuity of care for Medicaid-eligible individuals who are incarcerated. This includes federal grants for states to establish processes that facilitate Medicaid enrollment and access to care, such as:

- Suspending Medicaid coverage, rather than terminating it, upon incarceration;
- Standardizing Medicaid enrollment and renewal processes for this population; and
- Developing data exchanges.

Guidance to states on how to establish these processes will include the following:

- How to comply with Medicaid requirements, such as suspension of coverage rather than termination upon incarceration;
- Best practices to improve Medicaid enrollment and renewal during incarceration;
- Clarifying what federal funding is available to states to improve these processes;
- How to ensure individuals receive prescribed medications upon release; and
- How to establish case management for individuals returning to the community.

This funding and guidance can support states establishing processes that improve Medicaid coverage, access to prescribed medications and case management for individuals who are

[**] It is important to note that resuming services immediately can be more aspirational than real. Even in states with suspension policies, people still find themselves at the mercy of the state systems for turning on benefits and turning on pharmacy benefits.

incarcerated and returning to the community. This can help states ensure individuals receive tobacco cessation treatment during transition to the community and help them quit for good.

OTHER HEALTHCARE OPTIONS FOR FORMERLY INCARCERATED INDIVIDUALS

Not everyone who leaves jail or prison will qualify for Medicaid. Upon being released, individuals have a 60-day special enrollment period to sign up for private health coverage through the marketplace. After the 60-day period, individuals will not be able to purchase private health insurance until the next marketplace open enrollment period (unless they qualify for a special enrollment period for another reason). Persons formerly incarcerated may qualify for lower costs on monthly premiums and out-of-pocket costs. That is dependent on the household size and income during the year they are seeking coverage.

RECOMMENDATIONS

As states work to improve access to cessation treatments for the justice-involved population there are promising methods that have been shown to be successful. These include:

- Ensuring all state correctional facilities provide comprehensive cessation treatment to people who are incarcerated, as this is proven to help people who use tobacco successfully quit;
- Submitting a reentry section 1115 demonstration waiver for Medicaid coverage of tobacco cessation medication and counseling prior to release, that supports beginning the Medicaid application process early enough to ensure they have coverage on the day they are released;
- Establishing data exchanges between correctional facilities and state Medicaid agencies to alert managed care plans and providers when individuals are being released; and
- Suspending Medicaid coverage rather than terminating it. This will ensure that Medicaid coverage and services will resume immediately when people are released from correctional facilities.

CONCLUSION

There are many ways for states and localities to ensure the justice-involved population receive access to comprehensive tobacco cessation services during and after incarceration. This is especially important considering this population's high rates of mental health conditions, substance use disorders, physical health problems and various social determinants of health needs such as housing, food and other social supports – all of which can increase the risk of continued commercial tobacco use. States can take advantage of opportunities created by the Affordable Care Act, including Medicaid expansion, CMS' reentry section 1115 demonstration waivers and the 2024 Consolidated Appropriations Act to improve coverage and access to comprehensive tobacco cessation services. Incorporating these recommendations will support populations with a history of justice involvement by preventing commercial tobacco use, reducing their exposure to secondhand smoke and helping them to quit for good.

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GLOSSARY OF TERMS

Incarcerated/Inmate: Refers to individuals confined to a correctional facility (such as a jail or prison).

Justice-Involved Population: Refers to individuals who have interacted with the criminal justice system, more broadly. This includes individuals who have undergone arrest, are currently incarcerated or were previously incarcerated.

Tobacco: Refers to commercial tobacco products, including cigarettes.

Smoking: Refers specifically to tobacco cigarette smoking.

Cessation: Refers to quitting tobacco or smoking.

Jails: Facilities which typically house individuals awaiting trial and individuals convicted of misdemeanors who are serving sentences of less than one year. In most states, jails are run by counties or cities.

Prisons: Facilities which house incarcerated individuals who are convicted and serving sentences of more than one year. Federal prisons are under the legal authority of the federal government while state prisons are under the legal authority of individual states' governments.[59]

1115 Waiver: Allows states to "waive" one or more federal requirements for Medicaid programs by submitting an application to the Centers for Medicare and Medicaid Services. This issue brief refers specifically to Reentry Section 1115 Demonstration Waivers which would allow Medicaid coverage of healthcare costs for individuals who are incarcerated, between 30-90 days before release, if otherwise eligible. See our factsheet for more information on 1115 Waivers.

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