THE UNITED STATES JUSTICE-INVOLVED POPULATION & TOBACCO USE

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] The inequitable enforcement of laws and policies has led to certain populations, including Black Americans and Hispanic Americans, being disproportionately imprisoned.[2] Individuals who have been incarcerated are more likely to experience inequities related to behavioral and physical health outcomes.[3, 4]

Cigarette smoking in U.S. jails and prisons is a public health problem.[5] The smoking prevalence is four times higher among the justice-involved population than the general population.[6] Between 50% and 83% of incarcerated individuals smoke cigarettes,[7] versus 14% of the overall US adult population smoking cigarettes.[8] As a result of the high rates of smoking among individuals in jails and prisons, many states have passed laws implementing smokefree policies in correctional facilities. It is important to note that decisions regarding smokefree policies in local and state correctional facilities are entirely up to the locality or state as there is no federal mandate requiring it. Tobacco use is, however, prohibited in federal prisons as of 2015.[9] These smokefree policies protect the health of incarcerated individuals in addition to helping those that work in these facilities by both reducing smoking and the exposure to secondhand smoke. Given that commercial tobacco use is associated with chronic health outcomes, these smokefree policies also help in reducing the cost of additional medical care for prison employees and incarcerated individuals.[10]

Characteristics commonly found among the justice-involved population include substance use disorders (SUD), mental health conditions, poverty and lower education status.[11] These can all contribute to an increased risk of using tobacco products. Current and former inmates are also more likely to have chronic health conditions such as high blood pressure and diabetes, which can be caused, as well as further exacerbated by continued tobacco use.[*] Intensified by the lack of resources and social support upon release, adults who were previously incarcerated are more likely to experience substantial social stressors and engage in risky behaviors, such as be unemployed, experience housing insecurity, have a lack of a support system and alcohol and substance abuse.[12] Unfortunately, these challenges can be overwhelming, resulting in fewer quit-attempts and more individuals that were formerly incarcerated to continue their tobacco addiction or relapse.[13]

The higher percentage of inmates smoking becomes a larger public health concern when considering that incarceration and smoking disproportionately affect racial and ethnic minorities, specifically Black men.[14] 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 a unequal impact on Black Americans.[15, 16]

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[*] When using the phrase "tobacco use" throughout this document, the Lung Association is referring to commercial tobacco use and not sacred tobacco use.

In addition to policies that have resulted in the disparate imprisonment of the Black community, 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. Eighty-five percent of Black smokers in America use menthol cigarettes[17], which have been found to increase both the likelihood of becoming addicted and the degree of addiction.[18] Evidence indicates that menthol smokers are less likely than non-menthol smokers to successfully quit smoking, despite having a higher urge to end their tobacco dependence.[19] Furthermore, due to the higher number of Black men incarcerated in the U.S., the number of Black male smokers is higher than the number of non-Black smokers in prisons or jails.[20]

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

It is established that most smokers want to quit, including individuals in jails and prisons.[21] Smoking cessation 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 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 likelihood of successfully quitting smoking, particularly when used in combination.[22] Evidence suggests that cessation counseling and behavioral interventions in correctional facilities show similar effectiveness to those interventions among the general population.[23] When considering cessation methods, it is important to note that e-cigarettes are not approved cessation treatments and are commercial tobacco products. The FDA has not found any e-cigarette to be safe and effective in helping smokers quit. 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 they have a right to receive medical care while incarcerated.[24] However, under the provision of a federal law known as the "inmate exclusion," Medicaid is barred from covering the healthcare costs of anyone committed to a jail, prison, detention center or other penal facility regardless of the amount of time they are incarcerated for. There is an exception for individuals in correctional facilities that are treated in a medical institution outside the jail or prison for 24 hours or more.[25] Persons that are incarcerated are also barred from using the Marketplace to purchase private

health insurance, except for those pending disposition. An individual incarcerated *pending disposition* of charges 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.[26]

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

JAILS VERSUS PRISONS

- JAILS TYPICALLY HOUSE PEOPLE AWAITING TRIAL AND INMATES CONVICTED OF MISDEMEANORS WHO ARE SERVING SENTENCES OF LESS THAN ONE YEAR. IN MOST STATES, JAILS ARE RUN BY COUNTIES OR CITIES
- PRISONS HOUSE CONVICTED INMATES SERVING SENTENCES OF MORE THAN ONE YEAR
- BOTH EXPERIENCE SIMILAR INMATE HEALTHCARE CHALLENGES

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 FY15, states spent approximately $8.1 billion on healthcare in correctional facilities and the median healthcare expense per inmate was $5,720.[27]

Correctional facilities are required to provide healthcare services to individuals who are incarcerated. Correctional healthcare is delivered in a variety of ways across the 50 states and DC. These delivery methods include:

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

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 incarcerated individuals with chronic medical problems, 14% of federal inmates, 20% of state inmates and 68% of local jail inmates did not receive a medical exam while incarcerated.[28]

[†] 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.

Many U.S. prisons and jails provide tobacco cessation services to persons who are incarcerated and correctional staff through commissaries or medical personnel. Services can range from educational information, counseling, classes and/or tobacco cessation medications.[29] As correctional facilities are implementing smokefree indoor and outdoor policies, some facilities have reduced the availability of cessation services and aids.[30] This was the case in California's prisons, which have eliminated all commercial tobacco products from the grounds, including nicotine replacement therapy products.[31] Prison officials within tobacco-free facilities question the need for cessation aids since inmates and staff would not have exposure to tobacco products on the grounds.[32] With many individuals entering prisons who have a history of commercial tobacco use, accessibility and availability of cessation treatments and services are important to help these disproportionately impacted populations to quit and to maintain their abstinence from tobacco.

ENSURING A SMOOTH TRANSITION

Eventually, 95% of all persons who are incarcerated are released from state prison systems.[33] Having appropriate healthcare and treatment services available is important for a successful transition when reintegrating into their communities. Ensuring that they can access the care they need immediately can help prevent reoffending and a return to jail or prison. Unfortunately, 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 that are incarcerated and have mental health conditions or substance use disorders.

Most Americans have employer-sponsored health insurance. Unfortunately, there are 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.[34] 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 coverage.

Before the 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

[‡] 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.

August 2021, 38 states and DC have expanded Medicaid[§] to all adults with incomes below 138% of the federal poverty level or $2,525 per month for a family of three in 2021.[35] This has created an opportunity to provide coverage to even more individuals after they have been released from either jail or prison. New York and Colorado estimate that 80% and 90% of their prison populations, respectively, are likely eligible for Medicaid once released.[36] This improves individuals' access to tobacco cessation services including medications and counseling. Although only 15 states provide a comprehensive cessation benefit for their Medicaid enrollees, all states provide some cessation services which is an improvement from pre-ACA times.[37] 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.[38]

Some states are establishing data exchanges between correctional facilities and state Medicaid agencies.[39] States rely on the data exchanges to alert 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 INMATES 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.[40] These efforts require communication and coordination between the Department of Corrections and the state Medicaid program to ensure that once released, individuals formerly incarcerated have Medicaid coverage. These efforts also require an 1115 waiver, which states may apply for to administer experimental, pilot or demonstration projects that promote the objective of the Medicaid program.

SUSPENDING MEDICAID COVERAGE

Thirty-five states and DC have taken a different approach when working to ensure the continuity of care for individuals released from correctional facilities. They have adopted policies that suspend, rather than terminate, Medicaid for people during incarceration.[41] When states suspend

[§] 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.

Medicaid, it means that Medicaid coverage and services will resume upon an individual's release 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 former inmates without healthcare services while waiting to be re-enrolled.

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

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.

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.[42] 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.[43] Approximately 98% of former smokers released from tobacco-free correctional facilities relapse.[44] 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.

OTHER HEALTHCARE OPTIONS FOR FORMER INMATES

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 (Healthcare.gov). 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 another special enrollment period). 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.

** 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.

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 a comprehensive cessation benefit to persons who are incarcerated, as they are proven to help tobacco users successfully quit;
- Submitting an 1115 waiver to develop programs that begin the Medicaid application process early enough before an individual's release from incarceration 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 opportunities for states and localities to ensure the justice-involved population receive access to comprehensive tobacco cessation services during and after incarceration. However, healthcare coverage alone is insufficient to address the health and social needs of individuals who cycle between the justice and healthcare system. To take advantage of opportunities created by the Affordable Care Act, including Medicaid expansion, it is important to examine how to deliver care effectively and efficiently to people leaving jails and prisons. This is especially important considering the high rates of mental health conditions, substance use disorders, physical health problems and various social determinants of health such as housing, food and other social supports - all of which can increase the risk of continued commercial tobacco use. Focusing on improving these strategies can support populations with a history of justice involvement by preventing use, reducing their exposure to secondhand smoke and help them to quit the use of commercial tobacco.

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