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Icha Khaerunnisa
Universitas Diponegoro, Semarang, ikhaerunnisa9@gmail.com

Megah Andriany
Universitas Diponegoro, Semarang, megahandriany@fk.undip.ac.id

Luky Dwiantoro
Universitas Diponegoro, Semarang, lukydwiantoro@fk.undip.ac.id

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Post-Release Health Insurance Utilization Among Ex-Prisoners: A Scoping Review

Icha Khaerunnisa, Megah Andriany*, Luky Dwiantoro

Department of Nursing, Faculty of Medicine, Universitas Diponegoro, Semarang, Indonesia

Abstract

The lack of health insurance coverage after prison release significantly reduces access to essential healthcare services, hindering the continuity of care during community reintegration. The evidence on studies of health insurance use following prison release is limited. This scoping review aimed to summarize research on health insurance utilization after release from prison. Literature searches were conducted across databases including ScienceDirect, PubMed, and Scopus. Relevant articles were selected through a two-stage screening process. Data were extracted from the included studies and presented in tabular and descriptive formats. The keywords used were "health insurance AND post-release" and "inmates OR prisoners." This scoping review showed that post-release health insurance utilization varied internationally. Coverage gaps, such as those in the United States, limit access to and continuity of care, whereas Canada and Australia provide more stable services. Barriers included administrative challenges, housing and employment instability, stigma, and poor coordination within the health system. The findings highlight the influence of national insurance frameworks and the need for policies supporting prerelease-release enrollment, coverage continuity, cross-sector collaboration, and adherence to the World Health Organization and Nelson Mandela Rules for equitable healthcare.

Keywords: healthcare access, health insurance, inmates, post-release

Introduction

Individuals within the prison system have complex healthcare needs, including high rates of mental illness, substance use issues, cognitive disabilities, and communicable and noncommunicable diseases, all compounded by social disadvantages.[1] Multimorbidity, which is the coexistence of two or more chronic conditions, is common in this population and contributes to poor health outcomes. However, its specific patterns and prevalence among prisoners remain inadequately documented, limiting the understanding of their true health burden.[1,2] These health vulnerabilities indicate the urgent need for comprehensive health assessment and continuity of care within correctional settings.[3] Recognizing the vulnerability and marginalization of incarcerated individuals, the United Nations stipulates that they should receive the same standards of healthcare as the general population.[4,5] Healthcare provision within prisons varies globally; upon release, individuals should navigate disparate health services and systems.[5] Health insurance is a crucial supporting mechanism for improving healthcare access for inmates.[6]

Individuals involved in the justice system have significantly lower rates of health insurance coverage and healthcare utilization than the general population. This disparity, particularly post-release, creates a substantial barrier to accessing necessary health services.[7] This disparity creates a substantial barrier to accessing necessary health services, particularly after release.[7,8] Pre-incarceration lack of health insurance significantly decreases the utilization of crucial healthcare services, including nursing and mental health care, even within correctional facilities. Health insurance regulations for incarcerated individuals differ internationally. Countries such as the United Kingdom and Nordic nations integrate prison healthcare into their national systems to maintain continuity of care. In contrast, other countries, including the United States, terminate or suspend coverage during incarceration, further widening post-release gaps in healthcare access.[8] To improve continuity of care, postincarceration healthcare policies should prioritize the transferring and sharing of medical information, facilitating easy transitions to primary care and community services, especially for individuals with low engagement.[9,10] Reentering society after release can be challenging, with barriers to accessing health and social services, housing, and employment. Additionally, there is a higher risk of illness and death following release from prison.[11]

***Correspondence**:* *Megah Andriany, Nursing Department, Faculty of Medicine, Universitas Diponergoro, Semarang, Indonesia.*
Email: megahandriany@fk.undip.ac.id.

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Access to and continuity of care during reentry are critical because of significant health needs. However, individuals returning to the community after release from prison encounter various health-related challenges that can impede their ability to secure coverage and a good transition to care.[2] These challenges include difficulties in accessing and affording medications and treatments, limited electronic data sharing of health records between the justice system and community providers, scarce post-release resources (especially in low-income and rural areas), and systemic discrimination within the healthcare system against justice-involved individuals.[12,13] Additionally, the immediate post-release period presents numerous pressing needs, such as securing housing, food, and employment, and managing interpersonal relationships, with healthcare among many concerns.[9] Moreover, challenges in meeting basic needs, such as nutrition, housing, and employment, can hinder obtaining, affording, and accessing healthcare. Regarding coverage, some reentrants should navigate bureaucratic hurdles to reinstate health insurance benefits or reapply for coverage.[14,15] Others, particularly those in states that have not expanded health insurance eligibility, may not qualify for health insurance and could struggle to afford insurance through employers or federal and state-based health insurance marketplaces.[14]

Research using record-linkage studies, which combine incarceration records with health insurance data, is crucial for better understanding healthcare utilization and insurance access post-release.[5,16] These studies can determine patterns of care access, reveal barriers to care, and profile individuals at high risk following release.[16] Other results show that for serious juvenile offenders, particularly those without health insurance, barriers to appropriate healthcare are prevalent, leading to suboptimal healthcare use and an increased risk of reincarceration. Gaps in care continuity and limited healthcare access intensify existing health inequalities. Consequently, proactive measures are required to ensure seamless coordination of health insurance and service delivery within and outside of detention facilities to decrease detrimental health consequences.[17]

Many individuals released from correctional facilities lack health insurance, limiting access to essential medical services.[17] Post-incarceration, they often face a range of health challenges, including mental health disorders, substance use, and chronic illnesses that require ongoing treatment.[17] They often face various health challenges postincarceration, including mental health disorders, substance use, and chronic illnesses that require long-term treatment.[18] Despite the severity of these issues, there remains a lack of systematically mapped evidence on the use of health insurance following prison release. This review sought to address this gap by examining the health-related barriers to care and evaluating post-release health outcomes using diverse data sources.

Method

This scoping review mapped the scope and characteristics of peer-reviewed literature on health insurance for prisoners after release. Moreover, this review used the five-stage approach developed by Arksey and O'Malley (2005).[19] It focused on the breadth of evidence due to the field's early development and employed the scoping review checklist to improve methodological and reporting standards.[19] The study design was based on the methodology developed by the Joanna Briggs Institute (JBI)[20] This scoping review was conducted in five stages:

Stage 1: Identification of the Research Question

The research question focused on the scoping review "How is inmates' health insurance after prison release?"

Stage 2: Identifying Relevant Studies

The scope of this review encompassed publications from 2015 to 2025, including full-text articles that presented empirical studies or conceptual and theoretical viewpoints. Due to limited peer-reviewed literature, gray literature (e.g., reports) that provided insights into ongoing research, preliminary findings, policy trends, and post-release prisoner health insurance were also considered.[20] For facilitating a rapid synthesis of current evidence, theses and books were excluded, and only English-language publications were included.[19] This study used word strings related to four key concepts: health insurance (including medical coverage, healthcare coverage, Medicaid, insurance care), inmates (such as prisoners and detainees), post-release terms (including released inmates, ex-offenders, former prisoners), and healthcare access (such as health, medical, and service access).

Stage 3: Selection of Eligible Studies

An extensive search across 12 bibliographic databases yielded 1,043 initial publications (Figure 2). These databases included Science Direct (344), PubMed (392), and Scopus (377). Following the removal of duplicate records ($n = 1022$), the remaining studies were screened by title and keywords (Figure 1) to ensure that all four predefined categories were present. At this stage, exclusions included instances in which "inmate" referred to individuals in non-prison settings or to

the phrase "prisoner after release." After the initial title screening (1,022) and exclusion of studies prior to (n = 392), 72 publications remained for analysis.

The identified publications were managed using Mendeley and Rayyan AI. An initial title screening was conducted by one researcher to remove clearly irrelevant records. Subsequently, two researchers independently screened the remaining publications based on titles and abstracts to determine and exclude unsuitable publications. Then, the full texts of the remaining articles were independently assessed against the inclusion and exclusion criteria. Studies on health insurance for released inmates were included. Literature and systematic reviews were excluded to prioritize primary research and avoid redundancy; however, their bibliographies were consulted for potentially missed relevant articles. Only publications addressing health insurance of inmates post-release were included in the final analysis, totaling 12 publications.[20,21]

Stage 4: *Data Extracting and Charting Results*

The full texts of the 12 publications included in the final review were comprehensively examined, and data was systematically extracted using a standardized form. In this stage of the JBI scoping review method, the researchers extracted data from the included studies. The researchers gathered information on the following aspects to summarize the literature: study characteristics (first author and publication year), country, insurance plan, objectives or aims, study participants/sample size, history of health insurance usage, data sources, and analytical approach. To ensure consistency, two researchers extracted data from four randomly selected publications, discussed any discrepancies, adjusted the extraction as needed, and then completed data extraction from all included studies.[20,21]

Table 1. The Joanna Briggs Institute Appraisal Results

Author	Criteria											Results
	1	2	3	4	5	6	7	8	9	10	11	
Cohort Study												
Kouyoumdjian *et al.*[22]	√	√	√	X	X	√	√	√	√	√	√	81.8%
Fry *et al.*[23]	√	√	X	X	√	√	√	√	√	√	√	81.8%
Calais-Ferreira *et al.*[24]	√	√	X	X	√	√	√	√	√	√	√	81.8%
Wurcel *et al.*[25]	√	√	√	√	√	√	√	√	X	X	√	81.8%
Balio *et al.*[26]	√	√	√	√	√	√	√	√	√	X	√	90.9%
Easter *et al.*[27]	√	√	√	X	X	√	√	√	√	√	√	81.8%
Review												
Carroll *et al.*[28]	√	√	√	√	√	√	√	√	X	√	√	90.9%
Textual Evidence: Policy												
Albertson *et al.*[29]	√	√	√	√	√	√	√	√	X	√	√	90.9%
McNamara *et al.*[30]	√	√	√	√	√	√	X	-	-	-	-	85.7%
Qualitative												
Patel *et al.*[17]	√	√	√	√	√	√	√	√	√	X	√	90.9%
Matsumoto *et al.*[31]	√	√	√	√	√	√	√	√	√	X	√	90.9%
Quasi-Experimental Study												
Leaman *et al.*[32]	√	√	√	√	X	√	X	√	√	-	-	77.7%

Table 1 summarizes the methodological quality of the included studies using the JBI Critical Appraisal Tools, with appraisal conducted according to the official item numbers accessible on the JBI website. Cohort studies were evaluated using the 11-item checklist, which examines group similarity (Item 1), validity and reliability of exposure and outcome measurement (Items 2–4, 7), identification and management of confounding factors (Items 5–6), baseline outcome-free status (Item 6), adequacy and completeness of follow-up (Items 8–10), and statistical appropriateness (Item 11). The review was assessed using JBI's 11-item Review Checklist, with criteria mapped to official item numbers: clarity of the review question (Item 1), appropriateness of inclusion criteria (Item 2), adequacy of search strategy (Item 3), suitability of study selection methods (Item 4), rigor of critical appraisal processes including independence of reviewers (Item 5–6), transparency of data extraction (Item 7), appropriateness of synthesis methods (Item 8–9), assessment of publication bias (Item 10), and evidence-based conclusions aligned with the review question (Item 11), demonstrating high methodological adherence.

Textual evidence and policy documents were evaluated using the JBI Textual Evidence Critical Appraisal Tool, which assesses the credibility of the source, authenticity, defensibility of arguments, analytical rigor, and alignment between interpretations and extracted evidence (Items 1–8). Qualitative studies were assessed using the 10-item JBI checklist, evaluating methodological congruence (Items 1–5), researcher reflexivity (Items 6–7), representation of participants (Item 8), ethical considerations (Item 9), and analytic coherence (Item 10). The quasi-experimental study was appraised using the nine-item JBI checklist assessing clarity of cause–and–effect relationships (Items 1–3), similarity of comparison groups (Item 4), control of confounding (Items 5–6), reliability of outcome measurement (Item 7), completeness of follow-

up (Item 8), and appropriateness of analysis (Item 9). Most studies demonstrated sound methodological quality, with fulfillment rates of the criteria exceeding 80%. Studies with the highest percentages (90.9%) were by Balio *et al.*, Carroll *et al.*, Albertson *et al.*, Patel *et al.,* and Matsumono *et al.* The study by Leaman *et al.* exhibited the lowest percentage (77.7%), but, along with the study by McNamara et al., it was evaluated using a decreased set of criteria. Collectively, these tools provided a consistent and rigorous framework for evaluating methodological quality across diverse study designs.

Studies with high criterion-satisfaction rates provide stronger, more reliable evidence. Particular attention should be given to frequently unmet criteria, especially within cohort studies, to enhance the quality of future studies. The variation in the number of assessed criteria across studies indicates either differences in the appraisal systems employed or variations in the criteria's relevance to the respective study designs. In total, 1,043 publications were identified: PubMed = 392; Science Direct = 344; and Scopus = 307. After removing 61 duplicates, 426 publications were screened by title and abstract (step 1), and 102 publications were screened by full text. Among these 102 publications, 74 were excluded, 16 were uncertain, 12 were included, and 16 were referred back to reviewer one due to unresolved disagreements or uncertainty.

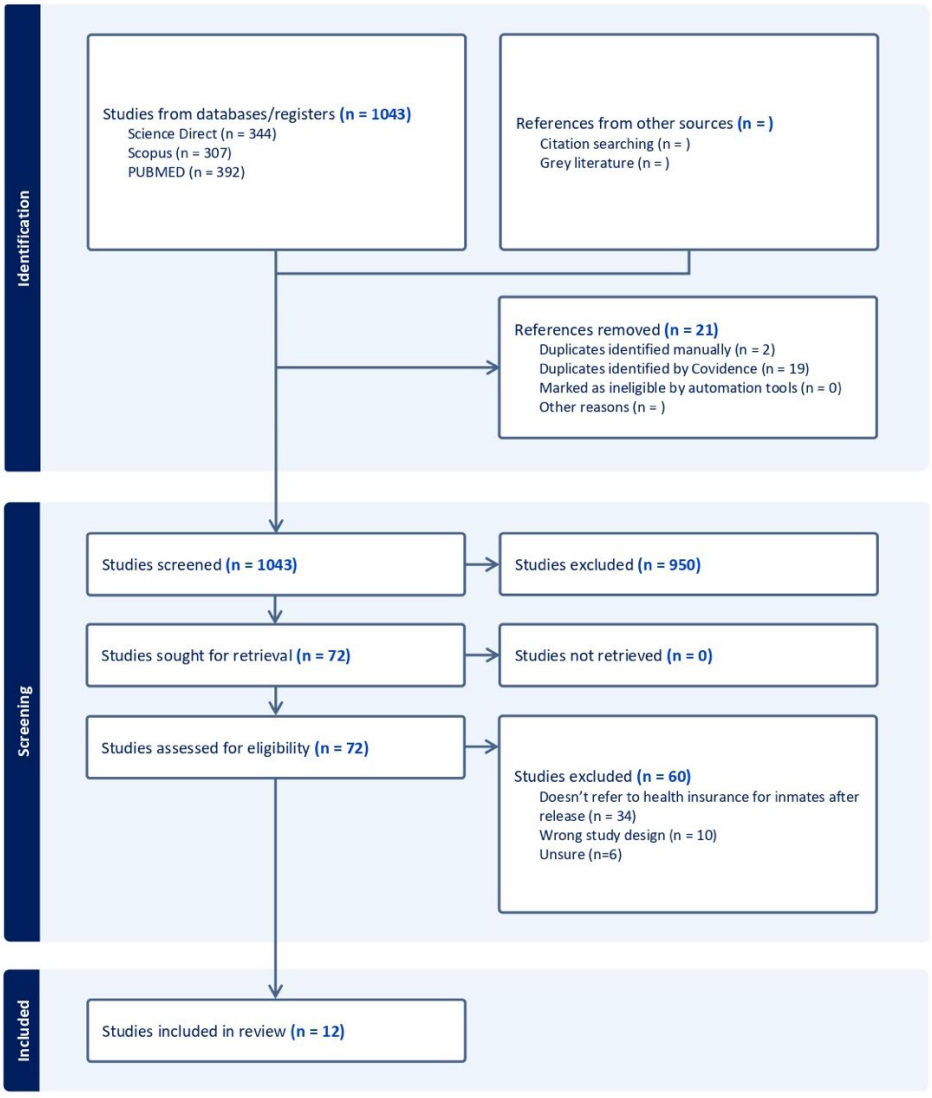

Figure 1. Publication Selection Process for Review

Stage 5: Collating, Summarizing, and Reporting the Results

The findings from the included studies were synthesized using descriptive and qualitative methods. The results were presented in tabular or descriptive formats to align with the aims and scope of the review. Additionally, this review revealed and discussed gaps in existing literature. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews checklist was utilized.[20,21]

Results

Table 2. Characteristics of Included Studies

Author	Publication Year	Journal Name	Custodial Setting	Health Insurance Care Utilization	State/ Country	Outcomes
Kouyoumdjian *et al.*[22]	2018	PLOS One	Prison	Accessed data in the OHIP database for ambulatory care visits, for emergency department (ED), and for psychiatric reasons.	Canada	This study compared healthcare utilization rates between individuals released from prison (N=48,861) and the general population (N=195,444). Results showed significantly higher utilization rates among former prisoners across all healthcare categories (ambulatory, emergency, medical-surgical, psychiatric), both during incarceration and post-release.
Balio *et al.*[26]	2023	Psychiatry Services	Prison	Frequent care health insurance utilization, with 47,5% of individuals who enrol in Medicaid after release having an ED visit and 39,9% having a subacute behavioural health visit within 120 days of initiating coverage	Indiana	Within 120 days of coverage, over 80% had a health encounter, with nearly 50% using the ER. Early Medicaid enrolment post-release was associated with higher behavioral health needs and greater sub-acute care utilization.
Leaman *et al.*[32]	2017	HHS Public Access	Prison	Prisoners using Medicaid enrolment resulted in more people enrolling in Medicaid and using mental health services.	USA	This is unique research with great value for supporting prison reform in England. It will also be of international interest due to the paucity of peer-reviewed literature on the impact of commissioning models on healthcare or health outcomes.
Fry *et al.*[23]	2020	HHS Public Access	Prison	The impact of Medicaid expansion on jail-related outcomes, particularly recidivism rates, shows mixed results, including increased access to healthcare services, an impact on recidivism, and better insights into health policy.	New York	This analysis examines how Medicaid expansion influences recidivism rates. Two case studies report reductions in recidivism, indicating potential benefits, while a third study observes an unexpected rise in jail-based recidivism following expansion.
Calais-Ferreira *et al.*[24]	2022	BMC Health Services Research	Prison	After release: Medicare (universal health insurance scheme). Primary care encounters included services provided by primary care doctors and nurse practitioners.	Australia	The quality of primary health facilities is defined by continuity of care and extended consultations. Outcomes use the Usual Provider Continuity Index (UPCI), Continuity of Care (COC) Index, and receipt of at least one extended primary care consultation (>20 min).
Carroll *et al.*[28]	2017	Medical Journal of Australia	Prison	Primary care attendance (defined by Medicare item description). GP attendance included services provided directly by GPs, practice nurses, or Indigenous health workers on behalf of a GP.	Australia	Rates of GP attendance during the 2 years after prison release.
Matsumoto *et al.*[31]	2022	The International Journal on Drug Policy	Prison	The study examines the perspectives of jail staff on coordinating post-release care for individuals with opioid use disorder, identifying barriers and facilitators to community Medications for Opioid Use Disorder (MOUD) linkages and highlighting the importance of partnerships and health insurance reinstatement for seamless care coordination.	USA	This study highlights factors that influence Medications for Opioid Use Disorder (MOUD) care coordination for people leaving incarceration. Effective reentry planning depends on early preparation, skilled staff, and strong collaboration. Proactive strategies, such as bridge scripts and resource lists, are needed to address unexpected release times. Strong community partnerships and rapid insurance reinstatement are also crucial.

Author	Publication Year	Journal Name	Custodial Setting	Health Insurance Care Utilization	State/ Country	Outcomes
Patel *et al.*[17]	2022	Journal of Substance Correctional Health Care	Prison	A process for establishing and reestablishing health insurance while incarcerated and for making first appointments in preparation for discharge from a large urban jail.	USA	Too often, those receiving mental health care in prison lose coverage and medication upon release. This study partnered with the Philadelphia Department of Prisons to enroll women in Medicaid before release and schedule their first doctor's appointments, ensuring uninterrupted treatment.
Albertson *et al.*[29]	2020	American Journal of Public Health	Prison	This study highlights how the disruption of Medicaid coverage upon incarceration creates substantial barriers to healthcare access for formerly incarcerated inmates.	USA	Maintaining or quickly reinstating Medicaid coverage upon release is essential to improving inmates' health outcomes, according to the study.
Easter *et al.*[27]	2024	PLOS One	Prison	Access to health insurance alone does not increase primary care use. Medicaid expansion must be paired with tailored support to encourage engagement, as engagement is just as important as access. Simply providing coverage does not ensure people will seek or use primary care, so additional strategies are needed to close the gap between insurance and actual healthcare engagement.	USA	Individuals involved with jails have low and inconsistent primary care use and often rely on the ER. To improve engagement, especially for those with chronic illnesses and frequent bookings, they must be quickly linked to primary care and insurance. Medicaid expansion should offer tailored support to overcome barriers, requiring immediate, targeted stakeholder action.
Wurcel *et al.*[25]	2024	Emerging Infectious Diseases	Jail dan Prison	The MIEP limits federally funded care for incarcerated people; states pursue Section 1115 waivers to improve transitional and infectious disease care	USA	This collaboration between the Massachusetts Sheriffs' Association, Massachusetts Department of Correction, Executive Office of Health and Human Services, and UMass Chan Medical School aims to improve infectious disease care before and after incarceration. The partners seek to equip criminal justice and healthcare stakeholders with tools to advance Medicaid policy, focusing on strengthening infectious disease treatment and prevention in jails and prisons by removing MIEP barriers through Section 1115 waivers.
McNamara *et al.*[30]	2024	Journal of Substance Use and Addiction Treatment	Correctional Facilities	Health insurance can act as an enabling factor for accessing outpatient care. It can reduce financial barriers, allowing individuals to afford necessary treatment, medications, and therapy.	USA	Even with health insurance, these persistent disparities in post-incarceration outpatient care underscore the urgent need for targeted policy solutions for adults leaving prison with a history of substance use.

Table 2 indicates varied health insurance utilization among prisoners after release. Studies demonstrated varying levels of health insurance utilization post-release; some individuals accessed emergency services, subacute behavioral healthcare, and mental health services, while others experienced difficulties in accessing primary care facilities. Barriers to accessing healthcare after release from prison include difficulties in enrolling in health insurance programs due to unclear residency status, negative social perceptions, and the absence of financial or institutional support, complicating navigation of complex healthcare systems and disrupting continuity of care (COC).[17,33,34] The studies consistently showed that formerly incarcerated individuals face substantial health needs upon release, often exceeding those of the general population. Kouyoumdjian *et al.* found significantly higher utilization rates across all healthcare categories (ambulatory, emergency, medical-surgical, and psychiatric) among former prisoners compared to the general population during and after incarceration.[22] In Indiana, reports revealed that over 80% of individuals with Medicaid enrollment post-release had a health encounter within 120 days; approximately 50% of these were for emergency care,[26,27] indicating a lack of consistent primary care engagement. Mental health and substance use disorders are prominent challenges, emphasizing that early Medicaid enrollment after release was associated with greater behavioral health needs and greater subacute care utilization.[26] Although mental health issues are often managed during incarceration, inadequate medical coverage and medication access upon release create significant disruptions.[17]

Albertson *et al.* and Patel *et al.* demonstrated that the disruption or lack of Medicaid coverage upon incarceration creates substantial barriers to accessing necessary healthcare after release, including medications and mental health

treatment.[17,29] The table underscores the critical need for improved healthcare access and support services for individuals transitioning from prison to the community. Addressing these challenges requires an approach that involves collaboration between correctional systems, health providers, and community-based organizations. Several barriers impede effective healthcare utilization for prisoners. The disruption of Medicaid coverage upon incarceration.[29] Although Medicaid expansion aims to improve access, access alone is insufficient.[27] These studies indicated that low and inconsistent primary care use persists among individuals with prison involvement, indicating the need to focus on engagement strategies and insurance provision. Additionally, financial barriers are significant. Health insurance can act as an enabling factor by decreasing these barriers.[30] These studies showed that differences in outpatient care utilization exist for individuals with a history of substance use, indicating that insurance alone does not guarantee equitable access or utilization.

Discussion

This scoping review examined health insurance utilization among individuals after release from prison. The review synthesized findings across studies, analyzed the methodologies and key outcomes, and identified critical gaps in the existing literature. In recent years, evidence in this field has significantly expanded, with the majority of the included studies published since 2017. Across the United States, Australia, India, and Canada, variations in health insurance patterns and healthcare utilization reflect differences in national policies and system integration; these affect disparities in coverage continuity, access to primary and mental health facilities, and post-release support, shaping overall health outcomes among formerly incarcerated individuals.[25,35] Among these countries, the United States provides the most detailed policy context; the disruption of Medicaid coverage during incarceration, largely driven by the Medicaid Inmate Exclusion Policy (MIEP), creates substantial care gaps upon release.[25,36] In addition to policy differences, formerly incarcerated individuals face persistent barriers to healthcare access, including administrative difficulties in insurance enrollment and residency status challenges,[33] social stigma from healthcare providers and mental health discrimination, financial instability and lack of institutional support,[34] and fragmented coordination between correctional and community care systems, all of which further disrupt continuity and equity in post-release health outcomes.[17]

Furthermore, structural and systemic barriers compound these issues. In states that have not adopted Medicaid expansion under the Affordable Care Act, individuals face greater difficulty accessing coverage. Bureaucratic inefficiencies, such as limited data sharing between correctional institutions and Medicaid agencies, delay reactivation processes and contribute to administrative burdens.[25,37] Moreover, the lack of prerelease enrollment assistance and limited Medicaid categories impede prompt access to care after incarceration, as many individuals encounter delays in reinstating suspended coverage.[29] Housing instability, unemployment, and discrimination are social determinants that further restrict healthcare access and exacerbate disparities, leading to poorer outcomes and untreated mental health or substance use issues.[38] Aligning with the World Health Organization (WHO) Prison Health Framework and Nelson Mandela Rules, the integration of prison and primary health care systems is critical to ensure continuity and equity in post-release care.[39]

In addition to structural barriers, individuals face personal and contextual challenges to securing and maintaining healthcare coverage post-release. Many experience low health literacy and face difficulties navigating complex healthcare systems without adequate support.[7] Furthermore, high rates of substance use disorders and untreated mental health conditions increase the risk of poor health outcomes. These challenges are exacerbated by the stigma associated with incarceration, race, and behavioral health diagnoses, which often deters individuals from seeking care or fully engaging with healthcare providers. Limited social support networks and unstable post-release environments complicate continuous engagement with health services.[40]

One of the most pronounced consequences of inadequate healthcare continuity is an increased reliance on Emergency Department services after release. A previous study has demonstrated that recently released individuals, particularly those enrolled in Medicaid, frequently utilize Eds, often as a substitute for primary care.[26] This overutilization shows unmet healthcare needs and challenges in navigating the healthcare system. Additionally, in this population, primary care utilization remains low despite high levels of chronic disease and behavioral health conditions.[27] Although expanding insurance coverage, especially through Medicaid, has been associated with increased use of outpatient and mental health services, insurance alone is not sufficient. Structural and social barriers such as administrative complexity, housing instability, stigma, and financial constraints continue to impede care access.[29,30] Moreover, disparities in the quality of care by insurance type further complicate healthcare delivery. Individuals with Medicaid often receive more consistent care than the uninsured; however, their health outcomes may differ from those with private insurance.[27]

To address these interesting barriers and challenges, policy interventions that promote coverage continuity are crucial. Suspending rather than terminating Medicaid during incarceration allows for faster reactivation and reduces administrative delays.[35] Furthermore, integrated care models that coordinate services between correctional facilities and community-based healthcare providers can promote more seamless transitions, especially for individuals with complex care needs.[27] Such models are associated with better health outcomes and have the potential to reduce recidivism and healthcare system costs.

This review was limited by the heterogeneity of included studies, including differences in methods, populations, and outcomes, and by the lack of standardized reporting, which restricts generalizability and prevents quantitative synthesis. Nonetheless, the patterns observed highlight the need for policy reforms and coordinated care. Future research should develop a standardized framework for measuring health insurance utilization among formerly incarcerated individuals, with clear variables on coverage status, service use, medication continuity, and financing. Consistent definitions and reporting will improve comparability and support stronger analyses. Incorporating indicators aligned with health system performance, such as quality, continuity of care, and cost-effectiveness, would further strengthen policy evaluation. Greater investment in prerelease insurance enrollment, post-release navigation, and cross-sector coordination is essential. Addressing structural factors, including housing, employment, and social integration, is also critical to ensure expanded coverage leads to better health outcomes and successful reintegration.

Improving health insurance continuity, particularly through Medicaid, is a critical component in supporting the health and reintegration of formerly incarcerated individuals. Holistic and systemic approaches that combine policy change, service coordination, and social support are warranted to reduce health disparities, improve public health outcomes, and lower recidivism rates in this vulnerable population. Policy changes that ensure continuous insurance coverage, support integrated care models, and facilitate reentry planning are vital for improving health outcomes and reducing recidivism among this vulnerable population. As the intersection of healthcare and the criminal justice system continues to gain attention, targeted interventions and collaborative policymaking are essential in promoting health equity and social reintegration for formerly incarcerated individuals.

Conclusion

This scoping review underscores the critical role of health insurance systems in ensuring access and COC for individuals transitioning from incarceration, with national policy differences shaping post-release health outcomes. Persistent barriers, including administrative complexity, housing and employment instability, stigma, and weak coordination between correctional and community health sectors, hinder equitable care. Addressing these challenges requires integrated policy strategies that maintain coverage during incarceration, support prerelease enrollment, and strengthen cross-sector collaboration through models such as the Transitions Clinic Network. Future research should use standardized longitudinal data and align national reforms with global frameworks, such as the WHO Prison Health Framework and the Nelson Mandela Rules, to promote health equity.

Abbreviations

JIB: Joanna Briggs Institute; COC: continuity of care; WHO: World Health Organization.

Ethics Approval and Consent to Participate

Not applicable.

Competing Interest

The authors declare no conflict of interest.

Availability of Data and Materials

Not applicable.

Authors' Contribution

IK developed the research concept, designed the methodology, supervised data collection, conducted data analysis, interpreted the results, and contributed to drafting the manuscript. MA and LD provided critical revisions, conducted literature synthesis, and supported the editing of the manuscript.

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