The fastest growing population group in America’s state and federal prisons is those age 65 and older. As these individuals are released back into society, they often face significant medical and financial needs. Public benefits can help to meet these needs, but connecting soon to be released prisoners to these programs can be laborious and challenging.

The following report summarizes the efforts of a pilot Benefits Enrollment Center (BEC) supported by the National Council on Aging (NCOA) to work specifically with Medicare-eligible prisoners in Connecticut who were re-entering society and needed to access benefits.

**Post-prison Health Care Options**

Accessing appropriate medical coverage upon release from prison is an important component of a successful transition to the community. The general prison population is 39-43% more likely to have at least one chronic health condition. In addition, 1 in 5 prison inmates has a serious mental illness. Insufficient access to prescriptions and medical care following incarceration can result in increased emergency room visits, hospitalizations, and a return to prison.

The Affordable Care Act fueled efforts to help people re-entering the community after incarceration access affordable health coverage. States that expanded Medicaid benefits can discharge individuals aged 18 to 64 with a new category of Medicaid. Others enroll them into Qualified Health Plans through the Health Insurance Marketplaces with tax credits and cost-sharing assistance. Unfortunately, these plans are not available to adults aged 65+ or those with Medicare.

Eligibility for Medicare poses unique challenges for this population. Social Security retirement and disability benefits (SSDI) are connected to Medicare Part A, which requires individuals to have sufficient work credit hours to receive premium free. Additionally, Part A cannot be refused without jeopardizing income from Social Security. For those formerly incarcerated adults who qualify for both Medicare and Medicaid, Medicare always pays first, and Medicaid never pays for prescriptions that are available under Medicare Part D.

For people who received Social Security benefits prior to incarceration, those payments get suspended when incarceration exceeds 30 days. This often means they have no income to pay for Medicare Part B while incarcerated. Additionally, individuals who were enrolled in a Medicare Savings Program (MSP) to pay their Part B premium prior to incarceration get disenrolled from MSP when they enter prison. If an individual fails to pay the Part B premium for more than three months, Social Security ends the active Medicare Part B status. This results in Medicare beneficiaries being released from prison without outpatient coverage, and with no Special Enrollment Period to receive that coverage promptly. Instead they must wait until the General Enrollment Period (Jan. 1 – March 31), with coverage beginning July 1.

Without Medicare
Part B, they cannot enroll into Parts C or D, and are prohibited by federal law from purchasing other insurance considered to be a duplication of Part A.

**Overview of the Connecticut BEC Pilot**

The Connecticut Benefits Enrollment Center (BEC) pilot was located within three prison sites in Connecticut: Cybulski (a re-integration unit for men), Osborn (for male prisoners with health issues) and York (the only female prison in the state). The goal was to meet with prisoners eligible for Medicare and provide education and assistance with applying for Medicaid, MSP, and the temporary Medicare Part D plan (LINET) for those eligible for the Part D Low-Income Subsidy (LIS/Extra Help). The BEC would follow up upon release to assist with other benefits and ensure federal benefits were in place. The BEC also worked to provide education and tools to prison re-entry staff and discharge planners to help Medicare beneficiaries once the pilot ended.

**Success Story**

On Aug. 30, the BEC received a referral from a discharge planner in another facility assisting “Dean”, a 58-year-old inmate scheduled for release on Oct. 4. Dean has been deaf and mute since childhood, has limited education, and is an insulin dependent diabetic. Dean lost his housing upon incarceration and anticipated would be homeless upon release.

Prior to his incarceration, Dean received $1,200 in SSDI monthly and was fairly independent. He worked at a laundry and drove a car. The BEC learned Dean had Medicare since 1999, but was removed from Part B benefits in the previous year for failing to pay premiums. He was placed onto Medicaid during his incarceration, which triggered enrollment into LIS. He was first enrolled into LINET and then auto-enrolled into a Medicare Part D plan despite being out of network. The BEC explained to the discharge planner that Dean’s SSDI benefits were suspended, but he would not need to re-apply; he would only need to show proof of his release for reinstatement. Since Dean would need special accommodations, the BEC reached out to the Social Security office to schedule an advanced appointment upon his release.

The discharge planner was provided information on getting Dean’s free mobile telephone, Safelink, reinstated. On Oct. 2, two days before his release, the BEC contacted the discharge planner through secure email, reviewed information about Dean’s Part D coverage, and explained the process for the pharmacist to bill the plan. An explanation of cost-sharing responsibilities was also given. The Medicare database already reflected an active status reinstating Dean’s Part B, which would mean he would not experience challenges obtaining his Part B-paid diabetic supplies upon release. The BEC offered to review his medications to ensure his Medicare Part D plan would be best for his prescriptions.

**Process for starting a BEC within the prison**

The CT State Department on Aging partnered with the Department of Correction (DOC) and established a Memorandum of Understanding that spelled out the needs of the BEC within the prison setting, and commitment of BEC staff to follow all DOC protocols.

The BEC submitted Medicaid applications online on behalf of prisoners who signed a written consent through a partnership with the State Medicaid Department. The online applications allowed for faster processing, eliminated the need to transport materials in and out of the prison, and permitted the BEC to see the status of applications submitted.

A state email address allowed for secure communication between the Social Security Administration, state Medicaid office, the BEC Statewide Coordinator, and contractor working with the BEC. It also afforded an opportunity to obtain
access to reference materials stored within the state email folders and email notes of interactions for easier reference.

Lessons Learned/Challenges

Delays with the process

The BEC experienced significant delays establishing the project in the prison. The signed Memorandum of Understanding between the BEC and the DOC took much longer than anticipated. Once inside the prison, the most significant challenge for the BEC pilot was obtaining good referrals. DOC was successful at identifying individuals eligible for Medicare due to age, but could not identify younger adults who may be eligible due to disability because they had no record of who had SSDI or Medicare. They referred individuals based on their health utilization or need for accommodations, which often resulted in referrals for individuals who did not have sufficient work credits for Medicare or SSDI.

Access to prisoners and resources

Access to prisoners was prohibited during lock downs or certain times of the day when prisoners were required to report to their unit. Certain sections of the prison did not have internet access for prisoners restricted to these units for psychiatric or behavioral issues. The BEC had access to telephones to call out, but it was challenging to receive calls. Some male inmates were moved to different prisons before they could be seen by the BEC. This was not an issue for women since there is only one prison for women. The date of release was very fluid, since an early release is possible based on good behavior. The BEC found most prisoners provided reliable information on the actual date of release.

Since personal cellular phones were prohibited, referrals coming from the community were primarily relayed through email from the State Department on Aging’s toll-free line to the BEC contractor. Most community referrals were typically crisis calls for an inability to access medications. The BEC developed a protocol for staff answering the telephone. A LINET brochure was provided as guidance for pharmacists billing LINET when the BEC was not immediately available for assistance.

Benefits access issues facing prisoners soon to be released

Inmates released from prison are usually eligible for expedited Supplemental Nutrition Assistance Program (SNAP) benefits since they do not receive Social Security benefits for the first month of release. Unfortunately, according to SNAP rules, they are ineligible to apply while they are in an institution. Without a Prisoner Pre-Release Waiver, individuals must apply when they are released. Since going in person is the fastest route for individuals without computers or internet, it creates unnecessary steps for individuals who also must go to Social Security to get their retirement or SSDI benefits reinstated.

It was the expectation of the BEC that education of re-entry staff and discharge planners would resolve access issues for Medicare beneficiaries at re-entry. However, system issues still result in ongoing challenges for this population. Since the state is responsible for the medical care of a prisoner in state prison, individuals are removed from a Medicare Part D plan for being out of network. States can temporarily enroll individuals into Medicaid if they receive care in a hospital setting, which triggers enrollment into LIS. That enrolls prisoners into LINET or auto-enrolls them into a Medicare Part D plan after two months. If the status of prescription benefits is uncertain at release, it is difficult to provide direction to prisoners, discharge planners, or re-entry staff on how best to direct the pharmacist to bill for medications.
Upon release, individuals enrolled in MSP can obtain Part B benefits on the date the state agrees to pay those benefits. However, information for the Part B buy-in is sent electronically once a month in CT, and Social Security does not reinstate benefits until it receives the state’s buy-in agreement. Consequently, providers cannot bill until this is in place, which may be a month or more.

Recommendations for Similar Agencies Working with This Population

- Anticipate a long planning process. Prisons have their own culture; it takes time to build trust with staff and to understand your role.
- Articulate the benefit for the prison staff so they do not view your contributions as extra work for them, but as a resource.
- If working within the prison is not feasible, consider a pre-arranged conference call with individuals scheduled for release. This will help to build rapport, to get needed releases and to help them with follow-up upon release.
- When possible, request an invitation to attend pre-release group presentations at the prison.
- Work with the DOC to request a data exchange with Social Security so that Medicare beneficiaries, or those on SSDI, can be identified. Until a data exchange can be arranged, include this information in the intake protocol and computer system.
- Consider working with your state to apply for a waiver with USDA to process SNAP applications before release from incarceration.

References


3. The Limited Income Newly Eligible Transition (LINET) program ensures that individuals with LIS who are not yet enrolled in a Part D drug plan are still able to obtain immediate prescription drug coverage. Learn more at: www.humana.com/pharmacy/pharmacists/linet


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