An Unsuspecting American With No Medicare Coverage—Me!

Health Affairs 21, no.6 (2002):202-206
An Unsuspecting American With No Medicare Coverage—Me!

The United States is creating coverage gaps faster than it is filling them.

by Gordon Schiff

Most Americans take it for granted that if they work hard their whole lives, Medicare will be there to cover their health care costs after they turn sixty-five. But that’s not always true. I have a patient who discovered too late that she wasn’t covered by Medicare and through her experience found out that I was in the same boat.

The story begins with a patient I’ll call Ms. Williams, a retired telephone operator at Chicago’s Cook County Hospital, where I have practiced medicine since 1976. I had helped her in the past with her diabetes but had not taken care of her for several years until she visited me last May. She entered my exam room with one chief complaint. “It’s not about my health,” she began, “it’s that I’ve lost my Medicare insurance.” I questioned how this was possible, knowing that she had retired the previous December after turning sixty-five. “All citizens over sixty-five are covered by Medicare,” I told her.

Her response came as a surprise. Ms. Williams lamented that Cook County (like about a quarter of the nation’s counties, which I learned later) did not deduct Social Security taxes from the paychecks of its employees who were hired before 1986. “If you don’t pay into Medicare through a share of those taxes over your career, you’re not covered by Medicare at age sixty-five,” she explained. According to Ms. Williams, many of her fellow county employees qualify for Medicare coverage by virtue of a spouse or a sufficiently long work stint with another employer. Others, like her, fall through the cracks. In tears, she related the nightmare of her confusion. She described her shock at showing up for a diabetes-related eye appointment that she had scheduled for a few weeks after her retirement, when she “would finally have time” to go. “The HMO eye doctor’s office turned me away, saying that I was no longer insured,” she told me. “So much for preventive medicine and continuity of care from an HMO,” she added in disgust.

Gordon Schiff, gdschiff@aol.com, is a practicing internist at Cook County Hospital in Chicago and director of clinical quality research in its Department of Medicine. He is also a past president of Physicians for a National Health Program and associate professor of medicine at Rush Medical College. The author thanks Craig Havighurst for editorial assistance.
Confused

Ms. Williams’s runaround had only just begun. By the time she came to see me, she had made dozens of phone calls and was still bewildered about her insurance status. She believed that she was still uninsured and would be uninsured for the next fifteen months. “I have to pay for Medicare out of my retirement savings, but even then it won’t take effect until a year from July,” because she had missed the last enrollment window, and coverage applied for in the next enrollment period wouldn’t begin for more than a year.

Instead of paying smaller monthly amounts into the Medicare fund via payroll deductions during her working years, as most U.S. workers do, Ms. Williams has to purchase Medicare coverage out of pocket. The price is currently $4,476 a year for a single person—a steep sum for Ms. Williams and many seniors living on fixed retirement incomes. This 2002 rate derives from the $319 Medicare Part A (hospital insurance) monthly premium, based on what an average senior costs Medicare, plus a $54 per month premium for Part B (for outpatient and physician services—a premium heavily subsidized by federal taxes).

Later I found out that although Ms. Williams didn’t realize it, in theory she did have health insurance—the county pension insurance plan (for which the fund pays 60 percent of the premium, the retiree the rest). This plan is partially subsidized by the pension fund and should have automatically provided her coverage upon retirement. But Ms. Williams said that because of bureaucratic mix-ups resulting from being unable to produce legal documents proving she was no longer married (she’d been divorced since 1955!), she received neither health insurance nor pension income for the first four months after retirement.

As this bizarre story unfolded in my exam room, I realized with growing discomfort that I was in a similar situation. Both my wife and I have been Cook County employees since the 1970s. Neither of us was ever informed that our taxes weren’t being applied to future Medicare coverage. I consider myself something of an expert on national health policy and problems of the uninsured, yet I was clueless about my own lack of Medicare coverage. I knew that as public employees we did not pay or receive Social Security, but we naïvely failed to realize that this also meant no Medicare benefits. Later I polled three other physician colleagues whose spouses also work at the hospital; they too were unaware of their lack of future Medicare coverage.
No-Man’s Land

Nobody knows exactly how many people nationwide fall into this no-man’s land of uninsured public employees. The Social Security Act originally excluded state and local government employees from coverage because of uncertainty concerning whether the federal government could legally tax state employers. Many of the earlier holes in the Social Security insurance legislation have been closed in the ensuing decades. But this ironic anomaly—that public employees are excluded from our nation’s public pension and health insurance—remains in place to varying degrees, in various states, for various workers. The coverage gap has been perpetuated, in part, by public employees and their unions, who often mistakenly believe that the status quo can offer them a better deal. Some think that not having Social Security deducted from their paychecks will allow them to retire early enough to take on another job and therefore reap the benefits of both their state or county pensions and Social Security benefits from a future (or past) job.

In 1986, motivated in part by a desire to increase the funding base for the Medicare program, Congress eliminated the Medicare exclusion of public employees, but only for those hired after 1986. Thus, new Cook County employees are automatically enrolled in the payroll deduction program and are covered by Medicare at age sixty-five. Learning this, I called the Social Security Administration and the county benefits manager to find out how my wife and I could sign up for payroll contributions and Medicare coverage. I found out that it is illegal for public employees who began work before 1986 to contribute and participate in the regular Medicare payroll deduction program.

Official estimates project that the magnitude of this problem is relatively small—only 1.5 percent of the forty million Americans over age sixty-five lack Medicare coverage. But such figures do not account for public employees who are covered because they individually purchase Medicare out of pocket. And no doubt, the figure undercounts undocumented immigrant workers, who are not legally eligible for the Medicare benefits that are subsidized by their wages.

Perhaps I’m looking at this the wrong way. In the spirit of current proposals to permit workers to opt out of compulsory contributions to public programs such as Social Security and Medicare and privately invest their nest eggs in the stock market, maybe I should view this as an opportunity to do better for myself. But over the past several years I have watched my modest contributions to socially responsible mutual funds plunge in value while the 5 percent interest rate of my certificates of deposit has been overtaken by double-digit medical inflation rates.
One doesn’t have to be a financial wizard to question the wisdom of this strategy for the average working person who wants secure and affordable health insurance at retirement.

The Cook County pension plan does offer health insurance now, but there is no guarantee that this will continue in the future or that it will be affordable for the typical retiring worker. Premiums have risen sharply in recent years, in part because of the higher risk pool of older retirees who avail themselves of the plan. I recently read about the woes of the Illinois Teachers Retirement Insurance Plan. Illinois teachers constitute another large group of public employees who are excluded from Medicare deductions. Their health insurance fund faces a 54 percent increase in premiums and is in a severe fiscal crisis because the state will not cover the increase. One of our recently divorced neighbors in her late fifties who teaches at a community college has just become aware of her own Medicare-less dilemma. To earn the extra “quarters” of salary and deductions required for Medicare eligibility, she has taken on two moonlighting teaching jobs. She now instructs students at three different schools, which is exhausting for her and shortchanges her students.

**What Road To Take?**

Ms. Williams now faces more than a year’s wait until her Medicare coverage takes effect and then at a cost that may drive her into poverty. What are my options? Now that we know we’re not covered by Medicare, my wife or I could leave Cook County Hospital to work at another job for the next ten years to earn Medicare coverage. We could seek additional part-time work like our teacher friend. Or at retirement we could begin annual payments of nearly $9,000 to buy into Medicare, a fee that we physicians are better able to afford than Ms. Williams can (and that will surely be much higher when we turn sixty-five in fifteen years).

But we don’t want to be forced to take other jobs or deal with brokering our own private health insurance and investment schemes. Instead, we’d like to keep working at the public hospital while contributing to and benefiting from the nation’s public insurance plan for seniors.

We know that Medicare has its inadequacies such as lack of prescription drug coverage and rising deductibles and copayments. But we are eager to cast our lot with our fellow senior citizens by being part of the program and even joining their struggles to remedy its shortcomings. Compared with the instability of private-sector alternatives, Medicare is the only route that makes sense to us. In retrospect, we should have been more savvy.
about the fact that by not paying FICA taxes, we were excluded from Medicare as well as Social Security benefits. But my wife and I paid substantial contributions into the pension plan, first as residents, then as attending staff physicians. We correctly assumed that doing so was in lieu of Social Security but failed to realize the consequences.

Simplicity Is All

Our nation’s health care system is riddled with exclusions, exceptions, and programs based on special circumstances for determining eligibility. Even reforms such as the State Children’s Health Insurance Program for uninsured kids, COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) for continuing coverage after job loss, and the Health Insurance Portability and Accountability Act of 1996 for protections against certain types of insurance discrimination for preexisting conditions further complicate an already complex and baffling situation. What we need is a simple universal system where everyone contributes and everyone is covered.

As we learned, even Medicare—the closest thing our country has to universal coverage—isn’t truly universal. And although Medicare’s public employee loophole has now been plugged for new workers, other gaping holes exist throughout the system. Still falling into the void are millions of uninsured workers, those who are between jobs and unable to afford insurance, and the small number of us who are not covered by Medicare when we turn sixty-five. It is unconscionable that a wealthy country such as ours is creating such gaps faster than it is filling them.