



## Medicare, COBRA and Implied Coverage: A False Equivalency

Conflicts between Medicare and COBRA rules have led to confusion about which system, and which set of rules governs eligibility for coverage and how responsibility for payment of health care benefits for eligible individuals is determined. These conflicts have left some Medicare eligible individuals subject to Medicare premium penalties and delays in coverage, mistakes in benefit payment, and claims for recovery of mistakenly paid COBRA benefits.

**Example:** Mary Smith received a demand from her COBRA carrier for repayment of \$150,000 for health care expenses the carrier had paid after she stopped working. The carrier alleged that while she was still working she became eligible for Medicare on her 65 birthday and should have enrolled for Medicare benefits. The carrier alleged that Medicare should have been her primary health coverage once she stopped working and COBRA should have paid secondary benefits, not the \$150,000 the carrier had paid for primary coverage.

This demand for repayment of primary benefits was based on her eligibility to enroll in Medicare or “implied coverage.” Several recovery actions like this one have been reported to a California advocacy program,<sup>1</sup> and the number of these actions has been steadily increasing over the last several years as more people continue working past their 65<sup>th</sup> birthday when they first become eligible for Medicare.

This paper discusses current conflicts in federal enrollment rules, and the quandary faced by individuals who fall into this quagmire of conflicts.

### Implied Coverage and Recovery of Paid Benefits

COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1996, prohibits carriers from refusing or terminating coverage on the basis that an individual is eligible for Medicare as long as enrollment for benefits occurred prior to their COBRA coverage. If enrollment occurs after COBRA has begun COBRA can be terminated.

Implied coverage is a concept that insurers and health plans are using to recoup primary payment of health care expenses from former employees who were *eligible* for Medicare but *not yet enrolled* in Medicare. However, being eligible for Medicare does not constitute having activated those benefits.<sup>2</sup> And, a Medicare eligible individual is not compelled to enroll in Medicare when eligible to do so.

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<sup>1</sup> The Health Insurance Counseling Program (HICAP) California HICAP is part of a national network of **State Health Insurance and Assistance Programs (SHIP)**. SHIP is a Federal grant **program** that helps **States** enhance and support a network of local **programs**, staff, and volunteers. ... The Centers for Medicare and Medicaid (CMS) administers the **SHIP** grant **programs** nationally.

<sup>2</sup> §54.4980B-7 Duration of **COBRA** continuation coverage, Q-A 3..... A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. **Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.** (Highlight added)

In fact, a Medicare eligible individual working for an employer that is subject to Medicare's Secondary Payer rules is protected from application of late enrollment premium penalties while employed and during an 8-month window of eligibility following separation from employment.<sup>3</sup>

## Background

Medicare eligibility begins at age 65 unless a person qualifies for benefits earlier as a result of a disabling physical or medical condition. And, for decades, Social Security eligibility for full retirement benefits also began at age 65. However, beginning in 1983, the age of eligibility for full Social Security retirement benefits has increased by two months each year and will end at age 67 in the year 2027. As a result, the ages of eligibility for Medicare and full Social Security retirement benefits no longer match. While an individual can enroll for early reduced Social Security retirement benefits at age 62, they will not be eligible to enroll in Medicare until age 65.

Because of the disconnect between the age of eligibility for Medicare and the age of eligibility for full Social Security retirement benefits an employed person turning 65 often has no knowledge about when or why to sign up for Medicare. Many employees pass their 65<sup>th</sup> birthday without even knowing they are eligible for Medicare benefits before they are eligible for full Social Security benefits.

Even when an employed individual knows they are eligible for Medicare there is no reason to sign up since they have employer health benefits. Signing up for Medicare benefits while working would require payment of an additional premium and Medicare would only provide secondary coverage to their employer benefits.

## Transitioning to COBRA

Medicare Secondary Payer rules prohibit employers from treating a Medicare eligible employee differently than other employees in regard to group health benefits or continued employment at age 65. Under federal law an employer group health plan is primary to Medicare when the employer has 20 or more employees and a Medicare eligible individual is 65 or older (100 or more employees when the Medicare eligible individual is eligible for Medicare due to a disabling condition). When an individual has permanent kidney failure known as ESRD an employer plan of any size is required to be primary during a 30-month coordination of benefit period.

The Department of Labor's Model COBRA Notice does not mention Medicare eligibility, Medicare eligibility or enrollment, or any effect that Medicare has on COBRA benefits in regard to primary and secondary coverage. Employer HR personnel rarely understand the interaction between Medicare and COBRA, and are often only aware of the requirement to pay primary benefits when a Medicare beneficiary has permanent kidney failure (ESRD) and is enrolled for Medicare benefits. Neither Medicare nor Social Security notifies a person when they become eligible for Medicare benefits at age 65.

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<sup>3</sup> **NOTE:** Part B is a voluntary program which requires the payment of a monthly premium for all months of coverage. See: <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/index.html>

When a Medicare eligible individual transitions into COBRA coverage, their health care benefits are generally the same as when they were employed.<sup>4</sup> While these former employees have to pay the full premium plus an administrative fee for their COBRA benefits, the only coverage change they are aware of is an increase in their premium payment. Often they don't know that they will no longer meet the federal requirement of active employment for primary coverage of their former employer's health benefits, or that if they aren't already enrolled in Medicare that they must enroll now and activate that primary coverage.

### Enrollment Rules

There is no Medicare premium penalty imposed for delayed enrollment while an eligible individual is actively employed and covered by a group health plan.<sup>5</sup> Once active employment ends however the former employee has an eight month special enrollment window to sign up for Medicare Part B without incurring a late enrollment premium penalty, and 60 days to sign up for Part D unless COBRA coverage provides equivalent prescription drug coverage as the Medicare benefit. After this Part B special enrollment window closes an annual late enrollment premium penalty begins to accrue and the window to enroll shrinks to an annual 3-month period, January thru March. Benefits are delayed until July of the same year of enrollment.

Since most Medicare beneficiaries are eligible for premium free Medicare Part A no delayed enrollment penalty for that part of Medicare is imposed.<sup>6</sup> There is no late enrollment penalty for Part D as long as current coverage provides equivalent prescription drug coverage as the Medicare benefit.

### Order of Payment Rules

The National Association of Insurance Commissioners (NAIC) Coordination of Benefits (COB) Model Regulation explains the order of health insurance benefits payments when an individual or a covered spouse or dependent is or could be eligible for health benefits under more than one health benefit plan. Federal Medicare Secondary Payer rules do not require employer health plans to pay primary benefits when an employer has fewer than 20 employees (or fewer than 100 employees in the case of a disabling condition).

The NAIC Model Regulation prohibits insurers from reducing benefits when an individual is covered or could have been covered under another health benefit plan, except in certain very restricted circumstances. One of those restricted circumstances, amended into the Model in 1984-85, is in regard to Medicare Part B benefits.<sup>7</sup>

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<sup>4</sup> Geissal v. Moore Medical Corporation, 118 S. Ct. 1869 (1998)

<sup>5</sup> Federal law does not impose a late enrollment penalty Medicare Part B when an eligible individual is "actively employed" under the IRS definition, regardless of the size of the employer, or into Medicare Part D when employer sponsored insurance is providing Medicare equivalent prescription drug benefits.

<sup>6</sup> Approximately 35% of employers offer a Medical Savings Account (MSA). A Medicare eligible individual could face tax penalties if they sign up for Medicare and continue contributions to their MSA.

<sup>7</sup> See: <https://www.naic.org/store/free/MDL-120.pdf?13>

The NAIC language allows insurers to reduce health plan benefits when a Medicare eligible individual “is or could have been” covered by Medicare Part B. There is no mention of Medicare Part A, nor any explanation for this one very focused exception. Most states have adopted the NAIC Coordination of Benefits Model Law language or similar language.

### Application of Implied Coverage

There are currently three situations in which insurers have applied this concept of implied coverage.

The first is when a Medicare eligible individual is eligible for COBRA coverage following a qualified event.<sup>8</sup>

The second is when a Medicare eligible employee is covered under the health plan of an employer with *fewer* than 20 employees (or *fewer* than 100 when the Medicare eligible individual has a disability).

The third is when a *former employee* is covered by the health benefits of an employer or union plan and becomes eligible for Medicare years later.

In each of these three situations the Medicare Secondary Payer (MSP) rules do not require the employer’s health plan to provide primary payment of benefits, and the NAIC COB Model allows secondary payment.<sup>9</sup>

### COBRA Coverage vs Medicare

COBRA provides continuation of employer or union health benefits upon separation from employment. When a covered employee transitions to COBRA they are no longer actively employed under federal law. If a former employee is also enrolled for Medicare benefits Medicare would become primary coverage. COBRA or employer or union group coverage would be secondary coverage under current rules.

A problem arises when a Medicare eligible individual does not understand the need to enroll for Medicare, and the COBRA carrier does not know the individual’s Medicare status.

In this situation a Medicare eligible individual loses or leaves employment and is covered by COBRA. Prior to leaving employment the Medicare eligible individual *did not* enroll in Medicare and relied solely on the employer plan health benefits. The individual transitions to COBRA and continues to ignore eligibility for Medicare since the employer’s health plan benefits haven’t changed under COBRA and the individual is paying the full premium.

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<sup>8</sup> Geissal v. Moore Medical Corporation, 118 S. Ct. 1869 (1998)

<sup>9</sup> None of these situations apply when an individual is eligible for Medicare due to permanent kidney failure (End Stage Renal Disease)

In a variation of this situation a Medicare eligible individual while actively employed may have accepted Medicare Part A because this part of Medicare doesn't require any premium payment, but declined Part B and Part D because both require additional monthly premium payments and appear to duplicate the employer's existing health benefits.<sup>10</sup> The individual then transitions to COBRA and continues to ignore eligibility for Medicare because they have no information regarding the consequences of that decision.

The COBRA notice does not alert the recipient to the need for Medicare, nor does it warn the Medicare eligible individual that any problems will result due to their eligibility for Medicare. More importantly the COBRA notice fails to inform the individual of the consequences of not enrolling in Medicare. These consequences include late enrollment premium penalties, delayed coverage, and the potential financial danger of future recovery actions by the COBRA carrier. There also is no notice from Medicare or Social Security that would alert a Medicare eligible beneficiary of the need to enroll for Medicare benefits or the consequences of not doing so.

In both of the situations described above the individual no longer meets the requirement of active employment once they transition to COBRA. At some point, if the COBRA carrier has paid primary benefits and later discovers an individual's potential availability of Medicare benefits it may begin a recovery action for any COBRA benefits paid as primary benefits.

#### Small Employers With Less Than 20 Employees (or 100 if the Medicare eligible individual has a disability):

In this situation a Medicare eligible individual is covered by an employer group health plan and the employer plan has *fewer than 20* or 100 employees. Medicare Secondary Payer rules do not require the health plan to pay primary benefits, and Medicare is primary if a beneficiary is enrolled for Medicare benefits.

Some health insurers have attempted recovery of benefit payments from Medicare eligible individuals who work for these small employers but who have NOT enrolled for Medicare benefits and instead use the employer plan as their primary health benefits.

#### Large Employer or Union Plans for Retirees:

In this situation former employees who are *not* yet Medicare eligible when they retire are covered by an employer or union retiree health plan. Later, when they become eligible for Medicare, often years after leaving employment, they may not know about the need to enroll in Medicare, and the plan administrator may not know when a member becomes eligible for Medicare and be able to advise them.

While plan documents may contain information related to Medicare eligibility the plan member may have no formal notice about when they become eligible for Medicare or understand the steps they must take as a result.

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<sup>10</sup> Has contributed the appropriate number of quarters to qualify for Social Security benefits and Medicare, or is eligible to pay some or all of the Medicare Part A premium and/or Medicare Part B premium

Plan administrators often do not have information to give plan members at the time they become eligible for Medicare. A review or an audit of the plan, or a change in the third party administrator may prompt a recovery action when the former employee has not enrolled in Medicare when eligible to do so.

### Implied Coverage

The theory of implied coverage creates a “phantom benefit” that exposes Medicare eligible individuals to aggressive collection efforts by insurers and COBRA carriers.

Recovery action by insurers and COBRA carriers disregards federal criteria that eligibility does not constitute enrollment for Medicare when a Medicare eligible individual is eligible for Medicare but has not yet enrolled for benefits. Federal law clearly states: “A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being entitled to enroll in Medicare *does not constitute being entitled to Medicare benefits*” (emphasis added).<sup>11</sup>

If a Medicare eligible employee did not enroll in either Part A or Part B *prior to applying for COBRA* under current law the individual’s COBRA coverage cannot be terminated. However, in current practice, if a Medicare eligible individual leaves employment without enrolling in either part of Medicare a COBRA carrier may insist that they enroll in that program to obtain primary coverage. If a Medicare eligible individual complies and does enroll while receiving COBRA benefits the COBRA carrier can terminate coverage on the basis that their enrollment occurred *after* their COBRA coverage was effective. This is a conflict that sets up a catch 22 for Medicare eligible employees and it must be resolved.

### Recommended Actions

Conflicts between eligibility for Medicare and COBRA are certain to increase as more people work past the age of 65. The Bureau of Labor statistics show that the number of employed seniors today is the highest it’s been in 55 years. The Bureau estimates that 36 percent of 65- to 69-year-olds will be active participants in the labor market by 2024.<sup>12</sup> Employers and COBRA carriers are unlikely to be prepared for the conflicts in coverage that are certain to accompany a growing number of Medicare eligible employees having employer coverage or transitioning to COBRA. As evidence of this trend, the California state health insurance counseling program HICAP (one of the federally funded SHIPs) has had an influx of clients with demands from COBRA carriers or insurance companies for repayment of primary benefits.<sup>13</sup>

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<sup>11</sup> <https://www.law.cornell.edu/cfr/text/26/54.4980B-7>

<sup>12</sup> <https://www.bls.gov/careeroutlook/2017/article/older-workers.htm>

<sup>13</sup> The Health Insurance Counseling Program (HICAP) **California HICAP** is part of a national network of **State Health Insurance and Assistance Programs (SHIP)**. **SHIP** is a Federal grant **program** that helps **States** enhance and support a network of local **programs**, staff, and volunteers. The Centers for Medicare and Medicaid (CMS) administers the **SHIP grant programs** nationally.

Information about interaction between COBRA and Medicare coverage is non-existent from federal sources such as the Department of Labor (DOL) and the Centers for Medicare and Medicaid Services (CMS). While one can readily find information about eligibility criteria for COBRA or Medicare, nothing about the relationship between the two health benefit programs is available.

Recovery actions based simply on presumed coverage for Medicare without the requisite enrollment for benefits could potentially be the subject of legal action against the carrier or an insurer given the employer's and the COBRA carrier's failure to inform employees about the conflict between Medicare and COBRA, as well as any potential legal liability for recovery of the primary benefits paid by the COBRA carrier.

State regulators play an important role in balancing the needs of consumers with the financial oversight of insurance companies, enforcing consumer protections, and setting and enforcing regulatory rules that ensure fairness in the marketplace. There are a number of actions state regulators and federal governmental agencies should take to help employers and insurers accurately and fairly administer the benefits of overlapping health benefit programs.

The Department of Labor (DOL) should prohibit the application of implied coverage if a Medicare eligible individual has failed to enroll in Medicare, and prohibit recovery actions based on failure to enroll in Medicare. DOL should revise the Model COBRA Notice to ensure that all of the pertinent information and the dangers of interaction between Medicare and COBRA are clearly described to all COBRA applicants.

The DOL should review ERISA notification requirement to ensure that employers are meeting their responsibilities to accurately and timely notify employees and their dependents of any requirements and conflicts in regard to the relationship and coordination of overlapping health benefits.

The Centers for Medicare and Medicaid Services (CMS) should develop a Special Enrollment Period (SEP) with equitable relief for Medicare eligible individuals caught in this conflict. CMS should revise all their Medicare information and publications to reflect issues related to COBRA. Medicare eligible individuals need to understand how COBRA and Medicare benefits interact and conflict, as well as the consequences of not enrolling for Medicare benefits when eligible for COBRA. CMS should work with the state SHIPs to ensure their understanding of these issues when counseling Medicare beneficiaries who leave employment.

The National Association of Insurance Commissioners (NAIC) should revise the current language in the Association's Coordination of Benefits Model Regulation. There is no justification for that language that penalizes people with Medicare who take advantage of COBRA protection. The current language expressly prohibits insurers from taking into consideration other coverage when determining coverage or denying a claim, and it prevents insurers from refusing to pay or reducing benefits based on the availability of other coverage, *except* when that other coverage is Medicare Part B coverage.

The NAIC should ensure that issuers provide accurate information about coordination of health insurance benefits between Medicare, COBRA, and employer sponsored health plans, and that companies fairly administer overlapping benefits.

The NAIC Senior Issues Task Force should develop a compliance notice for insurance companies and agents and an educational notice for consumers. Both notices should accurately explain the relationship of COBRA coverage to Medicare and the difference between being eligible for Medicare and being enrolled for benefits.

State insurance regulators should examine their laws and regulations to ensure that insurers and COBRA carriers are in compliance with all state and federal laws and regulations, and that Medicare *eligible* individuals are not subjected to unfair recovery actions.



## Additional Information

### COBRA Q and A

§ 54.4980B-7 Duration of [COBRA](#) continuation coverage.<sup>14</sup>

The following questions-and-answers address the duration of [COBRA](#) continuation coverage:

Q-3: When may a plan terminate a qualified beneficiary's [COBRA](#) continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

A-3: (a) If a qualified beneficiary first becomes entitled to Medicare benefits under title XVIII of the [Social Security Act](#) (42 U.S.C. [1395-1395ggg](#)) after the date on which [COBRA](#) continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's [COBRA](#) continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that [COBRA](#) continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's [COBRA](#) continuation coverage.

A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. **Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.** (Highlight added)

### The NAIC Coordination of Benefits Model Regulation (MDL-120)

The NAIC Coordination of Benefits Model Regulation (MDL-120) excludes Medicare Part B with the following language:

#### Section 5. Use of Model COB Contract Provision

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

- (1) Another plan exists and the covered person did not enroll in that plan;
- (2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or
- (3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

*[Author's Note: Notice that exempting Medicare Part B allows the prohibited practice described in (1), and potentially the prohibited practice described in (3).]*

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<sup>14</sup> <https://www.law.cornell.edu/cfr/text/26/54.4980B-7>

## **Summary Of Situations Discussed In This Paper:**

- Medicare eligible individuals not yet enrolled for benefits under Part A or Part B prior to becoming eligible for COBRA cannot be refused COBRA coverage
- Individuals enrolled in either Medicare Part A or Part B prior to becoming eligible for COBRA cannot be refused COBRA coverage
- Medicare eligible individuals who are eligible for Medicare while working but enroll after becoming eligible for COBRA can be terminated from COBRA coverage
- Medicare eligible individuals actively working for employers of less than 20 employee are not covered by Medicare Secondary Payer rules that require employer health care benefits to be primary to Medicare coverage
- COBRA covered individuals who are eligible for Medicare but not enrolled in Medicare Part A or Part B are penalized under both COBRA and Medicare law
- COBRA benefits and Medicare eligible individuals who are enrolled in either Medicare Part A or Part B are penalized under both COBRA and Medicare law
- Medicare Secondary Payment rules do not require COBRA coverage to be primary to Medicare
- The National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model Regulation establishes the order of payments for health benefits and requires health benefits to be secondary to Medicare, regardless of whether Medicare benefits have been activated.