

Have Job-Based Health Coverage at 65? You May Still Want To Sign Up for Medicare.

People who have group health insurance when they become eligible for Medicare sometimes find themselves on the hook for their medical bills because their group plan stops paying.

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When Alyne Diamond fell off a horse in August 2023 and broke her back, her employer-based health plan through UnitedHealthcare covered her emergency care in Aspen, Colorado. It also covered related pain management and physical therapy after she returned home to New York City. The bills totaled more than \$100,000.

The real estate lawyer, now 67, was eligible for Medicare at the time but hadn't enrolled. Since she was still working, she thought her employer health insurance plan would cover her.

That misunderstanding has had financial repercussions that she continues to deal with today.

More than a year after her riding accident, Diamond was back at the emergency room after she tripped on a step while entering a New York restaurant. Her face covered in blood, Diamond was examined by staff, who did multiple CT scans. The bill for that care: \$12,000.

This time, though, the insurance coverage wasn't routine. Nearly all her claims were denied.

Diamond was caught in a fairly common coverage snag: People who have group health insurance when they become eligible for Medicare sometimes find themselves on the hook for their medical bills because their group plan stops paying.

Diamond contacted several people at UnitedHealthcare before she found out why the insurer refused to pay her claims.

When Diamond turned 65 in 2022, Medicare — unbeknownst to her — became the “[primary payer](#)” for her claims, meaning the federal health program for older or disabled people was supposed to take the lead in covering her medical bills, before other insurers paid anything. (As secondary payer, Diamond's employer policy picked up 20% of what Medicare would have paid.)

Had she signed up for the government insurance plan when she turned 65, Diamond could have

avoided a financially perilous situation that left her unexpectedly responsible for the medical costs she incurred during that time.

She began to understand what had happened as she made inquiries about the denied claims.

Diamond said she was told that UnitedHealthcare audited her claims last year and determined it had been improperly paying for her care, perhaps because her pricey medical claims after her fall from the horse raised a red flag.

The insurer not only stopped paying current claims but also moved to claw back tens of thousands of dollars it had paid to providers in the two years since she turned 65. Some of those providers are now seeking payment from her.

“It’s horrifying,” she said. “For about two months I was devastated. I thought, ‘Where am I going to get the money to pay all these people? There goes my retirement.’”

The mistake has already cost her \$25,000 and may cost her much more if providers continue to bill her for amounts that UnitedHealthcare has clawed back for care she received before signing up for Medicare in February.

A UnitedHealthcare spokesperson declined to provide an on-the-record statement, citing safety concerns.

Patient advocates say they frequently hear from people who, like Diamond, thought they didn’t need to sign up for Medicare upon turning 65 because they had group health coverage.

That assumption is generally correct if they or their spouse is working at a company with at least 20 employees. In that case, employer coverage is considered primary and they can delay signing up for Medicare as long as they or their spouse continues to be employed there.

But if someone has employer coverage through a company with fewer than 20 workers, Medicare [generally becomes the primary payer](#) when they turn 65. The real estate law firm at which Diamond is a partner has a handful of employees.

Similarly, if someone is older than 65 and has retiree health coverage or has left their job and opted to continue their employer coverage under the Consolidated Omnibus Budget Reconciliation Act, also known as COBRA, Medicare pays first. The issue can also arise for people who are younger than 65 if they are eligible for Medicare because of a disability. In those instances, Medicare pays first if they or their family member works at a company with fewer than 100 employees.

If people in these groups don’t sign up for Medicare when they become eligible, they can find themselves responsible for all their medical bills for years. (They may also owe a penalty for late enrollment in the Medicare program.)

“It’s very alarming and there’s no current fix to the situation,” said Fred Riccardi, president of the New York-based Medicare Rights Center, a national patient advocacy organization.

The Centers for Medicare & Medicaid Services did not respond to a request for comment.

[Mark Scherzer](#), a lawyer in Germantown, New York, who helps people with insurance problems, and who advised Diamond, said he gets calls a couple of times a month from people who face this issue.

“What I see constantly now is that insurers go back and they claw back the money from the doctor and the doctor then claws the money back from the patient,” he said.

Costly claims may trigger an insurer to examine someone’s coverage.

Those big claims “seem to get on the insurer’s radar,” said Casey Schwarz, senior counsel for education and federal policy at the Medicare Rights Center.

UnitedHealthcare has recouped over \$50,000 in medical bills from some of the providers who treated Diamond in New York after her riding accident. She’s paid them about \$25,000 so far. Some have agreed to let her pay the amount Medicare would have paid.

But there may be more bills to come. Under New York law, health plans have two years after claims are paid to claw back payments from providers, and providers have three years to sue patients for medical debt. So, while there is still time for Diamond to be billed, the clock will eventually run out.

Diamond plans to sue the broker who manages her company’s health plan and other benefits for negligence.

“The Medicare secondary payment rules basically say that if you didn’t sign up because you didn’t know Medicare was supposed to be primary, that’s on you,” said Melanie Lambert, senior Medicare advocate at the Center for Medicare Advocacy in Connecticut.

Lambert said she has seen the issue “many, many times.” In some instances, if a beneficiary can demonstrate they were misled by an employer or a federal employee, they may qualify for relief or a special enrollment period, she said.

In a [2023 letter](#) to the acting secretary of the Department of Labor, the National Association of Insurance Commissioners advocated applying a “commonsense rule to COBRA plans, individual health insurance, and other coverage sources: those entitled to Medicare Part B but not enrolled in it should not lose benefits they pay for from a non-Medicare coverage source.”

The Department of Labor didn’t respond to a request for comment.

In earlier times, people started collecting Social Security benefits then automatically got Medicare

when they turned 65.

Now, enrolling in Medicare is more complicated for many people, said Tricia Neuman, a senior vice president and the executive director of the Program on Medicare Policy at KFF, a health information nonprofit that includes KFF Health News.

“As more people are delaying going on Social Security and delaying going on Medicare, there’s more opportunities for people to make mistakes, and those mistakes are costly,” Neuman said.

Coverage experts say there are no clear requirements for insurers, employers, or the federal government to notify people about how the payment rules governing coordination of benefits between health plans may change when they become eligible for Medicare.

The information appears in a chart in the government’s “Medicare & You” handbook, if someone knows to look for it. But it is not easy to find.

A straightforward fix could solve many of the problems people face in this area, Scherzer said. Since every health plan knows its enrollees’ ages, why not require them to notify people approaching 65 of possible benefit coordination issues with Medicare? “It’s so simple and such a no-brainer.”

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