

Group Insurance Budget Impasse FAQs

September 25, 2015

Q1: How is the budget impasse impacting the State Employees Group Insurance Program (SEGIP)?

A1: Because the General Assembly has not yet passed a balanced budget, no appropriation has been made for SEGIP for the current fiscal year. Therefore, CMS does not currently have the legal authority to release funds for the payment of claims or for premium payments to vendors providing fully-insured HMO coverage. SEGIP has been underfunded for the past decade, and healthcare providers and carriers have regularly endured payment delays of 8 months or longer. These payment delays will continue to increase until the General Assembly passes a balanced budget and funding is in place. Once fiscal year 2016 funding has been appropriated, payments will resume where they left off.

Q2: How is my coverage being affected?

A2: As a covered plan participant, your medical, prescription, dental and vision coverage has not been stopped or reduced in any way. Claims will continue to be processed in a timely manner. However, as the payment delay continues to increase, it is possible that providers may request payment from the member at the time of service. CMS and the plan administrators are working diligently with providers to try to avoid having providers charge members up front for services.

Q3: I am enrolled in an HMO or Medicare Advantage plan. When will my claims be paid?

A3: At this time, all of the vendors providing fully-insured HMO plans (BlueAdvantage, HMO Illinois, Health Alliance, and Coventry HMO) and Medicare Advantage plans have agreed to continue to pay claims to healthcare providers on their normal schedule. Therefore, it is anticipated that members enrolled in these plans will not see any significant changes due to the budget impasse.

Q4: I am enrolled in Cigna/QCHP, Coventry OAP, or HealthLink OAP plan, and/or have dental coverage through Delta Dental. When will my claims be paid?

A4: These are self-insured plans (Cigna/QCHP, Coventry OAP, HealthLink OAP, and Delta Dental). The State pays the direct cost of each claim, rather than paying a monthly premium to the insurance carrier as with the HMO and Medicare Advantage plans. Because funds cannot be released at this time, the delay in claim payments to healthcare providers will continue to increase until a balanced budget is passed. Once a budget is approved and appropriate funding is in place, CMS will resume releasing funds for the payment of covered services and claims will be paid according to the claim process date as funding becomes available.

Q5: What should I do if I have an upcoming procedure scheduled, or if I have a catastrophic injury or ongoing illness?

A5: You should continue to seek treatment as needed. As a covered plan participant, your medical, prescription, dental and vision coverage is still in effect and has not been reduced in any way. Claims will continue to be processed by the plan administrators in accordance with the applicable plan design. If you have any questions about coverage for a specific service, you should contact your plan administrator and your provider prior to services being rendered to ensure that the service is covered under your plan and to discuss whether any upfront payment will be required.

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Q6: What should I do if I am asked to pay up front for a service?

A6: At this time, many providers have indicated that they will not be requiring members to pay more than the member's applicable cost sharing amount (deductible, copay, etc.) at the time of service. If your provider asks you to pay more than the member portion of the cost up front for a service, you should contact your plan administrator. Your plan administrator will contact the provider to try to find a resolution. If a resolution cannot be reached and the provider continues to ask for an upfront payment, you should make arrangements with your provider to be reimbursed once the provider receives payment from the plan, including any interest that may apply to your claim.

Q7: If I am asked to pay at the time of service, will I be required to pay the plan's negotiated amount or the provider's total charge?

A7: CMS cannot guarantee the amount a provider will request. However, in-network providers should only charge the plan's negotiated amount. If a provider asks you to pay more than the member portion of the cost, you should contact your plan administrator who will reach out to the provider to assist you in reaching a resolution.

Q8: What is happening with the premium amount that is being collected from my paycheck?

A8: Because your insurance coverage remains in effect, premiums will continue to be collected as usual. All member contributions are deposited in the Health Insurance Reserve Fund. However, due to the lack of an appropriation, CMS does not have authority to release payments from the Fund until a balanced budget is passed.

Q9: Can I opt out of my coverage?

A9: The budget impasse does not constitute a qualifying event that would permit a mid-year change in insurance coverage. However, if you experience a qualifying event for which termination of coverage is an available option, such as enrolling in other coverage during a spouse's open enrollment period, then an opt out will be permitted. For more information on qualifying events, including a list of qualifying events and the corresponding changes that are permitted, please see pages 9-12 of the Benefits Handbook (available at http://www.illinois.gov/cms/Employees/benefits/StateEmployee/Documents/FY2016_State_Handbook.pdf)