Health Plans and Provider Contracts

Below are frequently asked questions (FAQs) that cover general information about options available to enrollees of health insurance whose providers, or hospital, no longer contract with their health plan.

Table of contents

Private health insurance

If my provider or hospital no longer contracts with my health insurance carrier, what are my options?

- Contracts between providers and hospitals and private insurance companies can change at any time.
- When this happens, plan members do not get the chance to change plans unless the Centers for Medicare & Medicaid Services (CMS) determines that a significant population is affected and allows a special enrollment period (SEP).
- If a SEP is available, you may choose another health plan with which your providers are contracted.
- If a SEP is not available due to the contract changes, you may be able to change plans if you have recently experienced another qualifying life event, such as moving, getting married, a significant change in income, or gaining a child through birth, adoption or placement in the home.

My plan offers out-of-network benefits. Does this help me?

- Plans that provide benefits when you see providers that are out-of-network will continue to provide coverage, but you will have higher copays and coinsurance costs.
- The deductible and maximum out of pocket limits are also higher for out-of-network benefits.
- When you pay for out-of-network services, the amount will go toward the out-of-network deductible and maximum out of pocket limits and will not count toward your in-network deductible or maximum out of pocket limits.
- Check with your provider first to be sure they will bill to your insurance plan even though they are out-of-network.

Can I still get emergency room services at a hospital?

- Emergency hospital services are covered.
- However, it is important to understand that if you go to the emergency room for a non-emergency situation, the services may not be covered.
- Whenever possible, make sure the services you receive are covered by your plan.

What if I need care after my provider or hospital stops accepting my health plan but before my new coverage begins?

- Those enrolled in a health plan affected by a terminated provider contract will need to contact their plan to find a new in-network provider.
- If the health plan has out-of-network coverage, and your provider is willing to bill to the plan as out-of-network, this may be an option. Check with your provider and with your plan.

If I am receiving financial assistance through the Marketplace, does this change my options?

- Your options are the same as if you were not receiving financial help.

If I am not eligible for a special enrollment period, when can I change my health plan?

- Every Marketplace enrollee has the option to change health plans during the annual open enrollment period – Nov. 1 to Jan. 15.
    - Coverage will begin on Jan. 1 if a new plan is selected by Dec. 15.
    - Coverage will begin on Feb. 1 if a new plan is selected by Jan. 1.
- If a current enrollee makes no changes to their health plan during open enrollment, they may be auto enrolled into the same health plan for the new year.

Who should I contact if I have questions?

- You may contact your insurance carrier and your providers and hospital to see if they still contract with each other.
- You can also contact the Oregon Health Insurance Marketplace at 855-268-3767 (all relay calls are accepted) or email info.marketplace@oha.oregon.gov.
- You may contact a local insurance agent using the Find Local Help (OregonHealthCare.gov/GetHelp) to review your options.

Who should I contact if I disagree with my plan or have issues with your health plan?

- Contact your provider to make sure billing is correct.
- Contact your health plan to file an appeal.
- Contact consumer advocacy at the Division of Financial Regulation (DFR) at 888-877-4894 or file a complaint online at DFR.Oregon.gov. DFR does not regulate OHP, Medicare Advantage, or self-funded plans.

Medicare

If my provider or hospital no longer contracts with my Medicare Advantage insurance carrier, what are my options?

- Providers and hospitals that contract with Medicare Advantage insurance carriers can terminate contracts at any time.
- When this happens, plan members do not get the chance to change plans unless the Centers for Medicare & Medicaid Services (CMS) determines that a significant population is affected and allows a special enrollment period (SEP).
- If an SEP is available, you may choose another Medicare Advantage plan with which your providers are contracted. Always check with your provider to make sure they accept your Medicare Advantage plan.
- If CMS allows a SEP, you also have the option to enroll in a stand-alone drug plan, also called Medicare Part D. Enrolling in Medicare Part D would return you to Original Medicare.
- It's important to remember that Original Medicare has a 20 percent co-insurance, has no cap on out-of-pocket costs and other services may cost more.

My plan offers out-of-network benefits. Does this help me?

- Plans that provide benefits when you see providers that are out-of-network will continue to provide coverage, but you may have a higher co-pay.
- It's important to know that while the plan may cover out-of-network services, not all providers will accept and bill to plans with which they are not contracted.
- Check with your provider first to be sure they will bill to your insurance plan even though they are out-of-network.

Do all medical providers accept Original Medicare?

- Most providers do contract with and bill Original Medicare. However, many will limit how many patients they take with this insurance.
- You may need to get on a waiting list to access your provider of choice until they are accepting new patients who have Original Medicare.

What is guaranteed issue, and does it apply if my provider or hospital no longer contracts with my Medicare Advantage plan?

- Guaranteed Issue (GI) means you have a special time period when you can purchase a Medicare Supplement policy, also called Medigap, to cover the out-of-pocket costs related to Original Medicare without completing a medical review.
- GI is available when you lose medical coverage through no choice of your own.
- If you are in a Medicare Advantage plan and your provider or hospital no longer contracts with that plan, you are not losing your plan. You are losing your provider.
- This situation would not provide GI protection. You may still apply for a Medigap policy but would need to complete a medical review. The insurer is not required to issue a policy.

Can I still get emergency room services at a hospital?

- Emergency hospital services are covered.
- However, it is important to understand that if you go to the emergency room for a non-emergency situation, the services may not be covered.
- Whenever possible, make sure the services you receive are covered by your plan.

What if I need care after my provider or hospital stops accepting my Medicare Advantage plan but before my new coverage begins?

- Those enrolled in Medicare plans affected by a terminated provider contract will need to contact their plan to find a new in-network provider.
- If the Medicare Advantage plan has out-of-network coverage, and your provider is willing to bill to the plan as out-of-network, this may be an option. Check with your provider and with your plan.

What if during open enrollment I switch to Original Medicare and later find out my Medicare Advantage plan will still be accepted by my provider or hospital?

- You can change your enrollment choice at any time during the open enrollment period, which runs from Oct. 15 through Dec. 7.
- This means if you are enrolled in Original Medicare, you can change your enrollment to Medicare Advantage or add additional options such as Part D or Medigap, any time before Dec. 7 for coverage to start Jan. 1.

How does the Medicare Advantage Open Enrollment period affect my choices?

- If you start the year on Jan. 1 enrolled in a Medicare Advantage plan, you have until March 31 to make a change.
- You may enroll in a stand-alone drug plan (Medicare Part D) which would return you to Original Medicare for all medical coverage. You may also choose a different Medicare Advantage plan.
- It's important to note that only one action is allowed during the Medicare Advantage open enrollment period.
- Do not terminate an enrollment during this period. Terminating enrollment in an existing Medicare Advantage plan would be one action and would leave you in Original Medicare without drug coverage.

What if I do nothing and make no changes during Open Enrollment?

- If you are already enrolled in a Medicare Advantage plan and you do not take action during the Oct. 15 to Dec. 7 open enrollment period, you will stay in your current plan.
- If your insurer decides to stop offering Medicare Advantage, you will be automatically enrolled in Original Medicare but may lose some important benefits like prescription benefits. You will have a small window of time to select a new drug plan.

If I am receiving financial assistance, does this change my options?

- If you are receiving financial assistance either for your prescription drugs (Extra Help) or your Medicare premium (Medicare Savings Program), you can change standalone Prescription Drug Plan enrollment once per month starting Jan.1, 2025.
- If you have both Medicare and Medicaid, you can switch from a Medicare Advantage Plan with drug coverage to Original Medicare and enroll in a standalone Prescription Drug Plan starting Jan.1, 2025.
- If you have both Medicare and Medicaid benefits, you can choose to enroll into, or switch between, integrated D-SNP Medicare Advantage plans once per month starting Jan. 1, 2025.
- When you enroll in the new plan you want, this will automatically terminate the plan that you do not want.
- Your new plan will take effect on the first day of the month following the enrollment action.

What else should I consider?

- If you return to Original Medicare, you need to pick a drug plan during Open Enrollment.
- If you do not pick a drug plan during Open Enrollment, you may need to pay a late enrollment penalty if you go more than 60 days without creditable drug coverage

Who can I contact if I have additional questions?

- You may contact your insurance carrier and your providers and hospital to see if they still contract with each other.
- You can also contact the state SHIBA office at 800-722-4134 for help. SHIBA provides free and confidential Medicare counseling to people in Oregon. SHIBA cannot provide information about insurance and provider contracts but can help you explore your options.
- You may contact a local insurance agent using the Agent Locator Tool to review your options.

How can SHIBA help?

- SHIBA is state sponsored and receives a federal grant to provide one-on-one counseling to Medicare beneficiaries about all their Medicare enrollment options, including traditional Medicare, Medicare Advantage, Medigap and Part D.
- SHIBA cannot recommend specific plans, but counselors can explain all enrollment options.

Group health plans

Can I change my health plan?

- Employers have the option to change health plans offered to employees at any time.
- Additionally, employers have the option to open an enrollment period at any time.
- You may only change health plans when eligible, according to the guidelines set by your employer, which may be during a special enrollment period or during the annual open enrollment period.
- Contact your employer's human resources (HR) department to learn about enrollment periods and plan offerings.

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Who should I contact if I have questions?

- You may contact your insurance carrier and your providers and hospital to see if they still contract with each other.
- Contact your employer for health plan information, including the name of your insurance carrier, policy number, and dates of coverage.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Oregon Health Insurance Marketplace at info.marketplace@oha.oregon.gov or 855-268-3767. We accept all relay calls.

Oregon Health Insurance Marketplace
Health Policy and Analytics
Oregon Health Authority
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OregonHealthCare.gov

Division of Financial Regulation
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350 Winter Street NE
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Senior Health Insurance Benefits Assistance Program
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