Oregon Health Insurance Marketplace
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OREGON HEALTHCARE.gov

Glossary

AAA - Area Agency on Aging (works with seniors and persons with disabilities).

ACA - Affordable Care Act, aka "Obamacare"; signed into law in 2010; fully operational in 2014 (marketplace plans and expanded Medicaid among the provisions).

Actuarial value – The percentage of total average costs for covered benefits that will be paid by a health insurance plan.

AI/AN - American Indian/Alaska Native; a member of an Indian or Alaska Native tribe, Alaska Native Claims Settlement Act (ANCSA) Corporation (regional or village), band, nation, pueblo, village, rancheria, or community that the Department of the Interior acknowledges to exist as an Indian tribe. See the list of federally recognized tribes at https://bit.ly/frTribes.

APD - Aging and People with Disabilities; part of the Oregon Department of Human Services.

Appeal - When you ask to review a decision. If you do not agree with a decision the plan made, you can ask to have the decision reviewed in a hearing. Appeals can be requested from the Oregon Health Plan, an insurance carrier, or the Marketplace, as appropriate.

Applicant portal - The publicly accessible part of ONE that has functions specific to submitting applications and managing applicant accounts.

Application date - The date the application is submitted. The application date is the default "Date of Request of Coverage." Coverage will begin on the first day of the date of request month. See "DOR" for information on changing the date of request and, therefore, the application start date.

Application intake - The process of collecting and entering an individual's information into the ONE system for the application for medical benefits.

Application number - System-generated unique identifier assigned to an application after the application is initiated. Community partners can search by application number in the applicant portal.

Assisters - People trained and certified to assist individuals in applying for Medicaid/CHIP and qualified health plans. Assisters have expanded access to client accounts via the processing Oregon Health Plan center. Assisters should not be designated as authorized representatives for consumers.

AT - Account transfer between the Marketplace and ONE application systems.

Authorized representative - A person you say can make decisions and sign documents for you. This person could be a family member or guardian. If you want an authorized representative, you must fill out a special form.

Binder payment – Initial premium payment for health coverage, which effectuates the plan and makes it active.

Case number – System-generated unique identifier assigned to an application that has been completed and submitted via ONE. Community partners can search by case number in the applicant portal.

CAWEM - Citizen Alien Waived Emergent Medical. Medicaid benefit level available to undocumented people, and adult lawful permanent residents, and those younger than 5 years old.

CAWEM Plus - Full Oregon Health Plan benefit level available to all pregnant women regardless of immigration status. Currently ends (and reverts to CAWEM) the day following the end of the pregnancy.

CCO - Coordinated Care Organization (managed care for Oregon Health Plan clients). A CCO is a local group of health care providers (doctors, counselors, nurses, dentists, and others) who work together in your community. CCOs help make sure Oregon Health Plan members stay healthy.

CHIP - Children's Health Insurance Program (federal).

CMS - Centers for Medicare and Medicaid Services (federal).

COBRA - Consolidated Omnibus Budget Reconciliation Act; a federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

COFA - Compact of Free Association. It pertains to citizens of Palau, Micronesia, and the Marshall Islands and their rights to reside and work legally in the U.S. As of March 10, 2021, all Medicaid eligibility has been reinstated to COFA citizens.

Co-insurance - The percentage of costs of a covered health care service paid by the consumer (e.g., 20 percent) after the deductible has been paid.

Combined Notice of Eligibility - A notice generated by the ONE system that informs individuals of approvals, denials, and termination of coverage.

Community partner - An organization that has certified assisters who help people apply for health care. Community partners are local. Help is free.

Community partner dashboard - An area in the applicant portal specifically for individual community partners where they can search for individuals/applications; access messages from the Oregon Health Authority; link directly to Groupsite; and assist individuals with managing their OHP enrollment.

Co-payment – A small fee that some health plans charge members when paying for services. An example of a co-pay is paying the pharmacy $2 for a prescription. OHP does not have co-pays.

CPOP - Community Partner Outreach Program; part of the Oregon Health Authority.

CSR - Cost-sharing reduction. It is financial assistance available for people with incomes from 139 percent to 250 percent of the federal poverty level who are purchasing a silver-tier qualified health plan. It is also available to American Indians/Alaskan Natives (AI/AN) up to 300 percent FPL as zero cost sharing, with any metal tier plan.

DACA - Deferred Action for Childhood Arrivals; immigration status; not eligible for Marketplace coverage.

DCBS - Department of Consumer and Business Services, the state agency that contains the Division of Financial Regulation (DFR).

Deductible - The amount the consumer pays for covered health care services before an insurance plan starts to pay at a higher rate. This amount varies from plan to plan.

DFR – Department of Financial Regulation; a division of the Department of Consumer and Business Services which regulates insurance plans and agents/brokers, in addition to other financial services.

DHS - Department of Human Services, the state agency in charge of programs such as Supplemental Nutrition Assistance Program (SNAP) and Medicaid. DHS often works with the Oregon Health Authority.

DOR - Date of request; establishes effective date of coverage for Oregon Health Plan. Coverage starts on the first of the month during which the date of request is established.

EHB – Essential health benefits; a set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Emergency medical condition - An illness or injury that needs immediate care. A physical health example is a broken bone or bleeding that won't stop. A mental health example is feeling out of control or feeling like hurting yourself.

Emergency services - Care people get during a medical crisis. These services help make people stable when they are in serious condition.

ER and ED - Emergency room and emergency department; this is the place in a hospital where people can get immediate care.

Excluded services - What a health plan does not pay for. Services to improve your looks (such as cosmetic surgery) and for things that get better on their own (such as colds) are usually excluded.

Explanation of Benefits (EOB) – Statement produced by insurance company describing services rendered and charged to the plan by a provider, facility, or supplier. This is not a bill.

Federal technology - The technology platform used by the Oregon Health Insurance Marketplace to apply and enroll in a qualified health plan (QHP) at HealthCare.gov.

FFS - Fee for service; also referred to as "Open Card"; with OHP coverage: unaffiliated with a

CCO.

Formulary - Specifies particular medications that are approved to be prescribed under a particular health insurance policy.

FPL - Federal poverty level; guidelines issued in late January of each year by the United States Department of Health and Human Services.

Grievance - A complaint about a plan, provider, or clinic. The law says coordinated care organizations must respond to each complaint.

Groupsite - The social media tool for application assisters, the Community Partner Outreach Program, and the Oregon Health Insurance Marketplace. Users can join a discussion, search for a form, and check the calendar for trainings, meetings, and other events.

Health insurance - A program that pays for some or all of its members' health care costs.

HHS - U.S. Department of Health and Human Services.

HICS - Health Insurance Casework System; System used by CMS for case escalation assignment and work.

HIG - Health insurance group; manages third-party liability (other insurance coverage) for Medicaid clients (www.reportTPL.org).

HNA - Heritage Native American (an OHP designation in the Medicaid Management Information System).

Hospice services - Services to comfort a person during end-of-life care.

Hospital inpatient and outpatient care - Inpatient care is care people receive when they stay at a hospital for at least three nights. Outpatient care is care people receive at a hospital, but they do not need to stay overnight.

Household - Family who live with you, such as your spouse, children, or other dependents who you would claim on your taxes. A household does not include roommates.

HPE - Hospital presumptive eligibility; available only in hospitals; provides temporary Oregon Health Plan coverage, but must be followed up with a full OHP application in order for benefits to continue; available only once in a 12-month period.

Indian health services, tribal programs, and urban Indian programs (I/T/Us) – Health programs available to American Indians and Alaska Natives. If a tribal member enrolls in Marketplace coverage, they can get or keep getting services from one of these programs as well as from any providers on the Marketplace plan.

Individual dashboard - Where individuals (non-community partner) manage their ONE account and application for health coverage.

Individual mandate - The fee paid if a person does not have health coverage (also called a

"penalty" or the "individual responsibility payment"). It is not paid if the consumer is exempt. This fee was reduced to $0 for plans starting in 2019.

In-network provider - The providers and facility (hospitals, clinics, etc.) that an insurance company covers at a preferred rate, or that is empaneled with a coordinated care organization.

Insurance company – Also called "insurer" or "insurance carrier." Company that issues health plans.

Justice involved population - Clients transitioning from incarceration. They can apply for OHP within 30 days before or after their scheduled release date.

LEP – Limited English proficiency.

LPR - Lawful permanent resident; an immigration status in which people can live and work in the United States; eligible for OHP if LPR status is more than five years as adult; no waiting time for children.

Marketplace account transfer - Facilitates sending account transfer responses from the state for application account transfers received from the marketplace, as well as sending application referrals from the state to the marketplace for applications that originate at the state.

MEC - Minimum essential coverage; the type of coverage an individual must have to meet the "individual responsibility requirement" under the Affordable Care Act.

Medicaid - A national program that helps with health care costs for people with low incomes. In Oregon, it is called the Oregon Health Plan.

Medically necessary - Services and supplies your doctor says are needed to prevent, diagnose, or treat a condition or its symptoms.

Medicare - A health care program for peoe age 65 and older. It also covers some people with disabilities of any age.

MFA - The purpose of the Multi-Factor Authentication (MFA) Services is to enable second-factor authentication using a generated one-time password (OTP) sent via email. Community partners must enter their generated OTP each time they log in to the ONE applicant portal.

MMIS - Medicaid Management Information System, the system of reference for Medicaid eligibility.

Network - The group of providers, facilities (hospitals, clinics, etc.), both that an insurance company covers at a preferred rate, or a coordinated care organization has a contract with. They are the doctors, dentists, therapists, and other providers that work together to keep people healthy. Facilities such as clinics and hospitals can also be part of a network.

Non-custodial parent - Also referred to as the absent parent of a child in the home.

Non-network provider - A provider that does not have a contract with the insurance carrier or coordinated care organization. They may not accept the carrier/CCO payment for their services. You might have to pay or pay more if you see a non-network provider.

Notice of Action - A letter that tells people when a decision is made about their health care.

OHA - Oregon Health Authority; administers Oregon's Medicaid and Public Health programs such as Women, Infants, and Children Nutrition Program (WIC).

OHP – Oregon Health Plan; Oregon's Medicaid program, which helps people with low incomes get access to care.

OMC - Oregon Mothers Care; an OHA Public Health program.

ONE - Short name for OregONEligibility, Oregon's online Medicaid benefits application system.

Open card - Members who do not have a coordinated care organization have open card. They can see any providers who accept Oregon Health Plan coverage.

Open enrollment - A period of time during the year when consumers can apply for (and enroll in) private health care with financial assistance, typically Nov. 1 to Dec. 15. Consumers may qualify for a special enrollment period if they have a qualifying life event outside of open enrollment. Consumers can apply for OHP at any time during the year.

Out-of-pocket maximum/limit - The most someone has to pay for covered services in a plan year. After people spend this amount on deductibles, co-payments, and co-insurance, their health plan pays 100 percent of the costs of covered benefits. The out-of-pocket limit does not include their monthly premiums. It also does not include anything they may spend for services their plan does not cover.

PCP - Primary care provider or physician; the provider or doctor who takes care of someone's health. The provider or doctor is usually the first person people call when they need care. A primary care provider can be a doctor, nurse practitioner, physician's assistant, osteopath, or a naturopath.

PCR - Parent or other caretaker relative: Medicaid/OHP benefit for relatives caring for children; income limit is about 42 percent FPL, but there is no age limit.

Per capita income - Average income earned per person in a given area in a specified year. It is calculated by dividing the area's total income by its total population. For the purposes of the Marketplace, generally used for tribal income in relation to casino or non-gaming (ex. farming) earnings.

Physician services - Services received from a doctor.

PII - Personally identifiable information is any information about an individual maintained by an agency, including criminal and employment history and information that can be used to distinguish or trace an individual's identity (name, Social Security number, date and place of birth, etc.), plus any other personal information that is linked or linkable to an individual.

Plan - The specific collection of benefits and levels of coverage a consumer may buy. An insurance carrier can have several plans with different benefits and coverage levels, and plans can vary by geographic location.

PNS - Privacy notice statement; a privacy statement or a legal document that discloses some or all of the ways a party gathers, uses, discloses, and manages a customer or client's data. It fulfills a legal requirement to protect a customer or client's privacy.

Pre-authorization - Permission for a service. This is usually a document that says the plan will pay for a service. Some plans and services require this before people get care.

Preferred drug list (PDL) - A list of medications covered by the Oregon Health Plan.

Premium - The cost of insurance.

Prescription drugs - Medications a doctor tells a patient to take.

Prevention - What people do to help keep themselves healthy and stop them from getting sick. For example, checkups and flu shots.

Preventive services – Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary care dentist - The main dentist who takes care of someone's teeth and gums.

Prime number - System-generated number and effectively a member's Oregon Health Plan ID, assigned to an individual used to identify the individual and for billing purposes system. Visible in the individual dashboard after submitting an application, as well as in MMIS.

Provider - A licensed person or group that offers a health care service. For example, a doctor, dentist, or therapist.

PTC – Premium tax credit; financial assistance available for people with incomes below 400 percent of the federal poverty level who are purchasing a qualified health plan and meet other eligibility requirements. If used throughout the year, it is called Advanced Premium Tax Credits (APTC).

Public charge – Refers to an individual who is likely to become “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense” (as defined by the U.S. Citizenship and Immigration Services).

QHP - Qualified health plan; private coverage available through the marketplace, typically 139 percent of the federal poverty level and above.

QLE - Qualifying life event; change in circumstances that affects eligibility for different forms of health coverage and allows clients to have a special enrollment period (SEP).

Renewal - QHP/OHP members must make sure they still qualify for health benefits on an annual basis. Changes in circumstances that might affect eligibility should typically be reported any time of year as they occur, within 30 days of the change taking place.

RFI - Request for information asks additional information to complete eligibility. It identifies specific information needed (proof of income). Each item requested includes a due date and

will be sent with a postage-paid envelope for each letter.

RIDP - Remote identity proofing; a one-time process necessary to set up an individual or community partner account in ONE.

Risk pool – A group of individuals whose medical costs are combined to determine premiums.

ROC - Regional outreach coordinator; there are eight regional outreach coordinators who serve seven regions in Oregon, plus two statewide campaign coordinators.

SEP - Special enrollment period; a time during which a client with a qualifying life event can purchase a qualified health plan.

SHIBA - Senior Health Insurance Benefits Assistance program; certified volunteers specializing in Medicare assistance. The Oregon Health Insurance Marketplace at the Department of Consumer and Business Services jointly administer the program.

Social Security - Retirement benefits can be collected started at age 62; taxable and nontaxable amounts that must be reported in the income section of the application; Social Security also includes survivors' benefits.

Specialist - A provider trained to care for a specific category of illness.

SSDI - Social Security Disability Income; taxable and nontaxable amounts that must be reported in the income section of the application. People receiving SSDI are eligible for Medicare after a two-year wait.

SSI - Supplemental Security Income; do not include this income on the application.

Summary of Benefits and Coverage (SBC) - An easy-to-read summary that lets consumers make apples-to-apples comparisons of costs and coverage between health plans. The document can compare options based on price, benefits, and other features that may be important to the consumer. The "Summary of Benefits and Coverage" (SBC) is available when shopping for coverage through HealthCare.gov, directly through an insurance company, or through a job, renew or change coverage, or request an SBC from the health insurance company.

TANF - Temporary Aid to Needy Families; formerly known as "welfare" (administered by the Department of Human Services).

Urgent care - Care that people need the same day. It could be for serious pain, to keep them from feeling much worse, or to avoid losing function in a part of their body.

USCIS - U.S. Citizenship and Immigration Services**.**

Verification documents - If HealthCare.gov or ONE identifies more information is needed to complete eligibility determination, a request for information is triggered and a notice is sent to the individual. The request for information identifies the specific items needing verification for the applicable individuals. Examples of verification documents include W-2, 1099, tax returns, unemployment letters, birth certificate, naturalization certificate, green card, visa, refugee

documents, and release documentation from incarceration.

WIC - Women, Infants, and Children Nutrition Program (administered by Public Health).

Worker portal - The side of the ONE system used by the Oregon Health Authority, which has greater access and functionality specific to determining eligibility.