GUIDE TO HEALTH CARE REFORM

The President has made it known that he wants Congress to pass health care reform legislation by October 15, 2009. Since the health care sector comprises nearly 17% of the U.S. economy, it is crucial that you know and understand the proposed changes.

As Congress proceeds to reform America's health care system, I have compiled some information and frequently used terminology to help you cut through all of the details and rumors surrounding the reform debate. Please keep in mind, however, that this is a very general guide. I encourage you to contact my office in Washington, (202) 225-1252, if you have any additional questions or wish to convey a message regarding the health care overhaul efforts.

- **"Public Option":** A public option is an insurance plan run and/ or funded by a governmental entity. A public plan would compete against the private insurers, because the government has the means to set the rates as low as feasibly possible. Since the rates of a public option cannot be beat and it would be more economical for employers, it is expected that millions of Americans would eventually lose their private insurance and be "dumped" onto the new government insurance plan.
- **Crowd Out:** This is a phenomenon whereby individuals drop their private health insurance coverage in order to enroll in government programs. This trend ultimately leads to a lack of competition between insurance providers.
- **Tax Treatment of Health Insurance:** Dating back to a ruling by the Internal Revenue Service during World War II, all health and related fringe benefits provided by an employer are excluded from income for purposes of payroll and income taxes without limit. This exclusion results in more than $246 billion in forgone revenue for the federal government. Health insurance purchased outside of an employer group market, however, must be purchased with after-tax dollars. Under this system, individuals without access to employer-sponsored insurance pay 30- 50% more for health insurance coverage.
- **Comparative Effectiveness:** Research that would contrast the merits of two drugs or methods for treating an illness. Proponents of this research look to the benefits of creating a "best-practices" system of care; opponents fear it may lead to the rationing of care based upon cost-effectiveness.
- **Health Insurance "Exchange":** An "Exchange" (a.k.a. Connector, Navigator) would provide a forum to comparatively shop for health insurance coverage. Proponents of an Exchange agree that it would increase the portability of coverage and choices available for individuals, resulting in a truer free-market system. Opponents believe that an Exchange would do the opposite, and could lead to the restriction of access if a plan does not meet certain regulatory requirements and bureaucratic mandates.
- **Health Information Technology:** The use of computer technology and programs to store, retrieve, and transfer clinical, administrative, and financial information electronically within the health care setting, in accordance with all personal privacy laws. Examples include electronic medical records and E-prescribing.
- **Provider:** The entity that actually administers care to an individual. For example, the doctor or hospital.
- **3rd Party Payer:** This refers to the outside entity, generally the insurer, who arranges payment for health care services given to the patient (1st party) by the health care provider (2nd party).
- **Health Insurance Mandate:** This is a requirement of the employer to provide insurance coverage to employees, or of the individual to purchase their own health insurance coverage. A mandate is usually accompanied with some form of enforcement measure or penalty for non-compliance, which takes the form of a tax or fee for not obeying the mandate.

For more information on health care reform, please visit my website www.adamputnam.house.gov.