



Statement of the U.S. Chamber of Commerce

ON: **Health Reform in the 21st Century: Proposals to Reform the Health System**

TO: **The House Committee on Ways and Means**

BY: **Randel K. Johnson**
 Senior Vice President, Labor, Immigration, & Employee Benefits
 U.S. Chamber of Commerce

DATE: **June 24, 2009**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility..

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – numbers more than 10,000 members. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 101 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. Currently, some 1,800 business people participate in this process.

**Statement on
Health Care Reform Legislation
THE HOUSE COMMITTEE ON WAYS AND MEANS
on behalf of the
U.S. CHAMBER OF COMMERCE (the “Chamber”)
by
Randel K. Johnson
Senior Vice President, Labor, Immigration & Employee Benefits
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Chairman Rangel, Ranking Member Camp, members of the Ways and Means Committee, thank you for the invitation to testify at this hearing. I am Randel K. Johnson, Senior Vice President of Labor, Immigration and Employee Benefits at the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world’s largest business federation, representing more than three million businesses of every size, sector and region. More than half of all Americans receive health insurance benefits voluntarily provided by their employers, and the Chamber is committed to reforming the health system to lower costs, improve quality, and expand coverage.¹

Process

The Chamber applauds Congress for making health reform a priority. However, we have grave concerns about the process being used to advance this legislation. This Committee, in cooperation with the two other committees of primary jurisdiction, crafted the legislation before us today behind closed doors. On Friday June 19th, only a few days ago, you released a more than 850-page bill, and although it still contains significant gaps (including missing cost estimates and expected offsets), already we are engaged in hearings, with markups no doubt quickly following, and the bill will be rushed to the floor without proper time for consideration and revision.

As you rush to pass the most sweeping changes ever to the health sector, which encompasses more than 16 percent of the U.S. economy, consider that in comparison Congress spent almost a decade devising and refining the Family and Medical Leave Act, which provides 12 weeks of unpaid leave, a much more straightforward, and less controversial concept. Now, Congress seeks to impose massive and incredibly complex new health care mandates and restructuring apparently in less than four months. In this regard, I have to note that I was working for a committee on the Hill when Mrs. Clinton’s plan was being considered 15 years ago, and she came under much criticism for drafting the plan behind closed doors. However, that bill was allowed serious and full scrutiny by both Congress and the public with many hearings, and I would argue that it was a model of transparency and a full deliberative process compared to the absurdly accelerated process Congress is undertaking now.

¹ See U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States 2007, p. 20, <http://www.census.gov/prod/2008pubs/p60-235.pdf>

As I was reviewing the legislation this weekend, I found myself almost wistfully recalling the days when I was on the Hill, when legislation was actually introduced as bills and time was allowed for review and analysis before hearings and markups were called. The idea, not novel at the time, was that those affected by these initiatives would actually have time to provide well-developed and meaningful feedback to policymakers. Unfortunately, Congress now appears to be in a time when the more complex a piece of legislation is, the less time that is given for its analysis.

While this paradox is sometimes justified as needed to pass legislation before its “opponents” can rally in opposition, it is actually a process which undermines democratic and open debate, a process which values “hiding the peanut” under the shell rather than revealing what lies beneath the shell. Finally, while many do describe our current situation with regard to health care as a “crisis,” this is surely not the type of crisis which demands that Congress proceed on the schedule which the White House appears to be demanding. The tragedy of September 11th, 2001 was a crisis which demanded swift action; problems with the health care system do not rise to this level, and the stakes are too high to rush to judgment under the cover of overwrought claims of saving the economy.

The Chamber hopes that the sponsors of this legislation will conduct a process that truly engages stakeholders and discards this rush to legislate, and that they build legislation that solves the problems we face without creating massive new problems. Congress continuing on its current course is a recipe for failure, problems, partisan politics, and a continuation of the unsustainable, unacceptable status quo.

The business community has been supportive of reform for some time now, as health care costs have continued to rise much faster than the rate of inflation. Even as health insurance premium costs have more than doubled in the past decades, employers continue to pay \$500 billion a year into the system voluntarily to cover employees.² It should be easy to draft a bill that employers can support – we are desperate in the face of these unsustainable cost increases. Unfortunately, rather than focusing on common sense, pragmatic reforms that both sides of the aisle could support, this legislation embodies a range of bad ideas that threaten to bring down many good initiatives which we do support.

Employer Mandate (“Pay-or-Play”)

First and foremost, the Chamber adamantly opposes the “pay-or-play” proposal that holds a Sword of Damocles over the heads of America’s job creators, requiring them either to provide some level of health insurance benefits (to be later defined by a government board) or surrender a huge eight percent of payroll to the government.³ This proposal will

² Employee Benefit Research Institute: “*EBRI Databook on Employee Benefits, Chapter 2: Finances of the Employee Benefit System.*” Updated September 2008.

<http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2002.pdf>

³ To put that amount in perspective, this new tax would be more than the FICA contribution tax of 7.65%, already being paid by an employer. Further, for example, an 8% payroll tax on a worker’s salary that is

hit hardest those businesses that can least afford to take another hit, especially from the government, and especially while we are trying to recover from one of the worst economic downturns in the nation's history. Talk of "shared responsibility" requirements is disingenuous – employers spent \$1,454.9 billion on employee benefits in 2007, or 18.6% of total compensation. Employers spent \$532.1 billion for group health insurance, and \$199.9 billion on retirement income benefits in 2007.⁴ Employers are already doing their share and more.

Such a broad new mandate will not increase coverage – rather it will lead to out-sourcing, off-shoring, hiring of independent contractors, spinning-off small new companies, reducing workforces, and reducing wages. While we struggle to create jobs and stem the tide of layoffs, this bill represents a stimulus plan for India, Brazil, China, and other countries where workers will be available for more competitive rates.⁵

Congress is divorced from reality on this issue – while such provisions make for good soundbites about taking from the greedy and giving to the needy, it is actually the poorest, and the lowest wage workers, who will feel the brunt of this new mandate. In the simplest terminology, the pay-or-play requirement greatly increases the costs (and thus lowers the value) of low-wage workers.⁶ In order to keep their total compensation aligned with their economic value, the workers will have their wages reduced to account for the increased benefits costs of hiring them – and in the many cases where this is impracticable due to other laws and circumstances, these workers will be laid off, or never hired in the first place.⁷ The RAND Corporation has estimated that depending on

earning \$40,000 is \$3,200. If the employer employed 20 additional workers at the same rate, the employer's total contribution in taxes would be \$64,000. In addition to the FICA tax paid by the employer, this is assuredly not an amount that can be absorbed as petty cash.

⁴ Employee Benefit Research Institute: "*EBRI Databook on Employee Benefits, Chapter 2: Finances of the Employee Benefit System.*" Updated September 2008.

<http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2002.pdf>

⁵ Further, of course, this new mandate is only one of many new obligations that Congress is considering imposing on employers, with others ranging from paid family leave to expansion of civil rights laws to include unlimited punitive and compensatory damages, radical expansion of OSHA criminal and civil penalties, and facilitating union organizing.

⁶ See Katherine Baicker and Helen Levy, "*Employer Health Insurance Mandates and the Risk of Unemployment,*" Working Paper No. 12528 (Cambridge, Mass.: National Bureau of Economic Research, October 2007), which concluded that an employer mandate for health insurance would be passed on to workers in the form of lower wages, and reduced job opportunities. The study estimated that 224,000 workers could become unemployed if firms were required to provide health insurance costing \$2 per hour worked, on average. Also see Richard Burkhauser and Kosali Simon, "*Healthcare Reform: The Economics of 'Play or Pay' Employer Mandates.*" Employment Policies Institute, September 14, 2007. Their study, which examined the effects of a combined increase in the federal minimum wage to \$7.25 and a \$3.00 per hour pay or play mandate (in 2005 dollars) for both part-time and full-time workers, ages 17-64, estimated that 750,178 workers could lose their jobs. Also see Ellen Meara, Meredith Rosenthal, and Anna Sinaiko. "*Comparing the Effects of Health Insurance Reform Proposals: Employer Mandates, Medicaid Expansions and Tax Credits.*" Employment Policies Institute. February 2007, which calculated that an individual mandate requirement coupled with the effects of an employer mandate for firms with at least 25 employees could potentially reduce employment by 1.7 million jobs and that under this same scenario, 2.8 million workers could be shifted from full-time to part-time status.

⁷ See Congressional Budget Office: "Key Issues in Analyzing Major Health Insurance Proposals-December 2008". Available at: <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf>.

firm size and the level of penalty, new mandated coverage will cost \$9.12 to \$17.89 billion in premium contributions by employers, and penalty payments will be \$4.23 to \$12.48 billion.⁸

This is because businesses that can afford to offer benefits, do so. Certainly, many may be driven primarily by a paternalistic desire to take care of employees, but the vast majority of employers provide benefits because it is necessary to do so in order to be competitive. Benefit offerings attract and retain the best employees, improve productivity, reduce the use of sick days, and ensure that employees are doing quality work.

The businesses who do not offer benefits are primarily very small, very new, or operating on very slim profit margins. If Congress exempts these businesses then the mandate will be ineffective at advancing your goals, yet if you do not, these businesses will have to lower their head counts or close their doors. This begs the question of why Congress insists on these provisions. Regardless, the Chamber (which is comprised of 96 percent small businesses) will oppose a mandate no matter who is carved out – we are all too familiar with how these carve-outs work; they initially help to divide and conquer a constituency, then they shrink and shrivel.

One of the worst aspects of this proposal is that it includes a *de facto* “cash-out” for employees who opt out of employer coverage, and obtain coverage through the exchange. This creates a situation in which employees can be driven to the exchange with government subsidies, which will be especially valuable for the youngest, healthiest workers. Employers will then have to contribute what they otherwise would have spent on their benefits to the exchange. This is a recipe for adverse risk, inability to plan, employer plan death spirals, and the end of any notion of “keeping the plans you have.”

Despite speculation on this issue by the Congressional Budget Office, virtually the only actual implementation of such a mandate thus far in the U.S. has been in the state of Massachusetts, where the pay-or-play program failed to generate significant revenue. Under that mandate, assessments on employers were expected to bring in \$45 million in its first year and \$36 million in 2008.⁹ It failed to bring in any revenue in 2007 and just \$7 million in 2008.¹⁰

In fact, an analysis done for the Office of Health Policy in the Department of Health and Human Services found that a payroll tax of 8% would cause more than 37 million people to be shifted into government-run or administered plans, as employers would pay rather than play.¹¹ This would constitute a massive disruption in health insurance.

⁸ RAND COMPARE: “Effects of Employer Mandated Policy Options- December 30, 2008.” Available at: http://www.randcompare.org/analysis/mechanism/employer_mandate.

⁹ John Hurst, “Small Businesses Pay for Plan’s Shortcomings,” *Boston Globe*, August 18, 2008.

¹⁰ Id.

¹¹ Cost and Coverage: The Impact of implementing Various State Health Care Reform Proposals Nationally. Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Summer 2008. <http://aspe.hhs.gov/health/reports/08/reform/report.pdf>

A better, smarter approach would be to focus on bringing down the costs of health insurance, and encouraging individuals to obtain coverage. This would bring market forces to bear on employers, as their employees would ask anew for benefits that satisfied their individual requirements, without hurting the economy – while also helping more people to obtain insurance and making health care more affordable for all.

Minimum Coverage (“Essential Benefits”)

Even businesses that already offer generous benefits are determined not to be burdened by government-mandated levels of benefits and prescriptive instructions on how benefits must be designed. Because most government employees enjoy the extremely expansive FEHBP (Federal Employees Health Benefit Plan), there is an apparent belief by some in Congress that it makes sense to force all businesses offering benefits to approach the offerings of FEHBP. However, this would be completely unaffordable and impractical. The design of benefits is a decision that needs to be left between employers and employees. Government-dictated one-size-fits-all plan designs will be disastrous for business – to suppose that a computer programming company and a coal-mining company require or can afford the same kinds and levels of benefits reveals a lack of understanding of the realities faced by businesses and working Americans.

We are especially concerned about proposals to anoint a new committee of unelected bureaucrats, the majority of whom will have had no experience in designing benefits plans, who will basically make laws regarding required levels of benefits. Although Congress may feel an urge to punt this controversial issue to an outside “public-private” group, it is too important, and too critical for understanding the true potential impact of legislation to be simply handed off.

As we again look to Massachusetts, we see many problems which indicate that this model is hardly one to follow. Costs have primarily risen for individuals, as under the mandatory insurance scheme, the government must define what constitutes an acceptable insurance policy.¹² As special interests have lobbied for inclusion in the “minimum benefits” package, mandated benefits have raised the costs of health insurance by 23 to 56 percent.¹³ The Massachusetts Division of Health Care Finance and Policy released a study that showed that mandated health insurance benefits cost insurance purchasers about \$1.3 billion or 12 percent of their premiums each year.¹⁴

¹² Paul Hsieh. “Mandatory Health Insurance: Wrong for Massachusetts, Wrong for America.” *The Objective Standard*. Fall 2008 Vol.3 No.3. <http://www.theobjectivestandard.com/issues/2008-fall/mandatory-health-insurance.asp>

¹³ Victoria Bunce and J.P. Wieske, “Health Insurance Mandates in the States 2009,” Council for Affordable Health Insurance, p. 4-7.

¹⁴ Massachusetts Division of Health Care Finance and Policy. “Comprehensive Review of Mandated Benefits in Massachusetts: Report to the Legislature.” July 7, 2008. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf

Government-Run Insurance Plan (“Public Option”)

This legislation contains an especially troubling incarnation of a proposal to create a new government-run health insurance plan to “compete” with the private sector. This flies in the face of common sense.

Recent studies continue to find that government cannot and would not compete on a level playing field with private competitors in the insurance market. Government programs tend to hide administrative costs by outsourcing to various other departments and agencies, forcing individuals, enrollees, and participating businesses to pick up the slack. Government costs are artificially low due to cost-shifting to private payers – the consulting firm Milliman recently found that private insurance costs 20-30 percent more because of underpayment by government payers.¹⁵ Proponents of government plans usually cite MedPAC reports that say government plans pay fairly and private plans overpay – however, numerous providers, hospitals and businesses have reported to the Chamber that private payers tend to support public plan enrollees, and reductions in payment from private plans (or increased enrollment in public plans) would be likely to put many out of business, or at least to severely curtail access to care. The fact that this proposal would directly use Medicare rates is extremely dangerous.

This would be compounded by the problem of a massive shift from the private sector to the public sector. The Lewin Group actuarial firm recently found that tens of millions would be drawn to a public plan by artificially low premiums – a situation that would only worsen the already debilitating cost-shift private payers experience.¹⁶ A loss of 119 million Americans from the private sector to the public sector, together with the cost-shifting that will occur, would devastate the remaining private sector, and likely could lead to the inevitable government-run insurance “option” as the only option available.

A recent report by the Pacific Research Institute indicated that Medicare’s costs have risen one-third more, per patient, than the total of all health care costs in America apart from Medicare and Medicaid.¹⁷ This further research suggests that a government-run public plan option would not curtail costs for private health insurance, and could indeed lead to further cost-shifting.

The business community joins most Americans in opposing a “public option” that would likely be an unfair competitor or lead us toward government-run health care for all. A

¹⁵ Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers. Milliman, December 2008. <http://www.ahip.org/content/default.aspx?docid=25216>

¹⁶ The Cost and Coverage Impacts of a Public Plan: Alternative Design Options. Lewin Group staff working paper #4, April 2009. <http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf>

¹⁷ Jeffrey Anderson. Medicare Costs Have Risen Far More Than the Costs of Private Health Care. The Pacific Research Institute, Health Policy Prescriptions, Vol 7. No.06, June 2009. <http://liberty.pacificresearch.org/publications/medicare-costs-have-risen-far-more-than-the-costs-of-private-health-care>

recent poll by the Kaiser Family Foundation found that while Americans are initially open to a “public option,” when they learn that it might have an unfair advantage over the private sector or that it might lead to single-payer, they strongly opposed it.¹⁸ Worse, this bill would create a government-run insurance plan that talks, walks, and pays like Medicare – despite the fact that proposals to enact Medicare-for-all have failed repeatedly, nearly every Congress for as long as most of us can remember.

Public plan proponents have continually changed their justification for the need for such a plan. First they said it was necessary to give new options to people who currently lack options in the insurance market – but the creation of a connector or exchange would solve this problem. Next they said it was necessary to “keep the private plans honest” – but private plans are going to be aggressively regulated (no more preexisting conditions, guaranteed issue and renewal, community rating), so this became another moot point. Next they said a public option was the only way to control costs and implement delivery system reforms, but it is apparent that public plans “control costs” by driving down reimbursement to providers, and this simply results in increased costs to the private sector. We can find no meaningful justification for creation of a new government-run insurance plan other than to gut the private market and bring a large portion of America into government-run health care. Whether or not this proposal is a Trojan horse for single-payer health care, it is apparent that its cause is ideological, not pragmatic or driven by a desire for market competition or good health policy.

ERISA Changes

The reason so many employers are able to offer quality, affordable health insurance to their tens of millions of employees is that the Employee Retirement Income Security Act of 1974 (ERISA) allows them to administer uniform benefits across state lines, with maximum flexibility to allow employers to design plans that meet their employees’ needs.¹⁹ This proposal would threaten the success of ERISA plans by apparently allowing a new host of lawsuits under state law, revisiting many issues raised by the Patients’ Bill of Rights of past Congresses. Obviously, if this is true, we would be very troubled by these provisions.

Congress should be focused on lowering the costs of health care and expanding access to those currently without coverage. Why is there an effort to interfere with the parts of the system that are working well? The Chamber views such initiatives as counterproductive at best, and at worst, efforts to force more Americans out of private, voluntary employer-provided coverage, and into a government-run exchange that will inevitably drive individuals into a government-run insurance plan. These solutions in search of a problem will cause unnecessary disruption in current plan offerings – contrasting with the claims

¹⁸ Kaiser Family Foundation Health Tracking Poll, April 2009.

<http://www.kff.org/kaiserpolls/upload/7891.pdf>.

¹⁹ Over a hundred million Americans have health, retirement and other valuable benefits voluntarily provided by their employer under a nationally uniform framework established by the Employee Retirement Income Security Act. See National Coalition on Benefits: About the Coalition. Available at: <http://www.coalitiononbenefits.org/About/>

of the President and many leaders in Congress that “if you like the plan you have, you can keep it.”

Offsets and Pay-Fors, Fiscal Responsibility

Under the leadership of Speaker Pelosi, Congress made the bold and fiscally responsible decision to offset new spending and operate under a pay-as-you-go structure to avoid increasing the deficit. However, this and other pending legislation show that Congress did not get the right message – the right recipe for a good economy is not to tax and spend our way through the roof. Rather, we should spend smarter, write more targeted legislation, realign current funds already in the system, and reduce the deficit through restraint and responsibility.

This proposal may end up appearing deficit neutral on its face, but only because there are numerous proposals to pair it with massive new taxes. These taxes would be devastating to the economy, to businesses, and to the workers they employ. Among these wrong-headed proposals is a movement to create a European-style Value-Added Tax (VAT). A VAT would have negative implications throughout the economy, particularly hurting those with the lowest incomes, who would see the same increases in the costs of affected goods that those with higher incomes would see. This would hurt the already lowered consumption levels we are currently experiencing, lengthening the economic downturn.

Proposals to tax sugary drinks and alcohol would be similarly regressive. The revenues gained under such a proposal would come directly from those with the lowest incomes who have the fewest options to purchase and the least time and ability to change their dietary habits. These would also be the people most likely to further forego needed care if health expenditures through tax-free vehicles like Flexible Spending Arrangements and Health Savings Accounts were threatened.

Proposals to tax employee health benefits would also have extremely negative reverberations in the economy. These taxes would fall directly on workers, who would see their taxable income increased – although employers would also see FICA and payroll taxes increase, and would have to pass some or all of those costs on to the workers.

To alleviate this pressure some in Congress are proposing that only certain individuals have their benefits taxed – an administrative nightmare for employers and a recipe for bad health policy. Worst of all, some are proposing to give union workers a pass, thus directly taxing every non-union American worker to subsidize generous union benefits. Over the past several months of investigation, it has become increasingly apparent that there is no simple, fair, or good way to tax employee benefits without causing disruption in health insurance.

Congress’ profligate spending has placed a serious strain on the good name of U.S. dollars and has made us a laughingstock to our creditors – just the other day, when Treasury Secretary Tim Geithner promised a Chinese audience that investments in the

United States were safe and smart assets, they laughed at him. Perhaps they have realized that despite the already tens of trillions of dollars in unfunded liabilities in our health programs, many in Congress are insistent on spending another trillion dollars or two on health care, which is sure to balloon out of control, as most of our government's health care spending has done.

The root problem here is not that Congress is having trouble finding palatable ways to raise taxes by more than a trillion dollars – it is that Congress is trying to spend more than a trillion dollars. Tax credits to families of four making more than \$88,000 a year, expansion of Medicaid, a plethora of new boards, panels, committees, and irresponsible and unaccountable new multi-billion dollar funds... this litany constitutes a massive overreach. Finding insurance for the uninsured would cost a small fraction of this number, and implementing the necessary insurance market and delivery reforms to improve the system would also constitute a much smaller spend.²⁰ All of this leads to a conclusion that Congress should take this legislation back to the drawing board.

Reform We Can All Believe In

There is no reason for Congress and stakeholders to get stuck in this ideological morass; if we let go of the massive spending overreach, the partisan politics embodied in creating a government-run insurance plan and forcing employers to provide health insurance, and the government-knows-best attitude that leads to urges to pierce ERISA and create new committees with massive powers, there is still room and time to pass meaningful reform that all stakeholders can and should support.

Congress has rightly recognized that now is the time to reform the insurance markets. This will necessitate some hard decisions about how to enact and enforce guaranteed issue of insurance to all comers, guaranteed renewals, rate control, increased access to competing options, and more. And Congress has rightly recognized that these reforms will not be feasible unless everyone is in the system and has skin in the game – no gaming the system and waiting to buy insurance until you are sick.

If we can build connectors that work, and reform the insurance market, much of the work is done. We need to focus on reducing costs and making coverage affordable, and the initial task will be complete. This will be extremely challenging, necessitating a variety of delivery system reforms, payment and reimbursement reform, implementation of comprehensive strategies to boost health information technology, wellness, prevention, disease management, coordination of care, initiatives to support primary care and much more. This will require sacrifice on the part of many groups – insurers, hospitals, pharmaceutical companies, providers, workers, and yes, employers.

Somehow this mammoth bill has left out many of the key solutions we believe could lower health care costs and improve quality. Medical liability reform was not explored,

²⁰ See Henry Aaron. "Covering the Uninsured: Cheap at Twice the Price." *Health Affairs*. August 25, 2008. http://www.brookings.edu/opinions/2008/0825_uninsured_aaron.aspx (Estimates that the uninsured could be covered for around \$120 billion)

not even test projects through creation of specialized health courts. The massive Medicare claims database, which could be used to jump start quality and transparency efforts, is left to corrode. Employers are not given any safe harbors or encouragement to create wellness programs for employees. Enrollees in public programs are not given the option to instead take their government premiums and enroll in competing private options. And individuals and the self-employed are not given options to use pre-tax dollars to purchase health insurance, and thus still will not have tax parity.

The business community stands ready to work with Congress to pass such reforms. The Chamber will be on the front line fighting for the success of legislation that truly addresses these problems and proposes these solutions. But the Tri-Committee bill is a far cry from such a targeted piece of legislation – it appears to be broken beyond repair.