

The attached conference letter concerning the House-passed Affordable Health Care for America Act (H.R. 3962) and the Senate-passed Patient Protection and Affordable Care Act (H.R. 3590) was sent on January 13, 2010.

It was addressed to Speaker of the House Nancy Pelosi and Senate Majority Leader Harry Reid, with copies to:

Senator Dianne Feinstein
Senator Barbara Boxer
Representative George Miller
Representative Pete Stark
Representative Henry Waxman
Senior Vice President Dan Dooley
Associate Vice President Gary Falle
Associate Vice President Santiago Muñoz

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January 13, 2010

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

SUBJECT: Affordable Health Care for America Act (H.R. 3962)
Patient Protection and Affordable Care Act (H.R. 3590)

Dear Madam Speaker and Majority Leader Reid:

On behalf of the University of California (UC) Health System and its academic medical centers located at the Davis, Irvine, Los Angeles, San Diego and San Francisco campuses, our 4,800 faculty physicians, and our schools of allied and public health, we thank you for your leadership and congratulate Congress for the historic progress to reform the nation's health care system. Through your efforts the nation has moved closer than ever before to our common goal of expanding healthcare coverage to millions of uninsured Americans.

The purpose of this letter is to outline our recommendations for a final bill. As you move forward to reconcile differences between the House-passed Affordable Health Care for America Act (H.R. 3962) and the Senate-passed Patient Protection and Affordable Care Act (H.R. 3590), we welcome the opportunity to work with you and your staffs to ensure the enactment of policies that improve the nation's health. While we understand our nation's budget difficulty, particularly for the Medicare and Medicaid programs, it is essential that all Americans – currently insured, newly insured, and the residual uninsured – have meaningful access to healthcare services, which is integrally tied to maintaining and enhancing a healthcare delivery infrastructure. As such, the University urges Congress to include in the final legislation provisions that address our key concerns regarding physician workforce, disproportionate share hospital (DSH) payments,

Medicare payments for teaching hospitals, comparative effectiveness research, and variation in healthcare spending.

The University of California operates the largest health sciences and medical education training program in the nation. Our network of five medical centers and associated facilities represents the fourth-largest health-care system in California and one of the state's largest providers of healthcare to low-income, medically vulnerable patients. UC medical centers provide a significant volume of high quality health care — each year, we provide 139,000 inpatient discharges, 246,000 emergency room visits and 3.6 million outpatient visits. We provide a full range of healthcare services throughout large geographic regions and serve as sites for developing and testing new diagnostic and therapeutic techniques and cutting-edge biomedical research. A major component of tertiary and quaternary services provided to Californians, which can often only be provided in a teaching setting, is done at a UC Medical Center. The UC Health System is an integral component of California's healthcare infrastructure and, in turn, critical to the state's economy.

Medicare Payments to Hospitals

It is essential that the hospital market basket reductions in 2010 through 2013 be minimized and consistent with the coverage expansion in those years. The University understands the budgetary pressures and is prepared to support the Senate approach (Sec. 3401 in H.R. 3590) to payment updates, which reduces the market basket by 0.25 percentage point in 2010 and 2011. While we embrace this approach to contain costs, we must respectfully oppose the permanent annual productivity reductions in both the Senate and House bills, and strongly urge the conferees to sunset the productivity adjustments after 2019, the end of the 10-year budget period.

While containing healthcare costs is a priority, as the rising cost of healthcare impacts all Californians, the historically insufficient levels of Medicare reimbursements and the need to maintain adequate provider access causes us serious concerns with the proposed Medicare payment cuts to our medical centers and the patients we serve.

Medicare Physician Payments

The University urges Congress to take immediate action to reform Medicare physician payments and supports the solution proposed in H.R. 3961 that puts in place a revised method for physician payment. UC supports replacing the current Medicare physician payment system with a long-term solution that will adequately compensate physicians based on such factors as the services provided and the complexity of patients, as well as increased costs due to inflation.

If Congress does not act this year to address the issue, Medicare payment rates for physicians will be cut significantly -- by 21 percent in 2010 and over 40 percent by 2016.

This would have a devastating impact on healthcare access throughout our communities. For UC faculty physicians alone, the direct effect of these pending payment reductions is substantial totaling over \$31 million in 2010. Since many other professional agreements are also tied to Medicare rates, indirect losses will account for an additional estimated \$8 million for a total financial impact of approximately \$39 million in 2010.

Medicare beneficiaries rely on the services of academic physicians and health systems like the University of California to provide high quality, innovative and accessible healthcare. The University's ability to continue to meet the diverse clinical needs of a growing Medicare population will be severely compromised by Medicare's continued reliance on the flawed physician payment formula.

Independent Payment Advisory Board

Teaching hospitals and faculty physicians serve a unique role in their communities, often providing care that is unavailable elsewhere and serving as referral centers for other providers who are unable to care for their sickest patients. Regrettably, broad payment policy decisions do not always take into account the special circumstances of these highly valued institutions and the potential unintended consequences these policies may have on communities. The University believes strongly that Congress should continue to exercise its ability to evaluate changes in payment policies on the communities and patients they serve.

Additionally, UC believes that the Medicare Payment Advisory Commission (MedPAC), as currently structured, serves adequately as an independent advisory body to Congress. MedPAC should continue in this role, which allows Congress to fully review and debate its recommendations. Such transparent interaction between the legislative and executive branches of our government is the most effective way to prevent unintended, yet potentially very harmful, consequences for patients and providers. The University believes the Independent Payment Advisory Board provisions in Sec. 3403 of Title III in the Senate bill (H.R. 3590) should not be included in the final health care reform legislation.

Physician Workforce

UC applauds language in both H.R. 3962 and H.R. 3590 which preserves current funding for physician training and for taking steps to ensure an improved distribution of physicians. However, without significant additional investment in physician training, efforts to expand healthcare coverage under healthcare reform will exacerbate California's current shortage of physicians. Even without coverage expansion, projections indicate a shortage of at least 17,000 multispecialty and primary care physicians by the year 2015. Expanded coverage and the anticipated increased demand for healthcare services will significantly increase that estimated shortage.

The University supports Senate Amendment (S.A.) 2909 to H.R. 3590 to increase physician training by 15%, which is a necessary first step towards expanding the physician workforce to meet the rising healthcare needs of Americans.

Unless Congress includes provisions to ease Medicare's limits on graduate medical education (GME) funding for physician training, current House and Senate language will add fewer than 3,000 additional physicians over the next decade and the number of physicians per capita will actually decrease.

UC urges you to preserve the following language related to GME funding and training:

- UC supports provisions in both H.R. 3962 and H.R. 3590 that address problematic regulatory barriers to training residents in non-hospital settings. Specifically, the University strongly supports and urges the preservation of Sec. 1502 and Sec. 1503 included under Division B, Title V of H.R. 3962, which is similar to Sec. 5504 and Sec. 5505 in Title V of HR 3590. These provisions allow for:
 - Counting didactic time spent by residents in non-hospital settings for the purposes of calculating direct graduate medical education (DGME) payments;
 - Counting didactic time spent by residents in inpatient settings for the purposes of calculating indirect medical education (IME) payments; and
 - Counting resident time spent in non-provider settings, as long as the hospital incurs the costs of resident stipends and fringe benefits while the resident is in the non-provider setting.
- UC supports inclusion of Sec. 5503 and Sec. 5506 in Title V of H.R. 3590 which preserve the existing medical residency training slots at facilities like Martin Luther King Medical Center in Los Angeles which operated an approved medical residency training program prior to closing more than two years before enactment.
- UC also strongly urges you to preserve language in H.R. 3962 and H.R. 3590 that maintains Medicare's IME adjustment at current levels.
- UC supports inclusion of Sec. 2539 in H.R. 3962, authorizing a total of \$500 million for grants to assist nonprofit organizations in their efforts to establish new medical schools. The University is currently in the process of establishing new independent medical schools on our Merced and Riverside campuses and believes that the new federal grants would serve to stimulate a more rapid development of medical schools on those campuses. The University strongly supports the House provision and requests its inclusion in the final bill.

The University has concerns with the following GME provisions and requests the following:

- UC strongly urges conferees to replace current language in Sec. 1501 of Division B, Title V in H.R. 3962 and Sec. 5503 of Title V in HR 3590 related to the redistribution of unused GME training slots. To address current and increased physician shortages, the language should be replaced with a 15 percent increase in Medicare-supported GME training slots as offered by S.A. 2909. These provisions will add nearly 40,000 additional physicians over the next 10 years, offsetting the expected shortage of at least 125,000 across the country.
- UC believes that Sec. 1744 of Division B, Title VII in H.R. 3962 is not necessary and should not be included in the final bill. The University believes that GME is already a recognizable patient care cost under Medicaid, and further efforts to codify the policy are not necessary.
- UC urges adoption of the appropriated funding source for support of “Teaching Health Centers” taken by the Senate bill in Sec. 5508 of Title V and to reject the expanded use of Medicare Part A funding for training at (Community Health Centers) CHCs (as established under Sec. 1502(d) of H.R. 3962). Any additional funding for training in CHCs should be derived from separately appropriated monies.
- UC opposes inclusion of Sec. 1505(b) in H.R. 3962, which would require the Government Accountability Office (GAO) to assess faculty expertise, develop curricular requirements, and assess accreditation, which are processes of the Accreditation Council for Graduate Medical Education (ACGME). All three of these activities fall far beyond the expertise and capabilities of the GAO and must remain within the purview of educational accreditation bodies whose expertise and processes are not likely to benefit from GAO review.

Medicaid Federal Medical Assistance Percentage (FMAP)

The University urges you to include the original House funding approach that would provide all states 100 percent of federal funds through 2019 for the expanded populations. In addition, UC supports adoption of the House provision to extend the American Reinvestment and Recovery Act (ARRA) temporary FMAP increase for an additional six months.

Disproportionate Share Hospital (DSH) Payments

The cuts in Medicare and Medicaid disproportionate share hospital (DSH) payments included in Sec. 2551 of Title II, Sec. 3133 of Title III, and Sec. 10316 of Title X of the Senate bill, H.R. 3590 will disproportionately affect teaching hospitals before it is determined whether the expansion of health care coverage is truly working. As coverage

expansion occurs it is important to remember that there will be individuals who, for a variety of reasons, will remain without health insurance coverage but will seek treatment by health care providers and that many patients will remain under-insured.

UC strongly urges you to limit DSH cuts to those established under Sec. 1112 of Div. B, Title I and Sec. 1704 of Div. B, Title VII in the House bill, H.R. 3962. At a minimum, cuts to Medicare DSH payments must be reduced if communities are to maintain access to major teaching hospitals and their services. Medicaid DSH funding remains highly dependent on individual states, which makes Medicare's support for the safety net critical to the communities, especially those served by UC's teaching hospitals.

Geographic Variations

A recent analysis by MedPAC and several studies published in peer-reviewed literature have demonstrated that overly simplistic interpretation of the Dartmouth Atlas has led to vast overestimates of variation in health services utilization. While the University believes more detailed, peer-reviewed analysis of these variations is warranted, we disagree with the approach taken by H.R. 3962 in Sec. 1160 under Div. B, Title I. Specifically, the House language authorizes the largest revision in Medicare payment policy in a quarter century after only a single study by the Institute of Medicine (IOM) and rapid adoption of payment reform recommendations by the Secretary.

Similarly, the University does not support inclusion of Sec. 1158 of Div. B, Title I in H.R. 3962. However, should this provision remain in the final bill, UC believes it must continue to "hold harmless" those providers in geographic areas of the country with higher geographic payment adjustments until all of the contributing factors are better understood. Failure to do so may unintentionally endanger the vulnerable patients healthcare reform legislation seeks to protect.

UC's faculty physicians and teaching hospitals frequently treat more complex cases of severely ill patients who are transferred from community providers unable to care for those patients. As a result, our medical centers provide the most intense and complex services. These legitimate differences tend to be amplified in urban areas with higher concentrations of low-income patients. Analyses of geographic variation that fail to properly account for patients' health and socio-economic status or that erroneously include special policy payments are inherently flawed and should not be used for setting payment policy. The risks of enacting deeply flawed policies are extremely high when complex decisions rest upon one study carried out over an insufficient period of time for proper analysis.

The Senate approach requesting the Secretary of Health and Human Services (HHS) to create a modifier to physician payments and including efficiency measures in hospital value-based purchasing (VBP) is more measured but not without shortcomings. Final

legislation intended to address regional variation in utilization should exclude Sec. 1158 and Sec. 1160 of H.R. 3962.

Expansion of 340B Program

The University supports the language in Sec. 7101 included under Title VII of H.R. 3590 that expands the 340B program to include inpatient services. Major teaching hospitals often serve as the ultimate safety-net providers for their communities and are more likely to be disproportionate share hospitals. The cost limits established in these hospitals' outpatient settings do not end with admission; in fact our medical centers routinely provide acute, inpatient care for the underserved which often results in significant costs for the University. UC greatly appreciates the recognition of these costs in H.R. 3590 and we urge you to retain this common-sense policy in the final legislation.

Readmissions

UC agrees that hospitals can do more to minimize the risk of readmissions; however, we have significant concerns with the readmission policy set forth in Sec. 3025 of Title III in H.R. 3590 and Sec. 1151 in Div B, Title I of H.R. 3962. Readmissions are the result of complex, system-wide issues that involve patient characteristics and multiple caregivers. In order to recognize these complexities and ensure a more equitable readmission policy the University urges the following be included in any final readmission policy:

- Ensure a risk adjustment methodology that accounts for severity of patient's illness, socio-economic status, and other relevant patient characteristics. Failing to recognize the higher readmissions rates for such patients would unfairly penalize teaching hospitals and the disadvantaged patients for whom they care.

At a minimum, the following types of readmissions should be excluded from the readmission payment policy:

- Those associated with dual-eligible or disabled patients;
 - Those in which the original discharge was associated with a diagnosis or treatment code for transplants, end-stage renal disease (ESRD), burn, cancer, trauma, or a primary or secondary diagnosis of mental illness or substance abuse; and
 - Planned readmissions or readmissions unrelated to the initial admission.
- UC supports the inclusion of language contained in Sec. 1151 in Div. B, Title I of H.R. 3962, which provides financial assistance for care transition services to hospitals with a high DSH patient percentage and requires monitoring of admission practices and patient transfer rates to ensure high-risk patients are not avoided due to their risk of readmission. These provisions will improve access to care which otherwise may be unavailable for patients at high risk of readmissions.

Hospital Acquired Conditions

The current House and Senate bills offer multiple avenues for hospitals to report hospital acquired conditions (HAC) and infections as well as multiple ways for hospitals to incur payment penalties on the same conditions/infections. UC supports a singular approach to HACs.

Any program to address HACs which includes payment penalties must have an appropriate risk adjustment methodology to account for complex and high-risk patients who are more susceptible to infections even if evidence based guidelines are followed. Major teaching hospitals treat a high percentage of these patients and the risk adjustment must ensure these providers are not disproportionately affected.

Any HAC policy must also include language to monitor the potential for unintended consequences, specifically for hospitals like the University of California who routinely treat complex cases of high risk patients.

Value Based Purchasing

UC supports Sec. 10309 under Title X of H.R. 3590 which removes the readmission measures from the Value Based Purchasing (VBP) Program ensuring that hospitals are not penalized twice by the VBP and readmission payment programs for the same measures.

The University believes it is premature to use simplistic efficiency measures such as Medicare spending per beneficiary in the VBP program. Without more sophisticated efficiency measures, hospitals that deliver fewer resources to patients may be considered 'efficient' even if withholding care is detrimental to patients. There is currently no agreed-upon definition of efficiency nor a clear understanding of all components included in determining and measuring efficiency at a particular institution. Until these issues have been resolved, efficiency measures should be excluded from any VBP program.

Physician Quality Reporting System

The University supports improvements to the physician quality reporting program, including the 0.5 percent additional bonus for eligible professionals' submission of Physician Quality Reporting Initiative (PQRI) data through a Maintenance of Certification Program (MoC) included under Sec. 3002 of Title III in H.R. 3590; however, language linking the MoC to the value-based payment modifier is unnecessary and should be removed from the final legislation.

The value-based payment modifier, as described in Sec. 3007 of Title III in H.R. 3590, applies a budget neutral adjustment to physician fee schedule payments based on the quality of care compared to cost. UC urges Congress to fully review both the premise

and impact of the value-based modifier before allowing the Secretary of Health and Human Services (HHS) to implement any related payment changes. As currently written, Sec. 3007 has the potential to penalize medical school faculty physicians, who often provide costly yet innovative and life-saving health care services that are unavailable elsewhere in the community.

Public Reporting of Performance Information

UC supports the creation of a Physician Compare website as described in Sec. 10331 under Title X of H.R. 3590 that displays useful, accurate and relevant data, including provisions that: (1) solicit feedback from a multi-stakeholder group; (2) provide eligible professionals the opportunity to review results prior to the public release of information, and (3) require appropriate patient attribution and risk adjustment.

Comparative Effectiveness Research (CER)

The University has serious concerns with provisions in Sec. 6301 under Title VI of H.R. 3590 that would have a limiting effect on the publication in peer-reviewed journals of the results of comparative effectiveness research (CER) funded by the Patient-Centered Outcomes Research Institute (the Institute). Specifically, the University is concerned with the provision pertaining to the “requirements for the publication of research” that authorizes the newly established CER Institute to withhold funding from any institution whose researchers publish results that are not “within the bounds of and entirely consistent with the evidence.”

Although the University does not object to third-party review of research data prior to publication and such agreements are commonly included in UC contracts, a provision requiring third-party permission or allowing a third party to set conditions for use is unacceptable to the University, unless the data is proprietary or classified confidential. UC believes such a restriction strikes at a core academic principle, that of free publication and access to information. UC believes these restrictions are unprecedented, unnecessary and pose a significant barrier to participation by any University of California campus in conducting CER for the Institute. The University strongly urges conferees to delete the language from the final legislation.

The University believes that the Patient-Centered Outcomes Research Institute should take advantage of the existing federal research infrastructure and considerable expertise located in the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ). UC urges that the current mandate in Sec. 6301 under Title VI of H.R. 3590 for the Institute to “give preference” to AHRQ and NIH when entering into contracts for research be amended to “require” the Institute to contract with AHRQ or NIH “if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.”

The University strongly supports efforts to improve the science and methodology of comparative effectiveness research. UC is concerned about the role of the Institute's Methodology Committee and the extent to which methodological standards developed by this committee authorized in the Senate bill will be imposed on both Federal agencies and researchers supported by Institute funds. The Senate bill states that contracts for research "shall require that the agency, instrumentality, or other entity...comply with the methodological standards adopted under paragraph (9) with respect to such research...."

UC urges the conferees to modify the scope of the methodology committee to contract with AHRQ and/or NIH to enable the scientific community to update CER standards through activities such as methods research and state of science conferences, and to disseminate CER standards to the research community, including through support for training and conference grants. The University also supports the Methodology Committee contracting with the Institute of Medicine to report periodically on the state of CER methods. The Institute's Methodology Committee should be advisory to, and supportive of, the grant-making processes of federal research agencies and of the CER scientific community, rather than the role implied in the current legislation, where it might be perceived as an independent regulator of the science of CER.

Health Professions Programs

UC commends Congress for provisions in both the House and the Senate bills to reauthorize the health professions education and training programs under Title VII of the Public Health Service Act.

The University strongly supports the establishment of a Public Health Investment Fund (PHIF) in Sec. 2002 of H.R. 3962, and provisions that make the Health Resources and Services Administration's (HRSA) Title VII health professions programs, Title VIII nursing education programs, and the National Health Service Corps (NHSC) eligible for supplemental funding through the PHIF.

While we appreciate that the Senate bill (H.R. 3590) establishes a Community Health Center Fund in Sec. 10503, and makes such funding available to the NHSC, we are disappointed that Title VII and Title VIII health professions programs are excluded. The health professions programs improve the supply, diversity, and distribution of the health care workforce, but have been limited by chronic underfunding. The University strongly urges that the final legislation include eligibility for Title VII and Title VIII to help reverse this funding trend and to strengthen the programs' ability to respond to the country's workforce needs.

The University greatly appreciates Sec. 2201 of the House bill and Sec. 10501(n) of the Senate bill to authorize half-time service, increased annual awards, and teaching to fulfill 20 percent of the service obligation under the National Health Service Corps.

UC applauds both the House and Senate for reauthorizing the Title VII diversity programs, including the Centers of Excellence, Health Careers Opportunity Program, Scholarships for Disadvantaged Students, and Faculty Loan Repayment Program (Sections 2281(b) and 2241 of the House bill and Sections 5401 and 5402 of the Senate bill). Similarly, the University appreciates that both the House and the Senate bills update the HRSA loan guideline parental information requirements (Sec. 2212 of the House bill and Sec. 5201 of the Senate bill). UC supports the proposed revisions to the loan guidelines and also urges inclusion Sec. 5201 of the Senate bill which would establish a more reasonable default rate.

UC is pleased that Sec. 5301 of the Senate bill adopts the provision restructuring the Title VII primary care programs by prioritizing applications submitted jointly with a community health center, Area Health Education Center (AHEC), or other entity serving underserved populations. Likewise, the University praises the Senate bill's provision to support training in new competencies identified by the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry. The University also supports reauthorization of the AHEC program and the geriatric education and training programs, as proposed in Sections 5403(a) and 5305 of the Senate bill.

The University appreciates that both the House and the Senate bills propose reauthorization of the workforce information and analysis program. In particular, UC strongly supports reauthorization of the Title VII workforce centers and provisions of the Senate bill that establish a national workforce database of Title VII-trained health professionals; support development of outcomes measures and benchmarks to evaluate success of the programs; and provide resources to grantees for longitudinal data collection (Sec. 5103). However, given the paucity of current, comprehensive data on the workforce, UC is concerned that the workforce commission proposed in Sec. 5101 of the Senate bill will be forced to make recommendations that cannot be substantiated. Further, we question the need to limit participation of health professionals on the panel, as we believe that a diversity of stakeholders should not come at the expense of expertise in the field. UC is also concerned that the commission's charge appears duplicative of existing HRSA advisory committees, and we urge that the new commission should not form until reliable data becomes available.

Student Health Insurance

The University appreciates that Sec. of 1560(c) of Title I, Subtitle G of H.R. 3590 recognizes the important role that institutions of higher education like the University of California play in providing comprehensive and affordable health insurance for our student populations. However, the ability to continue offering Student Health Insurance/Benefit Plans (SHIBPs) on a group-like basis may no longer be possible because by default and without additional clarification, SHIBPs could be interpreted as being subject to individual market rating requirements because of the way in which the group market is exclusively defined as an employer-based market of insurance in Title I,

Subtitle D, part I, Sec. 1304. UC requests that the final bill include clarifying language that explicitly retains SHIBPs group-like rating status. Without additional clarification, the University believes our students may face substantial increases in their health insurance premiums.

Telemedicine Credentialing and Privileging

The University applauds Sec. 1191(c) of H.R. 3962 that requires the Secretary of Health and Human Services to issue guidance for hospitals to simplify requirements regarding compiling practitioner credentials for the purpose of rendering a medical staff privileging decision. However, UC remains deeply concerned that this provision falls short of what is needed to ensure Californians living in remote or underserved areas have access to high quality essential telehealth services and requests adoption of a provision that requires CMS to develop regulations to implement both a process for telehealth practitioners to be credentialed and privileged by proxy, as well as inclusion of "hold harmless" criteria for those institutions using credentialing and privileging by proxy. The "hold harmless" criteria would remain until CMS's regulations regarding remote credentialing and privileging are finalized. This request is consistent with Senate Amendment 3136.

Revenue Provisions

The University of California has serious concerns regarding the potential impact of the proposed excise tax on high cost insurance plans. Under Section 9001 of H.R. 3960, beginning in 2013, an excise tax of 40 percent would be levied on insurance companies for the cost of plans valued above a threshold of \$8,500 for individuals and \$23,000 for families. UC estimates that if current coverage options are offered in 2013 and current health insurance plan cost estimates remain constant, a significant number of UC employees' health plans would be impacted, especially given the likelihood that insurance companies would pass the costs on to the University. The effect of this cost shift could result in the need to reduce the number of health insurance plans and coverage levels offered to our employees.

The University is also concerned with Section 9003 of H.R. 3960 which includes modifications to the definitions for "qualified medical expenses" for flexible spending accounts (FSA) and health reimbursement accounts (HRA). FSAs and HRAs are a useful tool in offsetting employees' out-of-pocket medical expenses. Narrowing allowable reimbursable expenses to preclude over-the-counter medicines unless doctor prescribed will reduce the overall value of FSA and HRA accounts, making the plans less attractive for our employees. UC supports retaining the existing definitions for qualified medical expenses.

Section 9005 of H.R. 3960 would reduce the amount allowable for FSA accounts to \$2,500 from the current \$5,000 per year. FSA plans are greatly valued by our employees because they help offset increasing medical costs. Lowering the amount to \$2,500 will

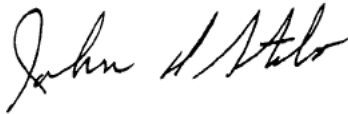
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reduce the overall benefit to our employees. UC supports retaining the current allowable amount for FSA accounts in order to continue to provide our employees with optimal benefits for offsetting medical costs.

The University of California offers its great appreciation for your commitment and leadership in working to achieve comprehensive healthcare reform that benefits all Americans. We continue to look forward to working with you and your staff to ensure the enactment of policies that strengthens our nation's healthcare delivery system and improves the health of the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "John D. Stobo". The signature is fluid and cursive, with the first name "John" being the most prominent.

John D. Stobo, M.D.
Senior Vice President, Health Sciences and Services
UC Office of the President

C: Senator Dianne Feinstein
Senator Barbara Boxer
Representative George Miller
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