The provision of health care services is a key element in the enhancement of individual and community health status, yet other factors also play critical roles. Genetic makeup, family health history, family structure, race/ethnicity, level of education, degree of health literacy, neighborhood characteristics, and the presence of suitable employment opportunities are important dots that need to be connected in one way or another in order to achieve satisfactory health policy goals.

Some factors that are more of an economical nature may not be as self-evident, yet they too can be highly influential in determining health outcomes. As noted in an article in the April 2016 issue of the journal *Psychological Science*, the past decade has entailed a rise in both economic insecurity and frequency of physical pain. Current research reveals a causal link between these two growing and consequential social trends. In five studies, researchers found that economic insecurity produced physical pain and reduced pain tolerance. In a sixth study, with data from 33,720 geographically diverse households across the United States, economic insecurity predicted consumption of over-the-counter painkillers.

The link between economic insecurity and physical pain emerged when individuals experienced insecurity personally (unemployment), when they were in an insecure context (they were informed that their state had a relatively high level of unemployment), and when they contemplated past and future economic insecurity. Overall, the findings show that it physically hurts to be economically insecure.

Similarly, the June 2016 issue of the *Journal of Economic Behavior and Organization* indicates that over the past three decades, the federal earned income tax credit (EITC) arguably has become the most important U.S. anti-poverty program. Enacted in 1975, the EITC was designed as a refundable tax credit to offset the rise in payroll taxes. Six million families received $5 billion in 1975 as measured in 2013 U.S. dollars. Today, the program is viewed primarily as a wage supplement whereby 28 million families received $64 billion. In 2011, the program lifted 9.4 million individuals, including 4.9 million children, above the poverty line.

In response to the growing prominence of the EITC, empirical work has begun to shift away from traditional economic outcomes (e.g., employment) toward an emphasis on the EITC’s potential health effects. In particular, recent studies examine whether EITC expansions have implications for infant health and birth weight, children’s cognitive ability test scores, and adult biomarkers and mental health. Research findings suggest that the EITC expansion has generated sizeable improvements in major categories of subjective well-being (SWB) that have a positive influence on mental health and happiness, which affect physical health status.

Thus, developments in health care may benefit from cross-fertilization of events from other domains, underscoring the importance of connecting dots among them.
Spring is here signaling growth and beautiful changes. I trust you welcome the change since it provides opportunities for rejuvenation. This month’s message is about a piece of our organization’s rejuvenation. You were recently asked, via a brief survey, for your feedback about the continuation of holding an annual Spring Meeting in addition to the Annual Conference. As a reminder,

**We Asked:**
1. When was the last time you attended the Spring Meeting?
2. Should ASAHP continue to hold the Spring Meeting?
3. If we were only to hold one meeting a year, would you like to have ASAHP offer a more extensive annual conference?

We are cognizant of the fact that everyone’s increased responsibilities as leaders on their home campuses creates very tight schedules, and multiple meetings per year places a strain on already limited travel budgets. The survey was designed to acquire feedback from our membership regarding the current sentiment on ASAHP’s offering of conferences.

**You Responded:**
1. 46% of the respondents attended the most recent spring meeting in Louisville.
2. 66% of the respondents would like to eliminate the ASAHP Spring Meeting.
3. 75% of the respondents would like to have ASAHP offer a more extensive annual conference.

**We Listened:**

At the April Board of Directors meeting, the Board reviewed survey information, and after thoughtful discussion voted to eliminate the Spring Meeting effective immediately. I think it is important to note that the elimination of the Spring Meeting is not due to a perception of the lack of a quality meeting. This was driven home when we saw that 46% of the survey respondents attended the recent Spring Meeting in Louisville and that conference registered a 97% satisfaction rate. The comments about the program venue were very strong. Therefore, it is worth once again thanking all of our speakers and conference planning committee for a great spring 2016 meeting!

**We Are Acting:**

Ouch! Change is difficult even when the information suggests that the time for change is now. As a result of your feedback, we will eliminate the Spring Meeting and have a full 3-day Annual Conference effective October 2016. The program planning committee is in the early stages of conference planning. They will take into account feedback received and in particular, time will be built into the meeting schedule for our working committees for that important in-person work time. “Networking with colleagues”and “learning information” are still the top survey responses indicating the primary reason for ASAHP conference attendance. The October program will reflect the various elements that have been identified as important to our members.

Thank you all for your feedback leading us to make a change. We will continue to engage you in various aspects of your organization. Your voice is important to our success.

“The secret of change is to focus all of your energy, not on fighting the old, but on building the new” Socrates
PROPOSED BUDGET OVERHAUL

Preparation of a federal budget each year often proves to be a difficult process owing to significant differences between the two legislative chambers and between Democrats and Republicans regarding how funds should be allocated. Budget Committee chairmen Tom Price (R-GA) in the House and Michael B. Enzi (R-WY) in the Senate have begun efforts to rewrite the current way of doing congressional business. Mr. Price plans to hold several hearings before July 15 to examine ways to revise the 1974 budget law that created the modern appropriations process while the Senate Budget Committee held a hearing on April 20 with the prospect of producing a bill that could be released as early as next month. The proposed legislation would move from an annual budget and appropriations process to one that takes place every two years. A related proposal would allow Congress to take up half of the 12 spending bills in one year, and the other half of the bills the next year.

Meanwhile, Congress was unable to meet the April 15 statutory deadline for approving a budget and beginning the process of passing annual spending bills. Conservative Republicans in the House continue to argue in favor of lower spending levels, against those who want to align with the $1.07 trillion discretionary spending level passed in last year’s bipartisan budget agreement. The law enables House appropriations bills to proceed to the floor after May 15 in the absence of a budget resolution. The budget agreement allows the Senate the option of simply naming the budget limits for the individual spending bills between April 15 and May 15 so that the chamber can proceed under regular order while the budget resolution continues to be negotiated. The Senate also is allowed to use House-passed FY 2016 appropriations as vehicles for FY 2017 as a means of avoiding procedural challenges that require appropriations bills to originate in the House.

A major piece of legislation in the health domain that demonstrates an ability to reach bipartisan agreements is exemplified by when the House passed the 21st Century Cures Act (H.R. 6) last July 10 on an exceptionally strong vote by Democrats and Republicans of 344-77. The Senate Health, Education, Labor and Pensions (HELP) Committee recently held its last of three markups of biomedical innovations legislation, advancing five bills: the FDA and NIH Workforce Authorities Modernization Act (S. 2700), the Promise for Antibiotics and Therapeutics for Health (PATH) Act (S. 185), the Advancing Precision Medicine Act of 2016 Act (S. 2713), the Advancing NIH Strategic Planning and Representation in Medical Research Act (S. 2745), and the Promoting Biomedical Research and Public Health for Patients Act (S. 2742), completing a total of 19 bipartisan bills on medical innovation.

2016 ASSOCIATION CALENDAR OF EVENTS

October 17-18, 2016—Leadership Development Program in New Orleans, LA—Part II

October 19-21, 2016—Annual Conference in New Orleans, LA

September 12, 2016—Institutional Profile Survey Data Collection Opens

November 30, 2016—Institutional Profile Survey Data Collection Ends

Note: Efforts are underway to identify future conference locations
AFFORDABLE CARE ACT DEVELOPMENTS

The Affordable Care Act became law six years ago last month. A remarkable feature of this comprehensive piece of legislation is that almost irrespective of which aspect of it is discussed in the health policy arena, conflicting opinions are generated. Some prominent examples are:

Comparing Health Status And Use Of Medical Services Before And After The ACA Took Effect

According to a recent study by Blue Cross Blue Shield (BCBS), new enrollees in BCBS individual health plans in 2014 and 2015 have higher rates of certain diseases, such as hypertension, diabetes, depression, coronary artery disease, human immunodeficiency virus (HIV) and Hepatitis C than individuals who already had BCBS individual coverage. Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical services in their first year of coverage, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015, as well as those with BCBS employer-based group health coverage. New enrollees used more medical services across all sites of care, including inpatient hospital admissions, outpatient visits, medical professional services, prescriptions filled, and emergency room visits. Medical costs associated with caring for the new individual market enrollees were, on average, 19% higher than employer-based group members in 2014 and 22% higher in 2015. For example, the average monthly medical spending was $559 for individual enrollees versus $457 for employer-based group members in 2015.

Officials at the Department of Health and Human Services (HHS) responded by indicating that the comparison between the newly insured and previously insured in the individual market was flawed. The report is considered to have provided a skewed picture of how consumers covered in the individual market compare to enrollees in employer-provided insurance because it contrasted only the newly insured in the individual market with everyone in job-based Blue Cross Blue Shield insurance. Also, in response to predictions that the newly insured would be costlier, the health care law created transitional stabilization programs to help insurers avoid big losses.

Premium Impact Of UnitedHealth Group's Potential Withdrawal From Insurance Exchanges

UnitedHealth Group’s announcement that it is leaving health insurance exchanges in Arkansas, Georgia, and Michigan, along with the possibility that it also could withdraw from some or all of the 31 other state exchanges in which it participates, has led to discussions about the likelihood of sharper increases in the cost of insurance premiums for consumers. A recent study by the nonpartisan Kaiser Family Foundation projects that withdrawal wouldn't drastically affect competition in most markets created by the ACA because United isn't the primary conduit for individuals buying coverage on their own. In about 34% of counties, a United exit would reduce the number of participating insurers below three, the number generally considered sufficient for competition. The reduction means that about 2.9 million exchange enrollees would find themselves in markets with just one or two options. ACA critics believe that the impact will be more significantly more substantial.

Effect of The “Cadillac Tax” On Health Care Services Use And Health Costs

Congress in December 2015 delayed implementation of the so-called “Cadillac Tax”, a 40% excise tax on high-cost employer health benefit plans. Now scheduled to be implemented in 2020, the Cadillac tax would effectively cap the current tax exclusion for employer health benefits. Many economists who support the tax believe that by excluding health benefits from taxable incomes, tax revenues will decrease and the current tax break creates incentives for employers to pay more of employees’ compensation via health benefits instead of taxable wages, possibly leading to overuse of health care services and driving up health costs. Meanwhile, many business groups, labor unions, and members of both parties in Congress favor outright repeal.
DEVELOPMENTS IN HIGHER EDUCATION

Accreditation is a topic with a long shelf life. From the perspective of the federal government, it is important that higher education institutions offer a quality education because of their involvement in distributing billions of dollars each year in student financial assistance. A substantial number of arguments have persisted over the past several decades regarding the most appropriate kinds of mechanisms to employ as a means of ensuring that quality education is being offered. For example, in the early 1990s, some critics of accreditation agencies believed that much more authority should be shifted to the states.

Government Accountability Office (GAO) Assessment Of Accreditors
A GAO study released in December 2014 indicated that over a 4-1/2-year period, accreditors— independent agencies recognized by the Department of Education (Education)—sanctioned about 8% of institutions for not meeting accreditor standards. They terminated accreditation for about 1% of accredited schools, thereby ending the schools' access to federal student aid funds. Accreditors must be recognized officially by the Department as reliable authorities on assessing academic quality and schools must be certified by these accreditors as meeting both academic and financial standards to qualify for federal student aid funds.

Institutions with weaker student outcomes were, on average, no more likely to have been sanctioned by accreditors than schools with stronger student outcomes. Researchers have reported that assessing multiple student outcomes could shed light on the quality of education provided by schools. Such outcomes are characteristics that the Department of Education and researchers consider important indicators of educational quality, but which accreditors are not necessarily required to use. Regarding academic quality, accreditors interviewed by the GAO reported that this area is difficult to oversee, saying that few quantifiable indicators exist. Yet, academic quality is a key accreditor responsibility under the Higher Education Act and student aid funds may be at risk when schools that do not provide a quality education have access to these funds.

Enforcing Standards That Measure Student Achievement
The Department of Education specifically is prohibited from evaluating academic quality at colleges. That responsibility is the province of accreditors, independent groups recognized by the Department, to be the reliable authorities charged with conducting the evaluation. Referring to that GAO report, 24 U.S. Senate Democrats sent a letter on April 22, 2016 to U.S. Secretary of Education John King urging him to ensure that college accreditors, the gatekeepers to the $150 billion dollars in federal financial aid revenue that flows to colleges and universities each year, are held accountable. They called for the Department of Education to engage in a thorough and comprehensive review process to determine if accreditors have and enforce sufficiently rigorous standards that examine student achievement and whether institutions are offering quality programs. They added that accreditors that significantly have failed to live up to their responsibilities do not deserve to serve as gatekeepers to federal funds and should not be recognized by the Department.

Under Secretary Ted Mitchell of the Department of Education sent a letter on April 22, 2016 to federally recognized accrediting agencies to clarify the flexibility they have in differentiating their reviews of institutions and programs, encouraging use of that flexibility to focus monitoring and resources on student achievement and problematic institutions and programs. The clarification follows: (1) a November 2015 Department announcement of a series of executive actions and legislative proposals “to improve accreditors,” and (2) a January 20, 2016 memorandum that outlined a number of areas for further action, including the need to provide clarification to accrediting agencies on the flexibility they have in applying standards and review processes.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Growing Numbers Of Arthritis Patients
About 53 million U.S. adults have arthritis, however, the number of men and women with this disease is growing and expected to reach more than 78 million in 2040, according to a new study by the Centers for Disease Control and Prevention (CDC). That agency estimates that the number of men and women with arthritis will increase almost 49% to more than 78 million in 2040. About half of those with the disease are working-age adults—age 18 to 64 years. An estimated 34 million adults will be limited in their usual activities because of their arthritis in 2040, an increase of 52%. As the number of individuals with arthritis increases, their need for special kinds of health care will grow as well. Providers who are experts in treating the disease may be harder to find and be expensive. Moreover, a growing number of arthritis patients also will have an impact on payment mechanisms, such as Social Security Disability Insurance and Medicare.

Accountable Care Organization (ACO) Expansion
As of the end of January 2016, Leavitt Partners, in partnership with the Accountable Care Learning Collaborative, has identified 838 active Accountable Care Organizations (ACOs) across the country with service areas in all 50 states and the District of Columbia. Collectively, the number of ACOs has grown by 94 over the past year, an increase of 12.6%. Growth has continued to vary across the country and across public and private health insurance programs, with significant growth in most population centers, but increasing activity in some rural areas. Certain markets have significant activity among providers in the region (e.g., California and Texas) while accountable care has failed to take hold in other regions (e.g., Idaho and Montana). Along with the increase in ACOs, the number of accountable care contracts has continued to grow, with 1,217 identified accountable care contracts.

HEALTH TECHNOLOGY CORNER

The Future Of Direct-Reading Methods And Sensors
Direct-reading methods and sensors are being used more frequently in many different settings ranging from personal monitoring of individual health to applications in research and in clinical practice. Researchers at the Center for Direct Reading and Sensor Technology at the National Institute for Occupational Safety and Health within CDC have developed a number of direct-reading methods and monitors and are exploring new ways to use these technologies to improve occupational safety and health. The use of sensors has increased exponentially as countless remote wireless sensors are employed for monitoring the environment, work sites, disaster response, “smart” buildings and facilities, and in agriculture and health. Wireless data transfer based on cell phone networks and smart phone technology is enhancing the adoption of these sensors and allowing integration of geographically disperse sensors to produce comprehensive exposure pictures. Wearable and even implantable sensors are being developed that could aid in exposure assessment and clinical practice.

Using Medical Devices With Phone-Like Qualities To Motivate Diabetes Patients
Traditional blood glucometers are starting to be replaced with a chronic care management system that uses a wireless glucometer to measure blood glucose levels. The Mount Sinai Health System and Livongo Health, a consumer digital health company, developed a comprehensive diabetes management program in the New York market. Already available to Mount Sinai employees, the program will be expanded to broader populations across the New York market. The program provides an end-to-end ecosystem that empowers patients with chronic conditions, including diabetes, to live better. It starts with a smart data analytics platform that captures information from a variety of sources, including electronic health records. Relevant and timely insights and alerts are then provided in real-time to patients with diabetes, their network of family and friends, and their Mount Sinai care team.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

When Race/Ethnicity Data Are Lacking

Despite improvements in access and quality, gaps persist, particularly among persons belonging to racial/ethnic minority and low-income groups. A report posted online by the RAND Corporation on March 28, 2016 describes the use of indirect estimation methods to produce probabilistic estimates of racial/ethnic populations to monitor health care utilization and improvement. One method described, Bayesian Indirect Surname Geocoding, uses an individual's Census surname and the racial/ethnic composition of the person's neighborhood to produce a set of probabilities that a given individual belongs to one of a set of mutually exclusive racial/ethnic groups. Advances in methods for estimating race/ethnicity are enabling health plans and other health care organizations to overcome a long-standing barrier to routine monitoring and actions to reduce disparities in care. The report can be accessed at http://www.rand.org/topics/health-and-health-care.html?page=1.

Affordable Care Act’s Impact On The Federal Budget From 2016-2026

The Congressional Budget Office (CBO) published updated projections of the ACA’s impact on the federal budget from 2016-2026. For 2016, CBO estimates that the ACA’s insurance coverage provisions will cost the federal government $110 billion, which is lower than the agency’s initial estimate before the law’s passage. Longer-term projections over the 10-year period of 2016-2025 increased by $136 billion, however, mostly due to higher enrollment in Medicaid than originally projected. Other key estimates include: Approximately 244 million noninstitutionalized US residents under age 65 will have health insurance each month in 2016; the insured rate is expected to remain at 90% during that period. Approximately 19 million individuals are projected to be enrolled in the exchanges by 2019, which is lower than the 22 million that CBO projected last year. The net costs to cover the newly insured are projected to be $1.4 trillion from 2017-2026. Federal subsidies for individuals under age 65 will rise by 5.4% annually through 2026. The report can be accessed at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf.

A Medicare Primer

In fiscal year 2016, the Medicare program will cover approximately 57 million beneficiaries (48 million aged and 9 million disabled) at a total cost of about $701 billion. Spending under the program (except for a portion of administrative costs) is considered mandatory spending and is not subject to the appropriations process. Since its inception, it has undergone many changes. A new report from the Congressional Research Service (CRS) provides a general overview of the program, including descriptions of its history, eligibility criteria, covered services, provider payment systems, and program administration and financing. The report can be accessed at http://fas.org/sgp/crs/misc/R40425.pdf.

Using Postsecondary Data To Promote Student Success

A new report from the Institute for Higher Education Policy (IHEP) highlights promising practices for institutions looking to use postsecondary data to improve student outcomes. Recommendations are provided for institutional leaders to use data in more effective ways, such as establishing a culture of data use for institutional improvement and reaching beyond campus boundaries to find and use data. The report can be accessed at http://www.ihep.org/sites/default/files/uploads/docs/pubs/ihep_leading_with_data_-_final.pdf.
INDEPENDENCE, TECHNOLOGY, AND CONNECTION IN OLD AGE

As individuals age, they risk losing social engagement and connectivity, along with cognitive and physical abilities. Technology advances may help to prevent or delay these risks for many older adults. The President’s Council of Advisors on Science and Technology (PCAST) reviewed these challenges and gathered recommendations from leading researchers in several professions, including biology, health, and engineering. The study focused on four key changes older Americans often experience: hearing loss; loss of social engagement and connectivity; cognitive change; and physical change.

PCAST’s recommendations span 12 areas, including four cross-cutting recommendations that cover a wide range of technologies and eight targeted recommendations concerning specific applications to improve mobility, cognitive function, and social engagement. Internet access, telehealth, monitoring technology, emergency preparedness systems, and intentional design are examples of technologies that will support healthy aging for all Americans. The report focuses on near-term Federal actions to advance these possibilities.

Although the report is split into chapters, the concepts are inter-related. For example, lack of mobility can affect social engagement that can affect cognitive decline. Hence, these areas cannot be addressed successfully independently. Instead, a systematic approach is needed to increase independence. This observation underlies a strong recommendation that the Federal Government create a standing cross-departmental, multi-agency council with responsibility and meaningful authority to address all these issues. The recommendations are:

**Recommendation 1: Integrating Federal Action**

**Recommendation 2: Engagement and Social Connectivity**

**Recommendation 3: Monitoring Technology for Frail and Vulnerable Elders**

**Recommendation 4: Research Needed to Spur Further Innovation**

**Recommendation 5: Education and Training in Online Technologies**

**Recommendation 6: Emergency Response and Communications**

**Recommendation 7: Financial Services**

**Recommendation 8: Cognitive Training**

**Recommendation 9: Improve Regulation and Payment to Reflect Innovation in Telehealth**

**Recommendation 10: Home Design to Sustain Independence**

**Recommendation 11: Improving Product Design for Older Adults’ Needs**

**Recommendation 12: Future Role of Assistive and Robotic Technologies**

The report, (which can be accessed at https://www.whitehouse.gov/sites/default/files/microsites/ostp/PCAST/pcast_independence_tech_aging_report_final_0.pdf), cites valuable resources, including the database AbleData, which has inventoried more than 20,000 technology products, such as prosthetics, therapeutic aids, and other tools for assisting with activities of daily living.