DYNAMICS OF THE HEALTH DOMAIN IN 2015

Not only is the health domain a significant component of the health economy of the United States, it also can be characterized as furnishing a robust illustration of dynamic societal changes that occur on a steady basis. The year 2015 promises to be no exception as evidenced by a case that will be decided by the U.S. Supreme Court regarding the matter of whether individuals who enrolled in the federal marketplace to obtain insurance coverage under the Affordable Care Act are legally entitled to receive tax credits to offset the cost of premiums.

On March 4, justices will hear oral arguments in King v. Burwell. When 36 states elected not to establish their own exchanges, the federal government created federally run exchanges in those states. Plaintiffs assert that when the IRS extended tax credits for insurance purchased through the federally run exchanges, it constituted a direct violation of the plain language of the law. The Supreme Court has been asked to decide whether the IRS’s interpretation will remain intact. If the Court strikes down this provision, Congress and the states will have to craft remedies to keep beneficiaries from losing insurance coverage.

The Medicare and Medicaid programs reach the ripe old age of 50 this year. Ongoing discussions in health policy circles will continue to examine challenges that confront these government offerings and weigh alternatives for both incremental and comprehensive reform involving ways to reward providers for improving quality and lowering costs.

The International Classification of Diseases—9th Revision, more commonly known as ICD-9, is more than 35 years old. Consisting of about 13,000 codes, it contains outdated, obsolete terms that are inconsistent with current health care practice. ICD-9 also limits the number of new codes that can be created. Moreover, many of its categories are full. ICD-10, which becomes operational on October 1 of this year will make it possible to use approximately 68,000 diagnostic codes and 87,000 procedural codes that are more specific to patient diagnoses. It is anticipated that the conversion to ICD-10 will improve coordination of a patient’s care across providers over time.

On Capitol Hill, Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) of the Senate Health, Education, Labor, and Pensions (HELP) Committee officially announced the launch of a bipartisan initiative to examine the process for moving safe and innovative treatments and cures to patients. The Initiative will look at the role that the FDA and the NIH play in development and discovery of new drugs and medical devices. In 2014, Energy and Commerce Committee Chairman Fred Upton (R-MI) partnered with Representative Diana DeGette (D-CO) to conduct a comprehensive examination of the cycle of cures. Since then, hearings and roundtable discussions have been held around the U.S. A 21st Century Cures Discussion Document White Paper was released in January 2015 for public comment.
Trends

PRESIDENT’S MESSAGE
By Richard E. Oliver, ASAHP President

If winter comes, can spring be far behind?

Percy Bysshe Shelley

I think we are all ready for winter to get behind us, especially those of us who live in the more northern regions of the United States. But alas, one of the very first signs of spring is seeing the date for the ASAHP Spring Meeting popping up on our March calendars. I hope the Spring Meeting is not only on your calendar but you are registered and are planning to attend.

The theme of the March 19 – 20, 2015 Spring Meeting is “Higher Education At A Crossroads.” Some of our more cynical ASAHP members might suggest that “higher education in the crosshairs” might be a more appropriate theme as we continue to deal with issues related to state authorization, competition for clinical sites, faculty shortages and higher education and health care reform. However, the best way for allied health leaders to combat such cynicism is to take an honest and realistic approach to staying informed about these issues and learning from others leaders how we can take proactive steps to best position our schools and colleges when we reach these crossroads in higher education.

We have lined up a superb list of featured speakers for the March meeting. Marshall Hill, Executive Director of the National Council for State Authorization Reciprocity Agreements, will provide an update of how states are working to establish sensible and workable options to promote needed collaboration across state lines. Cheryl Miller, National Director of Therapy Operations for HealthSouth, will discuss how our educational institutions can work with our industry partners to better cope with health care reform and the demands placed on our new graduates. Nikki Krawitz, Former VP of Finance and Administration, U. of Missouri System, will discuss trends and challenges in higher education. Mark Sothman, VP for Academic Affairs and Provost, Medical University of South Carolina, will share insights gained as he has moved from being an allied health dean to higher leadership responsibilities. Lee Foley, Co-Founder of Capitol Hill Partners and John Colbert, ASAHP Executive Director, will provide timely updates regarding key legislative and advocacy issues. Roy Anderson, Director, Education Partnerships, Cleveland Clinic, will describe how his institution is taking creative approaches to managing and enhancing clinical internships and related activities. And finally, Hugh Bonner, Dean of the College of Health Professions, SUNY Upstate Medical University, will share insight gained from a life of professional service when he delivers the ASAHP Deans’ Memorial Lecture.

There will also be ample time to interact with colleagues as well as learn more about the efforts that ASAHP is making to strengthen our Association and make its work even more relevant to the institutions we serve.

I look forward to seeing you in Myrtle Beach. Safe travels and have a happy spring!

Rich

HEALTH WORKFORCE LEGISLATION INTRODUCED IN HOUSE

Despite its importance, the health workforce does not generate much attention in Congress, but a bill (H.R. 1006—Building a Health Care Workforce for the Future Act) was introduced on February 13 in the House. Similar to H.R. 5458 that was introduced in 2014, it contains a provision to provide grants to health professions schools to promote priority competencies among dental hygienists and many other kinds of students, such as physician assistants.
SUSTAINABLE GROWTH RATE FORMULA: A CASE OF SHAMBOLIC DECISION-MAKING?

The Balanced Budget Act of 1997 (P.L. 105-33) contained a provision known as the Sustainable Growth Rate (SGR) formula to control the level of payments made to physicians who care for Medicare patients. The formula was designed to limit the annual increase in cost per Medicare beneficiary to the growth in the national economy such that if overall physician costs exceed target expenditures, an across-the-board reduction in payments would be triggered.

Since 2002, Congress has had to produce short-term legislation that often is referred to as either a “patch” or a “doc fix” to avert a payment reduction. Although this remedy has made it possible to maintain increases in payments below inflation over time, they also have resulted in a substantial divergence between the actual level of Medicare spending and the SGR formula target. The budgetary cost of permanently fixing the SGR would place a tremendous strain on the federal budget.

It is worth noting that physicians are not the only group of health professionals to experience distress if Congress fails to take action either to avert a scheduled payment cut at the end of March 2015 or permanently repeal the formula that would cause it. Absent doing anything constructively, a reduction of 21.2 percent would become effective on April 1. Nurse practitioners, physician assistants, psychologists, social workers, physical therapists, and diagnostic testing facilities are among the entities that will be affected. If history is any guide, it still may take until late in the evening of March 31 to produce a way of avoiding a precipitous reduction in payments. Just as importantly, the effort amounts to time that could be devoted to working on a wide range of issues that deserve Congressional attention.

One estimate is that developing a permanent solution would cost $150 billion over a 10-year period. Given existing concerns about federal budget deficits, this approach does not appear to be feasible, which helps to explain how Congress pursues a more realistic alternative of deciding annually to defer solving the problem until the following year. The government has developed a means of placing limits on the cost of many services, but it is challenging to control service volume in ways that relate to their value in producing favorable patient outcomes.

Two charts are displayed on page eight of this issue of the newsletter, which show that Medicare is a key component of the federal government’s involvement in the health care arena. Demographic changes that result in an increase in the older cohorts of the population will add to the pressure of discovering meaningful ways of paying for high quality health care services within federal budget constraints.

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**2015 ASSOCIATION CALENDAR OF EVENTS**

**February 2015**—2014 Institutional Profile Survey (IPS) Report Completed

**March 19-20, 2015**—Spring Meeting in Myrtle Beach, SC

**October 28-30, 2015**—Annual Conference in Scottsdale, AZ
AFFORDABLE CARE ACT DEVELOPMENTS

As mentioned on page one of this issue of the newsletter, the U.S. Supreme Court will begin hearing oral arguments on March 4 in the case of King v Burwell to determine the legality of providing IRS tax credits for insurance purchased through the federally run exchanges. A ruling that disallows this form of subsidy will have huge ramifications for the Affordable Care Act (ACA), which celebrates its fifth anniversary after being enacted in March 2010.

Approximately five million individuals could lose their subsidies as a result of an unfavorable court decision. If that event occurs, many beneficiaries will start to be confronted with the full cost of the unsubsidized premiums on their policies, which has the potential to lead to a drop in coverage. Both Congress and the states will have a role to play in preventing this outcome. Legislation will be necessary to enable these individuals to move to other kinds of subsidized coverage.

Other ripple effects are likely to occur if IRS tax credits are disallowed. Some possibilities are:

- The federal government may be unable to impose any employer-mandate penalties in states that have not established their own exchanges.
- The individual mandate may not apply if the lowest-priced coverage available costs more than eight percent of household income. The lack of subsidies could increase the net cost of coverage.
- Any weakening of such rules could result in fewer individuals opting to purchase ACA-prescribed coverage. A decline in the number of enrollees could provide an incentive for insurance companies to decline to participate in the ACA.

Health Insurance Marketplace Enrollment

An announcement from the Department of Health & Human Services (HHS) revealed that the goal for 2015 enrollment in the health insurance marketplaces was exceeded. More than one million consumers selected plans offered in week 13. As of the February 15 deadline, enrollment reached approximately 11.4 million, a figure that includes 8.6 million individuals who enrolled through the federally facilitated marketplaces. What remains unclear is whether these enrollment numbers will be maintained. Once beneficiaries begin to receive bills for monthly premiums, if the amounts are viewed as unaffordable, it could lead to a lowering in the number of enrollees.

An announcement from the Centers for Medicare and Medicaid Services (CMS) indicated that a six-week open enrollment period from March 15 to April 30 will be made available. It is mainly for individuals who learn they must pay for not having coverage when they file tax returns.

State Medicaid Programs

States around the country serve as laboratories for developing health insurance coverage that matches the needs of the population within their respective borders and the financial ability to pay for comprehensive health care services. Medicaid programs in these jurisdictions depend on matching funds from the federal government to meet expenses. Recognizing the great amount of diversity in the ways that each state conducts its own business, waivers from the CMS have been granted over the years.

One such waiver involves an alternate expansion plan to increase the number of enrollees. The state of Arkansas provides a good example of how a waiver has made it possible to reduce the number of uninsured individuals by 10 percent by making it possible to use ACA’s Medicaid expansion funds to purchase qualified health plans (QHPs) through the health insurance marketplace for newly eligible adults.
A federal regulatory apparatus has a dramatic effect on higher education institutions. Expectations are running high that Congress will complete the Reauthorization of the Higher Education Act (HEA) this year. A comprehensive law, it encompasses the following kinds of elements: college access, persistence, and completion; improved information for consumers; student financial assistance programs, accreditation and appropriate federal oversight; college affordability and cost reduction; innovations to benefit students; the federal regulatory burden; and special focus programs.

In November 2013, a bipartisan group of Senators on the Committee appointed a Task Force on Federal Regulation of Higher Education. The U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) conducted its first hearing in 2015 on February 24 regarding the reauthorization of the HEA. The topic was “Recalibrating Regulations of Colleges and Universities.” The co-chairpersons of the task force who testified on that occasion are: William E. Kirwan, Chancellor, University System of Maryland, and Nicholas S. Zeppos, Chancellor, Vanderbilt University. A summary of their comments about a recent task force report’s findings are shown below.

**William E. Kirwan**
We in higher education fully understand and support the important role that federal regulations play. Students, colleges, and universities across this country benefit from the strong federal investment in higher education, including significant funding for student aid programs. Through the task force’s work, we have learned that many regulations are well developed, address critically important issues, and provide appropriate means of institutional accountability. On the other hand, we have also discovered that too many regulations are poorly framed, confusing, overly complex, ill-conceived, or poorly executed. Some are even wholly unrelated to the mission of higher education.

In addition, over time, requirements have been layered upon requirements resulting in a tangle of regulations that too often has a harmful effect on higher education’s ability to serve students. Some regulations even restrict rather than contribute to student access to higher education, limit our ability to focus resources on student success, impede organizational efficiencies, and constrain innovation. And, quite frankly, the costs associated with compliance are one of the factors driving rising tuitions and harming affordability efforts. He also stated that there is no need for the federal government to be involved in state authorization of distance education programs.

**Nicholas S. Zeppos**
We are not here to ask you to deregulate higher ed. Rather, we want to bring attention to the fact that, over time, oversight of higher education has expanded in ways that undermine the ability of our institutions to serve students and accomplish our missions. As we conclude in our report, many of the Department’s regulations are unnecessarily voluminous and too often ambiguous, and the cost of compliance has become so unreasonable that it is having a real impact on college costs and tuition. Even more troublesome, some regulations are a barrier for students’ access to a college education.

Change is needed to address how the Department develops, implements and enforces regulations. Our report offers recommendations to improve each phase of the regulatory process; some of those recommendations follow. For example, (1) The negotiated rulemaking process should be reformed to ensure it achieves its purpose. Unrelated issues should not be bundled together. Facilitators should be permitted to serve as arbiters in reaching consensus, (2) The Department should provide clear regulatory safe harbors to help institutions that abide by certain standards to meet their compliance obligations. Such safe harbors exist in other areas of law that pertain to universities, and (3) The Department should not make significant changes in policy without following the Administrative Procedure Act’s (APA) notice and comment procedures.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

**Mortality That Results From Drug Poisoning**
According to the National Center for Health Statistics (NCHS), in 2013, a total of 43,982 deaths in the United States were attributed to drug poisoning, including 16,235 deaths (37 percent) involving opioid analgesics. From 1999 to 2013, the drug poisoning death rate more than doubled from 6.1 to 13.8 per 100,000 population, and the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled from 1.4 to 5.1 per 100,000.

**Orphan Drug Approval**
The Food and Drug Administration (FDA) Office of Orphan Products Development (OOPD) approved more orphan drugs in 2014 than any year prior, according to analysis done by the *FDA Law Blog*. That year, OOPD approved 49 orphan drugs, 53 percent more than in 2013. Orphan drugs are designed to treat rare diseases. The definition of rare is a two-part test: (1) The condition the drug treats must affect fewer than 200,000 patients in the U.S. or (2) If more than 200,000 individuals have the condition, a drug can be considered orphan if the drug manufacturer is not expected to recover the costs of developing and marketing a treatment drug.

**Measles Vaccination Rates**
Seventeen states have lower than a 90 percent vaccination rate among preschoolers ages 19 to 35 months for measles, mumps, and rubella (MMR) vaccine. Trust for America’s Health used the 2013 *National Immunization Survey* to analyze vaccination rates among children in all fifty states. Certain regions have higher rates of vaccination than others. Eight states in the South, five Western states, and four in the Midwest have vaccination rates below 90 percent, but all rates in the Northeast are above 90 percent. *Healthy People 2020* set a goal of vaccinating 90 percent of children in this age group for MMR and the national rate of 91.1 percent has surpassed this goal. Preschool-aged children are less likely to be immunized than grade school children because they have not entered the school system (most schools require proof of vaccination before children are allowed to attend). Thus, young children may be vulnerable to communicable diseases, especially those residing in communities with low vaccination rates.

**HEALTH TECHNOLOGY CORNER**

**Treating Obesity With Implantable Devices**
Obesity is a major public health problem that is associated with an increased risk of heart disease, stroke, type 2 diabetes, and certain cancers. Recent statistics from the Centers for Disease Control and Prevention (CDC) show that more than one-third of all U.S. adults are obese and the estimated annual medical cost of obesity in the U.S. was $147 billion in 2008 U.S. dollars. The Food and Drug Administration (FDA) recently approved an implantable device that treats obesity by curbing the appetite through blocking communication between the stomach and the brain using electrical signals. The Maestro Rechargeable System, made by EnteroMedics Inc., sends these electrical signals to the nerves that help control digestion leading to reduced hunger pangs and prolonged feelings of fullness. The implant is the first FDA-approved obesity device since 2007. It is approved in adults 18 and older who have a body-mass index of 35 to 45 and at least one other comorbid condition related to obesity, such as type 2 diabetes. The device was approved for use in individuals who have tried and failed in the previous five years to lose weight with a traditional weight loss program in order to qualify for the device.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

How Safe Is Health Information Under HIPAA?

According to a report from the Congressional Research Service, a recent data breach at Anthem, Inc.—the nation's second-largest health insurer, with more than 37 million enrollees in its health plans—raises new concerns about the vulnerability of electronic health information. Security experts question whether the Health Insurance and Portability and Accountability Act (HIPAA) privacy and security standards are sufficiently protective of sensitive patient information. On February 4, after several prior attempts, hackers succeeded in accessing an Anthem database containing as many as 80 million records of current and former Anthem customers as well as employees. The Anthem breach has led to renewed criticism of the HIPAA security standards, which are intended to protect electronic information—both at rest and during transmission—from unauthorized access, use, or disclosure. The standards are technology-neutral and scalable, based on the size and complexity of the organization. They include security management, data access controls, and data transmission security. The report can be accessed at [http://fas.org/sgp/crs/misc/IN10235.pdf](http://fas.org/sgp/crs/misc/IN10235.pdf).

Testing The Impact Of Accountable Care Organizations

In December 2011, the Robert Wood Johnson Foundation (RWJF) launched a national program, *Accountable Care Organizations: Testing Their Impact*, to learn more about how accountable care organizations (ACOs) are evolving and how they influence the delivery of health care. The number of ACOs has increased from about 100 when the program started to 626 as of May 2014. In a first round of funding (March 2013–March 2015), RWJF selected four research teams to produce qualitative case studies on ACOs serving the private health insurance market or Medicaid. A report describes key finding to date. The report can be accessed at [http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2015/rwjf417961](http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2015/rwjf417961).

Improving Genetics Education in Graduate and Continuing Health Professional Education

Despite the growing use of genomic applications in clinical practice, health professional knowledge about genomic information and confidence in using it have not kept pace. Many health care providers do not have either the knowledge or the tools they need in order to apply genetic information in their day-to-day practices. A workshop was conducted by the Institute of Medicine to examine the potential and the challenges of providing genetics education, to review promising and innovative approaches to providing education to both graduate health professional students and practicing health professionals, and to identify potential next steps for achieving effective genetics education. The report can be accessed at [http://www.iom.edu/Reports/2015/Improving-Genetics-Education-Graduate-Continuing-Health-Professional-Education.aspx?utm_source=IOM+Email+List&utm_campaign=c5d0fe7252-2_6_15_New_WS_WIB2_5_2015&utm_medium=email&utm_term=0_211686812e-c5d0fe7252-180272941](http://www.iom.edu/Reports/2015/Improving-Genetics-Education-Graduate-Continuing-Health-Professional-Education.aspx?utm_source=IOM+Email+List&utm_campaign=c5d0fe7252-2_6_15_New_WS_WIB2_5_2015&utm_medium=email&utm_term=0_211686812e-c5d0fe7252-180272941).

The Digital Health Revolution

Digital technologies have been transformational, but haven’t yet improved the way many individuals receive or participate in health care. A new multimedia essay from The Commonwealth Fund explores the arrival of new digital tools that transmit information to a patient’s team of health care providers. The essay can be accessed at [http://www.commonwealthfund.org/digital-health-revolution/?omnicid=EALERT694287&mid=thomas@asahp.org](http://www.commonwealthfund.org/digital-health-revolution/?omnicid=EALERT694287&mid=thomas@asahp.org).
HEALTH CARE AND THE FUTURE IMPACT ON FEDERAL/STATE BUDGETS

Demography is a useful predictor of destiny. The aging of the U.S. population has significant implications in two important ways: how the health care service realm will be influenced and costs associated with the provision of services for different groups that are funded by the federal government. The following two charts furnish a profile of future challenges that will have to be met.