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This past year, AHA’s Federal Advocacy team defied the conventional wisdom that nothing ever gets done in gridlocked Washington, DC. By staying focused on a handful of key strategic priorities, we proudly built on past successes and achieved a number of important wins with meaningful benefits for the research, prevention and treatment of cardiovascular disease and stroke. We remained a steadfast and tenacious advocate for those suffering from these terrible diseases; making a stand against short-sighted budget cuts to research, treatment and prevention while standing up for patients’ rights and access to quality care.

AHA’s Federal Advocacy team took a pragmatic and multi-pronged approach to achieving our goals on both the congressional and regulatory levels. Our clinical-based research, expertise and guidance were highly prized by both Members of Congress who supported our agenda and those in the Executive Branch who were charged with implementing new laws, such as the Affordable Care Act and the Family Smoking Prevention and Tobacco Control Act.

We also continued to be a pivotal force in rallying support from our partners, stakeholders and volunteers and worked in coalitions to achieve shared goals. We put “boots on the ground” in our advocacy efforts because of our ability to match fact-based research with the passion of the American Heart Association’s leadership and our network of You’re the Cure volunteers.

We sought every possible venue—including congressional hearings and briefings, federal advisory committee meetings, timely and targeted fly-ins, published policy papers, Congressional Record and committee report language placements, social media, issue advertising, press events and even a U.S. Postal Service “Heart Health” stamp—to help raise awareness about our nation’s No. 1 killer and to make sure that the voices of the patient, caregiver and researcher were heard.

However, we are operating in an atmosphere fraught with peril and risk. The threat of draconian, mandatory across-the-board spending cuts in 2013 loomed large throughout the year and was part of every conversation about funding federal government agencies, such as the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). That made it all the more important that our Federal Advocacy team remained vigilant and protected and preserved critical “must-have” investments in core programs for research, prevention, and treatment, and those that improve the quality and value of care that all Americans receive. We delivered on our advocacy agenda for 2012 and helped to deliver hope in the war against cardiovascular disease and stroke.
Heart Disease and Stroke Research

The decline in the death rates from cardiovascular disease (CVD), including coronary heart disease and stroke, can be directly linked to National Institutes of Health supported heart and stroke research—with more life-saving treatment and prevention results on the horizon. Using newly-gained knowledge about biological structures and functions, scientists may now have the opportunity to combat disease in previously unimagined ways, such as at the molecular level. Moreover, medical research is a major source of American innovation and an engine of economic growth. In 2011 alone, NIH funding led to the creation of more than 423,000 much needed jobs and generated more than $62 billion in new economic activity across the nation. There is a solid $2.60 return on investment for every federal dollar invested in NIH.

Although NIH enjoys broad bipartisan support, funding for the agency is nevertheless included within the nondefense discretionary category of the budget that has borne the brunt of deficit reduction efforts and previous spending cuts. That is where the AHA Federal Advocacy team swung into action. We became a pivotal force in pressing the case for adequate NIH funding and worked with our strategic partners in the health community, such as the United for Medical Research coalition that AHA helped to launch, to raise congressional awareness of its importance to both the physical and fiscal health of our nation. For example, AHA sponsored a congressional briefing during American Stroke Month on “Advances and Opportunities in Stroke Research” that highlighted the devastating impact that cuts to the NIH budget would have on stroke research.

The AHA also activated its You’re the Cure grassroots network to help secure signatures on two separate congressional letters to the two relevant appropriations subcommittees asking that NIH funding be a priority. The results were impressive: 49 signatories on the Senate letter and 153 on the House letter. In addition, we activated our network to help garner signatures on a letter to the House leadership asking them to consider the importance of the NIH during the deficit reduction debate. This letter resulted in 60 signatories.

In addition, the Federal Advocacy team organized a “fly-in” to Washington, DC of then AHA President Dr. Gordon Tomaselli, AHA CEO Nancy Brown, researchers, CVD and stroke survivors and health care professionals to urge Congress to protect the NIH from the mandatory sequestration. At the same time, You’re the Cure volunteers sent more than 12,000 e-mails to Members of Congress asking them to shield NIH from any further budget cuts.

In mid-June 2012, the Senate Appropriations Committee approved the FY 2013 Labor, Health and Human Services (HHS) and Education Appropriations bill by a party-line vote. It included $30.731 billion for the NIH, which is $100 million or 0.33 percent above the FY 2012 funding level.

Of great significance, the Federal Advocacy team succeeded in securing language in the Senate Appropriations Committee report—which accompanied the bill—expressing the belief that research in heart disease, stroke and other forms of cardiovascular disease should be a top priority. Report language provides direction from Congress to the agencies on how money should be spent within particular areas.
A month later, the House Appropriations Subcommittee on Labor-HHS-Education approved its version of the legislation. The House measure included the President's request, of $30.6 billion, which was the same as the 2012 level. In today's difficult budget environment, even holding steady must be considered a small victory.

However, the House Subcommittee-approved bill eliminated funding for the Agency for Healthcare Research and Quality (AHRQ) whose mission is to generate evidence to build a high-quality, high-value health care system. This is the first time that funding for AHRQ was proposed to be “zeroed-out” since a similar attempt in 1994. The AHA signed on to a letter to the House Subcommittee leadership opposing the proposed termination of AHRQ. The Patient Centered Outcomes Research Institute (PCORI) and the Center for Medicare and Medicaid Innovation (CMMI) were also zeroed out in the proposed House bill along with most other resources funded through the Affordable Care Act (ACA).

As previously noted, the American Heart Association has been particularly concerned by the potential for mandatory across-the-board spending cuts, also called sequestration or, the sequester, that are now scheduled to go into effect March 2013 in the absence of any national debt reduction plan. Under this scenario, the NIH's budget will be slashed by 5.1 percent, or nearly $1.6 billion in one year. A cut of this magnitude would have had a devastating effect on research funding, turning back the clock to FY 2007 funding levels. AHA was a leader in raising the alarm about the impact of the across-the-board cuts both through its fly-in in June and in developing a webpage with comprehensive news, reports, and a countdown to sequester. The webpage has been used as a model by other health and research groups concerned about sequestration.

On New Year's Day 2013, Congress passed a last-minute compromise that pushed back the sequester from January 2, 2013 to March 1, 2013. While NIH did not receive any direct cuts as part of this deal, the fight is not over. The NIH and its many institutions are still facing the possibility of crippling budget reductions in 2013 if Congress does not act—either through sequestration or as part of final FY 2013—which has not yet been decided—and FY 2014 appropriations that provide fewer resources.

While AHA Federal Advocacy often involves lobbying a Member of Congress, testifying before a congressional committee and working with Member and Committee staff, it is also about building and managing long-term relationships and raising the awareness of heart disease and stroke in less formal but nonetheless effective settings. To this end, AHA volunteer leaders including President Donna Arnett, Ph.D. and Advocacy Coordinating Committee Chair Elliott Antman, M.D. participated in a congressional reception in Washington, D.C. on December 12 to welcome the new director of the National Heart, Lung, and Blood Institute, Gary Gibbons, M.D.

The reception was hosted by the National Coalition for Heart and Stroke Research, the NHLBI Constituency Group and the Morehouse School of Medicine. Speakers included National Institutes of Health Director Francis Collins, M.D., Ph.D., and U.S. Surgeon General Regina Benjamin, M.D. Additional speakers included two-chairs of the Congressional Heart and Stroke Coalition: Senator Mike Crapo (R-ID) and Representative Lois Capps (D-CA). Dr. Gibbons is a longtime volunteer and fellow of the American Heart Association, a member of our Council on High Blood Pressure Research, and a past recipient of our Established Investigator Award. The AHA directed the working committee’s activities in planning this reception.
Investing in Prevention

We as a nation must transform the current healthcare delivery system that focuses on “sick care” to one that better incorporates, coordinates, values and financially rewards quality care and prevention. Investing in prevention is also a smart move and a proven winner during these fiscally-challenging times as it can foster both a robust economy and a healthy society.

The aforementioned FY 2013 Labor-HHS-Education Appropriations bills contained funding for several American Heart Association prevention priorities, including CDC’s Division for Heart Disease and Stroke Prevention, WISEWOMAN, Million Hearts, and the Prevention and Public Health Fund created under the Affordable Care Act. WISEWOMAN helps uninsured and under-insured low-income women avoid heart disease and stroke by providing preventive health services, counseling and access to local health care professionals. Million Hearts—a national initiative of which AHA is a proud partner—was created to prevent one million heart attacks and strokes over five years. Under the Senate measure, the CDC will receive almost $7 billion including $858 million for the Prevention and Public Health Fund, $5 million of which will go to Million Hearts. That translates to a $61 million or 0.88 percent increase over the FY 2012 funding level. Again, considering the current fiscal environment, even this small funding boost is a hard-won victory.

However, the numbers do no tell the entire prevention story. The Prevention and Public Health Fund (the Fund) is our first sustained national investment in preventative health programs. The programs supported by the Fund are essential if we are to reduce the growth of chronic diseases, such as heart disease, stroke, cancer, diabetes and their attendant drivers—obesity, poor nutrition, physical inactivity, and tobacco use.

In early 2012, the Fund sustained a heavy blow when Congress and the President approved a 30 percent cut to it—$6.25 billion—to pay for the payroll tax cut extension. The Fund was about to be raided yet again in the summer when the House leadership proposed using it to pay for a student loan interest rate fix.

However, through the hard work and dint of determination of advocates around the country, including those from the AHA’s You’re the Cure network, we staved off this crippling cut and forced Congress to look for other means to pay for the proposal. Recognizing the importance of the Fund, AHA CEO Nancy Brown joined other public health CEOs in a series of meetings with House and Senate members to stress the value of the Fund and shore up even greater congressional support. Nevertheless, the Fund remains vulnerable to be used as an “offset” while federal policymakers continue to negotiate budget cuts.

In addition, the Fund currently stands to sustain yet another round of cuts if sequestration goes in effect in March. AHA will continue to work with our partners to preserve this important source of funding that can help move this nation from a focus on sickness and disease to one based on wellness and prevention.

Million Hearts—national initiative of which AHA is a proud partner—was created to prevent one million heart attacks and strokes over five years. Under the Senate measure, the CDC will receive almost $7 billion including $858 million for the Prevention and Public Health Fund, $5 million of which will go to Million Hearts.
The facts are both startling and alarming. Heart disease, stroke, and other forms of CVD are the No. 1 cause of death of American women, claiming about 401,000 lives each year, or about one death each minute. CVD kills as many women as the next three causes of death combined, including all forms of cancer. Recent research suggests that the coronary heart disease mortality rate for women 35 to 44 is actually on the rise. Yet, almost half of America’s women are unaware of the risk and they are less likely to receive the recommended care to treat or prevent it. Together, we must change that imbalance; together we must reverse this disparity. Last year, we took a big step in that direction.

After six years of hard advocacy work, a key piece of the HEART for Women Act was signed into law as part of the Food and Drug Administration’s (FDA) user fee reauthorization legislation. This provision was offered by HEART for Women sponsor Senator Debbie Stabenow (D-MI) to the Senate bill. It requires the FDA to report on the extent to which clinical trial participation and safety and effectiveness data are reported by demographic subgroups including sex, age, race and ethnicity when the agency approves new drugs and medical devices for public use.

Women and Cardiovascular Disease

The American Heart Association also continued its efforts to educate policymakers and advocates about the risk that women face from heart disease. On Valentine’s Day, then AHA President Gordon Tomaselli hosted a congressional reception sponsored by the American Heart Association that premiered the Go Red For Women short film, Just A Little Heart Attack starring Elizabeth Banks. And AHA once again partnered with HHS Secretary Kathleen Sebelius, Surgeon General Regina Benjamin, and EPA Administrator Lisa Jackson on its 2nd annual State of Women’s Heart Health webinar in February.

The FDA is also required to develop an action plan for improving the quality and availability of this data by demographic subgroups. Making this information more available will allow women, minorities, and their health care professionals to make better decisions about the most effective treatment. A 2011 study found that today, only about 40 percent of clinical research studies included sex-specific analysis of data, despite being recommended by the FDA.

The AHA and its ASA Division worked jointly with the Society for Women’s Health Research, WomenHeart: The National Coalition for Women with Heart Disease, and other national and state health and women’s organizations to get the provision passed by the Senate and then included in the final legislation negotiated between the House and Senate. We are now working with FDA to ensure that a robust report is released on schedule in July 2013.
CVD and Emergency Care

The Rural Access to Emergency Devices Program is a competitive state-based initiative that allows rural areas to buy automated external defibrillators (AEDs) in bulk, place them where sudden cardiac arrests are likely to occur, and train lay rescuers and first responders in their use. Only an estimated 10 percent of people who suffer a sudden cardiac arrest outside of a hospital setting survive, but prompt CPR and early intervention using an AED, can more than double chances of survival.

This program, which languished for years, received a major boost thanks to AHA advocacy efforts. Under the Senate Appropriations Labor-HHS-Education bill, it will receive $5 million, which is $3.9 million or a 355 percent increase over the FY 2012 funding level. This would be the highest funding level for this program since FY 2005.

The AHA actively lobbied for these increased resources and applauds Congress for recognizing the significance and value of this life-saving program, which increases sudden cardiac arrest survival rates in rural areas. The Association's You're the Cure network sent 3,505 e-mails to their Members of Congress urging them to support the program.

AHA also worked with the Sudden Cardiac Arrest Coalition (SCAC), of which we are a steering committee member, to promote a petition during Sudden Cardiac Arrest Awareness Month in October supporting the placement of AEDs in schools and public places, along with strong emergency response plans. More than 10,000 people signed the petition, which the SCAC plans to share with members of the administration and Congress during Heart Month (February, 2013).

A comprehensive Emergency Medical Services (EMS) system is also essential to providing prompt, quality care to patients with acute traumatic and medical conditions. Recent studies have shown that effective emergency trauma care systems can improve survival from severe injuries by as much as 25 percent. The need for data systems to support a comprehensive EMS system is well established. Although many communities have these systems in place, they vary in structure and content making it difficult to compare or analyze data at the state or national level.

To address this issue, Congress directed the Department of Transportation to create a uniform national EMS data set with standard terms, definitions, and values augmented by a database that compiles select data elements from all states. The National Emergency Services Information System (NEMSIS) is used by EMS medical directors and administrators to improve health outcomes for victims of traffic accidents, and those suffering trauma or other acute medical conditions, such as sudden cardiac arrest, heart attack and stroke.

Not surprisingly, the American Heart Association took the lead in 2012 in advocating for increased congressional funding for NEMSIS. In another fly-in, AHA volunteer Dr. Graham Nichol from the State of Washington joined Dr. Clay Mann of Utah and Kevin McGinnis of Maine in meetings with the top Republican and Democratic staff for both the House and the Senate Appropriations Subcommittees on Transportation, Housing and Urban Development, and Related Agencies.

In preparation for the meetings, AHA circulated a pro-NEMSIS letter that garnered the support of 50 other organizations. These included many of our partners in the
EMS, fire, and health communities. AHA also prepared a one-pager and report language emphasizing the value of NEMSIS.

Unfortunately, we won't know the result of our work until the House and Senate act on their appropriations bills, and if the year ends with the anticipated continuing resolution, the program may end up funded at current levels or below. However, the staff and key members of the House and Senate now have a heightened awareness of NEMSIS and its value. NEMSIS funding is also subject to cuts from the sequester that is scheduled to occur on March 1, 2013 if the Congress and the President fail to agree on alternative budget reductions.

Killer Tobacco

For almost a half century, the American Heart Association has made smoking cessation and prevention a major priority and focus of our advocacy efforts. Our decades of work in this area demonstrates the real-world impact that advocacy can have on reducing tobacco consumption and in turn, CVD and stroke in the U.S. AHA advocacy has significantly contributed to a decline of cigarette smoking in our nation by more than 24 percent over the last decade.

The AHA employs a multi-pronged anti-tobacco strategy on the federal, state and local levels that includes advocating, publicizing and rallying support for regulating tobacco, smoke-free policies, increasing excise taxes on tobacco and working to make sure that tobacco and smoking cessation programs are properly funded and accessible to consumers at no cost. To magnify our individual efforts, we also work with partners such as the Campaign for Tobacco-Free Kids. It is the largest non-governmental initiative ever launched to protect children from tobacco addiction and exposure to secondhand smoke.

The AHA took pride in its leadership role in helping to pass the Family Smoking Prevention and Tobacco Control Act in 2009. It dramatically broke new ground by empowering the Food and Drug Administration with the authority to regulate the manufacture, marketing and advertising of tobacco products.

Following enactment of the bill, AHA is now focused on three areas: (a) assisting states and communities to address the regulation of often misleading tobacco advertising and marketing of tobacco products to children; (b) providing expertise to, and working closely with the FDA to implement the new law, such as the new Center for Tobacco Products and Tobacco Products Scientific Advisory Committee; and (c) advocating that Congress ratify the international Framework Convention on Tobacco Control.

However, the Act is already under attack. In the last Congress, Big Tobacco and some Members of Congress tried to weaken the FDA’s authority to regulate tobacco products by offering a bill that exempted cigars from regulation. Anticipating that the so-called Cigar Bill might be added as an amendment to the FDA funding bill in the House, AHA and its partners marshaled their forces to block the legislation from being included during committee consideration.

Advocates from You’re the Cure sent more than 4,600 messages to Members of Congress urging them to protect the Tobacco Control Act and the health of Americans from the deadly effects of tobacco use. We were successful in these efforts and the FDA spending bill was voted out of the House committee without the cigar legislation attached to it. But given the Cigar Bill’s unfortunate popularity due to disingenuous lobbying from cigar manufacturers, the bill will likely be reintroduced in the 113th Congress.
We will continue to work hard to ensure that no legislation usurps FDA’s authority to regulate all tobacco products, including cigars, and will be calling on our advocates to keep the pressure on Congress to reject any attempts to do so.

Physical Activity

The cause of childhood obesity can be expressed in a simple equation: too many calories consumed and too few calories burned. Congress has mostly focused on the first part of the equation by passing legislation that improves child nutrition. But it now needs to turn its attention to the second part by addressing physical education in schools.

In March, eighteen AHA volunteers from six states came to Washington, DC to meet with their Members of Congress and staff to advocate for Safe Routes to School. This is a program in the transportation reauthorization bill that helps communities build sidewalks, bike paths and crosswalks that make physical activity safe, fun and accessible for kids—and adults too.

The visit was part of a larger campaign that included more than 17,600 messages to Capitol Hill from the You're the Cure grassroots network and an advocacy ad run in the Washington, DC publications Politico, The Hill, and National Journal.

These efforts—done jointly with a coalition of public health and transportation partners—led to a major legislative victory with Safe Routes to School and other active transportation programs being strengthened in the Senate bill. The great news is that the Senate passed its legislation on March 14 by a bipartisan vote of 74-22 with the most robust provisions.

Unfortunately, that victory was short-lived. Despite advocacy work on the part of AHA and our partners that produced strong language in the Senate bill, these programs were eventually gutted and slashed during conference negotiations, leading to what could be up to a 70 percent cut for some localities. Thankfully, this is only a two-year bill, and transportation and public health advocates are working hard on the state level to try and take advantage of every funding opportunity available. In addition, our highly-engaged advocates will be a major force in helping us push for bike and pedestrian projects in the next reauthorization.
Along with regular exercise, weight management and not smoking, a healthy diet is proven to reduce cardiovascular disease, stroke and other chronic diseases and conditions. Following healthy dietary guidelines—such as those recommended by the American Heart Association—is one of the best, easiest, and smartest ways for individuals to take control of their health. However, many Americans do not have access to affordable and nutritious foods, such as fresh fruits and vegetables. Of great concern are children who need to learn about making better health choices at an early age. The AHA supports policy and regulatory efforts to promote greater awareness of the importance of a healthy diet and to provide all Americans with greater access to nutritious foods.

The Fresh Fruit and Vegetable Program (FFVP) was one nutrition program AHA focused on this year. It provides elementary schools in low-income areas with funds to purchase fresh fruit and vegetables that can be served to students as a snack. The program exposes children to a wide variety of fruits and vegetables and increases their consumption.

The U.S. Department of Agriculture, which oversees operation of the program at the national level, is in the process of revising the requirements for participating schools. The USDA has proposed a number of changes to ensure that: (1) the program’s limited funds are directed to schools with a high proportion of low-income students; (2) schools promote the program and encourage student participation; and (3) only fresh, raw produce, not frozen, canned, or dried fruits and vegetables are served.

The AHA offered our strong support for FFVP as well as the proposed changes. We also recommended that the USDA increase the minimum number of days schools must offer the program from two to four times a week and expand the evaluation requirements to better determine student engagement and program effectiveness. In addition, seven AHA volunteers from six states came to Washington, DC to meet with congressional members and staff to advocate for FFVP, and to participate in a briefing.

FFVP is a small program part of the larger farm bill legislation, which reauthorizes both agriculture and nutrition-related programs. While the Senate passed a strong farm bill with a 64-35 bipartisan vote on June 21, 2012, the House was unable to get a companion piece of legislation to the floor for a vote. The Senate bill would have kept FFVP as a fresh-only program and at current funding levels as well as protected other nutrition priorities that the AHA supports, such as initiatives to increase healthy food consumption in nutrition assistance programs, robust nutrition education initiatives and nutritious food availability in low-income neighborhoods. However, the House Agriculture Committee proposed to cut FFVP by 30 percent; allow for the inclusion of foods other than fresh fruits and vegetables; and slash funding for other AHA nutrition priorities.

Congress's failure to come to an agreement meant that farm bill programs expired on September 30, 2012. However, the fiscal cliff agreement gave the farm bill a reprieve—a temporary reauthorization until September 30, 2013 in hopes that the Senate and House can continue to negotiate a longer-term bill in the new Congress. Unfortunately, the fiscal cliff deal cut the Supplemental Nutrition Assistance Program education (SNAP-Ed) by nearly a third for the rest of the year to pay for dairy commodities. Nutrition programs will remain vulnerable during budget cut deliberations and continued farm bill negotiations.
Workplace Wellness

This past year, the American Heart Association participated in an initiative to produce comprehensive, consensus-driven employer guidance for the use of outcomes-based incentives in employer-sponsored wellness—or health management—programs.

The guidance is intended to: (1) help employers create worksite wellness programs that make employees' health and well-being their primary goal; (2) potentially reduce health care and other related costs over time; and (3) protect employees from discrimination and unaffordable coverage.

Published in the July issue of the Journal of Occupational and Environmental Medicine, the guidance represents the collaborative thinking of the AHA and five other well-respected health care organizations. The published guidance provides direction on two key questions:

- What are the elements of a reasonably designed wellness program that incorporates outcomes-based incentives?
- How can employers who use outcomes-based incentives be sure that their programs comply with HIPAA (Health Insurance Portability Accountability Act) guidelines for a “reasonable alternative standard” to those who cannot meet the health standard?

The paper also explores future areas of research that can help increase understanding of the impact of financial incentives on program effectiveness, employee health, health care costs and access to the delivery of health care to employees.

Air Pollution

The air we breathe should not pose a serious threat to our health, but unfortunately the polluted air in the US is doing just that. Air pollution, which contains particles from toxic acids, chemicals, and metals, comes from sources such as power plant and vehicle emissions, fires, and even windblown dust.

Coal-fired power plants are a significant source of air pollutants, including fine particulate matter generated from the combustion of materials such as coal, oil, diesel, gasoline and wood. A May 2010 AHA Scientific Statement concluded that exposure to fine particulate matter over just a few days or weeks can trigger harmful or fatal cardiovascular events such as heart attacks, strokes, arrhythmia and heart failure. Longer-term exposure further increases the risk of cardiovascular mortality and reduces life expectancy by months or years.

However, reducing exposure to dangerous polluted air can decrease the risk of cardiovascular events. The American Heart Association advocates for measures that reduce Americans' exposure to air pollution, and for more research on the impact of air pollution on health.

Late in 2011, the Environmental Protection Agency released its final rule for the Mercury and Air Toxic Standards for Power Plants (MATS) that will go a long way to reducing lethal particles being released into the air.

However, some in Congress sought to overturn EPA's rule. Senator James Inhofe (R-OK) sponsored a resolution that would have used the Congressional Review Act to block EPA from implementing these life-saving standards and permanently
prohibited the agency from issuing any “substantially similar” mercury and air toxics protections in the future without express congressional authorization.

That threat did not sit well with the AHA and a coalition of public health organizations, led by the American Lung Association. Together, the groups met with and wrote letters to Members of Congress and staff to explain the rule’s benefits and urge them to defeat the resolution. As a result, several Senators, including Barbara Boxer (D-CA), Sheldon Whitehouse (D-RI), and Bernie Sanders (I-VT) cited the AHA in floor speeches on the legislation, enhancing the Association's position and visibility on this important national health issue. Ultimately Senator Inhofe's resolution was defeated in the Senate by a vote of 46-53, allowing these important clean air protections to move forward.

AHA was also actively involved in urging the EPA to adopt tighter National Ambient Air Quality Standards (NAAQS) for fine particulate matter, also called soot. In coalition with our public health partners, we attended meeting with the Office of Management and Budget during the late fall to explain the cardiovascular risks of soot exposure. We also met with key congressional offices to urge them to support stronger standards. Our work paid off in December when the EPA tightened the annual standard from 15 µg/m³ to 12 µg/m³, a big win for clean air and public health.

AHA will continue to work with its public health partners to reduce air pollution in 2013 by supporting existing in protections under the Clean Air Act and by advocating for tighter regulations on fine particulate matter.

The Affordable Care Act

On June 28, 2012, the Supreme Court of the United States upheld by a vote of 5-4 the constitutionality of the Affordable Care Act, allowing implementation of this groundbreaking law to continue and its benefits to reach millions of Americans. The following are some key milestones:

- Since the law was enacted, approximately 2.5 million young adults have gained coverage through their parents' health insurance as a result of a provision that allows young people to remain on their parents' insurance policy until they turn 26.

- Approximately 82,000 patients have now enrolled in Pre-Existing Condition Insurance Plans (PCIP), the insurance option created through ACA to make coverage available to those with pre-existing medical conditions and who have been uninsured for at least six months. According to HHS data, 30 percent of the claims paid to PCIP enrollees in the federally-administered program have been for CVD, stroke, and other circulatory system diseases, so this program is clearly making an impact in the lives of our patients.

- A new resource, called the Summary of Benefits and Coverage (SBC), which became available in the fall, provides 150 million consumers with a short, plain language, uniform description of their health plan choices.

- The Obama administration released long-awaited guidance and proposed rules on a number of ACA provisions important to the AHA, including the definition of Essential Health Benefits (EHB), implementing the insurance market reforms that take effect in 2014, and further defining workplace wellness programs. The AHA/ASA submitted comments on these rules.

“The historic decision handed down today will benefit America’s heart health for decades to come. Questions about the Affordable Care Act’s constitutionality have overshadowed the law’s progress. With this ruling, that uncertainty has finally been put to rest.”

Nancy Brown
AHA CEO
High Quality/High Value Care

American Heart Association CEO Nancy Brown gave the keynote address at the annual eHealth Initiative’s (eHI) 2012 Annual Conference, held in early 2012 in Washington, DC. Her speech examined the positive impact of technology on cardiovascular health and stroke care and how the AHA has been involved in advancing health information technology adoption.

Specifically, Brown spoke about the American Heart Association's initiatives, including Get With The Guidelines, The Guideline Advantage, and Heart 360. “At the American Heart Association, we’ve seen how the technological component of initiatives like Get With The Guidelines is making a significant and documentable difference in the quality of care and patient outcomes. Around the world, others who’ve embraced technology are experiencing similar results. The bottom line is better patient care and better outcomes,” said Brown. She also spoke about the importance of telemedicine in stroke care and the up-and-coming use of Telestroke Centers in rural and remote locations.

The eHI conference agenda also included a panel session entitled “How to Successfully Analyze Data and Identify Trends in Heart Disease” on which AHA volunteer, Dr. Ileana Pina, served. Another session with AHA's Director of Outpatient Quality and Health IT, Chris Boone, and the Preventive Health Partnership's Alan Balch, was dedicated to The Guideline Advantage program and the history behind this collaboration with the American Diabetes Association and the American Cancer Society.

The AHA was also pleased that under the fiscal cliff tax deal, funding was provided for the National Quality Forum (NQF) to continue to develop quality metrics for medical care. The NQF consensus measures are crucial to the whole concept of higher value health care.

In addition, the legislation provides that physicians and clinicians who use HHS-certified registries (tools attached to Electronic Health Records (EHRs) that help track clinical care and outcomes) will be deemed to fully qualify for Medicare “PQRI” quality improvement bonus payments without having to submit annually the laborious required data to receive the up-to-two percent bonus. These analytic tools help physicians and other providers track and improve the quality of care they provide.
Standing Up for Patients

As part of the “fiscal cliff” agreement, Congress acted to temporarily protect Medicare beneficiaries from caps on outpatient physical, speech, and occupational therapy until December 31, 2013. By way of background, Medicare patients who have a stroke or other debilitating illnesses and who need outpatient physical, occupational, or speech therapy are subject to arbitrary limits or “therapy caps.” However, for the last several years, Medicare patients needing additional therapy above the limits have been able to receive an exception to the limits.

The AHA/ASA will continue to work with other patient and provider organizations to urge Congress to permanently protect Medicare beneficiaries from arbitrary caps. It is incumbent upon all of us stand up and stand by those who are trying to recover from a stroke or CVD.

There was more good news from the tax agreement. It extended the Medicare Qualified Individual (QI) program—which provides additional assistance to certain low-income Medicare beneficiaries—as well as the Transitional Medical Assistance and Medicaid and CHIP express lane eligibility options.

The AHA is also looking at the frontiers of medicine to protect patients’ rights. A perfect example is genetics. While the ready availability of human genetic data represents a great opportunity to improve health by personalizing health care and to transform how we think about disease risks, these advances also create new moral, ethical and legal challenges that must be addressed.

For example, a new AHA policy statement points out that although recent legislation protects individuals from discrimination by employers or health insurance providers based on their genetic information, important areas of potential discrimination such as life insurance are not included. Legislation should be formulated to provide broader protection.

Charitable Contributions

The American Heart Association supports a balanced approach to deficit reduction—which we recognize must include both revenue and spending proposals. For example, we have consistently advocated for higher tobacco taxes, which are a proven deterrent to tobacco use. However, we share the non-profit sector’s concerns about proposals to alter the charitable tax deduction. As part of the budget negotiations, both the President and congressional Republicans proposed to raise revenues by reducing deductions by differing amounts.

Working closely with the Independent Sector—the leading coalition of nonprofits, foundations, and corporate giving programs—and other partners, the AHA worked to raise awareness of how harmful such proposals would be to the health and well-being of Americans. AHA joined with scores of other non-profits and signed on to a letter to the President and Members of Congress urging them to reject putting a cap on charitable deductions. The AHA was also part of Independent Sector’s “Leadership Circle” that produced the advocacy advertisement, “Don’t Push Charities Over the Fiscal Cliff” that was placed in Washington, DC political newspapers.
Association CEO Nancy Brown was also invited to attend a high-level meeting at the White House with the President’s Chief of Staff, National Economic Advisor, and Director of the Domestic Policy Council to discuss capping tax deductions. Her message to the President’s inner circle was clear: Today—more than ever—Americans depend on a strong philanthropic sector of both large and small donors as nonprofits try to fill gaps created by cuts in federal, state and local budgets.

Specifically, the American Heart Association funds heart and stroke research, particularly for new investigators. The AHA’s role has become increasingly critical as it tries to help fill the research funding gap created by dwindling NIH appropriations over time. Even a relatively small decline in donations to the AHA—in percentage terms—can translate into millions less for research. She explained other ramifications in the fight against CVD and stroke system should lawmakers weaken the charitable deduction’s powerful incentive for giving:

- AHA is a trusted source for public information and education on prevention and treatment—something government agencies have fewer resources to do.
- AHA creates measures for CVD care that can help new payment models and reduce unnecessary and costly services.
- This is the wrong time to go after the health sector which is trying to help explain health reform to patients and help implement system changes that can lower health care costs.

Fortunately, the fiscal cliff agreement did not include a flat percentage or aggregate cap on itemized deductions. However, it did reinstate the so-called Pease limitation—named after former Representative Donald Pease—on itemized deductions for families earning over $300,000 per year and $250,000 for individuals. The Pease provision was first instituted in 1990, but was gradually phased out with the 2001 tax cut legislation. It is effectively an income tax surcharge, equal to 3 percent of the taxpayer’s marginal tax rate. This provision is likely to have some impact on charitable giving, but estimates are not yet available.

There was also some unexpected good news when Congress reinstituted the so-called IRA charitable rollover as part of the tax package. The provision, which had expired in 2011, allows taxpayers 70½ and older to transfer as much as $100,000 per-year from their traditional IRAs to charity. Under the deal struck, the charitable rollovers are also retroactive as taxpayers can make them in January 2013 and apply them to the 2012 tax year. Also, if people took mandatory distributions in December 2012 they will be allowed to convert them to charitable donations and not incur a tax penalty.
Fiscal Cliff

Just as our nation appeared to be ready to tumble off the fiscal cliff, Congress passed legislation and the President signed into law the American Taxpayer Relief Act of 2012 that addressed the impending tax increases and automatic spending cuts, or sequester, scheduled to begin in January 2013.

Although a number of thorny tax issues were resolved, the agreement fell short of the grand “go-big” bargain most had hoped for. It bought more time for negotiations but a deep divide remains over how best to address spending and the federal debt limit and there are no easy answers as to how that gap can be narrowed. The sequester was delayed until March 1, 2013 and decisions on the appropriations measures for fiscal year 2013 were also postponed until the current continuing resolution expires on March 27. That is the backdrop for yet another intense round of debate for the new 113th Congress over the next few months. The political positioning for the “grand bargain” has already begun and the American Heart Association will remain vigilant that our bedrock priorities are protected.

Going Forward

This past year was marked by both risk and reward. The American Heart Association Federal Advocacy team worked hard to manage the risk of potential deep funding cuts to heart and stroke research, treatment and prevention programs. And our efforts were rewarded when these investments in the health of Americans and economic growth were sustained. The coming year promises to be equally challenging but by staying resolute and steadfastly focused on our strategic priorities we can bring hope to those suffering from heart disease and stroke and be that much closer to a cure.