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May 25, 2017

The Honorable Orrin G. Hatch
Chairman, Committee on
Finance United States Senate
Washington, DC 20510

Dear Chairman Hatch,

The American Heart Association is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke – two of the leading causes of death in the United States. Our non-profit, non-partisan organization works with more than 30 million volunteers and supporters across the country and in your state. Today, one-out-of-three Americans suffer from one or more forms of cardiovascular disease (CVD). We appreciate the invitation to share our concerns and recommendations on behalf of our volunteers, clinicians, supporters, and the millions of other constituents with, or at risk of developing CVD.

We support your efforts to improve the way our healthcare system works, especially making health care more affordable and patient focused. We share those goals, and recognize the task is not an easy one. We hope this letter will be helpful in stating our views on both the House-passed American Health Care Act, and on the components of the existing law that should be maintained, strengthened, altered, or replaced.

The connection between health insurance and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality rates and poorer blood pressure control than their insured counterparts. Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays, and higher risk of death than similar patients covered by health insurance. Cardiovascular disease is also costly and burdensome for the individual, their families, and for communities.

Prior to 2010, one of the most common reasons for medical bankruptcy was cardiovascular disease. Heart transplants and surgeries for the approximately 40,000 babies born with heart defects each year are clear cut examples where caps on coverage can be quickly reached. The AHA is committed to developing strong, evidence-based policies that serve the millions of Americans with CVD in the United States and provide the basis for our recommendations.

Insurance Market Stability

We share your goal of bringing greater stability to the insurance marketplace. Regardless of whether it's done through legislative or executive branch action, or both, we believe steps must be taken immediately to preserve and strengthen the existing private health care marketplace.

In the short term, continued stable funding for ACA cost-sharing reductions must be ensured. In the absence of expedited congressional action, additional insurers could exit markets leaving patients without coverage options, while forcing premium increases of at least 15% both on and off the marketplace exchanges.

Other key stabilization concepts you might consider include development of risk reinsurance proposals. Examples of these types of proposals include those submitted by the State of Alaska or a similar proposal offered by Rep. Palmer in the House Rules Committee on April 7, 2017. Reinsurance reduces the risk to insurers covering high cost patients and provides stability in the markets. This in turn protects Americans from significant premium increases by offsetting the costs of sicker and more costly enrollees. We also urge Congress to consider other innovative proposals at either the state or federal level.

It remains imperative that the Administration and Congress devote adequate resources to state health insurance marketplace outreach and enrollment to ensure all eligible Americans have the opportunity to sign up for health insurance coverage. We know that states that devote robust resources to marketing, outreach, and enrollment assistance programs experience higher rates of enrollment than those that do not. A focus on enrollment also helps ensure that more low-cost individuals obtain insurance on the state health insurance exchanges to help offset the costs of older, sicker patients. We strongly believe these activities should be coupled with actions to streamline the application and enrollment process.

While we recognize the challenge of increasing program costs, we strongly support increasing financial support for individuals and families by expanding income eligibility for health insurance tax credits. Many middle-income families struggle to afford coverage with increasing premiums, deductibles and copays. As members of both parties have noted, affordability remains a barrier for many Americans to purchase adequate insurance. In fact, in a survey the American Heart Association conducted in April of this year, 75% of respondents (about half of whom had a CVD risk factor) indicated reducing the cost of health insurance premiums, deductibles, and co-pays as a "very important" priority for Congress.

We also support expanded use of Section 1332 of the ACA, as proposed by the Administration, that permits states to apply for Innovation Waivers. Innovation Waivers provide states an opportunity to modify existing laws to meet the unique needs of their communities. When designed carefully, these waivers can increase access to high quality, affordable health insurance while retaining the core protections of the ACA.

Health Care Reform Priorities

Our association, in collaboration with fourteen other non-partisan patient organizations, has developed a set of core principles that are fundamental to ensuring Americans continue to have access to affordable and adequate health care. (Attached) In addition to preserving the coverage gains we have achieved in recent years, we believe that three key elements – affordability, accessibility and adequacy of health care coverage – must be incorporated into any proposal to alter existing law. Patients need guaranteed issue and coverage that maintains the prohibition on underwriting for preexisting conditions, as well as the prohibition on lifetime and annual caps on out-of-pocket spending. Plans should also provide essential health benefits, including preventive services without cost-sharing, and access to an adequate network of providers. As the Senate works out how best to make substantial reforms to the Affordable Care Act (ACA), we hope you will keep our major concerns in mind. A few of our key priorities are discussed in more detail below.

Coverage. We believe that any changes to existing law must not jeopardize the health care coverage Americans currently have through employers, the private marketplace, Medicare or Medicaid. Any replacement plan should extend coverage to more Americans rather than causing people to lose coverage. A study released in 2016 by the American Heart Association revealed that more than six million adults at risk of CVD and 1.3 million who suffer from heart disease, hypertension or stroke gained health insurance between 2013 and 2014. As a result – these individuals could obtain preventive services – such as blood pressure and cholesterol screenings – and coverage for acute, emergency inpatient and post-acute care for heart attacks and strokes as well as ongoing ambulatory medical care related to these conditions. Congress needs to preserve and expand on these coverage gains.

Unfortunately, the House-passed American Health Care Act (AHCA) fell far short of meeting these goals. According to the nonpartisan Congressional Budget Office, the bill as introduced would reduce coverage for 23 million, or one out of every 10 non-elderly Americans who have health insurance, including many low-income and disabled individuals who rely on Medicaid. The increase in the number of uninsured would be disproportionately larger among older people with lower income, particularly people between 50 and 64 years old with income of less than 200% of the federal poverty level.

The House-passed health care bill would reverse all of the historic coverage gains achieved since the Affordable Care Act was enacted in 2010 and the resulting uninsured rate among the non-elderly would be the same as the 2010 level.

Coverage losses would be more concentrated among people with pre-existing conditions and serious health needs – the very people who need health insurance the most. Our association finds this coverage loss and the impact it would have on the lives and health of Americans with CVD unacceptable.

Preexisting Conditions. Many of our patients were uninsurable prior to the ACA. An analysis of some of the largest for-profit health insurance companies in the country revealed that between 2007 and 2009, one out of every seven applicants was denied coverage based on a health condition reflecting widespread discrimination impacting CVD patients for decades.

We were pleased that the AHCA manager’s amendment sponsors spoke about the importance of maintaining the pre-existing conditions requirement; however, despite the intent, the House-passed AHCA does not provide affordable protection comparable to current law. We believe that allowing states to waive protections against health status rating would weaken the rules and allow insurers to charge higher prices to people with pre-existing conditions possibly making insurance unaffordable for those who need it most. In states that obtain essential health benefit and community rating waivers, CBO estimates that less healthy individuals such as those with preexisting conditions, would be unable to purchase comprehensive coverage with premiums close to those under current law and might not be able to purchase coverage at all. For those who can acquire coverage, their premiums will likely rise despite additional funding.

States that waive health status rating protections would be required to set up a high-risk sharing program, which may include a high-risk pool or an invisible high-risk pool. Unfortunately, previous state high-risk pools resulted in higher premiums, long waiting lists and inadequate coverage. State after state found they had to limit coverage, close enrollment, and increase premiums, and in multiple cases the pools were closed because they became too costly. Experience has shown that when you can’t spread the risk for costlier care among a large population - which includes those who are not as costly - it becomes unaffordable. A recent analysis by the Robert Wood Johnson Foundation found that high risk pools require 3-5 times the funding provided in the AHCA to adequately support the number of patients with preexisting conditions.

While the ACA is by no means perfect, for patients with preexisting conditions, the law provides an opportunity for CVD patients who had previously been denied coverage on the individual open marketplace due to their preexisting conditions, or because of expensive premiums that were out of their financial reach. For the first time, they were offered a genuine pathway to real and meaningful health insurance coverage. As it considers reform, the Senate should work to build upon the success of provisions such as these.

Subsidies. Protection for preexisting conditions must be coupled with affordability to provide real access to care. In a recent national survey of more than 1,000 adults – about half with personal experience with cardiovascular disease, stroke, or conditions that can cause heart disease - the clear priority for them was lowering health care costs, and they wanted that to be a priority for Congress as well. Affordable coverage includes reasonable premiums and cost-sharing, limits on out-of-pocket expenses and no annual or lifetime caps.

The AHCA failed this test for older and sicker people – who make up a significant portion of our patient population. The bill allows insurers to charge older people much higher premiums and reduces their tax credits the most. For a typical 60-year-old making \$26,500 a year, premiums (after accounting for tax credits) would rise by more than \$11,000. For states that waive the preexisting conditions requirement, some estimate that as many as 6.3 million people might be vulnerable to even higher premiums. If the intent is to reduce premiums for patients, we would recommend that the Senate make refundable tax credits income and age-adjusted and far more robust than the AHCA.

Essential Health Benefits. In addition to maintaining access to insurance coverage, all plans should be required to cover a full range of needed health benefits with a comprehensive set of providers and plan features. The provision in current law that requires all individual and small-group plans, whether in or out of the marketplaces, to cover ten categories of required services is critically important to individuals with heart disease – including rehabilitation and habilitation services as well as preventive health care. Previously, many plans in the individual and small-group markets lacked coverage in one or more of these categories. For people living with or at risk of CVD, these benefit requirements protect insured individuals from overwhelming financial burden in the event of a CVD-related illness, and enable them to receive health care services that help prevent a recurrence or disease progression. According to the CBO, about half of the population resides in states that would make changes to essential health benefits under the AHCA. People who rely on these services could face drastic increases in out-of-pocket costs or forgo needed services, including maternity care, mental health and substance abuse treatment, and rehabilitative and habilitative services.

Preventive services required under current law apply to nearly all individual and small-group plans, most large group plans and all Medicaid expansion plans. Enrollees have access to a broad set of evidence-based preventive services without cost-sharing requirements, and these services include many that are relevant to preventing, identifying and managing CVD. Included are blood pressure screening, diabetes (type 2) screening, diet counseling, statin preventive medication for those with CVD risk, and obesity screening and counseling – all core components to preventing, diagnosing or treating CVD. Evidence demonstrates that when preventive services come with out-of-pocket costs, utilization rates fall, particularly for the working poor. An investment in preventive services prevents significant loss of work-days and improves quality of life for millions of heart and stroke patients.

Mandates and Continuous Coverage. We understand that individual and employer mandates may be repealed, however, we are concerned about the potential for unintended consequences if provisions requiring continuous coverage as a condition of retaining those protections are not crafted to recognize and allow for certain extenuating circumstances. Although continuous coverage is optimal for individuals and for the risk pool, the reality is that patients can face gaps in coverage for many reasons, including the inability to keep up with premiums, the loss of a job, or a change in family circumstances. For patients with chronic conditions, these challenges can be compounded by job instability linked to the demands of managing their health. We hear regularly from patients and family members about the burden of dealing with CVD and stroke. The burden is so high that it may require the patient or family member, often the parent of a child facing CVD or stroke, to miss time from a job or even lose the job entirely. These extenuating circumstances are real – particularly for low-income individuals.

An AHA survey of CVD patients from January 2010 demonstrates the challenges that many with heart disease or stroke face that make continuous coverage a challenge for many. Key findings included the fact that approximately 16% of non-elderly adults surveyed did not currently have health insurance. And even among those who did have insurance, 24% of CVD patients (and 36% of stroke patients) said they'd gone without health insurance at some time since their diagnosis. Of those CVD patients without insurance coverage, the high cost of the insurance premium was cited as the major reason why (48%), followed by losing insurance coverage because of job loss (37%), their employer didn't offer coverage or the employee didn't qualify, the insurance company wouldn't cover their condition, or the insurance company refused coverage due to a pre-existing medical condition.

Medicaid Reform. We understand the desire to reform Medicaid in a way to reduce the rate of growth for the federal dollars, and provide states greater flexibility to meet the needs of their residents. In order to meet the needs of individuals with heart disease, we feel our principles still reflect our position that Medicaid coverage - including the Medicaid expansion established in the ACA - must be maintained.

Low-income populations are disproportionately affected by CVD – with low-income adults reporting higher rates of heart disease, hypertension, diabetes, and stroke. Americans with a history of CVD make up 28% - or nearly one third - of the Medicaid population. Medicaid provides critical access to prevention, treatment, disease management and care coordination services for these individuals.

States that expanded Medicaid under the ACA have cut their non-elderly uninsured rate by more than half since 2010, according to the Centers for Disease Control and Prevention. Numerous state and national studies have found that in states that expanded Medicaid, there was a significant increase in adults receiving consistent care for their chronic conditions, an increase in the use of preventive services and screening, and increased access to specialty care. Medicaid expansion has been

particularly beneficial for individuals with or at risk of developing CVD. A 2016 study conducted by the George Washington University, found that adults who live in non-expansion states are at higher risk of CVD or are more likely to have experienced acute CVD while also having lower insurance coverage rates. Patients in non-expansion states may also have greater difficulties getting preventive, primary or acute care. It is also harder for the physicians treating these patients to collect insurance payments for their services. This translates into significantly worse health outcomes for patients and a lost opportunity to incentivize cost-efficient care.

The House-passed version of the AHCA cuts Medicaid by \$880 billion. According to the CBO, these cuts would result in 14 million fewer Medicaid enrollees by 2026, a reduction of about 17% relative to the number under current law and most of those losing Medicaid would likely end up uninsured.

This reduction in coverage would have a devastating effect on patients with CVD. We encourage you to reject the House Medicaid provisions, which reduce coverage, increase patients' out-of-pocket costs, and shift costs to States. We are encouraged by discussions that could lead to additional options for these remaining states to provide them with the flexibility and incentive to expand coverage to low-income Americans who do not qualify for Medicaid.

Improvements to current law

Although the law has expanded coverage to millions of individuals with or at risk of developing CVD, issues remain with affordability, access and adequacy. High co-pays and deductibles can continue to discourage patients to use the insurance benefits they have obtained under the ACA.

In addition, protections need to be in place to allow those being treated for an acute or chronic medical condition to switch health plans or continue to receive care from that provider at the in-network cost-sharing rate when patients face losing access to their doctor or hospital in the middle of a coverage period.

Health plans often choose to narrow in-network health care providers in an effort to keep costs low. Unfortunately, this can lead to inadequate networks of clinicians to meet the special needs of certain patients, denying them access or requiring them to go out-of-network, which can be cost prohibitive for many patients due to higher cost-sharing levels.

Conclusion

The American Heart Association recognizes that health reform remains a work in progress with opportunities to preserve provisions that have brought real improvements in care and coverage for those with or at risk of developing CVD, revisit components that are falling short on ensuring affordable or adequate coverage, and explore additional new approaches to achieve our shared goals of improving access to care. We welcome and appreciate the commitment to ensure any transition or replacement provisions will not result in lost insurance coverage,

patient protections, or disruptions to the public and insurance market programs our patients rely upon. Americans suffering from CVD and stroke and their families and friends are depending on you.

Thank you for your consideration of these comments and we hope this background is helpful. We are happy to work with you to ensure that any changes to the current health care system adequately address the needs of individuals with CVD. If you have questions or would like to discuss this issue, please do not hesitate to contact me directly or our team in Washington, D.C. Sue Nelson, our Vice President for Federal Advocacy, can be reached at sue.nelson@heart.org or 202-785-7912.

Sincerely,

A handwritten signature in black ink that reads "Nancy A. Brown". The signature is written in a cursive style with a large, looped initial "N".

Nancy A. Brown
Chief Executive Officer