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January 4, 2017

The Honorable Mitch McConnell
Majority Leader
United States Senate United States Senate
S-230, US Capitol
Washington, DC 20510

The Honorable Paul Ryan
Speaker
US House of Representatives
H-232, US Capitol
Washington, DC 20515

Dear Leader McConnell and Speaker Ryan:

The American Heart Association stands ready to work with you and the new Administration to ensure access to meaningful and affordable health care coverage while lowering costs and improving quality of care. We know that while your goal is clear, your task will not be simple. We hope this letter will be helpful in stating our views on components of the current health care law that should be maintained, strengthened, altered or replaced.

The American Heart Association is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke – the two leading causes of death in the world. Our non-profit and non-partisan organization includes more than 30 million volunteers and supporters. The American Heart Association and its American Stroke Association division fund innovative research to accelerate advances in preventing heart disease and stroke. We also fight for stronger public health policies, and provide critical tools and information to health care providers, patients, their families and loved ones to prevent and treat these deadly diseases. We know you are aware that millions of the individuals we serve have preexisting or chronic disease, and ensuring their coverage is critical to our mission, so we thank you in advance for recognizing why this is such an essential priority for our organization.

*"Building healthier lives,
free of cardiovascular
diseases and stroke."*

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Please remember the American Heart Association in your will.



Today, one-third of all deaths in the U.S. are attributed to cardiovascular disease (CVD) and almost half of our population has at least one risk factor for heart disease or stroke. There is a growing prevalence of hypertension – a major CVD risk factor – among children and adolescents. CVD and stroke exact an enormous physical and monetary strain upon our nation and its people. These twin killers are our costliest chronic diseases, with spending expected to soar in the coming years, surpassing medical cost estimates for other chronic diseases, such as diabetes and Alzheimer’s. Indeed, CVD is the most burdensome disease as measured by prevalence, death, disability and costs. In 2014, stroke and heart failure were the most expensive chronic conditions in the Medicare fee-for-service program.

As the 115th Congress begins its deliberations around the Affordable Care Act (ACA) and possible alternative approaches, we trust that a review of what is important to cardiovascular and stroke patients will be helpful to you. A study released in 2016 by the American Heart Association revealed that more than six million adults at risk for CVD and 1.3 million who suffered from heart disease, hypertension or stroke gained health insurance between 2013 and 2014. That figure is likely much higher today. We appreciate your public comments that reinforce our priority that first we must ensure no change is made that would undermine their coverage or see them fall back into the ranks of the uninsured.

There are several provisions in current law that are critical for individuals with CVD or those at risk of developing the disease. We hope you will consider them during the forthcoming deliberations on alternative approaches to health care reform. These include:

Protection from discrimination. 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. Now, individuals who have congenital heart disease, stroke, heart attack or high blood pressure can seek insurance coverage in the open individual marketplace.

More than a quarter of adults under the age of 65 have conditions that preclude them from health insurance coverage under the old preexisting condition and medical underwriting rules in most states. Lists of so-called “declinable conditions” included congestive heart failure, coronary artery/heart disease, bypass surgery and stroke. Issuers also had “declinable medications,” which they could use to deny coverage. Provisions for guaranteed renewability regardless of health status continue to be critical for heart disease and stroke patients.

Protection from rating based on health status. Currently, plans cannot charge people different premiums based on health status and, just as important, provide coverage that excludes care for preexisting conditions. This means that people with CVD cannot be charged higher rates or be forced to settle for coverage that does not meet their existing CVD health needs. The loss of protection for preexisting

conditions could significantly increase premiums or limit the scope of coverage for CVD patients.

No annual limits or lifetime limits. For health services that fall into the Essential Health Benefits categories, issuers are currently prohibited from setting either annual or lifetime coverage limits. Without this protection, insurers can simply cap their own liability, and when major health crises arise, consumers may be left coping with devastating financial burdens.

An analysis of bankruptcies in 2007 suggests that 62.1 percent of all bankruptcies that year were attributable to health care debt. One of the most common reasons for medical bankruptcy – prior to 2010 – was cardiovascular disease. Heart transplants and surgeries for children born with heart defects are clear cases where any coverage limit can be quickly reached. Hard-working families should not have to return to the days where they are one step away from personal bankruptcy due to having a child with a congenital heart defect.

Annual out-of-pocket caps. For plans sold through state marketplaces, we support maintaining out-of-pocket caps on the amount an enrollee, or his or her family, would have to pay for essential health benefits, not including premiums. In 2016, the level was \$6,850 for individuals and \$13,700 for families. People enrolled in these plans could therefore be assured that in a given year, their medical costs would not exceed a fixed amount. Loss of this protection could subject enrollees, particularly those with costly medical conditions, like cardiovascular disease, to large and unpredictable costs.

Gender rating. Insurers traditionally charged women more than men solely based on gender, but the prohibition of the practice of “gender rating” changed that. In the past five years, the percentage of women aged 18 to 64 without insurance dropped by almost half – from 19.3 percent to 10.8 percent. For the almost 44 million women with CVD, this improved access to care while ensuring that women paid no more for the same coverage than their male counterparts.

Age rating. Private insurers have traditionally charged higher premiums for older enrollees. This has led to greater costs for both individuals and small-group markets for the population most likely to need health care for CVD and other health conditions. ACA established an “age band” of a 1:3 ratio, which has been an important step in improving coverage. Thus, issuers can only charge the oldest enrollees a maximum of three times as much as the youngest. While we recognize that age-rating bands can have an unintended consequence of shifting premium costs to younger enrollees, we believe that some age rating protections need to be maintained to avoid returning to prohibitively high insurance premiums for people at greatest risk for CVD.

Medicaid expansion. Repeal of the Medicaid expansion would result in a loss of Medicaid coverage for an estimated 12.9 million people. Roughly 70.5 million

patients with one or more CVD risk factors who live in expansion states could also face potential loss of coverage. The American Heart Association strongly recommends that steps be taken to ensure coverage for these individuals is preserved in any revisions made in options given to states to expand coverage to even more Americans.

Marketplace reform. Many of our patients obtain coverage either directly or indirectly through the established state-level exchange marketplaces. To make this coverage affordable, a federal premium subsidy is available to roughly 84 percent of individuals. Nearly 60 percent of those insured through the marketplaces have access to health services through health plans with reduced cost sharing.

If these subsidies were eliminated, an estimated 9.3 million people who could have purchased coverage with premium tax credits in 2019 would lose the assistance. Overall, an estimated 17.7 million would lose individual private coverage, either directly by losing premium assistance or because of destabilization of the market that would result. A sizeable portion of individuals currently purchasing in the individual market suffer from CVD or have risk factors for the disease, which is why we believe it is essential to stabilize the individual market, including continuing some form of financial assistance or incentive for these working families.

Coverage for young adults. The provision that allows young adults to stay on their parents' insurance plans until age 26 is particularly important for those with serious health conditions, such as congenital heart disease, who may need comprehensive coverage and access to ongoing care. President-elect Trump has voiced his support for this popular provision in any new health care reform proposal. We appreciate that this provision enjoys bipartisan support.

Out-of-network emergency care. While not a lot of public attention is focused on the out-of-network protections, these are also critical to individuals suffering from a heart attack or stroke. Current law does not allow insurers to charge more for out-of-network emergency care, nor does it allow them to require prior approval for non-network emergency care. This protects CVD patients with private insurance from absorbing high and unpredictable medical bills because they had to visit an out-of-network emergency room for a heart attack, stroke or other cardiovascular crisis. This is particularly important for patients whose emergency room visits are recurrent. Where one emergency room visit can be costly, multiple emergency room visits without limitations on out-of-network billing for emergency care can be financially catastrophic.

Clinical Trails. The recent passage of the 21st Century Cures Act complements the current policy requiring issuers to cover routine care costs for enrollees when they are enrolled in clinical trials. In addition to the research benefits, this is important to CVD patients who want to promote better medical understanding of heart health.

Prescription drug costs. The phase out of the so-called “donut hole” – a coverage gap in the standard Medicare Part D drug benefit – first, by providing beneficiaries who entered it with a rebate check and then, by gradually phasing out cost-sharing for drugs within the donut hole is a provision we have strongly supported. Under current law, the donut hole will be completely closed by 2020, and beneficiaries will only be responsible for 25 percent of drug costs between \$2,800 and the yearly out-of-pocket spending limit. We believe that the elimination of this provision could significantly increase out-of-pocket drug costs for Medicare enrollees living with CVD. This includes the 12 percent of Medicare beneficiaries living with heart failure, 54 percent with hypertension, 27 percent with ischemic heart disease and 3 percent with stroke. Closing the donut hole has saved Medicare beneficiaries approximately \$5.7 billion on their prescription drugs, including in 2012 alone, \$436 million on medications for diabetes, \$240 million on drugs for high cholesterol and \$138 million on drugs for high blood pressure control.

Basic categories of coverage. In addition to maintaining access to insurance coverage, the provision in current law that requires all individual and small-group plans, whether in or out the marketplaces, to cover ten categories of required services has become critically important to individuals with heart disease. 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.

Preventive 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, leveling the playing field in how Americans get and receive preventive screening services and care. 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. Also 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.

Improvements to the 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. Based on a survey of our patients conducted prior to the enactment of the health care law, affordability was their greatest concern and highest priority. 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.

One strategy health plans use to keep costs low is to narrow their in-network health care providers. 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.

Finally, rates of uninsured remain high in states where Medicaid was not expanded. 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.

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 to our patients, and explore additional new approaches to achieve our shared goals of improving access to care for individuals with CVD. We welcome and appreciate the commitment we believe that you share to ensure any transition or replacement provisions will not result in lost patient protections, insurance coverage 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,



Nancy A. Brown
Chief Executive Officer
American Heart Association

cc:
The Honorable Lamar Alexander
The Honorable Orrin Hatch

The Honorable John Cornyn
The Honorable John Thune
The Honorable Kevin Brady
The Honorable Greg Walden
The Honorable Kevin McCarthy
The Honorable Steve Scalise