American Heart Association.

June 21, 2019

Mick Mulvaney
Director
Office of Management and Budget

Nancy Potok
Chief Statistician
Office of Management and Budget

Russell Vought
Deputy Director
Office of Management and Budget

Re: OMB-2019-0002 (Directive No. 14)

Dear Director Mulvaney, Deputy Director Vought, and Ms. Potok:

As the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke, the American Heart Association (AHA) would like to express its serious concerns about the Office of Management and Budget's (OMB) proposal to change the annual calculation of inflation used to determine the federal poverty line. We are troubled that this proposal, if implemented, would gradually lower the measurement of inflation – reducing the impact and value of assistance over time. The proposed changes would negatively impact a wide array of services and programs including those that increase the availability and affordability of health insurance coverage, nutrition programs, housing assistance and eligibility for other federal assistance that contribute to healthier lives for millions of people living in the United States.

Our nonprofit and nonpartisan organization represents more than 100 million patients with cardiovascular disease (CVD) and includes more than 33 million volunteers and supporters committed to our goal of improving the cardiovascular health of all human beings. The AHA has worked diligently for many years to support and advance evidence-based policies that prevent and treat these deadly diseases. Many Americans living with serious or chronic conditions like CVD rely on assistance programs for access to health care and to address food, housing, and income insecurity. For this reason, we urge OMB to refrain from changes that would impact an individual's ability to access critical safety net programs. Any substantial changes made to the program, such as those being proposed here, should be undertaken through rulemaking that includes a thorough analysis of the economic and health implications for individuals and families who utilize safety-net programs and a transparent public comment period.

Accuracy of the Poverty Measure

The current Official Poverty Measure (OPM) is based on an old formula that does not accurately or fully capture the number of individuals and families living in poverty in the United States today. As currently calculated, the OPM does not accurately reflect basic household expenses for families, and underestimates common expenses such as child care and housing.[1] The proposed changes to the inflation calculation would not fix the flaws with the current formula, but would reduce the annual adjustments to the poverty measure and, as a result, may exacerbate existing financial vulnerabilities, putting low-income Americans — including those with serious and chronic diseases — at great risk. Further lowering the poverty line would also give policymakers and the public less credible information about the number and characteristics of Americans living in poverty.

Increasing Healthcare Costs and Reducing Access to Care

The AHA believes that everyone living in the United States should have access to affordable health coverage to ensure needed care is received in a timely manner from an experienced provider without undue financial burden. We are concerned that the proposed changes to the OPM would drastically reduce the ability of Americans living with CVD to access and receive care.

Based on Congressional Budget Office estimates[2], updating the federal poverty level using chained CPI will cause millions of people to lose their eligibility or receive fewer benefits from health coverage programs including Medicaid and the Children's Health Insurance Program (CHIP), Medicare Savings Programs, and the Medicare Part D Low-Income Subsidy program, and Advance Premium Tax Credits (APTCs). If implemented, adjusting to a chained CPI inflation measurement would over time cause about six million marketplace consumers to see reductions in their premium tax credits and experience increases in their premiums.[3] The proposal would also eliminate eligibility for premium tax credits and cost sharing assistance for many consumers.

The Association believes that affordable coverage includes reasonable premiums and cost sharing, such as deductibles, copays and coinsurance. For millions of patients and consumers, cost sharing assistance programs are integral in helping them afford the care they need. Without cost sharing assistance, comprehensive care would be out of reach for many low- and moderate-income families due to unaffordable cost-sharing. APTCs, which reduce monthly insurance payments, are currently only available for consumers making between 100 and 400 percent of the federal poverty level. By effectively lowering the income threshold to qualify for an APTC, as

[1] National Research Council 1995. Measuring Poverty: A New Approach. Washington, DC: The National Academies Press.

[2] See CBO CPI chain estimates: https://www.cbo.gov/system/files?file=2018-09/44231_ChainedCPI_0.pdf and https://www.cbo.gov/sites/default/files/cbofiles/attachments/Governmentwide_chained_CPI_estimate-2014_effective.pdf.

[3] Poverty Line Proposal Would Cut Medicaid, Medicare, and Premium Tax Credits, Causing Millions to Lose or See Reduced Benefits Over Time, Center on Budget and Policy Priorities, Aviva Aron-Dine and Matt Broaddus, May 22, 2019. https://www.cbpp.org/research/poverty-and-inequality/poverty-line-proposal-would-cut-medicaid-medicare-and-premium-tax

this proposal would do, fewer consumers will be able to afford health insurance premiums on the exchange.

Limiting Expanded Coverage Under Medicaid

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care.[4] In fact, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease.[5] Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Low-income populations are disproportionately affected by CVD with adults reporting higher rates of heart disease, hypertension, and stroke. For millions of Americans with CVD, Medicaid is the coverage backbone for the healthcare services individuals need to maintain or improve their health.

The connection between health coverage and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance or are underinsured, have higher mortality rates[6] and poorer blood pressure control[7] than their insured counterparts. Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays,[8] and a higher risk of death[9] than similar patients covered by health insurance. The Medicaid program is critical to ensuring low-income individuals and families can receive care. Since the passage of the Affordable Care Act (ACA), Medicaid enrollment has increased by 27.5 percent, providing quality healthcare for millions of the previously uninsured.[10]

Currently, 37 states and the District of Columbia have opted to expand their Medicaid programs. If implemented, OMB's changes to the OPM using chained CPI would cause more than 250,000 adults who now benefit from the expansion of Medicaid to lose their coverage as the income threshold for eligibility decreases over time.[11] In addition, this change would further exacerbate the dilemma faced by many uninsured people in non-expansion states who are caught in an assistance gap, qualifying for neither Medicaid nor tax credits to purchase coverage via the marketplace.

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[4] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

[5] Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.

[6] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.

[7] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.

[8] Rice T,LaVarreda SA,Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.

[9] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007; 298:2886 –2894.

[10] Medicaid and CHIP Payment and Access Commission. Medicaid Enrollment Changes Following the ACA. Retrieved from: https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/#_ftn1. Accessed on June 20, 2019.

[11] Aron-Dine and Broaddus. *Poverty Line Proposal*, 6.

Financial Health and Wellness of Seniors

If enacted, changing the OPM utilizing chained CPI would hurt low-income seniors and people with disabilities by reducing or eliminating their eligibility for the Medicare Part D Low-Income Subsidy Program. This program helps pay premiums and cost sharing for Medicare prescription drug coverage and provides critical assistance for those living on a fixed budget. The policy change would also cause seniors to lose eligibility for Medicaid assistance that helps them pay for Medicare deductibles and cost sharing for hospital and doctor visits. A vast majority of Medicare beneficiaries have some form of CVD, and they depend on Medicare to provide stable, affordable health care for their conditions. By reducing these patients' eligibility for federal programs that help them pay for prescription drug coverage, premiums, and medical care, we are placing our seniors and those with disabilities in harm's way.

Nutrition Needs of Vulnerable Populations

Poor diet quality is a major risk factor for heart disease and stroke, two of the nation's deadliest and costliest, yet largely preventable chronic conditions. Among modifiable risk factors, poor dietary habits are a leading cause of death and disability. In particular, under resourced communities struggle to put food on the table – let alone healthy food – and are at the highest risk for heart failure. Food insecurity is associated with diabetes, heart disease, obesity, high blood pressure, chronic kidney disease, and depression,[12] and $178 billion in preventable health care, educational, and lost work productivity.[13]

Programs such as the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program (NSLP), the School Breakfast Program (SBP), and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) help address food insecurity and poor nutrition. These programs have a positive impact on health, educational attainment, and economic self-sufficiency.[14,15] Families experiencing food insecurity may choose to forgo other necessary expenses to help stretch the budget, such as forgoing medicine, medical treatment, or rationing food. These coping strategies exacerbate existing chronic conditions and compromise health.[16]

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[12] American Heart Association. Farm Bill Policy and the Supplemental Nutrition Assistance Program (SNAP). March 2017. http://www.heart.org/-/media/files/about-us/policy-positions/prevention-nutrition/farm-bill-policy-and-snap-ucm_494779.pdf?la=en&hash=6535F1BDA73DD46585CD868AB5A1AB0FDCD824. Accessed June 19, 2019.

[13] American Heart Association. Farm Bill Policy and the Supplemental Nutrition Assistance Program (SNAP). March 2017. http://www.heart.org/-/media/files/about-us/policy-positions/prevention-nutrition/farm-bill-policy-and-snap-ucm_494779.pdf?la=en&hash=6535F1BDA73DD46585CD868AB5A1AB0FDCD824. Accessed June 19, 2019.

[14] Ibid.

[15] American Heart Association. Stepping Up to the Plate: Nutrition Standards and School Meals. March 2019. https://www.heart.org/-/media/files/about-us/policy-research/fact-sheets/healthy-schools-and-childhood-obesity/nutrition-standards-and-school-meals-fact-sheet-2019.pdf?la=en&hash=65A283F35E8B24CF601EB759BB5F84BB87CE77E8. Accessed June 19, 2019.

[16] Food Research and Action Center. *Hunger and Health: The Role of the Supplemental Nutrition Assistance Program in Improving Health and Well-Being.* 2017. http://frac.org/wp-content/uploads/hunger-health-role-snap-improving-health-well-being.pdf. Accessed June 19, 2019.

Using the chained CPI method to determine OPM would cause hundreds of thousands of SNAP, NSLP, SBP, and WIC recipients to lose access to essential food and nutrition programs.[17] Decreasing eligibility to these programs would cost more money in the long run, worsen health outcomes, decrease academic success, lead to less workforce productivity, put a more onerous burden on states and the private sector, and hurt local economies.[18,19,20,21]

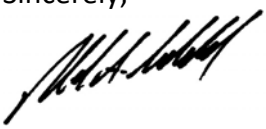
Conclusion

The American Heart Association appreciates the consideration of our views regarding potential changes to how the official poverty level is determined by the federal government. While the OMB notice states that the agency is not seeking input on how this would impact the Department of Health and Human Services poverty guidelines and program eligibility, we believe it is important for us to express our concerns regarding a reference in the notice that states, "Changes to the poverty thresholds, including how they are updated for inflation over time, may affect eligibility for programs that use the poverty guidelines."

We, therefore, respectfully request that you address the issues we have outlined and carefully consider how your next steps could potentially harm large portions of the population by reducing and restricting eligibility for federal health, nutrition, and other basic assistance programs. We recommend conducting a comprehensive analysis of the impact of this policy change and its alternatives over time and allow additional opportunities for public comment.

If you would like any additional information, please contact Katie Berge, AHA Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,



Mark Schoeberl
Executive Vice President for Advocacy

[17] Center of Budget and Policies Priorities. Administration's Poverty Line Proposal Would Cut Health, Food Assistance for Millions Over Time. June 18, 2019. https://www.cbpp.org/research/poverty-and-inequality/administrations-poverty-line-proposal-would-cut-health-food . Accessed June 19, 2019.

[18] Jyoti DF, Frongillo EA, Jones SJ. Food insecurity affects school children's academic performance, weight gain, and social skills. *Journal of Nutrition*, 135, 2831-2839. 2005.

[19] Shanafelt A, Hearts MO, Wang Q, Nanney MS. Food insecurity and rural adolescent personal health, home, and academic environments. *Journal of School Health,* 86(6), 472-480. 2016.

[20] Nelson BB, Dudovitz RN, Coker TR, Barnert ES, Biely C, Li N, Szilagyi PG, Larson K, Halfon N, Zimmerman FJ, Chung PJ. Predictors of poor school readiness in children without developmental delay at age 2. *Pediatrics*, 138(2), e20154477. 2016.

[21] Howard LL. Does food insecurity at home affect non-cognitive performance at school? A longitudinal analysis of elementary student classroom behavior. *Economics of Education Review*, 30, 157-176. 2011.