

May 22, 2009

Senate Finance Committee
219 Dirksen Building
United States Senate
Washington, DC 20510

Comments on Expanding Health Care Coverage: Section VI: Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles/Coverage of Evidence-Based Preventive Services

Dear Senate Finance Committee Members:

The National Aneurysm Alliance (NAA), a coalition of medical professional organizations, foundations, patient advocates and medical technology manufacturers dedicated to reducing the number of Americans who die needlessly each year from a ruptured abdominal aortic aneurysm (AAA), respectfully offers the following comments on the Senate Finance Committee's health care reform coverage proposal, specifically the section on "Coverage of Evidence-Based Preventive Services" that highlights AAA screening on page 45 of your May 14, 2009 document.

- **The NAA strongly urges the Finance Committee to modify the current AAA screening benefit to be consistent with the US Preventive Services Task Force recommendation such that all 65-75 year old male ever-smokers would be eligible.**

The current AAA screening benefit is severely limited in its scope because only Medicare beneficiaries in their first year of eligibility who undergo the Welcome to Medicare Physical Exam are eligible for AAA screening. Because of this, less than 10,000 beneficiaries were screened for AAA in 2007. Given the large number of new male Medicare beneficiaries each year, and the high prevalence of current or past smokers, only a tiny fraction of at-risk beneficiaries were actually screened for this disorder. The benefit eligibility should be revised to match the USPSTF recommendation for 65-75 year old male ever-smokers.

AAA ultrasound screening is non-invasive, highly accurate and inexpensive – the Medicare payment for AAA screening is less than that of digital screening mammography and substantially less than screening colonoscopy. It is estimated that over one million Americans have AAAs and at least 95% of these can be successfully treated if detected prior to rupture. In contrast, if AAAs remain undetected until they rupture, only 15% of patients survive.

The solution is to make two corrections to the original law. Representatives Gene Green (D-TX) and John Shimkus (D-IL) have introduced the SAAAVE Act of 2009, H.R. 1213,

which would unlink AAA screening with the Welcome to Medicare Physical Exam and extend the one-time benefit to at-risk 65-75 year old Medicare beneficiaries. We request that the language in this bill be included under the prevention and screening benefits section of any health care reform legislation voted on by the Senate this year.

➤ **AAA Screening in Men and Women with a Family History of AAA**

The NAA supported the original Screening Abdominal Aortic Aneurysms Very Efficiently (SAAAVE) Act, which was enacted into law as part of the 2005 Deficit Reduction Act and became effective on January 1, 2007. As mentioned in the Finance Committee proposal, the SAAAVE Act also included AAA screening coverage for men and women with a positive family history of AAA. The NAA notes that the USPSTF remained silent regarding recommendations for screening men or women with a family history of AAA, despite inclusion of the statement, “A first-degree family history of AAA requiring surgical repair also elevates a man’s risk for AAA; this may also be true for women but the evidence is less certain.”¹

The NAA notes that review of the scientific literature for AAAs prevalence in first-degree relatives of those with established AAA is very convincing although the numbers of patients in these articles is naturally less than studies of male smokers.² Evidence shows that even though there is a lower prevalence of AAAs in women, the natural history of AAA in women is even more dangerous than in men, with rupture occurring in smaller sized aneurysms and causing an even higher mortality rate. Thus, patient longevity is less for women than men with AAAs and death after rupture is greater in women than in men. In fact, studies performed after the USPSTF decision demonstrate that screening women for AAA is cost-effective.³ Thus, we strongly oppose any change in Medicare coverage that would withdraw this screening benefit for men or women with a family history of AAA.

Also important, denying women access to AAA screenings will create the misperception that Congress is more concerned about health and prevention issues for males than females. This would be perceived as similar to women being ignored for many years regarding the prevalence of heart disease.

We do appreciate that the proposal would allow Medicare coverage for AAA screening for women if it is deemed medically necessary by the prescribing physician.

For additional information or questions about AAA screening, please contact Pamela Phillips at pPhillips@vascularsociety.org or 703-573-7894.

Sincerely,

National Aneurysm Alliance

Abbott
American College of Surgeons
American Medical Association
American Osteopathic Association
American Registry for Diagnostic Medical Sonography
American Society of Echocardiography
Aneurysm Outreach
Aptus Endosystems
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Society for Vascular Surgery
Society for Vascular Ultrasound
Society of Interventional Radiology
Society of Thoracic Surgeons
SonoSite Inc.
Vascular Disease Foundation
W.L. Gore

References:

1. U.S. Preventive Services Task Force, "Screening for Abdominal Aortic Aneurysm: Recommendation Statement" *Ann Intern Med.* 2005;142:198-202
2. Frydman G, Walker PJ, Summers K, et al, "The Value of Screening in Siblings of Patients with Abdominal Aortic Aneurysm" *Eur J Vasc Endovasc Surg* 2003;26:396-400.
3. Wanhainen A, Lundkvist J, Bergqvist D, et al, "Cost-effectiveness of screening women for abdominal aortic aneurysm" *J Vasc Surg* 2006;43:908-14.

Appendix: Recent literature on AAA screening in women:

Cost-effectiveness of screening women for abdominal aortic aneurysm

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Background: Women are usually not considered for abdominal aortic aneurysm (AAA) screening because of their lower prevalence of disease. This position may, however, be questioned given the higher risk of rupture and the longer life expectancy among women. The purpose of this study was to assess the cost-effectiveness of screening 65-year-old women for AAA.

Methods: A systematic review of the literature was conducted to obtain data of importance to evaluate the effectiveness of screening women for AAA. Data were entered into a Markov simulation cohort model.

Results: The review suggested some main assumptions for women with AAA. Prevalence is 1.1%. In 6.8%, the AAA is of a size that merits surgery, and the patients are fit for a procedure. For patients with an AAA, the yearly risk for elective surgery and the rupture incidence was 3.1% and 2.4%, respectively, in the invited group and 1.1% and 5.7% in the noninvited group. The operative mortality for elective surgery was 3.5%, and the total mortality for ruptured AAA was 86.3%. The long-term mortality for AAA patients was 3.6 times higher than for an age-matched healthy population. Screening reduced the AAA rupture incidence by 33% and the AAA-related death rate by 35%. The cost per life year gained was estimated at \$5911.

Conclusion: The incremental cost-effectiveness ratio was similar to that found for screening men, which reflects the fact that the lower AAA prevalence in women is balanced by a higher rupture rate. Screening women for AAA may be cost-effective, and future evaluations on screening for AAA should include women. (*J Vasc Surg* 2006;43:908-14.)

The Value of Screening in Siblings of Patients with Abdominal Aortic Aneurysm

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Objectives. This study aimed to determine the incidence of abdominal aortic aneurysm (AAA) in a large group of siblings of Australian AAA patients to determine if screening in this group is justified.

Methods. 1254 siblings of 400 index AAA patients were identified and offered aortic ultrasound screening. An age and sex matched control group was recruited from patients having abdominal CT scans for non-vascular indications. AAA was defined by an infrarenal aortic diameter of ≥ 3 cm or a ratio of the infrarenal to suprarenal aortic diameter of ≥ 2.0 . A ratio of 1.0–1.5 was considered normal, and a ratio of > 1.5 to < 2.0 was considered ectatic. Aortic enlargement was defined as ectasia or aneurysm.

Results. 276 (22%) siblings could be contacted and agreed to screening or had previously been diagnosed with AAA. All 118 controls had normal diameter aortas. 55/276 siblings had previously been diagnosed with AAA. The remaining 221 siblings underwent ultrasound screening. Overall, 30% (84/276) had enlarged aortas (5% ectasia, 25% aneurysmal); 43% of male siblings (64/150) and 16% of female siblings (20/126). The incidence was 45% in brothers of female index patients, 42% in brothers of male patients, 23% in sisters of female patients, and 14% in sisters of male index patients.

Conclusions. The overall incidence of aortic enlargement of 30% found in this study warrants a targeted screening approach with ultrasound for all siblings of patients with AAA. A similar targeted approach for screening of the children of AAA patients would also seem advisable.

Key Words: Abdominal aortic aneurysm (AAA); Screening; Siblings; Ultrasound.