**Reviewer #1:**  
**Comment**: The study sought to estimate the proportion of adults with diabetes, CKD and at or older than 65 years that have high ASCVD score. This study extends previous reports that confirm high prevalence of high (>10%) ASCVD score in adults with diabetes, SKD and at or older than 65 years old. There are issues to be clarified:   
  
**Comment**: The results are rather unexpected since diabetes, renal failure are part of the ASCVD calculator.

**Response**: It is good that this reviewer was able to summarize the main finding and relevance of the paper. I do not think any changes are needed based on this comment.  
  
**Comment**: There is much focus on antihypertensive treatment in the discussion and not much on statin use and aspirin use which is also recommended in patients with high (>10%) ASCVD score.

**Response**: This is not my area of expertise, but I am not sure if it is of high relevance for our analysis because we are focusing on the predicted risk for ASCVD in sub-groups of adults in the US. We are not focusing on what medications they would be recommended if they were found to have high ASCVD risk.  
  
**Reviewer #2:**  
**Comment:** In this paper, the authors have computed 10 yr ASCVD risk in 8803 US adults participating in the NHANES(2013-2018) programs. The risk was evaluated in overall individuals and separately in those with diabetes, CKD, and, that 65yrs age at various levels of BP to determine the importance of stage 1 HTN.

**Response**: We did not do this analysis to ‘determine the importance of stage 1 HTN’.  
  
**Comment:** Overall, Stage 1 HTN was present in 4.3% of study participants, and in 8.9% of those with diabetes,7.4% in CKD,& 13.7% of the elderly pts. Overall, their findings show that when compared to diabetes or CKD, older age was the best predictor of the increased risk of ASCVD. A finding described previously in all predictive formulas for ASCVD. As stated below, there are several major issues with the authors' conclusions & interpretation of the data described in the paper.

**Response**: Our findings do not show that age is the best predictor of increased risk of ASCVD.  
  
**Comment:** It is stated on page 13, lines 10-13 "Although a substantial proportion of US adults with stage 1 hypertension and diabetes or CKD did not have a high ASCVD risk in the current study, these subgroups were more likely to have high ASCVD risk compared to the overall US population with stage 1 hypertension, and may therefore still benefit from initiating antihypertensive medication.". This statement is purely presumptive in nature and not based on any data presented in their paper. This should be deleted as it is quite misleading and could have major public health implications.

**Response**: Is this really a presumptive statement? It is based on our own data and previously published data. I don’t think this sentence needs to be removed.  
  
**Comment**: On pg 14, lines 17-19the authors cite " Although the current study suggests that a high proportion of US adults with stage 1 hypertension and diabetes or CKD do not have a 10-year predicted ASCVD risk {greater than or equal to} 10%, prior studies suggest that diabetes and CKD are associated with a high lifetime CVD risk. But the problem is their data in this paper do not show that. Then the authors also cite prior studies emphasizing the importance of cumulative exposure to high BP associated with increased risk of ASCVD, however, they have not shown any data from their study to support this.

**Response:** The reviewer is confusing *observed CVD risk (prior studies)* with *predicted CVD risk (current study)*. They also seem to take issue with us citing findings from other studies in our Discussion. I don’t think this is a problem and don’t see a need to revise the paper based on this comment.

3. As shown in table 2 the numbers of individuals with diabetes 8.9%(n=210),& CKD 7.4%(n=159)are quite small to reliably estimate risk at the national level in the entire US adult population.

**Response**: We already acknowledge this as a limitation: “A total of 1,271 participants had stage 1 hypertension, and some subgroups of this population based on diabetes, CKD, and ≥ 65 years of age were small.”  
  
**Comment:** Table 3 shows that based on a small number of participants (n=158) elevated BP was associated with a higher predicted risk of ASCVD than stage 1 HTN.This does not make sense & it appears to be counterintuitive biologically.

**Response**: There are no inferences in Table 3, so it doesn’t show association between anything. The proportions may not be intuitive in every case but (1) sampling variability inevitably leads to unintuitive results every now and then, (2) the CI’s around these proportions overlap a great deal, and (3) we can’t change what the data say.  
  
**Comment:** Figure S1 shows that in their analyses the authors estimate that 47% of those with diabetes,& 56% of CKD pts had <5%risk of ASCVD over 10 yrs. Similar numbers are shown in figureS2. however, in their enthusiasm, to recommend treatment for all individuals with stage 1 hypertension the authors have provided no discussion about these low risk individuals.

**Response:** We mentioned low risk individuals in the first paragraph of the discussion and created two figures showing the distribution of predicted risk among low risk individuals. Should we add more to the discussion about them? This may be the only change worth making.