FACTS

CRITICAL COVERAGE FOR HEART HEALTH:

Medicaid and Cardiovascular Disease

OVERVIEW

Medicaid is the nation's health insurance program for low-income Americans and is a vitally important part of our health care system. It covers many of the nation's poorest and sickest patients and provides a critical financing mechanism for the health care services these individuals receive – including care related to cardiovascular disease (CVD). In fact, more than 16 million adults with Medicaid coverage (53 %) have a history of CVD.[1]

In response to tight budgets, federal and state governments are considering a variety of approaches to reduce the growth of Federal and State Medicaid spending and give states more flexibility in how the program operates. The American Heart Association (AHA) opposes policies that reduce access to, or significantly increase the cost of, necessary care for individuals with CVD. The Association also encourages States to accept federal funding to cover low-income adults with incomes up to 138% of the federal poverty level as a way of ensuring that these individuals will have affordable access to the health care services they need.

WHO IS ELIGIBLE FOR MEDICAID?

Medicaid covers approximately 62 million low-income Americans. This includes nearly 31 million children, 15 million adults, 9.3 million individuals with disabilities, and more than 5 million seniors.[2] Approximately 9 million of these seniors and people with disabilities have Medicaid coverage as a supplement to Medicare.[2] Individuals with Medicaid coverage are also among the sickest and neediest individuals in our health system. Indeed, those with chronic conditions – such as heart disease and stroke – are more likely to use acute care services, and are more likely to need nursing home or other long-term care.[4]

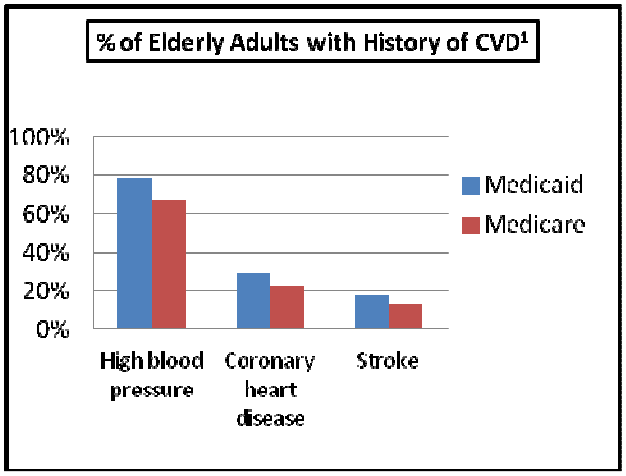
Under the Affordable Care Act ("the health reform law"), expansion of Medicaid to cover low-income adults up to 138% of the poverty level (approximately $15,800 in 2014) accounts for about half of the coverage gains the law is projected to achieve. By 2023, Medicaid is expected to cover an additional 20 million individuals.[5] However, since states have the option not to expand Medicaid, millions of poor adults could go without coverage. Nationally, nearly 5 million poor uninsured adults live in states that have not yet decided to expand Medicaid and will likely remain uninsured.[3]

WHAT DOES MEDICAID COVER?

Medicaid covers comprehensive care for children, and a wide range of acute and long-term care services for other enrollees. States are required to cover certain benefits, such as physician services, inpatient and outpatient hospital care, nursing home care, and may also choose to cover other categories of services, such as prescription drugs, dental care and rehabilitation. While states must cover long-term care services provided in a nursing facility, they may also cover long-term care services provided to a patient who continues to live at home.[4] Seven of 10 people living in nursing homes are covered by Medicaid.[5]

MEDICAID AND CVD

Medicaid provides an important safety net for approximately one-fifth of all Americans with CVD. A recent analysis of 2008 Medical Expenditure Panel Survey data shows that 53% of all adults with Medicaid coverage – more than 16 million individuals – have a history of some type of cardiovascular illness. This grows to nearly 91% of all individuals with Medicaid coverage who are over age 65.



American Heart Association • Advocacy Department • 1150 Connecticut Ave. NW • Suite 300 • Washington, DC 20036
Phone: (202) 785-7900 • Fax: (202) 785-7950 • www.heart.org/policyfactsheets

The most common health histories for Medicaid beneficiaries with CVD include:

- High blood pressure (40% of all Medicaid adults, or 12 million individuals; 78 % of elderly Medicaid adults, or 4.2 million seniors);
- High cholesterol (32% of all Medicaid adults, or 9.7 million individuals; 60% of elderly Medicaid adults, or 3.2 million seniors);
- Coronary heart disease (10% of all Medicaid adults, or 3 million individuals; 29 % of elderly Medicaid adults, or 1.6 million seniors); and
- Stroke (7.5% of all Medicaid adults, or 2.2 million individuals; 18% of elderly Medicaid adults, or nearly 1 million seniors).[1]
- If all currently-undecided states opt into Medicaid expansion, by 2015 the treatment rate among adults with hypertension is expected to increase by 11.8%.[9]
- If every state accepts federal funding to expand their Medicaid programs, an additional 3.8 million uninsured Americans with heart disease or stroke will gain coverage through Medicaid.[10]

Individuals with Medicaid coverage are more likely to have cardiovascular conditions than those who have other types of health insurance coverage.[1] For example, low-income adults over age 65 with Medicaid coverage are more likely to have a history of high blood pressure, coronary heart disease and stroke than seniors with only Medicare coverage. Similarly, individuals ages 18 to 64 with Medicaid coverage are more likely to have a history of high blood pressure, angina, heart attack, stroke or coronary heart disease than individuals with private health insurance.[1]

These findings are consistent with the overall trend that individuals with Medicaid are generally sicker and have poorer health status than other Americans, highlighting how critical this coverage is for low-income Americans with CVD.

In this way, Medicaid provides important financial protection to low-income individuals with CVD, covering critical health services and ensuring that these services remain affordable. Out-of-pocket expenditures for older adults on Medicaid averaged $375 per person in 2008, compared to $1,455 for Medicare beneficiaries with no Medicaid coverage.[1]

MEDICAID AND THE FEDERAL BUDGET

Medicaid is a shared responsibility between the federal government and the states. While states operate the program and make significant choices about coverage and who is eligible, the federal government establishes program parameters and matches state spending on health and long-term care services.

The Congressional Budget Office (CBO) currently projects that federal Medicaid spending will more than double in the next decade. This dramatic increase in federal support for health care services for lower-income Americans is driven by increases in health care spending, growing demand for long-term care as the Baby Boomers age, and eligibility changes made by the health care reform law, among other factors.

IMPLICATIONS FOR STATES

Proposals that shift much of the risk for increases in Medicaid spending to the states could lead to changes in eligibility, covered benefits, or both. In addition, the cost to states of implementing the Medicaid expansion is small relative to their total state Medicaid spending -- a 0.3% increase over what states would spend without the expansion. After factoring in state and local savings resulting from less uncompensated care, states as a whole are likely to see net savings from the expansion.[10]

THE ASSOCIATION ADVOCATES

We understand the significant budget challenges faced by both federal and state governments. However, the AHA supports efforts to expand Medicaid to low-income adults and opposes proposals that would reduce access to meaningful, affordable health care coverage for individuals with CVD. These include policies that cause states to scale back eligibility, cut benefits, or significantly increase cost sharing for Medicaid beneficiaries.

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[1] Leighton Ku and Christine Ferguson. Medicaid Works: A Review of How Public Insurance Protects the Health and Finances of Low-income Families and Individuals. Forthcoming, First Focus and George Washington University.
[2] Kaiser Family Foundation. Medicaid Primer: 2013. Accessed February 27, 2014 at: http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf
[2] Medicaid and CHIP Payment and Access Commission, "Medicaid and CHIP Program Statistics: MACStats," March 2011, available at: http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6MWJhZjM4Y2FiMzk0MmYwOA
[4] Kaiser Commission on Medicai and the Uninsured, "Dual Eligibiles: Medicaid's Role for Low-Icoms Medicare Beneficiaries," December 2010, available at http://www.kff.org/medicaid/upload/4091-07.pdf
[5] CBO Medicaid Baseline May 2013. Accessed Fevruary 27, 2014 at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204_Medicaid.pdf
[3] Kaiser Commission on Medicaid and the Uninsured. Issue Brief. Octob*er 2013. Accessed Februar 27, 2014 at:* http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8505-the-coverage-gap-uninsured-poor-adults7.pdf
[4] Kaiser Family Foundation, "Medicaid: An Overview of Spending on "Optional" versus "Mandatory" Populations and Services," October 2005, available at: http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf.
[5] Kaiser Family Foundation, "Medicaid Matters: Understanding Medicaid's Role in our Health Care System," March 2011, available at: http://www.kff.org/medicaid/upload/8165.pdf.
[9] Li S, Lantz PM, Bruen BK, Mendez D. Projecting the Effects of Health Insurance Expansion on Hypertension Control and Outcomes. 2014.
[10]The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis (Kaiser Commission on Medicaid and the Uninsured, November 2012) Accessed February 27, 2014 at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf