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medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

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The Role of Medicaid for People with Cardiovascular Diseases

Introduction

Cardiovascular diseases (CVD), including heart disease and stroke, are the leading cause of death in the United States, accounting for nearly a third of all deaths.[1] CVD is one of the most prevalent diseases among the adult population and disproportionately affects low-income populations, with low-income adults reporting higher rates of heart disease, hypertension, and stroke than higher-income adults.[2] Treatment for cardiovascular-related conditions accounts for one out of every six dollars spent on health care in the U.S., more than any other illness, and these costs are expected to triple over the next twenty years.[3] Risk factors for cardiovascular diseases include high blood pressure, high cholesterol, obesity and smoking, which are preventable and treatable. Yet access to care affects people's ability to control these conditions, as 80% of people with uncontrolled high blood pressure or cholesterol are uninsured.[4] Medicaid, as the nation's health coverage program for the low-income population, provides critical access to disease management and care coordination services for people with these conditions.

Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid eligibility to cover all individuals up to 138% of poverty, including adults without children, a group that has historically been ineligible for the program. Many in the newly enrolled Medicaid population will likely have been uninsured and enter the program with undiagnosed and untreated cardiovascular conditions. This brief examines Medicaid's role in providing care for adults with CVD and the program's potential to expand access to a range of medical and community services and supports for these new beneficiaries. It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to prevalence of CVD and, within the population with CVD, compares their health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.]

Findings

Prevalence & Health Status

Among nonelderly adults with incomes at or below 138% FPL, Medicaid beneficiaries were more than twice as likely as the uninsured to have a cardiovascular disease, with 28% and 13% of these groups, respectively, having one of these conditions (Table 1). The higher prevalence among the Medicaid population is, in part, a result of Medicaid eligibility rules that explicitly extend coverage to medically needy individuals and those with disabilities. Though the prevalence rate among people without insurance is lower than their Medicaid counterparts, it is still important to note that more than one in ten of the uninsured in this income range have heart disease. In addition, the figures in Table 1 capture only diagnosed illness, and it is possible that uninsured adults have currently undiagnosed CVD.

Notably, nearly three in four Medicaid beneficiaries with CVD also had a physical comorbidity, while the share among uninsured adults with CVD was around six in ten. Further, half of this group of Medicaid adults had a mental comorbidity, compared with three in ten of the uninsured. These rates of

comorbidity reflect the complex health needs of many individuals in these groups. Medicaid beneficiaries who did not have cardiovascular disease were also more likely than the uninsured to have other physical and mental conditions. With regard to self-reported health status, Medicaid beneficiaries with CVD were more likely (64%) than the uninsured with CVD (42%) to report that their health was fair or poor, and Medicaid beneficiaries who did not have CVD were similarly more likely than the uninsured to have this assessment of their health.

Table 1: The Health Status of Medicaid and Uninsured Nonelderly Adults ≤138% FPL

	Medicaid		Uninsured	
Prevalence of Heart Disease	28%[a]		13%	
	With CVD	**Without CVD**	**With CVD**	**Without CVD**
Had Other Chronic Condition				
Other Physical Condition	74%[ab]	30%[a]	61%	11%
Chronic Mental Condition	50%[ab]	30%[a]	30%	11%
Fair or Poor Health Status	64%[ab]	26%[a]	42%	15%

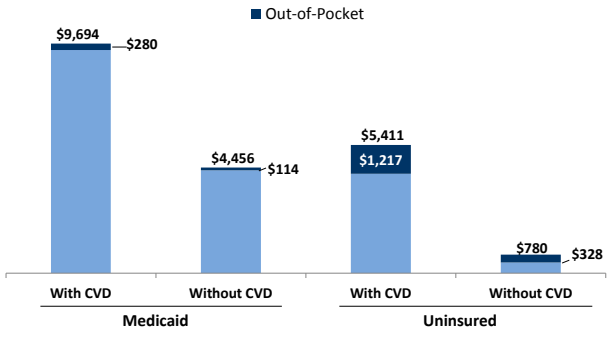
[a] Statistically significant difference from Uninsured population, p < .05
[b] Statistically different from Medicaid population without heart disease, p < .05
SOURCE: KCMU analysis of 2009 Medicaid Expenditure Panel Survey data.

Spending

Among low-income adults with CVD, health care spending was higher for Medicaid enrollees than it was for uninsured adults (Figure 1): Average annual per capita spending on all services was $5,411 for individuals without health insurance, while it was $9,694 for Medicaid beneficiaries. This difference likely reflects the poorer health status and higher rate of comorbidity among Medicaid enrollees. Spending was similarly much higher for Medicaid beneficiaries without CVD than for uninsured adults without these diseases. Despite higher overall spending for adults in Medicaid, program beneficiaries spent less out-of-pocket per year for health care services than people who were uninsured, both among adults with and without heart disease. Medicaid beneficiaries with heart disease spent an average of $280 out-of-pocket per year, while the uninsured with these conditions spent more than four times that amount ($1,217), with the remainder of spending on their behalf coming from providers or other funds devoted to uncompensated care. The lower out-of-pocket spending among Medicaid enrollees results from program rules that restrict cost-sharing to nominal amounts, providing an important level of financial protection for beneficiaries.

Figure 1

Total Annual Per Capita Health Expenditures Among Low-Income Adults Ages 18-64, by Insurance and CVD Status, 2009



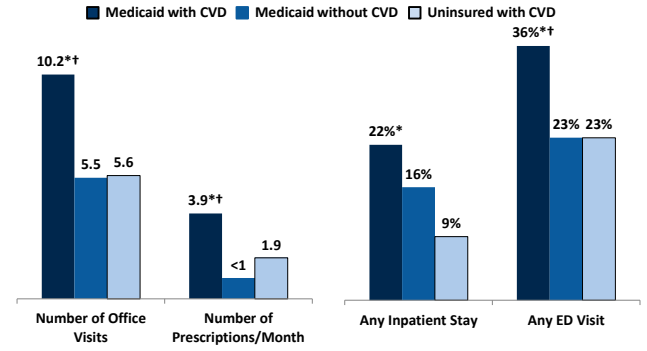
Notes: Differences within Medicaid population significant at the 0.01 level, two-tailed test.
Differences between Medicaid and uninsured significant at the 0.01 level, two-tailed test.
Source: KCMU analysis of the 2009 Medical Expenditure Panel Survey.

Utilization

The spending patterns above reflect differences in utilization by insurance coverage and illness status (see Figure 2). Among uninsured adults with CVD, the average number of office visits in the previous year was 5.6, while Medicaid beneficiaries with these illnesses had had nearly twice as many visits, 10.2. Medicaid beneficiaries with CVD also filled more than twice as many prescriptions as the uninsured, with Medicaid adults having filled an average of 3.9 prescriptions per month and uninsured adults having filled 1.9 per month. Low-income adults with CVD who were enrolled in Medicaid were also more than twice as likely (22% vs. 9%) to have had an inpatient stay in the previous year than uninsured low-income adults with CVD and more likely than the uninsured (36% vs. 23%) to have had an emergency department visit in the past year. As with spending, utilization was higher among Medicaid enrollees with CVD compared to Medicaid enrollees without, with the exception of inpatient stays (which were statistically similar across the two groups).

Figure 2

Service Utilization Among Medicaid and Uninsured Nonelderly Adults at or below 138% FPL, 2009



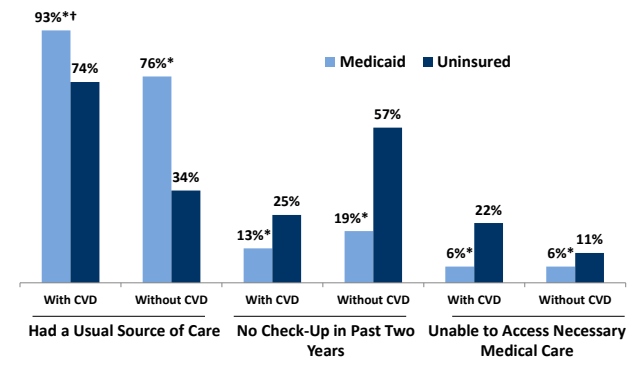
*Statistically different from Uninsured (p<0.05). †Statistically different from without CVD (p<0.05)
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Access

Despite their more complex care needs, Medicaid beneficiaries report better access to care than their uninsured counterparts. This pattern holds among those with and without CVD. Among adults with CVD, Medicaid beneficiaries were more likely (93%) than their uninsured counterparts (74%) to have a usual source of care. Not having a usual source of care indicates disconnection from the health system and may be especially problematic for people with diseases, such as CVD, that require ongoing medical attention. Notably, a quarter of uninsured adults with CVD reported that they had not had a check-up in the past two years, twice the rate their Medicaid counterparts. Medicaid beneficiaries with CVD were also less likely to have been unable to get necessary medical care (6% versus 22%) than uninsured adults with these illnesses (Figure 3).

Figure 3

Access to Care Among Medicaid and Uninsured Nonelderly Adults at or below 138% FPL, 2009



*Statistically different from Uninsured (p<0.05). †Statistically different from without CVD (p<0.05)
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Policy Implications

There is a high prevalence of cardiovascular disease among low-income adults covered by Medicaid, and most have at least one additional chronic health condition. This prevalence is in part a result of Medicaid eligibility rules that explicitly extend coverage to people with substantial health needs. Reflecting these needs, Medicaid adults with CVD have higher spending and utilization rates than enrollees without these illnesses. Despite their substantial need and complex health status, Medicaid enrollees with CVD are not more likely to report a problem getting needed medical care than those without.

Medicaid adults with CVD were more likely than low-income uninsured adults with CVD to have access to and utilize services; they also had lower out-of-pocket costs despite higher overall spending for their care. These findings indicate the important role Medicaid plays in supporting the health and well-being of these individuals by providing access to critical health care services with minimal financial burden.

Though low-income uninsured adults have a lower prevalence of CVD and comorbidity than their Medicaid counterparts, there is still a substantial share of uninsured adults who live with CVD. Many of these individuals may become eligible for Medicaid in 2014 and are likely to present with substantial health needs. The analysis in this brief suggests that these individuals may see improved access to health care services and prescription drugs that may help them manage their illnesses, as well as reduced out-of-pocket costs.

The ACA also offers opportunities for states to improve the care that Medicaid beneficiaries receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with CVD in this analysis indicates that there may be opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rate of mental health comorbidity among adults with cardiovascular disease presents opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs. This option extends a 90% federal matching rate for state spending on health home services for eight quarters. Qualifying health home services include care coordination and management, referral to community and social supports, and transitional and follow-up care.

While the ACA provides a number of opportunities to improve care for many uninsured adults with heart disease, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees will have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet these challenges, the results of this analysis suggest that enrollment in Medicaid may provide timely access to important services that would enable newly eligible adults with cardiovascular disease to better manage their conditions.

Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define "low-income" as having family income at or below 138% of the federal poverty level. Medicaid beneficiaries with Medicare ("dual-eligibles") are excluded.

For this analysis, "cardiovascular disease" includes chronic heart disease, stroke, hypertensive disease, and other circulatory conditions. To identify individuals with cardiovascular disease and comorbidities, we used the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any "priority" cardiovascular condition,[5] self-reports of individuals taking a day or more of disability during the year for a condition and of a condition "bothering" a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also used the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

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[1] Murphy SL, Xu JQ, Kochanek KD. *Deaths: Preliminary data for 2010*. National vital statistics reports; vol 60 no 4. Hyattsville, MD: National Center for Health Statistics. 2012.
[2] Schiller JS, Lucas JW, Ward BW, Peregoy JA. *Summary health statistics for U.S. adults: National Health Interview Survey, 2010*. National Center for Health Statistics. Vital Health Stat 10(252). 2012.
[3] American Heart Association. "Heart Disease and Stroke: 2012 Update." *Circulation.* 2012; 125: e2-e220.
[4] Centers for Disease Control and Prevention. *Vital Signs: High Blood Pressure and Cholesterol.* February 2011. Available at: http://www.cdc.gov/VitalSigns/CardiovascularDisease/index.html.
[5] See MEPS documentation available at http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4 for a list of priority conditions.

This publication (#8383_CD) is available on the Kaiser Family Foundation's website at www.kff.org.