



## Breaking Down the Barriers

# The Uninsured with Heart Disease and Stroke

### OVERVIEW

Although the Affordable Care Act (ACA) significantly expanded access to health insurance, an estimated 20.6 million Americans who suffer from cardiovascular disease (CVD) or cardiovascular risk factors (CVRF) are still uninsured.<sup>1</sup> People may lack insurance for a number of reasons, but certain populations lack insurance at disproportionate rates. People earning lower incomes, people of color, and people living in non-Medicaid expansion states are disproportionately likely to be uninsured.<sup>1</sup> They are also less likely to afford and receive timely, appropriate medical care.<sup>1,2</sup> As a result, people without insurance tend to suffer worse medical<sup>3</sup> and financial outcomes.<sup>4</sup> The underinsured often encounter similar problems.<sup>5</sup>

Uninsurance and underinsurance are especially problematic for individuals with CVD because of the high costs associated with CVD. Between 2014 and 2015, CVD made up 14% of all US health expenditures, more than any other disease, including cancer.<sup>6</sup> Research suggests average annual out-of-pocket expenditures for individuals with CVD between 2006 and 2015 was over \$2,000, even for those with health insurance.<sup>7</sup> Accordingly, the American Heart Association supports health reform efforts designed to protect CVD patients from debilitating costs by eliminating unacceptable barriers to healthcare coverage.

### A PROFILE OF THE UNINSURED

Overall, it is estimated that 10.3% of US residents of all ages are uninsured.<sup>8</sup> A National Health Interview Survey (NHIS) estimates nonelderly adults—those between the ages of 18 and 64—are most likely to be uninsured (14.7%) followed by children under the age of 18 (10.3%).<sup>8</sup> Because of Medicare, only a small percentage of elderly adults—those ages 65 and older—are uninsured (0.9%).<sup>8</sup> Other characteristics of the uninsured seen in data surveys include:

- **Low income:** The uninsured are predominantly poor (annual income <100% of the federal poverty level (FPL)) or near poor (annual income between 100% and 200% FPL).<sup>8</sup>
  - **Disproportionate impact on people of color:** Hispanic and black Americans are more likely to be uninsured than white Americans.<sup>8</sup>
  - **Lacking access to Medicaid expansion:** The uninsured are more likely to live in non-Medicaid expansion states than Medicaid expansion states.<sup>8</sup>
  - **Struggling to pay for coverage:** Nearly half of nonelderly adults (45%) cite the high cost of insurance as a reason for being uninsured while more than one in five report job loss or change as a reason for their uninsurance.<sup>9</sup>
- Lacking a regular source of care:** 52% of uninsured nonelderly adults report no usual source of care compared to only 13% and 12% of their publicly and privately insured counterparts, respectively.<sup>9</sup>

Many of these disparities also exist among patients with CVD. Uninsurance rates among those with CVD and CVRFs closely mirror uninsurance rates among the general population; an estimated 14.5% of nonelderly adults with CVD and CVRFs are uninsured.<sup>1</sup> Survey data show characteristics of uninsured CVD or CVRFs patients also include:

- **Low income:** Nonelderly adults with CVD or CVRFs with lower income—those with annual incomes less than \$35,000 a year—are nearly twice as likely to be uninsured as the general population of nonelderly adults with CVD or CVRFs (26.2% compared to 14.5%, respectively).<sup>1</sup>
- **Disproportionate impact on people of color:** 28.7% of nonelderly adult Hispanic Americans with CVD or multiple CVRFs and 12.9% of nonelderly adult black Americans with CVD or multiple CVRFs are uninsured compared to only 7.4% of their white counterparts.<sup>1</sup>
- **Lack access to Medicaid expansion:** Uninsurance rates among nonelderly adults with CVD or multiple CVRFs in non-Medicaid expansion states are 7.7% higher than in Medicaid expansion states.<sup>1</sup>
- **Cannot pay for care:** 1 in 5 uninsured nonelderly adults with CVD report deferring healthcare due to cost<sup>10</sup>

### DIRE HEALTH CONSEQUENCES

The detrimental health effects that result from being uninsured are well documented. Conversely, gaining coverage can provide enormous health benefits for individuals with CVD.

## **FACT SHEET: The Uninsured with Heart Disease and Stroke**

The uninsured are less likely to have ideal cardiovascular health, which the Association defines as having ideal health behaviors (nonsmoking, body mass index <25 kg/m<sup>2</sup>, physical activity at goal levels, and pursuit of a diet consistent with current guideline recommendations) and ideal health factors (untreated total cholesterol <200 mg/dL, untreated blood pressure <120/<80 mm Hg, and fasting blood glucose <100 mg/dL).<sup>11</sup> In particular, health factors like poor fasting blood glucose and poor blood pressure control, as well as health behaviors like smoking and lower levels of physical activity, are especially prevalent among the uninsured.<sup>12</sup>

Uninsured and underinsured patients are more likely to delay seeking medical care during an acute heart attack.<sup>13</sup> When they do seek care in the emergency room, uninsured patients with ST-elevation myocardial infarction (STEMI), a very serious type of heart attack, are more likely to be transferred to a different facility than STEMI patients with insurance, thereby delaying vital treatment.<sup>14</sup> Following a heart attack, research suggests an association between patients who had trouble paying for health care services and medications and worse recovery after a heart attack than patients who were not under such financial duress.<sup>15</sup> These patients have lower quality of life scores, higher rates of angina, and are more likely to be readmitted to the hospital within 1-year of treatment than those with insurance.<sup>15</sup>

Such health status disparities can negatively affect uninsured patients' survival. In 2002, the Institute of Medicine (IoM) released a review of insurance status and mortality data that concluded that a lack of health insurance is associated with increased mortality.<sup>16</sup> In the nearly two decades since the release of the IoM report, further research has reinforced this conclusion.<sup>17</sup>

## **UNDERINSURED – ALSO A PROBLEM**

A growing number of people are underinsured, meaning that their insurance does not provide adequate financial protection when they are sick or experience a catastrophic illness, such as a heart attack or stroke. A survey of 910 debtors showed, nearly two out of three bankruptcies filed between 2013 and 2016 were a result of medical bills or medical problems that caused patients to miss work or lose their job.<sup>18</sup> Despite the implementation of the ACA, medical bankruptcy remains largely unchanged from pre-ACA rates.<sup>19</sup> Further, research utilizing National Health Interview Survey data from 2013 to 2017 found 27% of insured patients with CVD reported they experienced financial hardship due to medical bills and 16.4% reported an inability to pay medical bills at all.<sup>20</sup> While the insured with CVD were less likely to report financial hardship due to medical bills or an inability to pay medical bills than their uninsured counterparts,<sup>20</sup> these results suggested underinsurance is also a significant issue.

The lack of universal Medicaid expansion and the proliferation of short term health insurance plans<sup>21</sup> and health care sharing ministries,<sup>22</sup> have likely sustained underinsurance. Such plans are not subject to many ACA comprehensiveness requirements but often have lower premiums than ACA compliant health plans, making them appealing to some consumers.

### **JEREMY**

Following heart valve surgeries at the age of 18, Jeremy was working toward a full recovery when the bills began to roll in. After getting over the initial "sticker shock," he and his family began the wait for the insurance company to pay and adjust the prices down. Unfortunately, that did not happen.

The insurance company decided that certain medications, hospital charges and parts of the overall surgeries were not required and would not cover them. The insurance company finally accepted the claims for coverage, but not until the hospital had placed all of the bills into collections.

Jeremy started back to college the same year as his operations, and all was going well, until his insurance provider dropped his coverage three years later because he no longer qualified as a dependent. He began to research other avenues for insurance coverage, including COBRA, private insurance, the South Dakota risk pool, short-term major medical, Medicare and Medicaid. Door after door was slammed in his face; it was either too costly, he wasn't eligible, or they wouldn't cover pre-existing conditions.

Jeremy had to go without insurance and pay out-of-pocket for all his medication and medical bills. The following year, he had to skip his annual checkup with his cardiologist because he could not afford to pay for the visit and tests.

After graduating from college with a job offer on the table, he thought his health insurance nightmares were over. Unfortunately, with his health history, the insurance company placed a rider and a waiting period on him that meant that anything preexisting would not be covered for almost two years.

Eventually, he was granted full coverage. However, he still requires pre-approval on most tests and procedures, and must save throughout the year to pay for cardiologist visits and tests. While his annual checkups appear to be fine, they still cost him over \$1,000.

## THE ASSOCIATION ADVOCATES

The Association supports the patient-centered protections gained through health reform efforts aiming to make insurance more accessible, affordable, equitable, and adequate for Americans with heart disease or stroke. Since last updating the Association's principles for healthcare reform in 2008, the United States enacted the largest health reform effort since the creation of Medicare and Medicaid in the ACA. As healthcare delivery systems continue to evolve in the wake of the ACA, the Association's priorities have also evolved. In February 2020,<sup>23</sup> the Association updated its principles for health reform that it hopes will guide policymakers in future health reform efforts to expand healthcare access to marginalized communities, including the uninsured.

### Health Reform Principles

AHA believes the following seven principles are crucial considerations for health reform efforts that will meaningfully create adequate, accessible, equitable, and affordable healthcare solutions in the United States:<sup>23</sup>

- **Principle 1:** All people living in the United States, regardless of health condition, should have comprehensive, understandable, and affordable health coverage.
- **Principle 2:** All people living in the United States should receive high-quality, affordable, patient-centered health care.
- **Principle 3:** All people living in the United States should have guaranteed access to evidence-based preventive services with minimal or no cost sharing, regardless of how they gain coverage.
- **Principle 4:** Race, sex, gender, and geographic disparities in health and health care must be eliminated.
- **Principle 5:** Public health infrastructure should be strengthened to effectively engage diverse stakeholders in multiple sectors, to adequately respond to social determinants of health, and to support the elimination of systemic inequities in health and health care.
- **Principle 6:** The US healthcare workforce should continue to grow and diversify through a sustained national commitment to culturally competent public health and medical education and clinical training.
- **Principle 7:** Support of biomedical and health services research should be a national priority, and inflation-adjusted funding for the NIH, CDC, and other agencies must be maintained and expanded.

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