Heart disease, an umbrella term for various types of problems with the heart and blood vessels, is the No. 1 cause of death for Americans, and its toll on the nation’s pocketbook and health is causing lawmakers to search for solutions. The tab for treating coronary heart disease is about $108 billion each year. Heart disease, along with strokes and other cardiovascular diseases, kill more than 800,000 U.S. adults annually.

Coronary heart disease, caused by the buildup of plaque in the heart’s arteries, can lead to a heart attack. During heart failure, the heart muscle slowly weakens and enlarges, preventing the heart from pumping enough blood. Leading risk factors—high blood pressure, high cholesterol (each affecting one in three Americans) and tobacco use—are largely preventable by maintaining a heart-healthy diet, engaging in physical activity, not smoking and taking medications as prescribed. Only 51 percent of Americans treated for hypertension (high blood pressure), adhere correctly to their long-term therapy, which includes making behavioral changes and taking medication.

Heart failure is expensive for states, especially when patients are readmitted to the hospital for care. Congestive heart failure, which requires timely medical attention, is the fourth leading diagnosis for hospital readmissions for Medicaid patients, at a cost of $273 million for approximately 18,800 readmissions. It is the leading diagnosis for hospital readmissions for Medicare patients, at a cost of $1.75 billion for 134,500 readmissions.

Significant differences in heart disease and death rates occur among members of certain racial, ethnic and socioeconomic groups and groups in different geographic areas. Although heart disease often is called a “man’s disease,” it is the No. 1 killer of women. In addition, women are more likely to die from heart attacks, according to the U.S. Office on Women’s Health, although heart disease death rates for women vary according to their location.

State Action
Policymakers have taken several steps to reduce the prevalence and costs of heart disease.

Increase access to quality health services. States encourage high-value care through coordinated care models, such as patient-centered medical homes, which provide comprehensive, patient-centered preventive and primary care through a team of providers. According to the National Committee for Quality Assurance, 37 states have public and/or private medical home initiatives. Indiana offers disease management programs for Medicaid recipients who suffer congestive heart failure or coronary heart disease with the intent to measure costs and improve health outcomes.
Promote health and wellness programs at schools, worksites, and health-care and community-based settings. A number of states promote wellness in a variety of settings. For example, Wisconsin passed legislation in 2014 to provide grants to help small businesses (50 or fewer employees) expand their worksite wellness programs to include health risk assessments.

Reduce health disparities. All 50 states have a minority health or health equity office or a point of contact. Massachusetts established a health disparities council, which makes annual recommendations related to education, environment, employment and other relevant determinants that contribute to health disparities, including heart disease and heart failure.

Promote medication compliance. In Washington and northern Idaho, state employee programs contract with the Group Health Cooperative to increase patient compliance with medications. Nurse case managers help patients understand and manage their medical conditions. The cooperative reports an annual savings of more than $476 per participant.

Educate the public about chronic disease prevention. Every state health agency provides health education services in some capacity, and many states dedicate staff and funding specifically for heart disease. Minnesota is one of many states that have heart disease and stroke prevention programs that include online public awareness and education resources for blood pressure control, cholesterol, diabetes, nutrition, obesity and other contributing factors for heart disease.

Convene partners to improve public health systems. The District of Columbia and 15 states—Alabama, Arkansas, Georgia, Illinois, Kansas, Maryland, Michigan, Minnesota, New Hampshire, New York, North Dakota, Ohio, Oklahoma, Vermont and Virginia—participate in a multi-state Million Hearts learning collaborative led by the Association of State and Territorial Health Officials (ASTHO) to reduce heart attacks and strokes. These states use best practices and evidence-based policies to identify adults with undiagnosed high blood pressure and to control blood pressure for diagnosed adults by using electronic health records and team-based care.

Federal Action
Several federal initiatives improve access to preventive services. The Surgeon General’s National Prevention Strategy recommends a shift in focus from treating sickness to emphasizing prevention. The Million Hearts’ initiative, launched by the U.S. Department of Health and Human Services (HHS) in 2011, aims to prevent 1 million heart attacks and strokes by 2017. Several states—including Arkansas, Tennessee, Maryland, New York, Pennsylvania and Virginia—have partnered with this initiative. The Affordable Care Act requires new insurance plans to cover several preventive services at no cost to patients, such as testing for high blood pressure and cholesterol; counseling on the daily use of aspirin; counseling and medication to quit smoking; and counseling on diet, weight loss and managing obesity.

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NCSL, Heart Disease and Stroke: An Overview
NCSL, Medication Adherence

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