

Relationship of Insurance Type with the Care of Acute Coronary Syndromes

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The full report is titled “Insurance Coverage and Care of Patients with Non–ST-Segment Elevation Acute Coronary Syndromes.” It is in the 21 November 2006 issue of *Annals of Internal Medicine* (volume 145, pages 739-748).

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What is the problem and what is known about it so far?

Acute coronary syndromes occur when there are blockages in blood flow to heart muscle. If the blockage lasts long enough, an area of heart muscle dies, a condition commonly known as a heart attack. Guidelines recommend treatments for acute coronary syndromes to keep heart muscle alive and prevent bad outcomes, such as heart attack or death. In the first 24 hours following heart attack, recommended treatments include medications to control heart rate and decrease blockages, cardiac catheterization to determine the extent of blockages, and procedures to open up or bypass blocked blood vessels in certain situations. Treatments recommended at the time of hospital discharge include some of the same medications recommended in the first 24 hours, medications and dietary advice to control cholesterol levels, counseling to stop smoking, and cardiac rehabilitation programs. Unfortunately, not all patients receive all recommended treatments.

Why did the researchers do this particular study?

To find out whether the care of acute coronary syndromes varies with insurance type.

Who was studied?

37,345 patients younger than 65 years of age and 59,550 patients 65 years of age or older who received care for acute coronary syndromes at 1 of 521 U.S. hospitals participating in a program to improve the care of patients with heart conditions. To be in the study, patients had to have insurance through Medicaid (if they were younger than 65 years of age), Medicare (if they were 65 years of age or older), a health maintenance organization (HMO), or other private insurance company. Medicaid is state-based insurance coverage for people with low incomes. Medicare is the federal insurance program for people 65 years of age or older.

How was the study done?

The researchers compared the frequency of use of recommended treatments and mortality rates in patients 65 years of age or older with Medicare and patients 65 years of age or older with HMO or other private insurance. For patients younger than 65 years of age, they compared recommended treatments and mortality rates for patients who had Medicaid insurance and patients with HMO or other private insurance.

What did the researchers find?

Patients younger than age 65 years with Medicaid insurance were less likely to receive some recommended services and were more likely to die than patients of a similar age with HMO or other private insurance. Patients older than age 65 years were just as likely to receive recommended treatments and had similar mortality rates, regardless of insurance type.

What were the limitations of the study?

The study did not include patients without insurance and was unable to identify reasons for the differences in care by insurance type. Possible explanations could be that patients with Medicaid are sicker than those with HMO or other private insurance or that the quality of care is worse for patients with Medicaid.

What are the implications of the study?

Further research is needed to identify reasons for variation in care and outcomes by insurance type and to identify strategies to reduce these differences.

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