RESOLUTION

Subject: Lipoprotein(a) Screening and Insurance Coverage

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, according to 2022 data from the CDC, heart disease is the leading cause of death in the state of Kentucky, which has the 8th highest heart disease mortality rate in the country[1]; and

WHEREAS, 12.4% of individuals in Kentucky have been diagnosed with coronary heart disease, heart attack, or stroke[2]; and

WHEREAS, Lipoprotein(a) [Lp(a)] is a genetically inherited lipoprotein and an established, independent risk factor for atherosclerotic cardiovascular disease (ASCVD), with a causal and continuous association with cardiovascular events[3]; and

WHEREAS, Lp(a) is similar in structure to low-density lipoprotein (LDL), and most individuals remain asymptomatic until they develop ASCVD, making early detection critical; and

WHEREAS, the American Heart Association's 2022 Scientific Statement recognizes Lp(a) as a genetically determined, causal, and prevalent risk factor for atherosclerotic cardiovascular disease, and recommends that Lp(a) be measured in adults to improve cardiovascular risk stratification and guide clinical management[10]; and

WHEREAS, recent insights from a large national biobank published in Arteriosclerosis, Thrombosis, and Vascular Biology demonstrated a linear relationship between Lp(a) concentrations and ASCVD in middle-aged adults[4]; and

WHEREAS, the landmark 2026 ACC/ AHA/ AACVPR/ ABC/ ACPM/ ADA/ AGS/ APhA/ ASPC/ NLA/ PCNA Guideline on the Management of Dyslipidemia — for the first time in U.S. guideline history — issued a Class I (strongest possible) recommendation for universal Lp(a) measurement at least once in all adults, recognizing Lp(a) as a well-established causal factor of ASCVD independent of LDL-C[5]; and

WHEREAS, Lp(a) screening once in a person's lifetime allows for earlier intervention and more personalized cardiovascular risk management at concentrations ≥50 mg/dL or ≥125 nmol/L, the threshold above which the 2026 guidelines identify substantially elevated cardiovascular risk[5]; and

WHEREAS, despite this Class I guideline recommendation, insurance coverage for Lp(a) testing has not been updated to reflect current evidence: Medicare's coverage policy for cardiovascular biomarkers, governed by LCD L36358, was last updated in January 2026 and continues to rely on a 2009 USPSTF evidence review that predates the large-scale genetic and epidemiological studies establishing Lp(a) as the strongest inherited risk factor for heart disease[6]; and

WHEREAS, Lp(a) screening is not currently required to be covered by insurance companies as part of the Patient Protection and Affordable Care Act of 2010; and

WHEREAS, Kentucky House Bills HB52 and HB180 require coverage for cancer screening and biomarker testing, respectively, but contain no provision requiring coverage of Lp(a) testing as a screening tool[7,8]; and

WHEREAS, a recent cost-effectiveness analysis demonstrated that improved awareness of Lp(a) risk and attendant lifestyle modifications would yield significant cost savings within the current healthcare system[9]; now, therefore, be it

RESOLVED, that KMA supports legislation requiring Lipoprotein(a) [Lp(a)] be a screening test recommended by primary care once in a person's adult life, consistent with the 2026 ACC/AHA/Multisociety Class I guideline recommendation; and be it further

RESOLVED, that insurance coverage for Lp(a) testing be mandatory as a preventive screening tool, and that KMA advocates for updating Medicare's cardiovascular biomarker coverage policy (LCD L36358) to reflect current evidence.

References:

1. Stats of the States — Heart Disease Mortality. Centers for Disease Control and Prevention. February 25, 2022. https://www.cdc.gov/nchs/pressroom/sosmap/heart_disease_mortality/heart_disease.htm
2. Explore Cardiovascular Diseases in Kentucky | AHR. America's Health Rankings. https://www.americashealthrankings.org/explore/measures/CVD/KY
3. Emerging Risk Factors Collaboration, Erqou S, Kaptoge S, et al. Lipoprotein(a) concentration and the risk of coronary heart disease, stroke, and nonvascular mortality. JAMA. 2009;302(4):412–423.
4. Patel AP, Wang M, Pirruccello JP, et al. Lp(a) concentrations and incident atherosclerotic cardiovascular disease. Arteriosclerosis, Thrombosis, and Vascular Biology. 2021;41(1):465–474.
5. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia. J Am Coll Cardiol. Published online March 13, 2026. doi:10.1016/j.jacc.2026.02.001
6. LCD L36358 — MolDX: Biomarkers in Cardiovascular Risk Assessment. Centers for Medicare & Medicaid Services. Last updated January 2026. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=36358
7. H.B. 52, 2024–2025, KY (2025)
8. H.B. 180, 2023–2024, KY (2024)
9. Adams J, Orfanos P, Hu X, et al. Review of current clinical strategies of managing patients with elevated Lp(a): cost-effectiveness of Lp(a) testing and patient awareness. Heart, Lung and Circulation. 2024;33(Suppl 4):S534.
10. Reyes-Soffer G, Ginsberg HN, Berglund L, et al. Lipoprotein(a): a genetically determined, causal, and prevalent risk factor for atherosclerotic cardiovascular disease: a scientific statement from the American Heart Association. Arterioscler Thromb Vasc Biol. 2022;42(1):e48-e60. doi:10.1161/ATV.0000000000000147