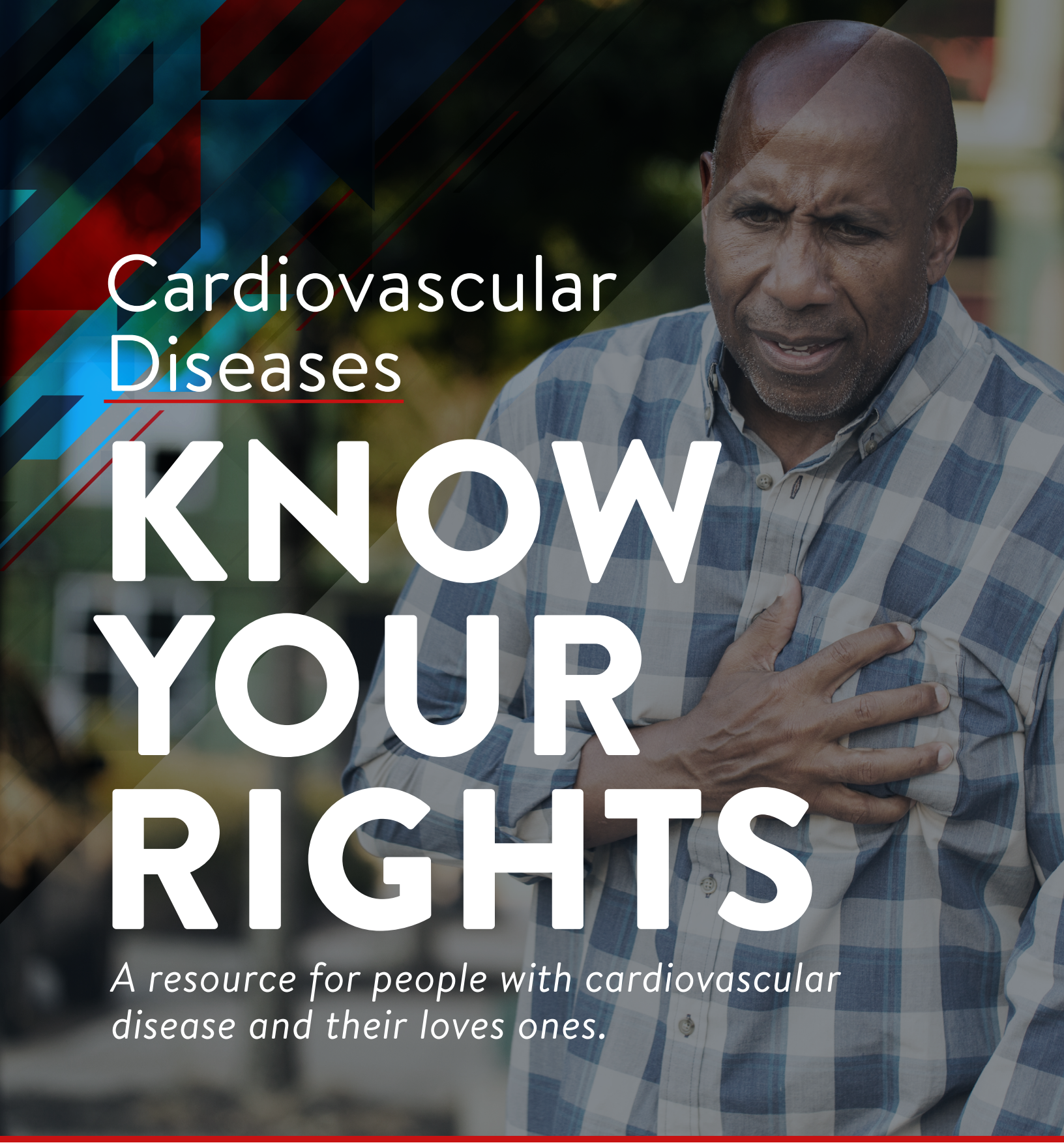

Cardiovascular Diseases

KNOW YOUR RIGHTS

A resource for people with cardiovascular disease and their loves ones.

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CARDIOVASCULAR DISORDERS DIAGNOSIS & TREATMENT

Cardiovascular disease is a group of disorders of the heart and blood vessels.[1] Nearly half of all U.S. adults will be diagnosed with some form of cardiovascular disease during their lifetime.[2] Cardiovascular disease also remains a leading cause of death in the United States, with more than 600,000 victims annually.[3] While there are many types of cardiovascular disease, three common conditions are coronary heart disease, cerebrovascular disease, and peripheral arterial disease.[4]

Coronary heart disease, often referred to as heart disease, develops when the arteries of the heart cannot deliver enough oxygen-rich blood to the heart.[5] Arteries can become unable to deliver oxygen-rich blood as a result of a waxy substance, known as plaque, building up on the artery walls due to increased "bad cholesterol" levels.[6] While anyone can develop heart disease, it is more likely to develop in individuals who smoke, have high blood pressure, or have high cholesterol levels.[7] Nationally, half of all Americans have at least one of the three above mentioned risk factors.[8] For many, heart disease is known as the "silent killer", with often the first symptom for the disease being chest pain, a heart attack, or sudden cardiac arrest.[9]

Cerebrovascular disease is a disease that impacts blood flow to the brain.[10] Blood flow to the brain can be reduced by multiple causes such as a narrowing of blood vessels (stenosis), clot formation (thrombosis), blockage (embolism), or blood vessels rupturing (hemorrhage).[11] As a result of reduced blood flow, patients with cerebrovascular disease can experience strokes and aneurysms.[12] Atrial fibrillation is the **most common cardiac arrhythmia** and a major risk factor for cerebrovascular accident, including ischemic stroke and transient ischemic attack. In the United States, strokes are also a leading cause of long-term disability and cost the healthcare system $41.2 billion annually in both direct and indirect costs.[13]

Peripheral artery disease is a disorder that causes circulatory problems in the limbs resulting from narrowed arteries and decreased blood flow. Patients with peripheral artery disease may experience pain in their legs when walking, leg numbness, coldness in lower limbs, sores on toes, and changes in leg color.[14] While all individuals may develop peripheral artery disease, individuals who smoke, have high blood pressure, diabetes, high cholesterol, and those over the age of 60 all have increased risk of developing peripheral artery disease.[15] Studies have also found that Black and Hispanic individuals have a higher risk of developing peripheral artery disease compared to whites.[16]

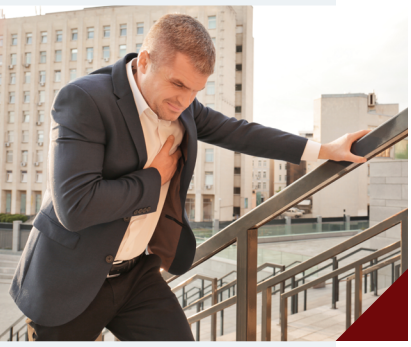
Healthcare professionals may use a wide variety of tests to diagnose and monitor cardiovascular disease including imaging tests such as MRI, ultrasounds, and CAT scans as well as blood tests to monitor patient's cholesterol levels including the type that contributes to the development of cardiovascular plaque.[17]

Treatment for heart disease is not one-size fits all; thus, patients and providers must work together to determine on case-by-case basis which treatment will work best.

Cardiovascular disease treatments can include pharmaceutical interventions such as blood pressure medication, antiplatelet medicines, anticoagulants, ACE inhibitors and beta blockers, calcium channel blockers, or other medications that help lower cholesterol and reduce plaque buildup, or blood pressure medication.[18] In some cases arterial blockage may be severe and require surgery to bypass the blocked arteries.[19] Deciding on a course of treatment should be left to clinicians and patients, not dictated by insurers' burdensome utilization management schemes designed to protect company profits.

Health insurance companies often take a number of steps to reduce their costs related to cardiovascular disease diagnosis and treatment. For example, health plans may limit coverage of certain treatments prescribed by your doctor, or the plan may require you to take a series of steps before your treatment is approved. The good news is that there are state and federal laws in place that may protect you from these practices.

To find out if your health insurer delayed or denied your cardiovascular disease treatments prescribed by your doctor, ask yourself the following questions:



STEP THERAPY

Did my insurer make me try a different treatment before covering the cardiovascular medication or therapy that my doctor prescribed?

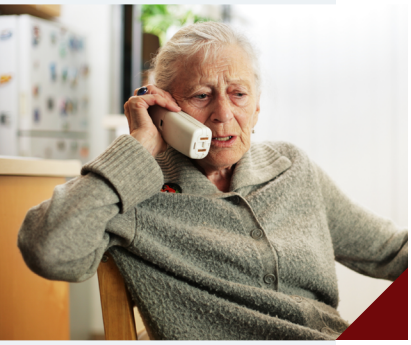
This practice is called "step therapy" or "fail first" because it requires patients to try other treatments first and demonstrate that they do not work or are intolerable, often causing discomfort and burdensome experiences while the patient waits. Your insurer may require you to try and fail a different medication or therapy before covering the one prescribed by your care team.[20] Step-therapy is a common practice utilized by almost 60% of insurers.[21] However, step therapy policies may also violate federal or state laws if your insurer treats you and others with similar diagnoses differently because of your health condition.[22] Additionally, you may be entitled to an exception from the step therapy process.

NON-MEDICAL SWITCHING

Is my insurer forcing me to take a different medication, even though my current cardiovascular treatment is working, by refusing to cover it any longer or increasing my copay?

This practice is referred to as "non-medical switching." It occurs when your insurer (not your health care professional or pharmacist) forces you to switch from your current medication to a different (but not a generic equivalent) medication by either refusing to cover your drug any longer or increasing the out-of-pocket cost of your drug.[23] When patients with cardiovascular disorders are forcibly switched to a new medication, patients may experience new side effects and reduced efficacy, gaps in treatment while transitioning to a new drug, and increased non-adherence.[24] For cardiovascular patients, these repercussions are not uncommon and particularly dangerous, as one study recently reported that 75% of patients who are non-medically switched will experience a negative impact on medication taking behaviors.[25] A separate study also found that 60% of forcibly switched patients reported having complications on their new medications and 40% reported their

new medication being less effective.[26] In addition to having harmful repercussions, non-medical switching may also violate certain states' consumer protection laws.[27]



PRIOR AUTHORIZATION

Do I need to get my insurer's approval before I can begin or continue my prescribed cardiovascular treatment or therapy?

This practice is called "prior authorization." It happens when your insurer requires you or your doctor to get your insurer's approval before the treatment is covered. Approval is based on the insurer's standards, which may be inconsistent with medical standards of care and harmful to patients. For example, one survey found that 92% of physicians reported prior authorization policies had a negative impact on clinical outcomes.[28] For those living with a cardiovascular disease, the results can be devastating. These policies can also violate state and federal laws if applied in a certain manner.

ADVERSE TIERING

Do I have to pay a high copay for certain medications that treat my condition?

This practice is called "adverse tiering." It can be used by insurers to shift much of the cost for newer or innovative therapies to patients by placing expensive drugs on what are called "specialty tiers". Certain tiering policies may also violate certain federal and state laws if used in a discriminatory way.[29]

COPAYMENT ACCUMULATORS

If I receive coupons or discounts to help pay for my medication copays, does my insurer prohibit those coupons or discounts from counting toward my annual deductible?

This policy is known as a "copayment accumulator." Copayment accumulators force patients to pay more out-of-pocket when copayment assistance runs out and the insurance deductible has not been met. These policies are frequently buried in the fine print of insurance contracts and may violate state consumer protection laws.[30]

My insurer refuses to cover a cardiovascular treatment or therapy that my health care professional prescribed to me. **What can I do?**

If your insurer refuses to cover your treatment, here are three steps you can take to change your insurer's decision:

- Appeal the decision;
- Request an external review; or
- File a consumer complaint.

How do I appeal the decision?

If your insurer denies your claim, you have the legal right to an internal appeal.[31] This means you can ask your insurer to conduct a full and fair review of its decision. To appeal the denial, you should do the following:

Review the determination letter. Your insurer should have sent you a determination letter to tell you that it would not cover your claim. Review this document so you can understand why your insurer denied your claim and how you can appeal the denial.

Collect information. Collect the determination letter and all other documents the insurance company sent you. This includes your insurance policy and your insurer's medical necessity criteria. "Medical necessity criteria" refers to your insurer's policy for determining whether a treatment or service is necessary for your condition.[32]

Request documents. If you did not receive the determination letter or do not have your policy information, the medical necessity criteria, or the instructions and forms for filing an appeal, call the insurer's customer service representative and ask for these documents. The company website will list the toll-free telephone number to call.

Call your health care professional's office. The health care professional's office or clinic has people on staff to help with the appeal process. They will tell you how to fill out the forms to request an appeal, write an appeal letter on your behalf, or handle the appeal request for you.

Submit the appeal request. It is important for you or your health care professional's office to submit the appeal request as soon as possible along with the letter from the health care professional and all additional information the insurer requested.

Once you file an appeal request, expect to wait up to 30 days to hear back from the insurance company regarding a treatment you hope to receive. It can take up to 60 days for a response if you received the treatment and are waiting for reimbursement.

Follow up. Follow up with your insurer regularly until you hear back. Be sure to keep a record of the name of any representative you speak with about the appeal, the date and time you spoke with that person, a confirmation number for the call, and a summary of your discussion.

What if my insurer denies my appeal?

Under law, you are entitled to take your appeal to an independent third party for an "external review," which means the insurance company no longer gets the final say over whether to approve a treatment or pay a claim. The situation applies if the insurer denies your appeal or if your medical situation is urgent and waiting would jeopardize your life or ability to function.

How do I request an external review?

To trigger an external review, file a written request with the independent organization within 60 days of the date your insurer sent you a final decision. The process should take no more than 60 days. However, in urgent situations requiring an expedited review, the process should take no longer than four business days. To find out whom to contact in your state to request an external review, please go to www.CoverageRights.org.

How do I file a complaint?

If your insurer denies your coverage after the external review process, you can file a complaint with the insurance commissioner or attorney general in your state. To determine whom to contact and how to submit the complaint, please go to www.CoverageRights.org.

Your complaint should include the following information:

- The name, address, email address, and telephone number of the person filing the complaint ("Complainant");
- The name of the insured individual, if different from the Complainant;
- The names of any other parties involved in the claim (for example, the plan administrator or pharmacy benefit manager);
- The name of the insurance company and the type of insurance;
- The state where the insurance plan was purchased;
- Claim information, including the policy number, certificate number, claim number, dates of denial, and amount in dispute;
- The reason for and details of the complaint; and
- What you consider to be a fair resolution.

You should also submit the following supporting documents with your complaint:

- A copy of your insurance card;
- Copies of coverage denials or adverse benefit determinations from your insurer;
- Copies of any determinations made by internal and external reviewers;
- Any materials submitted with prior appeals and complaints;
- Supporting documentation from your health care professional;
- A copy of your insurance policy; and
- All responses from your insurer.

What happens after the insurance commissioner or attorney general receives my complaint?

The insurance commissioner or attorney general will assign someone to research, investigate, and resolve your complaint. That person will examine your account, records, documents, and transactions. He or she may question witnesses, request additional documents from other parties, and hold a hearing. If the insurance commissioner or attorney general determines that the insurer violated laws or regulations, he or she may order the insurer to give you the requested coverage or compensate you.

Whom should I call if I have any questions about filing a complaint?

To determine whom to call in your state, please go to www.CoverageRights.org.

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