Continuity of Care – Talking Points
House Bill 1211/ Senate Bill 5160

**Background**

Continuity of care can be disrupted when health insurers change prescription drug benefits during the plan year. Also referred to as “non-medical switching,” insurers can force stable patients to switch drugs as a result of several changes, including:

- Moving a prescription to a higher cost-sharing tier;
- Increasing out-of-pocket costs by moving from co-pay to co-insurance; or
- Removing a prescription from a drug formulary altogether.

In plain language, this means that even after a person signs up for and is locked into a health plan, they may find that the benefits they signed up for are changed by their insurer.

- These changes can be made without notifying the patient or their healthcare provider.
- The patient may not find out until they show up at the pharmacist, and try to fill their prescription, only to find out that it is no longer covered—or that their co-pay has skyrocketed.

**This legislation matters to people with MS because:**

- Research shows that early and ongoing treatment with a disease-modifying therapy (DMT) is the best way to modify the course of relapsing forms of MS, prevent the accumulation of disability, and protect the brain from damage due to MS.
- MS can also be accompanied by a variety of life altering symptoms such as bladder problems, vision problems, and issues with gait, spasticity and extreme fatigue. These symptoms also often require physician or specialist prescribed medications.
- It can take years for a person living with a chronic health condition like MS to find the right course of treatment.
- Any changes or disruption in treatment that does not come from the patient’s healthcare provider can cause adverse reactions or side effects and put the patient’s health at risk.
- Any increase in co-pays or cost-sharing can make a person’s medication financially out-of-reach, forcing people to abandon treatment altogether, which can have serious negative consequences for their health and/or make tough financial decisions.

**What does this legislation do?**

**Washington Continuity of Care Legislation (SB 5160/HB 1211) would:**

- Ensure existing enrollees to a health plan have continued access to their prescription drugs;
- Prevent health insurers from increasing out-of-pocket costs for prescription drugs, except during open-enrollment periods; and
- Prohibit insurers from making mid-year changes to prescription drug formularies that limit or restrict access to medications.
Under this bill:

- Insurers could continue to add (not subtract) new drugs to the formulary, during the plan year.
- They could still remove drugs due to safety concerns, as well, or require substitution to a generic.

Possible question from legislators:

Q: How is it possible for health plans to change your coverage after you have enrolled?
A: Good question. A lot of people are surprised to hear this. But in most states, it is still possible for insurers to take steps during the health plan year that would force a person off their treatments. In addition, there is little to no regulation of pharmacy benefit managers at the state or federal level.

Who sponsors this bill?

- House Bill 1211 is sponsored by Representative Jinkins, and SB 5160 is sponsored by Senator Rivers. If you are a constituent, you do not need to ask for their support. Instead, thank them for sponsoring the bill.