

ESSB 6210 - H COMM AMD  
By Committee on Appropriations

NOT CONSIDERED 03/12/2026

1 Strike everything after the enacting clause and insert the  
2 following:

3 "NEW SECTION. **Sec. 1.** (1) The legislature finds that:

4 (a) Access to health care is fundamental to the health and safety  
5 of Washington state residents;

6 (b) Health insurance coverage is necessary for most people to  
7 access health care;

8 (c) Uncertainty in the health insurance marketplace is  
9 significantly impacted by the volatility in the federal legislative  
10 and regulatory environment;

11 (d) Rising health care costs are impacting access and  
12 affordability for Washington state residents;

13 (e) An unstable and volatile individual insurance market would be  
14 catastrophic and lead to:

15 (i) Deteriorating health outcomes;

16 (ii) Declining work force productivity;

17 (iii) Lower quality of life; and

18 (iv) Increased burdens on safety net providers from the rising  
19 demand for uncompensated care;

20 (f) Each year, the Washington health benefit exchange board uses  
21 19 basic criteria that were established in the affordable care act to  
22 review and certify health plans that will be offered to Washington  
23 state residents in the exchange market;

24 (g) These 19 basic criteria do not address access and  
25 affordability issues in the exchange market; and

26 (h) The affordable care act authorizes state exchanges to ensure  
27 that certified health plans are in the interest of the residents of  
28 the state by adopting additional health plan certification criteria  
29 to that effect. Access to and affordability of certified health plans  
30 are in the interest of residents of the state.

31 (2)(a) Therefore, the legislature intends to authorize the  
32 Washington health benefit exchange to add criteria in the health plan

1 certification process to address access and affordability issues  
2 impacting residents who purchase health insurance coverage on the  
3 exchange market and help reduce volatility in the exchange market.

4 (b) However, the legislature recognizes that the office of the  
5 insurance commissioner has the primary responsibility to review and  
6 approve a health carrier's:

7 (i) Proposed rate increases to ensure that any rate increases are  
8 reasonable, actuarially sound, nondiscriminatory, and comply with  
9 federal and state law; and

10 (ii) Provider networks to ensure adequate access to services.

11 **Sec. 2.** RCW 43.71.020 and 2018 c 44 s 2 are each amended to read  
12 as follows:

13 (1) The Washington health benefit exchange is established and  
14 constitutes a self-sustaining public-private partnership separate and  
15 distinct from the state, exercising functions delineated in chapter  
16 317, Laws of 2011. By January 1, 2014, the exchange shall operate  
17 consistent with applicable federal law subject to statutory  
18 authorization. The exchange shall have a governing board consisting  
19 of persons with expertise in the Washington health care system and  
20 private and public health care coverage. The membership of the board  
21 shall be appointed as follows:

22 (a) Each of the two largest caucuses in both the house of  
23 representatives and the senate shall submit to the governor a list of  
24 five nominees who are not legislators or employees of the state or  
25 its political subdivisions, with no caucus submitting the same  
26 nominee.

27 (i) The nominations from the largest caucus in the house of  
28 representatives must include at least one employee benefit  
29 specialist;

30 (ii) The nominations from the second largest caucus in the house  
31 of representatives must include at least one health economist or  
32 actuary;

33 (iii) The nominations from the largest caucus in the senate must  
34 include at least one representative of health consumer advocates;

35 (iv) The nominations from the second largest caucus in the senate  
36 must include at least one representative of small business;

37 (v) The remaining nominees must have demonstrated and  
38 acknowledged expertise in at least one of the following areas:  
39 Individual health care coverage, small employer health care coverage,

1 health benefit plan administration, health care finance and  
2 economics, actuarial science, or administering a public or private  
3 health care delivery system.

4 (b) The governor shall appoint two members from each list  
5 submitted by the caucuses under (a) of this subsection. The  
6 appointments made under this subsection (1)(b) must include at least  
7 one employee benefits specialist, one health economist or actuary,  
8 one representative of small business, and one representative of  
9 health consumer advocates. The remaining four members must have a  
10 demonstrated and acknowledged expertise in at least one of the  
11 following areas: Individual health care coverage, small employer  
12 health care coverage, health benefit plan administration, health care  
13 finance and economics, actuarial science, or administering a public  
14 or private health care delivery system.

15 (c) The governor shall appoint a ninth member to serve as chair.  
16 The chair may not be an employee of the state or its political  
17 subdivisions. The chair shall serve as a nonvoting member except in  
18 the case of a tie and any decision related to market factor  
19 certification criteria as established in section 4 of this act.

20 (d) The following members shall serve as nonvoting, ex officio  
21 members of the board:

22 (i) The insurance commissioner or his or her designee; (~~and~~)

23 (ii) The administrator of the health care authority, or his or  
24 her designee; and

25 (iii) The governor's senior policy advisor on health, who shall  
26 only attend meetings related to market factor certification criteria  
27 as established in section 4 of this act.

28 (2) Initial members of the board shall serve staggered terms not  
29 to exceed four years. Members appointed thereafter shall serve two-  
30 year terms.

31 (3) A member of the board whose term has expired or who otherwise  
32 leaves the board shall be replaced by gubernatorial appointment. Upon  
33 the expiration of a member's term, the member shall continue to serve  
34 until a successor has been appointed and has assumed office. When the  
35 person leaving was nominated by one of the caucuses of the house of  
36 representatives or the senate, his or her replacement shall be  
37 appointed from a list of five nominees submitted by that caucus  
38 within thirty days after the person leaves. If the member to be  
39 replaced is the chair, the governor shall appoint a new chair within  
40 thirty days after the vacancy occurs. A person appointed to replace a

1 member who leaves the board prior to the expiration of his or her  
2 term shall serve only the duration of the unexpired term. Members of  
3 the board may be reappointed to multiple terms.

4 (4) No board member may be appointed if his or her participation  
5 in the decisions of the board could benefit his or her own financial  
6 interests or the financial interests of an entity he or she  
7 represents. A board member who develops such a conflict of interest  
8 shall resign or be removed from the board.

9 (5) Members of the board must be reimbursed for their travel  
10 expenses while on official business in accordance with RCW 43.03.050  
11 and 43.03.060. The board shall prescribe rules for the conduct of its  
12 business. Meetings of the board are at the call of the chair.

13 (6) The exchange and the board are subject only to the provisions  
14 of chapter 42.30 RCW, the open public meetings act, and chapter 42.56  
15 RCW, the public records act, and not to any other law or regulation  
16 generally applicable to state agencies. Consistent with the open  
17 public meetings act, the board may hold executive sessions to  
18 consider proprietary or confidential nonpublished information.

19 (7) (a) The board shall establish an advisory committee to allow  
20 for the views of the health care industry and other stakeholders to  
21 be heard in the operation of the health benefit exchange.

22 (b) The board may establish technical advisory committees or seek  
23 the advice of technical experts when necessary to execute the powers  
24 and duties included in chapter 317, Laws of 2011.

25 (8) Members of the board are not civilly or criminally liable and  
26 may not have any penalty or cause of action of any nature arise  
27 against them for any action taken or not taken, including any  
28 discretionary decision or failure to make a discretionary decision,  
29 when the action or inaction is done in good faith and in the  
30 performance of the powers and duties under chapter 317, Laws of 2011.  
31 Nothing in this section prohibits legal actions against the board to  
32 enforce the board's statutory or contractual duties or obligations.

33 (9) In recognition of the government-to-government relationship  
34 between the state of Washington and the federally recognized tribes  
35 in the state of Washington, the board shall consult with the American  
36 Indian health commission.

37 **Sec. 3.** RCW 43.71.065 and 2018 c 44 s 5 are each amended to read  
38 as follows:

1 (1) The board shall certify a plan as a qualified health plan to  
2 be offered through the exchange if the plan is determined by the:

3 (a) Insurance commissioner to meet the requirements of Title 48  
4 RCW and rules adopted by the commissioner pursuant to chapter 34.05  
5 RCW to implement the requirements of Title 48 RCW;

6 (b) Board to meet the requirements of applicable federal law for  
7 certification as a qualified health plan; (~~and~~)

8 (c) Board to meet the market factor criteria that address access  
9 and affordability as established in section 4 of this act; and

10 (d) Board to include tribal clinics and urban Indian clinics as  
11 essential community providers in the plan's provider network  
12 consistent with federal law. If consistent with federal law,  
13 integrated delivery systems shall be exempt from the requirement to  
14 include essential community providers in the provider network.

15 (2) Consistent with applicable federal law, the board shall allow  
16 stand-alone dental plans to offer coverage in the exchange beginning  
17 January 1, 2014. Dental benefits offered in the exchange must be  
18 offered and priced separately to assure transparency for consumers.

19 (3) The board may permit direct primary care medical home plans,  
20 consistent with applicable federal law, to be offered in the  
21 exchange.

22 (4) Upon request by the board, a state agency shall provide  
23 information to the board for its use in determining if the  
24 requirements under subsection (1)(b) or (~~(c)~~) (d) of this section  
25 have been met. Unless the agency and the board agree to a later date,  
26 the agency shall provide the information within sixty days of the  
27 request. The exchange shall reimburse the agency for the cost of  
28 compiling and providing the requested information within one hundred  
29 eighty days of its receipt.

30 (5) A decision by the board denying a request to certify or  
31 recertify a plan as a qualified health plan may be appealed according  
32 to procedures adopted by the board.

33 NEW SECTION. Sec. 4. A new section is added to chapter 43.71  
34 RCW to read as follows:

35 (1) Each year, after the board has reviewed and certified health  
36 plans to be offered on the exchange market in the upcoming plan year,  
37 the exchange shall review market conditions and identify access and  
38 affordability issues in the exchange market that impact the upcoming  
39 plan year for which the exchange has not yet certified plans.

1 (2) Each year, the exchange may adopt market factor certification  
2 criteria for the upcoming plan year to address market conditions that  
3 impact access to and affordability of qualified health plans for  
4 individuals or employers who are eligible to purchase coverage on the  
5 exchange market in Washington state. When developing the criteria,  
6 the exchange may consider whether health plans available in each  
7 county are:

8 (a) Meaningfully different with respect to one or a combination  
9 of these measures, as determined by the exchange:

10 (i) Cost-sharing;

11 (ii) Covered benefits;

12 (iii) Premiums;

13 (iv) Prescription drug formularies;

14 (v) Provider networks; or

15 (vi) Quality;

16 (b) Offered by more than one carrier;

17 (c) Maximizing federal premium tax credits;

18 (d) Efficiently utilizing state premium assistance and other  
19 state investments; and

20 (e) Offered at each metal level required by the exchange.

21 (3) Market factor certification criteria adopted under this  
22 subsection shall be:

23 (a) Objectively defined, measurable, and consistently applied;

24 (b) Applied uniformly to all carriers that offer or seek to offer  
25 qualified health plans on the exchange in the state;

26 (c) Consistent with, and not duplicative of, minimum requirements  
27 or standards established by the commissioner related to rate review,  
28 network adequacy, solvency, or actuarial soundness; and

29 (d) Designed to complement and not conflict with applicable  
30 federal or state laws or regulations governing qualified health  
31 plans.

32 (4) Market factor certification criteria shall be developed in  
33 consultation with the commissioner and the authority, and the  
34 exchange shall consider comments from:

35 (a) Carriers that offer or seek to offer qualified health plans  
36 on the exchange in the state, including through the exchange plan  
37 certification workgroup;

38 (b) Licensed health insurance producers, including through the  
39 exchange agents and brokers technical advisory committee;

1 (c) Federally recognized tribes in the state through the American  
2 Indian health commission;

3 (d) Members of the exchange advisory committee and if applicable,  
4 other relevant exchange technical advisory committees; and

5 (e) Other health care stakeholders through their associations or  
6 organizations.

7 (5) For plan year 2028 and later, market factor certification  
8 criteria shall be developed in accordance with the following  
9 timeline:

10 (a) (i) By November 1st of the calendar year two years before the  
11 plan year in which the market factor certification criteria are to  
12 apply, the exchange shall identify any known market conditions that  
13 may impact access and affordability issues in the exchange market in  
14 the upcoming plan year for which the exchange has not yet certified  
15 plans; develop a market conditions assessment report; and provide the  
16 market conditions assessment report to the exchange advisory  
17 committee, all the exchange technical advisory committees, and all  
18 the exchange work groups.

19 (ii) The exchange may update the market conditions assessment  
20 after November 1st with market conditions that become known after  
21 this date. Updates to the market conditions assessment must be  
22 provided to the exchange advisory committee, all the exchange  
23 technical advisory committees, and all the exchange work groups.

24 (b) By December 15th of the calendar year two years before the  
25 plan year in which the market factor certification criteria are to  
26 apply, the exchange shall identify preliminary criteria and provide  
27 those criteria to the commissioner, the governor, the exchange  
28 advisory committee, all the exchange technical advisory committees,  
29 the chairs of the health care committees in the house of  
30 representatives and the senate, and any person requesting the  
31 information;

32 (c) By January 15th of the calendar year before the plan year in  
33 which the market factor certification criteria are to apply, the  
34 commissioner and the governor may submit to the exchange a written  
35 objection to any of the preliminary criteria;

36 (d) By January 31st of the calendar year before the plan year in  
37 which the market factor certification criteria are to apply, the  
38 exchange shall provide a written response to any objection, including  
39 whether and how the objection was addressed and what criteria were  
40 amended or removed based on the objection;

1 (e) By January 31st of the calendar year before the plan year in  
2 which the market factor certification criteria are to apply, the  
3 exchange shall publish a notice of the preliminary market factor  
4 certification criteria in the draft guidance of participation  
5 document on the exchange website and distribute the notice  
6 electronically to the exchange advisory committee, all exchange  
7 technical advisory committees, all exchange work groups, the  
8 governor, the chairs of the health care committees in the house of  
9 representatives and the senate, and any person requesting the notice.  
10 The notice shall include:

11 (i) An explanation of the proposed market factor certification  
12 criteria;

13 (ii) The time, date, and place for a public hearing; and

14 (iii) The procedures and timelines for submitting written  
15 comments and supporting information;

16 (f) No later than seven business days before the publication of  
17 the final market factor certification criteria, the exchange shall  
18 hold at least one public hearing;

19 (g) By March 1st of the calendar year before the plan year in  
20 which the market factor certification criteria are to apply:

21 (i) The board shall vote on the final market factor certification  
22 criteria; and

23 (ii) The exchange shall provide written notice of the final  
24 market factor certification criteria to carriers that offer health  
25 plans subject to certification under RCW 43.71.065, and shall publish  
26 the notice of the final market factor certification criteria in the  
27 guidance of participation document on the exchange website and  
28 distribute the notice electronically to the exchange advisory  
29 committee, all exchange technical advisory committees, all exchange  
30 work groups, the governor, the chairs of the health care committees  
31 in the house of representatives and the senate, and any person  
32 requesting the notice;

33 (h) After March 1st of the calendar year before the plan year in  
34 which the market factor certification criteria are to apply, the  
35 exchange may only modify the market factor certification criteria as  
36 necessary to respond to any applicable changes to state or federal  
37 laws or regulations. Any modification initiated under this subsection  
38 that impacts a carrier's preliminary health plan filings is only in  
39 effect if agreed to by the commissioner.

1 (6) (a) The exchange may require a carrier that intends to offer  
2 qualified health plans on the exchange to submit information,  
3 including the carrier's proposed service areas and proposed plan  
4 offerings on the exchange, and how the carrier intends to meet the  
5 market factor certification criteria.

6 (b) No earlier than March 1st and no later than May 1st each  
7 year, the carrier shall provide the information to the exchange. The  
8 specific date must be determined by the exchange before March 1st.

9 (7) (a) A carrier may request a waiver of the market factor  
10 certification criteria.

11 (b) Requests for a waiver must be submitted to the exchange at a  
12 date specified by the exchange but will be no earlier than March 1st  
13 and no later than 14 days prior to the deadline established by the  
14 commissioner each year for preliminary health plans filings.

15 (c) In evaluating a request for a waiver, the exchange may:

16 (i) Review information that demonstrates the carrier attempted to  
17 meet the market factor certification criteria, such as information  
18 that the carrier made a good faith effort to contract with providers  
19 to establish an adequate network, the cost of the potential provider  
20 network, the direction and magnitude of premium impact, legal  
21 prohibitions, or other barriers that impact the carrier's ability to  
22 offer coverage in certain service areas, and any impact on other  
23 service areas;

24 (ii) Request that the carrier submit information about service  
25 areas that would be in place with the market factor certification  
26 criteria and if the waiver were granted;

27 (iii) Consider the totality of the proposed qualified health  
28 plans and the impact of granting or not granting the waiver of the  
29 market factor certification criteria on the interests of Washington  
30 state residents.

31 (d) The exchange shall conclude any waiver determinations  
32 regarding market factor certification criteria from any carrier that  
33 has requested a waiver prior to the carrier submitting preliminary  
34 health plan filings for the upcoming plan year to the commissioner.

35 (8) Any information and data submitted by a carrier to the  
36 exchange under this section is confidential and not subject to public  
37 disclosure under chapter 42.56 RCW. If any rate information is  
38 received by the exchange from a carrier, that information is  
39 confidential and may not be disclosed or communicated to the public  
40 or to any other carrier before the commissioner makes the

1 corresponding rate filing information available for public inspection  
2 under RCW 48.02.120(5)(a).

3 (9) Market factor certification criteria may not impose lower  
4 network participation requirements or reimbursement limits on  
5 hospitals or providers except as otherwise required by federal or  
6 state laws.

7 (10) Nothing in this section prohibits a carrier from offering a  
8 health plan that does not meet the requirements in RCW 43.71.065 in  
9 the individual market or small group market outside the exchange.

10 (11)(a) By July 1st of each year, beginning in 2029, the  
11 exchange, in consultation with the commissioner and authority, shall  
12 submit to the legislature a report that includes:

13 (i) The following information, if available, about the exchange  
14 and the individual market outside the exchange:

15 (A) Total enrollment by county;

16 (B) Subsidized and unsubsidized enrollment by county;

17 (C) Weighted average health plan rates by county;

18 (D) Number of people no longer eligible for medicaid coverage and  
19 enrolling in a health plan without a gap in coverage, by county;

20 (E) The following information for the previous plan year and as a  
21 four-year trend:

22 (I) Total number of plans in a county;

23 (II) Total number of carriers that offer health plans in a  
24 county; and

25 (III) Total number of plans by metal level offered in each  
26 county; and

27 (H) Public option, standardized plan, and nonstandardized plan  
28 enrollment by county;

29 (ii) Percentage of enrollees by county, who are enrolled in a  
30 qualified health plan on the exchange and who receive federal premium  
31 tax credits, state premium assistance, or both;

32 (iii) The number of market factor certification criteria waivers:

33 (A) Requested by a carrier and reasons for the request; and

34 (B) Granted by the exchange;

35 (iv) Other relevant information, as determined by the exchange,  
36 commissioner, or authority.

37 (b) To the extent that any of the information in (a) of this  
38 subsection is included in reports or other publications prepared by  
39 the exchange, commissioner, or authority, the exchange may reference

1 those sources in the report submitted under this section as an  
2 alternative to replicating that information.

3 (12) Nothing in this section, including the market factor  
4 certification criteria and exchange decisions that apply the market  
5 factor certification criteria, shall create requirements that cause a  
6 health plan premium to be actuarially unsound, to fail to meet  
7 requirements or standards established by the commissioner related to  
8 rate review, network adequacy or solvency, or to conflict with  
9 applicable federal or state laws or regulations governing qualified  
10 health plans.

11 (13) For purposes of this section, "meaningfully different" means  
12 there is a material difference between health plans within the county  
13 and metal level that is in the interest of consumers to advance  
14 access, affordability, and quality, as determined by the exchange.

15 NEW SECTION. **Sec. 5.** A new section is added to chapter 42.56  
16 RCW to read as follows:

17 Any information or data submitted by a health carrier to the  
18 health benefit exchange for the purposes of the market factor  
19 certification criteria under section 3 of this act is confidential  
20 and exempt from disclosure under this chapter.

21 NEW SECTION. **Sec. 6.** A new section is added to chapter 43.71  
22 RCW to read as follows:

23 For any county with one or fewer carriers offering health plans  
24 during the current or upcoming plan year, the exchange and the  
25 commissioner shall jointly work with carriers offering health plans  
26 on the exchange and hospitals operating in the impacted county and  
27 health care referral region to discuss a pathway to help prevent any  
28 county from being left without carrier coverage options and to  
29 provide an opportunity for carriers and providers to negotiate  
30 contracts for care delivery."

31 Correct the title.

EFFECT: • Requires the Exchange to consider comments from the  
Health Benefit Exchange (Exchange) work groups, Advisory Committee,  
and technical advisory committees.

• Requires the Exchange to provide preliminary market factor  
certification criteria (criteria) by December 15th two calendar years  
before the plan year in which the criteria would apply to the  
Exchange Advisory Committee, all Exchange technical advisory

committees, chairs of the health care committees in the House of Representatives and Senate, and any person requesting the information, in addition to the Insurance Commissioner (Commissioner) and Governor.

- Requires the Exchange to publish a notice of the preliminary criteria and the final criteria in the draft guidance of participation document on the Exchange's website and to distribute it electronically to all entities listed above.

- Requires the Exchange Board to vote on the final criteria by March 1.

- Specifies that the Exchange may consider whether health plans available in each county are meaningfully different with respect to one or a combination of measures when establishing criteria, rather than a combination or all of the measures.

- Provides that the criteria must be consistent with and not duplicative of minimum standards or requirements established by the Commissioner, rather than standards or requirements established by the Commissioner.

- Specifies that the criteria may not impose lower network participation requirements or reimbursement limits (rather than impose network participation requirements or reimbursement limits) on hospitals or providers, except as otherwise required by federal or state law.

- Requires the Exchange to submit the first report to the Legislature in 2029 rather than 2030 and removes requirements for the initial report to include information for plan year 2028 and 2029.

- Adds the total number of plans in a county, the number of carriers offering health plans in a county, the number of plans by metal level offered in each county, and public option, standardized plan, and nonstandardized plan enrollment by county on a plan year and four-year trend basis to the annual report the Exchange must submit to the Legislature.

- Modifies the requirement that the Exchange and Commissioner must work jointly with carriers and hospitals in counties with one or fewer carriers offering health plans, by requiring them to discuss a pathway to help prevent any county from being left without carrier coverage options and to provide an opportunity to negotiate contracts for care delivery (rather than requiring them to discuss a pathway to have at least two carriers offering health plans in the impacted county, including hospitals contracting with at least two carriers).

- Defines "meaningfully different" as a material difference between health plans within the county and metal level that is in the interest of consumers to advance access, affordability, and quality, as determined by the Health Benefit Exchange (Exchange).

- Requires the Exchange to identify any known market conditions that may impact access and affordability issues in the Exchange market in the upcoming plan year; develop a market conditions assessment report; and provide the report to the Exchange Advisory Committee, all the Exchange technical advisory committees, and all the Exchange work groups by November 1st of the calendar year two years before the plan year in which the market factor certification would apply.

--- END ---