

ESSB 6210 - H COMM AMD

By Committee on Health Care & Wellness

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.

1 (2) (a) Therefore, the legislature intends to authorize the
2 Washington health benefit exchange to add criteria in the health plan
3 certification process to address access and affordability issues
4 impacting residents who purchase health insurance coverage on the
5 exchange market and help reduce volatility in the exchange market.

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

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

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

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

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

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

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

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

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

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

1 (v) The remaining nominees must have demonstrated and
2 acknowledged expertise in at least one of the following areas:
3 Individual health care coverage, small employer health care coverage,
4 health benefit plan administration, health care finance and
5 economics, actuarial science, or administering a public or private
6 health care delivery system.

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

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

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

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

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

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

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

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

1 within thirty days after the person leaves. If the member to be
2 replaced is the chair, the governor shall appoint a new chair within
3 thirty days after the vacancy occurs. A person appointed to replace a
4 member who leaves the board prior to the expiration of his or her
5 term shall serve only the duration of the unexpired term. Members of
6 the board may be reappointed to multiple terms.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 NEW SECTION. **Sec. 4.** A new section is added to chapter 43.71
36 RCW to read as follows:

37 (1) Each year, after the board has reviewed and certified health
38 plans to be offered on the exchange market in the upcoming plan year,
39 the exchange shall review market conditions and identify access and

1 affordability issues in the exchange market that impact the upcoming
2 plan year for which the exchange has not yet certified plans.

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

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

12 (i) Cost-sharing;

13 (ii) Covered benefits;

14 (iii) Premiums;

15 (iv) Prescription drug formularies;

16 (v) Provider networks; or

17 (vi) Quality;

18 (b) Offered by more than one carrier;

19 (c) Maximizing federal premium tax credits;

20 (d) Efficiently utilizing state premium assistance and other
21 state investments; and

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

23 (3) Market factor certification criteria adopted under this
24 subsection shall be:

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

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

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

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

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

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

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

3 (c) Federally recognized tribes in the state through the American
4 Indian health commission;

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

7 (e) Other health care stakeholders through their associations or
8 organizations.

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

12 (a) By December 15th of the calendar year two years before the
13 plan year in which the market factor certification criteria are to
14 apply, the exchange shall identify preliminary criteria and provide
15 those criteria to the commissioner, the governor, the exchange
16 advisory committee, all the exchange technical advisory committees,
17 the chairs of the health care committees in the house of
18 representatives and the senate, and any person requesting the
19 information;

20 (b) By January 15th of the calendar year before the plan year in
21 which the market factor certification criteria are to apply, the
22 commissioner and the governor may submit to the exchange a written
23 objection to any of the preliminary criteria;

24 (c) By January 31st of the calendar year before the plan year in
25 which the market factor certification criteria are to apply, the
26 exchange shall provide a written response to any objection, including
27 whether and how the objection was addressed and what criteria were
28 amended or removed based on the objection;

29 (d) By January 31st of the calendar year before the plan year in
30 which the market factor certification criteria are to apply, the
31 exchange shall publish a notice of the preliminary market factor
32 certification criteria in the draft guidance of participation
33 document on the exchange website and distribute the notice
34 electronically to the exchange advisory committee, all exchange
35 technical advisory committees, all exchange work groups, the
36 governor, the chairs of the health care committees in the house of
37 representatives and the senate, and any person requesting the notice.
38 The notice shall include:

39 (i) An explanation of the proposed market factor certification
40 criteria;

1 (ii) The time, date, and place for a public hearing; and
2 (iii) The procedures and timelines for submitting written
3 comments and supporting information;

4 (e) No later than seven business days before the publication of
5 the final market factor certification criteria, the exchange shall
6 hold at least one public hearing;

7 (f) By March 1st of the calendar year before the plan year in
8 which the market factor certification criteria are to apply:

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

11 (ii) The exchange shall provide written notice of the final
12 market factor certification criteria to carriers that offer health
13 plans subject to certification under RCW 43.71.065, and shall publish
14 the notice of the final market factor certification criteria in the
15 guidance of participation document on the exchange website and
16 distribute the notice electronically to the exchange advisory
17 committee, all exchange technical advisory committees, all exchange
18 work groups, the governor, the chairs of the health care committees
19 in the house of representatives and the senate, and any person
20 requesting the notice;

21 (g) After March 1st of the calendar year before the plan year in
22 which the market factor certification criteria are to apply, the
23 exchange may only modify the market factor certification criteria as
24 necessary to respond to any applicable changes to state or federal
25 laws or regulations. Any modification initiated under this subsection
26 that impacts a carrier's preliminary health plan filings is only in
27 effect if agreed to by the commissioner.

28 (6) (a) The exchange may require a carrier that intends to offer
29 qualified health plans on the exchange to submit information,
30 including the carrier's proposed service areas and proposed plan
31 offerings on the exchange, and how the carrier intends to meet the
32 market factor certification criteria.

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

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

38 (b) Requests for a waiver must be submitted to the exchange at a
39 date specified by the exchange but will be no earlier than March 1st

1 and no later than 14 days prior to the deadline established by the
2 commissioner each year for preliminary health plans filings.

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

4 (i) Review information that demonstrates the carrier attempted to
5 meet the market factor certification criteria, such as information
6 that the carrier made a good faith effort to contract with providers
7 to establish an adequate network, the cost of the potential provider
8 network, the direction and magnitude of premium impact, legal
9 prohibitions, or other barriers that impact the carrier's ability to
10 offer coverage in certain service areas, and any impact on other
11 service areas;

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

15 (iii) Consider the totality of the proposed qualified health
16 plans and the impact of granting or not granting the waiver of the
17 market factor certification criteria on the interests of Washington
18 state residents.

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

23 (8) Any information and data submitted by a carrier to the
24 exchange under this section is confidential and not subject to public
25 disclosure under chapter 42.56 RCW. If any rate information is
26 received by the exchange from a carrier, that information is
27 confidential and may not be disclosed or communicated to the public
28 or to any other carrier before the commissioner makes the
29 corresponding rate filing information available for public inspection
30 under RCW 48.02.120(5)(a).

31 (9) Market factor certification criteria may not impose lower
32 network participation requirements or reimbursement limits on
33 hospitals or providers except as otherwise required by federal or
34 state laws.

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

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

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

3 (A) Total enrollment by county;

4 (B) Subsidized and unsubsidized enrollment by county;

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

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

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

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

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

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

15 (H) Public option, standardized plan, and nonstandardized plan
16 enrollment by county;

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

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

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

22 (B) Granted by the exchange;

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

25 (b) To the extent that any of the information in (a) of this
26 subsection is included in reports or other publications prepared by
27 the exchange, commissioner, or authority, the exchange may reference
28 those sources in the report submitted under this section as an
29 alternative to replicating that information.

30 (12) Nothing in this section, including the market factor
31 certification criteria and exchange decisions that apply the market
32 factor certification criteria, shall create requirements that cause a
33 health plan premium to be actuarially unsound, to fail to meet
34 requirements or standards established by the commissioner related to
35 rate review, network adequacy or solvency, or to conflict with
36 applicable federal or state laws or regulations governing qualified
37 health plans.

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

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

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

7 For any county with one or fewer carriers offering health plans
8 during the current or upcoming plan year, the exchange and the
9 commissioner shall jointly work with carriers offering health plans
10 on the exchange and hospitals operating in the impacted county and
11 health care referral region to discuss a pathway to help prevent any
12 county from being left without carrier coverage options and to
13 provide an opportunity for carriers and providers to negotiate
14 contracts for care delivery."

15 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).

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