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## Health Care & Wellness Committee

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### ESSB 6210

**Brief Description:** Concerning the health plan certification process.

**Sponsors:** Senate Committee on Health & Long-Term Care (originally sponsored by Senators Slatter, Nobles and Saldaña).

**Brief Summary of Engrossed Substitute Bill**

- Authorizes the Health Benefit Exchange to develop market factor criteria as additional criteria for carriers to meet as part of the health plan certification process.

**Hearing Date:** 2/20/26

**Staff:** Kim Weidenaar (786-7120).

**Background:**

Through Washington's Health Benefit Exchange (Exchange), individuals may compare and purchase qualified health plans (QHPs) and access premium subsidies and cost-sharing reductions. Qualified health plans are offered in the following actuarial value tiers:

- bronze—60 percent actuarial value
- silver—70 percent actuarial value;
- gold—80 percent actuarial value; and
- platinum—90 percent actuarial value.

The Exchange annually certifies health plans and only those health plans certified by the Exchange may be offered as QHPs through the Exchange Market. Under federal law, a QHP must meet all federal requirements and any provisions imposed by the Exchange, or a state in connection with its Exchange, that are conditions of participation or certification. As part of the

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certification process, carriers must submit plans and supporting documentation as required to demonstrate compliance with each of the 19 certification criteria. Each criterion is reviewed and approved by the Office of the Insurance Commissioner (OIC), the Exchange, or both. The Exchange may certify a health plan as a QHP if the health plan meets all federal requirements for certification and the Exchange determines the plan is in the interests of individuals and employers in the state.

The Exchange is governed by a nine-member Board appointed by the Governor from a list submitted by all four caucuses of the House of Representatives and the Senate. The Governor must appoint a chair who may not be an employee of the state or its political subdivisions. The chair must serve as a nonvoting member except in the case of a tie. The Insurance Commissioner (Commissioner) or his or her designee and the Health Care Authority (HCA) administrator or his or her designee shall serve as nonvoting, ex officio members of the Board.

### **Summary of Bill:**

Each year, after QHPs have been certified to be offered on the Exchange Market for the upcoming plan year, the Exchange must review market conditions and identify access and affordability issues that impact the upcoming plan year. Following the review, the Exchange may adopt market factor certification criteria (criteria) for the upcoming plan year to address market conditions that impact access to and affordability of qualified health plans for individuals or employers who are eligible to purchase coverage on the Exchange Market. When developing the criteria, the Exchange may consider whether health plans available in each county are:

- meaningfully different with respect to a combination of or all of these measures: cost-sharing, covered benefits, premiums, prescription drug formularies, provider networks, or quality;
- offered by more than one carrier;
- maximizing federal premium tax credits;
- efficiently utilizing state premium assistance and other state investments; and
- offered at each metal level required by the Exchange.

The criteria must be objectively defined, measurable, and consistently applied; applied uniformly to all carriers that seek to offer QHPs; be consistent with and not duplicative of OIC requirements or standards related to rate review, network adequacy, solvency, or actuarial soundness; and designed to complement federal and state laws. The criteria must be developed in consultation with the OIC and the HCA, and the Exchange shall consider comments from other health care stakeholders.

For plan year 2028 and later, criteria must be developed in accordance with the following timeline:

- By December 15 of the calendar year two years before the plan year in which the criteria are to apply, the Exchange must identify preliminary criteria and provide those criteria to the OIC and the Governor.
- By January 15 of the calendar year before the plan year in which the criteria are to apply,

the OIC and the Governor may submit written objections to any of the preliminary criteria and the Exchange must submit a written response to those objections by January 31.

- By January 31 of the calendar year before the plan year in which the market factor certification criteria are to apply, the Exchange must publish the notice of the proposed criteria on its website and must distribute notices electronically to any person requesting the notice. The notice must include an explanation of the proposed criteria and the procedures and timelines for submitting written comments and supporting information.
- By March 1 of the calendar year before the plan year in which the criteria are to apply, the Exchange shall provide written notice of the final criteria to carriers that offer plans on the Exchange Market and publish the criteria on its website.
- After March 1 of the calendar year before the plan year in which the criteria are to apply, the Exchange may only modify the criteria as necessary to respond to any applicable changes to state or federal laws or regulations. The OIC must agree to any modification that impacts a carrier's preliminary health plan filings.

The Exchange may require a carrier that intends to offer QHPs on the Exchange to submit information, including the carrier's proposed service areas, proposed plan offerings, and how the carrier intends to meet the criteria.

A carrier may request a waiver of the criteria. In evaluating a request for a waiver, the Exchange may:

- review information that demonstrates the carrier attempted to meet the criteria;
- request that the carrier submit information about service areas that would be in place with the criteria met and if the waiver was granted; and
- consider the totality of the proposed health plans and the impact of granting or not granting the waiver on the interests of Washington residents.

The Exchange must conclude any waiver determinations prior to the carrier submitting preliminary health plan filings for the upcoming plan year to the OIC.

For any county with one or fewer carriers offering health plans during the current or upcoming plan year, the Exchange and the OIC must jointly work with carriers offering health plans on the Exchange and hospitals operating in the impacted county and health care referral region to discuss a pathway to have at least two carriers offer health plans in the impacted county during the upcoming plan year, including hospitals contracting with at least two carriers to provide in-network services.

#### Report.

By July 1 of each year, beginning in 2030, the Exchange, in consultation with the OIC and HCA, must submit to the Legislature a report that includes:

- the total enrollment by county, subsidized and unsubsidized enrollment by county, weighted average health plan rates by county, and the number of individuals no longer eligible for Medicaid coverage enrolling in a health plan without a gap in coverage, by Exchange and off-Exchange individual plans;

- the percentage of enrollees by county, who are enrolled in a QHP and who receive federal premium tax credits, state premium assistance, or both; and
- the number of criteria waivers requested by a carrier, the reasons for the request, and the number granted by the Exchange.

Any information and data submitted by a carrier pursuant to these requirements is confidential and not subject to public disclosure. If any rate information is received by the Exchange from a carrier, that information is considered confidential and may not be disclosed or communicated to the public or to any other carrier before the Commissioner makes the corresponding rate filing information available for public inspection.

Board Membership.

The chair must serve as a nonvoting member except in the case of a tie and any decision related to market factor certification criteria. The Governor's senior policy advisor on health, who must only attend meetings related to market factor certification criteria, is appointed as a third nonvoting, ex officio member.

**Appropriation:** None.

**Fiscal Note:** Available.

**Effective Date:** The bill takes effect 90 days after adjournment of the session in which the bill is passed.