

HOUSE BILL REPORT

ESSB 6210

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to safeguarding access and affordability for exchange customers through the health plan certification process.

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 History:

Committee Activity:

Health Care & Wellness: 2/20/26, 2/25/26 [DPA].

Brief Summary of Engrossed Substitute Bill
(As Amended by Committee)

- 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 11 members: Representatives Bronoske, Chair; Lekanoff, Vice Chair; Rule, Vice Chair; Davis, Macri, Obras, Parshley, Shavers, Simmons, Stonier and Thai.

Minority Report: Do not pass. Signed by 7 members: Representatives Schmick, Ranking Minority Member; Marshall, Assistant Ranking Minority Member; Valdez, Assistant Ranking Minority Member; Engell, Low, Manjarrez and Stuebe.

Staff: Kim Weidenaar (786-7120).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

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 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 Amended 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 QHPs 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 one or a combination 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 minimum 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 must consider comments from other health care stakeholders. Market factor certification criteria may not impose lower network participation requirements or reimbursement limits on hospitals or providers, except as otherwise required by federal or state laws.

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, the Governor, the Exchange Advisory Committee, all the Exchange technical advisory committees, the chairs of the health care committees in the House of Representatives and the Senate, and any person requesting the information (collectively referred to as notified parties).
- 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 criteria are to apply, the Exchange must publish the notice of the preliminary criteria in the guidance of participation document on its website and must distribute notices electronically to the notified parties. 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 Board must vote on the final criteria; and
 - the Exchange must provide written notice of the final criteria to carriers that offer plans on the Exchange Market, publish the criteria in the guidance of participation documentation on its website, and provide electronic notice to the notified parties.
- 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 work jointly 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 help prevent any county from being left without carrier coverage options, and to provide an opportunity for carriers and providers to negotiate contracts for care delivery.

Report.

By July 1 of each year, beginning in 2029, 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;
- the following information for the previous plan year and as a four-year trend: total number of plans in a county; total number of carriers that offer health plans in a county; total number of plans by metal level offered in each county; and public option, standardized plan, and nonstandardized plan enrollment by county; 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.

Amended Bill Compared to Engrossed Substitute Bill:

The amended bill:

- requires the Exchange to consider comments from the Exchange work groups, Exchange Advisory Committee, and technical advisory committees;
- requires the Exchange to provide preliminary criteria by December 15 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 the Senate, and any person requesting the information, in addition to the Commissioner and Governor (collectively referred to as notified parties);
- 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 the notified parties;
- 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 years 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;
- requires the final criteria to be published at least seven days before the public hearing rather than five days before; and
- 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.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) If a person does not have employer-based coverage or coverage through Medicaid, then they must get insurance through the Health Benefit Exchange and see what plans that are available in that county. Right now, coverage is disappearing in parts of Washington. In San Juan County, for example, two carriers have already left the marketplace and only one is remaining. Families are forced to pay more than they normally want to, or can, or must go uninsured. This loss of available plans is a canary in the coal mine and going forward we may be seeing coverage lost in other parts of Washington. The 2026 enrollment period recently ended with 290,000 Washingtonians signed up, which is about 20,000 fewer than last year. It is anticipated that 5 to 10 percent may drop coverage once their first monthly bills arrive. That means up to 30,000 more people could lose their safety net in the next few weeks.

The declines are driven by a number of factors including the expiration of enhanced federal premium tax credits, federal policy changes, and double-digit premium increases.

This bill allows a long runway so that carriers can adjust plans to any new criteria. There is also an opportunity for carriers to seek waivers from the criteria based on certain conditions.

The Exchange is going to need new tools to respond to the changes in the unstable federal landscape. Giving the Exchange the authority to raise standards will help ensure that families get better value in the plans and meet their needs, which is important as federal actions are limiting patients' access to affordable and high-quality coverage. There are concerns about health care access and affordability, especially as they affect rural communities in the state. It is very important that the state continue to ensure access to health insurance in very rural areas where tribes are located.

Choosing health insurance is incredibly difficult for families who must weigh both costs and coverage. Insurance plan design is often confusing, leaving families unsure of what their plan actually covers. This is one of the most important financial decisions a patient

will make, and it should be transparent and straightforward.

The Exchange is an outlier compared to 11 other state-based marketplaces that set higher plan standards already. The Exchange already follows a public stakeholder process that is more robust than the practices at other states' agencies.

(Opposed) This bill expands the Exchange's authority that discourages carrier participation and now is not the time to make it harder for carriers to remain in the market. Consumers do not benefit when competition shrinks. While the bill currently allows market factor criteria to be implemented in plan year 2028, the timeline for development and implementation by carriers is unrealistic. Plan design must start well in advance of required rate filing so actuarial and other supporting analysis can be completed before OIC deadlines. Any new criteria required by the Exchange must allow for this process, as well as any downstream contracting and network changes. Changing new criteria on an annual basis will disrupt the market and lead to unintended consequences and Washington should proceed with caution since there is currently enough volatility at the federal level. Clarifying language should be added to the bill regarding the meaningful difference between new criteria, additional consultation with the OIC, and further refinement of the waiver process. The definition of "meaningfully different" in the bill gives wide discretion to the Exchange to decide what qualifies as meaningfully different.

(Other) The goal of strengthening covered options is appreciated, but the structure frames the pathway discussion around a specific carrier benchmark and a hospital contracting reference. The specific two-carrier benchmark and the hospital contracting reference should be removed and, instead, focus on preserving coverage options while supporting voluntary negotiations.

Persons Testifying: (In support) Senator Vandana Slatter, prime sponsor; Jane Beyer, Office of the Insurance Commissioner; Vicki Lowe; Ingrid Ulrey, Washington Health Benefit Exchange; Stephany Shackelford, Acrisure; Adam Zarrin, Blood Cancer United, formerly the Leukemia and Lymphoma Society; and Emily Brice, Northwest Health Law Advocates.

(Opposed) Marissa Ingalls, Association of Washington Healthcare Plans; and Andrea Davis, Coordinated Care.

(Other) Jennifer Brackeen, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: None.