

SENATE BILL REPORT

SB 6210

As Reported by Senate Committee On:
Health & Long-Term Care, February 3, 2026

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: Senators Slatter, Nobles and Saldaña.

Brief History:

Committee Activity: Health & Long-Term Care: 1/22/26, 2/03/26 [DPS, DNP].

Brief Summary of First Substitute Bill

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

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6210 be substituted therefor, and the substitute bill do pass.

Signed by Senators Cleveland, Chair; Orwall, Vice Chair; Slatter, Vice Chair; Bateman, Chapman, Riccelli and Robinson.

Minority Report: Do not pass.

Signed by Senators Muzzall, Ranking Member; Christian, Harris and Holy.

Staff: Greg Attanasio (786-7410)

Background: Through Washington's Health Benefit Exchange (Exchange), individuals may compare and purchase qualified health plans (QHPs) and access premium subsidies

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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; and
- gold—80 percent actuarial value.

High-deductible catastrophic plans may also be offered on the Exchange.

The Exchange annually certifies QHPs and only those health plans certified or recertified by the Exchange may be offered as QHPs through the Exchange. 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 criterion. Each criterion is reviewed and approved by the Office of the Insurance Commissioner (OIC), the Exchange, or both.

Summary of Bill (First Substitute): Each year, after QHPs have been certified to be offered on the exchange market for the following plan year, the Exchange shall review market conditions and identify access and affordability issues in the Exchange market that impact the next plan year for which plans have not been certified. Following the review, the Exchange may adopt market factor certification criteria for the next plan year to address market conditions that impact access to and affordability of health plans for individuals or employers who are eligible to purchase coverage on the Exchange. 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, as determined by the Exchange:
 1. cost-sharing;
 2. covered benefits;
 3. premiums;
 4. prescription drug formularies;
 5. provider networks; or
 6. 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.

Market factor certification criteria shall be developed in consultation with OIC and the Health Care Authority, and the Exchange shall consider comments from carriers, federally recognized tribes, licensed health insurance producers, and other health care stakeholders. The Exchange board president shall have voting power on any decision related to market factor certification criteria. The Governor's senior policy advisor on health shall only attend meetings related to market factor certification criteria as a nonvoting member.

Market factor certification criteria adopted under this subsection shall be:

- objectively defined, measurable, and consistently applied;
- applied uniformly to all carriers that offer or seek to offer qualified health plans on the exchange in the state;
- consistent with, and not duplicative of requirements or standards established by the commissioner related to rate review, network adequacy, solvency, or actuarial soundness;
- designed to complement and not conflict with applicable federal or state laws or regulations governing qualified health plans.

For plan year 2028 and later, market factor certification criteria shall be developed in accordance with the following timeline:

- by December 15th of the calendar year two years before the plan year in which the market factor certification criteria are to apply, the Exchange shall identify preliminary criteria and provide those criteria to OIC and the Governor;
- by January 15th of the calendar year before the plan year in which the market factor certification criteria are to apply, 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 31st;
- by January 31st of the calendar year before the plan year in which the market factor certification criteria are to apply, the Exchange shall publish the notice of the proposed market factor certification criteria on its website and distribute the notice electronically to any person requesting the notice. The notice shall include:
 1. an explanation of the proposed market factor certification criteria;
 2. the time, date, and place for a public hearing; and
 3. the procedures and timelines for submitting written comments and supporting information;
- no later than five business days before the publication of the final market factor certification criteria, the Exchange shall hold at least one public hearing;
- by March 1st of the calendar year before the plan year in which the market factor certification criteria are to apply, the Exchange shall provide written notice of the final market factor certification criteria to carriers that offer plans on the Exchange and publish the criteria on its website; and
- after March 1st of the calendar year before the plan year in which the market factor certification criteria are to apply, the Exchange may only modify the market factor certification criteria as necessary to respond to any applicable changes to state or federal laws or regulations. Any modification that impacts a carrier's preliminary health plan filings is only in effect if agreed to by OIC.

For plan year 2027, market factor certification criteria shall be developed in accordance with procedures established by the Exchange.

The Exchange may require a carrier that intends to offer qualified health plans on the

Exchange to submit information, including the carrier's proposed service areas, proposed plan offerings, and how the carrier intends to meet the market factor certification criteria.

A carrier may request a waiver of the market factor certification criteria. In evaluating a request for a waiver, the exchange may:

- review information that demonstrates the carrier attempted to meet the market factor certification criteria, such as information that the carrier made a good faith effort to contract with providers to establish an adequate network, the cost of the potential provider network, the direction and magnitude of premium impacts, legal prohibitions, or other barriers that impact the carrier's ability to offer coverage in certain service areas, and any impact on other service areas;
- request that the carrier submit information about service areas that would be in place with the market factor certification criteria and if the waiver was granted; and
- consider the totality of the proposed qualified health plans and the impact of granting or not granting the waiver on the interests of Washington State residents.

The exchange shall conclude any waiver determinations from any carrier that has requested a waiver prior to the carrier submitting preliminary health plan filings for the upcoming plan year to OIC.

Market factor certification criteria may not directly impose network participation requirements or reimbursement limits on hospitals or providers except as otherwise required by federal or state laws.

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

By July 1st of each year, beginning in 2030, the Exchange, in consultation with OIC and the Health Care Authority, shall submit to the Legislature a report that includes:

- the following information about the Exchange and the individual and small group market outside the Exchange:
 1. total enrollment;
 2. Subsidized and unsubsidized enrollment;
 3. health plan premiums; and
 4. number of people no longer eligible for Medicaid coverage and enrolling in a health plan;
- percentage of enrollees by county, who are enrolled in a qualified health plan on the Exchange and who receive federal premium tax credits, state premium assistance, or both;
- the number of market factor certification criteria waivers requested by a carrier and reasons for the request and granted by the Exchange; and

- other relevant information, as determined by the Exchange, OIC, or the Health Care Authority.

The initial report in 2030 shall include information for plan year 2028 and 2029.

Nothing in the act or in the market factor certification criteria shall create requirements that cause a health plan premium to be actuarially unsound.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (First Substitute):

- Gives the chair of the Exchange board voting power on decisions related to market factor criteria.
- Adds the Governor's health policy advisor as a nonvoting member of the board for meetings related to market factor criteria.
- Adds differences in prescription drug formularies to the list of factors to consider when developing market factor criteria.
- Clarifies that the market factor criteria must be objectively defined, consistently applied, and consistent with OIC regulations, federal and state standards.
- Adds licensed health insurance producers to the list of stakeholders the Exchange must consider comments from.
- Removes the submission of proposed rates from the information that a carrier may be required to submit as part of the certification process and clarifies that any rate information must be confidential until after rate filings are made public by OIC.
- Clarifies the criteria cannot impose network participation requirements or reimbursement limits on hospitals or providers.
- Requires the Exchange to submit an annual report beginning in 2030 with certain enrollment and market factor criteria data.
- Requires the Exchange and OIC to work with carriers and hospitals on a plan to increase market participation when there is a county with one or fewer carriers offering health plans.

Appropriation: None.

Fiscal Note: Requested on January 16, 2026.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony on Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This bill is designed to strengthen access to affordable coverage. It will ensure access in every county by requiring carriers to offer plans in underserved counties as a participation requirement in other areas. The bill

can be a step toward addressing access issue like what is currently happening in San Juan County. The Exchange should have more tools to manage the market and ensure meaningful choice. Other states have enhanced criteria above federal requirements and have not seen a significant exit from the market.

CON: Carriers are concerned about an expansion of the Exchange's authority without clear guidelines. The bill was not developed through a transparent process. The situation in San Juan County is unique because there are a limited number of providers in the area and it is difficult to build a network. There are currently no bare counties in the state. The bill does not address the underlying cost drivers for coverage. This bill could result in carriers exiting the market completely. Any new criteria should be static and not change year to year.

Persons Testifying: PRO: Senator Vandana Slatter, Prime Sponsor; Ingrid Ulrey, Washington Health Benefit Exchange; Karen Keiser, Washington Health Benefit Exchange; Emily Brice, Northwest Health Law Advocates; Ed Travalia; Lori Taylor, Health Insurance Northwest; Sara Abbott, Better Health Together; Jim Freeburg, Patient Coalition of Washington; Jane Beyer, Office of the Insurance Commissioner; Margurite Ro, AARP Washington.

CON: Christine Brewer, Premera Blue Cross; David Foster, Assoc of WA Healthcare Plans; Andrea Davis, Coordinated Care; Jennifer Muhm, Cambia Health Solutions; Chris Bandoli, National Association of Insurance and Financial Advisors Washington.

Persons Signed In To Testify But Not Testifying: No one.