Multiple Agency Fiscal Note Summary

Bill Number: 5629 E S SB	**Title:** Prosthetic limb coverage

Estimated Cash Receipts

Agency Name	2025-27			2027-29			2029-31		
	GF-State	NGF-Outlook	Total	GF-State	NGF-Outlook	Total	GF-State	NGF-Outlook	Total
Washington State Health Care Authority	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Total $	0	0	0	0	0	0	0	0	0

Estimated Operating Expenditures

Agency Name	2025-27				2027-29				2029-31			
	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total
Washington State Health Care Authority	Non-zero but indeterminate cost and/or savings. Please see discussion.											
Office of Insurance Commissioner	.3	0	0	94,867	.1	0	0	19,726	.1	0	0	19,726
Total $	0.3	0	0	94,867	0.1	0	0	19,726	0.1	0	0	19,726

Estimated Capital Budget Expenditures

Agency Name	2025-27			2027-29			2029-31		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Washington State Health Care Authority	.0	0	0	.0	0	0	.0	0	0
Office of Insurance Commissioner	.0	0	0	.0	0	0	.0	0	0
Total $	0.0	0	0	0.0	0	0	0.0	0	0

Estimated Capital Budget Breakout

Prepared by: Jason Brown, OFM	**Phone:** (360) 742-7277	**Date Published:** Final 3/26/2025

FNPID 74537

FNS029 Multi Agency rollup

Individual State Agency Fiscal Note

Bill Number: 5629 E S SB	Title: Prosthetic limb coverage	Agency: 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

Non-zero but indeterminate cost and/or savings. Please see discussion.

Estimated Operating Expenditures from:

Non-zero but indeterminate cost and/or savings. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Amanda Cecil	Phone: 360-786-7460	Date: 03/14/2025
Agency Preparation:	Sarah Domai	Phone: 360-725-0000	Date: 03/19/2025
Agency Approval:	Tanya Deuel	Phone: 360-725-0908	Date: 03/19/2025
OFM Review:	Marcus Ehrlander	Phone: (360) 489-4327	Date: 03/24/2025

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

See attached narrative.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

See attached narrative.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

See attached narrative.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Non-zero but indeterminate cost and/or savings. Please see discussion.

III. B - Expenditures by Object Or Purpose

Non-zero but indeterminate cost and/or savings. Please see discussion.

III. C - Operating FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.*

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

HCA Fiscal Note

Bill Number: **5629 ES SB** HCA Request #: 25-164 Title: **Coverage requirements for prosthetic limbs and custom orthotic braces**

Part I: Estimates

☐ No Fiscal Impact

Estimated Cash Receipts to:

Estimated Operating Expenditures from:

Estimated Capital Budget Impact:
NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Bill Number: **5629 ES SB** HCA Request #: 25-164 Title: **Coverage requirements for prosthetic limbs and custom orthotic braces**

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

This version of the bill differs from the original bill in the following ways:

- Removes Section 2, which amends RCW 41.05.017 (State Health Care Authority - Provisions applicable to health plans offered under this chapter), to require health plans renewed after January 1, 2026, to provide coverage for one or more prostheses per limb and custom orthotic braces per limb including instruction, services, supplies, repairs, and replacement.
- Explicitly states that the provisions apply to non-grandfathered group health plans except:
  - Small group health plans
  - Health plans offered to public employees and their dependents under RCW 41.05

Note: A fiscal note was not requested for SSB 5629

Section 1 adds a new section to RCW 48.43 (Insurance Reform) requiring non-grandfathered group health plans other than those considered small group health plans or those offered to public employees and their dependents, issued on or renewed after January 1, 2026, to provide coverage for one or more prostheses per limb and custom orthotic braces per limb as determined medically necessary, to allow:

- Completing activities of daily living or essential job-related activities
- Performing physical activities that maximize the enrollee's lower and/or upper limb function

These provisions do not apply to health plans considered small group health plans or those offered to public employees and their dependents under RCW 41.05 (State Health Care Authority).

Section 1(2) requires that coverage include:

- Necessary materials to use the device
- Instructions for proper use
- Reasonable repairs or replacement devices

Section 1(3) requires that coverage for replacement of a prosthetic or custom orthotic device or any parts not be subject to continuous use or useful lifetime restrictions if the treating health care provider determines necessity due to:

- A physiological change in the member
- An irreparable change in the device or related part's condition
- The cost to repair a device or replacement part would exceed 60 percent of the cost of a replacement device or of the replacement part

Health care provider confirmation may be required if the device or part being replaced is less than three years old.

Section 1(4) prohibits health plans from denying coverage of prosthetic or orthotic coverage for members with a disability that would be otherwise be covered for those without a disability seeking to restore or maintain the ability to perform the same physical activity.

Section 1(5) allows health plans to apply normal utilization and prior authorization practices to the coverage of this benefit and requires health plans to issue denials of coverage in writing.

Bill Number: **5629 ES SB** HCA Request #: 25-164 Title: **Coverage requirements for prosthetic limbs and custom orthotic braces**

Section 1(6) requires that payment and coverage are at least equivalent to that of Medicare for the same or similar covered device.

Section 1(7) requires carriers to report the number of claims and total amount of claims paid in the state for services covered by this section for plan years 2026 and 2027 to the office of the insurance commissioner (OIC) by December 1, 2028.

II. B - Cash Receipts Impact

Indeterminate cash receipts impact.

Based on carrier feedback from Regence, the self-insured Uniform Medical Plans (UMP) plans' third-party administrator (TPA), HCA assumes that this bill could result in increased costs to the state, through impacts to the future UMP bid rates and the employer medical contribution (the state's contribution towards benefits for employees under the PEBB and SEBB programs). Any increase in expenditure is assumed to require a parallel increase in revenue by an increase in the PEBB and SEBB funding rates.

II. C – Expenditures

Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) Program Impacts:

Indeterminate fiscal impact.

HCA assumes that this bill could result in additional state costs resulting from administrative and coverage changes required for Regence's book-of-business (BOB), which may include changes to the state's self-insured Uniform Medical Plans (UMP).

Section 1 adds a new section to RCW 48.43 (Insurance Reform) requiring non-grandfathered health plans renewed after January 1, 2026, to provide coverage for one or more prostheses per limb and custom orthotic braces per limb including instruction, services, supplies, repairs, and replacement. These provisions do not apply to health plans considered small group health plans or those offered to public employees and their dependents under RCW 41.05 (State Health Care Authority).

Self-Insured Plan Impact and State Costs

Although the amended language does not directly apply to the self-insured Uniform Medical Plans (UMP) offered to PEBB and SEBB programs under RCW 41.05 (State Health Care Authority), this bill's requirements could lead to increased state costs via changes to Regence's BOB coverage requirements.

Feedback from Regence, UMP's third-party administrator (TPA), indicated that the bill may result in fiscal impact but these impacts are unknown at this time. Because the bill applies to large group fully-insured health plans, should UMP require customized benefit design, Regence may have to set up custom benefit administration for UMP. Any benefit or coverage changes to Regence's Book of Business (BoB) that require custom UMP provisions could result in increased administrative costs needed to maintain coverage standards for UMP or a fee schedule

change for prosthetics and orthotics coverage. Regence did not provide a cost estimate at the time, but noted that the bill "has a very low estimated pricing" to their fully-insured lines of business.

It's important to note that any increases in projected claims liability in UMP is assumed to impact the underlying trends, bid rates and projected state expenditure related to the employer contribution toward PEBB and SEBB employee premiums, known as the EMC. The EMC is calculated using the non-Medicare UMP Classic (PEBB) and UMP Achieve 2 (SEBB) plan bid rates. As plan cost liability increases in each of these plans, the State's contribution toward employee medical premiums is also expected to increase.

Fully-Insured Health Plans

As RCW 48.43 governs the PEBB and SEBB fully-insured health plans, the requirements set forth by this legislation would result in a change to current benefit coverage levels in the PEBB and SEBB programs for the Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Northwest, and the SEBB-only Premera plan offerings.

RCW 48.43.290 (Coverage for prescribed durable medical equipment and mobility enhancing equipment—Sales and use taxes—Definitions) sets a durable medical equipment and mobility enhancing equipment benefit standard that is applicable to all plans offered to employees under the PEBB and SEBB Programs. Section 1 requires fully-insured health plans to expand coverage to include devices that "maximize the enrollee's lower and/or upper limb function" and ensure their definitions of "prosthetic limb", "prosthesis", and "custom orthotic brace" align with those in Section 1(8). Both Kaiser and Premera currently cover custom orthotic devices when billed with a diabetes diagnosis. They have indicated that the bill's provisions may require updating coverage to include more than one prosthetic or orthotic device and expanding custom orthotics coverage to include those not associated with a diabetes diagnosis.

Respectively, Sections 1(3) and 1(4) prohibit health plans from imposing continuous use or useful lifetime restrictions on replacement devices and denying coverage for prosthetic or orthotic benefits for members with a disability that would otherwise be covered for non-disabled persons. However, Section 1(5) allow health plans to implement cost containment measures through utilization management and prior authorization practices.

Based on carrier feedback from Kaiser, fully-insured health plan bid rates are expected to increase by 0.5%-2% annually. The updated bid rates reflect costs associated with an expected utilization increase and the benefit's inclusion of custom orthotic coverage outside of a diabetes diagnosis. As a result of the change, health plans may offset costs by increasing member premiums. Premera did not indicate whether provisions related to additional prosthetics and orthotics coverage would have any impact on future bid rates.

PEBB Medicare Plan Impacts

UMP Classic Medicare is a coordination of benefits (COB) plan offering; that is, for services covered by Medicare UMP pays secondary to Medicare and resulting plan liability is muted given primary payments. Because DME, the category in which prostheses and orthotics fall under, is considered a Medicare-covered service, Medicare acts as the primary payer for these service types. Therefore, there is no assumed resulting fiscal impact, and no assumed increase to retiree premiums.

Bill Number: **5629 ES SB** HCA Request #: 25-164 Title: **Coverage requirements for prosthetic limbs and custom orthotic braces**

Because state laws are pre-empted by Federal laws for MA and Part D offerings, the benefit coverage requirements under this legislation do not apply to the fully-insured Medicare Advantage (MA) plans offered to Medicare eligible PEBB retirees.

Key Assumptions

Part III: Expenditure Detail

III. A - Operating Budget Expenditure

III. B - Expenditures by Object Or Purpose

III. C - Operating FTE Detail

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout:

NONE

IV. D - Capital FTE Detail:

NONE

Bill Number: **5629 ES SB** HCA Request #: 25-164 Title: **Coverage requirements for prosthetic limbs and custom orthotic braces**

Part V: New Rule Making Required

NONE

Individual State Agency Fiscal Note

Bill Number: 5629 E S SB	Title: Prosthetic limb coverage	Agency: 160-Office of Insurance Commissioner

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

	FY 2026	FY 2027	2025-27	2027-29	2029-31
FTE Staff Years	0.5	0.1	0.3	0.1	0.1
Account					
Insurance Commissioners Regulatory Account-State 138-1	85,004	9,863	94,867	19,726	19,726
Total $	85,004	9,863	94,867	19,726	19,726

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

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☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Amanda Cecil	Phone: 360-786-7460	Date: 03/14/2025
Agency Preparation:	Delika Steele	Phone: 360-725-7260	Date: 03/19/2025
Agency Approval:	Tom Zuvela	Phone: (800) 562-6900	Date: 03/19/2025
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 03/26/2025

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Section 1(1) requires nongrandfathered health plans other than small group and PEBB/SEBB health plans issued or renewed on or after January 1, 2026 to provide coverage for one or more prostheses per limb and custom orthotic braces per limb when medically necessary for the enrollee to participate in any of the following:

- complete activities of daily living or essential job-related activities; or
- perform physical activities, including but not limited to running, biking, swimming, and strength training, for maximizing the enrollee's lower limb function, upper limb function, or both.

Section 1(2) and 1(3) requires the coverage required in section 1(1) must also include coverage for materials, components, and related services necessary to use the devices for their intended purposes; instruction to the enrollee on using the devices; reasonable repair or replacement of the devices; and replacement or repair of a prosthetic limb or custom orthotic brace or any part of such devices without regard to continuous use or useful lifetime restrictions, if medically necessary because:

- of a change in the physiological condition of the patient;
- of an irreparable change in the condition of the device or a part of the device; or
- the device, or any part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Section 1(4) prohibits a health plan subject to section 1 from denying coverage for a prosthetic limb or custom orthotic brace for an enrollee with a disability if health care services would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

Section 1(5) requires any denials of coverage to be issued writing with an explanation for determining coverage was not medical necessity.

Section 1(6) requires health plans subject to section 1 to provide payment for coverage that is at least equal to the payment and coverage provided by Medicare.

Section 1(7) requires that, no later than July 1, 2028, each health carrier must report to the Office of the Insurance Commissioner (OIC) the number of claims and the total amount of claims paid in the state for the services required by this act for plan years 2026 and 2027. OIC must aggregate this data by plan year in a report and submit the report to the relevant committees of the Legislature by December 1, 2028.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

NONE.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Section 1(1) requires nongrandfathered health plans other than small group and PEBB/SEBB health plans issued or renewed on or after January 1, 2026 to provide coverage for one or more prostheses per limb and custom orthotic braces per limb when medically necessary for the enrollee to participate in any of the following:

- complete activities of daily living or essential job-related activities; or
- perform physical activities, including but not limited to running, biking, swimming, and strength training, for maximizing the enrollee's lower limb function, upper limb function, or both.

Section 1(2) and 1(3) requires the coverage required in section 1(1) to also include coverage for materials, components, and related services necessary to use the devices for their intended purposes; instruction to the enrollee on using the devices; reasonable repair or replacement of the devices; and replacement or repair of a prosthetic limb or custom orthotic brace or any part of such devices without regard to continuous use or useful lifetime restrictions, if medically necessary because:
- of a change in the physiological condition of the patient;
- of an irreparable change in the condition of the device or a part of the device; or
- the device, or any part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Section 1(4) prohibits a health plan subject to section 1 from denying coverage for a prosthetic limb or custom orthotic brace for an enrollee with a disability if health care services would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

Section 1(5) requires any denials of coverage to be issued writing with an explanation for determining coverage was not medical necessity.

Section 1(6) requires health plans subject to section 1 to provide payment for coverage that is at least equal to the payment and coverage provided by Medicare.

Section 1(7) requires that, no later than July 1, 2028, each health carrier must report to the Office of the Insurance Commissioner (OIC) the number of claims and the total amount of claims paid in the state for the services required by this act for plan years 2026 and 2027. OIC must aggregate this data by plan year in a report and submit the report to the relevant committees of the Legislature by December 1, 2028.

Section 1 will require additional review of health plan form filings to ensure health plans cover prosthetic limbs and custom orthotic braces. The OIC will require one-time costs, in FY2026, for 13 hours of a Functional Program Analyst 4 to update filing review standards and speed-to-market tools, update checklist documents and filing instructions, and train staff.

Additionally, the OIC receives an average of 300 large group health plan form filings each year and assumes the new review standards will result in an additional 20 minutes of review per form filing in FY2026 and an additional 5 minutes of review per form filing in FY2027 and thereafter. Therefore, the OIC requires 100 hours (3000 form filings x 20 minutes) in FY 2026 and 25 hours (300 form filings x 5 minutes) in FY2027 and thereafter of a Functional Program Analyst 3.

The provisions in section 1 add a new benefit mandate for health plans and will lead to an increase in enforcement actions related to coverage violations for prosthetic limbs and custom orthotic braces. The OIC anticipates an additional two enforcement actions per year as a result of this bill. Enforcement actions require the equivalent of approximately 40 hours per case. Therefore, the OIC requires 80 hours (2 cases x 40 hours) of an Insurance Attorney starting in FY2026 and thereafter. In addition, the OIC anticipates one-time costs, in FY2026, for 24 hours of an Insurance Attorney to provide advice related to this statutory change and its interpretation, implementation, and enforcement.

The changes to Section 1 of the bill will likely create additional referrals to review concerns about potential coverage violations. The OIC anticipates an additional ten referrals, which will require at least a Level 1 review that takes on average 4 hours to complete (20 hours total). Approximately three referrals will be moved to a Level 2 review, which take about 40 hours to complete (120 hours total). An estimated two referrals would be require further investigation, each taking about 80 hours (160 hours total). Therefore, the OIC anticipates one-time costs, in FY2026, for 300 hours of an Functional Program Analyst 3 to complete this work.

Section 1 would require 'normal' rulemaking, in FY2026, to revise WAC 284-43-5640. Subsection (7) may also require rulemaking to detail how carriers should submit their data to OIC.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2026	FY 2027	2025-27	2027-29	2029-31
138-1	Insurance Commissioners Regulatory Account	State	85,004	9,863	94,867	19,726	19,726
		Total $	85,004	9,863	94,867	19,726	19,726

III. B - Expenditures by Object Or Purpose

	FY 2026	FY 2027	2025-27	2027-29	2029-31
FTE Staff Years	0.5	0.1	0.3	0.1	0.1
A-Salaries and Wages	51,458	5,935	57,393	11,870	11,870
B-Employee Benefits	16,545	1,955	18,500	3,910	3,910
C-Professional Service Contracts					
E-Goods and Other Services	17,001	1,973	18,974	3,946	3,946
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total $	85,004	9,863	94,867	19,726	19,726

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2026	FY 2027	2025-27	2027-29	2029-31
Functional Program Analyst 3	78,468	0.3	0.0	0.1	0.0	0.0
Functional Program Analyst 4	86,712	0.1		0.0		
Insurance Attorney	95,652	0.1	0.1	0.1	0.1	0.1
Senior Policy Anlayst	131,328	0.2		0.1		
Total FTEs		0.5	0.1	0.3	0.1	0.1

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

NONE.

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

Section 1 would require 'normal' rulemaking, in FY2026, to revise WAC 284-43-5640. Subsection (7) may also require rulemaking to detail how carriers should submit their data to Office of Insurance Commissioner.