STATE OF NEW YORK

11406

IN ASSEMBLY

May 15, 2026

Introduced by COMMITTEE ON RULES -- (at request of M. of A. Ramos) -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, the social services law and the public health law, in relation to requiring certain health insurance coverage for prostheses and custom orthoses

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Subsection (i) of section 3216 of the insurance law is
2 amended by adding a new paragraph 42 to read as follows:
3 (42) (A) Every policy that provides coverage for hospital, medical or
4 surgical expenses shall include coverage for prosthetic and orthotic
5 devices that equals the coverage and payment provided for by federal
6 laws and regulations for the aged and disabled pursuant to 42 U.S.C.,
7 sections 1395k, 1395l and 1395m and 42 C.F.R., sections 414.202,
8 414.210, 414.228 and 410.100, and any successor regulations, including
9 payment at a rate no less than the current quarter's medicare durable
10 medical equipment, prosthetics, orthotics and supplies fee schedule
11 established by the centers for medicare and medicaid services for pros-
12 thetic and orthotic devices and services.
13 (B) Coverage provided under this paragraph shall include:
14 (i) a prosthetic or orthotic device determined by the enrollee's
15 health care provider to be the most appropriate model that adequately
16 meets the medical needs of such enrollee;
17 (ii) a prosthetic or custom orthotic device determined by the
18 enrollee's health care provider to be the most appropriate model that
19 meets the medical needs of such enrollee for purposes of performing
20 physical activities, including, but not limited to, running, biking,
21 swimming, strength training, and to maximize such enrollee's whole-body
22 health and lower and/or upper limb function;
23 (iii) a prosthetic or custom orthotic device determined by the
24 enrollee's health care provider to be the most appropriate model that
25 meets the medical needs of such enrollee for purposes of showering or
26 bathing;

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD15475-02-6

1 (iv) all materials and components necessary for the use of the
2 prostheses and orthoses;
3 (v) instruction to the enrollee on using the device; and
4 (vi) with respect to the prostheses and orthoses covered under items
5 (i), (ii), and (iii) of this subparagraph, the medically necessary
6 repair or replacement of such prosthetic or orthotic device.
7 (C) For an enrollee to receive a prosthesis or orthosis under items
8 (i), (ii), and (iii) of subparagraph (B) of this paragraph, the treating
9 health care provider shall be required to determine whether the addi-
10 tional prosthetic or custom orthotic device is necessary to enable such
11 enrollee to engage in physical activities, as applicable, including, but
12 not limited to, running, biking, swimming, strength training, showering,
13 bathing, and to maximize enrollee's whole-body health and lower and/or
14 upper limb function.
15 (D) Every policy that is delivered, issued for delivery or renewed in
16 this state that provides coverage for prosthetic and custom orthotic
17 devices shall consider such devices habilitative or rehabilitative bene-
18 fits for the purposes of any state or federal requirement for coverage
19 of essential health benefits.
20 (E) An insurer shall not deny a prosthetic or orthotic benefit for an
21 individual with limb loss or absence that would otherwise be covered for
22 a non-disabled individual seeking medical or surgical intervention to
23 restore or maintain the ability to perform the same physical activity.
24 (F) Prosthetic and custom orthotic device coverage shall not be
25 subject to separate financial requirements that are applicable only with
26 respect to that coverage. Cost-sharing may be imposed on prosthetic or
27 custom orthotic devices; provided, however, that any cost-sharing
28 requirements shall not be more restrictive than the cost-sharing
29 requirements applicable to coverage for inpatient physician and surgical
30 services.
31 (G) (i) If coverage for prosthetic or custom orthotic devices is
32 provided, payment shall be made for the replacement of such prosthetic
33 or custom orthotic device or for the replacement of any part of such
34 devices, without regard to continuous use or useful lifetime
35 restrictions, if an ordering health care provider determines that the
36 provision of a replacement device, or a replacement part of such a
37 device, is necessary because of any of the following:
38 (1) a change in the physiological condition of the enrollee;
39 (2) an irreparable change in the condition of the device or in a part
40 of such device; or
41 (3) the condition of the device, or the part of the device requires
42 repairs and the cost of such repairs would be more than sixty percent of
43 the cost of a replacement device or of the part being replaced.
44 (ii) Confirmation from a prescribing health care provider may be
45 required if the prosthetic or custom orthotic device or part being
46 replaced is less than three years old.
47 § 2. Subsection (l) of section 3221 of the insurance law is amended by
48 adding a new paragraph 24 to read as follows:
49 (24) (A) Every group or blanket policy delivered or issued for deliv-
50 ery in this state that provides coverage for hospital, medical or surgi-
51 cal expenses shall include coverage for prosthetic and orthotic devices
52 that equals the coverage and payment provided for by federal laws and
53 regulations for the aged and disabled pursuant to 42 U.S.C., sections
54 1395k, 1395l and 1395m and 42 C.F.R., sections 414.202, 414.210, 414.228
55 and 410.100, and any successor regulations, including payment at a rate
56 no less than the current quarter's medicare durable medical equipment,

prosthetics, orthotics and supplies fee schedule established by the centers for medicare and medicaid services for prosthetic and orthotic devices and services.

(B) Coverage provided under this paragraph shall include:

(i) a prosthetic or orthotic device determined by the enrollee's health care provider to be the most appropriate model that adequately meets the medical needs of such enrollee;

(ii) a prosthetic or custom orthotic device determined by the enrollee's health care provider to be the most appropriate model that meets the medical needs of such enrollee for purposes of performing physical activities, including, but not limited to, running, biking, swimming, strength training, and to maximize such enrollee's whole-body health and lower and/or upper limb function;

(iii) a prosthetic or custom orthotic device determined by the enrollee's health care provider to be the most appropriate model that meets the medical needs of such enrollee for purposes of showering or bathing;

(iv) all materials and components necessary for the use of the prostheses and orthoses;

(v) instruction to the enrollee on using the device; and

(vi) with respect to the prostheses and orthoses covered under items (i), (ii), and (iii) of this subparagraph, the medically necessary repair or replacement of such prosthetic or orthotic device.

(C) For an enrollee to receive a prosthesis or orthosis under items (i), (ii), and (iii) of subparagraph (B) of this paragraph, the treating health care provider shall be required to determine whether the additional prosthetic or custom orthotic device is necessary to enable such enrollee to engage in physical activities, as applicable, including, but not limited to, running, biking, swimming, strength training, showering, bathing, and to maximize enrollee's whole-body health and lower and/or upper limb function.

(D) Every group or blanket policy delivered, issued for delivery or renewed in this state that provides coverage for prosthetic and custom orthotic devices shall consider such devices habilitative or rehabilitative benefits for the purposes of any state or federal requirement for coverage of essential health benefits.

(E) An insurer shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a non-disabled individual seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

(F) Prosthetic and custom orthotic device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. Cost-sharing may be imposed on prosthetic or custom orthotic devices; provided, however, that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to coverage for inpatient physician and surgical services.

(G) (i) If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of such prosthetic or custom orthotic device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(1) a change in the physiological condition of the enrollee;

1 (2) an irreparable change in the condition of the device or in a part
2 of such device; or
3 (3) the condition of the device, or the part of the device requires
4 repairs and the cost of such repairs would be more than sixty percent of
5 the cost of a replacement device or of the part being replaced.
6 (ii) Confirmation from a prescribing health care provider may be
7 required if the prosthetic or custom orthotic device or part being
8 replaced is less than three years old.
9 § 3. Section 4303 of the insurance law is amended by adding a new
10 subsection (yy) to read as follows:
11 (yy) (1) Every policy that provides coverage for hospital, medical or
12 surgical expenses shall include coverage for prosthetic and orthotic
13 devices that equals the coverage and payment provided for by federal
14 laws and regulations for the aged and disabled pursuant to 42 U.S.C.,
15 sections 1395k, 1395l and 1395m and 42 C.F.R., sections 414.202,
16 414.210, 414.228 and 410.100, and any successor regulations, including
17 payment at a rate no less than the current quarter's medicare durable
18 medical equipment, prosthetics, orthotics and supplies fee schedule
19 established by the centers for medicare and medicaid services for pros-
20 thetic and orthotic devices and services.
21 (2) Coverage provided under this subsection shall include:
22 (A) a prosthetic or orthotic device determined by the enrollee's
23 health care provider to be the most appropriate model that adequately
24 meets the medical needs of such enrollee;
25 (B) a prosthetic or custom orthotic device determined by the
26 enrollee's health care provider to be the most appropriate model that
27 meets the medical needs of such enrollee for purposes of performing
28 physical activities, including, but not limited to, running, biking,
29 swimming, strength training, and to maximize such enrollee's whole-body
30 health and lower and/or upper limb function;
31 (C) a prosthetic or custom orthotic device determined by the
32 enrollee's health care provider to be the most appropriate model that
33 meets the medical needs of such enrollee for purposes of showering or
34 bathing;
35 (D) all materials and components necessary for the use of the
36 prostheses and orthoses;
37 (E) instruction to the enrollee on using the device; and
38 (F) with respect to the prostheses and orthoses covered under subpara-
39 graphs (A), (B), and (C) of this paragraph, the medically necessary
40 repair or replacement of such prosthetic or orthotic device.
41 (3) For an enrollee to receive a prosthesis or orthosis under subpara-
42 graphs (A), (B), and (C) of paragraph two of this subsection, the treat-
43 ing health care provider shall be required to determine whether the
44 additional prosthetic or custom orthotic device is necessary to enable
45 such enrollee to engage in physical activities, as applicable, includ-
46 ing, but not limited to, running, biking, swimming, strength training,
47 showering, bathing, and to maximize enrollee's whole-body health and
48 lower and/or upper limb function.
49 (4) Every policy delivered, issued for delivery or renewed in this
50 state that provides coverage for prosthetic and custom orthotic devices
51 shall consider such devices habilitative or rehabilitative benefits for
52 the purposes of any state or federal requirement for coverage of essen-
53 tial health benefits.
54 (5) An insurer shall not deny a prosthetic or orthotic benefit for an
55 individual with limb loss or absence that would otherwise be covered for

1 a non-disabled individual seeking medical or surgical intervention to
2 restore or maintain the ability to perform the same physical activity.
3 (6) Prosthetic and custom orthotic device coverage shall not be
4 subject to separate financial requirements that are applicable only with
5 respect to that coverage. Cost-sharing may be imposed on prosthetic or
6 custom orthotic devices; provided, however, that any cost-sharing
7 requirements shall not be more restrictive than the cost-sharing
8 requirements applicable to coverage for inpatient physician and surgical
9 services.
10 (7) (A) If coverage for prosthetic or custom orthotic devices is
11 provided, payment shall be made for the replacement of such prosthetic
12 or custom orthotic device or for the replacement of any part of such
13 devices, without regard to continuous use or useful lifetime
14 restrictions, if an ordering health care provider determines that the
15 provision of a replacement device, or a replacement part of such a
16 device, is necessary because of any of the following:
17 (i) a change in the physiological condition of the enrollee;
18 (ii) an irreparable change in the condition of the device or in a part
19 of such device; or
20 (iii) the condition of the device, or the part of the device requires
21 repairs and the cost of such repairs would be more than sixty percent of
22 the cost of a replacement device or of the part being replaced.
23 (B) Confirmation from a prescribing health care provider may be
24 required if the prosthetic or custom orthotic device or part being
25 replaced is less than three years old.
26 § 4. Subdivision 4 of section 364-j of the social services law is
27 amended by adding a new paragraph (x) to read as follows:
28 (x) A managed care provider shall provide or arrange, directly or
29 indirectly, including by referral, for access to and coverage of
30 services for the provision of prosthetic and orthotic devices to ensure
31 access to medically necessary clinical care. Such access shall include,
32 but not be limited to, prosthetic and custom orthotic devices and tech-
33 nology from no less than two distinct prosthetic and custom orthotic
34 providers within the managed care provider's network. In the event that
35 medically necessary covered prosthetics and orthotics are not available
36 from an in-network provider, such managed care provider shall establish
37 and maintain processes to refer a participant to an out-of-network
38 provider and shall fully reimburse such out-of-network provider at a
39 mutually agreed upon rate reduced by any participant cost-sharing deter-
40 mined on an in-network basis.
41 § 5. Subsection (a) of section 4902 of the insurance law is amended by
42 adding a new paragraph 17 to read as follows:
43 (17) When conducting utilization review for the purposes of determin-
44 ing health care coverage for prosthetic and orthotic devices, a utiliza-
45 tion review agent shall conduct such review in a nondiscriminatory
46 manner and not deny coverage for habilitative or rehabilitative bene-
47 fits, including prosthetics or orthotics, solely on the basis of an
48 insured's actual or perceived disability.
49 § 6. The public health law is amended by adding a new section 4406-j
50 to read as follows:
51 § 4406-j. Prosthetic and orthotic device coverage. No health mainte-
52 nance organization subject to this article shall, by contract, written
53 policy, or procedure, limit a patient enrollee's access to and coverage
54 of services for the provision of prosthetic and orthotic devices if such
55 services are covered pursuant to paragraph forty-two of subsection (i)
56 of section three thousand two hundred sixteen of the insurance law,

paragraph twenty-four of subsection (l) of section three thousand two hundred twenty-one of the insurance law, or subsection (yy) of section four thousand three hundred three of the insurance law; provided, however, that such patient enrollee's access to such services are otherwise subject to the terms and conditions of the plan under which such patient enrollee is covered.

§ 7. Section 345 of the insurance law, as added by section 12 of part YY of chapter 56 of the laws of 2020, is amended to read as follows:

§ 345. Health care claims reports. An insurer authorized to write accident and health insurance in the state, a corporation organized pursuant to article forty-three of this chapter, or a health maintenance organization certified pursuant to article forty-four of the public health law shall report to the superintendent quarterly and annually on health care claims payment performance with respect to comprehensive health insurance coverage. The reports shall be submitted in the manner and form prescribed by the superintendent after consultation with representatives of insurers and health care providers but at minimum shall include the number and dollar value of health care claims by major line of business and categorized as follows: health care claims received, health care claims paid, health care claims pended and health care claims denied during the respective quarter or year. **Such reports shall also include the number of claims filed and the total amount of claims paid in the state of New York for the services required by paragraph forty-two of subsection (i) of section three thousand two hundred sixteen of this chapter, paragraph twenty-four of subsection (l) of section three thousand two hundred twenty-one of this chapter, subsection (yy) of section four thousand three hundred three of this chapter, or section forty-four hundred six-j of the public health law.** The data shall be provided in the aggregate and by major category of health care provider. The reports should address any patterns or suspected areas of revenue maximization that may have contributed to the number of denials. The reports shall be due to the superintendent no later than forty-five days after the end of the respective quarter or year and shall be made publicly available including on the department's website. The superintendent, in conjunction with the commissioner of health, may promulgate regulations requiring additional reporting requirements on insurers, corporations, or health maintenance organizations or health care providers to assess the effectiveness of the payment policies set forth in this section, which may be informed by the administrative simplification workgroup authorized by subsection (k) of section three thousand two hundred twenty-four-a of this chapter.

§ 8. This act shall take effect January 1, 2027 and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date; provided, however, that the amendments to section 364-j of the social services law made by section four of this act, shall not affect the repeal of such section and shall be deemed repealed therewith. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.