

# STATE OF NEW YORK

11406--A

## 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 -- committee  
discharged, bill amended, ordered reprinted as amended and recommitted  
to said committee

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 Assem-  
bly, 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 at a rate no less than the current quarter's medicare durable  
6 medical equipment, prosthetics, orthotics and supplies fee schedule  
7 established by the centers for medicare and medicaid services for pros-  
8 thetic and orthotic devices and services.

9 (B) Coverage provided under this paragraph shall include:

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

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

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

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

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

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

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

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

12 (D) Every policy that is delivered, issued for delivery or renewed in  
13 this state that provides coverage for prosthetic and custom orthotic  
14 devices shall consider such devices habilitative or rehabilitative bene-  
15 fits for the purposes of any state or federal requirement for coverage  
16 of essential health benefits.

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

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

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

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

36 (2) an irreparable change in the condition of the device or in a part  
37 of such device; or

38 (3) the condition of the device, or the part of the device requires  
39 repairs and the cost of such repairs would be more than sixty percent of  
40 the cost of a replacement device or of the part being replaced.

41 (ii) Confirmation from a prescribing health care provider may be  
42 required if the prosthetic or custom orthotic device or part being  
43 replaced is less than three years old.

44 § 2. Subsection (1) of section 3221 of the insurance law is amended by  
45 adding a new paragraph 24 to read as follows:

46 (24) (A) Every group or blanket policy delivered or issued for deliv-  
47 ery in this state that provides coverage for hospital, medical or surgi-  
48 cal expenses shall include coverage for prosthetic and orthotic devices  
49 at a rate no less than the current quarter's medicare durable medical  
50 equipment, prosthetics, orthotics and supplies fee schedule established  
51 by the centers for medicare and medicaid services for prosthetic and  
52 orthotic devices and services.

53 (B) Coverage provided under this paragraph shall include:

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

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

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

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

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

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

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

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

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

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

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

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

49 (2) an irreparable change in the condition of the device or in a part  
50 of such device; or

51 (3) the condition of the device, or the part of the device requires  
52 repairs and the cost of such repairs would be more than sixty percent of  
53 the cost of a replacement device or of the part being replaced.

54 (ii) Confirmation from a prescribing health care provider may be  
55 required if the prosthetic or custom orthotic device or part being  
56 replaced is less than three years old.

1 § 3. Section 4303 of the insurance law is amended by adding a new  
2 subsection (yy) to read as follows:

3 (yy) (1) Every policy that provides coverage for hospital, medical or  
4 surgical expenses shall include coverage for prosthetic and orthotic  
5 devices at a rate no less than the current quarter's medicare durable  
6 medical equipment, prosthetics, orthotics and supplies fee schedule  
7 established by the centers for medicare and medicaid services for pros-  
8 thetic and orthotic devices and services.

9 (2) Coverage provided under this subsection shall include:

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

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

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

23 (D) all materials and components necessary for the use of the  
24 prostheses and orthoses;

25 (E) instruction to the enrollee on using the device; and

26 (F) with respect to the prostheses and orthoses covered under subpara-  
27 graphs (A), (B), and (C) of this paragraph, the medically necessary  
28 repair or replacement of such prosthetic or orthotic device.

29 (3) For an enrollee to receive a prosthesis or orthosis under subpara-  
30 graphs (A), (B), and (C) of paragraph two of this subsection, the treat-  
31 ing health care provider shall be required to determine whether the  
32 additional prosthetic or custom orthotic device is necessary to enable  
33 such enrollee to engage in physical activities, as applicable, includ-  
34 ing, but not limited to, running, biking, swimming, strength training,  
35 showering, bathing, and to maximize enrollee's whole-body health and  
36 lower and/or upper limb function.

37 (4) Every policy delivered, issued for delivery or renewed in this  
38 state that provides coverage for prosthetic and custom orthotic devices  
39 shall consider such devices habilitative or rehabilitative benefits for  
40 the purposes of any state or federal requirement for coverage of essen-  
41 tial health benefits.

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

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

53 (7) (A) If coverage for prosthetic or custom orthotic devices is  
54 provided, payment shall be made for the replacement of such prosthetic  
55 or custom orthotic device or for the replacement of any part of such  
56 devices, without regard to continuous use or useful lifetime

1 restrictions, if an ordering health care provider determines that the  
2 provision of a replacement device, or a replacement part of such a  
3 device, is necessary because of any of the following:

4 (i) a change in the physiological condition of the enrollee;

5 (ii) an irreparable change in the condition of the device or in a part  
6 of such device; or

7 (iii) the condition of the device, or the part of the device requires  
8 repairs and the cost of such repairs would be more than sixty percent of  
9 the cost of a replacement device or of the part being replaced.

10 (B) Confirmation from a prescribing health care provider may be  
11 required if the prosthetic or custom orthotic device or part being  
12 replaced is less than three years old.

13 § 4. Subdivision 4 of section 364-j of the social services law is  
14 amended by adding a new paragraph (x) to read as follows:

15 (x) A managed care provider shall provide or arrange, directly or  
16 indirectly, including by referral, for access to and coverage of  
17 services for the provision of prosthetic and orthotic devices to ensure  
18 access to medically necessary clinical care. Such access shall include,  
19 but not be limited to, prosthetic and custom orthotic devices and tech-  
20 nology from no less than two distinct prosthetic and custom orthotic  
21 providers within the managed care provider's network. In the event that  
22 medically necessary covered prosthetics and orthotics are not available  
23 from an in-network provider, such managed care provider shall establish  
24 and maintain processes to refer a participant to an out-of-network  
25 provider and shall fully reimburse such out-of-network provider at a  
26 mutually agreed upon rate reduced by any participant cost-sharing deter-  
27 mined on an in-network basis.

28 § 5. Subsection (a) of section 4902 of the insurance law is amended by  
29 adding a new paragraph 17 to read as follows:

30 (17) When conducting utilization review for the purposes of determin-  
31 ing health care coverage for prosthetic and orthotic devices, a utiliza-  
32 tion review agent shall conduct such review in a nondiscriminatory  
33 manner and not deny coverage for habilitative or rehabilitative bene-  
34 fits, including prosthetics or orthotics, solely on the basis of an  
35 insured's actual or perceived disability.

36 § 6. The public health law is amended by adding a new section 4406-j  
37 to read as follows:

38 § 4406-j. Prosthetic and orthotic device coverage. No health mainte-  
39 nance organization subject to this article shall, by contract, written  
40 policy, or procedure, limit a patient enrollee's access to and coverage  
41 of services for the provision of prosthetic and orthotic devices if such  
42 services are covered pursuant to paragraph forty-two of subsection (i)  
43 of section three thousand two hundred sixteen of the insurance law,  
44 paragraph twenty-four of subsection (l) of section three thousand two  
45 hundred twenty-one of the insurance law, or subsection (yy) of section  
46 four thousand three hundred three of the insurance law; provided, howev-  
47 er, that such patient enrollee's access to such services are otherwise  
48 subject to the terms and conditions of the plan under which such patient  
49 enrollee is covered.

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

52 § 345. Health care claims reports. An insurer authorized to write  
53 accident and health insurance in the state, a corporation organized  
54 pursuant to article forty-three of this chapter, or a health maintenance  
55 organization certified pursuant to article forty-four of the public  
56 health law shall report to the superintendent quarterly and annually on

1 health care claims payment performance with respect to comprehensive  
2 health insurance coverage. The reports shall be submitted in the manner  
3 and form prescribed by the superintendent after consultation with repre-  
4 sentatives of insurers and health care providers but at minimum shall  
5 include the number and dollar value of health care claims by major line  
6 of business and categorized as follows: health care claims received,  
7 health care claims paid, health care claims pending and health care  
8 claims denied during the respective quarter or year. Such reports shall  
9 also include the number of claims filed and the total amount of claims  
10 paid in the state of New York for the services required by paragraph  
11 forty-two of subsection (i) of section three thousand two hundred  
12 sixteen of this chapter, paragraph twenty-four of subsection (l) of  
13 section three thousand two hundred twenty-one of this chapter,  
14 subsection (yy) of section four thousand three hundred three of this  
15 chapter, or section forty-four hundred six-j of the public health law.  
16 The data shall be provided in the aggregate and by major category of  
17 health care provider. The reports should address any patterns or  
18 suspected areas of revenue maximization that may have contributed to the  
19 number of denials. The reports shall be due to the superintendent no  
20 later than forty-five days after the end of the respective quarter or  
21 year and shall be made publicly available including on the department's  
22 website. The superintendent, in conjunction with the commissioner of  
23 health, may promulgate regulations requiring additional reporting  
24 requirements on insurers, corporations, or health maintenance organiza-  
25 tions or health care providers to assess the effectiveness of the  
26 payment policies set forth in this section, which may be informed by the  
27 administrative simplification workgroup authorized by subsection (k) of  
28 section three thousand two hundred twenty-four-a of this chapter.

29 § 8. This act shall take effect January 1, 2027 and shall apply to all  
30 policies and contracts issued, renewed, modified, altered or amended on  
31 or after such date; provided, however, that the amendments to section  
32 364-j of the social services law made by section four of this act, shall  
33 not affect the repeal of such section and shall be deemed repealed ther-  
34 ewith. Effective immediately, the addition, amendment and/or repeal of  
35 any rule or regulation necessary for the implementation of this act on  
36 its effective date are authorized to be made and completed on or before  
37 such effective date.