STATE OF NEW YORK

10292

IN SENATE

May 11, 2026

Introduced by Sen. WEBB -- read twice and ordered printed, and when printed to be committed 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:

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 42 to read as follows:

(42) (A) Every policy that provides coverage for hospital, medical or surgical expenses shall include coverage for prosthetic and orthotic devices that equals the coverage and payment provided for by federal laws and regulations for the aged and disabled pursuant to 42 U.S.C., sections 1395k, 1395l and 1395m and 42 C.F.R., sections 414.202, 414.210, 414.228 and 410.100, and any successor regulations, including payment at a rate 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;

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

LBD15475-02-6

(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 policy that is 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;

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

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

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

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

(24) (A) Every group or blanket policy delivered or issued for delivery in this state that provides coverage for hospital, medical or surgical expenses shall include coverage for prosthetic and orthotic devices that equals the coverage and payment provided for by federal laws and regulations for the aged and disabled pursuant to 42 U.S.C., sections 1395k, 1395l and 1395m and 42 C.F.R., sections 414.202, 414.210, 414.228 and 410.100, and any successor regulations, including payment at a rate 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;

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

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

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

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

(yy) (1) Every policy that provides coverage for hospital, medical or surgical expenses shall include coverage for prosthetic and orthotic devices that equals the coverage and payment provided for by federal laws and regulations for the aged and disabled pursuant to 42 U.S.C., sections 1395k, 1395l and 1395m and 42 C.F.R., sections 414.202, 414.210, 414.228 and 410.100, and any successor regulations, including payment at a rate 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.

(2) Coverage provided under this subsection shall include:

(A) 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;

(B) 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;

(C) 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;

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

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

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

(3) For an enrollee to receive a prosthesis or orthosis under subparagraphs (A), (B), and (C) of paragraph two of this subsection, 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.

(4) Every 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.

(5) 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.

(6) 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.

(7) (A) 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:

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

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

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

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

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

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

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

(17) When conducting utilization review for the purposes of determining health care coverage for prosthetic and orthotic devices, a utilization review agent shall conduct such review in a nondiscriminatory manner and not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an insured's actual or perceived disability.

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

§ 4406-j. Prosthetic and orthotic device coverage. No health maintenance organization subject to this article shall, by contract, written policy, or procedure, limit a patient enrollee's access to and coverage of services for the provision of prosthetic and orthotic devices if such services are covered pursuant to paragraph forty-two of subsection (i) 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.