

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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(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 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;

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.

§ 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 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

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-
34ewith. 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.