2026 Regular Session

HOUSE BILL NO. 477

BY REPRESENTATIVE HEBERT

INSURANCE/HEALTH: Modifies provisions of law regarding health insurance coverage of prosthetic and custom orthotic devices and services

AN ACT

To enact R.S. 22:1049.1 and Part IX of Chapter 5-E of Title 40 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:1259.11, and to repeal R.S. 22:1049, relative to health insurance; to require coverage for prosthetic and custom orthotic devices and associated services; to establish criteria for medical necessity determinations; to delineate coverage standards, encompassing multiple devices, materials, components, repair, and replacement; to provide requirements for prior authorization and cost-sharing; to provide nondiscrimination provisions; to provide for network adequacy standards; to set reporting requirements; to provide for definitions; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1049.1 is hereby enacted to read as follows:

§1049.1. Coverage for prosthetic and custom orthotic devices and services

A. As used in this Section:

(1) "Accredited facility" means any entity that is accredited by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABCop) or by the Board for Orthotist/Prosthetist Certification (BOC) and that provides prosthetic devices or prosthetic services.

(2) "Advanced practice provider" means a healthcare professional who is licensed in this state and authorized under state law to evaluate patients and to prescribe orthotic and prosthetic devices within the provider's scope of practice.

(3) "Health coverage plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the Office of Group Benefits programs.

(4) "Prosthetic device" or "prosthesis" means an artificial limb designed to maximize function, stability, and safety of the patient. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

(5) "Prosthetic services" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It also includes any medically necessary clinical care.

(6) "Orthosis" means a custom-designed, custom-fabricated, custom-fitted, pre-fabricated, or modified device to treat a neuromusculoskeletal disorder or acquired condition.

(7) "Orthotic services" means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing a custom orthosis. Prosthetists, orthotic assistants, and orthotic fitters who are credentialed by a nationally recognized Orthotic, Prosthetic and Pedorthic certifying board or are licensed, if applicable, may be privileged based on written objective criteria to provide orthotic care. Certified or licensed pedorthists may be privileged based on written objective criteria to provide lower extremity orthotic care.

B. Any health coverage plan specified in Subsection P of this Section that is delivered, issued for delivery, renewed, or otherwise contracted for in this state on or after January 1, 2027, shall provide coverage for prosthetic and custom orthotic devices and services. At a minimum, such coverage shall equal the coverage and prevailing payment rates for prosthetic and orthotic devices provided under federal laws and regulations for older adults and persons with disabilities pursuant to 42 U.S.C. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100. Covered benefits shall be provided for more than one prosthesis or orthosis when medically necessary as further provided in this Section.

C. Eligibility for prosthetic and custom orthotic devices and services is based on medical necessity as determined by the enrollee's physician or other advanced practice provider. Medical necessity includes the most appropriate prosthesis or custom orthosis that adequately meets the medical needs of the enrollee to restore or maintain the ability to perform activities of daily living and essential job-related functions.

D. In addition to the device required pursuant to Subsection B of this Section, a prosthetic or custom orthotic device determined by the enrollee's prosthetic or orthotic care provider to be the most appropriate device to meet the enrollee's medical needs for purposes of performing physical activities including but not limited to running, biking, swimming, and strength training, shall be covered when the treating physician or other advanced practice provider determines that such device is necessary to enable the enrollee to engage in physical activity and to maximize whole-body health and lower or upper limb function.

E. In addition to the devices required pursuant to Subsections B and C of this Section, a prosthetic or custom orthotic device determined by the enrollee's prosthetic or orthotic care provider to be the most appropriate device to meet the enrollee's medical needs for purposes of showering or bathing shall be covered when the treating physician or other advanced practice provider determines that such

device is necessary to enable the enrollee to safely engage in bathing and showering and to maintain whole-body health and lower or upper-limb function.

F. Coverage required by this Section includes all materials and components necessary for the use of prosthetic and custom orthotic devices.

G. Coverage required by this Section includes instruction to the enrollee on the proper use of the prosthetic or custom orthotic device.

H. Coverage required by this Section includes medically necessary repair or replacement of a prosthetic or custom orthotic device. Payment shall be made for the replacement of a device or any part thereof, without regard to continuous use or useful lifetime restrictions, when an ordering healthcare provider determines that replacement is necessary due to 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 a part of the device.

(3) The condition of the device or part requires repairs, and the cost of such repairs would exceed sixty percent of the cost of a replacement device or part.

I. A health coverage plan may require confirmation from the prescribing healthcare provider if the prosthetic or custom orthotic device or part being replaced is less than three years old.

J. A health coverage plan that covers prosthetic and custom orthotic devices shall include in its evidence of coverage a description of the insured's rights under this Section. Any denial of coverage based on medical necessity shall be in writing and shall include clear reasoning and an explanation of how the request does not meet medical necessity standards. Any denial or limit of coverage based on a lack of medical necessity may be appealed in accordance with R.S. 22:3070 et seq. Medical necessity determinations shall consider information and recommendations from the treating physician in consultation with the enrollee, including information in the medical record of the treating orthotist or prosthetist and the results of a functional assessment. Such assessment shall consider but not be limited to all of the following:

(1) The insured's past history, including prior use of prosthetic or orthotic devices if applicable.

(2) The insured's current condition, including the status of the residual limb.

(3) The insured's desire to ambulate with respect to lower limb prosthetic devices, maximize upper limb function with respect to upper limb prosthetic devices, and the insured's desire and ability to use an orthosis to maintain functional abilities.

K. An individual health plan delivered, issued for delivery, or renewed in this state that covers prosthetic and custom orthotic devices shall consider these benefits rehabilitative and habilitative services and devices for purposes of any state or federal requirement for coverage of essential health benefits.

L. A health coverage plan may require prior authorization for prosthetic and custom orthotic devices and services in the same manner as other covered benefits, if such procedures are applied in a nondiscriminatory manner. Utilization review procedures shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or custom orthotics, solely on the basis of an insured's actual or perceived disability.

M. A health coverage plan may impose co-payments, deductibles, or coinsurance amounts on prosthetic and custom orthotic devices and services. Such cost-sharing shall not be greater than that applied to other benefits under the plan. Repair and replacement of prosthetic and custom orthotic devices shall be covered subject to cost-sharing that is no more restrictive than that applied to other benefits, unless necessitated by theft or loss.

N. A health coverage plan shall require that prosthetic and custom orthotic devices be provided by an accredited facility. The prescription for such prosthetic and custom orthotic services shall be issued by a licensed physician, and the provision of these services shall occur at an accredited facility.

O. Coverage required in accordance with this Section shall be aligned with, and not more restrictive than, the provisions applicable to other benefits within the health coverage plan. An insurer shall not deny a prosthetic or custom orthotic benefit to an individual with limb loss, limb absence, or limb impairment if such

benefits would otherwise be available to a non-disabled individual seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

P. A health coverage plan that provides coverage for prosthetic and custom orthotic services shall ensure access to medically necessary clinical care for prosthetic and custom orthotic devices and technology. There shall be a minimum of two distinct prosthetic and custom orthotic service providers within this state who are also part of the plan's authorized provider network. If medically necessary covered orthotic or prosthetic devices or services are not available from an in-network provider, the insurer shall establish and maintain a process to refer the enrollee to an out-of-network provider. The insurer shall reimburse that provider at a mutually agreed-upon rate, reduced only by the member's cost-sharing that would apply if the service were obtained from an in-network provider.

Q. Each carrier that issues a health plan subject to this Section shall report to the commissioner of insurance on its experience pursuant to this Section for plan years 2027-2028. The report shall be in a form prescribed by the commissioner of insurance and shall include the number of claims and the total amount of claims paid in this state for the services required by this Section. The commissioner of insurance shall aggregate this data by plan year in a report and submit the report to the House and Senate committees on insurance.

R. The provisions of this Section do not apply to limited benefit health insurance policies or contracts.

Section 2. Part IX of Chapter 5-E of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1259.11, is hereby enacted to read as follows:

PART IX. PROSTHETIC AND CUSTOM ORTHOTIC DEVICES AND SERVICES COVERAGE

§1259.11. Prosthetic and custom orthotic devices and services; Medicaid coverage

A. The Louisiana Medicaid program shall provide coverage for prosthetic and custom orthotic devices and services to an enrollee when such devices or

services are deemed medically necessary in accordance with the standards and clinical criteria set forth by the Medicaid program.

B. Coverage includes the devices, services, materials, components, instruction, repair, and replacement as delineated in R.S. 22:1049.1, including but not limited to services required to restore or maintain the ability to perform activities of daily living, essential job-related functions, and medically necessary physical activity. The definitions provided in R.S. 22:1049.1 apply to this Section unless the context clearly requires otherwise.

C. Pursuant to this Section, the secretary of the Louisiana Department of Health shall do all of the following:

(1) Submit to the Centers for Medicare and Medicaid Services all necessary state plan amendments.

(2) Promulgate all necessary rules and regulation in accordance with the Administrative Procedure Act.

(3) Take any other actions necessary to implement the provisions of this Chapter.

Section 3. R.S. 22:1049 is hereby repealed in its entirety.

Section 4. The coverage requirements provided by the provisions of R.S. 22:1049.1 as enacted by Section 1 of this Act shall apply to any health coverage plan delivered, issued for delivery, renewed, or otherwise contracted for in this state beginning January 1, 2027.

Section 5. The report required to be compiled and submitted to the commissioner of insurance as required by the provisions of R.S. 22:1409.1(Q) as enacted by Section 1 of this Act shall be due beginning July 1, 2029.

Section 6. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor, and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 477 Original 2026 Regular Session Hebert

Abstract: Mandates that health coverage plans provide comprehensive coverage for prosthetic and custom orthotic devices and associated services. This includes coverage for multiple devices, materials and components, instructional support, repairs and replacements when deemed medically necessary. Outlines protocols for medical necessity determinations, prior authorization processes, cost-sharing obligations, nondiscrimination provisions, network adequacy standards, relevant definitions, and reporting requirements. Excludes limited benefit health insurance policies or contracts. Establishes Medicaid coverage for prosthetic and custom orthotic devices and associated services.

Present law requires health coverage plans to provide coverage for prosthetic and orthotic devices. Defines "accredited facility", "health coverage plan", "prosthetic device", and "prosthetic services". Present law specifies that devices be deemed medically necessary and prescribed by a licensed physician. Present law authorizes health coverage plans to apply standard utilization review procedures and cost-sharing requirements to benefits. Provides that coverage for prosthetic and orthotic devices be subject to the same terms and conditions applicable to other medical and surgical benefits under the plan.

Proposed law repeals present law (R.S. 22:1049) and enacts proposed law (R.S. 22:1049.1) to require health coverage plans delivered, issued for delivery, renewed, or otherwise contracted for in La. on or after Jan. 1, 2027, to provide comprehensive coverage for prosthetic and custom orthotic devices and services. Proposed law mandates that coverage be at least equal to Medicare coverage and payment rates for devices and services. Proposed law ensures that multiple devices are covered when medically necessary.

Proposed law stipulates that eligibility for prosthetic and custom orthotic devices and services be based on medical necessity at the discretion of the treating physicians and practicing providers. Requires coverage for additional devices, materials, components, instructions, and the repair or replacement of devices when deemed medically necessary.

Proposed law mandates that health coverage plans incorporate a description outlining the rights of the insured in the evidence of coverage. Present law requires that insurers issue clear and reasonable written denials of coverage.

Proposed law establishes standards for medical necessity determinations and appeals. Requires that benefits be treated as rehabilitative and habilitative services for essential health benefits purposes.

Proposed law creates prior authorization procedures if applied in a nondiscriminatory manner. Prohibits denial of habilitative or rehabilitative benefits on the basis of disability. Authorizes cost-sharing but prohibits cost-sharing requirements that are more restrictive than those applied to other benefits.

Proposed law requires prosthetic and custom orthotic devices to be provided by an accredited facility and prescribed by a licensed physician. Prohibits insurers from implementing more restrictive standards for benefits compared to other benefits. Proposed law prevents the denial of benefits to individuals with limb loss or limb impairment when comparable benefits are accessible to non-disabled individuals.

Proposed law requires health coverage plans to ensure access to medically necessary clinical care and to maintain a network that includes at least two prosthetic and orthotic service providers. Requires referral to and reimbursement of out-of-network providers when medically necessary services are unavailable in-network.

Proposed law defines “accredited facility”, "advanced practice provider", “health coverage plan”, “prosthetic device”, “prosthetic services”, “orthosis”, and “orthotic services”.

Proposed law requires carriers to report to the commissioner of insurance by Jan. 1, 2029, on claims experience for plan years 2027–2028. Requires the commissioner to aggregate and report this information to the House and Senate committees on insurance by July 1, 2029.

Proposed law provides that the provisions of proposed law do not apply to limited benefit health insurance policies or contracts.

Proposed law requires the Louisiana Medicaid program to provide coverage for prosthetic and custom orthotic devices and services when medically necessary, in accordance with Medicaid standards and clinical criteria.

Proposed law requires the secretary of the La. Dept. of Health to submit necessary state plan amendments, promulgate implementing rules, and take other actions needed to carry out the law.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Adds R.S. 22:1049.1 and R.S. 40:1259.11; Repeals R.S. 22:1049)