HOUSE COMMITTEE AMENDMENTS

2026 Regular Session

Substitute for Original House Bill No. 477 by Representative Hebert as proposed by the House Committee on Insurance

This document reflects the content of a substitute bill but is not in a bill form; page numbers in this document DO NOT correspond to page numbers in the substitute bill itself.

To amend and reenact R.S. 22:1049 and to enact 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, relative to health insurance; to require coverage for prosthetic and 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 is hereby amended and reenacted to read as follows:

§1049. Requirement for coverage of prosthetic and orthotic devices and ~~prosthetic~~ services

A. ~~Notwithstanding the provisions of R.S. 22:1047 to the contrary, any~~ Any health coverage plan specified in Subsection ~~H~~ J of this Section which is issued for delivery, delivered, renewed, or otherwise contracted for in this state ~~on or after January 1, 2009~~, shall provide coverage of prosthetic and orthotic devices and prosthetic and orthotic services as further provided in this Section.

B. Eligibility and limits of coverage for prosthetic and orthotic devices and ~~prosthetic~~ services shall be determined by the health coverage plan in consultation with the enrollee's medical providers and their assessment of ~~based on~~ medical necessity. In determining medical necessity, the health coverage plan shall consider the recommendations by the insured's physician or advanced practice provider. Such recommendations shall be based on the most appropriate prosthesis or orthosis that

adequately meets the medical needs of the insured to restore or maintain the ability to perform activities of daily living and essential job-related functions. Such coverage shall, at a minimum, equal the coverage and prevailing payment rate for prosthetic and orthotic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. In accordance with Subsection C of this Section covered benefits shall be provided for more than one prosthesis or orthosis when determined by the health coverage plan to be medically necessary and may not exclude coverage for orthotic or prosthetic devices designed for physical activity or showering and bathing pursuant to blanket exclusions of items used for "recreation or leisure", "athletic or sports purposes", or "luxury or convenience". Any denial or limit of coverage based on lack of medical necessity may be appealed in accordance with ~~R.S. 22:1121~~ R.S. 22:1241 et seq. and R.S. 22:2431, et seq. and with respect to claim denials based on medical necessity, such denials shall be in writing and include clear reasoning and descriptions of how and why the request or claim does not meet medical necessity standards. Such medical necessity determination shall consider information and recommendation from the treating physician in consultation with the insured, including but not limited to information in the medical record of the treating orthotist or prosthetist, and the results of a functional ~~limit test~~ assessment. Such ~~test~~ assessment shall consider but not be limited to the following factors:

(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 and the nature of other medical problems.

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

C. (1) In addition to the primary prosthetic or orthotic device of the upper or lower extremity, the health coverage plan shall provide coverage for an additional upper or lower extremity prosthetic or orthotic device when:

(a) The treating physician or other advanced practice provider determines that the additional prosthesis or orthosis is necessary to enable the enrollee to engage in physical activities, as applicable, such as running, biking, swimming, strength training, showering, bathing, and to maximize the enrollee's whole-body health and lower and upper limb function.

(b) The single additional prosthetic or orthotic device is determined to be medically necessary by the health coverage plan as being the most appropriate device to meet the insured's medical needs for purposes of performing physical activities such as running, biking, swimming, strength training, and other similar activities.

(c) This Subsection does not require coverage for a replacement of the additional prosthetic or orthotic device of the upper or lower extremity unless determined by the health coverage plan, in consultation with the enrollee's medical providers, to be medically necessary.

(2) If neither the original prosthetic or orthotic devices described in Subsection B nor the additional upper or lower extremity prosthetic or orthotic device provided in Paragraph (C)(1) of this Section is sufficient to enable the insured to safely engage in bathing and showering, then in addition to those devices, a single additional prosthetic or orthotic device recommended by the insured's physician or other advanced practice provider for purposes of showering or bathing shall be covered when determined to be medically necessary to enable the enrollee to safely engage in those activities.

~~C.~~D. A health coverage plan may require prior authorization for prosthetic and orthotic devices and ~~prosthetic~~ services in the same manner that prior authorization is required for any other covered benefit, if such procedures are rendered 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.

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

~~D.~~E. A health coverage plan may impose co-payments, deductibles, or coinsurance amounts on prosthetic and orthotic devices and ~~prosthetic~~ services. The co-payments shall not be greater than the co-payments that apply to other benefits under the plan. ~~The repair and replacement of prosthetic devices also shall be covered subject to co-payments, coinsurance, and deductibles that are no more restrictive than the co-payments, coinsurance, and deductibles that apply to other benefits under the plan, unless necessitated by misuse or loss.~~

F.(1) The repair and replacement of prosthetic and orthotic devices also shall be covered subject to co-payments, coinsurance, and deductibles that are no more restrictive than the co-payments, coinsurance, and deductibles that apply to other benefits under the plan, unless necessitated by ~~misuse~~ theft or loss.

(2) Coverage of repair or replacement of prosthetic and orthotic devices, subject to coverage as outlined in Subsection B, of this Section shall meet medical necessity requirements of the health coverage plan, and be recommended by the treating healthcare provider.

(3) The treating healthcare provider may recommend that replacement of the device is required if any of the following apply:

(a) There is a change in the physiological condition of the enrollee.

(b) There is an irreparable change in the condition of the device or any component of the device.

(c) The condition of the device requires repairs that are too extensive to be cost effective in accordance with the health coverage plan's guidelines.

G. A health plan that provides coverage for prostheses or orthoses shall ensure access to medically necessary clinical care and to prostheses and custom orthoses from not less than two distinct prosthetic and orthotic providers in the managed care plan's provider network located in the state. In the event that medically

necessary covered orthoses and prostheses are not available from an in-network provider, the insurer shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

~~E.~~H. A health coverage plan shall include a requirement that prosthetic devices be provided by an accredited facility and a requirement that prosthetic services be prescribed by a licensed physician and provided by an accredited facility.

~~F.~~I. Coverage of prosthetic and orthotic devices and ~~prosthetic~~ services may be made subject to but no more restrictive than the provisions of a health coverage plan that apply to other benefits under the plan. An individual health plan that is delivered, issued for delivery, or renewed in this state that covers prostheses and custom orthoses shall consider these benefits rehabilitative and habilitative services and devices for purposes of any state or federal requirement for coverage of essential health benefits.

~~G.(1) A health coverage plan may apply an annual limit of benefits payable under this Section of no less than fifty thousand dollars per limb.~~

~~(2) This Subsection does not prohibit a health benefit plan from providing coverage that is greater or more favorable to an insured than the requirements of this Subsection.~~

~~(3) An insured may choose a prosthetic device that is priced higher than the benefit payable under the health benefit plan and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the provider of the device.~~

J. A health coverage plan subject to this Section shall report to the commissioner on its experience pursuant to this Section for plan years 2027-2028. The report shall be in a form prescribed by the commissioner and shall include the number of claims and the total amount of claims paid in this state for the services required under this Section. The commissioner shall aggregate this data by plan year in a report and submit the report to the House and Senate committees on insurance no later than July 1, 2029.

~~H~~K. As used in the Section:

(1) "Accredited facility" means any entity that is accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) 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 prescribe prosthetic and orthotic devices within the provider's scope of practice.

~~(2)~~(3) "Health coverage plan" shall mean 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) "Orthotic device" or "Orthosis" means a custom-designed, custom-fabricated, custom-fitted, or modified device to treat a neuromusculoskeletal disorder or acquired condition. For purposes of this Section, orthosis shall be limited to devices utilized for the upper or lower limbs.

(5) "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.

~~(3)~~(6) "Prosthetic device" or "prosthesis" means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic device or prosthesis also means an artificial medical device ~~that is not surgically implanted and~~

that is used to replace a missing limb. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

~~(4)~~(7) "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 shall also include any medically necessary clinical care.

~~H~~K. The provisions of this Section shall not apply to limited benefit health insurance or short-term 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, 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 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 regulations in accordance with the Administrative Procedure Act.

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

Section 3. The coverage requirements provided by the provisions of this Act as enacted by Section 1 of this Act shall apply to any new health coverage plan delivered, issued for delivery or otherwise contracted for in this state beginning on or after January 1, 2027. Any health coverage policy, contract, or plan in effect prior to January 1, 2027, shall convert to conform to the provisions of Section 1 of this Act upon renewal, on or before the renewal date, but no later than January 1, 2028.

Section 4. The report required to be compiled and submitted to the commissioner of insurance as required by the provisions of R.S. 22:1049(J) as enacted by Section 1 of this Act shall be due beginning July 1, 2029.

Section 5. 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 Draft 2026 Regular Session

Abstract: Modifies the requirements for health insurance coverage of prosthetic and custom orthotic devices and services. Specifies medical necessity standards, expands coverage for additional devices, and sets guidelines for prior authorization, repair and replacement services, and network access. Establishes annual benefit limits, outlines reporting requirements, and definitions. Mandates Medicaid coverage for prosthetic and custom orthotic devices and services.

Present law mandates that health coverage plans provide coverage for prosthetic and orthotic devices and services. It establishes guidelines for medical necessity, cost-sharing, repair and replacement, prior authorization, and provider accreditation. Additionally, it defines key terms while outlining limitations and exceptions.

Proposed law modifies medical necessity determinations to ensure consideration of recommendations from the treating physician or advanced practice provider, as well as input from the treating orthotist or prosthetist, including the outcomes of a functional assessment.

Proposed law requires that coverage be at least equivalent to the prevailing Medicare payment rate for prosthetic and orthotic devices. Furthermore, it mandates coverage for an

additional upper or lower extremity prosthetic or orthotic device, when medically necessary for physical activity, bathing, showering, or whole-body health.

Proposed law stipulates coverage for a separate bathing or showering device when neither the primary nor additional device facilitates safe bathing.

Proposed law permits prior authorization but forbids the denial of habilitative or rehabilitative benefits solely based on actual or perceived disability. Proposed law prohibits the denial of prosthetic or custom-orthotic benefits to individuals with limb loss when comparable benefits would be available to nondisabled individuals.

Proposed law allows for copayments, deductibles, and coinsurance that are no more restrictive than those applied to other benefits. Proposed law also mandates coverage for repair and replacement when medically necessary, which includes instances where the enrollee's physiological condition changes, the device is irreparably damaged, or when repair is not cost-effective.

Proposed law guarantees access to medically necessary prostheses and custom orthoses from a minimum of two distinct in-state providers. Proposed law stipulates that referral and full reimbursement (with the exception of in-network cost-sharing) is required when medically necessary devices are unavailable within the network.

Proposed law requires that prosthetic devices are supplied by an accredited facility and that prosthetic services are prescribed by a licensed physician. Proposed law stipulates that individual health plans must recognize prostheses and custom orthoses as rehabilitative and habilitative services for the purpose of essential health benefits.

Proposed law authorizes an annual benefit limit of no less than $50,000 per limb, allowing for more favorable coverage if applicable. Furthermore, it mandates that health coverage plans report claims data for the plan years 2027-2028 to the commissioner, with aggregated reporting due to legislative committees by July 1, 2029.

Proposed law directs the Louisiana Medicaid program to provide coverage for prosthetic and custom orthotic devices and services when medically necessary. Proposed law delineates coverage for devices, services, materials, components, instruction, repair, and replacement as specified in R.S. 22:1049.

Proposed law tasks the Department of Health with submitting state plan amendments, promulgating rules, and undertaking necessary actions for implementation. Coverage requirements are set to take effect for new plans beginning January 1, 2027, and for existing plans upon renewal, but no later than January 1, 2028. The reporting requirements will commence on July 1, 2029.

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

(Amends R.S. 22:1049; Adds R.S. 40:1259.11)