

2026 Regular Session

HOUSE BILL NO. 1235 (Substitute for House Bill No. 477 by Representative Hebert)

BY REPRESENTATIVES HEBERT, ADAMS, BAYHAM, BOUDREAUX, BOYD, BRASS, CHASSION, COX, FISHER, FREIBERG, JACKSON, MIKE JOHNSON, LAFLEUR, JACOB LANDRY, LARVADAIN, LYONS, MELERINE, MOORE, NEWELL, SPELL, TAYLOR, WALTERS, AND WILEY

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

1 AN ACT

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

11 Be it enacted by the Legislature of Louisiana:

12 Section 1. R.S. 22:1049 is hereby amended and reenacted to read as follows:

13 §1049. Requirement for coverage of prosthetic and orthotic devices and ~~prosthetic~~  
14 services

15 A. ~~Notwithstanding the provisions of R.S. 22:1047 to the contrary, any~~ Any  
16 health coverage plan specified in Subsection H J of this Section which is issued for  
17 delivery, delivered, renewed, or otherwise contracted for in this state ~~on or after~~

1        ~~January 1, 2009~~, shall provide coverage of prosthetic and orthotic devices and  
2        prosthetic and orthotic services as further provided in this Section.

3            B. Eligibility and limits of coverage for prosthetic and orthotic devices and  
4        ~~prosthetic~~ services shall be determined by the health coverage plan in consultation  
5        with the enrollee's medical providers and their assessment of ~~based on~~ medical  
6        necessity. In determining medical necessity, the health coverage plan shall consider  
7        the recommendations by the insured's physician or advanced practice provider. Such  
8        recommendations shall be based on the most appropriate prosthesis or orthosis that  
9        adequately meets the medical needs of the insured to restore or maintain the ability  
10       to perform activities of daily living and essential job-related functions. Such  
11       coverage shall, at a minimum, equal the coverage and prevailing payment rate for  
12       prosthetic and orthotic devices provided under federal laws and regulations for the  
13       aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and  
14       1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and  
15       410.100. In accordance with Subsection C of this Section covered benefits shall be  
16       provided for more than one prosthesis or orthosis when determined by the health  
17       coverage plan to be medically necessary and may not exclude coverage for orthotic  
18       or prosthetic devices designed for physical activity or showering and bathing  
19       pursuant to blanket exclusions of items used for "recreation or leisure", "athletic or  
20       sports purposes", or "luxury or convenience". Any denial or limit of coverage based  
21       on lack of medical necessity may be appealed in accordance with R.S. 22:1121 R.S.  
22       22:1241 et seq. and R.S. 22:2431, et seq. and with respect to claim denials based on  
23       medical necessity, such denials shall be in writing and include clear reasoning and  
24       descriptions of how and why the request or claim does not meet medical necessity  
25       standards. Such medical necessity determination shall consider information and  
26       recommendation from the treating physician in consultation with the insured,  
27       including but not limited to information in the medical record of the treating orthotist  
28       or prosthetist, and the results of a functional ~~limit test~~ assessment. Such ~~test~~  
29       assessment shall consider but not be limited to the following factors:

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

3 (2) The insured's current condition, including the status of the residual limb  
4 and the nature of other medical problems.

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

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

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

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

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

25 (2) If neither the original prosthetic or orthotic devices described in  
26 Subsection B of this Section nor the additional upper or lower extremity prosthetic  
27 or orthotic device provided in Paragraph (C)(1) of this Section is sufficient to enable  
28 the insured to safely engage in bathing and showering, then in addition to those  
29 devices, a single additional prosthetic or orthotic device recommended by the

1 insured's physician or other advanced practice provider for purposes of showering  
2 or bathing shall be covered when determined to be medically necessary to enable the  
3 enrollee to safely engage in those activities.

4 ~~C.~~ D. A health coverage plan may require prior authorization for prosthetic  
5 and orthotic devices and ~~prosthetic~~ services in the same manner that prior  
6 authorization is required for any other covered benefit, if such procedures are  
7 rendered in a nondiscriminatory manner. Utilization review procedures shall not  
8 deny coverage for habilitative or rehabilitative benefits, including prosthetics or  
9 custom orthotics, solely on the basis of an insured's actual or perceived disability.  
10 An insurer shall not deny a prosthetic or custom-orthotic benefit for an individual  
11 with limb loss, limb absence, or limb impairment that would otherwise be covered  
12 for a non-disabled person seeking medical or surgical intervention to restore or  
13 maintain the ability to perform the same physical activity.

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

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

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

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

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

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

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

8           G. A health plan that provides coverage for prostheses or orthoses shall  
9           ensure access to medically necessary clinical care and to prostheses and custom  
10           orthoses from not less than two distinct prosthetic and orthotic providers in the  
11           managed care plan's provider network located in the state. In the event that  
12           medically necessary covered orthoses and prostheses are not available from an  
13           in-network provider, the insurer shall provide processes to refer a member to an  
14           out-of-network provider and shall fully reimburse the out-of-network provider at a  
15           mutually agreed upon rate less member cost sharing determined on an in-network  
16           basis.

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

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

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

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

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

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

15          H K. As used in the Section:

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

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

23          ~~(2)~~ (3) "Health coverage plan" shall mean any hospital, health, or medical  
24          expense insurance policy, hospital or medical service contract, employee welfare  
25          benefit plan, contract or agreement with a health maintenance organization or a  
26          preferred provider organization, health and accident insurance policy, or any other  
27          insurance contract of this type, including a group insurance plan and the Office of  
28          Group Benefits programs.



1           A. The Louisiana Medicaid program shall provide coverage for prosthetic  
2           and custom orthotic devices and services to an enrollee when such devices or  
3           services are deemed medically necessary in accordance with the standards and  
4           clinical criteria set forth by the Medicaid program.

5           B. Coverage includes the devices, services, materials, components,  
6           instruction, repair, and replacement as delineated in R.S. 22:1049, including but not  
7           limited to services required to restore or maintain the ability to perform activities of  
8           daily living, essential job-related functions, and medically necessary physical  
9           activity. The definitions provided in R.S. 22:1049 apply to this Section unless the  
10          context clearly requires otherwise.

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

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

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

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

19          Section 3. The coverage requirements provided by the provisions of this Act as  
20          enacted by Section 1 of this Act shall apply to any new health coverage plan delivered,  
21          issued for delivery or otherwise contracted for in this state beginning on or after January 1,  
22          2027. Any health coverage policy, contract, or plan in effect prior to January 1, 2027, shall  
23          convert to conform to the provisions of Section 1 of this Act upon renewal, on or before the  
24          renewal date, but no later than January 1, 2028.

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

28          Section 5. This Act shall become effective upon signature by the governor or, if not  
29          signed by the governor, upon expiration of the time for bills to become law without signature

1 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If  
2 vetoed by the governor, and subsequently approved by the legislature, this Act shall become  
3 effective on the day following such approval.

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#### 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)]

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HB 1235 Reengrossed

2026 Regular Session

Hebert

**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 be supplied by an accredited facility and that prosthetic services be 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 La. 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)