H.432

Introduced by Representatives Burke of Brattleboro, Cina of Burlington, Howard of Rutland City, Lalley of Shelburne, Masland of Thetford, Morgan, L. of Milton, and Ode of Burlington

Referred to Committee on

Date:

Subject: Health; health insurance; prosthetics; orthotics

Statement of purpose of bill as introduced: This bill proposes to expand health insurance coverage requirements for prosthetic and orthotic devices. It would also require health insurers to report their claims experience with coverage for prosthetic and orthotic devices for plan years 2026, 2027, and 2028 to the Department of Financial Regulation, which the Department would aggregate into a report to the General Assembly.

An act relating to health insurance coverage for prosthetic and orthotic devices

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4088f is amended to read:

§ 4088f. ~~PROSTHETIC PARITY~~ COVERAGE FOR PROSTHETIC AND ORTHOTIC DEVICES

(a) As used in this section:

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term shall not include policies or plans providing coverage for a specific disease or other limited benefit coverage.

(2) "Prosthetic ~~device~~ and orthotic devices" means ~~an artificial limb device to replace, in whole or in part, an arm or a~~ leg, arm, back, and neck braces and artificial legs, arms, and eyes, whether standard or custom-made.

(b) A health insurance plan shall provide coverage for prosthetic and orthotic devices ~~in all health plans~~ that is at least equivalent to ~~that~~ the coverage provided by the federal Medicare program pursuant to 42 U.S.C. §§ 1395k, 1395l, and 1395m and 42 C.F.R. §§ 414.202, 414.210, 414.228, and 140.100. Coverage ~~may be limited to the~~ shall be provided for all of the following:

(1) a prosthetic or orthotic device that is determined by the covered individual's treating health care provider to be the most appropriate model that ~~is medically necessary to meet the patient's~~ adequately meets the covered individual's medical needs;

(2) a prosthetic or orthotic device that is determined by the covered individual's treating health care provider to be the most appropriate model that

meets the covered individual's medical needs for purposes of performing physical activities, such as running, biking, swimming, and strength training, as applicable, and that maximizes the covered individual's whole-body health and the functions of the individual's lower or upper limbs, or both;

(3) a prosthetic or orthotic device that is determined by the covered individual's treating health care provider to be the most appropriate model that meets the covered individual's medical needs for purposes of showering or bathing;

(4) all materials and components necessary for the covered individual's use of the prostheses and orthoses described in subdivisions (1)–(3) of this subsection;

(5) instruction to the covered individual on using the device or devices, materials, and components described in subdivisions (1)–(4) of this subsection; and

(6) the medically necessary repair or replacement of a prosthetic or orthotic device, material, or component described in subdivisions (1)–(4) of this subsection, as further described in subsection (f) of this section.

(c)(1) A health insurance plan shall consider coverage for prosthetic and orthotic devices to be habilitative or rehabilitative benefits for purposes of any federal or State requirement regarding coverage of essential health benefits.

(2) For purposes of the coverage required by subdivisions (b)(2) and (3) of this section, a health plan may require the covered individual's treating health care provider to determine that the additional prosthetic or orthotic device is necessary to enable the person to engage in physical activities, such as running, biking, swimming, strength training, showering, and bathing, as applicable, and to maximize the covered individual's whole-body health and the functions of the individual's lower or upper limbs, or both.

(3) A health plan shall make its utilization review determinations in a nondiscriminatory manner and shall not deny coverage for a prosthetic or orthotic device solely on the basis of a covered individual's actual or perceived disability.

(4) A health insurance plan shall not deny coverage for a prosthetic or orthotic device for a physical activity for a covered individual with limb loss or absence if the plan would provide coverage for an individual without a disability who was seeking a medical or surgical intervention to restore or maintain the individual's ability to perform the same physical activity.

(5) A health insurance plan shall include language describing a covered individual's rights pursuant to subdivisions (3) and (4) of this subsection in the plan's evidence of coverage and in any benefit denial letters.

(6) Any dispute between ~~the insured and the carrier~~ a covered individual and a health insurance plan concerning coverage and the application of this

section shall be subject to independent external review under section 4089f of this title.

~~(c)~~(d) A health insurance plan may require prior authorization for prosthetic devices in the same manner and to the same extent as prior authorization is required for any other covered benefit under the plan.

(e) A health insurance plan shall ensure access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not fewer than two distinct prosthetic and orthotic providers who are located in this State and are in the plan's network. In the event that medically necessary covered prosthetic and orthotic devices are not available from an in-network provider in this State, the plan shall provide processes for referring a covered individual to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed-upon rate, less the covered individual's cost sharing as determined on an in-network basis.

~~(d)~~(f)(1) A health insurance plan shall provide coverage under this section for the ~~medically necessary repair or~~ replacement of a prosthetic or orthotic device or for the replacement of any part of the device, without regard to continuous use or useful lifetime restrictions, if the covered individual's treating health care provider determines that the provision of a replacement device or replacement part is necessary because of any of the following:

(A) a change in the covered individual's physiological condition;

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

(C) the condition of the device or part of the device requires repairs, and the cost of the repairs would equal more than 60 percent of the cost of a replacement device or of the part being replaced.

(2) A health insurance plan may require confirmation from the covered individual's treating health care provider if the prosthetic or orthotic device or part being replaced is less than three years old.

~~(e)~~(g) A health insurance plan shall not impose any annual or lifetime dollar maximum on coverage for ~~prosthetics~~ prosthetic and orthotic devices that is less than the annual or lifetime dollar maximum that applies generally to all terms and services covered under the plan.

~~(f)~~(h) The coverage required ~~may~~ shall not be subject to a deductible, co-payment, or coinsurance provision that is less favorable to a covered individual than the deductible, co-payment, or coinsurance provisions that apply generally to other non-primary care items and services under the health plan.

Sec. 2. PROSTHETIC AND ORTHOTIC DEVICES; HEALTH INSURANCE CLAIMS; REPORT

(a) On or before July 1, 2029, each health insurer that is subject to the annual reporting requirements of 18 V.S.A. § 9414a shall also report to the

Department of Financial Regulation regarding the health insurer's experience with providing coverage for prosthetic and orthotic devices pursuant to 8 V.S.A. § 4088f, as amended by Sec. 1 of this act, for plan years 2026, 2027, and 2028. The report shall be in the form required by the Commissioner of Financial Regulation and shall include the number of claims for the goods and services required by 8 V.S.A. § 4088f in each of the plan years and the total amount of claims paid in this State for those goods and services in each of the plan years.

(b) On or before December 1, 2029, the Commissioner shall provide a report with aggregated data for all health insurers by plan year to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance.

Sec. 3. EFFECTIVE DATE

(a) Sec. 1 (8 V.S.A. § 4088f) shall take effect on January 1, 2026 and shall apply to all health insurance plans issued on and after January 1, 2026 on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than January 1, 2027.

(b) The remaining sections shall take effect on passage.