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Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Jarrells and Schmidt

Jason Hoskins, Attorney

SUMMARY

- Requires qualifying health benefit plans to provide coverage for prosthetic and orthotic devices that, at a minimum, equals the coverage and payment provided for those devices under federal law and regulations for aged and disabled individuals.
- Prohibits a health plan issuer from denying a prosthetic or orthotic benefit for a covered person with limb loss, absence, or difference that would otherwise be covered for a nondisabled person seeking intervention to restore or maintain the ability to perform the same physical function.
- Classifies the above practice and a health plan issuer canceling or changing premiums, benefits, or conditions under a qualifying health benefit plan on the basis of a covered person's actual or perceived disability as unfair and deceptive acts or practices in the business of insurance.
- Requires each health plan issuer to submit reports to the Superintendent of Insurance concerning coverage of prosthetic and orthotic devices.
- Requires the Superintendent to issue public guidance regarding care and devices that are needed to restore full function for individuals with limb loss, limb difference, or mobility impairment.
- Delays the bill's effective date until January 1, 2027.

DETAILED ANALYSIS

Coverage of prosthetic and orthotic devices

Coverage of devices under a health benefit plan

The bill requires any health benefit plan[1] issued, amended, or renewed on or after January 1, 2027, that provides coverage for hospital, medical, or surgical expenses to also provide coverage for prosthetic and orthotic devices. This coverage must, at a minimum, equal the coverage and payment provided under federal law and regulations for aged and disabled individuals.[2]

The coverage must include the purchase, fitting, adjustment, repair, and replacement of one or more devices as needed to accomplish (1) the replacement of all or part of a missing body part and its adjoining tissues, and (2) when possible, the replacement of all function of a permanently useless or malfunctioning body part as necessary to complete activities of daily living, perform physical activities, and shower or bathe. The bill additionally requires coverage of all materials and components necessary to use a prosthetic or orthotic device and any instruction provided to a covered person on how to use the device.[3]

Under the bill, a health benefit plan must also provide coverage for the replacement of a prosthetic or orthotic device that is covered under the bill, or for the replacement of any part of a device, with regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that a replacement device or replacement part is necessary due to any of the following:[4]

- A change in the physiological condition of the covered person;
- An irreparable change in the condition of the device or a part of the device;
- The condition of the device or a part of the device requires repairs and the cost of the repairs is more than 60% of the cost of replacing the device or part of the device.

Before covering the replacement of a device or part of a device that is less than three years old, a health plan issuer may require a prescribing health care provider to confirm the replacement.[5] The bill provides that for the purpose of any state or federal requirement for coverage of essential health benefits, coverage of a prosthetic or orthotic device is considered a habilitative or rehabilitative benefit.

[1] Referred to as a "qualifying health benefit plan" under the bill; *See* R.C. 3902.65(A).

[2] R.C. 3902.65(B).

[3] R.C. 3902.65(B).

[4] R.C. 3902.65(K)(1).

[5] R.C. 3902.65(K)(2).

Utilization review

The bill permits a health plan issuer to impose utilization review procedures with regard to the coverage described above; however, the review may not be applied in a discriminatory manner solely on the basis of a covered person's actual or perceived disability and a health plan issuer may not deny coverage solely on the basis of the person's disability.[6]

Medical necessity and network adequacy

Coverage of one or more prosthetic or orthotic devices is considered medically necessary under the bill if it is determined by a covered person's health care provider to be the most appropriate model that adequately meets the medical needs of the covered person. A device is medically necessary if it helps a covered person do any of the following:[7]

- Complete activities of daily living or essential job-related activities;
- Perform physical activities such as running, biking, swimming, or strength activities;
- Maximize the covered person's whole-body health or maximize the covered person's lower or upper limb function;
- Shower or bathe.

Each health benefit plan must ensure access to medically necessary clinical care and prosthetic and orthotic devices and technology from at least two distinct prosthetic and orthotic device providers located in Ohio, as part of the plan's provider network. If medically necessary devices are not available from an in-network provider, the bill requires a health plan issuer to provide processes to refer a covered person to an out-of-network provider. A health plan issuer must fully reimburse an out-of-network provider at a mutually agreed upon rate, determined on an in-network basis.[8]

Policy language

The bill requires each health benefit plan to include language describing a covered person's rights in its evidence of coverage documents and any benefit denial letters. Any denial of coverage or prior authorization or pre-determination decisions regarding coverage of prosthetic and orthotic devices must be issued in writing.[9]

Cost-sharing requirements

The bill provides that nothing in its provisions should be construed as prohibiting a health plan issuer from imposing cost-sharing requirements concerning coverage for prosthetic and orthotic devices. Any cost-sharing requirements may not be more restrictive than any cost-sharing requirements that are applicable to a health benefit plan's coverage for inpatient and

[6] R.C. 3902.65(C) and (F).

[7] R.C. 3902.65(E).

[8] R.C. 3902.65(J).

[9] R.C. 3902.65(H).

surgical services, and coverage of prosthetic and orthotic devices cannot be subject to separate cost-sharing requirements that are applicable only with respect to that coverage.[10]

Unfair and deceptive acts or practices in the business of insurance

The bill prohibits a health plan issuer from denying a prosthetic or orthotic benefit for a covered person with limb loss, absence, or difference that would otherwise be covered for a nondisabled individual seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.[11] Additionally, a health plan issuer may not cancel or change premiums, benefits, or conditions under a health benefit plan on the basis of a covered person's actual or perceived disability.[12]

The bill classifies both of those actions as unfair and deceptive acts or practices in the business of insurance. Under continuing law, penalties for unfair and deceptive acts or practices include a requirement that the Superintendent of Insurance issue a cease and desist order, and may include a suspension or revocation of license, a prohibition against employing the person involved, an order to pay up to half the costs of conducting an investigation, and a civil penalty up to $3,500 per violation.[13]

Reporting requirements

Beginning March 1, 2029, and every March 1 thereafter, the bill requires each health plan issuer to submit a report to the Superintendent of Insurance regarding the health plan issuer's experience with providing coverage of prosthetic and orthotic devices. The report must be submitted in a form prescribed by the Superintendent and include the number of claims made and the total amount of claims paid for those covered services. The Superintendent must aggregate the data and submit a report to the standing committees in the House of Representatives and Senate with jurisdiction over health coverage and insurance matters.[14]

Similarly, beginning no later than January 1, 2028, and annually thereafter for five years, each health plan issuer must issue a report to the Superintendent detailing the health plan issuer's experience related to coverage of prosthetic and orthotic devices. The report must be submitted in a form prescribed by the Superintendent and include the number of claims made and the total amount of claims paid for those covered services. The Superintendent must aggregate the data and submit a report to the standing committees in the House of Representatives and Senate with jurisdiction over insurance matters. It is unclear from the bill what the substantive difference is between the content of the two reports.[15]

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[10] R.C. 3902.65(I).

[11] R.C. 3902.65(G).

[12] R.C. 3902.651(A).

[13] R.C. 3902.651; *See also* R.C. 3901.20 and 3901.22, not in the bill.

[14] R.C. 3902.652.

[15] R.C. 3902.653.

Public guidance

The bill requires the Superintendent, not later than January 1, 2028, to issue public guidance in relation to coverage of prosthetic and orthotic devices under the bill that details what care and devices are needed to restore full function for covered persons with limb loss, limb difference, or mobility impairment.[16]

HISTORY

Action	Date
Introduced	11-04-25

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[16] R.C. 3902.654.