As Introduced

136th General Assembly

Regular Session 2025-2026

H. B. No. 564

Representatives Jarrells, Schmidt

Cosponsors: Representatives Piccolantonio, Rogers, Brennan, Troy, Lett, Rader, Sigrist, Sims, Baker, Grim, Thomas, C., Upchurch, Lawson-Rowe, White, E., Holmes, LaRe

То	enact sections 3902.65, 3902.651, 3902.652,	1
	3902.653, and 3902.654 of the Revised Code to	2
	require health insurance coverage of orthotic	3
	and prosthetic devices.	4

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3902.65, 3902.651, 3902.652,	5
3902.653, and 3902.654 of the Revised Code be enacted to read as	6
follows:	7
Sec. 3902.65. (A) For the purposes of sections 3902.65 to	8
3902.654 of the Revised Code, "qualifying health benefit plan"	9
means a health benefit plan issued, amended, or renewed in this	10
state on or after the effective date of this section, and that	11
provides coverage for hospital, medical, or surgical expenses. A	12
health benefit planned is "renewed" for the purposes of this	13
division not later than the first anniversary of the original	14
contract date that occurs on or after the effective date of this	15
section.	16
(B) Notwithstanding section 3901.71 of the Revised Code, a	17
qualifying health benefit plan shall provide coverage for	18

prosthetic and orthotic devices that, at a minimum, equals the	19
coverage and payment for prosthetic and orthotic devices	20
provided under federal laws and regulations for the aged and	21
disabled pursuant to 42 U.S.C. 1395k, 1395l, and 1395m, and 42	22
C.F.R. 410.100, 414.202, 414.210, and 414.228. The coverage	23
shall include both of the following:	24
(1) Coverage for the purchase, fitting, adjustment,	25
repair, and replacement of one or more prosthetic or orthotic	26
devices as needed to accomplish both of the following, as	27
applicable:	28
(a) The replacement of all or part of a missing body part	29
and its adjoining tissues;	30
(b) The replacement of, when possible, all of the function	31
of a permanently useless or malfunctioning body part as	32
necessary to do all of the following:	33
(i) Complete activities of daily living or essential job-	34
related activities;	35
(ii) Perform physical activities such as running, biking,	36
swimming, or strength training, and to maximize the covered	37
person's whole-body health and lower and upper limb function;	38
(iii) Showering or bathing.	39
(2) Coverage for both of the following with respect to the	4 C
devices described in division (B)(1) of this section:	41
(a) All materials and components necessary to use the	42
<pre>devices;</pre>	43
(b) Instruction to a covered person on using the devices.	4 4
(C) A health plan issuer may impose utilization review	45

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procedures with regard to coverage provided under division (B)	46
of this section, provided that such review is not applied in a	47
discriminatory manner solely on the basis of a covered person's	48
actual or perceived disability.	49
(D) For purposes of any state or federal requirement for	50
coverage of essential health benefits, coverage of a prosthetic	51
or orthotic device shall be considered a habilitative or	52
rehabilitative benefit.	53
(E) With respect to a covered person, coverage of one or	54
more prosthetic or orthotic devices is medically necessary if it	55
is determined by a covered person's provider to be the most	56
appropriate model that adequately meets the medical needs of the	57
covered person, including any orthotic or prosthetic devices	58
that enable the covered person to do any or all of the	59
<pre>following:</pre>	60
(1) Completing activities of daily living or essential	61
<pre>job-related activities;</pre>	62
(2) Performing physical activities, such as running,	63
biking, swimming, or strength training;	64
(3) Maximizing the covered person's whole-body health;	65
(4) Maximizing the covered person's lower or upper limb	66
<pre>function;</pre>	67
(5) Showering or bathing.	68
(F) A health plan issuer shall render utilization review	69
determinations in a nondiscriminatory manner and shall not deny	70
coverage for habilitative or rehabilitative benefits, including	71
prosthetics or orthotics, solely on the basis of a covered	72
person's actual or perceived disability.	73

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(G) A health plan issuer shall not deny a prosthetic or	74
orthotic benefit for a covered person with limb loss, absence,	75
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or difference that would otherwise be covered for a nondisabled	
person seeking medical or surgical intervention to restore or	77
maintain the ability to perform the same physical activity.	78
(H)(1) A qualifying health benefit plan shall include	79
language describing a covered person's rights under this section	80
in its evidence of coverage and any benefit denial letters.	81
(2) With regard to prosthetic and orthotic device	82
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coverage, any denials of coverage or prior authorization or pre-	
determination decisions shall be issued in writing.	84
(I) Nothing in this section shall be construed as	85
prohibiting a health plan issuer from imposing cost-sharing with	86
regard to coverage of prosthetic or orthotic devices, provided	87
that any cost-sharing requirements are not more restrictive than	88
the cost-sharing requirements applicable to the plan's coverage	89
for inpatient physician and surgical services. Prosthetic and	90
orthotic device coverage shall not be made subject to separate	91
cost-sharing requirements that are applicable only with respect	92
to that coverage.	93
(J)(1) A qualifying health benefit plan shall ensure	94
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access to medically necessary clinical care and to prosthetic	
and orthotic devices and technology from not less than two	96
distinct prosthetic and orthotic providers located in this state	97
in the plan's provider network.	98
(2) In the event that medically necessary covered	99
orthotics and prosthetics are not available from an in-network	100
provider, a health plan issuer shall provide processes to refer	101
a covered person to an out-of-network provider and shall fully	102

reimburse the out-of-network provider at a mutually agreed upon	103
rate, less any applicable cost-sharing, determined on an in-	104
<pre>network basis.</pre>	105
(K)(1) A qualifying health benefit plan shall provide	106
coverage for the replacement of a prosthetic or orthotic device	107
covered pursuant to this section, or for the replacement of any	108
part of such a device, as applicable, without regard to	109
continuous use or useful lifetime restrictions, if an ordering	110
health care provider determines that the provision of a	111
replacement device, or a replacement part of such a device, is	112
necessary due to any of the following:	113
(a) A change in the physiological condition of the covered	114
<pre>person;</pre>	115
(b) An irreparable change in the condition of the device	116
or in a part of the device;	117
(c) The condition of the device, or a part of the device,	118
requires repairs and the cost of such repairs is more than sixty	119
per cent of the cost of a replacement device or of the part	120
being replaced.	121
(2) A health plan issuer may require, before covering a	122
replacement prosthetic or orthotic device or part of such a	123
device that is less than three years old, that a prescribing	124
health care provider confirm the replacement.	125
Sec. 3902.651. Both of the following are unfair and	126
deceptive practices in the business of insurance under sections	127
3901.19 to 3901.26 of the Revised Code:	128
(A) Canceling or changing premiums, benefits, or	129
conditions under a qualifying health benefit plan on the basis	130
of a covered person's actual or perceived disability;	131

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(B) Denying a prosthetic or orthotic benefit under a	132
qualifying health benefit plan for a covered person with limb	133
loss, absence, or difference that would otherwise be covered for	134
a nondisabled person seeking medical or surgical intervention to	135
restore or maintain the ability to perform the same physical	136
activity.	137
Sec. 3902.652. Not later than the first day of March of	138
the second year that begins after the effective date of this	139
section, and annually thereafter, each health plan issuer that	140
issues a qualifying health benefit plan shall report to the	141
superintendent of insurance on the health plan issuer's	142
experience providing coverage pursuant to section 3902.65 of the	143
Revised Code for the previous plan year. The report shall be in	144
a form prescribed by the superintendent and shall include the	145
number of claims made and the total amount of claims paid in	146
this state for the services required by section 3902.65 of the	147
Revised Code. The superintendent shall aggregate this data by	148
plan year in the report and submit the report to the standing	149
committees of the senate and the house of representatives having	150
jurisdiction over health coverage and insurance matters.	151
Sec. 3902.653. (A) Not later than one year after the	152
effective date of this section, and annually thereafter for five	153
years, each health plan issuer that issues a health benefit plan	154
in this state shall report to the superintendent of insurance on	155
the health plan issuer's experience related to coverage provided	156
under section 3902.65 of the Revised Code.	157
(B) The report shall be in a form prescribed by the	158
superintendent and shall include, at minimum, the total number	159
of claims made, as well as the total amount paid, in this state	160
for the coverage required under section 3902.65 of the Revised	161

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Code.	162
(C) The superintendent shall aggregate the data received	163
under this section by plan year and make a report to the	164
standing committees of the senate and house of representatives	165
having jurisdiction over insurance matters.	166
Sec. 3902.654. (A) Not later than one year after the	167
effective date of this section, the superintendent of insurance	168
shall issue public guidance on what care and devices are needed	169
to restore full function for a covered person with limb loss,	170
limb difference, or mobility impairment in relation to the	171
coverage required under division (B)(1) of section 3902.65 of	172
the Revised Code.	173
(B) The superintendent shall update this guidance as often	174
as the superintendent deems necessary.	175
Section 2. Sections 3902.65, 3902.651, 3902.652, 3902.653,	176
and 3902.654 of the Revised Code, as enacted by this act, shall	177
take effect on January 1, 2027, and apply to health benefit	178
plans issued, amended, or renewed on or after that date.	179