

As Introduced

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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**

To 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 40
devices described in division (B) (1) of this section: 41

(a) All materials and components necessary to use the 42
devices; 43

(b) Instruction to a covered person on using the devices. 44

(C) A health plan issuer may impose utilization review 45

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
following: 60

(1) Completing activities of daily living or essential 61
job-related activities; 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
function; 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

(G) A health plan issuer shall not deny a prosthetic or 74
orthotic benefit for a covered person with limb loss, absence, 75
or difference that would otherwise be covered for a nondisabled 76
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
coverage, any denials of coverage or prior authorization or pre- 83
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
access to medically necessary clinical care and to prosthetic 95
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
network basis. 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
person; 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

(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

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