RÉSUMÉ DIGEST

ACT 719 (HB 1235) **2026 Regular Session** **Hebert**

Existing law mandates that certain health coverage plans provide coverage for prosthetic devices and prosthetic services, and establishes standards for medical necessity, cost-sharing, repair and replacement, prior authorization, and provider accreditation. It further stipulates that those annual benefits not be less than $50,000 per limb, while permitting more favorable coverage options.

New law expands required coverage to encompass both prosthetic and orthotic devices and services under specified conditions. New law provides that determinations regarding eligibility and limitations of coverage be predicated on medical necessity, which must integrate the recommendations of the insured's physician or advanced practice provider and take into account input from the treating prosthetist or orthotist. Such considerations include functional assessment criteria, encompassing patient history, current condition, and functional goals.

New law mandates that coverage for these devices and services be no less than the coverage and prevailing payment rates established under federal Medicare law and regulations. New law requires coverage for multiple prosthetic or orthotic devices when deemed medically necessary, including supplementary devices intended to facilitate participation in physical activities or to promote whole-body health. New law requires the provision of a separate device for bathing or showering when such a device is necessary to ensure the safe execution of these activities.

New law stipulates that prior authorization may be mandated if applied in a non-discriminatory manner; however, it prohibits the denial of coverage for habilitative or rehabilitative benefits solely on the basis of an insured's actual or perceived disability. New law prohibits the denial of benefits for individuals with limb loss, limb absence, or impairment when comparable benefits would be available to a nondisabled individual.

Insurers are permitted to impose copayments, deductibles, and coinsurance for such coverage, provided that these cost-sharing requirements are no more restrictive than those applicable to other benefits under the plan. New law mandates coverage for the repair and replacement of prosthetic and orthotic devices when deemed medically necessary, including instances where the enrollee's physiological condition undergoes change, the device sustains irreparable damage, or repair is not deemed cost-effective.

New law establishes network adequacy requirements, including access to a minimum of two in-state providers and provisions for out-of-network referrals and reimbursements when medically necessary devices are unavailable within the network. Devices must be supplied by accredited facilities and prescribed by a licensed physician, with the recognition that prosthetic and orthotic devices and services be considered habilitative and rehabilitative benefits for the purposes of essential health benefits.

New law retains the authorization for annual benefit limits of not less than $50,000 per limb while allowing for more favorable coverage options. Health coverage plans are mandated to report claims data for plan years 2027 and 2028 to the commissioner of insurance, with an aggregated report due to the legislature by July 1, 2029.

New law directs the Louisiana Medicaid program to provide coverage for prosthetic and custom orthotic devices and services when medically necessary and instructs the Louisiana Department of Health to undertake all actions necessary for implementation, including the submission of state plan amendments and the promulgation of rules.

Coverage requirements apply to plans issued on or after Jan. 1, 2027, and to existing plans upon renewal, but no later than Jan. 1, 2028.

Effective upon signature of governor (June 3, 2026).

(Amends R.S. 22:1049; Adds R.S. 40:1259.11)