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HOUSE BILL NO. 216

Offered January 14, 2026

Prefiled January 7, 2026

A BILL to amend and reenact §§ 38.2-3418.15, and 38.2-3418.15:1 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-325.6, relating to health insurance; State Plan for Medical Assistance; coverage for prosthetic and custom orthotic devices and components; reports.

Patron—Helmer

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3418.15, and 38.2-3418.15:1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-325.6 as follows:

§ 32.1-325.6. Payment of medical assistance for prosthetic and custom orthotic devices and components.

A. The Department shall, conditional on the receipt of all necessary approvals and the securing of federal financial participation pursuant to subsection D, provide payment of medical assistance services for medically necessary prosthetic and custom orthotic devices, and their repair, fitting, replacement, and components, that, at a minimum, equals the coverage and payment for prosthetic and custom orthotic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 U.S.C. §§ 1395k, 1395l, and 1395m and 42 C.F.R. §§ 410.100, 414.202, 414.210, and 414.228.

B. Such coverage shall be provided as follows:

1. Prosthetic and custom orthotic device coverage does not include repair and replacement due to theft or loss.

2. Coverage shall include more than one prosthetic or custom orthotic device when medically necessary as determined by the enrollee's provider. Coverage shall include the most appropriate models that adequately meet the medical needs of the enrollee, as determined by the enrollee's provider for each of the following purposes:

a. Performing activities of daily life or essential job-related activities;

b. Performing physical activities, as applicable, including running, biking, swimming, and strength training, and maximizing the enrollee's full body health and lower or upper limb function; and

c. Showering and bathing.

3. The Department and any managed care plans administering Medicaid benefits in the Commonwealth shall consider such coverage benefits rehabilitative and habilitative services and devices for the purposes of any state or federal requirements for coverage of essential health benefits.

4. The Department and any managed care plans administering Medicaid benefits in the Commonwealth shall not deny coverage for a prosthetic or custom orthotic device for an individual with limb loss, limb absence, or limb impairment that would otherwise be covered for a nondisabled individual seeking medical or surgical intervention to restore or maintain the ability to perform physical activities.

5. The Department and any managed care plans administering Medicaid benefits in the Commonwealth shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from no less than two distinct providers in the health plan's provider network. In the event that medically necessary prosthetics and custom orthotic devices are not available from an in-network provider, the Department shall provide a process to refer the patient to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate, less any enrollee cost sharing as determined on an in-network basis.

6. The Department and any managed care plans administering Medicaid benefits in the Commonwealth may apply utilization review procedures, provided that such procedures are rendered in a nondiscriminatory manner. Utilization review procedures shall not deny coverage for rehabilitative and habilitative devices or services, including prosthetics or custom orthotic devices or services, solely on the basis of an enrollee's actual or perceived disability.

7. The Department and any managed care plans administering Medicaid benefits in the Commonwealth that provide coverage pursuant to this section shall include language describing a patient's rights pursuant to subdivisions 4 and 6 in its evidence of coverage, and with respect to claim denials based on medical necessity, such denials shall be in writing and include clear reasoning and descriptions of why and how the request or claim does not meet standards for medical necessity.

C. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a

prosthetic or custom orthotic device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Medically necessary prosthetic device" includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the patient's rehabilitation potential.

"Orthotic device" means a custom-designed, fabricated, fitted, prefabricated, or modified device used to treat a neuromuscular or musculoskeletal disorder or acquired condition. "Orthotic device" does not include items that are sold over-the-counter.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

D. The Department shall submit any state plan amendments or waiver applications as may be necessary to implement the provisions of this section and to secure federal financial participation for state Medicaid expenditures under the federal Medicaid program. The coverage for medically necessary prosthetic and custom orthotic devices pursuant to this section shall be contingent on securing all necessary federal approvals and federal financial participation as may be necessary to implement the provisions of this section.

§ 38.2-3418.15. Coverage for prosthetic and custom orthotic devices and components.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall ~~offer and make available~~ *provide* coverage for medically necessary prosthetic *and custom orthotic* devices, *and* their repair, fitting, replacement, and components~~.~~*. Such coverage shall include the coverage and payment for prosthetic and custom orthotic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 U.S.C. §§ 1395k, 13951, and 1395m and 42 C.F.R. §§ 410.100, 414.202, 414.210, and 414.228. Additionally, such coverage shall be provided* as follows:

1. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic *or custom orthotic* device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Medically necessary prosthetic device" includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that has been determined by peer-reviewed literature to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential

"Orthotic device" means a custom-designed, fabricated, fitted, prefabricated, or modified device used to treat a neuromuscular or musculoskeletal disorder or acquired condition. "Orthotic device" does not include items that are sold over-the-counter.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

2. Prosthetic *and custom orthotic* device coverage does not include repair and replacement due to ~~enrollee neglect, misuse, or abuse~~ *theft or loss*. Coverage ~~also does not include prosthetic devices designed primarily for an athletic purpose~~ *shall include more than one prosthetic or custom orthotic device when medically necessary, as determined by the enrollee's provider. Coverage shall include the most appropriate models that adequately meet the medical needs of the enrollee, as determined by the enrollee's provider for each of the following purposes:*

a. Performing activities of daily life or essential job-related activities;

b. Performing physical activities, as applicable, including running, biking, swimming, and strength training, and maximizing the enrollee's full body health and lower or upper limb function; and

c. Showering and bathing.

3. *An individual health plan that is delivered, issued for delivery, or renewed in the Commonwealth that covers prosthetic and custom orthotic devices shall consider the benefits listed in subdivision 2 rehabilitative and habilitative services and devices for the purposes of any state or federal requirements for coverage of essential health benefits.*

4. No insurer shall deny coverage for a prosthetic or custom orthotic device for an individual with limb loss, limb absence, or limb impairment that would otherwise be covered for a nondisabled individual seeking medical or surgical intervention to restore or maintain the ability to perform physical activities.

5. No ~~An~~ insurer shall ~~not~~ impose any annual or lifetime dollar maximum on coverage for prosthetic *or custom orthotic* devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

~~4.~~ *6.* An insurer shall not apply amounts paid for prosthetic *or custom orthotic* devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

~~5.~~ *7.* No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for

such prosthetic *or custom orthotic* device or services when such device or service is provided by an in-network provider. *A health plan that provides coverage for prosthetic or custom orthotic devices or services shall ensure access to medically necessary clinical care and access to prosthetic and custom orthotic devices and services from no less than two distinct providers in the health plan's provider network. In the event that medically necessary prosthetics and custom orthotic devices are not available from an in-network provider, the insurer shall provide a process to refer the enrollee to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate, less any enrollee cost sharing as determined on an in-network basis.*

~~6.~~ *8.* An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components, in the same manner that prior authorization is required for any other covered benefit. *Utilization review procedures shall not deny coverage for rehabilitative and habilitative devices or services, including prosthetics or custom orthotic devices or services, solely on the basis of an enrollee's actual or perceived disability.*

9. Any health plan delivered, issued for delivery, or renewed in the Commonwealth that provides coverage pursuant to this section shall include language describing an enrollee's rights pursuant to subdivisions 4 and 8 in its evidence of coverage, and with respect to claim denials based on medical necessity, such denials shall be in writing and include clear reasoning and descriptions of why and how the request or claim does not meet standards for medical necessity.

B. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2010, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

C. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-3418.15:1. Coverage for prosthetic and custom orthotic devices and components.

A. As used in this section:

"Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic *or custom orthotic* device.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Medically necessary prosthetic device" includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential.

"Orthotic device" means a custom-designed, fabricated, fitted, prefabricated, or modified device used to treat a neuromuscular or musculoskeletal disorder or acquired condition. "Orthotic device" does not include items that are sold over-the-counter.

"Prosthetic device" means an artificial device to replace, in whole or in part, a limb.

B. Notwithstanding the provisions of § 38.2-3418.15 or 38.2-3419, each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, each corporation providing group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary prosthetic *and custom orthotic* devices and their repair, fitting, replacement, and components~~.~~*. Such coverage shall include the coverage and payment for prosthetic and custom orthotic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 U.S.C. §§ 1395k, 13951, and 1395m and 42 C.F.R. §§ 410.100, 414.202, 414.210, and 414.228.*

C. The coverage required under subsection B shall be ~~subject to the following~~ *provided as follows*:

1. Coverage for medically necessary prosthetic devices does not include~~:~~

~~a. The~~ *the* cost of repair and replacement due to ~~enrollee neglect, misuse, or abuse; or~~

~~b. Prosthetic devices designed primarily for an athletic purpose~~ *theft or loss*.

2. The coverage required under subsection B shall include more than one prosthetic or custom orthotic device when medically necessary, as determined by the enrollee's provider. Coverage shall include the most appropriate models that adequately meet the medical needs of the enrollee, as determined by the enrollee's provider for each of the following purposes:

a. Performing activities of daily life or essential job-related activities;

b. Performing physical activities, as applicable, including running, biking, swimming, and strength training, and maximizing the enrollee's full body health and lower or upper limb function; and

c. Showering and bathing.

D. The coverage required under subsection B shall be subject to the following:

~~2.~~ *1. An individual health plan that is delivered, issued for delivery, or renewed in the Commonwealth that covers prosthetic and custom orthotic devices shall consider the benefits listed in subdivision 2 rehabilitative and habilitative services and devices for the purposes of any state or federal requirements for coverage of essential health benefits.*

2. No insurer shall deny coverage for a prosthetic or custom orthotic device for an individual with limb loss, limb absence, or limb impairment that would otherwise be covered for a nondisabled individual seeking medical or surgical intervention to restore or maintain the ability to perform physical activities.~~An~~

3. No insurer shall ~~not~~ impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy. The coverage may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

~~3.~~ *4.* An insurer, corporation, or health maintenance organization shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

~~4.~~ *5.* An insurer, corporation, or health maintenance organization shall not impose upon any person receiving benefits pursuant to this section any coinsurance in excess of 30 percent of the carrier's allowable charge for such prosthetic device or service when such device or service is provided by an in-network provider. *A health plan that provides coverage for prosthetic or custom orthotic devices or services shall ensure access to medically necessary clinical care and access to prosthetic and custom orthotic devices and services from no less than two distinct providers in the health plan's provider network. In the event that medically necessary prosthetics and custom orthotic devices are not available from an in-network provider, the insurer shall provide a process to refer the enrollee to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate, less any enrollee cost sharing as determined on an in-network basis.*

~~5.~~ *6.* An insurer, corporation, or health maintenance organization may require preauthorization to determine medical necessity and the eligibility of benefits for prosthetic devices and components in the same manner that prior authorization is required for any other covered benefit. *Prior authorization procedures shall not deny coverage for rehabilitative and habilitative devices or services, including prosthetics or custom orthotic devices or services, solely on the basis of an enrollee's actual or perceived disability.*

7. Any health plan delivered, issued for delivery, or renewed in the Commonwealth that provides coverage pursuant to this section shall include language describing an enrollee's rights pursuant to subdivisions 2 and 6 in its evidence of coverage, and with respect to claim denials based on medical necessity, such denials shall be in writing and include clear reasoning and descriptions of why and how the request or claim does not meet standards for medical necessity.

D. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2023, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

E. The provisions of this section shall not apply to (i) short-term travel, accident-only, or limited or specified disease policies; (ii) policies, contracts, or plans issued in the individual market or small group markets; (iii) contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, Title XIX of the Social Security Act, known as Medicaid, Title XXI of the Social Security Act, or any other similar coverage under state or federal governmental plans; or (iv) short-term nonrenewable policies of not more than six months' duration.

2. That the provisions of this act shall apply to (i) insurance policies, contracts, and plans delivered, issued for delivery, or renewed in the Commonwealth; (ii) the State Plan for Medical Assistance Services; and (iii) any managed care plans administering Medicaid benefits in the Commonwealth on and after January 1, 2027, or at any time thereafter when any term of the policy, contract, or plan is changed.

3. That no later than January 1, 2029, each health insurance carrier subject to the provisions of § 38.2-3418.15 or 38.2-3418.15:1 of the Code of Virginia, as amended by this act, shall submit a report to the Health Insurance Reform Commission (the Commission) on its implementation of the requirements of §§ 38.2-3418.15 and 38.2-3418.15:1 of the Code of Virginia, as amended by this act, for plan years 2027 and 2028. Such report shall be submitted in a form and manner as prescribed by the Commission and shall include the total number of claims and total amount of claims paid in the Commonwealth for the coverage required under §§ 38.2-3418.15 and 38.2-3418.15:1 of the Code of Virginia, as amended by this act. The Commission shall aggregate the data from such reports by plan year and submit a report to the Governor and General Assembly no later than March 1, 2029.

4. That no later than January 1, 2029, the Department of Medical Assistance Services and any managed care plan administering Medicaid benefits in the Commonwealth shall prepare a report on its implementation of the requirements of § 32.1-325.6 of the Code of Virginia, as created by this act, for plan years 2027 and 2028. Such report shall be submitted in a form and manner as prescribed by the Health Insurance Reform Commission (the Commission) and shall include the total number of claims and total amount of claims paid in the Commonwealth for the coverage required under § 32.1-325.6 of the Code of Virginia, as created by this act. The Commission shall aggregate the data from such reports by plan year and submit a report to the Governor and General Assembly no later than March

1, 2029.

5. That if the Department of Medical Assistance Services does not receive the necessary approval or federal financial participation from the Centers of Medicare and Medicaid Services to implement the medical assistance services component of this act, then § 32.1-325.6 of the Code of Virginia, as created by this act, shall expire on July 1, 2027.