

304.17A-128 Coverage for prostheses and orthoses -- Utilization review decision -- Denial letter -- Network adequacy -- Reports. (Effective January 1, 2027)

- (1) As used in this section, "health benefit plan" has the same meaning as in KRS 304.17A-005, except for purposes of this section, the term includes student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.
- (2) All health benefit plans shall provide coverage for prostheses and orthoses.
- (3) The coverage required under this section:
 - (a) Shall, at a minimum, be equivalent to the coverage of, and payment for, prostheses and orthoses provided for the aged and disabled under the following, as amended:
 1. 42 U.S.C. sec. 1395k;
 2. 42 U.S.C. sec. 1395l;
 3. 42 U.S.C. sec. 1395m;
 4. 42 C.F.R. sec. 410.100;
 5. 42 C.F.R. sec. 414.202;
 6. 42 C.F.R. sec. 414.210; and
 7. 42 C.F.R. sec. 414.228;
 - (b) To the extent not covered under paragraph (a) of this subsection, shall include:
 1. Subject to paragraph (e) of this subsection, coverage for any one (1) or more prostheses and orthoses prescribed by an insured's health care provider and determined by a licensed prosthetist or orthotist to be the most appropriate model or models that adequately meet the medical needs of the insured for purposes of each of the following:
 - a. Completing activities of daily living;
 - b. Completing essential job-related activities;
 - c. Performing physical activities, including but not limited to running, biking, swimming, and strength training;
 - d. Maximizing the insured's whole-body health, including lower and upper limb function; or
 - e. Showering and bathing;
 2. For any prosthesis or orthosis covered under this section, coverage for:
 - a. All materials and components necessary to use the prosthesis or orthosis;
 - b. Instruction to the insured on using the prosthesis or orthosis; and
 - c. The repair of the prosthesis or orthosis or any of its parts; and
 3. a. Subject to subdivision b. of this subparagraph, coverage for the replacement of a prosthesis or orthosis, or any of its parts, covered under this section without regard to continuous use or useful lifetime restrictions, if the prescribing health care professional

determines that a replacement or part is necessary because of any of the following:

- i. A change in the physiological condition of the patient;
 - ii. An irreparable change in the condition of the prosthesis or orthosis or any of its parts; or
 - iii. The cost to repair the device or part would be more than sixty percent (60%) of the cost of a replacement device or of the part being replaced.
 - b. If a prosthesis or orthosis that is less than three (3) years old is being replaced, the insurer offering or providing the health benefit plan may require confirmation of the need for a replacement from the ordering health care professional;
 - (c) Shall not be subject to cost-sharing requirements that are applicable only with respect to the coverage required under this section;
 - (d) May be subject to cost-sharing requirements if the requirements are not more restrictive than the cost-sharing requirements for inpatient physician and surgical services;
 - (e) May be subject to a limit of three (3) prostheses and orthoses per affected limb within a three (3) year period; and
 - (f) Shall be considered habilitative or rehabilitative services and devices for purposes of any federal requirements to provide coverage for essential health benefits.
- (4) (a) With respect to the coverage required under this section, a utilization review decision rendered by an insurer or its private review agent shall:
1. Be made in a nondiscriminatory manner; and
 2. Not deny coverage solely on the basis of the insured's actual or perceived disability.
- (b) An insurer or its private review agent shall provide a description of the insured's rights under paragraph (a) of this subsection in:
1. The health benefit plan's evidence of coverage; and
 2. Any denial letter relating to the coverage required under this section.
- (5) If an insurer or its private review agent denies the coverage required under this section based on medical necessity, the insurer or agent shall provide a denial letter to the insured and the provider that:
- (a) Is in writing;
 - (b) Explains why the claim does not meet medical necessity standards; and
 - (c) Complies with any other applicable state and federal laws.
- (6) (a) An insurer or administrator that utilizes a network to provide prostheses and orthoses under a health benefit plan shall ensure that the network is reasonably adequate and accessible with respect to the provision of prostheses and orthoses required to be covered under this section.
- (b) A reasonably adequate network, with respect to the provision of prostheses

and orthoses that are required to be covered under this section, shall, at a minimum, offer an adequate number of accessible prosthetists or orthotists in accordance with the requirements set forth for managed care plans in KRS 304.17A-515.

- (7) (a) By June 1 of each year, each insurer that offers or provides a health benefit plan shall submit a report to the commissioner detailing the insurer's experience with providing the coverage required under this section.
- (b) The report required under paragraph (a) of this subsection shall:
1. Be in a form prescribed by the commissioner in an administrative regulation promulgated in accordance with KRS Chapter 13A; and
 2. With respect to the coverage required under this section, include the following for the preceding plan year:
 - a. The number of claims received; and
 - b. The number of claims paid.
- (c) By October 1 of each year, the commissioner shall submit a report to the Legislative Research Commission, for referral to the Interim Joint Committee on Banking and Insurance, that provides the aggregated data of the reports submitted under paragraph (b) of this subsection by plan year.

Effective: January 1, 2027

History: Created 2026 Ky. Acts ch. 51, sec. 1, effective January 1, 2027.

Legislative Research Commission Note (1/1/2027). 2026 Ky. Acts ch. 51, sec. 4, provides that Section 1 of that Act, which created this statute, applies to health benefit plans issued or renewed on or after January 1, 2027.