Why prosthetic coverage remains out of reach

Despite the life-changing necessity of prosthetic limbs, many insurance plans in the United States offer limited or no coverage.

Modern prosthetics, particularly advanced models designed for everyday use, work, or athletic activities, can cost thousands of dollars. Yet, most insurance companies classify only basic prosthetics as "medically necessary," often denying coverage for multiple devices or higher-functioning components.

Krystina Pacheco recently paid out of pocket for new aesthetic hands. Like many amputees, she faces challenges with insurance approvals for prosthetics that fit her lifestyle as a mother, educator and active member of her community.

Adding to the burden, insurers' replacement timelines often fail to reflect prosthetics' real-world wear and tear. Some plans allow only one prosthetic every five years, even though devices wear out much faster, especially for active users or growing children.

There is no federal mandate requiring private insurers to provide full prosthetic coverage. Only 21 states, including Texas, have enacted "prosthetic parity" laws requiring insurers to treat prosthetics like any other medical device—but those laws have many loopholes and don't apply to Medicare, Medicaid, or self-funded employer plans, leaving many gaps in access.

Organizations like the Amputee Coalition and San Antonio Amputee Foundation continue to advocate for improved insurance coverage and policy reform at both the state and federal level. Advocacy groups continue to work towards broader and more consistent coverage for prosthetic devices to ensure that individuals with limb loss have access to the necessary tools for mobility and independence.