FAQs

1. What is So Kids Can Move?
    a. So Kids Can Move is a new policy and advocacy initiative working to expand access to recreational prostheses as medically necessary healthcare for children on a state-by-state basis.
2. Who is behind the initiative?
    a. So Kids Can Move is the result of a collaboration between the American Orthotic Prosthetic Association (AOPA), the National Association for the Advancement of Orthotics and Prosthetics (NAAOP), and the American Academy of Orthotists and Prosthetists (AAOP).
3. What are considered recreational prostheses?
    a. Recreational prostheses are devices specifically developed to assist patients with recreational physical activities like running, cycling, and swimming (as opposed to standard prostheses, which assist patients with activities of daily living). Such devices are unique to each patient, specially designed to maximize performance and minimize injury.
4. Why aren't recreational prostheses already covered by insurance?
    a. In the vast majority of cases, recreational prostheses are considered "not medically necessary" and denied by insurance, requiring individuals to pay prohibitively high out-of-pocket costs: a running blade, for example, is up to $15,000-$25,000 per limb. As a result, access to these devices and the physical activity they provide is severely limited.
5. Why should recreational prostheses be deemed medically necessary?
    a. Recreational prostheses are medically necessary because they create opportunities for physical activity, one of the most important factors in maintaining overall health throughout one's lifetime. Whether it's vigorous exercise or simple day-to-day movement, being physically active increases strength and balance, improves mental health, supports better-quality sleep, and reduces the risk of disease and cancer. Recreational prostheses are also medically necessary because they are critical to injury avoidance when children and adults with limb loss or limb difference engage in physical activity. Utilizing an inappropriately designed prosthesis for recreational activities is unsafe for the prosthetic user and can lead to secondary musculoskeletal conditions like osteoarthritis (joint disintegration) from overuse, as well as knee, hip, and back pain, skin sores and discomfort, higher fall rates, and faster breakdown and less reliability of the standard prosthesis. Additionally, without access to the appropriate recreational prostheses, adults and children may struggle to reach aerobic capacity (i.e. 50-85% of one's maximum heart rate) for the amount of time recommended by the U.S. Department of Health and Human Services for Americans to be healthy. The 2nd Edition of the Physical Activity Guidelines released in 2019 recommends children have 60 or more minutes each day of moderate- or vigorous-intensity aerobic physical activity. For adults, the recommendation is 150 minutes weekly.

6. What laws concerning this type of coverage already exist in the U.S.?
    a. Currently, only one state has enacted a law mandating that insurance carriers consider the recreational needs of children when determining prosthetics coverage: Maine's LD 1003. Passed in May 2022, LD 1003 is the result of efforts from limb loss advocate Jordan Simpson, whose graduate-level social work project on the issue caught the attention of Maine State Representative Colleen Madigan during a campus visit. This law goes into effect in 2024.
7. Why focus on devices for children?
    a. Physical activity is an essential component of a healthy childhood, playing a role in musculoskeletal, cognitive, emotional, and social development. Because of this, improving access to recreational prostheses for children with disabilities is necessary to ensuring positive outcomes. Due to the success of LD 1003 in Maine, along with other successful public health campaigns focusing on children in the U.S. and abroad, for example the United Kingdom's National Health Service (NHS) fund for children's activity and sports prostheses , we believe that similar policy can (and should) be implemented in other states across the country.
8. Why start So Kids Can Move in Oregon and Washington?
    a. The Pacific Northwest, in particular Oregon and Washington, has a strong O&P community as well as grassroots interest in advancing this effort. Additionally, Oregon has existing insurance fairness legislation, and Washington is actively pursuing this law, which the So Kids Can Move policy depends on. Residents in Oregon and Washington are also among the most physically active in the nation, according to a new analysis released by the Centers for Disease Control & Prevention (CDC). The CDC study on self-reported activity levels found that Washington was the second and Oregon was the fourth most active state in the nation. So Kids Can Move has also built a strong partnership with PNW-based advocacy nonprofit, Forrest Stump, dedicated to promoting physical activity for individuals with disabilities. To help kickstart the initiative, Forrest Stump put together a team of 12 physically challenged "athlete-advocates" to compete in the Hood to Coast (HTC) relay, a 200-mile, 36-hour race from Mount Hood to the Pacific Ocean. By running in HTC, Forrest Stump raised awareness for So Kids Can Move and the need for access to recreational prostheses for children.
9. How many children in Oregon and Washington would this policy impact?
    a. According to the Amputee Coalition, there are currently around 25,000 children living with limb loss and/or limb difference in the U.S. Adjusting that to the populations of Oregon (1.27% of the U.S.) and Washington (2.28% of the U.S.) results in around 318 and 570 children living with limb loss and/or limb difference in each state impacted by the policy, respectively. For comparison, Maine's LD 1003 will affect 144 children living with limb loss and limb difference.
10. How many providers in Oregon and Washington would this impact?
    a. There are currently about 15 suppliers and patient care facilities in Oregon, and 25 suppliers and patient care facilities in Washington, that would be impacted by So Kids Can Move's proposed policy. In Maine, there are around 10 suppliers and patient care facilities affected by LD 1003.
11. How will So Kids Can Move decide which states to focus their advocacy efforts on?

    a. The decision to initiate an advocacy effort in a state involves several factors, including legislative engagement levels of state and regional O&P associations, the history of O&P legislation in a state, O&P provider relationships with policymakers, and insurance favorability to the O&P industry. So Kids Can Move will assess the likelihood of success and determine our ability to intervene on a holistic, case-by-case basis.

12. How long do state legislative advocacy efforts typically take?
    a. The reality is: it depends! Each state has its own legislative calendar, key players, and pressing issues of the day, so there is no one-size-fits-all approach to improving access to recreational prostheses for children that will work in every state. What is important to keep in mind regardless of state, however, is that generating awareness and building legislative support for an issue takes time and persistent effort.
13. How can I get involved?
    a. If you are interested in bringing So Kids Can Move to your state, we'd love to hear from you! Please contact Sam Miller, AOPA State and Federal Advocacy Manager at SMiller@AOPAnet.org to let us know how we can help you begin the process of advocating for recreational prostheses for children. Whether it's coalition-building, legislative drafting, or contacting policymakers, So Kids Can Move has the resources you need to make your voice heard.