LYMPHEDEMA
ADVOCACY GROUP

2025
COVERAGE REPORT
Lymphedema Compression Treatment Items

LYMPHEDEMA
Education & Awareness
PROJECT

2025 Coverage Report

Annual Patient Survey Findings

Contents

Introduction

Why This Report Matters

This was the first annual Insurance Coverage survey of people living with lymphedema. The survey is intended to better understand how health insurance plans cover compression therapy supplies. Compression garments and pumps are essential tools for managing lymphedema, but coverage can vary widely depending on the type of plan and payer.

This report summarizes the results from our 2025 coverage survey, with the intent that patients can use this information to make a more informed decision when selecting their 2026 insurance plan. This data is self-reported and has not been independently verified. The results reflect patient experience, which can differ from actual insurer policy.

If you are unfamiliar with any of the insurance-related terminology used in this report, please refer to this Glossary of Health Coverage and Medical Terms.

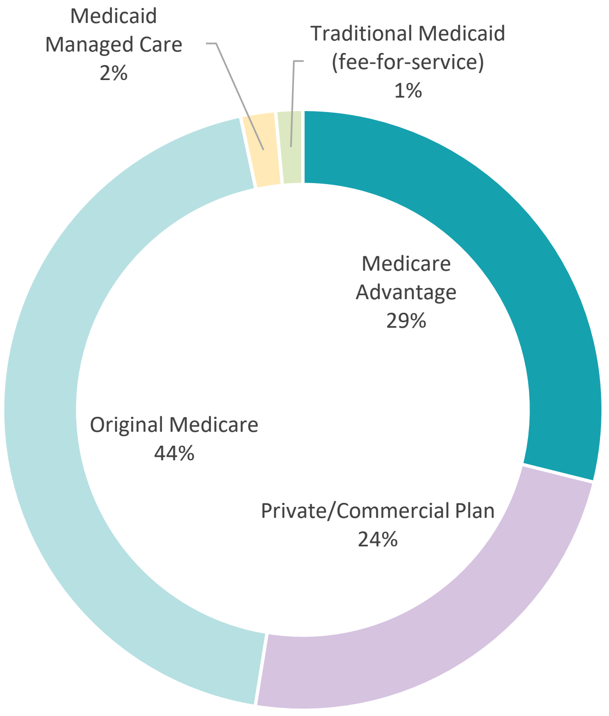
Executive Summary

Most patients reported at least some coverage for lymphedema supplies, however, network access and coverage limitations restrict care for some patients. With the exception of Original Medicare, coverage rates and supplier adequacy vary widely by insurance plan and state.

Where The Data Came From

- Online survey distributed to patients with lymphedema nationwide
- Collected September 2025
- 984 total responses
- 698 complete and unique responses were used to create this report

Most survey respondents were covered by Medicare, with 44% reporting Original Medicare (fee-for-service) and 29% enrolled in Medicare Advantage plans. Private or commercial insurance accounted for 24% of respondents. Medicaid participation was limited, with only 2% under Medicaid Managed Care and 1% under Fee-for-service Medicaid.

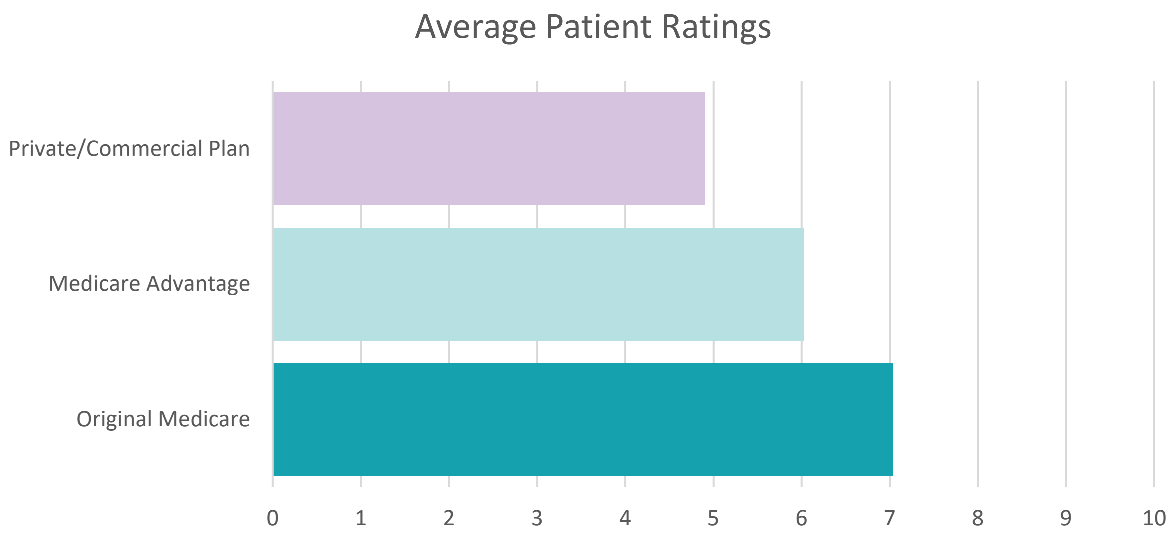


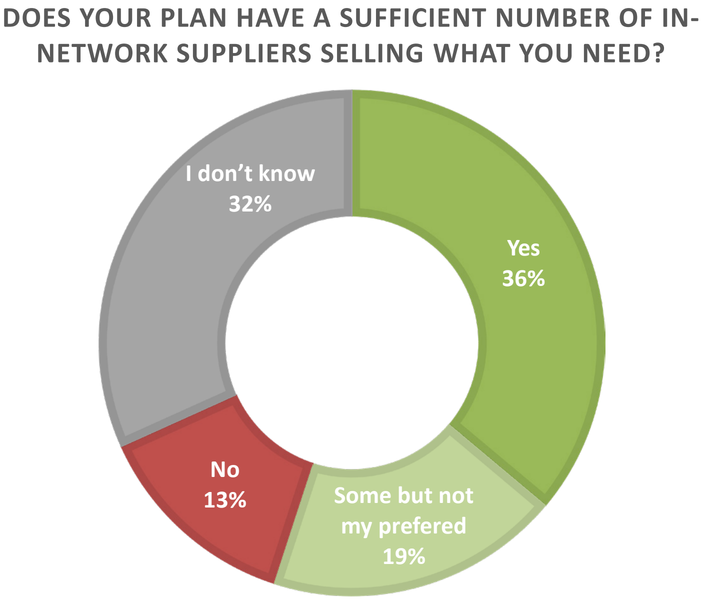
This distribution indicates that the majority of survey participants were Medicare beneficiaries, which may influence overall findings and limit the ability to generalize results to populations primarily covered by private insurance or Medicaid. CHIP, Tricare, and VA have been excluded from this report as the number of respondents for these categories was too low.

Results for individual payers were only included as individual results in the graphs in subsequent sections of this report if they accounted for more than 4% of the total responses for the respective plan type. Responses for individual payers that did not meet this threshold were included in the "other" category.

Overall Patient Satisfaction with Coverage

When asked to rate their satisfaction:



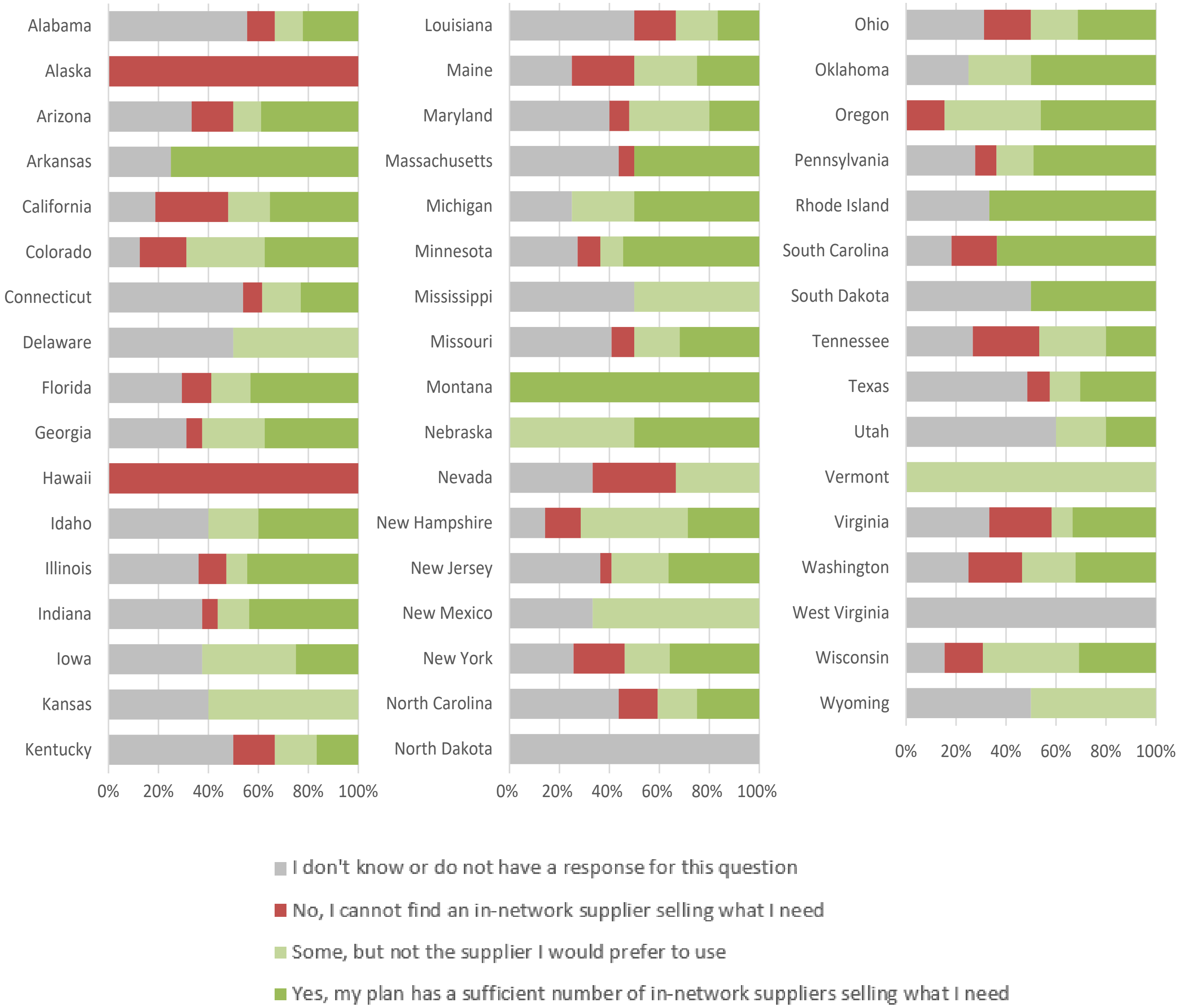


Overall In-Network Supplier Access

Across all payers and product categories, just over one-third of respondents (36%) reported that their insurance plan has a sufficient number of in-network suppliers selling the compression supplies they need. Another 19% indicated that while some suppliers are available, they cannot access their preferred supplier. Thirteen percent reported being unable to find any in-network supplier offering their prescribed products. A sizable portion, 32%, either did not know or did not respond to the question. These results suggest that while many patients experience adequate network access, a notable share still face barriers in finding covered suppliers.

The graph below shows the responses sorted by state, for the question "**Does your insurance plan have enough in-network suppliers that sell the compression garments you have been prescribed?**"

Some states showed nearly universal satisfaction, while others revealed significant gaps in access. These differences suggest that network adequacy for compression garment coverage is inconsistent across the country. However, it is important to note that the number of survey respondents in some states was small, which may skew the results and limit comparability between states.



Hearing from numerous patients that they were having difficulty finding a supplier, especially one that accepts their insurance plan, led to our creation of a Lymphedema Supplier Directory.

Key Considerations when Selecting an Insurance Plan

Verify coverage for lymphedema supplies: Ask if the plan has a written coverage policy for lymphedema compression treatment items. Also ask if there are any exclusions related to lymphedema compression treatment items. If you are unable to obtain this information you can ask what the coverage is for the specific item(s) you need by giving them the billing code, also called the HCPCS code. The current billing codes for all lymphedema compression supplies can be found on the 2025 DMEPOS Fee Schedule.

If you are shopping for a **Medicare Advantage** plan, be cautious of generalizations such as, "we cover everything Medicare does and more." Insist on specific plan information, as those details may greatly impact your ability to access the coverage you are entitled to under the Lymphedema Treatment Act rules. For more information, please see our Medicare Advantage page.

Ask about quantity and frequency limits: Verify how many compression garments will be covered each policy year and how often they can be replaced. Original Medicare covers 3 sets of daytime garments per affected body part every 6 months, 2 sets of nighttime garments per effected body part every 2 years, and no limits on bandaging supplies.

Check supplier access: Ask for a list of in-network suppliers for lymphedema compression treatment items and then contact those suppliers to confirm if they sell the exact items/brands you need. Limited networks can be a significant issue with some plans. Our Lymphedema Supplier Directory can also serve as a resource for finding the supplier best suited to meet your needs, but you should always confirm in-network status with your insurance plan.

Compare all coverage-related costs: In addition to the monthly/annual premiums, it's very important to consider any applicable **deductibles, copays, and coinsurance.** Under almost all plans, policy holders are required to meet a deductible before the plan begins covering Durable Medical Equipment (DME) supplies, after which the plan pays a percentage of the costs for those items, and you also pay a percentage (this is your coinsurance). The deductible and coinsurance can change yearly, even if you don't switch plans, and these amounts can greatly impact what your out-of-pocket costs will be, even if your plan covers all of your lymphedema compression supplies.

With **Original Medicare**, lymphedema compression treatment items are covered under Part B, and the 2026 annual deductible is set at $288. Once that is met, the plan will pay for 80% of the cost of your compression supplies, with the patient responsibility being 20%. If you have a secondary or supplemental plan it may cover the other 20%.

Consult our website: Under the Insurance topic on the main menu of the Lymphedema Advocacy Group website you will find additional information specific to different types of insurance. We also have an insurance-related Frequently Asked Questions page.

Original Medicare & Medicare Advantage Plans

Thanks to passage of the Lymphedema Treatment Act, Medicare is now required to coverage lymphedema compression treatment items as of January 1, 2024.

If you enroll in **Original Medicare** your coverage for compression supplies is clearly defined by the Centers for Medicare and Medicaid Services (CMS) and is outlines on their Lymphedema Compression Treatment Items page.

Although **Medicare Advantage** plans are required to cover anything that Original Medicare does, how Medical Advantage plans implement their coverage can vary significantly. Details such as: available in-network suppliers, the reimbursement rates, out-of-pocket costs, and other factors influencing access to care and are determined by each individual Medicare Advantage plan. It's important to research these differences when choosing your plan each year

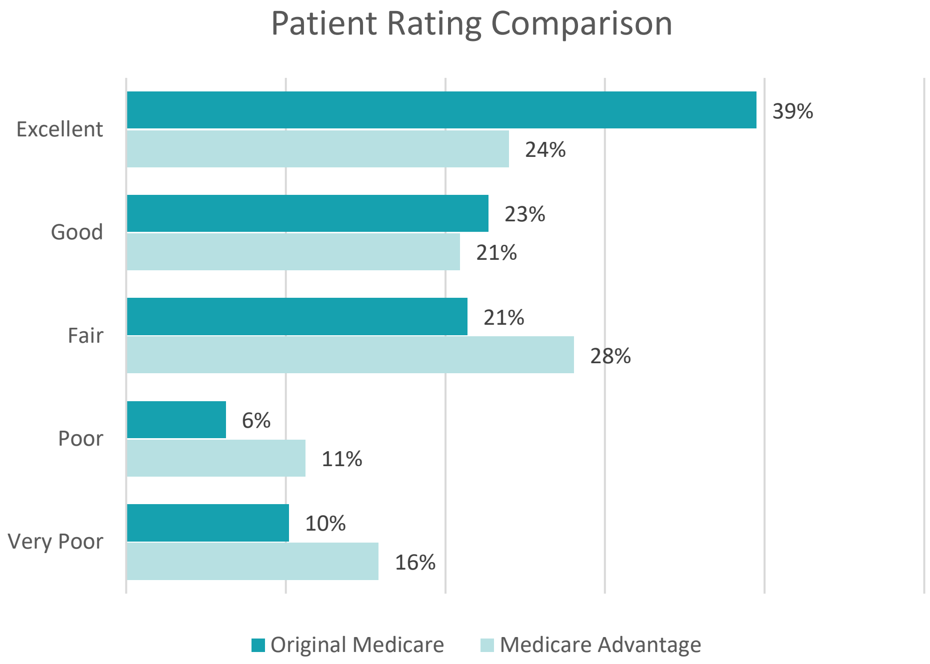
For a more detailed explaination of the differences between Original Medicare, Medicare Advantage, and associated details please visit the CMS.gov page Compare Original Medicare & Medicare Advantage.

The following chart compares **Overall Satisfaction for Original Medicare and Medicare Advantage plans**.

Average Overall Rating

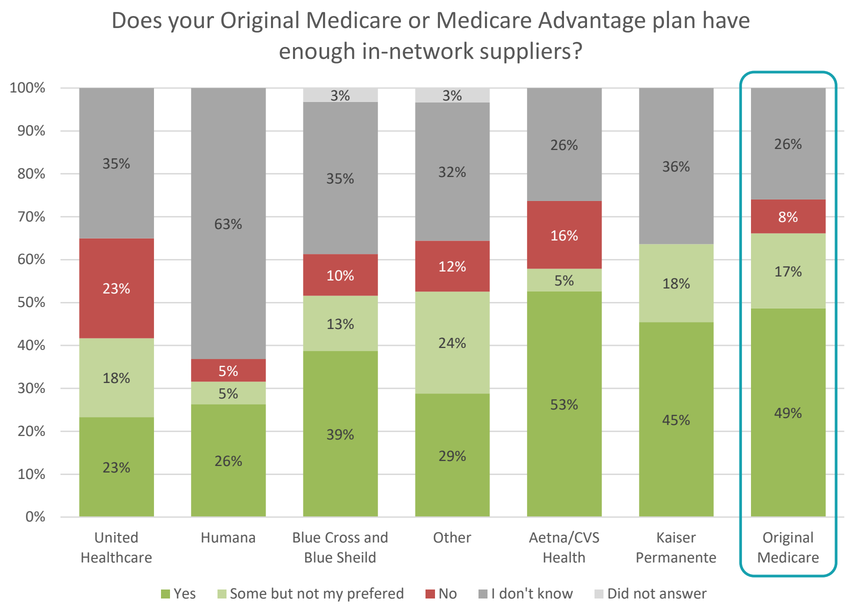
7 Original Medicare

6 Medicare Advantage

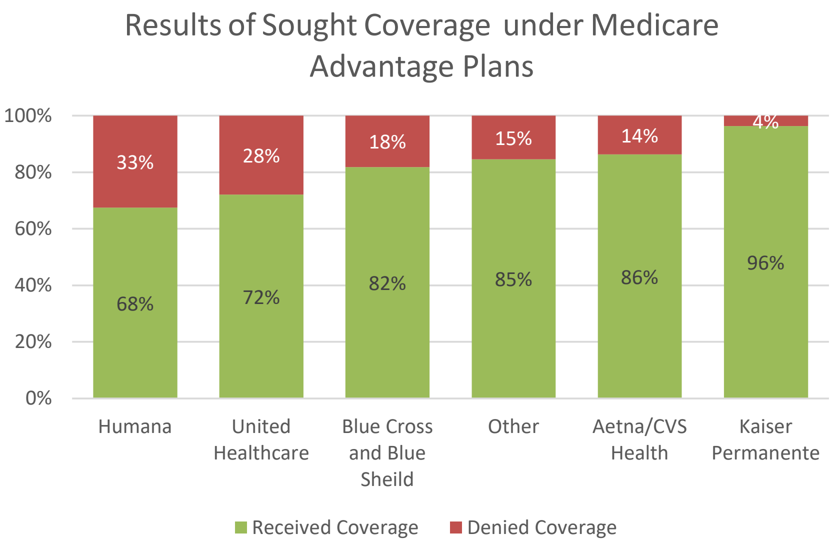


Please see the "**Key Considerations when Selecting an Insurance Plan**" on page 6 for tips.

Reported access to in-network suppliers amongst Medicare Advantage beneficiaries differed considerably by insurer. These findings highlight ongoing variability in supplier availability. As with other survey sections, the results are patient-reported, and small sample sizes for some insurers may affect accuracy and representativeness.



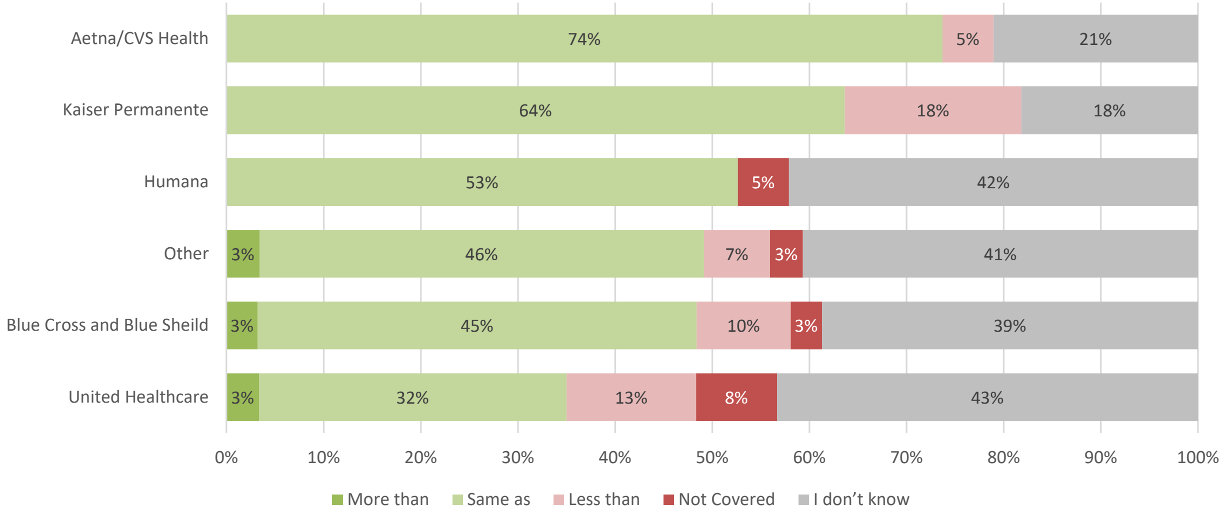
Reported coverage experiences amongst Medicare Advantage policy holders differed considerably by insurer. These results suggest notable inconsistency among Medicare Advantage plans in approving coverage for compression therapy. As with other sections, these findings reflect patient-reported data, and smaller sample sizes for certain insurers may influence the apparent differences.



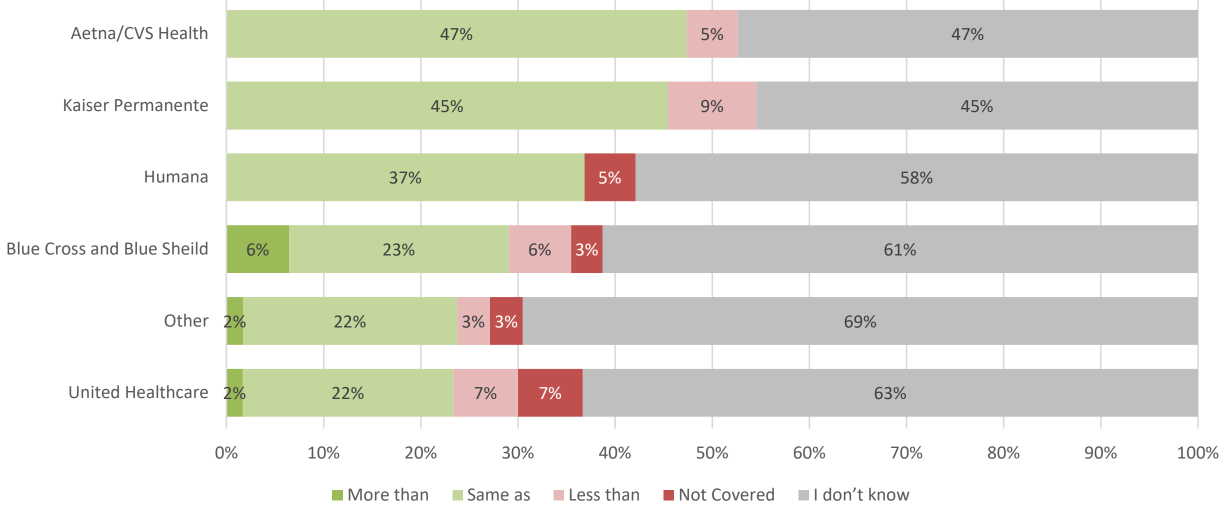
<u>NOTE</u>: Our survey did not collect data on the results of sought coverage under Original Medicare, because coverage for qualifying beneficiaries is guaranteed under the Lymphedema Treatment Act Rules. The purpose of the survey was to compare coverage compliance amongst Medicare Advantage plans, to assist patients in choosing between Original Medicare or one of the many Medicare Advantage plans.

Reported **quantity and frequency limitations amongst Medicare Advantage policy holders** differed considerably by insurer. These results suggest that there is a great deal of variability across Medicare Advantage plans. ***Original Medicare covers 3 sets of Daytime garments for each affected body part every 6 months and 2 sets of Nighttime garments for each affected body part every 2 years.*** While some patients reported receiving coverage that matched the quantity and frequency limitations under Original Medicare, others reported receiving less or even no coverage. As with other sections, these findings reflect patient-reported data, and smaller sample sizes for certain insurers may influence the apparent differences.

How do Medicare Advantage plan quantity and frequency limits for daytime compression (ready to wear and custom) compare to Original Medicare?



How do Medicare Advantage plan quantity and frequency limits for nighttime compression (ready to wear and custom) compare to Original Medicare?



Private Commercial Insurance Plans

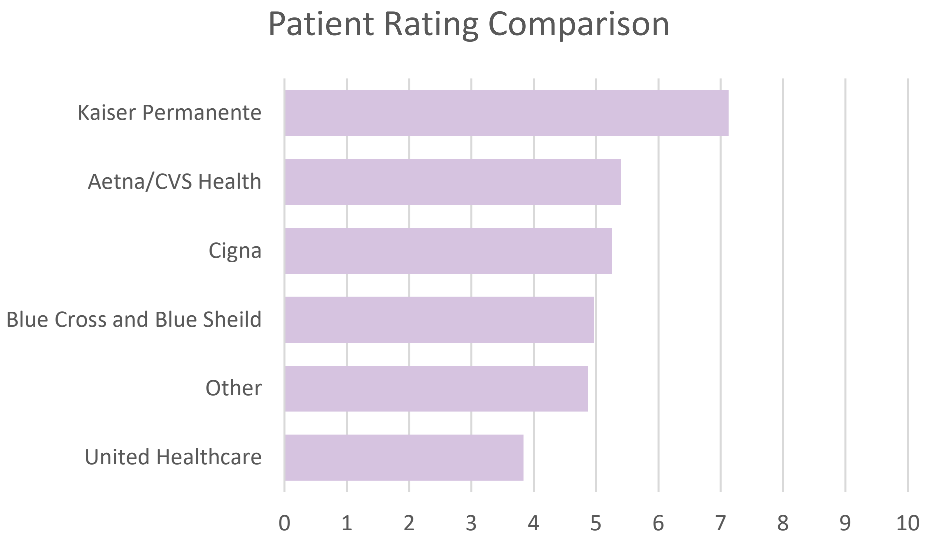
Coverage, costs, and rules can vary widely between private insurance plans that are offered by commercial insurance companies. Unlike Medicare, private plans are not standardized and are not required to comply with the coverage rules established by the Lymphedema Treatment Act, so confirming what benefits will be provided by the plan and what your out-of-pocket costs will be is essential.

Additionally, unlike Medicare, many private plans provide coverage that differs depending on the cause of your lymphedema, what body parts are affected, the state in which your policy is based, and other factors. Some examples include:

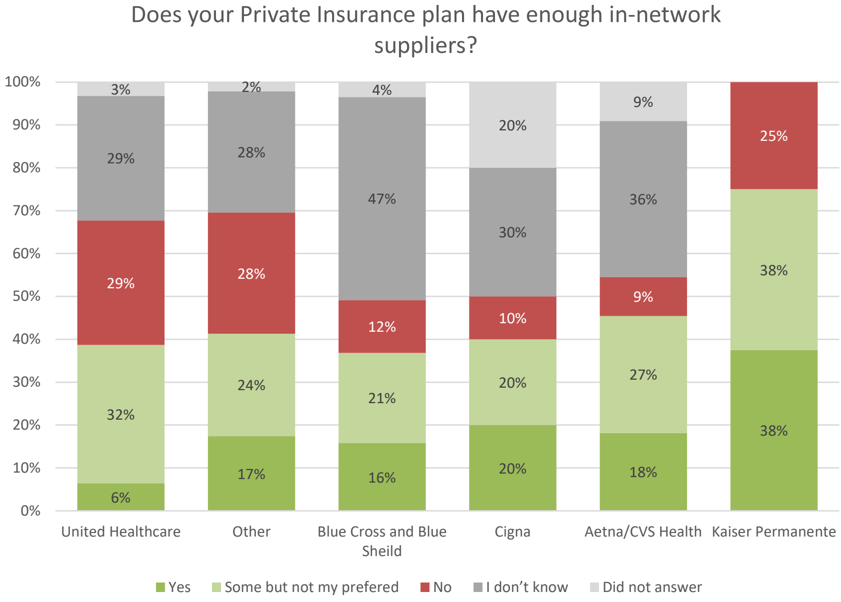
- The Women's Health and Cancer Rights Act requires most private plans to cover breast cancer-related lymphedema, but the coverage only applies to female breast cancer survivors, and only to the parts of the body directly affected by the breast cancer treatment.
- Some policies have exclusions on compression garments for non-limb areas of the body, and some have exclusion on specific brands, so be sure to ask if the plan has any exclusion related to lymphedema or compression garments.
- A handful of states have lymphedema treatment mandates that require certain types of health insurance plans based in that state to provide coverage for compression garments. For a list of these states and links to these state laws visit our Private Insurance page.
- Some policies are adopting mandatory trials of ready-to-wear garments before a patient can qualify for coverage of a custom garment, so if you need custom garments, be sure to ask if there are any pre-requisites for coverage.

For additional tips, please see the "**Key Considerations when Selecting an Insurance Plan**" on page 6.

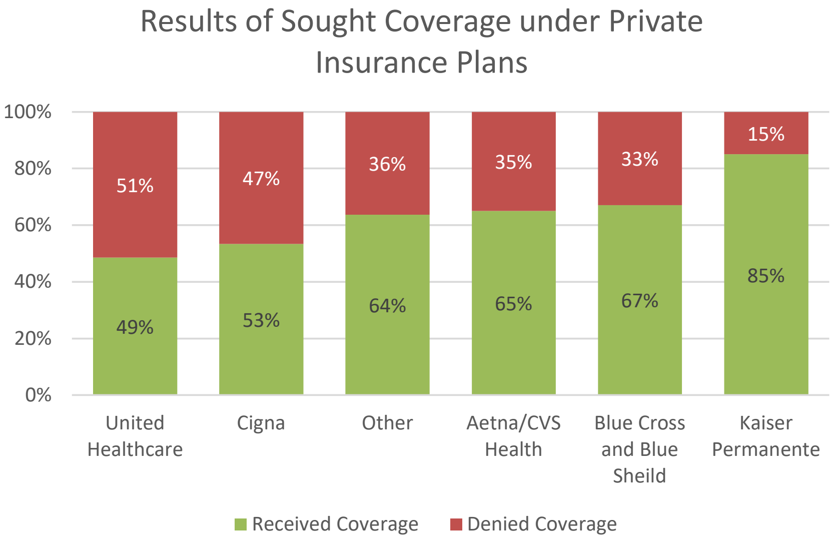
Overall Satisfaction for Private Insurance Plans



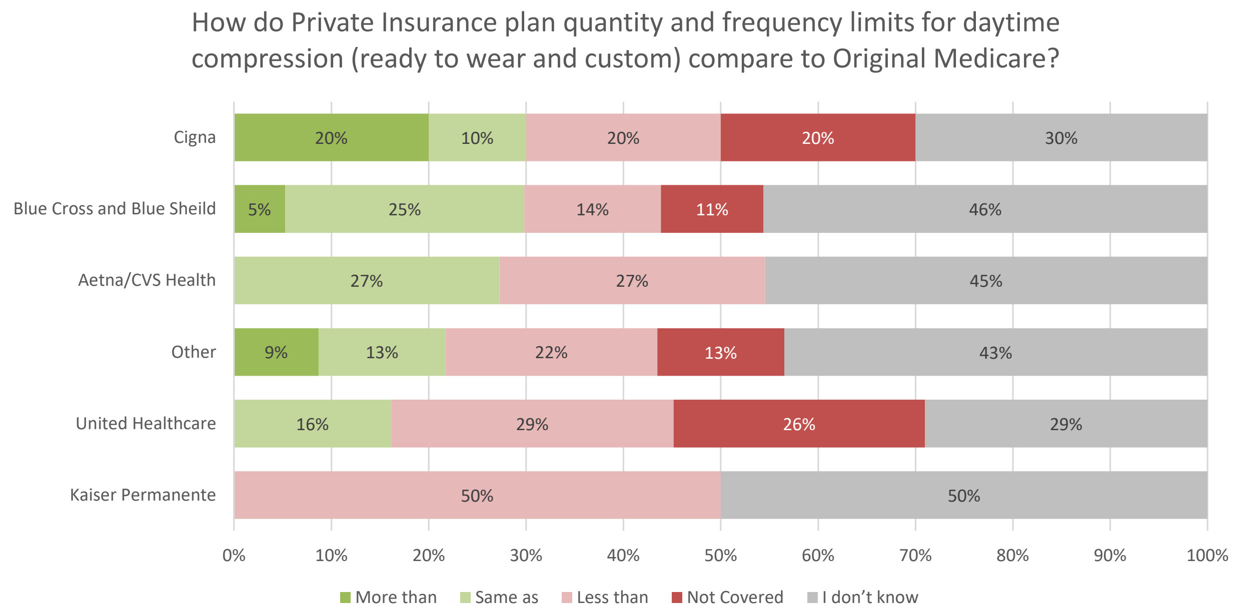
Reported access to in-network suppliers for prescribed compression garments among privately insured patients show considerable variation. These findings suggest significant insurer-to-insurer variation in network adequacy. As with state-level results, the number of respondents per insurer may vary and smaller sample sizes could affect the representativeness of the data.

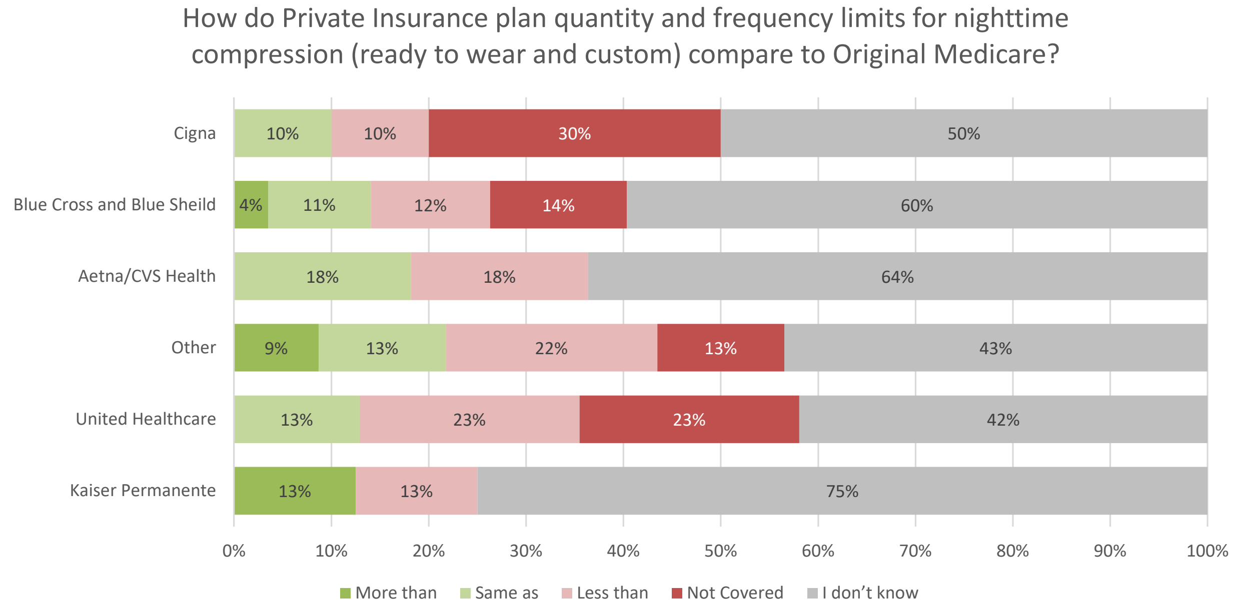

Does your Private Insurance plan have enough in-network suppliers?

Reported coverage experiences amongst privately insured patients differed considerably by insurer. As with other sections, findings are based on patient-reported data, and smaller sample sizes for some insurers may influence apparent differences.


Results of Sought Coverage under Private Insurance Plans

Reported **quantity and frequency limitations amongst Private/Commercial plans** differed considerably by insurer. ***Original Medicare covers 3 sets of Daytime garments for each affected body part every 6 months and 2 sets of Nighttime garments for each affected body part every 2 years.*** While some patients reported receiving coverage that matched the quantity and frequency limitations under Original Medicare, others reported receiving less or even no coverage. As with other sections, these findings reflect patient-reported data, and smaller sample sizes for certain insurers may influence the apparent differences.


How do Private Insurance plan quantity and frequency limits for daytime compression (ready to wear and custom) compare to Original Medicare?


How do Private Insurance plan quantity and frequency limits for nighttime compression (ready to wear and custom) compare to Original Medicare?

Conclusion

The 2025 survey indicates meaningful progress in insurance coverage since the implementation of the Lymphedema Treatment Act, though notable gaps remain. These findings are based on patient-reported data and are limited by smaller sample sizes for certain insurers and the overall number of respondents. Additionally, insurance plans can change from year to year, so patients should carefully research their options using the **"Key Considerations when Selecting an Insurance Plan"** on page 6.

This report will be updated annually. As participation grows, future editions will provide deeper insights—such as coverage by product type and more detailed comparisons across insurance companies. We extend our sincere thanks to all who contributed to this inaugural survey. Your shared experiences strengthen the case for improved coverage policies nationwide. Please share this report with others who may benefit.

This report can be accessed at Insurance Coverage Reporting, or by scanning the QR code.

If you would like to continue to receive information from us, please join our mailing list.

If you've been denied coverage or are receiving insufficient coverage under any insurance plan, please use our denial reporting form.

bitly

ABOUT US

The **Lymphedema Advocacy Group (LAG)** is an all-volunteer, grassroots organization of patients, caregivers, healthcare professionals and industry partners. LAG's mission is to advance care in the United States by improving lymphedema-related insurance coverage, and leads ongoing efforts to better coverage through legislation, regulatory actions, and policy decisions. The Lymphedema Advocacy Group is a 501(c)(4) nonprofit organization.

The **Lymphedema Education & Awareness Project (LEAP)** was founded by members of the Lymphedema Advocacy Group after passage of the Lymphedema Treatment Act, and the two groups work in partnership. LEAP's mission is to improve access to care for this underserved patient population through lymphedema education and awareness initiatives. The Lymphedema Education and Awareness Project is a 501(c)(3) nonprofit organization.