



Evaluation of SF 1101 – Coverage for Augmentative and Alternative Communication Systems

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J. 26

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Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

Bill Requirements

This Senate bill is sponsored by Sen. Wiklund and was introduced in the 94th Legislature (2025-26) on February 6, 2025.

If enacted, this bill would require health issuers to provide coverage for augmentative and alternative communication systems, including repair and replacement, as determined medically necessary and appropriate. This proposed mandate also requires coverage for habilitation services as medically necessary. Health issuers would be prohibited from imposing separate financial requirements or quantity limits on augmentative and alternative communication systems or associated habilitation services. While prior authorization may be required for these systems and services, it must be applied in a manner consistent with other covered benefits that require prior authorization. If performing utilization reviews, health issuers must use the most current version of evidence-based guidelines relevant to the system or service and conduct reviews in a non-discriminatory fashion.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, the State Employee Group Insurance Program (SEGIP), and Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to Medicare supplemental policies, self-insured employer plans, or grandfathered plans.

This bill would create Minn. Stat. § 62Q.671 and amend Minnesota Statutes 2024, section 256B.0625, subdivisions 31 and 31a, and Minnesota Statutes 2024, section 256B.4914, subdivision 12.

Key Terms

For the purpose of this bill and its evaluation:

- "Augmentative and alternative communication system" means any electronic or nonelectronic device and related software and components, including mounting systems, that assist a person with severe expressive communication limitations to supplement existing speech or replace speech that is not functional.
- "Habilitation services" means speech therapy provided for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal speech to assess, select, and develop augmentative and alternative communication systems and to provide training in their use.

Related Health Conditions and Associated Services

Augmentative and alternative communication systems and habilitation services are associated with speech-language impairments due to conditions such as:¹

- Cerebral palsy;
- Developmental disability;
- Genetic disorders; and
- Amyotrophic lateral sclerosis (ALS).

Augmentative and alternative communication systems and habilitation services include, but are not limited to:²

- Use of an electronic tablet with an application that allows a person to communicate;
- Use of a computer as a speech-generating device; and
- Speech language therapy.

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from three commercial health issuers, one health care organization, two advocacy organizations, one health care professional, and three individual advocates.

Current Coverage and Access to Services. There is a wide variety of current coverage for augmentative and alternative communication systems and habilitation services. One respondent noted that at least one issuer does not currently provide coverage as directed under the bill, while another noted that at least one issuer currently provides coverage for cochlear implants and hearing aids, but does not provide coverage for other services or devices under the scope of this mandate (e.g., speech generating devices). One respondent suggested that the specific billing codes would be needed to determine whether these services are currently covered. Several respondents noted that any requirement of commercial health plans to cover augmentative and alternative communication should allow plans to institute quantity limits and prior authorization to ensure appropriate use.

Multiple respondents expressed concern about the current misalignment between Medical Assistance coverage and private insurance, as Medical Assistance already mandates coverage for augmentative and alternative communication systems. Additionally, multiple respondents indicated that while schools can provide access to augmentative and alternative communication devices during school hours, that access can be limited and schools struggle with a backlog of requests.

Advancing Disability Services. Multiple respondents noted that augmentative and alternative communication is essential for empowering individuals with disabilities. This includes the ability to express when they feel pain and describe symptoms of illness, communicate within their communities, gain independence, and be engaged members of society. Respondents emphasized that a child’s voice is a medical necessity and should be considered as such for purposes of coverage decisions. Many respondents also suggested that coverage of augmentative and alternative communication systems also aligns with Minnesota’s Olmstead Plan goal to help fulfill the rights of people with disabilities to live full, integrated lives in their communities.

Clarity of Bill Language. Several respondents expressed concern with the broad language of the bill and suggested updates. One respondent suggested defining “severe” expressive communication or ensuring coverage requirements followed clinical guidance or language. One respondent suggested limiting coverage to “dedicated speech generating devices.” Two respondents noted that coverage should include backup devices to be utilized during repair of the main device and should include coverage for care giver training, as well as access methods and accessories (e.g., eye-gaze systems, adaptive switches, keyguards, mounts, speakers). Three respondents noted that Medicare can be utilized as a baseline of coverage but is often inadequate for pediatric and complex cases.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB’s health plan administrators estimated the average state fiscal impact of the proposed mandate to be \$0.10 per member per month (PMPM), as the bill would expand the current health care coverage for augmentative and alternative communication systems and associated habilitation services (see [State Fiscal Impact section](#)).
- Respondents noted that if this mandate were enacted, it may result in an estimated cost increase ranging from \$0.09 PMPM to \$14.24 PMPM.

Stakeholders’ results may or may not reflect generalizable estimates for this mandate, depending on the methodology, data sources, and assumptions used for analysis.

Evaluation Limitations

The evaluation of the potential public health and economic impacts for this mandate was limited by several factors. Coverage for augmentative and alternative communication systems includes a vast array of services and devices under the broad list of potential conditions and associated diagnosis codes included in the bill language. Given the broad range of potential Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases, Tenth Revision (ICD-10) codes needed for a representative analysis, this proposed mandate would require significant narrowing of scope that may or may not represent the most significant cost drivers associated with coverage.

Additionally, given the mandate’s coverage for associated repair and replacement, it is outside of a feasible scope for the evaluation to determine the range of frequency and cost for repair and replacement for each

device covered under the broad definition of augmentative and alternative communication systems. Each device may have differing timelines, requirements, and lifespan. As a result, a claims analysis using the Minnesota All Payer Claims Database may not be representative of the potential economic impact of the proposed mandate. Furthermore, the available literature focuses primarily on the pediatric population and school-based settings, which are not representative of the broader populations and care environments addressed in the proposed language. There was also limited literature available on the financial requirements and the impact of quantity limits for augmentative and alternative communication systems and associated habilitative services.

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to Minnesota Health Care Programs.

- MMB estimates the cost of this legislation for the state plan to be \$79,800 for partial Fiscal Year 2027 (FY 2027) and \$167,580 for FY 2028.
- It is unclear if the proposed mandate would be subject to partial defrayal.
- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare).

Fiscal Impact Estimate for SEGIP

MMB provided SEGIP's fiscal impact analysis, which is based on the 2024 large group book of business claims data. MMB's analysis predicted a fiscal impact ranging from \$0.05 PMPM to \$0.15 PMPM, with an average of \$0.10 PMPM. MMB noted that the impact range is due to the uncertainty in utilization. They also noted that SEGIP currently covers habilitative and rehabilitative therapy services, but does not cover augmentative and alternative communication systems. The PMPM estimate assumes that member cost-sharing would be aligned with other durable medical equipment and that prior authorization would be applied in alignment with other covered benefits. The partial fiscal year impact of the proposed legislation on SEGIP is estimated to be \$79,800 for partial FY 2027 (\$0.10 PMPM medical cost x 133,000 members x 6 months). The estimated impact for FY 2028 equals \$167,580, and the amount is estimated to increase by a 5% annual inflation factor each of the following years due to the increasing cost of medical services.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

If enacted, it is unclear if this proposed mandate would constitute an additional benefit mandate requiring partial defrayal due to new requirements for specific care, treatment, or services that are not already covered by Minnesota's EHB Benchmark Plan. Due to the broad definition of augmentative and alternative communication systems, some devices may not be considered durable medical equipment and would therefore require defrayal. Additional repair and replacement of these systems may also require defrayal. Without more detailed definitions, Commerce is unable to provide an educated estimate of defrayal costs to the state at this time. Future estimation may also be difficult absent language addressing quantity limits for the proposed services and devices.

Fiscal Impact of State Public Programs

This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) and may have a cost. While Medical Assistance and MinnesotaCare currently cover augmentative and alternative communication systems, additional costs may be incurred from specific coverage requirements of the proposed mandate. However, a fiscal estimate has not yet been completed on this proposed mandate.

Appendix A. Bill Text

Section 1. [62Q.671] COVERAGE FOR AUGMENTATIVE AND ALTERNATIVE COMMUNICATION SYSTEMS.

Subdivision 1. Definitions.

- (a) For the purposes of this section, the terms in this subdivision have the meanings given.
- (b) "Augmentative and alternative communication system" means any electronic or nonelectronic device and related software and components, including mounting systems, that assist a person with severe expressive communication limitations to supplement existing speech or replace speech that is not functional.
- (c) "Habilitation services" means speech therapy rendered for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal speech to assess, select, and develop augmentative and alternative communication systems and to provide training in their use.

Subd. 2. Coverage.

- (a) A health plan must provide coverage for augmentative and alternative communication systems, including repair and replacement, determined by the enrollee's prescribing physician to be both medically necessary and the most appropriate system to meet the enrollee's communication needs.
- (b) A health plan must provide coverage for habilitation services determined by the physician who prescribed the augmentative and alternative communication device to be medically necessary.
- (c) A health plan must not subject augmentative and alternative communication systems and associated habilitation services to separate financial requirements that apply only to those benefits.
- (d) A health plan must not apply any quantitative limits to habilitation services associated with a prescribed augmentative and alternative communication system when the habilitation services are ordered by the prescribing physician.

Subd. 3. Prior authorization.

- (a) A health plan may require prior authorization for augmentative and alternative communication systems and associated habilitation services in the same manner and to the same extent as prior authorization is required for any other covered benefit.
- (b) When performing a utilization review for a request for coverage of augmentative and alternative communication systems and associated habilitation services, a health plan company must apply the most recent version of evidence-based guidelines recognized by relevant clinical specialists.
- (c) A health plan company must render utilization review determinations in a nondiscriminatory manner and must not deny coverage for augmentative and alternative communication systems and associated habilitation services solely on the basis of an enrollee's actual or perceived disability.

Subd. 4. Reimbursement.

(a) The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Augmentative and alternative communication systems and associated habilitation services covered by the health plan as of January 1, 2025, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2025, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to all health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. Medical supplies and equipment.

(a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

- (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;
- (2) the vendor serves ten or fewer medical assistance recipients per year;
- (3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under ~~subdivision 31a, paragraph (a)~~ section 62Q.671. To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat a health condition of the recipient that causes the seizure activity.

(j) For purposes of paragraph (i), "seizure detection device" means a United States Food and Drug

Administration-approved monitoring device and related service or subscription supporting the prescribed use of the device, including technology that provides ongoing patient monitoring and alert services that detect seizure activity and transmit notification of the seizure activity to a caregiver for appropriate medical response or collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity. The medical assistance reimbursement rate for a subscription supporting the prescribed use of a seizure detection device is 60 percent of the rate for monthly remote monitoring under the medical assistance telemonitoring benefit.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 31a, is amended to read:

Subd. 31a. Augmentative and alternative communication systems.

(a) Medical assistance covers augmentative and alternative communication systems ~~consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability as defined under section 62Q.671.~~

(b) Augmentative and alternative communication systems must be paid the lower of the:

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 4. Minnesota Statutes 2024, section 256B.4914, subdivision 12, is amended to read:

Subd. 12. Customization of rates for individuals.

(a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6 to 9. The customization rate with respect to deaf or hard-of-hearing persons shall be \$2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf and hard-of-hearing" means either:

(1) the person has a developmental disability and:

- (i) an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;
 - (ii) an expressive communications score that indicates the person uses single signs or gestures, uses an augmentative and alternative communication ~~aid system~~, or does not have functional communication, or the person's expressive communications is unknown; and
 - (iii) a communication score which indicates the person comprehends signs, gestures, and modeling prompts or does not comprehend verbal, visual, or gestural communication, or that the person's receptive communication score is unknown; or
- (2) the person receives long-term care services and has an assessment score that indicates the person hears only very loud sounds, the person has no useful hearing, or a determination cannot be made; and the person receives long-term care services and has an assessment that indicates the person communicates needs with sign language, symbol board, written messages, gestures, or an interpreter; communicates with inappropriate content, makes garbled sounds or displays echolalia, or does not communicate needs.

EFFECTIVE DATE. This section is effective January 1, 2026.

Works Cited

1. Augmentative and alternative communication (AAC). American Speech-Language-Hearing Association. Accessed September 8, 2025. <https://www.asha.org/njc/aac/?srsId=AfmBOoq3LqziEplnAdLauqYG1obCWBq7XFBKojljk-KABgkJC0esiPq>
2. Augmentative and alternative communication (AAC). American Speech-Language-Hearing Association. Accessed September 8, 2025. <https://www.asha.org/practice-portal/professional-issues/augmentative-and-alternative-communication/?srsId=AfmBOopzSxNVMxfR8JDEJmHi6ZR-UbY0A-tQxzO20FpQ5IWA1a33SICA>