



Evaluation of SF XXXX – Coverage for Power Standing Systems

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

January 28, 2025

Report Prepared By

This report was prepared by the American Institutes for Research (AIR) at the request of the Minnesota Department of Commerce. AIR created this document for internal use by the Minnesota Department of Commerce pursuant to Contract No. 216732. The document assumes reader familiarity with the proposed mandated health benefits currently under consideration by the Minnesota State Legislature. The document was prepared solely to assist the Minnesota Department of Commerce. No other use of this document or the information or conclusions contained herein is authorized. The period of data collection for any policies and literature analyzed for the proposed mandate ended on December 31, 2024.

Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

Minnesota Department of Commerce
85 7th Place East
St. Paul, MN 55101
651-539-1734
HealthInsurance.DivisionRequests@state.mn.us
mn.gov/commerce/

As requested by Minnesota Statute § 3.197: This report cost approximately \$33,797.00 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper. A 508 compliant version of this report is forthcoming.

Contents

- Executive Summary4
- Introduction.....5
- Bill Requirements5
- Related Health Conditions and Associated Services5
- Related State and Federal Laws6
 - Relevant Federal Laws.....6
 - Relevant Minnesota Laws6
 - State Comparison6
- Public Comments Summary.....6
 - Key Stakeholder Comment Themes7
 - Cost Estimates Provided in Stakeholder Comments7
- Evaluation of Proposed Health Benefit Mandate.....8
 - Methodology8
 - Public Health Impact8
 - Economic Impact 11
 - Limitations..... 12
 - Data Limitations 12
- State Fiscal Impact..... 12
 - Fiscal Impact Estimate for SEGIP 13
 - Patient Protection and Affordable Care Act Mandate Impact and Analysis 13
 - Fiscal Impact of State Public Programs 13
- Appendix A. Bill Text..... 14
- Appendix B. Key Search Terms for Literature Scan 16
- Works Cited 17

Executive Summary

If enacted, the proposed mandate would require a health issuer to provide coverage for at least one power standing system recommended by a provider for individuals in a wheelchair every five years.

There are no specific health conditions identified by the proposed mandate. Power standing systems are used by individuals with a broad range of conditions, including spinal cord injury or other chronic neurological conditions, who require a wheelchair for primary mobility and are non-ambulatory.

There are no current federal laws requiring coverage of power standing systems. While both Minnesota law and federal law have coverage requirements for durable medical equipment (DME), power standing systems are not currently included in this category. There were no similar state health benefit mandates identified in this evaluation, but five states have Medicaid guidelines relating to power standing systems or DME that are relevant to the proposed coverage.

Overall, public comments submitted by health issuers and advocacy organizations expressed concern regarding the eligibility criteria for power standing systems and replacement criteria. Respondents recommend adding provisions related to medical necessity criteria, as well as specific health care professionals who would be required to make eligibility determinations.

The literature related to the potential public health and economic impact of the proposed coverage is limited, given the various conditions that may be appropriate for power standing systems use, condition-specific comorbidities of individuals impacted by relevant conditions, and limited studies evaluating the cost and potential cost-effectiveness of power standing systems. There are some studies that suggest the potential benefit of power standing systems on various health outcomes, including reduced risk of pressure ulcers and cardiovascular system functioning. However, there were no studies identified in the evaluation inclusion criteria that addressed the long-term impact of power standing systems on health outcomes.

An actuarial analysis was not feasible for the proposed mandate, given the considerable variation of conditions that would be covered by the proposed mandate and anticipated sample size challenges from the Minnesota All Payer Claims Database given the current levels of coverage.

The potential state fiscal impact of this mandate is as follows:

- Minnesota Management and Budget estimates the cost of this proposed mandate for the State Employee Group Insurance Program to be \$0.05 per member per month, which equals \$39,000 for partial Fiscal Year 2026 (FY 2026) and \$81,900 for FY 2027.
- Commerce has determined that this proposed mandate would likely require full defrayal under the Patient Protection and Affordable Care Act, with an estimated cost between \$400,000 and \$1,500,000 in the first year.
- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) and may have a cost.

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 an evaluation of 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

Senate File (SF) XXXX is sponsored by Senator Kari Dziedzic.^a At the time Commerce received the request for evaluation, the bill had not yet been introduced.

If enacted, this bill would require a health issuer to provide coverage for at least one power standing system, recommended by a provider for individuals in a wheelchair, every five years. Additionally, a health issuer would not be able to apply cost-sharing (e.g., deductible, co-insurance, or co-payment) or limit referrals for power standing systems to more than what is applicable for other coverage items in the plan (e.g., utilization reviews, referral requirements, or delay periods).

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 self-insured employer plans, grandfathered plans, and Medicare supplemental policies.

This bill would create Minn. Stat. § 62Q.667 and amend Minn. Stat. § 256B.0625, by adding a subdivision.

Related Health Conditions and Associated Services

There are no specific conditions identified by the proposed mandate. Power standing systems are used by individuals with a broad range of conditions who require a wheelchair for primary mobility and are non-ambulatory. This may include individuals with spinal cord injury or other chronic neurological conditions.¹

Equipment that must be covered by insurance includes power standing systems, which move power wheelchair users from a seated position, with horizontal seat position parallel to the floor, into a supported standing position.¹ The standing position can range from less than 50 to 90 degrees (vertical to the floor) with therapeutic benefits. To be operated safely, it can only be applied to specific power wheelchairs.

^a Senator Kari Dziedzic passed away on December 27, 2024.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

Relevant Federal Laws

There are no current federal laws specific to coverage for power standing systems. However, as of May 2023, Medicare revised coverage to include power seat elevation systems as durable medical equipment (DME).² This coverage does not extend to power standing systems, as the Centers for Medicare & Medicaid Services (CMS) considers power seat elevation systems and power standing systems as distinct categories of power wheelchair accessories. In July 2023, a congressional letter was sent to CMS requesting coverage of power standing systems as DME.³ As of November 2024, power standing systems remain uncovered.

Relevant Minnesota Laws

Under Minn. Stat. § 297A.67, subd. 7, DME includes equipment that is used to serve a medical purpose, is not useful in the absence of illness or injury, is not worn on or in the body, and can withstand repeated use.⁴ This encompasses wheelchairs and some wheelchair accessories (e.g., wheelchair cushions), but excludes mobility enhancing equipment such as power standing systems.^{4,5}

State Comparison

While there were no similar state health benefit mandates identified in this evaluation, five states have Medicaid guidelines relating to power standing systems or DME. Iowa Medicaid covers a power standing system when the patient requires the system to complete activities of daily living (ADL).⁶ Colorado Medicaid covers power standing systems if the system reduces the need for a caregiver and enables the user to perform ADL.⁷ New York, Massachusetts, and California Medicaid programs have overarching DME guidelines that can include coverage for power standing systems in some instances when medical necessity guidelines are met.⁸⁻¹⁰ These three states mention that DME must meet certain characteristics, including “withstand repeated use for a protracted period of time” and “must not be useful to an individual in the absence of an illness, injury or congenital anomaly”.⁸⁻¹⁰ No state health benefit mandates were found for private insurance coverage for power standing systems.

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 four commercial health issuers, one health care organization, and three advocacy organizations.

Current Coverage. Three respondents confirmed that some commercial health insurance plans in Minnesota provide limited coverage for power standing systems with cost-sharing and prior authorization for qualifying members. However, another respondent stated that power standing systems are not covered for adults, as they are not considered medical in nature, which they noted aligns with CMS's justification for not covering them under Medicare.

Eligibility, Replacement, and Referral Concerns. Three respondents shared concerns and recommendations regarding eligibility criteria for power standing systems. One respondent highlighted that mandating replacement of power standing systems every five years, regardless of medical necessity, may not be appropriate. They added that the proposed coverage could lead to increased costs passed on to patients, as current coverage allows for repair, replacement, or revision only when necessary due to normal wear and use. Another respondent recommended increasing the period of replacement to 10 years, and that eligibility for replacement should be based on medical necessity at that time period. This respondent recommends clarifying the bill language by changing the term "recommend" to "ordered" by a provider. The third respondent proposed limiting who can recommend power standing systems to licensed and contracted health care professionals with expertise in power standing systems. Respondents emphasized that any cost increases resulting from the proposed mandate could lead to higher premiums for all enrollees.

General Comments. One respondent highlighted Minnesota's implementation of [Minn. Stat. § 62M.07](#), effective January 1, 2026, which prohibits prior authorization for certain medical conditions, including outpatient mental health or substance use disorder treatment, antineoplastic cancer treatment per National Comprehensive Cancer Network® guidelines (excluding medications), preventive services, pediatric hospice care, neonatal abstinence program treatment by pediatric pain or palliative care specialists, and chronic condition treatment. The respondent suggested that many of this year's proposed mandates fall under this new statute and expressed concerns that removing prior authorization could increase health care costs and negatively affect health outcomes for Minnesotans.

Another respondent noted that all of the proposed health benefit mandates have the potential to broadly improve health outcomes for Minnesotans by enhancing their quality of life, supporting individuals, families, and caregivers, and increasing workforce participation, while also benefiting the broader health care system.

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 \$0.05 per member per month (PMPM), as the bill would expand the Advantage Plan to include coverage for power standing systems (see State Fiscal Impact section).

- Commercial health insurance plans in Minnesota currently provide limited coverage for durable medical equipment, prosthetics, and medical supplies including wheelchairs and power standing systems for wheelchairs, with cost-sharing and prior authorization requirements. If enacted, respondents indicated that plans that currently provide coverage for power standing systems would not expect an increase in premiums. However, some plans with limited coverage may expect an increase of up to \$0.10 PMPM.

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

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review performed to examine the potential public health and economic impact of the mandate. The literature review includes moderate- to high-quality relevant peer-reviewed literature and/or independently conducted research with domestic data that was published within the last 10 years and is related to the public health, economic, or legal impact of the proposed health benefit mandate. For further information on the literature review methodology, please reference <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

Public Health Impact

Background on Associated Conditions

Prevalence of Ambulatory Disabilities and Wheelchair Use. In the United States (U.S), 0.02% of individuals under age 18, 0.06% between ages 18 and 64, and 0.15% aged 65 and over use an electric wheelchair.¹¹ Across wheelchair users (manual and electric), 25.8% have difficulty standing and 61.0% are unable to stand for at least 20 minutes. In Minnesota, approximately 593,700 individuals have one or more disabilities, representing 10.9% of the population.¹² Of those living with a disability, 265,800 have an ambulatory-based (e.g., walking) disability, which may or may not require fulltime use of a wheelchair. As noted, there are many conditions that may result in full-time wheelchair use for mobility, including many neurological and congenital health conditions.¹ The conditions most commonly associated with ambulatory disabilities and full-time wheelchair use include spinal cord injury (SCI), Duchenne muscular dystrophy (DMD), and progressive neurological conditions such as multiple sclerosis (MS). While other conditions are likely covered by the proposed mandate, the literature scan focuses on these conditions.

SCI can occur at different levels of the spinal cord.¹³ Spinal cord injuries may result in the permanent loss of the ability to voluntarily control movement in the arms, torso, and/or legs. As of 2018, there were an estimated 10,800 individuals living in Minnesota with some level of paralysis from SCI.¹⁴ Unlike SCI, DMD and MS are progressive conditions that may first present with weakness, and can eventually progress to requiring fulltime use of a wheelchair.^{15,16} The prevalence estimates for DMD and MS in Minnesota were not identified through this evaluation, and current models for national prevalence anticipate underestimating impacted populations.

Additionally, the percentage of individuals that would be prescribed a power standing system for SCI, DMD, and MS are not currently known, given the variation in functional level for these conditions.

Clinical Practice and Power Standing Systems. Depending on an individual's condition and level of function, different wheelchairs may be prescribed. Power wheelchairs represent a broad category of electric wheelchairs with a variety of accessories, including specialized seat cushions, tilt controls, or headrests to address horizontal mobility. Power standing systems and power elevated seats^b address vertical mobility not otherwise addressed by power chairs alone.^{1,17} Similar to power standing systems, power elevated seats have limited coverage.¹⁷ While there is no one standard of care for all individuals with a wheelchair or with a specific condition, leading wheelchair guidelines recommend that wheelchair prescription should be based on individual considerations that include condition, function, and home environment.^{18,19}

While supported standing and power standing systems are used in clinical practice, clinical practice guidelines do not currently include standing interventions. As such, there are no guideline-based recommendations for specific standing interventions (e.g., equipment type or supported standing), standing duration, and/or standing frequency for optimal health outcomes.²⁰ The benefits of standing, and duration required to receive a benefit from standing, may be based on an individual's condition.²⁰ For DMD, a consensus statement on power standing systems recommends power standing systems for individuals with specific clinical presentations to improve independence and quality of life.²¹ The statement indicates that several factors should be considered by clinicians as to which patients would benefit from these systems. These factors include a non-ambulatory function or prediction of non-ambulatory status within 1-2 years, a support system for use and function of a power standing system, and tolerance in supported standing.

Effectiveness of Power Standing Systems to Impact Health Outcomes

Those with full-time wheelchair use may be at higher risk for specific health consequences and comorbidities, such as decreased joint mobility, loss of bone mineral density, kidney and bladder dysfunction, gastrointestinal issues (e.g., digestive issues), and pressure injuries.^{1,22,23} Additionally, some comorbidities associated with extended sitting may also result from an individual's primary injury or condition.²³⁻²⁵ The literature is limited in evaluating the impacts of power standing systems on health outcomes and its effectiveness for specific conditions. However, some studies have evaluated the impacts of standing to reduce and/or improve comorbidities associated with wheelchair use.

Musculoskeletal System Impacts. Fulltime wheelchair use and extended sitting is associated with reduced joint mobility, contractures, pain, and reduced function.^{1,23} These comorbidities are also common among the relevant conditions, independent of wheelchair use. Standing interventions may improve joint mobility, and reduce pain for non-ambulatory individuals, except for those with long-standing severe joint restriction (contractures).²⁰ Standing interventions may also improve strength, which may be important for wheelchair transfer safety and

^b Power elevated seats raise the wheelchair seat base to allow individuals more independence in activities of daily living, but do not facilitate supported standing.

function.²⁰ The degree to which standing impacts muscular strength may depend on an individual's diagnosis and their duration of standing per day. The degree to which power standing systems specifically address these concerns compared to other inventions is unknown.

Nervous and Cardiovascular System Impacts. Individuals with neurological conditions, like SCI, DMD, and MS may be more prone to nervous and cardiovascular system comorbidities, such as orthostatic hypotension and spasticity. Frequent and regular standing may reduce spasticity, improve blood pressure tolerance when changing position, and improve circulation.²⁰ A systematic review found that standing for 5 times a week for 30 minutes had the greatest impact on many health outcomes.

Bone Health. Reduced bone mineral density can lead to fractures, and non-ambulatory individuals lose bone mineral at a faster rate than those who are ambulatory.²³ The use of standing interventions may reduce the impacts of a non-ambulatory status for individuals living with conditions that impair mobility.^{1,23,24} There is some evidence that 60 minutes of daily standing, which may be possible with power standing systems, may be most impactful on slowing bone loss that can result from extended sitting.²⁰ However, the impact of standing on bone mineral density may depend on the stage at which a standing intervention is implemented (e.g., duration of time since wheelchair use began), and may be less effective if initiated years after fulltime wheelchair use.²⁰

Urinary and Digestive Systems. Individuals living with neurological conditions often have digestive and gastrointestinal impacts directly from their condition, which may be further exacerbated through extended sitting.²³ Standing may reduce instances of kidney stones, urinary tract infections, and constipation, and improve independence with bowel and bladder management.^{1,20,22,23} These effects have been observed across different types of standing interventions.

Pressure Ulcers. Individuals using wheelchairs for primary mobility face risks associated with skin breakdown, including pressure ulcers, which can significantly impact quality of life, independence, and lifespan.²⁵ Power standing systems and other power chair accessories (e.g., tilt mechanisms and specialized cushions) have been used for pressure ulcer prevention. Power standing systems may offer some benefits in addressing skin breakdown compared to other power chair accessories, as power standing systems may allow individuals to perform pressure release during more functional activities, such as home tasks or work.^{1,23}

Safety. An individual's tolerance for standing, and safety in sit-to-stand transfers, may be important for evaluating what individuals are appropriate candidates for power standing systems.^{22,23} Sudden changes in heart rate and blood pressure are a primary concern for individuals with spinal cord injury using standing interventions, due to cardiovascular dysregulation associated with the condition that may be impacted by extended standing.^{20,22} However, no studies comprehensively evaluated the safety considerations of power standing systems.

Comparative Effectiveness Considerations for Power Standing Systems.

Standing Interventions. As previously mentioned, there are other interventions designed to address some of the same comorbidities as power standing systems, such as tilt tables, standers, and other specialized wheelchair accessories.²⁰ There is no literature directly comparing these interventions versus power standing systems for specific health outcomes, functional status, quality of life, and safety for specific conditions. In addition, standing

interventions are used in physical therapy settings without the aforementioned equipment.¹ However, supported standing in clinical practice is often impractical for individuals to continue outside of a health care setting, particularly at the frequency required for potential benefit. Additionally, power standing systems allow individuals to stand during activities of daily living, which may provide more sustainable benefit than supported standing provided in a health care setting practice.

Comorbidity-Specific Interventions. There is limited literature comparing power standing systems to other interventions designed for wheelchair-associated comorbidities. Transfer education, wheelchair seat selection, pressure shifting techniques, and recline and tilt chair options may be used for pressure ulcer prevention, but have not been evaluated compared to power standing systems for this outcome.²⁵ However, many of these interventions do not address other benefits potentially provided by power standing systems, such as strength development and joint mobility.¹

Health Equity

Minnesotans with disabilities are more than two times as likely to live in poverty as those without a disability, and 2.6 times more likely to be unemployed.¹² Across individuals who would be eligible for or likely to use power standing systems, such those with SCI, Black non-Hispanic men have higher rates of SCI compared to other populations, and may face disparities in care, such as less frequent receipt of evidence-based acute care (e.g., decompressive surgery).²⁶ Similarly, disparities exist in MS, with Black and Hispanic individuals facing worse health outcomes compared to their White counterparts,²⁷ which may impact both condition-specific comorbidities and mobility. The degree to which coverage for power standing systems would reduce disparities in outcomes is unknown and has yet to be evaluated.

Economic Impact

Product Costs. The literature related to cost, coverage, and utilization of power standing systems is exceptionally limited. Based on a review of manufacturer data and literature published more than 10 years ago, power standing systems may cost between \$5,500 and \$34,311.^{28–30} The specific cost for prescribed systems may be related to the individual and condition-specific system requirements. The average cost of systems that may be covered by the proposed mandate and the prospective trend of per-product costs has not been reported in the available literature. Additionally, it is not clear at what frequency power standing systems need to be replaced and to what degree that functions with the coverage requirements.

Utilization of Power Standing Systems. While 265,800 Minnesotans have an ambulatory-based disability, it is not known what percentage of this population would be eligible for and/or tolerate a power standing system. If enacted, the potential utilization cannot be determined based on the range of potentially applicable conditions and variations in individual need that might impact utilization rates. Additionally, the degree to which specific interventions for condition and wheelchair-specific comorbidities are used, as well as patient preferences between available products, is unknown.

Total Health Expenditures and Downstream Savings. As previously discussed, fractures, digestion-related issues, and pressure ulcers impact individuals using wheelchairs at a disproportionate level to those with full

ambulatory status.^{1,23} The costs of these secondary issues can be substantial.²³ Individuals with SCI with a pressure injury require \$73,000 more in medical expenditures than those without SCI.¹ To date, no studies have directly assessed the cost-effectiveness of power standing systems on directly limiting the instances of these comorbidities and avoiding downstream medical expenditures. Additionally, studies have directly compared power standing systems against other interventions, such as regular physical therapy and other power chair accessories, at avoiding these costs.

The extent to which power standing systems may reduce or modify these comorbidities is unknown. One retrospective evaluation assessed the incidence of comorbidities requiring emergency room and/or hospitalization in a small sample at a level 1 trauma center.²³ This study looked at differences in diagnoses and urinary tract infections by different types of wheelchair use, including power systems, and found that across different types of wheelchair use, the burden of comorbidities remained high. However, some differences in comorbidity rate, such as those for urinary tract infection, were different for users of power standing systems compared to those without those systems.

Limitations

Based on the available literature, it is difficult to assess the potential economic and public health impacts associated with the proposed coverage. None of the studies identified for this literature review directly address the actual costs and cost-effectiveness of the mandate as a whole, given the limited data available to evaluate average cost and utilization. There were no studies identified by the mandate addressing the longer-term impact of power standing systems on health outcomes. Given the considerable variation in conditions for which power standing systems may be used, the presence of a variety of comorbidities and the complexity of health outcomes, there is limited data to comprehensively address the economic impact of the proposed mandate.

Data Limitations

An actuarial analysis to estimate the potential economic impact of the mandate is not feasible. The mandate coverage requirements could potentially apply to all conditions requiring full-time wheelchair use, and thus there is no clearly defined set of conditions with claims to analyze from the Minnesota All Payer Claims Database (MN APCD). Additionally, power standing systems may be less prevalent in commercial claims, which would be necessary for a representative sample to estimate cost and utilization.

State Fiscal Impact

The potential state fiscal impact of this proposed mandate 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 potential impact to Minnesota Health Care Programs.

- MMB estimates the cost of this proposed mandate for SEGIP to be \$39,000 for partial Fiscal Year 2026 (FY 2026) and \$81,900 for FY 2027.

- Commerce has determined that this proposed mandate would likely require full defrayal under the ACA, with an estimated cost between \$400,000 and \$1,500,000 in the first year.
- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) and may have a cost.

Fiscal Impact Estimate for SEGIP

MMB provided SEGIP’s fiscal impact analysis, which is based on the average cost of power standing systems and 2021-2024 claims data of assumed eligible members. MMB’s analysis predicted a PMPM fiscal impact of \$0.05 PMPM. The partial fiscal year impact of the proposed mandate on SEGIP is estimated to be \$39,000 for partial FY 2026 (\$0.05 PMPM medical cost × 130,000 members × 6 months). The estimated impact for FY 2027 equals \$81,900, and the amount is estimated to increase by a 5% annual inflation factor each of the following years.

Patient Protection and 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, this proposed mandate would likely require full defrayal as it related to new coverage requirements that are not already covered by Minnesota’s benchmark plan.³¹ Commerce used the U.S. prevalence estimates¹¹ from the evaluation’s literature scan (see [Prevalence of Ambulatory Disabilities and Wheelchair Use](#)) to develop its assumptions that 0.06% of individual market enrollees use an electric wheelchair and a range of 44% to 62% of those individuals will utilize a power standing system. Commerce used product cost data from the Economic Impact section (see [Product Costs](#)) to assume an average total cost per power standing system between \$12,700 and \$27,100. Finally, Commerce assumed the proportion of the total cost paid for by the health plans will range between 62% and 80%. Under these assumptions, Commerce estimates the cost of defrayal associated with this proposed mandate to be between \$400,000 and \$1,500,000 in the first year.

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 Minnesota Health Care Programs provide coverage for standing systems for individuals who require assistance standing, the medical necessity determinations and time period for required replacement may differ from current coverage.³² However, a fiscal estimate has not yet been completed on this proposed mandate.

Appendix A. Bill Text

Section 1. [62Q.667] COVERAGE OF POWER STANDING SYSTEMS.

Subdivision 1. **Definition.** For the purposes of this section, "power standing system" means any type of power standing system, recommended for the insured by a provider licensed in this state, for a wheelchair.

Subd. 2. **Required coverage.** All health plans must cover power standing systems.

Subd. 3. **Cost-sharing requirements.** A health plan must not impose on the coverage under this section any cost-sharing requirement that is not generally applicable to other coverages under the plan, including but not limited to the following requirements:

- (1) deductible;
- (2) co-payment; or
- (3) coinsurance.

Subd. 4. **Review and referral limitations.** A health plan must not impose on the coverage under this section any review or referral limitation that is not generally applicable to other coverages under the plan, including but not limited to the following limitations:

- (1) utilization review, as defined in section 62M.02;
- (2) referral requirement; or
- (3) delay period.

Subd. 5. **Quantity limitations.** A health plan must not impose on the coverage under this section any quantity limitation, except that the health plan may limit the coverage to one power standing system every five or fewer years.

Subd. 6. **Reimbursement.**

(a) The commissioner of commerce must reimburse health plan companies for coverage under this section, as required by Code of Federal Regulations, title 45, section 155.170. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments, services, supplies, and equipment covered by the health plan as of January 1, 2025, are ineligible for payments 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. 7. **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 sold on or after that date.

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

Subd. 77. **Power standing systems.**

(a) Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.667.

(b) Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.667, except that medical assistance is not required to comply with any provision of section 62Q.667 if compliance with the provision would prevent the state from receiving federal financial participation for the coverage under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. **DEFRAYAL OF COSTS FOR MANDATED COVERAGE OF POWER STANDING SYSTEMS.**

(a) \$..... in fiscal year 2027 and \$..... in fiscal year 2028 are appropriated from the general fund to the commissioner of commerce for the estimated amount of defrayal costs for mandated coverage of power standing systems.

(b) \$..... in fiscal year 2027 and \$..... in fiscal year 2028 are appropriated from the general fund to the commissioner of commerce for administrative costs to implement mandated coverage of power standing systems.

Appendix B. Key Search Terms for Literature Scan

Function

Mobility

Power mobility

Power standing systems

Powerchair

Pressure ulcers

Standup power

Wheelchairs

Works Cited

1. Masselink CE, LaBerge N, Detterbeck A. Policy analysis on power standing systems. *Prev Med Rep.* 2021;24:101601.doi:10.1016/j.pmedr.2021.101601
2. Social Security Administration. Compilation of the Social Security Laws. Part E—Miscellaneous provisions, definitions of services, institutions, etc., Sec. 1861, Spell of illness. Accessed October 31, 2024. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
3. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). RESNA calls for action on standing systems in power wheelchairs. News release. March 25, 2024. Accessed November 4, 2024. <https://www.resna.org/About/RESNA-News/RESNA-Blog/resna-calls-for-action-on-standing-systems-in-power-wheelchairs-1>
4. Minnesota Legislature, Office of the Revisor of Statutes. Minnesota Statutes. Excise and Sales Taxes, Section 297A.67 General Exemptions. Accessed November 22, 2024. <https://www.revisor.mn.gov/statutes/cite/297A.67>
5. Minnesota Department of Human Services. Minnesota Health Care Programs Provider Manual. Equipment and supplies. Mobility devices. Revised August 15, 2024. Accessed November 22, 2024. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_140901
6. State of Iowa Department of Health and Human Services. Power seat elevation for power wheelchairs DME-014. April 12, 2024. Accessed November 1, 2024. <https://hhs.iowa.gov/media/7240/download?inline=>
7. Colorado Department of Health Care Policy and Financing. Wheelchair Benefit Coverage Policy. Accessed November 1, 2024. <https://hcpf.colorado.gov/wheelBenPol#toc>
8. New York State Medicaid, Office of Health Insurance Programs, Department of Health. *DME Procedure Codes & Coverage Guidelines*. April 1, 2024. Accessed November 1, 2024. https://www.emedny.org/providermanuals/dme/pdfs/dme_procedure_codes.pdf
9. MassHealth, Massachusetts Medicaid. Mass Health Regulations 130 CMR 409.000: durable medical equipment services. 2023. Accessed November 4, 2024 <https://www.mass.gov/doc/130-cmr-409-durable-medical-equipment-services/download>
10. California Department of Social Services, State Hearings Division. Changes in definition of durable medical equipment and period of validity for authorization of Medi-Cal benefits. November 23, 2000. Accessed November 12, 2024. <https://www.cdss.ca.gov/shd/docs/notes/00-08-02D.htm>
11. Kaye HS, Kang T, LaPlante MP. *Mobility Device Use in the United States. Disability Statistics Report 14*. Disability Statistics Center, University of California, San Francisco, 3333 California St; 2000. Accessed January 13, 2025. <https://eric.ed.gov/?id=ED444296>
12. Egbert A. *Minnesotans with Disabilities: Demographic and Economic Characteristics*. March 2017. Accessed November 4, 2024. https://mn.gov/admin/assets/minnesotans-with-disabilities-popnotes-march2017_tcm36-283045_tcm36-283045.pdf

13. National Institute of Neurological Disorders and Stroke. Spinal Cord Injury. Accessed November 6, 2024. <https://www.ninds.nih.gov/health-information/disorders/spinal-cord-injury>
14. Minnesota Spinal Cord & Traumatic Brain Injury Research Symposium kicks off during Super Bowl week. News release. Hennepin Healthcare. January 24, 2018. Accessed November 6, 2024. <https://www.hennepinhealthcare.org/newsroom/minnesota-spinal-cord-traumatic-brain-injury-research-symposium-kicks-off-during-super-bowl-week/>
15. Venugopal V, Pavlakis S. Duchenne Muscular Dystrophy. In: *StatPearls*. StatPearls Publishing; 2024. Accessed November 6, 2024. <http://www.ncbi.nlm.nih.gov/books/NBK482346/>
16. Venugopal V, Pavlakis S. Duchenne Muscular Dystrophy. In: *StatPearls*. StatPearls Publishing; 2024. Accessed November 6, 2024. <http://www.ncbi.nlm.nih.gov/books/NBK482346/>
17. Masselink CE, LaBerge NB, Piriano J, Detterbeck AC. Policy analysis on power seat elevation systems. *Arch Phys Med Rehabil*. 2022;103(12):2454-2462. doi:10.1016/j.apmr.2022.04.003
18. Michael E, Sytsma T, Cowan RE. A primary care provider's guide to wheelchair prescription for persons with spinal cord injury. *Top Spinal Cord Inj Rehabil*. 2020;26(2):100. doi:10.46292/sci2602-100
19. World Health Organization. *Wheelchair Provision Guidelines*. Geneva: World Health Organization; 2023.
20. Paleg G, Livingstone R. Systematic review and clinical recommendations for dosage of supported home-based standing programs for adults with stroke, spinal cord injury and other neurological conditions. *BMC Musculoskelet Disord*. 2015;16:358. doi:10.1186/s12891-015-0813-x
21. Schofield C, Evans K, Young H, et al. The development of a consensus statement for the prescription of powered wheelchair standing devices in Duchenne muscular dystrophy. *Disabil Rehabil*. 2022;44(10):1889-1897. doi:10.1080/09638288.2020.1810786
22. Hong E, Elliott M, Kornfeld S, Spungen AM. Use of an upright power wheelchair in spinal cord injury: a case series. *Front Rehabil Sci*. 2024;5:1267608. doi:10.3389/fresc.2024.1267608
23. LaBerge NB, Detterbeck A, Nooijen CFJ. Comorbidities and medical complexities of mobility device users: a retrospective study. *Disabil Rehabil Assist Technol*. 2023;18(7):1035-1042. doi:10.1080/17483107.2021.1969453
24. Birnkrant PDJ, Bushby PK, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 2: respiratory, cardiac, bone health, and orthopaedic management. *Lancet Neurol*. 2018;17(4):347. doi:10.1016/S1474-4422(18)30025-5
25. Vecin NM, Gater DR. Pressure injuries and management after spinal cord injury. *J Pers Med*. 2022;12(7):1130. doi:10.3390/jpm12071130
26. Escalon MX, Houtrow A, Skelton F, Verduzco-Gutierrez M. Health care disparities add insult to spinal cord injury. *Neurol Clin Pract*. 2021;11(6):e893. doi:10.1212/CPJ.0000000000001095
27. Moore MZ, Pérez CA, Hutton GJ, Patel H, Cuascut FX. Health disparities in multiple sclerosis among Hispanic and Black populations in the United States. *Biomedicines*. 2023;11(4):1227. doi:10.3390/biomedicines11041227

28. Ward AL, Sanjak M, Duffy K, et al. power wheelchair prescription, utilization, satisfaction, and cost for patients with amyotrophic lateral sclerosis: preliminary data for evidence-based guidelines. *Arch Phys Med Rehabil*. 2010;91(2):268-272.doi:10.1016/j.apmr.2009.10.023
29. Living Spinal. Standing power wheelchairs/standing electric wheelchair. Accessed November 7, 2024. <https://livingspinal.com/standing-powered-wheelchairs/?srsId=AfmBOoqVJFPGFn5yAzFZwAXB6ecCeE7WzO3hPd6yTV9TVEJ82brB9mw->
30. Electric Wheelchairs USA. Karman Healthcare standup power chairs. Accessed November 7, 2024. <https://www.electricwheelchairsusa.com/collections/karman-healthcare-stand-up-power-chairs>
31. Centers for Medicare & Medicaid Services. Minnesota EHB Benchmark Plan (2025-2027). Accessed November 4, 2024. <https://www.cms.gov/files/document/mn-bmp-summary-py2025-2027.pdf>
32. Minnesota Department of Human Services. Minnesota Health Care Programs Provider Manual. Equipment and supplies. Urological and bowel supplies. Revised December 6, 2024. Accessed December 9, 2024. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_144328