



Evaluation of SF XXXX – Coverage for Intermittent Catheters

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

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Executive Summary

This proposed mandate would require a health carrier to provide health insurance coverage for intermittent urinary catheters and insertion supplies if catheterization is recommended by the enrollee's health care provider. This coverage would include up to 180 short-term or daily-use catheters per month, along with insertion supplies, unless a smaller amount is prescribed by the enrollee's health care provider.

Intermittent catheters may be used with incomplete bladder emptying and urinary incontinence (leaking), which may occur secondary to a health condition such as multiple sclerosis or spinal cord injury. Intermittent catheters may also be recommended or needed after a medical procedure or surgery.

Currently, Minnesota Health Care Programs provide coverage for intermittent catheters and insertion supplies. The proposed mandate would require commercial health plans in Minnesota to provide equivalent coverage for intermittent catheterization. Medicare and Medicaid programs across 14 states, including Minnesota, also provide coverage for intermittent catheters and supplies.

Respondents to the request for information stated that the proposed mandate will not affect Minnesotans' access to care or raise health care coverage costs for insurance plans that already fully cover intermittent catheters and supplies. For plans where only partial coverage of intermittent catheters and supplies is offered, however, costs per member per month (PMPM) would be expected to increase.

While some studies address the conditions that may require intermittent catheterization, as well as the potential risks associated with use of catheters and nonadherence to recommended catheter use, recent literature provides limited information on the safety and medical necessity of a specific monthly quantity of catheters. The literature does discuss quality-of-life and feasibility considerations associated with sterilization and reuse of catheters more thoroughly, along with the negative outcomes associated with catheter reuse.

Estimated expenditures from the proposed mandate are projected to result in a net increase of \$0.46 PMPM under the low-impact scenario and \$2.06 PMPM under the high-impact scenario in the first year. By Year 10, these expenditures are projected to result in an increase of \$2.92 PMPM under the low-impact scenario and \$15.40 PMPM under the high-impact scenario.

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

- This proposed mandate is estimated to have no fiscal impact on the State Employee Group Insurance Program.
- There are no defrayal costs associated with this proposed mandate.
- There is no estimated cost to Minnesota public health coverage programs.

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. Hoffman and has yet to be introduced.

If enacted, this bill would require a health carrier to provide health insurance coverage for intermittent urinary catheters and insertion supplies if catheterization is recommended by the enrollee's health care provider. For the purpose of this mandate, "intermittent catheterization" refers to the placement of a catheter, or tube, to drain the bladder several times a day. Individuals may use this process for the short term or may require it for the rest of their lives. The coverage would include up to 180 short-term or daily-use catheters per month, along with insertion supplies, unless a smaller amount is prescribed by the enrollee's health care provider.

This proposed mandate does not allow a health carrier to apply cost-sharing (e.g., co-payment, deductible, or coinsurance) or other restrictions for intermittent catheters and insertion supplies unless the health insurance plan applies the same cost-sharing or restrictions for other medical equipment used at home.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, and the State Employee Group Insurance Program (SEGIP). It would not apply to self-insured employer plans, grandfathered plans, Medicare and Medicare supplemental policies, and Minnesota public health coverage programs.

Related Health Conditions

Diagnoses associated with the use of intermittent catheters include but are not limited to

- incomplete bladder emptying and
- urinary incontinence (leaking).

These diagnoses are often associated with specific health conditions, such as multiple sclerosis or spinal cord injury. Intermittent catheters may also be recommended after a medical procedure or surgery.

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

Under section 1861(n) and (s)(8) and 1862(a)(1)(A) of the Social Security Act, Medicare covers durable medical equipment, and prosthetic and orthotic supplies, such as intermittent catheters.^{1,2} Medicare provides coverage for up to 200 sterile intermittent catheter kits per month for a enrollee if intermittent catheterization is deemed medically necessary by a health care provider.³

Relevant Minnesota Laws

Medical Assistance and MinnesotaCare currently provide coverage for intermittent catheters and supplies. The proposed mandate would require commercial health carriers in Minnesota to provide equivalent coverage for intermittent catheterization. In the *Minnesota Health Care Programs (MHCP) Provider Manual*, intermittent

catheterization is classified under “Urological and Bowel Supplies.”⁴ Any MHCP member can receive coverage for 150–180 intermittent catheters per month, and up to 300 may be allowed without insertion supplies if the member has a medical history indicating that more than six daily episodes of catheterization are required.

Additionally, according to Minn. Rule 4685.0700 subsection 3B, health maintenance organizations must cover, but may impose restrictions on, durable medical equipment, prosthetic and orthotic supplies, and nondurable medical equipment.⁵ Intermittent catheters typically fall under the classification of durable medical equipment or prosthetics/orthotics.

State Comparison

State commercial plan coverage for intermittent catheterization is predominantly required by states through regulations for durable medical equipment or prosthetic and orthotic supplies rather than state-mandated legislation. Therefore, it is difficult to identify state-mandated coverage for intermittent catheters in commercial plans. No comparable state mandates were identified.

Medicaid coverage for intermittent catheters was found in at least 14 states, including Minnesota: Colorado, Connecticut, Florida, Georgia, Illinois, Massachusetts, Minnesota, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, and Texas.⁶ Medicaid coverage in these states covers from 30 to 250 intermittent catheters per month.

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 that responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received comments from four commercial health carriers that provided information related to insurance coverage.

Most respondents noted that this proposed mandate aligned with their plan’s coverage for intermittent catheters. One health carrier noted that this proposed mandate would be a new statutory requirement for coverage of both catheters and insertion supplies and that per member per month (PMPM) costs would increase for plans currently offering only partial coverage of intermittent catheters and supplies. The three other organizations anticipate that the proposed mandate will not affect Minnesotans’ access to care or raise health care coverage costs because they already cover intermittent catheters and supplies prescribed by a member’s physician on a monthly basis.

Cost Estimates Provided in Stakeholder Comments

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

- MMB does not estimate any fiscal impact to the state plan from this legislation based on current and upcoming coverage for intermittent urinary catheters and insertion supplies (see the State Fiscal Impact section).

- According to one respondent, the coverage of intermittent catheters and insertion supplies would result in an increase of less than \$0.05 PMPM.

Cost estimates shared in RFI responses may reflect different methodologies, data sources, and assumptions than those used in the actuarial analysis for this evaluation. Stakeholders' results may or may not reflect generalizable estimates for the mandate.

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review and actuarial analysis 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 domestic research 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

Literature Review

Clinical Considerations for Intermittent Catheter Use. Catheter safety and comfort vary widely owing to the features possessed by different catheter types. Some of these features affect cost and some also affect adherence, safety, and appropriateness for a given patient. Intermittent catheters are used for a wide variety of conditions associated with urinary retention, where obstruction of structures for urination or interference with the nerves and muscles used for urination may occur.⁷ Many neurological conditions are associated with urinary retention, such as spina bifida, multiple sclerosis, enlarged prostate, and spinal cord injuries.⁷⁻⁹ Complications due to unmanaged urinary retention include urinary tract infections (UTIs) as well as damage to the bladder and kidneys. Kidney damage associated with urinary retention can lead to chronic kidney disease and failure.⁷

Both indwelling and intermittent catheters are used to manage urinary retention. The reduced rates of UTIs for intermittent catheters compared with indwelling catheters is a primary reason for the preferred use of intermittent catheters.⁸ While intermittent catheters can mitigate the negative effects of urinary retention, their use is not without risk. Intermittent catheters can introduce bacteria into the urinary tract and cause infection, and the insertion of the catheter itself can damage the urinary tract.⁷ The most common reasons for emergency department visits and hospitalizations related to intermittent catheters are UTI, blood in urine (hematuria), and sepsis/bacteremia.⁸ UTI is the most common complication due to intermittent catheter use.⁹ The risks associated with UTI, however, are multifactorial and vary by condition.¹⁰

Different types of catheters may be appropriate for different patients, depending on their specific clinical needs.¹¹ While the straight tip catheter, which is the least complex and least expensive, is used most often, curved tip and sterile kit catheters may be recommended based on criteria such as sex, immune system complications, pregnancy, history of UTIs, pain with insertion, and clinical condition.⁷ For example, individuals with spinal cord injuries may be most likely to use sterile kit catheters due to the potential for a backflow of urine and resulting complications.⁷ Comfort and ease of use are considered critical factors for compliance with

intermittent catheterization.^{7,11} Different features associated with catheters, such as hydrophilic coatings to ease insertion, may play a role in patient compliance, patient quality of life, catheter cost, and infection risk.^{7,9,11} Given the range of manufacturers and the variation in features and quality, it is unclear whether this mandate would require coverage for the most appropriate catheter based on the prescription provided by the patient's medical provider.

Limitations in Data to Assess Relative Safety and Utilization for Intermittent Catheters. It is difficult to assess the level of need, rates of utilization, and safety considerations associated with intermittent catheter coverage. The frequency of intermittent catheter use varies by condition. The rate and duration of use of intermittent catheters is not well documented in the U.S. literature. Some conditions, such as an enlarged prostate, require short-term catheterization, whereas others, such as spinal cord injuries, might require lifelong use. Studies have found that between 16% and 56% of individuals living with spinal cord injury use intermittent catheters, depending on age and severity.⁹ Among individuals with multiple sclerosis, 65% face some form of bladder dysfunction and may require acute or long-term use of intermittent catheters within 10 years of diagnosis.⁹

The CDC recommends frequent changing of intermittent catheters to avoid complications, such as UTIs or overdistention of the bladder.⁷ Frequent changing and certain catheter features, such as hydrophilic coating, are recommended for reducing the risk of UTI.⁹ In trying to assess how policies that reduce the reuse of catheters affect these risks, one study found that Medicare's policy change increasing monthly intermittent catheter coverage from 4 to 200 catheters per month did not alter genitourinary-related hospitalizations and emergency department visits for individuals with spinal cord injuries.¹⁰ However, as the study notes, this finding may not be relevant to all conditions requiring intermittent catheterization, given the high prevalence of UTI associated with spinal cord injuries. It is unclear whether the genitourinary complications occurred secondary to intermittent catheterization or were specific types of complications related to intermittent catheterization. Another study found that interventions such as patient education on how to reduce risks, as well as financial support for catheter supplies, were associated with reduced UTI rates.⁸ However, there is limited quality data addressing whether reuse itself affects safety and whether coverage requirements affect compliance and safety.

Economic Impact

Literature Review

Intermittent Catheter Cost and Coverage Data. Literature appropriate for assessing the potential costs of the mandate for issuers and enrollees, as opposed to costs specific to Medicare, is quite limited. However, differences in costs associated with catheter features and catheter types are documented in the literature.^{7,9,11} One study found that, in the Medicare population, utilization rates differ for different types of catheters, and the utilization rate is lowest for most expensive catheters.⁷ The degree to which cost-sharing, provider prescription patterns, and the condition-specific makeup of the Medicare population are drivers of the utilization patterns found in this study is unknown. Also unknown is the degree to which the findings apply to the commercial population.

Reimbursement and coverage for clinically required catheter types may be critical for catheter use.¹¹ Features that increase safety and improve quality are typically associated with higher acquisition costs for issuers and/or patients.⁷ The acquisition costs for specific catheters and manufacturers partly drive the costs associated with increased issuer coverage requirements, and the degree to which this mandate would increase accessibility across catheter types and manufacturers is unknown.⁷ It is challenging to assess the potential cost-effectiveness

of the mandate, as the existing literature does not address whether changes in coverage reduce adverse events or affect the utilization of specific types of catheters.⁷

Limitations

There is limited literature related to intermittent catheter cost, safety, and utilization in the United States compared with other countries. Furthermore, the quality of the literature and the generalizability of findings are also limited, given the differences in populations and associated conditions studied, the variations in required assistance for catheterization, and the complex nature of the genitourinary risks associated with the conditions requiring catheterization. In addition, the existing literature does not address the link between clinical practice guidelines and recommended coverage of intermittent catheters, average monthly use, and risk of adverse events specific to reuse. Given the broad clinical criteria associated with intermittent catheters, we are unable to assess the prevalence of condition-specific intermittent catheter use and potential changes in market behavior associated with the proposed mandate. The international literature, along with several studies published over 10 years ago, does provide some help in addressing questions about the practicality, quality of life, and safety associated with catheter reuse versus single use and is more relevant to assessing the increased coverage required by the mandate. However, this literature was outside of the inclusion criteria for the evaluation, as the findings may be out of date or not applicable to the U.S. health system.

Actuarial Analysis^a

Objective

This actuarial analysis includes an analysis of current prevalence of related diagnoses, current levels of utilization, and the potential effects of increased utilization on cost-sharing, expenditures, and overall premiums if coverage is expanded, as well as potential downstream medical savings.

Assumptions and Approach

MDH provided tabulations of Minnesota All Payer Claims Database (MN APCD) data for all enrollees diagnosed with conditions often associated with intermittent catheterization and relevant diagnosis and procedure codes from 2019 to 2022.¹² These tabulations served as a snapshot of current prevalence, utilization, expenditures, and enrollee cost-sharing for intermittent catheterization for Minnesota commercial health plan enrollees.

MDH used the following criteria to identify enrollees diagnosed with a condition often associated with intermittent catheterization and to identify claims for intermittent catheters and related supplies:

- Enrollees were identified as having a condition often associated with intermittent catheterization based on the diagnosis codes found in Appendix C.
- Claims for intermittent catheters and related supplies indicating utilization, expenditures, and enrollee cost-sharing were tabulated based on the Healthcare Common Procedure Coding System (HCPCS) procedure codes found in Appendix C.

On average for each year of analysis and utilization of different types of catheters and supplies, 80%–90% of claims for the identified HCPCS codes were for enrollees who also had at least one of the associated diagnosis

^a Michael Sandler and Anthony Simms are actuaries for Actuarial Research Corporation. They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

codes. In the full commercial population in the MN APCD (approximately 40% of the total commercial market in Minnesota), the percentage of enrollees diagnosed with a condition often associated with intermittent catheterization fluctuated between 7.1% and 8.8% between 2019 and 2022 and averaged 8.2% overall. Observed utilization rates for intermittent catheters and related supplies among enrollees identified as having an associated diagnosis varied between 5.9% and 6.7% during this period. For each of the three distinct types of intermittent catheters—Straight Tip (A4351), Curved Tip (A4352), and Sterile Kit (A4353)—the data include the average cost per claim, the average claims per year for each user, and the average quantity per claim. Most enrollees exclusively use the type that works best for them and their condition. Based on the historic utilization, it was assumed that 65% would use an A4351, 25% would use an A4352, and 10% would use an A4353.

For the purposes of this analysis, diagnosis prevalence rates and total expenditures, along with cost-sharing, were projected based on existing policy as well as four different assumption-level scenarios:

1. The current law scenario projects a 3% annual increase in catheter utilization among enrollees with an associated diagnosis.
2. The low-impact scenario of the proposed mandate projects a 7% annual increase in catheter utilization among enrollees with an associated diagnosis, an increase in the average number of claims per year for each user, and an average quantity per claim of about a quarter of the difference between the historic average and the maximum allowed by the mandate for each of the three types of catheters.
3. The medium-impact scenario projects a 10% annual increase in catheter utilization among enrollees with an associated diagnosis, an increase in the average number of claims per year for each user, and an average quantity per claim of about half the difference between the historic average and the maximum allowed by the mandate for each of the three types of catheters.
4. The high-impact scenario projects a 13% annual increase in catheter utilization among enrollees with an associated diagnosis, an increase in the average number of claims per year for each user, and an average quantity per claim of about three quarters of the difference between the historic average and the maximum allowed by the mandate for each of the three types of catheters.

Actual historic cost-sharing for intermittent catheters and supplies were similar to cost-sharing for all other specified durable medical equipment (DME) HCPCS codes, and we assumed this would continue in compliance with the mandate. The per-claim expenditure rates for each of the three types of catheters were trended forward to the projection period (2025–2034) using projection factors derived from the National Health Expenditure data compiled by CMS and the 2023 Medicare Trustees Report (see the Data Sources section).

Overall Minnesota population projections for base year 2025 through 2034 are based on Minnesota State Demographic Center data and the historic non-public health insurance coverage levels from Minnesota Public Health Data Access.¹³ Sixty-five percent of the total state population were assumed to be included in the non-public insured population (see the Data Sources section).

Results

Table 1 shows the results for the total projected intermittent catheter utilization and expenditures under current law.

Table 2 shows the total projected intermittent catheter utilization and expenditures and the net projected effect on the total non-public insured population PMPM under the low-impact scenario.

Table 3 shows the total projected intermittent catheter utilization and expenditures and the net projected effect on the total non-public insured population PMPM under the medium-impact scenario.

Table 4 shows the total projected intermittent catheter utilization and expenditures and the net projected effect on the total non-public insured population PMPM under the high-impact scenario.

Table 1. Total Projected Intermittent Catheter Utilization and Expenditures Under Current Law^b

	Population		Projected prevalence and utilization		Projected expenditures	
	Total Minnesota population	Non-public insured population	Total diagnoses	Total users	Plan paid	Cost-sharing
2025	5,833,655	3,101,454	254,939	18,108	\$59,352,817	\$6,234,531
2026	5,863,731	3,107,430	255,431	18,687	\$65,171,285	\$6,845,714
2027	5,893,080	3,112,920	255,882	19,281	\$71,817,677	\$7,543,864
2028	5,921,625	3,117,886	256,290	19,892	\$79,054,267	\$8,304,008
2029	5,949,303	3,122,300	256,653	20,517	\$86,678,258	\$9,104,847
2030	5,976,058	3,126,137	256,968	21,159	\$94,304,662	\$9,905,939
2031	6,001,850	3,139,298	258,050	21,885	\$103,492,841	\$10,871,082
2032	6,026,651	3,151,878	259,084	22,632	\$113,660,348	\$11,939,096
2033	6,050,458	3,163,936	260,076	23,400	\$124,804,128	\$13,109,660
2034	6,073,273	3,175,472	261,024	24,190	\$137,015,992	\$14,392,417

^b The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

Table 2. Total Projected Intermittent Catheter Utilization and Expenditures and Total Non-Public Insured PMPM, Low Impact^c

	Population		Projected prevalence and utilization		Projected expenditures		Change in PMPM
	Total Minnesota population	Non-public insured population	Total diagnoses	Total users	Plan paid	Cost-sharing	
2025	5,833,655	3,101,454	254,939	20,300	\$76,358,626	\$8,004,957	\$0.46
2026	5,863,731	3,107,430	255,431	21,763	\$87,100,291	\$9,131,046	\$0.59
2027	5,893,080	3,112,920	255,882	23,328	\$99,710,576	\$10,453,029	\$0.75
2028	5,921,625	3,117,886	256,290	25,000	\$114,020,185	\$11,953,158	\$0.93
2029	5,949,303	3,122,300	256,653	26,788	\$129,871,290	\$13,614,888	\$1.15
2030	5,976,058	3,126,137	256,968	28,699	\$146,785,343	\$15,388,051	\$1.40
2031	6,001,850	3,139,298	258,050	30,837	\$167,342,554	\$17,543,139	\$1.69
2032	6,026,651	3,151,878	259,084	33,128	\$190,920,085	\$20,014,859	\$2.04
2033	6,050,458	3,163,936	260,076	35,582	\$217,780,074	\$22,830,691	\$2.45
2034	6,073,273	3,175,472	261,024	38,212	\$248,374,498	\$26,038,018	\$2.92

^c The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

Table 3. Total Projected Intermittent Catheter Utilization and Expenditures and Total Non-Public Insured PMPM, Medium Impact^d

	Population		Projected prevalence and utilization		Projected expenditures		Change in PMPM
	Total Minnesota population	Non-public insured population	Total diagnoses	Total users	Plan paid	Cost-sharing	
2025	5,833,655	3,101,454	254,939	22,056	\$104,299,398	\$10,903,992	\$1.21
2026	5,863,731	3,107,430	255,431	24,308	\$122,307,253	\$12,786,625	\$1.53
2027	5,893,080	3,112,920	255,882	26,787	\$143,940,411	\$15,048,266	\$1.93
2028	5,921,625	3,117,886	256,290	29,512	\$169,212,390	\$17,690,327	\$2.41
2029	5,949,303	3,122,300	256,653	32,509	\$198,140,147	\$20,714,583	\$2.97
2030	5,976,058	3,126,137	256,968	35,804	\$230,224,176	\$24,068,811	\$3.62
2031	6,001,850	3,139,298	258,050	39,550	\$269,825,838	\$28,208,971	\$4.42
2032	6,026,651	3,151,878	259,084	43,680	\$316,473,731	\$33,085,780	\$5.36
2033	6,050,458	3,163,936	260,076	48,232	\$371,118,922	\$38,798,667	\$6.49
2034	6,073,273	3,175,472	261,024	53,248	\$435,121,824	\$45,489,858	\$7.82

^d The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

Table 4. Total Projected Intermittent Catheter Utilization and Expenditures and Total Non-Public Insured PMPM, High Impact^e

	Population		Projected prevalence and utilization		Projected expenditures		
	Total Minnesota population	Non-public insured population	Total diagnoses	Total users	Plan paid	Cost-sharing	Change in PMPM
2025	5,833,655	3,101,454	254,939	23,910	\$136,197,902	\$14,212,869	\$2.06
2026	5,863,731	3,107,430	255,431	27,071	\$164,069,022	\$17,121,347	\$2.65
2027	5,893,080	3,112,920	255,882	30,644	\$198,354,873	\$20,699,231	\$3.39
2028	5,921,625	3,117,886	256,290	34,683	\$239,540,005	\$24,997,086	\$4.29
2029	5,949,303	3,122,300	256,653	39,247	\$288,140,385	\$30,068,756	\$5.38
2030	5,976,058	3,126,137	256,968	44,404	\$343,928,636	\$35,890,513	\$6.65
2031	6,001,850	3,139,298	258,050	50,388	\$414,082,334	\$43,211,370	\$8.24
2032	6,026,651	3,151,878	259,084	57,166	\$498,915,038	\$52,064,047	\$10.19
2033	6,050,458	3,163,936	260,076	64,845	\$601,018,421	\$62,718,998	\$12.54
2034	6,073,273	3,175,472	261,024	73,542	\$723,887,887	\$75,540,984	\$15.40

^e The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

The total statewide non-public insured population potential plan paid expenditures for intermittent catheters and related supplies are projected to be \$76.4 million under the low-impact scenario and \$136.2 million under the high-impact scenario in Year 1. In Year 10, the expenditures would increase to \$248.4 million under the low-impact scenario and to \$723.9 million under the high-impact scenario. These expenditures are projected to result in a net increase of \$0.46 PMPM under the low-impact scenario and \$2.06 PMPM under the high-impact scenario in the first year. By Year 10, these expenditures are projected to result in a net increase of \$2.92 PMPM under the low-impact scenario and \$15.40 PMPM under the high-impact scenario.

A more comprehensive actuarial analysis and modeling of all services associated with intermittent catheter utilization, including more comprehensive downstream effects and potential savings, and a full picture of the current coverage environment for Minnesota were not possible with the available data. We conducted an additional literature review to assess the broader environment of coverage, utilization, and expenditures as well as explore avenues of potential long-term savings and improved health outcomes.

- A study published in January 2013 found median duration of intermittent catheter use to be 60 months. This same study found a significant rate of UTIs, the most common complication, of 77%. According to one study, the biggest challenge is getting patients to follow a prescribed catheterization schedule. This study found that only 10% of patients performed clean intermittent self-catheterization according to the doctor's prescription and that the remainder catheterized relying on their own schedule and perception.^{14,15}
- A National Institutes of Health study suggests that participation in an intermittent catheterization support program group resulted in about a 10% increase in long-term adherence and a significant decrease in hospital overnight stays and emergency department visits within the first month of intermittent catheter use.⁸
- One common potential misconception regarding intermittent catheterization is that it lowers the risk of infection compared to indwelling catheterization. Two recent studies concluded that the current available data do not support the hypothesis that indwelling catheters cause more UTIs than intermittent catheters.^{16,17}

Data Sources

- Minnesota state population projections are from the "Long-Term Population Projections for Minnesota" published by the Minnesota State Demographic Center.¹⁸
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.¹³
- Trends and projection factors are derived from the National Health Expenditure data compiled by CMS as well as the 2023 Medicare Trustees Report.^{19,20}
- MDH tabulations of MN APCD data from 2019–2022 were used for the estimation of prevalence of related diagnoses as well as historic utilization, expenditures, and enrollee cost-sharing for intermittent catheters and insertion supplies.¹²

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by SEGIP 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 state public programs.

- This proposed mandate is estimated to have no fiscal impact on SEGIP.
- There are no defrayal costs associated with this proposed mandate.
- There is no estimated cost to state public programs.

Fiscal Impact Estimate for SEGIP

MMB does not estimate any fiscal impact on the state plan from this legislation. SEGIP currently provides coverage in its medical benefit package for intermittent catheters and insertion supplies ordered by a member's physician, with no limitation placed on the number that may be prescribed. SEGIP's health benefits do not restrict intermittent catheters or catheterization supplies or apply any member cost-sharing that is not also applied to other supplies or durable medical equipment in the insurance policy.

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.^{21,22} For further defrayal requirements and methodology, please visit <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

If enacted, Commerce assumes this bill would not constitute an additional benefit mandate, as it does not relate to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's benchmark plan. Intermittent catheters can be classified under either durable medical equipment or prostheses/orthoses, both of which are included for coverage in the state's benchmark plan.²³

Fiscal Impact on State Public Programs

There is no estimated cost to Minnesota public health coverage programs, as the proposed health benefit mandate does not apply to these programs.

Appendix A. Bill Text

A bill for an act relating to insurance; requiring health plans to cover intermittent catheters; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62Q.665] INTERMITTENT CATHETERS.**

Subdivision 1. **Required coverage.** Every health plan must provide coverage for intermittent urinary catheters and insertion supplies if intermittent catheterization is recommended by the enrollee's health care provider. Up to 180 intermittent catheters per month with insertion supplies must be covered unless a lesser amount is prescribed by the enrollee's health care provider.

Subd. 2. **Cost-sharing requirements.** No health plan may impose a deductible, co-payment, coinsurance, or other restriction on intermittent catheters and insertion supplies that the health plan does not apply to durable medical equipment in general.

EFFECTIVE DATE. This section is effective for any health plan issued or renewed on or after January 1, 2025.

Appendix B. Key Search Terms for Literature Scan

Adverse effects

Bladder management

Clean intermittent catheterization

Clean technique self-catheterization

Closed-system catheters

Coude-tip catheters

Hydrophilic catheters

Indwelling catheter adverse effects

Intermittent catheterization

Intermittent urethral catheterization

Neurogenic bladder

Quality of life

Spinal cord injuries

Straight catheters

Urinary bladder

Urinary catheterization

Urinary complications

Urinary tract infections

Appendix C. Associated Codes

International Classification of Diseases (ICD-10) Code(s):

Name	Code
Retention of urine	R33
Other difficulties with micturition	R39.1
Unspecified urinary incontinence	R32
Other specified urinary incontinence	N39.4
Retention of urine unspecified	R33.9
Neuromuscular dysfunction of bladder unspecified	N31.9
Feeling of incomplete bladder emptying	R391.4
Other retention of urine	R33.8

HCPCS Code(s):

Name	Code
Intermittent urinary catheter; straight tip, with or without coating	A4351
Intermittent urinary catheter; coude (curved) tip, with or without coating	A4352
Intermittent urinary catheter, with insertion supplies	A4353
Lubricant, individual sterile packet	A4332
Incontinence supply; miscellaneous	A4335
Intermittent urinary catheter; straight tip, with or without coating	A4351
Intermittent urinary catheter; coude (curved) tip, with or without coating	A4352
Intermittent urinary catheter, with insertion supplies	A4353
Lubricant, individual sterile packet	A4332
Incontinence supply; miscellaneous	A4335

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