JOINT TASK FORCE ON UNIVERSAL HEALTH CARE

January 2022

Outstanding Design Element 3: Private Insurance (Supplemental Coverage)

Background

Senate Bill 770 (2019) stipulates that the coverage provided by the Health Care for All Oregon Plan (Plan) must preserve the coverage of services provided by Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Patient Protection and Affordable Care Act of 2010 (ACA). While the Health Care for All Oregon Board (Board) is ultimately responsible for deciding specific coverage details, SB 770 did charge the Task Force with developing recommendations for criteria to guide coverage decisions. In its June 2021 Interim Status Report, the Task Force outlined its recommendation that the Health Care for All Oregon Plan (Plan) provide a level of benefit coverage that compares to the coverage offered by the Public Employees' Benefit Board (PEBB) in order to ensure coverage of service categories not currently covered by ACA plans and the Oregon Health Plan (OHP). Implementing this recommendation means that the Plan's coverage will be comprehensive, providing coverage of primary and preventive care, prescription drugs, laboratory services, emergency services, hospitalization, behavioral health and substance use disorder services, prenatal, maternity and newborn care, dental and vision care, complementary care and physical and occupational therapy services.

In addition to its coverage recommendations, the Task Force's recommendations on provider participation and reimbursement practically eliminates the need for health insurance as it is currently defined and utilized because levels for all payer types will be tied to Plan rates and the Plan will be responsible for the coordination of payment when there is secondary coverage. Even so, implementation of the Plan as currently envisioned may not totally remove the desire for, and potentially utility of, health-related insurance products that could coexist with the Plan.

Private Coverage in Countries with Universal Public Plans

As summarized below, many countries offering universal health care coverage through a public plan, including those that operate a single-payer model, have a role for private insurance that coexists with the public plan. Some countries permitting private insurance also offer incentives to purchase that coverage. The types of private insurance that exists in these countries includes complementary, supplementary, and substitutive coverage.[1] For purposes of this discussion, the term "complementary coverage" describes coverage of a gap in the public plan either by covering statutory cost-sharing or services that are not otherwise covered by the plan. "Supplementary coverage" describes insurance coverage providing faster or improved access to

[1] Liu JL, Brook RH. What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S. J Gen Intern Med. 2017 Jul;32(7):822-831. doi: 10.1007/s11606-017-4063-5. Epub 2017 May 10. PMID: 28493177; PMCID: PMC5481251.

services covered by the plan. Countries with a supplementary insurance market often have dual or multi-payer systems where the government is the primary payer for health care services with private insurance offering enhancements to that coverage. “Substitutive coverage” describes coverage that replaces coverage offered by the public plan, either to individuals who are excluded or opt-out of coverage.

Country	Role of Private Supplemental/Complementary Insurance[2]
Australia	Private insurance helps cover charges above what public plan pays and covers visits outside of public hospitals which can avoid wait times. Tax credits and penalties are used to encourage purchase of supplementary insurance.
Brazil	Private insurance covers services provided at plans’ own facilities or accredited health care organizations. Most private insurance offered as an employment benefit. Tax incentives exist for individuals and entities who purchase private insurance.
Canada	Private insurance covers services excluded by public plan, such as vision and dental care, outpatient prescription drugs, rehabilitation services, and private hospital rooms. Most private insurance is employer-sponsored.
China	Private insurance can be used to cover cost-sharing, as well as to provide coverage for expensive services not paid for by public plan. Primarily purchased by employers for employees and higher-income individuals.
Denmark	Complementary insurance covers statutory copayments (mainly for pharmaceuticals and dental care) and services not fully covered by the public plan, such as physiotherapy. Supplementary insurance provides expanded access to private providers, mostly for physiotherapy and minor elective surgeries. Mainly provided as a employment benefit.
England	Private insurance offers more rapid access to care, choice of specialists, and better amenities, especially for elective hospital procedures. Offered as an employment benefit and purchased individually.
France	Private insurance covers cost-sharing and services covered minimally by public plan (e.g. vision and dental).
Germany	Substitutive policies are permitted. Private insurance can be both supplementary (e.g. cost-sharing and private hospital services) and complementary (e.g. services not covered by public plan).
Israel	Private insurance can be both supplementary (e.g. access to private providers and improved amenities) and complementary (e.g. services excluded from public plan).
Italy	Private insurance can be both supplementary (e.g. private hospital rooms and greater provider choice) and complementary (e.g. coverage of copayments and services not covered by public plan). Tax benefits favor complementary insurance over supplementary.
Netherlands	Complementary private insurance available that covers services not covered by the public plan (e.g. dental care, alternative medicine, physiotherapy, eyeglasses and lenses, and contraceptives).
New Zealand	Private insurance can both be supplementary (e.g. faster access to nonurgent care) and complementary (e.g. cost-sharing requirements, elective surgery in private hospitals, and private outpatient specialist consultations)

[2] Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic, George A. Wharton, *International Profiles of Health Care Systems*, Commonwealth Fund, December 2020.

Norway	Supplementary private coverage available for quicker access to specialists and elective treatments. Coverage most often provided through employer.
Sweden	Supplementary private insurance provides quicker access to specialists and elective treatment. Coverage most often provided through employer.
Switzerland	Private insurance for services not covered by public plan and to ensure free choice of hospitals or doctors and preferred hospital accommodation.
Taiwan	Private insurance provides disease-specific cash indemnity provisions that policyholders can use the cash for private hospital rooms or medical devices.

Role of Private Insurance in the Health Care for All Oregon Plan

Substitutive Coverage

Senate Bill 770 established the fundamental value that the Plan secure access to health care services for all Plan participants on an equitable basis. In its Interim Status Report, the Task Force determined that meeting this guiding value requires that all eligible individuals be enrolled in the Plan. The Task Force further found that an option to "opt out" of contribution to the Plan through taxes (and associated "automatic" coverage) would undermine the financial sustainability the Plan. These findings and recommendations are not consistent with the provision of substitutive coverage, to the extent that the availability of such coverage is within the state's control.

In its recommendations on Provider Participation, the Task Force has acknowledged the inability to explicitly prohibit the continued offering of self-funded health insurance coverage offered by employers, protected from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA). To the extent that this employer-sponsored coverage could be similarly comprehensive to that offered by the Plan, and that enrollment in employer-sponsored plans could be preferred by some individuals, these plans are likely beyond the ability of the state to regulate.

Supplementary Coverage

The equity value established in Senate Bill 770 also challenges the concept of supplementary coverage. A market that provides coverage of enhancements to the Plan's coverage implies a market with levels of access or quality available only to those with the means to purchase or otherwise obtain supplementary coverage. The Task Force's recent recommendations on Provider Participation further weaken the potential role of supplementary insurance. These recommendations include prohibitions against providers charging rates in excess of those established by the Plan for services covered by the Plan and providing preferential treatment to patients paying for services outside of the Plan. These recommendations challenge the spirit and administration of the two primary ways supplementary coverage offers value in other countries providing universal publicly funded health care (i.e. enhanced access or quality).

Complementary Coverage

In contrast to substitutive and supplementary coverage, the existence of which undermines the equity and sustainability of the Plan, complementary insurance could exist to the extent it remains consistent with these and other Plan values and principles. Whereas supplementary coverage has the potential to enhance plan coverage in ways that undermine equity in access and quality, complementary coverage seeks to provide additional protection from financial exposure to health care related expenses that may exist due to gaps in Plan coverage.

In its Interim Status Report, the Task Force recommended that the Plan have no premiums, deductibles, copays, or other forms of cost-sharing. This recommendation removes one aspect of complementary coverage seen in other universal coverage countries. Although the Task Force's recommendation to align Plan coverage with the coverage offered by PEBB will result in comprehensive coverage of service categories, the Board may choose to impose reasonable limitations on coverage scope and/or duration that could be backfilled by complementary coverage. For example, while the Plan will cover physical therapy services, the Board could adopt reasonable visit limitations. Similarly, the Task Force's Interim Status Report recommends adoption of a single state formulary for the Plan's prescription drug benefit, potentially exposing Plan members to the cost of drugs not on the formulary. Finally, the Task Force has yet to finalize its recommendations for the Plan's treatment of long term care. Given the complexity of this segment of care and coverage, there could be an appropriate and desirable role for complementary coverage to play. Complementary insurance could be utilized to limit members' financial exposure in instances like these where there are reasonable limits to the scope of the Plan's coverage.

Ironically, complementary coverage more appropriately describes two forms of insurance currently available that adopt "supplement" terminology. First, Medicare supplement (a.k.a. "Medigap") policies are private insurance plans that help fee-for-service Medicare enrollees cover out-of-pocket costs. Even though both Senate Bill 770 and the Task Force strongly recommend the inclusion of Medicare enrollees and associated funding streams in the Plan, this inclusion is contingent on unique federal approval no state has been granted. Should the Task Force's recommendations be implemented and: (1) Medicare enrollees and funds be included in the Plan, and (2) the Plan have no cost-sharing, Medicare supplement plans will no longer be relevant as there will be no cost-sharing gap to fill. However, should Medicare enrollees and funds be excluded from the Plan, Medicare supplement policies probably still have a place as complementary to coverage that would continue to be administered and regulated federally.

The second type of "supplement" coverage currently available that is more complementary in nature are the "lump sum" supplemental policies that provide direct cash payments to insureds in cases of injury or illness. These lump sum policies could complement Plan coverage by limiting financial exposure to health care needs that extend beyond Plan coverage limits or to other expenses that are a consequence of injury or illness but are not health care services covered by the Plan (e.g. child care, transportation, lodging, etc.). Countries that permit these types of policies tend to view them as supplements to nonmedical policies, such as life and car insurance.

As complementary insurance could coexist with Plan coverage consistent with the values and principles of Senate Bill 770, this coverage could be utilized by employers to continue to offer health care insurance as an employment benefit. As the summary above indicates, complementary insurance in other universal health care countries is commonly most-often offered by employers.

Private Insurance Recommendations

The Task Force recommends:

- **Prohibit substitutive and supplementary insurance.** Legislation implementing the Plan should expressly prohibit state-regulated insurance companies from offering substitutive and supplementary insurance plans to the extent permitted by state and federal law. The existence of such insurance compromises equity in access and quality and potentially undermines the financial sustainability of the Plan.
- **Regulation of complementary insurance.** Regulation of complementary insurance is outside of the scope of the Board and should remain with the Department of Consumer and Business Services (DCBS) or other agency with applicable regulatory authority. To be consistent with the values and principles of Senate Bill 770 and the Plan, the Task Force recommends coverage that complements Plan coverage be offered on a guaranteed issue basis and be subject to DCBS' rate review or similar process.