

Glossary for understanding health insurance



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Swiss health insurance is among the best in the world, but also one of the most expensive. Our country spends 12.1% of its gross domestic product (GDP) on healthcare (a total of CHF 77.8 billion in 2015). Over a third of this amount (35.3%) is covered by health insurance (compulsory health insurance – AOS/OKP), a relatively complex field managed by health insurers. The work of the health insurers is little known and often misunderstood.

This glossary contains some essential definitions to help you understand the health insurance system and how it operates.

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Compulsory health insurance (social insurance)

Health insurance is compulsory for all Swiss residents.
Compulsory health insurance is governed
by the Federal Law of 1996 on Health Insurance (LAMa/KVG).

Federal Law on Health Insurance (LAMa/KVG)

The Federal Law of 1996 governing health insurance.

OAMa/KVV

The ordinance implementing the health insurance law.

Compulsory health insurance (AOS/OKP)

Governed by LAMa/KVG, compulsory health insurance, also known as «basic health insurance», offers quality medical coverage for everyone, ensuring general access to a broad range of healthcare benefits.

LSAMa/KVAG

Law on the Supervision of Insurance Undertakings.



OPAS/KLV

Ordinance on Healthcare Insurance Benefits. Also known as «catalogue of benefits», this ordinance defines the medical benefits covered or not by the basic health insurance.

LiMA/MiGeL

List of medical aids and appliances that are reimbursed by the compulsory health insurance.

Alternative healthcare models or Managed Care models

Health insurance models offering insureds the choice of a main contact (doctors or medical advice call centres) acting as a hub for all their health questions. Insureds accept a restricted choice. In exchange, insureds can obtain premiums up to 20% cheaper depending on the savings achieved thanks to the insurance model and according to the authorization of the Federal Office of Public Health (FOPH).

Telemedicine model

Insureds who choose this alternative model are required to contact a medical call centre for advice before seeing a doctor. The medical staff of the call centre analyses the situation and makes recommendations (self-medication or referral to a doctor or a hospital).

Family doctor insurance model

Alternative model in which the insured undertakes to consult his family doctor first (general practitioner) who will then refer the insured person further down the health chain, if required: specialists, hospital, etc.

Health networks, Health Maintenance Organisation (HMO) or group practices

Alternative model in the form of a regional group or network of doctors bringing together various medical disciplines in the same place (e.g. medical emergency services). The objective is to improve the coordination of treatments in order to avoid unnecessary consultations or duplicating tests. The patient's first contact is always the same doctor, as a rule a GP, who refers the patient onwards to a specialist where necessary.

Health network agreements

These health networks sign an agreement with the health insurer in which they generally assume a budgeting responsibility. The agreement provides for lump-sum or flat-rate indemnities based on a predefined budget. The network is thus encouraged to provide best value for money.

Daily allowance benefit insurance

This optional insurance is designed to protect the insured against a loss of earnings as a result of illness or an accident. The basic LAMa/KVG coverage may be backed up by supplemental insurance.

Not-for-profit insurance

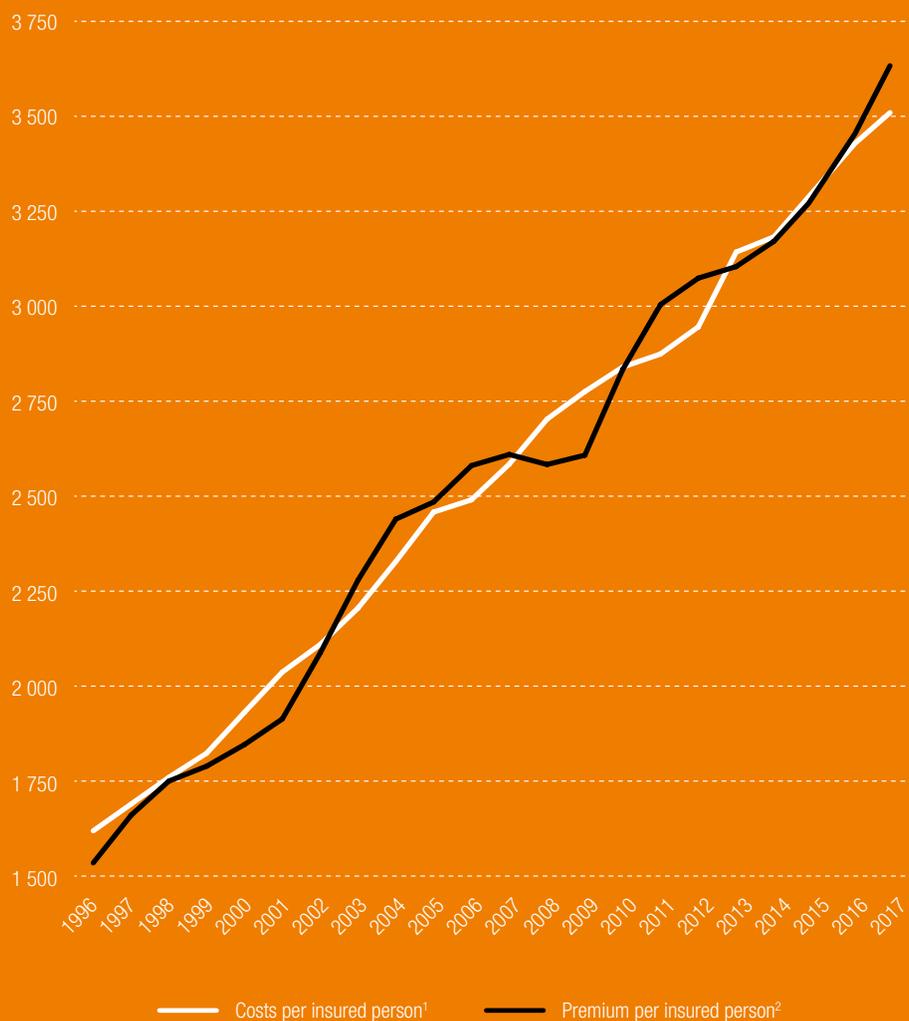
Compulsory health insurance is a not-for-profit area. Any surpluses are paid into the insurer's reserves so as to guarantee the payment of benefits under all circumstances (see «reserves»).

CGA – General Terms and Conditions of Insurance in accordance with LAMa/KVG

The rules governing compulsory health insurance and voluntary daily allowance benefits.

Evolution of average premiums and net cost, in CHF per person insured under AOS/OKP – 1996-2017 (all health insurers in Switzerland)

Premiums and cost per insured person, in CHF



¹ Costs per insured person = net cost of medical benefits + administrative costs, per year

² Premiums per insured person = average premiums per insured, per year

Source: Swiss Federal Office for Public Health, compulsory health insurance statistics, table 1.01, Bern 2018.

Evolution of compulsory health insurance costs (AOS/OKP), premiums and reserves in Switzerland (1996-2017)

	1996	2005	2012	2015	2016	2017	Average annual increase 1996-2017
Gross total cost (in CHF millions)	12'459	20'348	25'901	30'122	31'484	32'318	4.6%
Net cost per insured person¹ (in CHF)	1'616	2'460	2'950	3'307	3'426	3'501	3.7%
Average national premium per insured person² (in CHF)	1'539	2'480	3'075	3'289	3'442	3'605	4.1%
Administrative costs (in % of total premiums)	8.15%	5.40%	5.16%	4.73%	4.75%	4.86%	N/A
Total reserves (in CHF millions)	— ³	— ³	6'504	6'062	6'249	7'193	N/A
Reserves per insured person (in CHF)	— ³	— ³	818	735	750	857	N/A

¹ Net cost: gross benefits reimbursed by health insurers minus the participation, paid by insured persons, plus administrative costs.

² Average premiums invoiced by health insurers regardless of the insurance model.

³ The calculation method for legal minimum reserves was changed in 2012. Therefore, a comparison with previous years is impossible.

Source: Swiss Federal Office for Public Health, compulsory health insurance statistics, table 1.01, Bern 2018.

The progression of health costs is a long-standing reality. In the past 20 years, the pace of growth has picked up driven by medical progress and, more recently, by increasing life expectancy and the demographic imbalance, i.e. the decreasing proportion of young people and the growing ranks of their elders.

The above table shows the current trend, namely the average annual increase in costs, premiums and reserves. Over time, premiums have followed the curve of health costs so that, since revenues match expenditure, deficits have been avoided in one of the most sensitive areas of our social system. The proportion of administrative costs with regard to premiums, in %, was practically halved since the introduction in 1996 of the Federal Law on Health Insurance (LAMal/KVG) and has dropped below 5%; 95% of the premiums serve to fund the medical benefits of insured persons.

Reserves serve to guarantee the financial security of health insurers and make it possible to absorb any deficits in the event of an unexpected rise in health costs. Therefore, their role is essential for the stability of the system. New rules for the calculation of reserves were implemented in 2012.

Supplemental private insurance

Regulated by the Federal Law on Insurance Contracts (LCA/VVG).
Non compulsory (optional) private insurance covering supplemental benefits for hospitalisation (semi-private, private and general wards anywhere in Switzerland), healthcare (alternative medicine, thermal cures, unlisted drugs, etc.) and various other insurance products (travel insurance, legal protection, etc.).
In Switzerland, four out of five insureds contract supplemental insurance.

Private ward

The comfort of a single room. Free choice of doctor.

Semi-private ward

The comfort of a double room. Free choice of doctor.

Hospitalisation anywhere in Switzerland

Hospitalisation coverage in a general ward; insureds can be admitted to any public or private hospital in Switzerland. This coverage covers any difference in costs compared to the canton of residence.

CGC - Special Terms and Conditions for Supplemental Health Insurance in accordance with the LCA/VVG

Rules governing private supplemental insurance.



Health insurers

Insurance companies offering compulsory health insurance plans.

There are 51 health insurers in Switzerland (as at 01.07.2018).

Other health insurers offer private supplemental insurance. Some of them, such as Groupe Mutuel, belong to groups that comprise several health insurers.

The ten largest AOS/OKP insurers account for about 80% of the market.

This plurality ensures that insureds are able to choose the insurance company of their choice. This leads to competition between insurers who ensure that they contain their overheads and offer reasonable premiums and a quality service.

Premiums

The amount invoiced by insurers to cover health costs. Social health insurance is a «pay as you go» system. However, this means that the premiums for any given year have to cover the health costs for the same year (Art. 12 and 16 LSAMa/KVAG).

Deductibles

The insured's share of health costs. By this mechanism, the insured must pay a portion of the costs generated by him. If he chooses an optional deductible, his premium will be reduced.

Adults Ordinary deductible	CHF 300 per year: the minimum amount payable by all insureds. The insured is not entitled to a reduction in premium.
Adults Optional deductibles	CHF 500 - CHF 1,000 - CHF 1,500 - CHF 2,000 - CHF 2,500 per year.
Children Ordinary deductible	CHF 0.
Children Optional deductibles	CHF 100 - CHF 200 - CHF 300 - CHF 400 - CHF 500 - CHF 600 per year.

Co-insurance

10% participation in the cost of the healthcare services actually consumed by the insured over and above his deductible. By law, the maximum amount of the co-insurance is CHF 700 per year for adults. For children, the maximum amount is CHF 350.

Example (adult)

Treatment costs:	CHF 1,200
Deductible:	CHF 300
Co-insurance:	CHF 1,200 - CHF 300 = CHF 900 / CHF 900 x 10% = CHF 90
For the insured's account:	CHF 300 (deductible) + CHF 90 (co-insurance) = CHF 390
For the insurer's account:	CHF 1,200 - CHF 390 = CHF 810

Economic efficiency

The principle whereby health insurance benefits must be effective, appropriate and economic is enshrined in the Federal Law on Health Insurance. The three criteria are cumulative (Article 32 LAMaI/KVG).

Cost control

Cost control is the essential procedure by which health insurers verify the invoices received to ensure they are consistent with the three principles of economic efficiency specified above. This control activity allows a reduction in annual expenditure of approximately 10% of the benefits covered, i.e. more than CHF 3 billion per year.

Compulsory health insurance costs represent some CHF 1.5 billion per year; the net cost-savings per year are thus CHF 1.5 billion each year. In terms of premium relief, this translates into a reduction of about 5% in premiums each year.

The efficiency of the invoice verification process is the consequence of the competition between health insurers who do their best to contain both health costs and administrative fees in order to offer competitive premium rates to their insured members.

Premium reductions (subsidies)

Financial support for premium payments granted by cantons to low-income insureds. The allocation criteria (minimum income, % covered, etc.) are set by each canton. In 2017, 2.2 million persons, or 26.4% of insured persons, were granted a premium reduction. The aggregate subsidies paid by the Confederation and the cantons reached CHF 4.5 billion.

Risk compensation

This is a financial compensation mechanism between health insurers.

Insurers which represent higher risk groups of insureds (more serious illnesses with greater frequency) receive financial support from insurers whose portfolio contains fewer insureds with illnesses.

Criteria: The compensation is calculated based on four criteria: age (the young and the elderly), gender and hospital stays over a minimum duration of three days in a hospital or special residential facilities (EMS) and, since 1 January 2017, the costs of drugs for the previous year. The four criteria are cumulative.

The compensation amounts are calculated anew each year. In 2016, the global compensation exchanged between insurers reached CHF 1.7 billion.

Example: An insurer whose portfolio comprises more women, elderly persons and people having been hospitalised for more than three days in a calendar year receives a compensatory amount from insurers with more men, more young people and fewer persons having been hospitalised for over three days.

Obligation to contract

The obligation incumbent on health insurers to reimburse all healthcare providers authorised to practice under the LAMal/KVG.

Freedom to contract

The possibility for health insurers or healthcare providers to choose with whom to contract a tariff agreement.

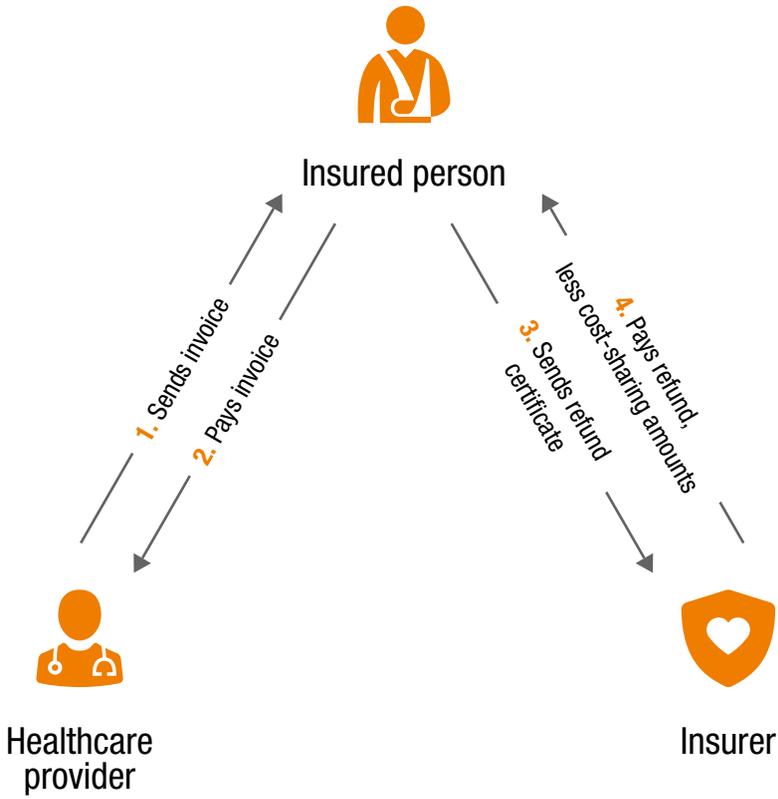
Free choice of insurer

Possibility for the insured person to choose his health insurer. Free choice is intrinsic to the compulsory health insurance system.

Free choice of doctor

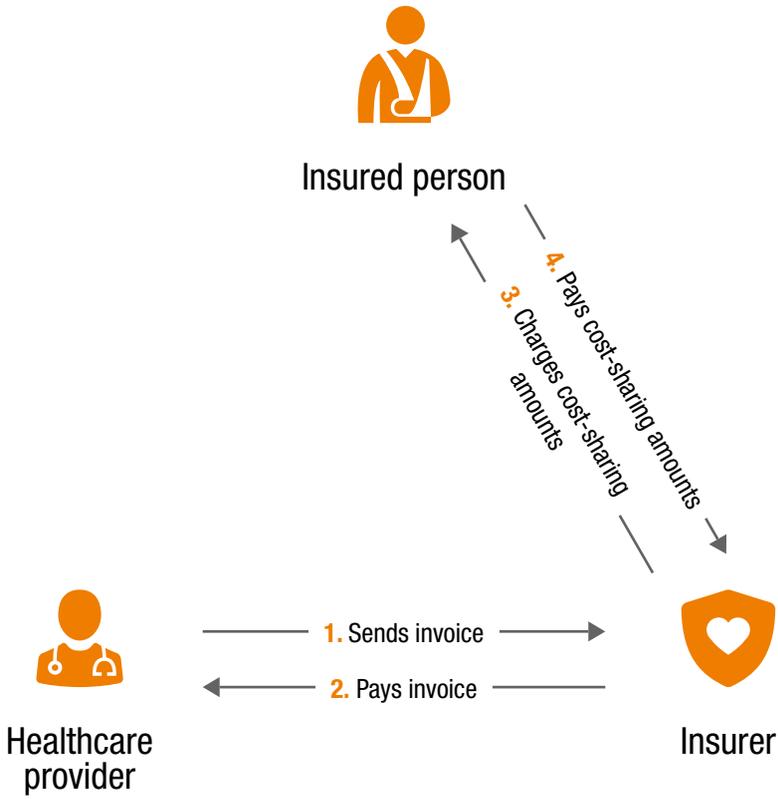
Possibility for each patient to be treated by the doctor of his choice, whether a general practitioner or a specialist, provided that his insurance coverage is a standard model. In the case of insurance models with special conditions, please go to page 5 («Alternative healthcare models or Managed Care models»).





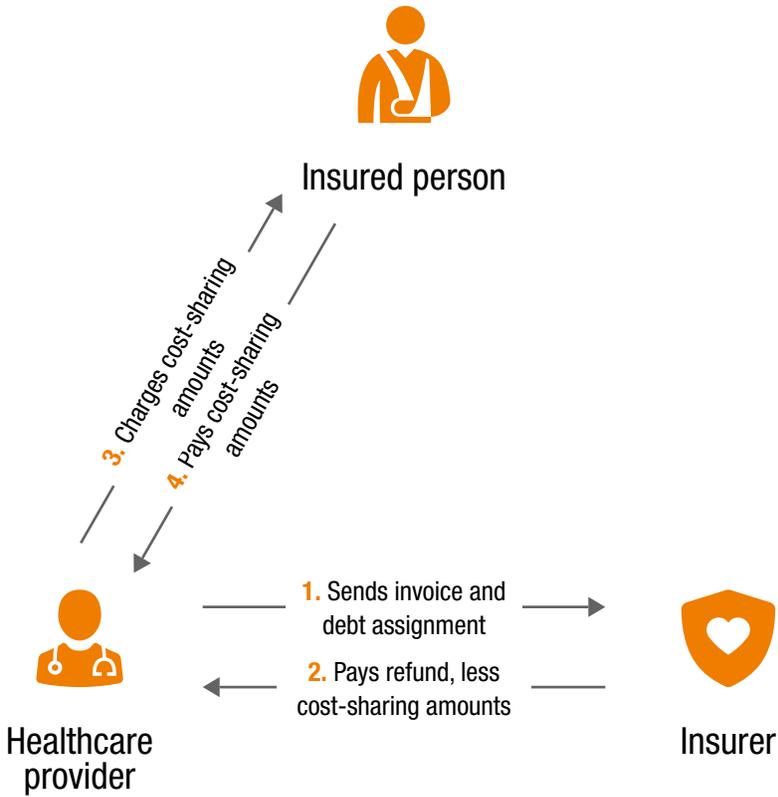
Third-party guarantor

Unless otherwise agreed, the insured is the debtor of the healthcare provider’s fees. Accordingly, the insured pays the invoice and then claims reimbursement from his insurer. This is called the «third-party guarantor» system.



Third-party payer

In this system, an agreement provides that the insurer is the debtor of the invoice and pays the healthcare provider directly; the insurer then claims the cost-sharing amounts (deductible, co-insurance) from the insured.



Third-party payer, excluding cost-sharing amounts

The healthcare provider sends the invoice directly to the insurer, along with a debt assignment signed by the patient. The insurer then pays the money directly to the healthcare provider, less the cost-sharing amounts due by the insured person (deductible, co-insurance). The healthcare provider charges the remaining balance to the patient.



Provisions

Amounts set aside to cover healthcare benefits which have already been delivered but not yet invoiced and/or reimbursed. Provisions generally cover three months' benefits: they are used to reimburse the claims relating to the last quarter of a year which the insurer receives in the first quarter of the following year.

Reserves

Own funds which insurers are obliged to set aside to cover the reimbursement, in any event and circumstance, of healthcare providers' invoices. Reserves must equal a minimum threshold set by law. Since 1 January 2012, reserve requirements are calculated based on the risks faced by insurers. These include the actuarial risk, the market risk and the credit risk, which are all taken into consideration in the LAMa/KVG solvency test. An insurer's risk bearing capacity is assessed depending on its level of solvency which shows the ratio between available reserves and the minimum reserves required.

Reserves play an important role in balancing the system: if costs are higher than premium revenues, the insurer uses his reserves to continue reimbursing healthcare providers. If premium revenues exceed costs, the surplus is used to increment the reserves which are taken into account in calculating premiums: as a result, premium increases are contained.

Supervision

The activities of health insurers are monitored by the competent federal authorities. For compulsory health insurance under LAMa/KVG (social insurance), the supervisory authority is the Federal Office of Public Health (FOPH). A specific law, the Law on Insurance Supervision (LSA/VAG), was enacted on 1 January 2016. For private supplemental insurance under LCA/WVG, the Swiss Financial Market Supervisory Authority (FINMA) is the body which closely supervises the activities of insurers in this field.

Healthcare providers

Medical professionals and establishments licensed to provide healthcare services. They include: doctors, pharmacies, hospitals, special residential centres (EMS), cure centres, diagnostic and therapeutic equipment delivery centres, medical laboratories, chiropractors, midwives, birthing centres, persons providing treatment on medical prescription or on medical instructions (physiotherapists, etc.), a contribution to the cost of medically required transport and rescue costs (Articles 24 to 31 LAMal/KVG).

Benefits

The amounts reimbursed to insureds or paid to healthcare providers by health insurers.

TARMED

Medical fees' system which serves as the basis for all outpatient health services administered by a doctor. The nomenclature of medical acts - comprising 4,600 tariff positions - is standardised for the whole of Switzerland, but TARMED point values vary from one canton to another (see: www.tarmedsuisse.ch).

DRG

The abbreviation for «Diagnosis Related Groups» which means «flat rate per case». This tariff system classifies hospital stays by pathology group. Healthcare benefits are paid on a lump-sum or flat-rate basis. This type of invoicing replaces the former system which was based on a daily rate (per day of illness).

Tariff agreements

Agreements regulating the relationship between health insurers and healthcare providers and setting tariffs (tariff protection).

LAMal/KVG agreements: agreements covering compulsory healthcare services (AOS/OKP).

Disputes are settled by the canton in the first instance. Cantonal decisions may be appealed before the Federal Court, as the court of last instance, whose decisions are final.

LCA/VVG agreements: agreements on supplemental insurance which are privately negotiated directly between health insurers and healthcare providers.

Hospitals

Inpatient: hospital stays of more than one day or including at least one night. A new system introduced in 2012 provides for a distribution key splitting the financing of services between the cantons, which pay 55%, and health insurance funds, which pay 45%. The tariff is based on the DRG system.

Outpatient: hospital stays of less than one day or which are not overnight. Fully financed by the health insurers in accordance with the TARMED rate.

Doctors (medical practices)

Visit for medical care. Financed according to TARMED.

Long-term care

EMS: special residential facilities for the elderly and the disabled.

Home care: also called Spitex (from the German term): medical care covered by the catalogue of LAMal/KVG benefits and administered at the insured's home.

Alternative medicine or naturopathy

Covers what is known as alternative or complementary medicine: naturopathy, homeopathy, aromatherapy, reflexology, sophrology, etc. There are more than 200 different methods of alternative medicine practiced by some 25,000 therapists.

Supplemental insurance: provided the therapist belongs to an association recognised by the insurer, such as the Swiss Foundation for Complementary Medicine (ASCA) or the Register of Empirical Medicine (RME/EMR), these treatments are generally reimbursed by supplemental insurance.

Basic insurance: since 1st August 2017, basic insurance covers four other alternative medicine methods in addition to acupuncture, namely homeopathy, anthroposophy, phytotherapy and traditional Chinese medicine.

Treatment is only reimbursed if administered by specially qualified doctors.



Managed Care

Case management: monitoring complex medical cases – patients suffering from lung and heart disease, for example – from the beginning to the end of the treatment chain with a view to providing the best care, in the best place and at the best price.

Disease management: managing treatment for patients suffering from chronic diseases (diabetes, congestive heart failure) by coordinating the intervention of the various actors in the healthcare chain and encouraging greater responsibility on the part of the patient.

Drugs

Listed drugs covered by a tariff (LMT/ALT) and specialty drugs (LS/SL): comprehensive lists of the products and active substances used in pharmaceutical preparations and of drugs, as well as their prices, reimbursed by compulsory health insurance (AOS/OKP). The lists are prepared by the Swiss Federal Office of Public Health. Reimbursement is subject to a medical prescription. (www.listedesspecialites.ch)

Non reimbursable drugs: commercially available drugs which are not listed on the specialty drugs' list (LS/SL) and, therefore, not covered by basic health insurance. They may be partially reimbursed by supplemental health insurance.

LPPA/LPPV drugs: list of drugs and pharmaceutical products which are for the insured's account (reimbursed neither by compulsory health insurance nor by supplemental coverage).

Generic drugs: copies of original drugs which are no longer protected by a patent. The generic drug contains the same active substances and has the same properties (effectiveness, indications, dosage) as the original drug. Since their price does not have to cover research costs, generic drugs are considerably cheaper (up to 70%) than the originals.



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