



**Groupe Mutuel**

Assurances  
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**Swiss Power Group.**

## **FACT SHEET**

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**HOW DOES THE HEALTH CARE SYSTEM WORK?**

# **The basics of health care insurance**

## HOW DOES THE HEALTH CARE SYSTEM WORK?

# The basics of health care insurance

Swiss health insurance is among the best in the world: it is also one of the most expensive. Our country devotes 11.4% of its GDP to health care (a total of CHF 61 billion in 2009). Half of this amount (CHF 30 billion) is covered by health insurance, a relatively complex field managed by health insurers. The work of the health insurers is little known and often misunderstood. This document contains some essential definitions to help you understand the mechanisms of the health insurance system and how it functions.

### COMPULSORY HEALTH INSURANCE (SOCIAL INSURANCE)

Health insurance is compulsory for all Swiss residents. Compulsory, or basic, health insurance is governed by the Federal Law of 1996 on Health Insurance.

#### **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, which is also known as “basic health insurance“, offers quality medical coverage for everyone, ensuring general access to a broad range of health care services.

#### **Alternative health care models (MAA) or Managed Care models**

Health insurance models offering insureds the choice of a main contact (doctors or medical call centres) acting as a hub for all their health questions. Insureds accept a restricted choice in exchange for a reduction (between 5% and 20%) in the premium rates set by law.

#### **Telemedicine model**

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

#### **Family doctor model**

This model obliges the insured to see his family doctor (first recourse) who will then refer him, if necessary, to a specialist or hospital, etc.

#### **Health Maintenance Organisation HMO or group practices**

A regional group or network of doctors bringing together various medical disciplines under one roof (e.g. medical centres). The aim is to better coordinate treatment so as to avoid duplicating tests and examinations. The patient's first contact is always the same doctor, as a rule a GP, who calls in a specialist where necessary.

#### **Health network agreements**

These health networks sign an agreement with the 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 cash 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 under “reserves“).

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

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

## SUPPLEMENTAL PRIVATE INSURANCE

### Supplemental 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), health care (alternative medicine, thermal cures, unlisted drugs, etc.) and various other insurance products (travel insurance, legal protections, 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 general ward; insureds can be treated in any public or private hospital in Switzerland.

### 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 and maybe also supplemental insurance. There are 70 health insurers in Switzerland. Some of them, such as Groupe Mutuel, belong to groups that comprise several health insurance funds. The ten largest insurers account for about 80% of the market.

This plurality ensures that insureds have a free choice of insurance company. As a result, insurance companies compete with each other: they will therefore seek to contain their overheads and offer reasonable premiums and quality service. This spur would disappear if Switzerland were to adopt a single health fund system.

### Premiums

The amount invoiced by insurers to cover health costs. Social health insurance is a "pay as you go" system. That means that the premiums for any given year have to cover the health costs for the same year. Since, in any given year, health costs may be higher or lower than the premiums for the same year, insurers are required to balance income and expenditures over a two-year financing period (Article 78 OAMal/KVV).

### Deductibles

The insured's share of the cost. By this mechanism, the insured agrees to 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 p.a.

### 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 health care 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.

### Examples

treatment costs:  
CHF 1,200 (adult)

**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 LAMal/KVG).

### Cost controlling

Cost controlling is the essential procedure whereby health insurers verify all the invoices received to ensure they are consistent with the three above-mentioned principles of economic efficiency. The controlling process produces annual cost-savings of about 10% of benefits which equal approx. CHF 2 billion per year.

Compulsory health insurance costs represent some CHF 1 billion per year; the net cost-savings per year are thus CHF 1 billion. In terms of premium relief, this translates into a reduction of about 5% in premiums per year.

The efficiency of the claims controlling process is the consequence of the competition between health insurance companies which do their best to contain costs so as to offer their insureds competitive premium rates.

### **Premium reductions (subsidies)**

Financial support for premium payments granted by the cantons to low-income insureds. The allocation criteria (minimum income, % covered, etc.) are set by each canton. In 2009, one third of the Swiss population (2.4 million persons), or nearly one half of all households, was granted a premium reduction. The aggregate subsidies paid by the Confederation and the cantons total CHF 3.5 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 three criteria: age (the young and the elderly), gender and, since 1 January 2012, the hospital stays over a minimum duration of three days in a hospital or special residential facilities. The three criteria are cumulative. The compensation amounts are calculated anew each year. In 2010, the global compensation exchanged between insurers attained CHF 1.5 billion. The 15 largest contributors – of which Groupe Mutuel is one – covered about 90% of the total compensation amount. The 15 largest recipients accounted for 99% of the total amount.

**Example:** An insurer whose portfolio comprises more women, elderly persons and people having been hospitalised for more than 3 days in a calendar year receive a compensatory amount from insurers with more men, more young people and

fewer persons having been hospitalised for over 3 days.

### **Obligation to contract**

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

### **Freedom to contract**

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

### **Free choice of insurer**

Possibility for the insured to choose his health insurer. Free choice, the basis for competition between health insurers, does not exist in a single health fund system.

### **Free choice of doctor**

Possibility for each patient to be treated by the doctor - general practitioner or specialist - of his choice. The free choice also applies to the pharmacist or physiotherapist, subject to a medical prescription.

### **Third-party guarantor**

Unless otherwise agreed, the insured is the debtor of the health care 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 health care provider directly; the insurer then claims the insured's participation (deductible, co-insurance) from the insured.

### **Reserves**

Own funds which insurers are obliged to set aside to cover the reimbursement, in any event and circumstance, of health care providers' invoices. Reserves must equal a minimum threshold set by law, expressed as a percentage of the premium volume:

### **Minimum reserves set by law:**

- ▶ 10% for insurers with more than 150,000 insureds
- ▶ 15% for insurers with between 50,000 and 150,000 insureds
- ▶ 20% for insurers with less than 50,000 insureds

From 2012, reserve requirements are calculated on a new basis taking into account actual risks.

Reserves play an important role in balancing the system: if costs are higher than premium revenues, the insurer uses his reserves to continue reimbursing health care 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.

**Limits:** reserve requirements were of CHF 400 per insured in 2010, or less than two months' premium revenues. By comparison, the social security fund (AVS/AHV) covers 12 months' expenditures despite the fact that pensions are infinitely easier to manage in view of the 80 million claims processed by health insurers each year.

### **Provisions**

Amounts set aside to cover health care 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 of the last quarter of a year which the insurer receives in the first quarter of the following year.

## HEALTH CARE PROVIDERS

Medical professionals and establishments licensed to provide health care 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 health care providers by health insurers.

### Tarmed

Schedule of medical fees which serves as the basis for all outpatient health services at the doctor's surgery, patient's home and in hospital outpatient services. 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](http://www.tarmedsuisse.ch)).

### DRG

The abbreviation for "Diagnosis Related Groups". DRG is a tariff system classifying hospital stays in groups of pathologies; health care services 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 sickness day).

### Tariff agreements

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

**LAMaL/KVG agreements:** agreements covering compulsory health care 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 health care 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 schedule.

### 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 services and administered at the insured's home.

### Alternative medicine or naturopathy

Covers what is known as alternative or complementary medicine: naturopathy, homeopathy, aroma therapy, reflexology, sophrology, etc. There are more than 200 different methods of alternative medicine practiced by some 20,000 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 the beginning of the year, basic insurance covers five alternative medicine methods, namely homeopathy, anthroposophy, neural therapy, phytotherapy and Chinese medicine; coverage is for a trial period expiring in 2017.

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 drugs and pharmaceutical preparations, and their prices, reimbursed by compulsory health insurance. The lists are prepared by the Swiss Federal Office of Public Health. Reimbursement is subject to a medical prescription.

**Non reimbursable drugs:** commercially available drugs which are 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 60%) than the originals.

**Development of compulsory health insurance costs, premiums and reserves in Switzerland (1996 - 2010).**

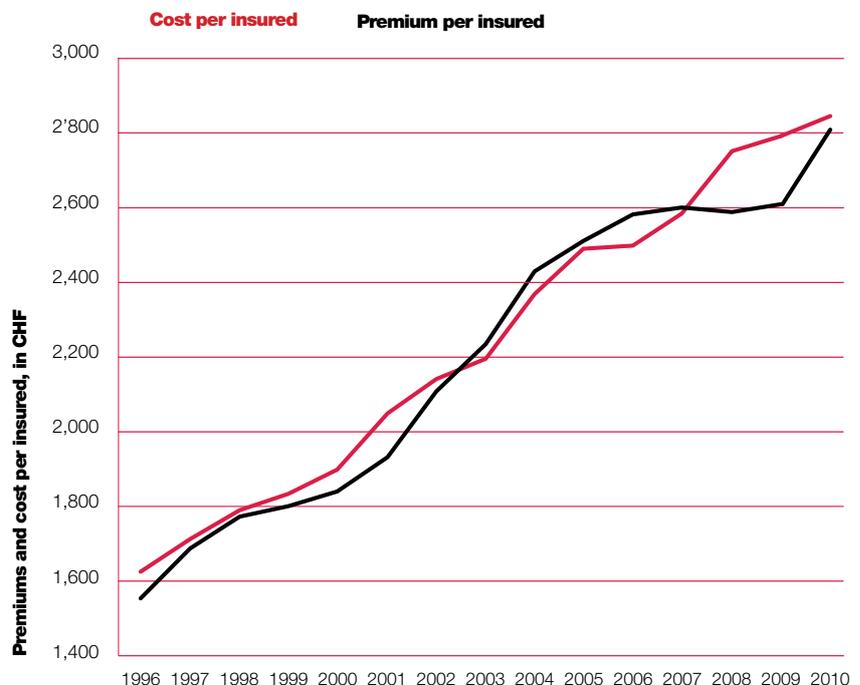
	1996	2000	2005	2007	2008	2009	2010	Average annual increase 1996-2010
Gross total cost (in CHF millions)	12,459	15,478	20,348	21,579	22,722	23,656	24,292	4.9%
Net cost per insured <sup>1</sup> (in CHF)	1,624	1,935	2,468	2,586	2,705	2,777	2,842	4.1%
Average national premium per insured <sup>2</sup> (in CHF)	1,539	1,850	2,487	2,612	2,586	2,611	2,834	4.4%
Total reserves (in CHF millions)	2,856	2,832	3,184	3,970	3,252	2,863	3,115	0.6%
Reserves per insured (in CHF)	395	390	428	527	427	371	400	0.1%
Reserves (in % of total premiums)	25.7%	21.1%	17.2%	20.2%	16.5%	14.2%	14.1%	

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. The reserves show that insurers have not been setting money aside, since the reserves per insured in 2010 (CHF 400 per insured) have hardly changed since 2000 (CHF 390 per insured). This also means that the premiums invoiced over this period match the services reimbursed by the health insurers over the same period. In other words, over time, premiums have followed health costs so that, since revenues match expenditures, deficits have been avoided in one of the most sensitive areas of our social system.

<sup>1</sup> Net cost: gross services reimbursed by health insurers minus the participation, paid by insureds, plus administrative costs.  
<sup>2</sup> Average premiums invoiced by health insurers regardless of the insurance model.

Source: Swiss Federal Office for Public Health

**Development of average premiums and net cost, in CHF per insured, in compulsory health insurance in Switzerland (1996 - 2010).**



Source: Swiss Federal Office for Public Health