Position of CSS on key health policy issues

1. Single (cantonal) health insurance scheme

The Swiss electorate has rejected the idea of a single public health insurer on several occasions. The most recent initiative to introduce a single health insurance scheme nationwide was held on 28 September 2014, and it was clearly rejected with 61.8% 'No' votes, indicating the population's continuing clear endorsement of the competition-based healthcare system whose funding is based on social solidarity A popular initiative was launched in western Switzerland in autumn 2017 to create a single health insurance scheme for each canton. The initiative ultimately failed to secure enough signatures. In 2020, the Canton of Neuchâtel launched an identical proposal in the form of a cantonal initiative. However, Parliament again rejected the idea of revisiting a single cantonal health insurance scheme. The debate about a single health insurance scheme has flared up again in recent months. In August 2023, delegates to the SP party conference discussed the launch of a new initiative for a state-run single health insurance scheme. This initiative puts forward the idea that each canton should run its own public health insurance programme, with the possibility of inter-cantonal schemes. Premiums would be linked to economic capacity and capped at 10% of income.

CSS rejects the idea of a single health insurance scheme for all of Switzerland – as well as at the regional and cantonal level. Competition between health insurers currently leads to high quality and efficient invoice checking, which works in favour of the premium payers by preventing benefits from being paid unnecessarily. In addition, insured persons have a wide range of innovative products and services to choose from and enjoy premium discounts when opting for an alternative insurance model. Under a system monopolised by a single general health insurer, insured persons would lose this freedom of choice and thus the possibility afforded them by law of changing health insurers. Moreover, it can be assumed that administration costs would rise in the case of a monopolist general health insurer without competition. And, lastly, the idea behind a single health insurance scheme is to massively reduce its reserves, which would in turn jeopardize the institution’s financial stability given even the slightest misjudgement of how costs were likely to develop. The resulting financial imbalance could then only be corrected through a substantial increase in premiums or using taxpayers’ money.

2. Supervision of supplementary insurance (FINMA)

Among other duties, the Swiss Financial Market Supervisory Authority (FINMA) supervises supplementary health insurance. It checks whether the proposed premiums are kept within reasonable limits, such that the solvency of the individual insurance institutions is guaranteed and the insured persons are protected against abusive practices. Insurers may only offer their products once FINMA has approved the premiums.

Protecting insured persons from any abuse is a key and unequivocal concern of the Insurance Supervision Act (VAG). What is meant by 'abuse' has never been specified in more detail by law. However, FINMA's current understanding of what constitutes abuse is very broad and the resulting interventions into insurers' entrepreneurial and contractual freedom are very far-reaching.

CSS recognises the importance of having a politically independent and transparent supervisory system. However, supplementary health insurance is supervised under stricter criteria than other forms of non-life insurance. CSS calls for equal treatment in this respect and rejects interventions in the insurers' freedom of decision, which have an insufficient legal basis. It is committed to establishing operating conditions that allow enough room for individual and innovative insurance options.

You can find further information on the topic of supplementary insurance in our publication on health policies «im dialog» 2/2021.

3. Integrated care

Promoting integrated care is a key concern of CSS Insurance. Integrated care aims to create binding rules for the management of patients throughout their entire course of treatment, thus optimising the quality of treatment and achieving savings in service costs. The customers benefit from better quality and lower costs, which are achieved through efficient treatment. Implementing the fine-tuned system of risk adjustment will strengthen the incentives to promote integrated care models. CSS sees the introduction of a uniform system of financing for outpatient and inpatient services (EFAS) as a further way in which to promote integrated care. Such a system would allow additional discounts to be offered for integrated care models, thus making them more attractive. Conversely, the law must not arrive at too narrow a definition of integrated care as this could hinder the implementation of innovative ideas.

CSS recognises the Federal Council's determination to further promote integrated care through its second package of cost-containment measures. The Federal Council's aim of ensuring the coordination of care provision across the entire treatment chain by means of networks is generally to be welcomed. CSS already has ways in which to satisfy the Federal Council's requirement of coordinating treatment throughout the entire care chain, and considers cooperation based on tariff partnerships to be more appropriate.

Insured persons already benefit from good agreements with the tariff partners: around 70% of insured persons have already restricted their choice of service provider. As a result, their risk-adjusted costs are lower, i.e. these restrictions actually do cut costs. If we want to strengthen the efficient models, it is important to establish a direct link between coordination and savings in service/benefit costs, and to reflect this link in the discounts that are granted. In other words, the amount of discount granted by a model should be even more dependent on the level of coordination provided. This is already possible within the current legal framework, but the supervisory authority does not insist on its application strongly enough. It goes without saying that the traditional managed care models are slowly becoming outdated. They do not offer service providers enough financial incentives to coordinate the entire care pathway. Digitalisation especially provides new opportunities to bypass the primary care providers and connect. To give a specific example: via an online platform such as WELL that ensures digitally supported integrated care.

You can find further information on the topic of integrated care in our publication on health policies «im dialog» 2/2020.

4. Risik compensation

A system of mandatory insurance, with a requirement to admit all applicants and a uniform premium, needs a functioning system of risk sharing and compensation between insurers. Otherwise the incentives under the current system to hold as many «good risks» (and as few «bad risks») as possible in the portfolio are too great. Optimised risk compensation makes the hunt for healthy insured persons and the marginalisation of sick ones unattractive. It is the prerequisite for meaningful competition on the domestic market, with a focus on the cost of services. CSS therefore welcomed the Federal Council's decision to further refine the risk compensation system by taking into account a further morbidity factor in two steps (the cost of medication since 2017 and pharmaceutical cost groups since 2020). The current design of the risk compensation system has proven fit for purpose and contributed to the consolidation of the health insurance market; there is no need to expand it further.

In 2023, the Federal Council adopted an amendment to the Ordinance on Risk Compensation in Health Insurance (VORA). This amendment allows the general market statistics on risk compensation to be supplemented with additional information (number of months of insurance, gross benefits, co-payments, etc.), thus

enabling insurers to better estimate the risk compensation and calculate mandatory healthcare insurance premiums even more appropriately.

5. Hospital financing and hospital planning

The hospital financing system that came into force in 2012 saw a shift away from the previous cost-reimbursement principle to the current activity- or service-based funding. Since then, a flat-rate payment system has applied to all stays in hospital. In other words, the costs generated by an individual hospital must no longer be allowed to determine the tariff. Instead, it should be based on a price achieved by hospitals that work efficiently. When awarding the performance mandates for inpatient services, the cantons are required to give equal consideration to both private and public providers. Patients are able to select a hospital anywhere in Switzerland from the approved list. This is intended to kick start or boost competition amongst hospitals. In the long term, those service providers that deliver their services efficiently and maintain an adequate quality should be able to establish themselves on the market.

The Federal Constitution assigns responsibility for hospital planning to the cantons. As part of this task, the Federal Health Insurance Act (KVG) requires the cantons to determine which hospitals may charge their services to mandatory healthcare insurance by including them on approved hospital lists (i.e. awarding performance mandates); in doing so, they must take the planning criteria set out in the Health Insurance Ordinance (KVV, Articles 58a to 58e) into account. Planning must be geared to demand, and the cantons are called upon to coordinate their plans in this area with the clear goals of preventing any oversupply, containing costs and ensuring the necessary quality. Apart from a few instances of cooperation, all of which are confined to a small geographical area, the coordination of plans between the cantons is not yet taking place to the desired degree. Most cantons' hospital plans reflect the situation within their own borders and are primarily driven by local and economic interests. This 'competition' between cantons means that new surplus capacities are being created in addition to those that already exist. Many locations are seeking to strengthen their appeal by promoting the image of their hospitals (through public services, investments, setting lower reference tariffs for treatment outside the canton of residence, etc.). As well as restricting insured persons in their freedom of choice, actions of this kind ultimately distort the market by putting other hospitals at a disadvantage. The current intercantonal race to invest shows the extent to which local, economic interests act as a driving force. Instead of curbing costs, this kind of hospital planning necessarily causes them to rise – as a rule, the existing surplus capacities are refinanced by way of overprovision. The cantons have clearly failed to use the considerable planning leeway they enjoy as a means of achieving overarching healthcare policy objectives. Their multiple role as hospital operator, supervisory and licensing body must surely be a factor. Therefore, it is crucial that existing conflicts of interest are resolved so that a system of hospital planning which is both meaningful and covers the actual needs of the population can be introduced at the regional level.

In the meantime, the Federal Council has decided to further harmonise the requirements for hospital and nursing home planning by amending the relevant ordinance. This step serves to increase the quality of inpatient care and contain costs. All hospitals in Switzerland are to undergo the same performance audit. With regard to quality, the requirements for the institutions in question are to be set out in greater detail. In addition, hospitals on cantonal lists would no longer pay out any volume-related compensation or bonuses. The aim here is to combat increased service volumes that are not medically justified. The cantons are therefore being asked to better coordinate their planning of hospitals and nursing homes. The new provisions on the recognition criteria and on hospital and nursing home planning in the Ordinance on Health Insurance came into effect on 1 January 2022. CSS basically agrees with the amendments to the ordinance as far as the planning criteria are concerned. Establishing a uniform set of criteria for hospital planning should have been done long ago. Specifying a system of remuneration based on groups of services, taking cost-effectiveness into consideration and, above all, placing greater emphasis on the quality of hospitals in healthcare planning can lead to a clarification and standardisation of cantonal procedures. The amendment of the ordinance also

seeks to expand intercantonal cooperation, which will do much to step up the desired concentration of the services on offer.

As far as the setting of maximum service volumes to afford the cantons steering capabilities is concerned, the FDHA sadly did not respond to CSS's demand. Insurers are not able to verify whether the specific cantonal quotas have been met. That is why it should have been imperative for the ordinance to ensure that a canton could not unilaterally release itself from its obligation to cover costs if a hospital failed to satisfy one or more of the stated requirements.

CSS also welcomes the right of health insurance associations to appeal against hospital-planning decisions in the cantons, which came into force on 1 January 2024.

You can find further information on the topic of hospital planning in our publication on health policies «im dialog» 3/2020.

6. Uniform outpatient / inpatient financing (EFAS)

Although outpatient treatment is mostly cheaper than inpatient procedures, many cases are nevertheless treated on an inpatient basis. One of the reasons can be found in the way the system is financed. Outpatient treatment is funded entirely through the premiums paid by insured persons, inpatient care only up to 45%. As a result, some procedures are performed on an inpatient basis although the same level of medical care could be provided on an outpatient basis for less money. This holds back both the sensible shift towards outpatient care and the development of integrated care. These false incentives can be eliminated by means of a uniform system of financing for outpatient and inpatient services (EFAS), which proposes that, in future, health insurers will pay 100% of the costs in all service areas while the cantons fund a share of the total costs in their canton (currently at least 26.9% of the total costs), equivalent to the contribution they are currently making towards inpatient care. These funds would find their way back into the system, thus preventing a rise in premiums for insured persons. EFAS is supported by all the market participants and relevant professional associations.

After 14 years of discussions in Parliament, the EFAS bill was adopted in the winter session of 2023. The following points in particular remained disputed right to the end:

- **Inclusion of care:** The uniform system of financing is also to apply to care, with a transitional period of seven years. That is the deadline by which the contracting parties must ensure that tariffs for care services are determined on the basis of uniform and transparent costs and data. However, Parliament did not insist that the ‘Care Initiative’ be fully implemented by then.
- **Data access and invoice checking:** Despite the change in the system, the cantons will continue to enjoy access to original inpatient invoices. In addition, they have been granted a right of objection. This means that the cantons can challenge an insurer’s assumption of costs if the service provider does not meet the licensing requirements, an unacceptable tariff has been applied or a tariff has not been applied correctly.

The bill comes into force for acute services on 1 January 2028 and for nursing services on 1 January 2032. The trade unions have already announced their intention to call for a referendum. Whether or not they will succeed remains to be seen.

CSS welcomes the adoption of this important reform, which boosts the shift towards outpatient care and gives fresh impetus to integrated care. At the same time, CSS regrets that the practice of double-checking invoices for inpatient care will remain in place. Parliament has missed an opportunity here to come up with a solution capable of making the most of EFAS’s efficiency potential. In implementing the reform, it will be important to ensure that these checks are kept as lean and unbureaucratic as possible. As several members of

parliament have pointed out, the cantons should merely check that the formalities have been correctly observed and not conduct a full effectiveness, appropriateness and cost-effectiveness review. Including nursing care in the reform without setting more binding conditions in terms of cost transparency is also less than optimal. The contracting parties have been called upon to create conditions by 2032 that will enable EFAS to be implemented in relation to care.

7. Outpatient tariff organisation (OAAT)

In the summer of 2021, as part of the 1a package of measures to contain costs, the Swiss parliament decided to make the establishment of a tariff organisation for outpatient medical services compulsory. This tariff organisation will have an important role in ensuring that outpatient tariff structures are regularly updated and adapted as necessary in the future. All the tariff partners joined forces to found the Organisation für ambulante Arzttarife AG (OAAT AG, Organisation for Outpatient Medical Tariffs) on 15 November 2022. Now that curafutura has been admitted to SwissDRG AG as a full member (March 2023), the relevant partners are represented in both tariff organisations.

Separate requests for the approval of TARDOC and outpatient case rates were submitted on 1 December 2023. OAAT is expected to become fully operational in 2024, and the transfer of the tariff systems to OAAT will then be completed – as soon as approval is granted. ats-tms AG has been liquidated.

8. Oupatient case rates

Outpatient case rates play a prominent role in the public discussion due to the first package of measures, i.e. the proposal to enshrine national flat-rate structures in law and set up a tariff organisation for outpatient care (see position on outpatient tariff organisation OAAT). A wide variety of contractually agreed outpatient case rates currently exist along-side Tarmed and are a functioning reality. The partners in the newly established OAAT AG submitted their tariff structures to the Federal Council for approval at the end of 2023: TARDOC for curafutura, SWICA and FMH, and an outpatient case-rate structure for santésuisse and Hplus. Once the initial versions of each have been approved, the intention is for the tariff structures to be further developed within OAAT AG.

You can find further information on the topic of outpatient case rates in our publication on health policies «im dialog» 3/2021.

9. Financing of care

The new system of care financing that came into effect on 1 January 2011 reflected the political will to achieve two major goals: firstly, to avoid placing an additional financial burden on mandatory healthcare insurance (OKP), which had previously taken on more and more of the rising costs of age-related care, and, secondly, to improve the difficult social situation of certain groups of people who are reliant on care. The core element of these new arrangements, and thus the main factor in attaining the stated goals is the capping of OKP and patient contributions to care, with responsibility for the remaining costs being transferred to the cantons. Additional social policy measures include: increasing the eligibility threshold for supplementary benefits to the old-age and survivors' insurance (EL), introducing an attendance allowance for people demonstrating a slight degree of disability (‘helplessness’) who wish to receive care at home, and obliging the cantons to ensure that admission to a care home does not result in the patient becoming dependent on social assistance. These rules will inevitably – and as desired by the policymakers – result in the cantons and communes shouldering an increased burden of costs. The evaluation report on these new arrangements, published in July 2018, shows that the first major objective of limiting the additional financial burden on the OKP has been achieved. Spending on care under mandatory healthcare insurance has stabilised and the share of

costs funded by premiums has not increased. The second main objective, of improving the difficult sociopolitical situation of persons in need of care, has been only partly achieved. Shortcomings in implementing the reform, and therefore a need for action, can be found in particular with regard to flaws in the financing of the uncovered care-related costs by the cantons and the failure of service providers to delineate properly between care-related costs that fall under the KVG and those that do not. In addition, the restrictions on the patient's share of these costs is not always observed. The cantons have mostly complied with their duty to avoid persons becoming dependent on social assistance because of a stay in a care home, yet there are still indications of this happening in individual cases that should no longer be occurring, which suggests uneven implementation by individual cantons.

Two decisions handed down by the Federal Administrative Court in 2017 (C-3322/2015 and C-1970/2015), condemned the customary practice of agreeing payments for nursing supplies in service agreements with health insurers as unlawful. This has made the situation worse for service providers, especially those providing outpatient services, although payments in this area would be ensured without any actual funding gap arising if the cantons would simply comply with their legal obligation (Federal Supreme Court decision (9C_446/2017) to cover the remaining costs. Regardless of this, the Federal Council has made changes to the laws and ordinances and an amendment to the aids and appliances list (MiGeL) that introduce new rules for the payment of medical care products as of 1 October 2021. The provisions state that, in future, medical care products in accordance with MiGeL – whether used in outpatient care or nursing homes – are to be fully covered under mandatory healthcare insurance (OKP), regardless of whether the products in question are being used by the insured persons themselves or by a healthcare professional. These new rules will burden the OKP with an additional CHF 65-100 million a year and relieve the canton of costs of the same magnitude.

Growing cost pressure, which is demographically driven, has caused cantons and communes to voice greater criticism of the financing system as we know it, question its viability and step up the political pressure for system changes, if not a complete overhaul. This is reflected in the political initiatives that are regularly launched. In CSS's view, especially given the amendments that have already been enacted, there is no need to amend the legislation further or to make any fundamental changes to the financing model (e.g. by making nursing insurance compulsory).

Ensuring arrangements for providing and financing care of the elderly and long-term care are and remain within the remit of the state and its social policy. Regardless of the financing model, the sources of funding used thus far (taxes, premiums, direct co-payment / self-financing) cannot be extended. Alternative financing models do nothing to change financing requirements. They merely change who pays and the share of costs to be borne. Therefore, before any change to a new model takes place, the question of social compatibility and solidarity must be answered.

The maintenance of the current contribution system is being stretched more and more to its limits in political terms, as the burden placed on the cantonal and local authorities as a result of the growth in volume and rising costs is disproportionately high. The costs of nursing care are to be integrated into EFAS over a transitional period of seven years. That is the deadline by which the contracting parties must ensure that tariffs for care services are determined on the basis of uniform and transparent costs and data. In this way, a financing model based on solidarity will be preserved and demands for a fundamental system change (nursing care insurance, care savings account, etc.) will be silenced.

10. Prevention

CSS advocates as a health partner that all insured persons take responsibility for their health. This includes acting in a way that promotes health and taking preventive measures. CSS makes relevant products and services available to its insured persons.

The current system of prevention and health promotion has gaps: compared to the three pillars of medical healthcare (treatment, rehabilitation and care), prevention and health promotion are only partly enshrined in law; this separation of powers between the federal government, cantons and insurers has not yet been conclusively clarified. The result is a lack of control and coordination in many areas of disease prevention and health promotion, but also in terms of transparency regarding the services on offer and how they perform. The federal government's activities should be restricted to its mandate in accordance with Art. 118 of the Federal Constitution, which covers the combating of communicable diseases, the use of foodstuffs, therapeutic products, narcotics, organisms, chemicals and items that may be dangerous to health, and protection against ionising radiation. In the field of health and accident insurance however, prevention is the responsibility of the insurers and the cantons. They maintain institutions that are de facto financed by premiums (Swiss Foundation for the Promotion of Health, Swiss Council for Accident Prevention) and which implement and coordinate measures to promote health and to prevent occupational and non-occupational accidents and occupational diseases. The cantons are responsible for setting down prevention and health promotion measures in law, and for implementing them together with the communes .

CSS believes that prevention and health promotion should be given greater importance in today's system. Health insurers should also legitimately be able to help insured persons to promote their own individual health – and not be constrained by the current legal framework of medical prevention. Providing individual support in disease prevention and when someone falls ill is an aspect that is becoming increasingly important. CSS wants to do even more to boost the well-being and health of its clients. It welcomes a proposal discussed within the framework of the second package of measures (MNP2), which seeks to enable the use of insured person data by insurers to provide their customers with personalised information regarding preventive measures and ways in which they can reduce costs. The matter is currently under discussion.
As CSS sees it, prevention taxes financed by premiums must satisfy the requirement that the benefit to the insured persons of such measures can be proven and that the measures are directly related to the business of health insurance. Basically, insurers should also not be deprived of the opportunity of giving their insured persons incentives to take voluntary prevention measures.

11. Promoting personal responsibility

CSS campaigns to prevent health costs from rising more sharply in the future. There is no patent remedy for this. But there are a number of possible solutions. One of these is promoting personal responsibility among patients. By assuming responsibility for their own health, patients can make a contribution to reducing the rate of growth in health care costs. Mandatory health insurance has two main pillars through which patients can assume greater self-responsibility. On the one hand, there are alternative insurance models where insured persons undertake to follow the recommendations of their family doctor or doctors' network, for example. In this way, insured persons are guided efficiently through the healthcare system, receiving better care, and unnecessary treatment costs are eliminated. On the other, self-responsibility can be supplemented by means of a sensible co-payment arrangement. The various levels of deductible, in particular, reduce the take-up of benefits and thus create an incentive to make savings. As a health partner, CSS helps its insured persons to take more responsibility when they fall ill («becoming healthy» and «living with illness»). The Well app Symptom Checker, for example, gives insured persons access to a digital service developed by medical professionals and health informatics specialists. The Symptom Checker assesses their symptoms and provides recommendations on whether they should go to the doctor, pharmacy or hospital. And if they don’t need to see anyone, it gives them tips on how to treat their complaint.

CSS sees products and offers related to prevention («stay healthy»), e.g. with the help of apps, as an important way in which to promote self-responsibility. At present, this applies in particular to supplementary insurance. As far as basic insurance is concerned, the following criteria must be observed if the principle of solidarity and risk equalisation is not to be undermined: The offer must be voluntary and may only be made

in connection with alternative insurance models that are taken out voluntarily. In this context, it must be made available to all insured persons regardless of their age or state of health, and it must bring benefits to everyone involved. Health-conscious behaviour must not be rewarded through additional premium discounts or other benefits in kind. A reward in the form of a reduction in the co-payment if any bene-fits are drawn constitutes the one exception.

There is no specific mandate at present that would allow the special provisions on prevention and health promotion to be coordinated, the common principles and aims to be firmly established, and any partnerships to be enshrined in law. From CSS's point of view, such a mandate would be pivotal in supporting targeted health promotion and awareness-raising, and thus in strengthening the personal responsibility of the insured persons.

You can find further information on the topic of self-responsibility in our publication on health policies «im dialog» 1/2019.

12. Tarif structures

CSS is committed to the active development of tariff structures (in particular TARDOC, LOA, physiotherapy, inpatient tariff structures). It espouses the primacy of the criterion of 'appropriateness' and advocates a strict separation of structure and price. The tariff structures must reflect current medical knowledge, enable services to be provided cost effectively and take changing healthcare structures into consideration. However, it rejects revisions that are purely financially motivated and not relevant to the matter in hand. CSS considers tariff autonomy and a functioning tariff partnership to be an important element of competition and supports every effort to find a solution to the negotiations, while also supporting subsidiary interventions by the Federal Council if tariff autonomy fails to lead to a solution that is both fit for purpose and acceptable to the premium payers.

13. TARDOC

TARMED has been the national uniform pricing structure for outpatient medical services provided by doctors or in hospitals since 2004. TARMED has not undergone any fundamental changes in the past 15 years. As a result, it no longer properly reflects the current state of technical and medical progress. Doctors and hospitals bill services worth CHF 12 billion through TARMED each year. The tariff partners curafutura, FMH and MTK felt that the situation regarding TARMED, whose structure was outdated and no longer fit for purpose, was no longer tenable and have therefore spent the last few years working intently on the new TARDOC fee-for-service structure.

CSS considers the complete overhaul of TARMED, which is being conducted by the tariff partners, to be necessary. The existing TARMED tariff structure leads to false incentives in the behaviour of service providers, which has negative con-sequences for both cost efficiency and the quality of service provision.

In July 2019, FMH and curafutura were finally ready to submit the pricing proposal they had developed jointly with the Medical Tariffs Commission (MTK), which is responsible for accident, disability and military insurance, for initial approval. In June 2022, the Federal Council again declined to approve TARDOC, but proposed doing so if specific demands regarding cost neutrality were met and a plan for remedying the further shortcomings identified in the FOPH report was presented. It found that TARDOC is based on a fee-for-service structure and can be approved as such. The Federal Council no longer expects TARDOC to be revised again before its approval. Work on this has now been completed following further small amendments to accommodate the Federal Council’s suggestions, including limiting cost growth to 2% annually until

supplementary flat-rate tariffs are introduced. The current version of TARDOC (1.31) was submitted to the Federal Council at the end of 2023 for approval and entry into force on 1 January 2025.

You can find further information on the topic of tariff partnerships in our publication on health policies «im dialog» 2/ 2017 and 3/2021.

14. Quality

Ensuring good quality and developing the necessary quality systems (criteria, indicators, etc.), as well as measuring quality and disclosing the measurement results are vital to an efficient and effective healthcare system and primarily the task of the service providers. Alongside process and structural quality, measurements of the quality of indications and results are particularly intended to ensure transparency regarding quality among service providers. This transparency constitutes an important competitive criterion.

As part of the implementation of the new quality legislation (KVG Art. 58), CSS is campaigning for the quality of service provision in the Swiss healthcare system to be transparently recorded and disclosed. The rules on quality development and transparency should be binding and subject to sanctions. However, implementation of the new quality legislation (Art. 58 of the Federal Health Insurance Act) is proving challenging as the associations representing the service providers and those representing the health insurers are obliged to uphold cost neutrality. The newly achieved quality transparency is meant to enable premium payers to compare offers between service providers and allow tariff partners to compete on a price as well as a quality level.

15. Medicine prices and margins

Various false incentives and inadequate regulations affect the pricing and approval of medicines today. This means that medication in Switzerland is still more expensive than medication abroad and that unreasonable price demands by the industry go unchallenged.

Many new high-price medicines will be licensed in the coming years. This raises questions of financeability and how to curb expenditure on medication. The current rules do not allow for new phenomena such as the personalisation of medicine, the handling of a lack of evidence (uncertainty) or combination products to be taken into account.

Future pricing models must also face up to these challenges.
The following points are important:

- Making the pricing rules more flexible: The set of rules must be updated regularly to take account of the latest challenges (e.g. a solution for the combination problem). If there is no clear evidence (as yet), products should be added to the Specialty List (SL) temporarily, with conditions attached and at a lower price (a procedure sometimes known as ‘managed entry schemes’). If they fail to meet these conditions or subsequently provide evidence of their effectiveness, such products would have to be removed from the list again. The proposal put forward by the Federal Council in its second package of measures is a step in this direction. A certain lack of transparency could be accepted in making pricing more flexible, e.g. if net prices were to no longer appear on the Specialty List. However, the net prices must automatically be made known to those paying for the medication and, ideally, also to the service providers. From the point of view of the insured persons and premium payers, a complete lack of transparency such as that entailed by the proposal for a reimbursement fund solution is not an option and should be rejected.
- Developing and implementing a differentiated pricing system: A system of this kind would take account of prevalence and budget impact. In other words, if a product is to be widely used or its use is to be expanded, a low price must be set or the current price lowered. Pricing, on the other hand,

must not be driven by a product's theoretical benefits to the economy as this will lead to unacceptable prices having to be borne by social insurance – prices that are not found on any other market.

At present, only the company which submitted the application can appeal an FOPH decision on approval or pricing. This means that, as cost bearers, the health insurers cannot react in the interests of their clients when a medication is admitted to the catalogue of benefits in spite of doubts regarding its WZW criteria or if it is given a price that is too high to be considered justified. Like the Federal Council's group of experts on cost-cutting, CSS therefore advocates introducing to the pricing system a right of appeal for the stakeholders concerned (insurers, consumers/patients).

Unfortunately, a contractual arrangement for compensation of the distribution cost element, established by means of negotiations with the service providers in each distribution channel, is not politically feasible at the moment. The federal government has sought to create new rules for the distribution markup on medicines for some time now. To this end, the FDHA drew up a proposal together with the stakeholders in 2022. The Federal Council approved the relative ordinance in December 2023:

the distribution markup is being adjusted in two ways: on the one hand, the model for calculating the distribution markup on prescription medicines is being changed and, on the other, a standardised distribution markup is being introduced for medicines with the same active ingredients. To date, the distribution markup for more expensive medicines has been higher than that for lower-priced medication, thus creating an incentive to dispense more expensive products. A uniform distribution markup has now been introduced for medicines containing the same active ingredient. In other words, service providers will earn the same amount regardless of whether they dispense a more expensive originator product or a cheaper generic. The changes to the calculation model will make the distribution markup of more expensive medicines lower, thus also reducing the selling price, whereas it will become higher for cheaper medicines. These measures are intended to encourage the dispensing of lower-priced medicines, in particular generics and biosimilars. Savings totalling CHF 60 million are expected. The rules on distribution markups will take effect on 1 July 2024.

You can find further information on the topic of medication in our publication on health policies «im dialog» 1/2016, 3/2022 and 1/2024.

16. Ad hoc reimbursementof medicines in accordance with Articles 71a to 71d KVV

The ad hoc reimbursement of medicines under Articles 71a to 71d KVV gives patients important access to life-saving therapies that have not yet been approved. However, requests for reimbursement have increased considerably in recent years and can no longer be considered 'exceptional'. CSS therefore welcomes the federal government's efforts to optimise the processes for assessing ad hoc cases and reducing the number of cases in this area.

To once more make ad hoc case assessments the exception rather than the rule, CSS is calling for two things to happen:

- On the one hand, the scope of Articles 71a to 71d KVV should be limited to medical conditions which, if not treated immediately, will in all probability lead to the death of the insured person or leave their health seriously and chronically impaired.
- On the other hand, the refunding of cases under Article 71b should be limited to two years in order to give the industry more of an incentive to submit applications for their products to be included on the Specialties List.

CSS takes a critical view of new legal rules that make high, fixed discounts dependent on a therapy's benefit to the patient. Fundamental questions arise regarding the enforceability of such discounts, given that the licence holders are not service providers as defined by the KVG. Licence holders will exert more and more

pressure on the assessment of the benefits by medical officers in order to achieve a better outcome for themselves and thus have to contribute less to the cost. Acceptance of fixed discounts will make it all the more difficult to reject medicines whose price is considered to be unreasonably high, thus potentially leading to significant additional costs. In addition, there is a risk that fixed price discounts will make patients' access to life-saving therapies more difficult as companies will either insist on their previous pricing expectations or withdraw completely from the Swiss market and no longer offer the respective product in Switzerland.

You can find further information on the topic of the ad hoc reimbursement of medicines in our publication on health policies «im dialog» 3/2019.

17. Digitalisation

The coronavirus pandemic has exposed a large number of digital deficits, in particular in healthcare and administration. Digitalisation cannot (yet) develop its potential to boost the efficiency of the healthcare system as there is no overarching strategy or coordination of activities. For example, the general public has been waiting in vain for years for electronic patient records to be introduced. The pandemic has shown that a need exists among the population and that digital offers are more in demand than ever. That is why CSS is committed both to working with others and launching its own innovative offerings in the field of digital health as a means of ensuring that digitalisation in the healthcare sector is given the impetus it needs and that clients can benefit from it. CSS views digitalisation as an instrument for optimising quality and efficiency in the healthcare system.

Two of the main aims of digital health are to strengthen self-responsibility and improve networking among the actors in the healthcare system.

Together with its partners, CSS has launched the digital health platform WELL, which offers interactive access to healthcare to everyone living in Switzerland and is open to all stakeholders (service providers, insurance companies, pharmacies, etc.). The health platform provides the basis for nationwide, digitally supported, integrated care.

Within projects such as «active365», insured persons can take responsibility for their own health. With the aid of mobile devices, chronically ill patients are able to monitor their illness, stay mobile and get in touch with healthcare professionals at any time thanks to telecommunications. Service providers will be networked through electronic health records in future. For their part, patients will give the necessary approvals to allow the exchange of data and in so doing benefit from personalised medicine based on the (anonymised) analysis of their data. Insured persons will not be the only ones to notice greater transparency thanks to digitalisation: the data analyses conducted by the institutions will also enhance transparency in terms of the services provided. This could promote quality and curb costs. Digitalisation also enables better coverage of client needs. Thus, for example, CSS offers its clients personalised medical advice, among other things, through Well, which is available 24/7.

However, digitalisation can only progress if there is a good and efficient data system. This calls for the right framework – one which guarantees the security of data without threatening the principle of solidarity within mandatory healthcare insurance. Personal health data, for example, has great potential when it comes to delivering healthcare. Better coordination of medical treatment thanks to the use of personal health data leads to higher quality and therefore also to lower costs. Outside Switzerland, health data is handled by what are known as 'trust centres'. They link and manage personal health data and make it available in a safe environment while also ensuring high quality. This enables patients, research institutes and service providers to view high-quality, structured and up-to-date health data.

The aim must be to create an ecosystem by means of technology and regulation that allows trusted use of data and preserves patients' data sovereignty. In addition to proper regulation, the main requirements for a digital ecosystem are technical infrastructures, applications and high-quality data. CSS supports the Federal Council's efforts to move forward with the challenges associated with data management and data flows in partnership with stakeholders in the healthcare sector and to establish a model for the creation of a data ecosystem in the healthcare sector.

You can find further information on the topic of digitalisation in our publication on health policies «im dialog» 2/2016, 1/2020 and 1/2022.

18. Cost targets and cost containment measures

Per capita healthcare costs continue to rise at rates that by far outstrip the cost of living and wage growth, with above-average increases in 2023 and 2024. As a result, an increasing number of insured persons find themselves struggling to pay their monthly premiums. At the same time, many cantons are increasingly withdrawing from the premium reduction system in an attempt to make savings.

That is why CSS welcomes the now intense discussion, first launched back in 2017, on suitable measures for reining in costs within the mandatory healthcare insurance (OKP) system. To this end, it mainly actively supports the introduction of a uniform system of financing for outpatient and inpatient services (EFAS), the rapid revision of central tariff structures such as TARDOC and LOA, and the wider spread of digitally supported, integrated care.

These three key reforms could be accompanied by further measures from the Federal Council's cost-containment packages, such as the right of health insurers to appeal against hospital planning, and new approaches to medicine prices.

If these measures do not have the desired effect, it would make sense to set multi-year targets for OKP growth and to set up a cost-monitoring task force in order to keep future cost growth in check and make it measurable in qualitative terms. The measures adopted by Parliament as part of **the counter-proposal to the cost-containment initiative** are a step in the right direction. Essentially, the counter-proposal would like to see the introduction of cost and quality targets for the healthcare sector. The Federal Council should set targets once every four years for the services governed by the Federal Health Insurance Act. In addition, services should no longer be reimbursed under mandatory healthcare insurance if an evidence-based procedure has shown that they are no longer effective, suitable or cost-effective. On the other hand, Parliament rejects **the Centre alliance's cost-containment initiative**, which it considers too inflexible. CSS shares this opinion.

Targets of this kind for the growth of healthcare costs could serve as benchmarks for all future cost containment measures, thus making the latter both measurable and manageable. Broadly-accepted goals would put pressure on the stakeholders (federal government, tariff partners) to increase efficiency and quality and to reduce volumes and/or prices – e.g. to limit non-necessary services or to carry out services more efficiently while providing the same or better quality. In addition, they would strengthen the tariff partnership by increasing the pressure on tariff partners to enter into agreements that place greater emphasis on cost-effectiveness, thus reining in cost growth.

You can find further information on the topic of cost containment measures in our publication on health policies «im dialog» 3/2017 and 3/2018

19. Brokers' commissions

When it comes to acquiring new clients, CSS relies heavily on its own sales force. But it also works with brokers. In order to promote high quality and cost-effective advice, CSS is in favour of stepping up cooperation throughout the entire health insurance industry by means of a self-regulatory industry agreement for basic and supplementary insurance.

A new industry agreement regulating unwanted sales calls and brokers' commissions, which have been giving rise to discussions for years, has been in place since 1 January 2021. CSS has joined forces with the national industry associations curafutura and santésuisse in efforts to improve the quality of advice through the adoption of uniform standards and to limit the compensation of intermediaries for client acquisition in the OKP and VVG business. CSS gives its unequivocal backing to this industry agreement and also supported the Federal Act on the Regulation of Insurance Intermediaries, which seeks to make the industry agreement generally binding on all insurers. However, CSS feels that the adopted legislation goes too far – in particular, it opposes extending the rules to in-house employees, thus treating internal sales staff the same as external intermediaries. Excesses and unwanted phone calls are problems caused by external brokers and not in-house staff. As employees of CSS, they are already committed to the highest quality standards. Regulating internal sales staff means regulating an area in which there is no market failure. curafutura and santésuisse have adapted the industry agreement on brokers further in light of the most recent changes to the legislation. This revised industry agreement on brokers satisfies the new legal requirements set out in the Federal Act on the Regulation of Insurance Intermediaries, which was passed by Parliament in December 2022. Thanks to the new agreement, which entered into force on 1 September 2023, an application can be made for it to be declared generally binding. CSS applies the new industry agreement.

20. SP's 10% initiative and indirect counter-proposal

Per capita healthcare costs continue to rise at rates that by far outstrip the cost of living and wage growth, even more so in 2023 and 2024 than previously. Health insurer's premiums rise at the same rate, as premiums must always cover costs. CSS agrees with the initiative in the sense that this tendency is causing many households – especially middle-income families – to experience financial difficulties. For CSS, a worrying situation.

The popular initiative aims to cap this premium burden at 10% of the household's available income and harmonise the system of individual premium reductions (IPR). However, CSS believes this initiative is merely an expensive way of tackling symptoms. The initiative does nothing to address the root causes of cost growth. First, it is to be feared that much-needed efforts to improve efficiency and quality will be slowed down if rising costs are concealed by a massive expansion of the IPR system. Second, individual premium reductions would have to double within the space of 20 years in order to achieve the same level of cushioning as they do today. In other words, the initiative is not sustainable in the long term. In addition, unlike in the indirect counter-proposal, the main financial burden would have to be borne by the federal government and not the cantons, although it is the latter who actually play a key role in avoiding inefficiency and oversupply. Furthermore, the initiative weakens alternative insurance models: were the initiative to be adopted, insured persons would have to spend at most 10% of their income on premiums, leaving them with fewer incentives to take out cheaper forms of insurance – depending on how the initiative was implemented.

That is why CSS supports the indirect counter-proposal, which suggests linking a canton's contribution to premium reductions to the gross spending on healthcare in the respective canton. According to the counter-proposal, the cantons should henceforth spend a minimum amount equivalent to 3.5-7.5% of the costs for mandatory basic insurance on premium reductions. The concept also proposes that the cantons should retain their powers to calculate the exact amount of the premium reduction. This compromise will leave the cantons with additional costs of CHF 356 million. The counter-proposal would mean that cantons with higher healthcare costs and a higher household premium burden would have to pay more overall than cantons with lower costs. The counter-proposal also creates incentives for taking action to contain healthcare costs

(hospital planning, admission, etc.): cantons would be in charge of hospital planning, approving or setting tariffs, and would continue to control the recognition of outpatient service providers. Therefore, they would also be expected to exercise responsibility for premium reductions. Parliament rejects the SP's initiative to cap premiums, which will be put to a referendum in June 2024.

Reforms in the health sector, which have an impact not only on the financing side but also on the cost side, remain necessary. Even though CSS believes the indirect counter-proposal to be a step in the right direction, it is especially important to also curb healthcare costs and thus relieve the burden placed on the insured persons. This is the aim of the current reforms.

21. Reserves

The Federal Council adopted an amendment to the Federal Ordinance on the Oversight of Social Health Insurance (KVAV), effective 1 June 2021, which makes it easier for health insurers to resort to voluntary reductions in reserves. The minimum threshold from which a voluntary reduction in reserves is permitted has been lowered. Originally, insurers were required to have reserves exceeding 150% of the minimum amount stipulated in the ordinance. The revision lowers this limit to a minimum level of 100%.
The financial buffer is there to cushion unforeseen additional costs (e.g. vaccination costs) and to keep the premium burden as low as possible for insured persons. CSS does not believe the accumulation of unnecessary reserves to be expedient. Ultimately, the reserves belong to the insured persons. The thrust of the KVAV revision generally corre-sponds to CSS's position that premiums should be calculated as tightly as possible and ultimately not result in exces-sively high reserves.
CSS is in favour of a reduction in reserves that takes place on a voluntary basis and respects the entrepreneurial free-dom of health insurers. Any compulsory or excessive reduction in reserves, on the other hand, would jeopardise their financial stability, especially during a pandemic that has brought many uncertainties and unforeseeable fluctuations in solvency.

You can find further information on the topic of reserves in our publication on health policies «im dialog» 2/2022.