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. Nevertheless, in view of rising healthcare spending, the debate about a single health insurance scheme has flared up again. In August 2023, delegates to the SP party conference discussed the launch of a new initiative for a state-run single health insurance scheme, for which signatures are to be collected in 2025. This initiative demands that each canton run its own public general 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.

Healthcare costs are not rising because of health insurers and their administration costs, which only account for 5% of the total. The main cost drivers are benefit costs, which make up around 95% of total expenditure, and on which a single health insurance scheme would have no impact whatsoever. Moreover, it can be assumed that administration costs would rise in the case of a monopolist general health insurer without competition. Lastly, the idea behind a single health insurance scheme is to massively reduce the reserves, which would in turn jeopardise 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 has been a key concern of CSS for many years. 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. The standardised financing of benefits, which was approved by the Swiss electorate on 24 November 2024, gives integrated care renewed impetus (see our standpoint on the "Implementation of uniform financing").

CSS recognises the Federal Council's determination to further promote integrated care through its second package of cost-containment measures. However, the Federal Council's proposed inclusion in the Federal Health Insurance Act (KVG) of networks as new service providers, which would allow for stricter regulation, is counter-productive and will drive costs up. Instead, the practice of cooperation based on tariff partnerships should be maintained and even better use made of the scope that exists for shaping it. To achieve this, CSS intends to step up its partnerships with integrated care networks, such as the Ensemble Hospitalier de la Côte (EHC), for example. At the same time, alternative insurance models must be made even more attractive, especially for people with chronic illnesses.

Insured persons already benefit from good agreements with the tariff partners: More than three-quarters 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.
Digital networking has emerged as a key factor in making integrated care a success: The use of digital health records by all actors in the network ensures that service providers share information, thus avoiding duplication. A real-life example is the online platform WELL, which guarantees digitally supported integrated care within the EHC care network.

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

4. Risk 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.

The current design of the risk compensation system has proven fit for purpose and contributed to the consolidation of the health insurance market; however, optimising the hospitalisation indicator, for instance, would be one way in which it could be developed 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, 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 was introduced in 2012 replaced the cost-reimbursement principle with an activity- or service-based arrangement. Since then, stays in hospital have been paid at a fixed rate based on a price achieved by hospitals that work efficiently, instead of on the costs generated by an individual hospital. When awarding performance mandates, the cantons must treat private and public providers equally. To encourage competition, patients may choose any hospital in Switzerland that features on the official lists. In the long term, efficient service providers that maintain adequate quality levels should win out.

According to the Federal Constitution, the cantons are responsible for hospital planning. Their hospital lists must be drawn up in line with the criteria set down in the KVG, geared to demand, and coordinated. The aim is to prevent oversupply, contain costs and assure quality. Planning must be geared to demand, and the cantons are called upon to coordinate their plans with one other. Nevertheless, the cantonal authorities rarely look beyond their own borders when drawing up their plans, usually for locational and economic reasons. This leads to surplus capacities, distortion of competition and rising costs as the cantons tend to promote their own hospitals (through public services, investments, setting lower reference tariffs for treatment outside the canton of residence, etc.). The cantons have failed to use the 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.

The Federal Council harmonised the planning requirements for hospitals and nursing homes as of 1 January 2022 in order to boost quality and reduce costs. The relevant ordinance requires uniform assessments of economic efficiency and quality to be performed at institutions throughout Switzerland, and encourages greater coordination between the cantons. To prevent unnecessary volume growth, hospitals included on cantonal hospital lists may no longer pay volume-related bonuses. CSS generally welcomes these adjustments as they can help make cantonal procedures more precise and more standardised. They can also contribute to a concentration of the services on offer.

Health insurance associations have had the right to appeal against hospital-planning decisions in the cantons since 1 January 2024. CSS also welcomes this.

You can find further information on the topic of hospital planning and federalism in our publication on health policies "im dialog" 3/2020 and 1/2025.

6. Implementation of uniform financing

The standardised financing of benefits was approved by 53.3% of the Swiss electorate on 24 November 2024. CSS supports this important reform, which will boost the shift towards outpatient care, give fresh

impetus to integrated care and have a positive effect on healthcare costs and premiums. The amendment comes into force for acute services on 1 January 2028 and for nursing and care services on 1 January 2032.

The uniform financing of healthcare benefits means that, in future, health insurers will pay 100% of the costs in all service areas while the cantons will fund a share of the total costs in their canton (currently at least 26.9% of the total costs). These funds will find their way back into the system, thus benefiting the premium payers.

The next few years will decide whether the full potential of uniform financing can be unlocked. All the actors in the healthcare system are now called upon to play their part in ensuring that implementation succeeds. The following areas take priority:

Promoting outpatient services
Outpatient treatment is generally cheaper than inpatient treatment and often makes more sense medically. However, at present the costs are completely covered by the premiums. As a result, the bill for shifting from inpatient to outpatient care, as championed by the policymakers, is borne solely by the premium payers. Uniform financing eliminates this false incentive and paves the way for accelerating the shift towards outpatient settings. Measures such as the cantons setting targets for outpatient care in their hospital plans and health insurance providers targeting their insured persons with information about the (cost) advantages of outpatient treatment could support this. In addition to having a positive effect on costs, greater outpatient delivery will also bring qualitative benefits for patients, as outpatient procedures tend to be less stressful.

Strengthening integrated care
Duplication and unnecessary treatment can be avoided through properly coordinated care, especially for the chronically ill, which then has a positive effect on quality and costs. However, until now, the different financing arrangements have restricted the potential of integrated care: Coordination costs are primarily incurred in an outpatient setting, which is funded through premiums, while savings are mostly made in inpatient care (e.g. by avoiding hospitalisation). Uniform financing will enable such savings to be passed on to the insured persons more directly in future (e.g. in the form of higher discounts on alternative insurance models), thus making coordinated care more attractive to everyone.

Lean implementation of invoice double-checking
The legislators have decided that insurers and cantonal authorities should continue to double-check bills for inpatient care. In implementing the reform, it will be important to ensure that these cantonal checks are kept as lean and unbureaucratic as possible.

Cost transparency in relation to long-term care
With regard to long-term care, the tariff partners have been asked to create conditions that will enable the standardised system of financing to be implemented from 2032. Their main task is to develop new tariffs for nursing care using a transparent data and cost basis.

You can find more information on the proposals here (in German and French).

7. Outpatient tariffs

The outdated TARMED tariff, which has been in use since 2004, is the principal tariff arrangement for outpatient treatment, with CHF 13 billion in services invoiced under it each year. Work on a new outpatient tariff dragged on for many years, accompanied by intense political debate on the subject. As part of the first package of cost containment measures, it was decided to introduce nationwide flat rates and to set up a national tariff organisation by law.

At the end of 2023, the tariff partners curafutura, SWICA and FMH submitted the TARDOC fee-for-service tariff to the Federal Council for approval, while santésuisse and H+ put forward a flat-rate outpatient tariff structure for consideration. The aim was to replace the outdated TARMED tariff with a new outpatient medical tariff. The Federal Council decided on 19 June 2024 to partly approve both tariff structures. At the same time, it announced that the new outpatient tariff should be ready to replace TARMED from 1 January 2026. The Federal Council therefore asked the tariff partners to revise their proposals by 1 November 2024, so that the two separate tariffs could be coordinated. OAAT AG oversaw the work required and the coordination of the various actors. The tariff partners presented an implementation agreement for harmonising the structures at the end of October 2024.

For CSS, the real issue at stake is creating tariffs that are fit for purpose and which will guarantee efficient, quality-driven medical care. In addition, it must be ensured that any new tariffs introduced satisfy the cost neutrality criteria required by law.

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

8. Financing of care

The uniform financing of benefits, which was approved in a referendum on 24 November 2024, heralds a fundamental shift in the care financing arrangements that have been in place since 2011. It eliminates the previous distinction between financing systems for health services. Uniform financing paves the way for a future-proof model of care financing and encourages high-quality care delivery. The objective is to standardise the way services are financed and to contain costs while at the same time ensuring appropriate medical care. The cantons will now bear a uniform share of at least 26.9% of the cost of services in all areas. Nursing care costs are to be fully integrated after a transitional period of seven years – i.e. from 2032.

The contracting parties have until then to set tariffs for care services that are determined on the basis of uniform and transparent costs and data. They are also obliged to ensure that the process of integrating care services, especially those in the area of long-term care, into the system of uniform financing runs smoothly.

CSS has noticed that the number of Spitex organisations hiring family caregivers has risen sharply following the Federal Supreme Court's 2019 decision. CSS has been working closely with the basic insurers association since that decision to advocate for a clear and binding implementation framework. Making sure that family caregivers are always given an employment contract guaranteeing them access to social insurance is one of the key concerns. Beyond that, national criteria should be determined as to who may receive care, what respite and relief options are available, and how dependencies can be managed transparently and sustainably.
In addition, the cantons and the GDK must standardise the criteria by which they officially recognise Spitex organisations, and must link these to quality criteria. These approval conditions should be reviewed and adjusted regularly. It is also important to define the benefit catalogue for care services more clearly. An exhaustive list would be one way to achieve this, for example.

9. 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; the 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.

CSS believes that prevention and health promotion should be given greater importance in today's system. Providing individual support in disease prevention and when someone falls ill is an aspect that is becoming increasingly important. Health insurers should legitimately be able to help insured persons to promote their own personal health, and should not be constrained by the current legal framework of medical prevention. That is why CSS welcomes the proposal discussed in relation to the second package of measures, which would allow health insurers to target the people they insure with information about specific preventive measures, such as check-ups for chronic medical conditions, or about suitable special forms of insurance, such as medical networks in the region.

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 not be deprived of the opportunity of giving their insured persons incentives to take voluntary prevention measures.

10. Promoting personal responsibility

When it comes to reining in healthcare costs, CSS believes that the promotion of personal responsibility among patients plays an important role. Mandatory health insurance has two main pillars through which this can be achieved: On the one hand, there are alternative insurance models where insured persons undertake to consult a certain first point of contact (known as a 'gatekeeper') and to follow the treatment pathways recommended to them. In this way, insured persons are guided efficiently through the healthcare system and receive targeted care, thus preventing unnecessary treatment. On the other hand, self-responsibility can be encouraged by means of incentives in relation to the co-payment. The various levels of deductible, in particular, reduce the take-up of benefits and thus create an incentive to make savings. Increasing the minimum deductible, as is currently being discussed in Parliament, is another step in this direction supported by CSS. Allowing health insurers to target their insured persons with information on more cost-effective services or suitable care and insurance models, which is also being discussed by Parliament as part of the second package of measures, could play an important role in this context.

What's more, as a health partner, CSS helps its insured persons to take more responsibility when they fall ill. 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 a recommendation on whether they should go to a doctor, pharmacy or hospital. And if that is not necessary, the Symptom Checker gives them tips on how to treat their complaint.

CSS also seeks to encourage more self-responsibility when it comes to prevention. However, the possibilities here are limited as far as basic insurance is concerned if the principle of solidarity and risk compensation 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 addition, it must be open to all insured persons in this setting, regardless of their age and state of health. Health-conscious behaviour may not be rewarded through additional premium discounts or other benefits in kind. Only certain medical prevention measures can be exempted from the co-payment. This leads CSS to question whether this restriction is in keeping with the times or whether new approaches and incentives that would encourage health-promoting activities in a more targeted way should be considered.

CSS believes health literacy to be essential for taking personal responsibility in health matters. Health literacy helps people to navigate the healthcare system more efficiently, to prevent illness more effectively

and to manage their own health with greater care. That is why CSS is committed to strengthening this literacy at various levels.

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

11. Tariff structures

CSS champions the active further development of the 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. But it also supports 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.

12. 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 (Art. 58 KVG), CSS is campaigning for the quality of service delivery 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.

13. 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-priced medicines will be licensed in the coming years. This raises pressing questions about financial feasibility and how to curb rising costs in relation to medication. The current set of rules is not equipped to respond adequately to new developments such as the personalisation of medicine, the handling of uncertainty where there is a lack of evidence or the evaluation of combination products.

Future pricing rules must face up to these challenges:

- 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 Federal Council's proposal in its second package of measures is a step in this direction – the important point now is to design it in such a way that it does not drive up prices. 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 and in terms of good governance, a complete lack of transparency such as that entailed by the proposal for reimbursement via a separate fund set up by the *Gemeinsame Einrichtung KVG* 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 widely used or its use is expanded, a low price must be set or the current price lowered. CSS views the cost impact models discussed under the second package of measures, which provide for a volume discount when sales reach a certain threshold, as a sensible approach that will help contain costs without jeopardising the security of supply.
- Reviewing the current pricing mechanisms: The parameters used – external reference pricing, internal reference pricing, innovation surcharge – are outdated and do not take sufficient account of new developments such as the personalisation of medicine, lack of evidence or combination therapies. Furthermore, the current mechanisms are not aligned with long-term therapies for chronic medical conditions, where the improved quality of life comes at a very high financial cost.
- Although lifestyle products such as weight loss injections prevent secondary disorders and can temporarily reduce costs in other areas, including avoidable costs in the tariff classification nevertheless creates new pricing benchmarks.

At present, only the company which submitted the application can appeal an FOPH decision on approval or pricing. This means that, as cost bearers, 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 effectiveness, appropriateness or cost-effectiveness ('WZW criteria'). The same applies if it has been given a questionable limitation or a price that is too high to be considered justified. CSS will therefore continue to advocate for the introduction of a right of appeal for the stakeholders concerned (insurers, consumers, patients) when it comes to the approval and pricing of medicines.

Good progress has been made in promoting generics and biosimilars. The Federal Council adopted two reforms in 2023 encouraging the use of substitutable medication. These came into effect in 2024 and have resulted in higher price differentials between generics and originator products, plus market-based pricing for biosimilars. In addition, the differentiated retention fee for more expensive originator products was increased from 20% to 40%. The changes to the distribution markup are intended to minimise false incentives when dispensing originator products. The introduction of a standardised distribution markup for medicines with identical active ingredients is meant to ensure that pharmacists and doctors receive the same remuneration regardless of whether they dispense originator products or generics or biosimilars. To date, the distribution markup for more expensive pharmaceuticals has been considerably higher than that for lower-priced medication, thus making it more lucrative to dispense more expensive medicines.

CSS welcomes these developments but also sees further optimisation potential. Targeted measures such as channel-specific compensation for medical practices, pharmacies and hospitals could lead to improved compensation of the actual business expenses incurred by service providers (e.g. storage or transport costs), as well as cutting down on false incentives while also lowering costs. To achieve additional savings, efforts to refine the margin-setting parameters so that they conform with the rules of the market economy should continue.

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.

14. Ad hoc reimbursement of 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. The revision of the KLV/KVV that came into effect on 1 January 2024 sought to reduce the administrative burden and harmonise implementation, while at the same time increasing equality of access. Applications for reimbursement have risen sharply since the beginning of 2024. The expected optimisation effect has not yet been achieved with regard to administration. Health insurers' power to negotiate over high-priced therapies has been removed and replaced by fixed price discounts. Nevertheless, more and more requests are being turned down as certain manufacturers refuse to accept the fixed price discounts. According to current assessments, the aim of getting manufacturers to place expensive pharmaceuticals on the SL sooner by means of high discounts is only being partly achieved.

To once more make ad hoc case assessments the exception rather than the rule, CSS is calling for the following:

- 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 reimbursement of cases under Articles 71b and c KVV should be limited to a maximum of 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.
- In addition, CSS would like to see an effectiveness report in the form of implementation controls along with a cost evaluation by the Federal government.

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.

15. Digitalisation and the use of data

Digitalisation and the use of data play a fundamental role in shaping the healthcare system of the future. Although there is basic agreement that the healthcare system must be digitalised, the transformation is making only slow progress. In particular, the revision concerning electronic patient records (EPR) has yet to take place. CSS believes that fast-tracking further development of the EPR is key to digitally transforming the healthcare system. The current EPR is barely used because it does not offer sufficient added value to patients and service providers.

To fill the existing gap and accelerate the pace of digitalisation in the Swiss healthcare system, CSS champions its own innovative solutions for future-proof healthcare. For example, 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.). With the aid of mobile devices, chronically ill patients can monitor their condition and get in touch with healthcare professionals at any time thanks to Well. Moreover, Well guarantees digitally supported integrated care within the EHC care network, with which CSS cooperates.

Digitalisation not only increases transparency for insured persons. Thanks to data analyses conducted by the institutions, it also boosts transparency regarding the services they provide. This, in turn, can improve quality and rein in 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.

Insured persons can also take responsibility for their personal health within programmes such as active365. The programme conveys knowledge on various aspects of leading a healthy lifestyle and rewards activities in relation to nutrition, exercise, mindfulness and mental health.

To unlock the benefits of digitalisation, all partners should coordinate and align their respective competencies. Standardised data structures and content are essential to ensuring that systems are interoperable and can work together seamlessly. Digitalisation can only make headway if there is a good and efficient data system. This calls for the right framework – one which guarantees the security of data without hampering the potential of digitalisation. 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. This approach could also make sense in Switzerland.

Technology and regulation should be used to create an ecosystem that allows the trusted use of data and seamless interaction between actors while preserving patients' data sovereignty. In addition to proper regulation, the main requirements for a digital ecosystem are technical infrastructures, applications and high-quality interoperable data. The "DigiSanté" programme launched by the Federal Council in November 2023 addresses the majority of political demands. In 2024, Parliament approved a guarantee credit of CHF 392 million, stipulating that priorities must be set and a yearly report delivered to Parliament. CSS supports these efforts to finally lay the groundwork for data-driven healthcare.

You can find further information on the topic of digitalisation in our publication on health policies "im dialog" 2/2016, 1/ 2020, 1/2022 and 3/2024.

16. 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. 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 ongoing intense discussion, first launched several years ago, on suitable measures for reining in costs within the mandatory healthcare insurance (OKP) system. To this end, CSS has primarily given its active support to the introduction of uniform financing, the revision of central tariff structures and the further 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 (package 1b), and new approaches to medicine pricing (package 2, still under discussion). However, further measures to curb costs remain necessary in other areas, e.g. better management of the OKP benefit catalogue and more consistent implementation of the WZW criteria.

Reinforcing this, CSS supports the introduction of cost and quality targets in the healthcare sector as set out in the adopted counter-proposal to the cost-containment initiative. This requires the Federal Council to set targets every four years for the maximum growth in OKP costs. A commission will monitor the development of these costs and make recommendations on suitable corrective action. The consultation procedure on implementation of the counter-proposal is scheduled for 2025.

At the end of 2024, the Federal Council launched a round table on cost containment in which various actors from the healthcare sector take part. The forum meets twice a year with the goal of jointly developing specific measures to rein in costs. At the first meeting, its members agreed to make savings of around CHF 300

million a year from 2026. CSS welcomes the initiative's intention to identify broad-based, effective measures capable of reining in costs.

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.

17. 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.

An industry agreement regulating unwanted sales calls and brokers' commissions, which have given rise to discussions for years, has been in place since 1 January 2021. CSS has applied this industry agreement from the very beginning. CSS has joined forces with the national industry associations curafutura and santésuisse in an effort to get the Federal Council to declare the agreement generally binding and so create a level playing field for all insurers. On 14 August 2024, the Federal Council declared the industry agreement on brokers 3.0 generally binding, effective 1 September 2024. It is crucial that all insurers stick to the new rules. CSS expects the authorities (the FOPH for KVG, and FINMA for VVG) to monitor compliance with the rules.

18. 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. Health insurance premiums rise at the same rate, as premiums must always cover costs. CSS sees this tendency, which is causing many households – especially middle-income families – to experience financial difficulties, as a matter of concern.

The 'Premium Relief initiative' (or 10% initiative) rejected by the electorate on 9 June 2024 sought to cap the premium burden at 10% of a household's available income and to harmonise the system of individual premium reductions (IPR). However, CSS believed the initiative did nothing to address the root causes of cost growth and saw it merely as an expensive way of tackling symptoms. Instead, CSS supported the indirect counter-proposal that will now enter into force. This means that the cantons must henceforth spend a minimum amount equivalent to 3.5-7.5% of the costs for mandatory basic insurance on premium reductions. In other words, cantons with higher healthcare costs and a higher household premium burden will have to pay more overall than cantons with lower costs, thus creating incentives for the cantons to take measures to rein in costs (e.g. hospital planning, tariff approvals or the recognition of providers of outpatient services). The consultation procedure on implementation of the counter-proposal began in December 2024.

Reforms in the healthcare sector, which have an impact not only on the financing side but also on the cost side, remain necessary. Therefore, in addition to implementing the indirect counter-proposal, it is especially important to curb healthcare costs and thus relieve the burden placed on the insured persons, as is the aim of the current reforms (e.g. implementation of uniform financing, outpatient medical tariff, medication prices).

19. 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 corresponds to CSS's position that premiums should be calculated as tightly as possible and ultimately not result in excessively high reserves.

CSS is in favour of a reduction in reserves that takes place on a voluntary basis and respects the entrepreneurial freedom of health insurers. Many factors influence the development of reserves, which means they can sometimes be subject to sizeable fluctuations.

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