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Supplementary health insurers: FINMA sees need for comprehensive action regarding settlement

Based on its recent analyses, the Swiss Financial Market Supervisory Authority FINMA notes that invoices in the supplementary health insurance sector are often lacking in transparency and in some cases appear to be unreasonably high or unjustified. FINMA expects the insurance companies to implement more effective controlling in order to address this matter. In addition, FINMA is calling on the insurance companies to review the contracts with service providers and to make improvements where necessary. It will only approve new supplementary hospital insurance products under these conditions.

The federal authorities and the insurance industry have been focussing on the topic of settlement in the health insurance sector for a number of years. The starting point was external evidence indicating that medical services may not be being charged correctly to the supplementary health insurance companies. FINMA took up the issue as part of its supervisory remit and has focussed on it with increasing intensity since then.

In 2020, FINMA conducted on-site supervisory reviews at a number of insurance companies, covering more than 50% of the total premium volume for private and semi-private hospital insurance. FINMA's analysis shows that many contracts between supplementary health insurers and service providers – doctors and hospitals – do not provide the necessary cost transparency. The individual settlements are therefore often lacking in transparency. Overall, this combination can lead to false incentives and offers scope for liberal cost shifting to supplementary health insurers, which include these costs in the premium calculation and then pass them on to customers. FINMA therefore sees a need for comprehensive action here.

What exactly did FINMA discover?

The results of the on-site supervisory reviews show that doctor and hospital bills in the supplementary health insurance sector appear to be unreasonably high or unjustified in some cases. In many settlements it is not clear what additional benefits of supplementary insurance are being billed on top of the defined case-based fixed rates covered by the compulsory health

insurance. As a result, insurers cannot effectively check to what extent the reimbursed costs are appropriate in proportion to the additional benefits actually provided.

- There are duplicate charges, which means that case-based benefits that are already covered by the compulsory health insurance are at least in some cases billed again.
- If a policyholder has semi-private or private insurance, this automatically triggers higher doctors' fees under many contracts, regardless of which doctor is active and whether the respective patient has asserted their right to freely choose their doctor.
- In addition, in the case of products with free choice of doctor, for example, not only the specifically selected doctors providing treatment charge fees, but also other involved doctors. In its spot checks, FINMA encountered examples in which around 40 doctors charged fees for a patient through the supplementary insurance, although this would not have been justified.
- Very different additional costs are charged for identical treatment depending on the hospital and doctor. In the case of single hip replacement operations, for example, in addition to the some 16,000 francs that are covered by the compulsory health insurance as the case-based fixed rate, between 1,500 and up to 25,000 francs are billed through the supplementary insurance.
- Very different additional costs are also billed for hotel-style services. It is often not apparent from the invoice what additional benefit justifies the price difference. Certain hospitals only offer two-bed rooms in any case, for instance. However, patients with semi-private insurance are charged a premium compared with the compulsory health insurance for the "two-bed room" service.
- In addition, there are indications that the costs billed for hotel-style services in the hospitals may systematically exceed the effective costs. One hospital, for instance, discloses the additional costs for hotel-style services for a semi-private policyholder as being around 200 francs per case. It bills the supplementary insurer over 350 francs per day. Since each patient stays in hospital for around five days on average, the result is that the invoices are several times higher than the disclosed costs.
- As a rule, the insured do not receive a copy of the bill issued by the service provider for the services provided. And even if they do, it is difficult to understand. Policyholders are thus not able to check the services being billed. Transparency is not sufficiently guaranteed.

It is currently not possible to quantify the extent of the overcharged services in the supplementary hospital insurance sector. However, based on its analysis FINMA presumes that the amount that should not have been charged to premium payers is significant for the overall market.

The role of insurance companies

“With a premium volume of over 3.7 billion francs, the supplementary hospital insurance market is of great significance in the healthcare sector and for patients. It is therefore all the more important that the premiums paid by privately insured persons are transparent and comprehensible. Customers should pay a fair price for genuine additional benefits compared with the basic insurance,” says Mark Branson, FINMA CEO.

Among other things, FINMA expects supplementary health insurance providers to only accept invoices for genuine additional benefits outside the compulsory health insurance. Furthermore, the insurance companies must ensure that the billed costs are appropriate for the actual additional services.

The supplementary health insurers must be able to provide evidence to FINMA that the principles set out above are being observed and that effective controls are in place, so that excessive or inappropriate billing is prevented.

The situation as revealed by FINMA’s analyses and on-site supervisory reviews now needs to be remedied swiftly and comprehensively. FINMA therefore reiterates its expectations of the insurance companies as follows:

- The insurance companies must ensure that the service providers issue transparent and comprehensible invoices.
- The insurance companies may only charge for benefits that are justified owing to additional services, i.e. that go beyond the benefits covered by the compulsory health insurance and are justifiable in terms of price. For comparable benefits, for instance, they should draw comparisons with other service providers.
- Where necessary, the insurance companies should amend the contracts with the service providers or conclude new agreements in order to take account of these criteria.
- If they have not done so already, the insurance companies must introduce effective controlling which ensures that the requirements mentioned above are implemented and permanently met.

Transparent and correct settlement will remain a focus of supervision

Supervision of settlement, its controlling and transparency will be a focus of FINMA’s supervision in the coming years. It is clear that FINMA will only approve new products which meet the above-mentioned criteria. In addition, it will investigate the magnitude of the overcharged amounts and what this means for future tariffs.

Fair premiums for policyholders

The premium charged by each insurance company results in the long term from the service provided, to which administrative costs and profit margins are added. If stricter invoicing procedures are now implemented, this will exert pressure on the billed service costs and thus also on the premium level. At the present moment it is difficult to estimate to what extent and how quickly these effects will be seen.

Policyholders remain covered

If insurance companies negotiate new contracts with the service providers, usually hospitals and clinics, this may result in unregulated situations during transition periods or in the event of disagreement. However, such cases should be the exception rather than the rule. It is important for the policyholders to know that they are covered by their insurance regardless of a contract between the supplementary health insurance company and the service provider. The policyholder is entitled to the services promised in accordance with the terms and conditions of their supplementary health insurance.

Close alignment and coordination

In 2018, the Federal Council launched a plan to reduce costs that is binding on the various actors in the sphere of public health and, among other things, aims to prevent abusive business practices in supplementary insurance.

Through its activities, FINMA is fulfilling its mandate to protect privately insured persons from abuse. It is working towards greater cost fairness and increased transparency with regard to which additional services are really provided. If the corrections that are necessary from a supervisory point of view are made, this should increase competition in the supplementary hospital insurance sector in the long term and lead to a market that offers genuine added value for customers at a reasonable price. This can also encourage the development of new, innovative products.

Overall, this process can have consequences for the entire system in the health sector. The close alignment and coordination of actions is therefore key. For this reason, FINMA is liaising closely with the Federal Office of Public Health and the Federal Department of Finance (FDF). In addition, FINMA is in contact with the insurance industry, service provider and consumer protection organisations as well as the price supervisor.