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Supplementary health insurers: progress and challenges regarding settlement

In 2020, the Swiss Financial Market Supervisory Authority FINMA found that invoices in the supplementary health insurance sector are often lacking in transparency and in some cases appear to be unjustifiably high. FINMA took this as an opportunity to carry out more specific on-site supervisory reviews at selected supplementary health insurers. Thanks to FINMA's initiative, price and premium reductions have been achieved since 2020. Despite progress, supplementary health insurers are still confronted with implementation deficiencies in the area of service provision. FINMA sees a need for further action to guarantee the protection of policyholders and is examining further measures for 2025.

After FINMA published its press release in December 2020 on the need for action due to irregularities in the area of additional benefits, the Swiss Insurance Association (SIA) drew up an industry framework on additional benefits under the Insurance Contract Act, which serves as a guideline for insurers for the recording and assessment of additional benefits in supplementary health insurance, among other things. The implementation period expired at the end of 2024. FINMA believes that significant progress has now been made.

Transparency and assessment of additional benefits: supplementary health insurers implement FINMA's requirements
FINMA's latest investigations revealed significant progress in the implementation of important requirements by supplementary health insurers. For example, many insurers have now largely implemented the definition and distinction of additional benefits in contracts and the transparency of service providers' invoices. Furthermore, many supplementary health insurers have now developed their own assessment models to identify and assess additional benefits compared with those services which should already be covered by compulsory health insurance. These models are now largely mature.
On the basis of these assessments, the insurers were able to reduce the contractually agreed prices for additional benefits in their negotiations in several cases if the previous compensation was unreasonably high in relation to the additional benefits provided.

Stable premiums since FINMA intervened
Overall, the efforts made to date have meant that prices for in-patient hospital stays in semi-private and private wards have stagnated for the most part since 2020 despite the simultaneous rise in healthcare costs and general inflation, and have been reduced in many high-price cases in particular. This contributed to the fact that premiums for supplementary hospital insurance products also stagnated or fell in many areas.

Focus on existing shortcomings
In addition to progress in the implementation of important requirements, FINMA's latest findings nevertheless continue to reveal gaps among supplementary health insurers. While several insurers have now largely implemented the differentiation of additional benefits and transparency in invoices, there are still considerable shortcomings in the application of these standards to certain service providers.

FINMA criticises the fact that numerous contracts with service providers still do not meet the requirements under supervisory law – particularly with regard to the correct distinction of additional benefits from those services which should already be covered by compulsory health insurance and compliance with the reference prices determined by the insurers. In addition, some insurers have concluded contracts with service providers whose term extends beyond 2024, although these contracts still do not fulfil the regulatory requirements.

Prices for additional benefits are still too high
Even though progress has been made on prices, as mentioned above, current findings, for example from on-site supervisory reviews, show that many market prices are still significantly higher than the insurers' internal reference prices. Particularly striking is the persistently high level of doctors' fees in some cases, which were often initially calculated on a cost-neutral basis in the negotiations compared to the previous models. Another problem is that medical services are still sometimes billed twice – both via basic insurance and supplementary insurance. In this regard, it should be noted that the requirements regarding transparency of service provision and appropriateness of prices also apply in particular to employed doctors and affiliated doctors.

FINMA also found serious differences between the costs billed by various service providers, which cannot always be explained by defined additional benefits or regional price differences. In some cases, insurers conclude contracts with hospitals at prices that are far above the comprehensible reference values. For example, one on-site supervisory review revealed that a supplementary health insurer had used its own assessment model for hospitality services to arrive at a reference price of CHF 191 per night for a bed in a semi-private ward. However, the supplementary health insurer then agreed a price of CHF 855 with the hospital.

FINMA requires insurers to contractually determine the prices for the agreed and provided additional benefits based on their models with the service providers and

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to document all price deviations transparently. Prices that deviate significantly from the internal reference prices must be reduced.

Focus is on protecting policyholders

It is the responsibility of supplementary health insurers to guarantee the contractually agreed benefits in accordance with the insurance conditions. All requirements under supervisory law must be complied with. Among other things, these include ensuring that the compensation for all additional benefits paid via the invoices of the service providers and by the supplementary health insurers with premiums from the policyholders is within an appropriate and comprehensible range. Otherwise, a temporary or, in individual cases, even permanent situation with no contract with the service providers may be a necessary alternative in the interests of the policyholders. This measure serves to protect policyholders from abuse in the medium and long term.
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.

FINMA on-site supervisory reviews to continue

The deadline for implementing the SIA industry framework expired at the end of 2024, but key problems remain unresolved – and the need for action remains acute in 2025. FINMA concludes that the requirements under supervisory law have not yet been fully met in order to effectively eliminate abuse. This is a clear sign that supplementary health insurers still have a duty to fulfil.

FINMA will therefore continue to refrain from authorising any new supplementary hospital insurance products unless it can be ensured that FINMA's requirements can be met in the long term. FINMA expects supplementary health insurers to ensure that there are currently no serious shortcomings with regard to the requirements under supervisory law. If serious shortcomings persist – for example with regard to implementation timescales or due to a persistent mismatch between the reference price and the contractually agreed price for additional benefits – FINMA will have to impose stricter and more far-reaching measures on the insurers concerned. FINMA will also carry out on-site supervisory reviews of selected supplementary health insurers in 2025.