

# HEALTH INSURANCE IN SWITZERLAND: A CLOSER LOOK AT A SYSTEM OFTEN OFFERED AS A MODEL FOR THE UNITED STATES

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## I. INTRODUCTION

A recent Google search on the words, “Switzerland health care system,” turned up three news reports in the first screen of results presenting Switzerland as a model for the United States.<sup>1</sup> The common thread in these works was the idea that the Swiss system, which mandates that individuals choose their health care coverage from among the offerings of competing, private, not-for-profit insurers,<sup>2</sup> might be more politically palatable in the United States than models with greater reliance on government-provided health insurance, such as Canada’s single-payer approach.<sup>3</sup> A front page *New York Times* article headlined,

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1. GOOGLE, [http://www.google.com/search?hl=en&source=hp&biw=1189&bih=564&q=switzerland+health+care+system&aq=0&aql=g10&aql=&oq=switzerland+health&gs\\_rfai=](http://www.google.com/search?hl=en&source=hp&biw=1189&bih=564&q=switzerland+health+care+system&aq=0&aql=g10&aql=&oq=switzerland+health&gs_rfai=) (search “Switzerland health care system”) (last visited Jan. 19, 2011).

2. See, e.g., Regina Herzlinger, *Why Republicans Should Back Universal Health Care*, ATLANTIC (Apr. 13, 2009, 9:16 AM ET), <http://www.theatlantic.com/politics/archive/2009/04/why-republicans-should-back-universal-health-care/13013/>.

3. Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance:*

“Swiss Model for Health Care Thrives Without Public Option,” illustrates the way in which American commentators cast Switzerland in the role of counterweight to the Canadian example as a Congress sharply divided along partisan lines debated health care reform last autumn.<sup>4</sup>

Indeed, the Patient Protection and Affordable Care Act<sup>5</sup> (“ACA”) signed into law by President Barack Obama on March 23, 2010, does share some characteristics with the Swiss system (“LAMal”) established by the 1994 Revised Health Insurance Law. Both laws include an individual mandate to purchase health insurance meeting legally established standards.<sup>6</sup> Both impose requirements on insurers designed to ensure that individuals with health problems have access to coverage on the same terms as those without such problems.<sup>7</sup> Both include public subsidies to make coverage more affordable for lower income individuals.<sup>8</sup> And both rely on competing health insurers.<sup>9</sup> There are also significant differences in the legal frameworks established by LAMal and ACA. In some important respects, the Swiss law is less market-oriented than ACA. For example, LAMal forbids health insurers from earning profits on their sales of social health insurance.<sup>10</sup> It also provides for regulated or negotiated prices for pharmaceuticals, medical devices, and the services of health care providers,<sup>11</sup> and places primary responsibility for funding hospital care on cantonal governments.<sup>12</sup> On the other hand, despite America’s oft-vaunted love affair with private markets, the government plays a much bigger role in the provision of health coverage in the United States than it does in Switzerland. While all Swiss in a given region—be they rich or poor, young or old—choose their health coverage from an identical menu of private insurance

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*Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 205, 221-22.

4. Nelson D. Schwartz, *Swiss Model for Health Care Thrives Without Public Option*, N.Y. TIMES, Oct. 1, 2009, at A1.

5. In the interest of brevity, we will use the abbreviation ACA to refer to the final health reform legislation, as laid out in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010), and in the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

6. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1501, 5000A, 124 Stat. 119, 242, 244 (2010) (mandating that an individual maintain “minimum essential coverage” for themselves and their dependents); *id.* § 1302(a)–(b) (establishing legal standards); LOI FÉDÉRALE SUR L’ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 3, para. 1 (Switz.); *id.* art. 25.

7. Patient Protection and Affordable Care Act § 2704(a); LAMAL art. 13, para. 2(a).

8. Patient Protection and Affordable Care Act § 1413; LAMAL art. 66, paras. 1–2.

9. Patient Protection and Affordable Care Act § 1311; LAMAL art. 41, para. 1.

10. See LAMAL art. 43, paras. 4–5 (explaining that insurance rates are based on a uniform tariff structure set by the Swiss federal government); EUROPEAN OBSERVATORY ON HEALTH CARE SYS., HEALTH CARE SYSTEMS IN TRANSITION: SWITZERLAND 17 (2000).

11. LAMAL art. 44, para. 1.

12. *Id.* art. 49, paras. 1–3.

offerings,<sup>13</sup> almost a third of U.S. health coverage is provided through government programs.<sup>14</sup> The proportion of Americans with government coverage will increase substantially as a result of ACAs Medicaid expansions.<sup>15</sup>

Two other significant differences between the two systems are less easy to place on the spectrum from less to more market-oriented. The first of these is that LAMal expressly forbids employers from providing basic social health insurance as a benefit of employment, while ACA strengthens, or at least slows the erosion of, employer-sponsored health insurance.<sup>16</sup> The second of these is that the market share of managed care products is much lower in Switzerland than in the United States,<sup>17</sup> and the contractual provisions of the managed care products offered are quite different in the two countries as well.<sup>18</sup>

Both the similarities and the differences between the two countries' systems for funding and delivering health care deserve to be more widely understood if Americans are to learn from the Swiss experience, rather than use it merely as a touchstone for particular points of view in

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13. See EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 17.

14. The U.S. Census' Current Population Survey estimates that twenty-nine percent of the population was covered under government programs in 2008. See U.S. CENSUS BUREAU, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 64 tbl.C-3 (2009), available at <http://www.census.gov/prod/2009pubs/p60-236.pdf>. The picture is muddled somewhat by the fact that Medicare and Medicaid/Children's Health Insurance Program ("CHIP") contract with private health plans to cover some of their enrollees. Almost a quarter of Medicare enrollees receive their coverage through private Medicare Advantage plans. There has been a substantial increase in Medicare private plan enrollment since passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1860D-1, 117 Stat. 2066, 2071, which created a Medicare Part D prescription drug benefit that is only available via enrollment in a private plan. See MARSHA GOLD ET AL., KAISER FAMILY FOUND., MEDICARE ADVANTAGE 2010 DATA SPOTLIGHT: PLAN ENROLLMENT PATTERNS AND TRENDS 1, 3 (2010), available at <http://www.kff.org/medicare/upload/8080.pdf>; KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., MEDICAID: A PRIMER 24 (2010), available at <http://www.kff.org/medicaid/upload/7334-04.pdf>. About seventy percent of Medicaid and CHIP enrollees receive their services through managed care organizations that hold contracts with state Medicaid programs, although there is wide variation in the degree to which these contracting organizations are risk-bearing. See KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra*, at 18.

15. Rand Institute simulations project increases in Medicaid/CHIP enrollment of twelve million by 2019 due to the ACA. See RAND CORP., ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R. 3590), at 3 tbl.1, available at [http://www.rand.org/pubs/research\\_briefs/2010/RAND\\_RB9514.pdf](http://www.rand.org/pubs/research_briefs/2010/RAND_RB9514.pdf).

16. RAND projects that the ACA will result in six million more individuals enrolled in employer-provided coverage in 2019 than would have been enrolled in the absence of the legislation. *Id.* at 3. While one could argue that it is more "market-oriented" to have individuals choose their insurer and coverage package than to have an employer make those decisions for its employees, one could also argue that it is less "market-oriented" to have the government restrict the nature of the benefits that can be offered in the contract between employer and employee.

17. See Peter Zweifel, *Switzerland*, 25 J. HEALTH POL. POL'Y & L. 937, 938 tbl.1 (2000).

18. See *infra* Part IV.

the on-going political debate. Our goal in this Article is to describe some important aspects of the Swiss system since LAMal reforms took effect in 1996 and, with a certain amount of trepidation, to explore the lessons that policy makers and interested citizens in the United States might draw from the Swiss experience. Since we are economists, rather than legal scholars, we will highlight the ways in which ideas from our discipline have influenced the Swiss legal framework.

## II. HOW THE SWISS SYSTEM WORKS

In December 1994, the revised Health Insurance Law was narrowly approved by one of the popular referendums for which Switzerland is famous.<sup>19</sup> Its provisions went into effect in 1996.<sup>20</sup> The 1996 reforms stipulate that all Swiss purchase Compulsory Basic Social Insurance (“CBSI”).<sup>21</sup> That is, translating into American parlance, the law imposes an individual mandate. Employers are not permitted to offer CBSI coverage to their employees, although they may provide supplemental coverage.<sup>22</sup> The terms of the rather comprehensive CBSI benefit

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19. Chancellerie Fédérale Suisse, *Votation populaire du 4 décembre 1994 [Popular Vote on Dec. 4, 1994]*, <http://www.admin.ch/ch/f/pore/va/19941204/index.html> (last visited Jan. 19, 2011).

20. Marcel Bilger, *Progressivity, Horizontal Inequality and Reranking Caused By Health System Financing: A Decomposition Analysis for Switzerland*, 27 J. HEALTH ECON. 1582, 1582 (2008). The LAMAL was approved by fifty-two percent of voters. Paul J. Donahue, *Federalism and the Financing of Health Care in Canada and Switzerland: Lessons for Health Care Reform in the United States*, 21 B.C. INT’L & COMP. L. REV. 385, 423 (1998). Swiss voters overwhelmingly rejected a proposed move to a single-payer system in a 2007 referendum. Chancellerie fédérale, *Votation no 528 Tableau récapitulatif [Vote No. 528 Summary Table]*, <http://www.admin.ch/ch/f/pore/va/20070311/det528.html> (last visited Jan. 19, 2011). However, voters also overwhelmingly rejected a 2008 proposal to introduce more market-oriented reforms. Chancellerie fédérale, *Votation populaire du 1er juin 2008 [Popular Vote on June 1, 2008]*, <http://www.admin.ch/ch/f/pore/va/20080601/index.html> (last visited Jan. 19, 2011); see Luca Crivelli, *Swiss Deny More Competition in Health Insurance*, HEALTH POL’Y MONITOR, [http://www.hpm.org/en/Surveys/USI\\_-\\_Switzerland/12/Swiss\\_deny\\_more\\_competition\\_in\\_health\\_insurance.html](http://www.hpm.org/en/Surveys/USI_-_Switzerland/12/Swiss_deny_more_competition_in_health_insurance.html) (last visited Jan. 19, 2011).

21. See Bilger, *supra* note 20, at 1582.

22. RS 830.10, art. 3 makes individuals and individual families responsible for their own CBSI insurance. LOI FÉDÉRALE SUR L’ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 3 (Switz.). Article 62 forbids all third parties from covering the differential premiums or the differential out-of-pocket cost-sharing consequent to each individual’s choice of CBSI policy. *Id.* art. 62, para. 2(a). The employer penalties and incentives designed to bolster employer coverage in the ACA are found in Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237, 244 (2010) (credit for employee health insurance expenses of small businesses), and sections 1511–15, 124 Stat. at 254–58 (employer responsibilities). A lively strand in the literature explores labor market distortions associated with America’s reliance on employer-provided health coverage. For a review, see generally Jonathan Gruber, *Health Insurance and the Labor Market*, in HANDBOOK OF HEALTH ECONOMICS: VOL. 1A (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

package are established by the federal government under guidelines laid out in the statute.<sup>23</sup>

In 2006, eighty-seven insurers were registered to participate in the CBSI market, down from 145 in 1996.<sup>24</sup> Collectively, the largest fifteen insurers had an eighty percent market share.<sup>25</sup> As will be the case for policies offered in the new Health Benefit Exchanges to be created under the terms of ACA, Swiss CBSI policies are subject to community rating and guaranteed issue.<sup>26</sup> “Community rating” means that each insurer must charge all enrollees in a specific plan in a given geographic region the same premium, regardless of health status or health risk (with some carefully defined exceptions for those below the age of twenty-five).<sup>27</sup> “Guaranteed issue” means that insurers may not deny coverage on the basis of health status or risk.<sup>28</sup> Swiss supplemental coverage, however, is subject to neither community rating nor guaranteed issue.<sup>29</sup> Premiums for both types of products are set by insurers,<sup>30</sup> although CBSI premiums are subject to governmental review.<sup>31</sup>

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23. See LAMAL arts. 25–31 for the catalogue of services that must be covered under CBSI. Article 33 charges the Swiss Federal Council with determining the details of coverage on the basis of, “efficacy, appropriateness and economy.” *Id.* art. 33; see EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 33.

24. EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 18 tbl.2; OFFICE FÉDÉRAL DE LA SANTÉ PUBLIQUE, STATISTIQUE DE L’ASSURANCE-MALADIE OBLIGATOIRE 2006 [STATISTICS OF MANDATORY HEALTH INSURANCE 2006] 120 tbl.5.01 (2006), available at [http://www.bfs.admin.ch/bfs/portal/fr/index/infothek/lexikon/bienvenue\\_\\_\\_login/blank/zugang\\_lexikon.Document.106221.pdf](http://www.bfs.admin.ch/bfs/portal/fr/index/infothek/lexikon/bienvenue___login/blank/zugang_lexikon.Document.106221.pdf).

25. Authors’ calculation from data reported by the Swiss Federal Office of Public Health. OFFICE FÉDÉRAL DE LA SANTÉ PUBLIQUE, *supra* note 24, at 120 tbl.5.01.

26. LAMAL art. 61, para. 1 (establishing community rating); *id.* art. 4, para. 2 (establishing guaranteed issue).

27. *Id.* art. 61, para. 2. ACA will permit more extensive age rating for policies sold through the exchanges than Switzerland allows. The Secretary of Health and Human Services, in consultation with the state insurance commissioners, will define permissible age bands, and premiums for the oldest age band may be as much as three times as large as premiums for the youngest group. Patient Protection and Affordable Care Act § 2701(a)(1)(A)(iii), (a)(3), 124 Stat. at 155. In addition, ACA will permit insurers to offer a cheaper, less comprehensive benefit package (“catastrophic coverage”) to individuals under the age of thirty. *Id.* § 1302(e), 124 Stat. at 168.

28. LAMAL art. 61, para. 1 establishes community rating, and LAMAL art. 4, para. 2 establishes guaranteed issue. ACA also will enforce community rating and guaranteed issue for policies purchased individually and in the small group market. Risk rating will continue to be permitted at the group level in the large group market. Patient Protection and Affordable Care Act § 2701(a)(1)(A)(i), 124 Stat. at 155 (amending the Public Health Service Act to enforce guaranteed issue in all markets and community rating in the individual and small group markets).

29. See CLAIRE DALEY & JAMES GUBB, CIVITAS: INST. FOR THE STUDY OF CIVIL SOC’Y, THE SWISS HEALTH SYSTEM 5 (2007), <http://www.civitas.org.uk/nhs/download/Switzerland.pdf>.

30. LAMAL art. 61, para. 1.

31. *Id.* art. 61, para. 5.

About a third of the population purchases supplemental coverage.<sup>32</sup> The proportion has fallen since 1996, because the reforms made CBSI coverage more comprehensive at the same time as they effectively suppressed the pre-reform subsidization of supplemental coverage by CBSI premiums, leading to a substantial hike in supplemental premiums.<sup>33</sup> Some observers have portrayed Swiss supplemental coverage as a matter of “hotel amenities,”<sup>34</sup> but in fact, the coverage entitles beneficiaries to preferential access to senior physicians when hospitalized, which is probably at least as important to beneficiaries as the amenity of a private or semi-private hospital room.<sup>35</sup> Health insurers are not permitted to earn profits on CBSI policies, although they may earn profits on supplemental coverage.<sup>36</sup> Many insurers offer both CBSI and supplemental products,<sup>37</sup> which may permit them to evade the restrictions on profits to some extent through charging overhead expenses to the CBSI account.

Given community rating and guaranteed issue, and in accordance with the economic theory of “one price,” CBSI premiums for any given coverage package would be expected to converge across companies over time as policy holders—whether healthy or sick—gravitated to the companies offering the lowest premiums.<sup>38</sup> In fact, however, there is surprisingly wide and persistent variation in CBSI premiums for identical coverage from different companies, as a large subset of consumers appear reluctant to switch insurers.<sup>39</sup> Both consumers’ desire to maintain CBSI and supplemental coverage with the same insurer, and their concern that they may lose supplemental coverage or have supplemental premiums increase if they switch companies for the CBSI

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32. CIVITAS: THE INST. FOR THE STUDY OF CIVIL SOC’Y, THE SWISS HEALTH CARE SYSTEM 4 (2002), <http://www.civitas.org.uk/pdf/Switzerland>.

33. See EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 33.

34. See WORLD HEALTH ORG. EUR., WHAT ARE THE EQUITY, EFFICIENCY, COST CONTAINMENT AND CHOICE IMPLICATIONS OF PRIVATE HEALTH-CARE FUNDING IN WESTERN EUROPE? 9 (2004), [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/74694/E83334.pdf](http://www.euro.who.int/__data/assets/pdf_file/0003/74694/E83334.pdf).

35. See *Hospital. L’assurance complémentaire d’hospitalisation intelligente*, SANITAS, <https://www.sanitas.com/pub/ServiceBroker?PAGEID=1261> (last visited Jan. 19, 2011) (providing an example of complementary coverage from one of the major Swiss insurers).

36. LAMAL art. 12, paras. 1–2.

37. See EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 17.

38. See Karl Gunnar Persson, *The Law of One Price*, EH.NET (Feb. 5, 2010, 14:59), <http://eh.net/encyclopedia/article/persson.LOOP> (last visited Jan. 19, 2011).

39. For example, a recent search for traditional coverage for a family of four in the town of Nyon in the canton of Vaud (just outside Geneva) with a deductible of CHF1500 found policies for sale with monthly premiums ranging from CHF663.20 to CHF1036.80 (a Swiss franc is worth a little less than a dollar). See also OFFICE FÉDÉRAL DE LA SANTÉ PUBLIQUE, *supra* note 24, at 23, 24 tbl.G3d (stating that most people remain with the insurers that offer high premiums and displaying in box plots the degree of premium variation for the policies actually purchased by canton).

coverage, may contribute to the persistence of premium variation, although “status quo bias” may play a role as well.<sup>40</sup>

LAMal provides for a risk adjustment scheme in the CBSI market, which is administered by *santésuisse*, the Swiss health insurer trade association.<sup>41</sup> In general, the goal of risk adjustment is to avoid rewarding insurers for attracting healthy enrollees or for discouraging sick ones so that insurers compete on cost and quality, not on risk selection.<sup>42</sup> Thus, risk adjustment schemes are designed to transfer funds from insurers whose enrollees have a lower-than-average risk profile (a *favorable* selection) to insurers whose enrollees have a higher-than-average risk profile (an *adverse* selection).<sup>43</sup> At present, the Swiss scheme takes into account only age and gender, but prior-year hospitalization is to be added in 2012.<sup>44</sup>

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40. A number of parliamentary initiatives have been put forward to make it easier for individuals to receive their CBSI and supplemental coverage from two different insurers. *See, e.g., Normes de gouvernance et critères de transparence dans l'assurance-maladie [Governance Standards and Transparency Requirements in Health Insurance]: Hearing on 08.434 Before the Comm'n on Soc. Sec. & Pub. Health* (2008) (presented by Jacqueline Fehr), [http://www.parlament.ch/e/suche/pages/geschaefte.aspx?gesch\\_id=20080434](http://www.parlament.ch/e/suche/pages/geschaefte.aspx?gesch_id=20080434); *Faciliter le changement de caisse d'assurance-maladie selon la LAMAL. Simplification de la facturation pour les patients et les assurés [To Facilitate Switching Health Insurance Plans Under the LAMAL: Simplification of Billing for Patients and Enrollees]: Hearing 08.484 Before the Comm'n on Soc. Sec. & Pub. Health* (2008) (presented by Steiert Jean-François), [http://www.parlament.ch/f/Suche/Pages/geschaefte.aspx?gesch\\_id=20080484](http://www.parlament.ch/f/Suche/Pages/geschaefte.aspx?gesch_id=20080484); *Faciliter le changement de caisse d'assurance-maladie selon la LAMAL. Levée du chargement pour frais sur les assurances complémentaires [To Facilitate Switching Health Insurance Plans Under the LAMAL: Lifting the Administrative Charge for Supplemental Insurance Expenses]: Hearing 08.485 Before the Comm'n on Soc. Sec. & Pub. Health* (2008) (presented by Steiert Jean-François), [http://www.parlament.ch/f/suche/pages/geschaefte.aspx?gesch\\_id=20080485](http://www.parlament.ch/f/suche/pages/geschaefte.aspx?gesch_id=20080485); *cf. SANTÉSUISSE, INTERVENTIONS POLITIQUES EN MATIÈRE D'ASSURANCE-MALADIE [HEALTH INSURANCE POLICY INTERVENTIONS] 7-8* (2010), <http://www.santesuisse.ch/datasheets/files/201101171453450.pdf> (stating *santésuisse*'s position, which opposes Steiert's parliamentary initiatives).

41. LAMAL art. 105, para. 3; *see* OFFICE FEDERAL DES ASSURANCES SOCIALES, ANALYSE DES EFFETS DE L'ASSURANCE-MALADIE: RAPPORT DE SYNTHÈSE [STUDY OF THE EFFECTS OF HEALTH INSURANCE: SUMMARY REPORT] 90 (2001).

42. OFFICE FÉDÉRAL DES ASSURANCES SOCIALES, *supra* note 41, at 23; Konstantin Beck et al., *Risk Adjustment in Health Insurance and Its Long-Term Effectiveness*, 29 J. HEALTH ECON. 489, 489 (2010).

43. *See* OFFICE FEDERAL DES ASSURANCES SOCIALES, *supra* note 41, at 24.

44. EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 29; DAVID SQUIRES, THE COMMONWEALTH FUND, THE SWISS HEALTH CARE SYSTEM, 2009, at 1, [http://www.thinkswiss.org/attachments/-01\\_swiss\\_health\\_care\\_system.pdf](http://www.thinkswiss.org/attachments/-01_swiss_health_care_system.pdf); Beck et al., *supra* note 42, at 491.

In keeping with a philosophy of demand-side cost control,<sup>45</sup> LAMal also sets out cost-sharing provisions in considerable detail. The law specifies a minimum annual deductible of approximately \$400 (at the 2010 exchange rates), with a choice of deductible up to \$2500 in return for lower premiums.<sup>46</sup> Patients are liable for ten percent co-insurance for expenditure in excess of the deductible, with a cap of \$700.<sup>47</sup> Maximum annual CBSI cost-sharing is therefore limited to \$3200.<sup>48</sup> Giving a nod to the supply-side approach to cost control, the law also allows for a variety of managed care models.<sup>49</sup> Insurers are permitted to offer limited discounts on premiums for their managed care plans, ranging from fifteen to twenty-five percent, depending on the type of plan.<sup>50</sup> Cost-sharing is also reduced for managed care enrollees.<sup>51</sup> Except for these managed care models, LAMal requires CBSI insurers to cover care from any qualified health care provider at the established rates.<sup>52</sup>

*Santésuisse* has advocated abolishing this “obligation to contract,” arguing that it makes doctors reluctant to enter into capitated or salaried contracts with insurers.<sup>53</sup> The Federal Office of Social Insurance

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45. The basic principle behind demand-side approaches to cost control is that consumers’ costs should increase as they use more (or more expensive) health care, thus giving each individual an incentive to use less (or less expensive) care, which in turn should reduce society’s health care costs. The different forms of patient cost-sharing—co-payments, co-insurance, and deductibles—are the standard items in the demand-side cost-control toolkit. See Randall P. Ellis & Thomas G. McGuire, *Supply-Side and Demand-Side Cost Sharing in Health Care*, J. ECON. PERSP., Fall 1993, at 135, 136. In general, higher premiums are not cost-control tools, since premiums do not vary with utilization. However, one model of insurance contract available in Switzerland rewards patients with no claims during one year with a lower premium in subsequent years. Since the premium varies with utilization, this is another example of a demand-side approach to cost control.

46. See LAMAL art. 64, para. 2(a); OFFICE FÉDÉRAL DE LA SANTÉ PUBLIQUE, *supra* note 24, at 183 tbl.11.08; SQUIRES, *supra* note 44, at 1.

47. SQUIRES, *supra* note 44, at 1.

48. This is the total of the maximum deductible and the maximum co-insurance payable in excess of the deductible.

49. LAMAL art. 62; *id.* art. 64, para. 6(c).

50. Konstantin Beck et al., CSS Inst. for Empirical Health Econ., *Efficiency Gains Thanks to Managed Care?: Evidence from Switzerland 7* (Jan. 30, 2010) (unpublished manuscript), [http://www.css.ch/en/zwillingsanalyse\\_socialpolitik\\_englisch\\_gekuerzte\\_version2.pdf](http://www.css.ch/en/zwillingsanalyse_socialpolitik_englisch_gekuerzte_version2.pdf).

51. *Modèle d’assurance: HMO*, BONUS.CH, <http://www.bonus.ch/Assurance-maladie/Modeles-assurance/HMO-modele-assurance.aspx> (last visited Jan. 19, 2011) (noting that HMO enrollees are free from all cost-sharing). Thus far, no insurer has emerged offering only managed care plans. If such an insurer were to emerge, regional average premiums for conventional coverage would probably be used as the benchmark against which permissible discounts would be measured.

52. See LAMAL art. 41, paras. 1, 4. The Swiss refer to this provision of the law as “obligation to contract.” In the United States, the analogous statutes are known as “any willing provider” laws, since they require insurers to cover the costs of care procured from any provider who is willing to accept the insurer’s payment schedule. See *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 331-32 (2003).

53. GIANFRANCO DOMENIGHETTI & LUCA CRIVELLI, *SECURITE DE L’APPROVISIONNEMENT EN MEDECINE DE VILLE DANS LE CADRE DE LA SUPPRESSION DE L’OBLIGATION DE CONTRACTER*

(“FOSI”), however, has expressed concern that eliminating the obligation to contract might lead to two-tiered care or might undermine consistent quality of care.<sup>54</sup> The danger of substandard care is counteracted by dissatisfied consumers’ legal right to switch coverage on an annual basis.<sup>55</sup>

The limited menu of CBSI contract types facilitates price transparency and comparison shopping.<sup>56</sup> Individuals can easily generate lists of the premiums charged for each type of contract by the insurers in their area through commercial websites, such as Comparis and Bonus.<sup>57</sup>

In presenting LAMal reforms to the Swiss public, advocates stressed that their purpose was to maintain *solidarity* within the Swiss community.<sup>58</sup> Community rating and guaranteed issue are designed to buttress solidarity between the healthy and the sick and the young and the old.<sup>59</sup> The system of subsidies for individuals and families of “modest means” is designed to buttress solidarity across class and income lines.<sup>60</sup> The subsidies, termed “individual premium reductions” (“IPR”), are administered by the cantons, under federal guidelines that specify that premiums net of the subsidies should cost recipients no more than about eight percent of income.<sup>61</sup> The federal government funds roughly two-thirds of the subsidies, with the cantons responsible for the remainder.<sup>62</sup> As a general rule, the subsidy is tied to the average premium in the canton.<sup>63</sup> This means that even individuals receiving public subsidies bear the extra cost if they select unusually expensive coverage, thus ensuring that all consumers have an incentive to make cost-effective choices.<sup>64</sup> In 2001, about a third of the population

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[SECURITY OF SUPPLY CITY OF MEDICINE UNDER THE ABOLITION OF THE OBLIGATION TO CONTRACT] 2 (2001), [http://www.ti.ch/DSS/DSP/SezS/pdf/GD-LC-securite\\_approvisionnement\\_medicine\\_de\\_ville.pdf](http://www.ti.ch/DSS/DSP/SezS/pdf/GD-LC-securite_approvisionnement_medicine_de_ville.pdf).

54. OFFICE FEDERAL DES ASSURANCES SOCIALES, *supra* note 41, at XII.

55. In response to evidence that managed care enrollees tend to switch to conventional coverage after they develop health problems, there was a proposal to extend the enrollment commitment for managed care to three years, which was, however, rejected by Parliament (information obtained from private communication from Mr. Altermatt of *santésuisse*).

56. OFFICE FÉDÉRAL DE LA SANTÉ PUBLIQUE, *supra* note 24, at 120 tbl.5.01.

57. *Comparez les assurances maladie et payez moins*, COMPARIS.CH, <http://fr.comparis.ch/krankenkassen/default.aspx> (last visited Jan. 19, 2011); *Der beste Preis per Mausclick!*, BONUS.CH, <http://www.bonus.ch> (last visited Jan. 19, 2011). The ACA contains similar policy standardization provisions with its specification of Bronze, Silver, Gold, and Platinum benefit packages. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302, 124 Stat. 119, 167 (2010).

58. OFFICE FEDERAL DES ASSURANCES SOCIALES, *supra* note 41, at 1.

59. *Id.* at 75.

60. *Id.*

61. *Id.* at 35.

62. *Id.* at 92-93.

63. *See id.* at 94.

64. *Id.* at 101. Thus, the Swiss subsidies more-or-less conform to the principles of the

received some level of subsidy, and IPR payments accounted for about fifteen percent of total CBSI premiums.<sup>65</sup>

The law, and the subsequent amendments, also provide for negotiated and/or regulated prices for medical devices, pharmaceuticals, and the services of health care providers.<sup>66</sup> Hospitals are funded partly by payments from insurers, but mainly by the cantons, despite lobbying by *santésuisse* to channel all hospital funding through its members.<sup>67</sup>

Prior to 2004, doctor fees were negotiated at the cantonal level between *santésuisse* and the doctors' professional associations.<sup>68</sup> A new federal scheme, called TARMED, went into effect on January 1, 2004.<sup>69</sup> The scheme is implemented via an organization called TARMED Suisse,<sup>70</sup> with membership composed of the Swiss hospital organization,

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“managed competition” approach to health insurance, which requires that individuals bear the expense at the margin of choosing more expensive coverage. See, e.g., Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 29 (1993), available at [http://content.healthaffairs.org/content/12/suppl\\_1/24.full.pdf+html](http://content.healthaffairs.org/content/12/suppl_1/24.full.pdf+html). For a critical analysis of the ability of the managed competition approach to deliver effective cost control in the American context, see Rachel Kreier, *Economic Theory and Political Reality: Managed Competition and U.S. Health Policy*, 34 POL. & POL'Y 579 (2006).

65. ROBERT E. LEU & MARTIN SCHELLHORN, INST. FOR THE STUDY OF LABOR, THE EVOLUTION OF INCOME-RELATED INEQUALITIES IN HEALTH CARE UTILIZATION IN SWITZERLAND OVER TIME 4-5 (2004), <http://www.econstor.eu/bitstream/10419/20582/1/dp1316.pdf>.

66. LOI FÉDÉRALE SUR L'ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 44, para. 1 (Switz.); *id.* art. 49, paras. 1–3.

67. See SANTÉSUISSE, PAPIER DE POSITIONNEMENT: FINANCEMENT DES HÔPITAUX [POSITION PAPER: HOSPITAL FUNDING] 1-3 (2008), <http://www.santesuisse.ch/datasheets/files/200804221315420.pdf>. The Swiss describe this as a “unitary system” of hospital funding, because hospitals would receive all payments from insurers, rather than from both insurers and cantonal governments, as is currently the case. *Id.* at 1.

68. INST. FOR POLICY INNOVATION, THE DANGERS OF UNDERMINING PATIENT CHOICE: LESSONS FROM EUROPE AND CANADA 17 (2006); Peter Zweifel & Ming Tai-Seale, *An Economic Analysis of Payment for Health Care Services: The United States and Switzerland Compared*, 6 J. HEALTH CARE FIN. & ECON. 197, 198-99 (2009).

69. TARMED—un tarif à l'acte détaillé [TARMED—A Tariff Act Detailed], FMH FÉDÉRATION DES MÉDECINS SUISSES [FMH SWISS MED. ASSOC.], <http://www.fmh.ch/fr/tarifs/tarmed-tarif.html> (last visited Jan. 19, 2011). The name TARMED is related to the phrase “tarif médical,” which translates as “medical pricing schedule.” The TARMED scheme bears many similarities to the Resource Based Relative Value Scale that U.S. Medicare has used to set physician payments since 1992. See, e.g., *The Resource Based Relative Value Scale: Overview of the RBRVS*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/overview-of-rbrvs.shtml> (last visited Jan. 19, 2011). TARMED establishes the relative values of different services—for example, TARMED specifies the ratio of the payment for an office visit to a cardiologist relative to the payment for a well-baby visit with a pediatrician. These relative values are uniform across Switzerland, but the actual monetary payments vary across cantons, reflecting differences in cost-of-living and medical costs across the cantons. See *infra* note 74 and accompanying text.

70. TARMED Suisse, TARMED SUISSE, <http://www.tarmedsuisse.ch/gesellschaft.html> (last visited Jan. 19, 2011).

the federation of Swiss doctors, *santésuisse*, and the trade associations representing Swiss accident, military, and disability insurers.<sup>71</sup> TARMED Suisse has responsibility to draw up a schedule of “tariff points” that applies to each of some 4600 ambulatory services,<sup>72</sup> which then must be approved by the Federal Council that serves as Switzerland’s executive body.<sup>73</sup> The schedule establishes the relative value of each of the services on a nationwide basis, but the monetary value of each point differs from canton to canton.<sup>74</sup>

In 2007, the Swiss parliament passed legislation providing for a move to a diagnosis-related group (“DRG”) system of prospective hospital payments, which is scheduled to go into effect on January 1, 2012.<sup>75</sup> The DRG approach to hospital payments was pioneered by U.S. Medicare during the Reagan administration,<sup>76</sup> although the Swiss version will take the German implementation of the approach as its jumping-off point.<sup>77</sup> A DRG payment regime is based on a schedule of diagnosis-related payments.<sup>78</sup> For each admission, the hospital receives the specified payment regardless of how many procedures are performed or how many days the patient is hospitalized,<sup>79</sup> thus creating incentives for the hospital to rein in resource use. The Swiss legislation provided for the creation of a public benefit corporation called SwissDRG, charged with responsibility for developing the schedule of DRG payments.<sup>80</sup> In addition to the professional and trade associations

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71. *Id.*

72. Zweifel & Tai-Seale, *supra* note 68, at 198; *TARMED—un tarif à l’acte détaillé*, *supra* note 69.

73. LOI FÉDÉRALE SUR L’ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 46, para. 4 (Switz.).

74. The requirement to maintain cost neutrality within each canton for the first eighteen months that the system was in place dictated the initial conversion rates from points to money. *See TARMED—un tarif à l’acte détaillé*, *supra* note 69. For a critical review of TARMED’s incentive effects and a comparison with the U.S. relative value based system, see Zweifel & Tai-Seale, *supra* note 68, at 203-05, 208.

75. *SwissDRG aktuell [SwissDRG Currently]*, SWISSDRG, <http://www.swissdrg.org/de/index.asp?navid=0> (last visited Jan. 19, 2011).

76. *See* Rick Mayes, *The Origins, Development, and Passage of Medicare’s Revolutionary Prospective Payment System*, 62 J. HIST. MED. & ALLIED SCI. 21, 41-43, 46-48, 54 (2007).

77. WORLD HEALTH ORG., TECHNICAL BRIEFS FOR POLICY-MAKERS NO. 2: PROVIDER PAYMENTS AND COST-CONTAINMENT LESSONS FROM OECD COUNTRIES 3 (2007), available at [http://www.who.int/health\\_financing/documents/pb\\_e\\_07\\_2-provider\\_payments.pdf](http://www.who.int/health_financing/documents/pb_e_07_2-provider_payments.pdf).

78. William C. Hsiao et al., *Lessons of the New Jersey DRG Payment System*, 5 HEALTH AFF. 32, 33 (1986), available at <http://content.healthaffairs.org/content/5/2/32.full.pdf>.

79. *Id.*

80. LOI FÉDÉRALE SUR L’ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 49, paras. 1–2, 5–6 (Switz.); *SwissDRG aktuell*, *supra* note 75.

participating in TARMEDES Suisse, SwissDRG includes representation from the Swiss Conference of Cantonal Health Ministers.<sup>81</sup>

### III. SWISS SYSTEM PERFORMANCE

In 2001, the Swiss FOSI issued a report evaluating the achievements of the first five years of reforms under LAMal based on a series of expert studies.<sup>82</sup> In a cover letter to the report, the FOSI director noted that the law had been crafted with three goals in mind: “to reinforce solidarity” among recipients “young and old, healthy and ill, rich and poor;” to assure high quality care; and to “put a damper on rising costs.”<sup>83</sup> The director noted that the experts generally gave the reformed Swiss system high marks with respect to the first two goals, but found that the reforms “have hardly influenced the augmentation of costs.”<sup>84</sup> Although most political observers continue to view its high costs as the Achilles’ heel of the Swiss system, they may well be the expression of citizens’ preferences.<sup>85</sup>

Switzerland ties with oil-rich Norway for having the second most expensive health care system in the world,<sup>86</sup> but still spends about forty percent less per capita than the United States.<sup>87</sup> In 2007, Swiss per capita health care spending was \$4417,<sup>88</sup> versus an Organization for Economic Cooperation and Development (“OECD”) average of \$2984,<sup>89</sup> and U.S. spending of \$7290.<sup>90</sup> Switzerland devoted 10.8% of its GDP to health

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81. *Die SwissDRG AG [The SwissDRG AG]*, SWISSDRG, [http://www.swissdrg.org/de/06\\_swissdrg\\_ag/SwissDRG\\_AG.asp?navid=1](http://www.swissdrg.org/de/06_swissdrg_ag/SwissDRG_AG.asp?navid=1) (last visited Jan. 19, 2011); see *supra* notes 69-71.

82. O. Piller, *Foreword* to OFFICE FEDERAL DES ASSURANCES SOCIALES, *supra* note 41.

83. OFFICE FEDERAL DES ASSURANCES SOCIALES, *supra* note 41, at XXXIII.

84. See *id.* at XXXIII-XXXIV.

85. This statement is based on two types of evidence. First, typically, whenever there is a cantonal vote on a hospital project, the project passes by a wide majority. For instance, there was a 57.7% majority in favor of modernization of the university hospital of the canton of Zurich (May 21, 2006), following a 70.9% majority for creating a new central psychiatric clinic the previous year (Feb. 27, 2005). See *Kantonale Volksabstimmung vom 21. Mai 2006*, [http://www.statistik.zh.ch/abstimmungen/2006\\_05\\_21/pdf/zuezh.pdf](http://www.statistik.zh.ch/abstimmungen/2006_05_21/pdf/zuezh.pdf); *Kantonale Volksabstimmung vom 27. Februar 2005*, [http://www.statistik.zh.ch/abstimmungen/2005\\_02\\_27/pdf/zuezh.pdf](http://www.statistik.zh.ch/abstimmungen/2005_02_27/pdf/zuezh.pdf). Second, choice experiments indicate that the Swiss would have to be compensated by a premium reduction of some twenty-five percent for accepting a delay of a mere two years in access to medical innovation (which constitutes the main driver of health care expenditure). See Peter Zweifel et al., *Consumer Resistance Against Regulation: The Case of Health Care*, 29 J. REG. ECON. 319, 324, 326, 330 (2006).

86. ORG. FOR ECON. CO-OPERATION & DEV., HEALTH AT A GLANCE 2009: OECD INDICATORS 160, 161 tbl.7.1.1 (2009), <http://www.oecd.org/dataoecd/55/2/44117530.pdf>.

87. See *id.* at 161 tbl.7.1.1.

88. *Id.*

89. *Id.*

90. *Id.*

care,<sup>91</sup> placing it third among thirty OECD nations, behind the United States (16%) and France (11%).<sup>92</sup> Nevertheless, that figure represented a decline from 11.2% in 2005.<sup>93</sup> Swiss spending grew at an average annual rate of 2.3% during the period from 1997 to 2007 (versus an OECD average of 4.1%, and 3.4% in the United States),<sup>94</sup> giving Switzerland the second lowest rate of growth (after Germany) over the decade.<sup>95</sup>

In general, Switzerland scores well on measures of quality of care and health outcomes. At almost eighty-two years, Swiss life expectancy in 2007 was second only to Japan's (the American figure was four years below Switzerland's and a full year below the OECD average).<sup>96</sup> Switzerland's infant mortality rate is less impressive, equal in 2007 to the OECD average of 3.9 deaths per 1000 live births,<sup>97</sup> although still much better than the scandalously high American figure of 6.7 deaths per 1000 live births.<sup>98</sup> Of course, life expectancy and infant mortality reflect many aspects of society apart from the performance of the health care system, including lifestyle, education, living conditions, and the proportion of the population comprised of immigrants,<sup>99</sup> racial and ethnic minorities, and the poor. However, Switzerland also generally scores well on measures more closely tied to the health care system per se, such as avoidable hospitalizations for asthma.<sup>100</sup> Waiting lists for surgeries and diagnostic procedures are almost unheard of in Switzerland.<sup>101</sup>

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91. *Id.* at 163 tbl.7.2.1.

92. *Id.*

93. *Id.* at 198 tbl.A.12.

94. *Id.* at 161 tbl.7.1.2.

95. *Id.* As OECD statisticians note, high-spending countries generally exhibited slower rates of growth in per capita health spending, while lower spenders, such as Korea, Spain, Portugal, and the Eastern European members of the OECD, tended to exhibit faster rates of increase. *Id.* at 161 tbls.7.1.1 & 7.2.1. Taking into account the high level of American spending, the United States had an unexpectedly high rate of growth, even though its rate was below the OECD average. *Id.* Also note that an increase in the share of GDP devoted to health care results from health care costs that increase more quickly than does GDP. *Id.* at 162. In Switzerland's case, multiple years of slow GDP growth during the first years of the twenty-first century contributed to an increase in the share of GDP devoted to health care. *Id.* at 163 tbl.7.2.3, 196 tbl.A.10.

96. *Id.* at 17 tbl.1.1.1.

97. *Id.* at 31 tbl.1.8.1.

98. *Id.*

99. *Id.* at 30. While it is often the case that new immigrants have worse health outcomes than the general population, the maternal and child health outcomes of Hispanic immigrants to the United States are an exception, with better outcomes than would be expected after controlling for income and education. See RUBÉN G. RUMBAUT, ASSIMILATION AND ITS DISCONTENTS: IRONIES AND PARADOXES 4-5 (1999), <http://www.hks.harvard.edu/inequality/Seminar/Papers/Rumbaut3.pdf>.

100. See ORG. FOR ECON. CO-OPERATION & DEV., *supra* note 86, at 117 tbl.5.1.1.

101. See HEALTH POL'Y CONSENSUS GRP., OPTIONS FOR HEALTHCARE FUNDING 13,

Switzerland also performs comparatively well on measures of equity in health outcomes and health care utilization,<sup>102</sup> although Switzerland does not escape the universal pattern that richer, better educated people live longer, healthier lives.<sup>103</sup> Interestingly, the equity of Swiss outcomes and utilization does not appear to have changed much since the 1996 reforms went into effect, although perhaps the reforms prevented deterioration in equity.<sup>104</sup>

Switzerland may do worse on measures of the equity of health care financing. A recent analysis by Marcel Bilger concludes that, “by international standard[s,] health system financing is highly regressive in Switzerland.”<sup>105</sup> Bilger argues that Swiss financing is even more regressive than that of the United States, which had been judged the most regressive in earlier work by Eddy van Doorslaer, et al.<sup>106</sup> However, his data excludes cantonal taxation as a source of finance,<sup>107</sup> which is progressive and covers half of hospital operating expenses<sup>108</sup> as well as all hospital capital costs.<sup>109</sup> It is not clear whether the combination of the cantonal financing with IPR subsidies suffice to balance the inherently regressive nature of per capita premiums and the possibly regressive high share of costs covered by out-of-pocket expenditures.

#### IV. MANAGED CARE AND CONSUMER PREFERENCES IN SWITZERLAND

Managed care remains a small part of the Swiss market, with less than ten percent of enrollees,<sup>110</sup> even if we include the “Family Doctor” variant,<sup>111</sup> which probably would not be counted as managed care in the United States. The CBSI component of health insurance is a matter of

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<http://www.civitas.org.uk/pdf/hpcgSystems.pdf>

102. See ORG. FOR ECON. CO-OPERATION & DEV., *supra* note 86, at 151 tbl.6.5.1.

103. LEU & SCHELLHORN, *supra* note 65, at 9-10.

104. ALBERTO HOLLY & MOHAMED BENKASSMI, UNITED NATIONS RESEARCH INST. FOR SOC. DEV., HEALTH AND HEALTH CARE INEQUALITIES IN SWITZERLAND: A BRIEF REVIEW OF THE LITERATURE 1-2 (2003), [http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/CB79D3646056853EC1256E200037E3E0/\\$file/holly.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/CB79D3646056853EC1256E200037E3E0/$file/holly.pdf); LEU & SCHELLHORN, *supra* note 65, at 12-15, 18.

105. Bilger, *supra* note 20, at 1592.

106. *Id.* at 1592 & n.12 (arguing that Eddy van Doorslaer et al., *The Redistributive Effect of Health Care Finance in Twelve OECD Countries*, 18 J. HEALTH & ECON. 291, 302 tbl.1 (1999), underestimated Swiss out-of-pocket costs).

107. See Bilger, *supra* note 20, at 1585-88 (providing a method to compute the redistributive effect of a tax, which does not take into account cantonal taxation).

108. EUROPEAN OBSERVATORY ON HEALTH CARE SYS., *supra* note 10, at 68.

109. *Id.*

110. See *id.* at 43.

111. See *infra* notes 135-36 and accompanying text.

individual consumer choice in Switzerland.<sup>112</sup> With no employer involvement, managed care's low market share can be interpreted as an expression of consumer preference. Whether American preferences would reveal similar patterns if the role of employers were curtailed is an open question.

The one common defining characteristic of managed care is "selective contracting," meaning that the health insurance plan has contracts with a subset of health care providers,<sup>113</sup> and either does not cover care provided by doctors or hospitals outside its contracted network, or limits its coverage of such care.<sup>114</sup> In general, as discussed earlier, LAMal outlaws selective contracting, but it makes an exception for several types of managed care plans that insurers may offer alongside their other coverage packages.<sup>115</sup> The managed care plans are also exempted from using the TARMED fee schedule, if they can find health care providers willing to enter into contracts with them under alternate payment arrangements.<sup>116</sup>

As in the United States, managed care in Switzerland comprises health maintenance organizations ("HMO") and preferred provider organizations ("PPO").<sup>117</sup> However, the Swiss imported the concept of the HMO in the 1980s, and their usage of the term reflects the situation in the United States at the time.<sup>118</sup> In the United States today, the term HMO applies to any health plan that restricts coverage to care provided by the network of providers with whom it has contracts, whether those providers are integrated into a single organization or not.<sup>119</sup> In the Swiss context, the term HMO applies only to a group of physicians who practice in a unified organization (very much like a staff model HMO in

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112. *See id.* at 43-44.

113. *See* Jill A. Marsteller et al., *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL. POL'Y & L. 1133, 1134-35, 1139-40 (1997).

114. LOI FÉDÉRALE SUR L'ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 41a, paras. 1-2 (Switz.).

115. ROBERT E. LEU ET AL., *THE COMMONWEALTH FUND, THE SWISS AND DUTCH HEALTH INSURANCE SYSTEMS: UNIVERSAL COVERAGE AND REGULATED COMPETITIVE INSURANCE MARKETS 2* (2009).

116. *See* HMO, COMPARIS.CH, <http://en.comparis.ch/krankenkassen/info/glossar/hmo.aspx> (last visited Jan. 19, 2011).

117. Zweifel, *supra* note 17, at 940.

118. ROWENA JACOBS & MARIA GODDARD, CTR. FOR HEALTH ECON., *SOCIAL HEALTH INSURANCE SYSTEMS IN EUROPEAN COUNTRIES* 57 (2000), <http://www.york.ac.uk/che/pdf/op39.pdf>; Peter Zweifel, *Managed Care in Germany and Switzerland: Two Approaches to a Common Problem*, 14 PHARMACOECONOMICS 1, 6 (1998).

119. Joseph L. Marcarelli, *When Friends or Patients Ask About . . . : Health Maintenance Organizations*, 235 J. AM. MED. ASS'N 536, 536-37 (1976), available at <http://jama.ama-assn.org/content/235/5/536.full.pdf>.

the United States).<sup>120</sup> HMO personnel always include primary care physicians, and may also include specialist physicians as well as non-physician health care workers.<sup>121</sup> However, Swiss HMO (and PPO) networks do not include hospitals, because by law, CBSI coverage is limited to public hospitals or listed private hospitals, both of which are heavily regulated by the cantons.<sup>122</sup> This means that managed care plans cannot negotiate hospital rate discounts, causing cost savings achieved by Swiss managed care plans to be more limited than those possible for their U.S. counterparts.<sup>123</sup> In some cases, HMOs are owned by the health insurer;<sup>124</sup> in other cases, they are owned by the doctors themselves.<sup>125</sup> Doctors may be paid a salary or a fixed monthly fee per patient (capitation).<sup>126</sup> Individuals who sign up for HMO coverage are freed from the cost-sharing responsibilities (co-insurance and deductibles) otherwise specified under the terms of LAMal,<sup>127</sup> but are restricted to using HMO physicians or outside specialists to whom they are referred by their gatekeeper HMO doctor.<sup>128</sup> Premiums are discounted by about twenty-five percent.<sup>129</sup>

Turning to the PPO variant of managed care, a PPO in the United States is a health plan that has different levels of patient cost-sharing depending on whether or not the care is provided by doctors and hospitals with whom the health plan has contracted for discounted fees.<sup>130</sup> The Swiss PPO maintains a physician list and *only* covers the cost of care from providers on its list.<sup>131</sup> Unlike the HMO, the health care providers on the PPO list are not part of a unified organization,<sup>132</sup> and the individual enrollee is not required to sign up with a single

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120. See JACOBS & GODDARD, *supra* note 118, at 57; Marcarelli, *supra* note 119, at 536-37; Zweifel, *supra* note 118, at 6.

121. JACOBS & GODDARD, *supra* note 118, at 58.

122. CIVITAS: THE INST. FOR THE STUDY OF CIVIL SOC'Y, *supra* note 32, at 5.

123. *Id.* at 3.

124. Béatrice Despland, *HMO*, SOCIALINFO: DICTIONARY SUISSE DE POLITIQUE SOCIALE, <http://www.socialinfo.ch/cgi-bin/dicoposso/show.cfm?id=398> (last visited Jan. 19, 2011).

125. *Id.*

126. *Id.*

127. *Modèle d'assurance: HMO*, *supra* note 51; see LOI FÉDÉRALE SUR L'ASSURANCE-MALADIE [LAMAL] [FEDERAL LAW ON HEALTH INSURANCE], Jan. 1, 2010, RS 832.10, art. 62, paras. 1-2(a) (Switz.).

128. *Modele d'assurance: HMO*, *supra* note 51.

129. *Id.*

130. See Gregory C. Pope et al., *Medicare Preferred Provider Organization Demonstration: Plan Offerings and Beneficiary Enrollment*, 27 HEALTH CARE FIN. REV. 95, 95 (2006).

131. Konstantin Beck, *Waiting for Stronger Integrated Networks of Care*, HEALTH POL'Y MONITOR, Apr. 2008, [http://www.css-institute.ch/en/waiting\\_for\\_stronger\\_integrated\\_networks\\_of\\_care.pdf](http://www.css-institute.ch/en/waiting_for_stronger_integrated_networks_of_care.pdf).

132. Konstantin Beck, *Growing Importance of Capitation in Switzerland*, 3 HEALTH CARE MGMT. SCI. 111, 113 (2000).

gatekeeper physician and does not need referrals to seek care from health care providers so long as they are on the PPO list.<sup>133</sup> Premiums for Swiss PPO coverage are discounted by about twenty percent.<sup>134</sup>

The Swiss also have a “Family Doctor” managed care model in which the individual signs up with a gatekeeper doctor chosen from a list maintained by the insurer. In this case, the gatekeeper is in independent practice and is paid on a fee-for-service basis by the health insurer.<sup>135</sup> Premiums for this model are discounted by five to fifteen percent.<sup>136</sup>

Finally, the Swiss have developed a “TelMed” model, which requires the individual to phone a medical counsel center before visiting the doctor, except for certain types of specified preventive care, such as an annual gynecological exam.<sup>137</sup> Premiums for TelMed model coverage are discounted up to fifteen percent.<sup>138</sup> All of these discounts are close to their regulated maximum values.<sup>139</sup>

In the United States, the vast majority of individuals with employer-sponsored coverage are enrolled in managed care plans,<sup>140</sup> with U.S.-style PPOs the dominant form of coverage.<sup>141</sup> In Switzerland, however, the various models of managed care have achieved less than ten percent market share,<sup>142</sup> with the Family Doctor and Swiss-style PPO accounting for the lion’s share of Swiss managed care enrollment.<sup>143</sup> Consumers have preferred to retain unrestricted provider choice while opting for higher deductibles to benefit from premium reductions.<sup>144</sup>

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133. *Modèle d’assurance: PPO—Light [Insurance Model: PPO—Light]*, BONUS.CH, <http://www.bonus.ch/Assurance-maladie/Modeles-assurance/PPO-Light-modele-assurance.aspx> (last visited Jan. 19, 2011).

134. *Id.*

135. *Modèle d’assurance: médecin de famille [Insurance Model: Family Doctor]*, BONUS.CH, <http://www.bonus.ch/Assurance-maladie/Modeles-assurance/Medecin-famille-modele-assurance.aspx> (last visited Jan. 19, 2011).

136. *Id.*

137. *Modèle d’assurance: telmed (télémédecine) [Insurance Model: TelMed (Telemedicine)]*, BONUS.CH, <http://www.bonus.ch/Assurance-maladie/Modeles-assurance/Telmed-modele-assurance.aspx> (last visited Jan. 19, 2011).

138. *Id.*

139. *Krankenversicherung: Alle Versicherungsmodelle [Health Insurance: Insurance Models]*, BONUS.CH, <http://www.bonus.ch/Krankenversicherung/Informationen/Verschiedene-Versicherungsmodelle-HMO-Hausarzt.aspx> (last visited Jan. 19, 2011).

140. *Managed Care and the States*, NAT’L CONFERENCE OF STATE LEGISLATURES (last updated Jan. 2011), <http://www.ncsl.org/default.aspx?tabid=14470>.

141. KAISER FAMILY FOUND. & HEALTH RES. & EDU. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 65 (2010), available at <http://ehbs.kff.org/pdf/2010/8085.pdf>.

142. Beck, *supra* note 131.

143. LEU ET AL., *supra* note 115, at 17; Beck, *supra* note 131.

144. Although recall that this applies only in the ambulatory sector. Free choice of hospital physician requires supplemental coverage, in addition to CBSI coverage. Beck, *supra* note 131; *see*

The choice experiments referenced above<sup>145</sup> may help explain managed care's low market share in Switzerland in general and in its French-speaking part in particular.<sup>146</sup> These experiments were designed to elicit consumers' preferences in the guise of willingness-to-pay ("WTP") values.<sup>147</sup> The status quo was a conventional plan with no restrictions on out-patient provider choice; the alternative, a plan with managed care features but a lower premium.<sup>148</sup> Key findings included:

- WTP to avoid restrictions on physician choice amounts to 38% of the average premium for conventional coverage, which clearly exceeds the 25% reduction offered for an HMO plan and the 20% offered for a PPO plan.<sup>149</sup> However, the WTP value of the 38% figure represents an average across all consumers.<sup>150</sup> For low-income consumers, the figure drops to 24%, while it exceeds 50% among high-income consumers.<sup>151</sup>
- For a country of no more than 7.6 million inhabitants, there is an amazing regional heterogeneity in WTP values.<sup>152</sup> In the French-speaking western part of the country, WTP to avoid restrictions on provider choice is almost twice as high as among German-speaking consumers.<sup>153</sup> Similar differences were found with regard to other managed care features such as hospital choice restrictions to more centralized regional units.<sup>154</sup>
- As one would expect, WTP values increase with age and are

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CIVITAS: THE INST. FOR THE STUDY OF CIVIL SOC'Y, *supra* note 32, at 4.

145. *See supra* note 85.

146. Karolin Becker & Peter Zweifel, *Age and Choice in Health Insurance: Evidence from a Discrete Choice Experiment*, 1 *PATIENT* 27, 32 (2008).

147. *Id.* at 28.

148. *Id.* at 31.

149. Acceptance of a physician list based on cost criteria would require 103 Swiss francs, while the nationwide average premium was 270 Swiss francs. *See* Zweifel et al., *supra* note 85, at 325.

150. *See id.*

151. To fully measure willingness to pay for conventional versus managed care, one should also account for managed care's reduction in cost-sharing. From another choice experiment (involving a different sample), avoiding twenty percent co-insurance (rather than being able to keep with the current ten percent rate) was estimated to be worth eight percent of average premium. Becker & Zweifel, *supra* note 146, at 35. Since going from ten percent to no co-insurance at all may be even more highly valued, the net compensation required for the average Swiss to accept restrictions on physician choice may amount to twenty-seven percent of average premium or even less. *See id.*

152. Zweifel et al., *supra* note 85, at 327 tbl.3, 328, 330; *The World Factbook: Switzerland*, CENT. INTELLIGENCE AGENCY, <https://www.cia.gov/library/publications/the-world-factbook/geos/sz.html> (last updated Jan. 20, 2011).

153. Zweifel et al., *supra* note 85, at 327 tbl.3, 328.

154. *See id.* at 328.

about 60% higher among individuals who were hospitalized during the preceding year than among those who are in good subjective health.<sup>155</sup> Again, similar differences in WTP values also apply to other features of managed care.

It would evidently take higher premium discounts to make managed care acceptable to the average Swiss citizen. Internal records provided by a major health insurer on costs in its conventional and managed care plans suggest that far higher discounts than those permitted would be possible in principle.<sup>156</sup> However, these records also indicate that managed care enrollees tend to switch to a conventional plan as soon as they expect major health care expenditures.<sup>157</sup> Risk selection, therefore, occurs not only on the part of insurers but on the part of consumers as well.

## V. TENTATIVE LESSONS FROM SWISS EXPERIENCE

In the United States, many of the advocates of moving insurance choices (and the costs of those choices, at least at the margin) to the individual consumer have assumed that empowered and accountable individuals would choose “cost-effective” managed care delivered by tightly integrated health care provider networks.<sup>158</sup> Yet in Switzerland, which more closely approximates this model than does the United States, managed care has remained a small part of the market for health coverage, and HMOs with integrated physician organizations enroll only a minority of the small fraction of consumers who choose managed care.<sup>159</sup> Empirical work reveals that this is no fluke. Swiss consumers are willing to pay a substantial premium to maintain their choice of outpatient health care provider.<sup>160</sup> In the United States, individuals with employer-provided coverage often do not control the decision whether or not to enroll in managed care—to a large degree, their employer (sometimes in negotiation with their union) makes this choice for them.<sup>161</sup> Most Medicaid beneficiaries also must enroll in managed care

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155. *Id.* at 327 tbl.3, 328.

156. *See id.* at 330-31.

157. *See* Christiaan J. Lako et al., *Switching Health Insurance Plans: Results from a Health Survey*, 18 HEALTH CARE ANALYSIS 6 (2010), <http://www.springerlink.com/content/x304261672n15278/fulltext.pdf>.

158. Alain Enthoven, *Health Care with a Few Bucks Left Over*, N.Y. TIMES, Dec. 28, 2008, at WK9.

159. *See* Beck, *supra* note 131.

160. *See* Iva Bolgiani et al., *The Role of Health Insurance in Regulating the Swiss Health Care System*, 6 REVUE FRANÇAISE DES AFFAIRES SOCIALES 227, 234 & fig.1 (2006), [http://www.cairn.info/load\\_pdf.php?ID\\_ARTICLE=RFAS\\_EN606\\_0227](http://www.cairn.info/load_pdf.php?ID_ARTICLE=RFAS_EN606_0227).

161. *See* Enthoven, *supra* note 158 (“[M]ost employers offer workers no choice of insurance

as a condition of coverage.<sup>162</sup> American political, economic, and health policy elites embraced managed care in the 1980s and 1990s as the supposed solution to America's acute problems with escalating health care costs.<sup>163</sup> Yet other wealthy democracies, including Switzerland, have better track records on cost control than does the United States, despite a much more limited use of managed care approaches.<sup>164</sup>

Why costs seem to be easier to control in countries that do not use the type of managed care programs seen in the United States is a question on which the authors of this Article have somewhat different perspectives. One of the authors (Kreier) feels that the Swiss systems of regulated and negotiated prices, whatever their imperfections, are the key to the comparative success of Swiss cost control. While American managed care organizations do negotiate steep discounts in doctor, hospital, and pharmaceutical prices relative to prices paid by other payers, Kreier believes they have not been successful at controlling the average level of health care prices. Instead, the fragmented negotiation process has driven greater price variation, with different providers receiving different rates for the same service from the same payer, and with each individual provider receiving different rates for the same service from different payers. The fragmentation also increases administrative costs. Commonly, the weakest payers, including small employers and individuals without insurance, end up paying the highest prices.<sup>165</sup> Medicaid consistently pays less than either Medicare or commercial payers.<sup>166</sup> Two-tier, or multi-tier, health care is already evident in the U.S. market. Its contribution to socioeconomic disparities in health outcomes is only likely to increase as more and better information becomes available about provider quality.

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companies.”).

162. See KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 14, at 18 (explaining how the Medicaid Program is set up to work with the private healthcare market, and identifying that “[i]n 2008, about 70% of Medicaid enrollees received some or all of their services through managed care arrangements”).

163. *Insurance Premiums Still Rising Faster than Inflation and Wages*, N.Y. TIMES PRESCRIPTIONS (Sept. 15, 2009, 10:00 AM), <http://prescriptions.blogs.nytimes.com/2009/09/15/insurance-premiums-still-rising-faster-than-inflation-and-wages/> (“Since the country backed away from H.M.O-style managed care in the late 1990s, it has been without ‘a new answer to the rising cost of health care.’”).

164. See Schwartz, *supra* note 4 (describing how the Swiss health care system, although based in consumer choice, leads to lower costs than those in the United States, for the national income as a whole, as well as for individual citizens).

165. Gina Kolata, *Medical Fees Are Often Higher for Patients Without Insurance*, N.Y. TIMES, Apr. 2, 2001, at A1.

166. Stephen Zuckerman et al., *Trends in Medicaid Physician Fees, 2003–2008*, 28 HEALTH AFF. w510, w510 (2009), <http://content.healthaffairs.org/content/28/3/w510.full.pdf+html>.

Zweifel, on the other hand, challenges upfront the tenet that cost concerns should be at the center of attention, arguing that consumers in their daily lives look at cost-benefit ratios or “value for money” (precisely what the standard textbook model of consumer choice predicts). Therefore, policy should be designed to enable individuals to choose plans that offer value for money, even if that entails a lot of money. At least if under sufficient pressure of competition (and that is a big “if” in both countries), health insurers need to act as prudent purchasers of health care services in order to offer value for money. According to this line of thought, Swiss managed care already makes a contribution to improving cost-benefit ratios by offering products that match the preferences of a (small) subset of the population.<sup>167</sup> It could make an even greater contribution if it were freed from its current constraints, including the requirement to negotiate prices with cantonal hospital associations. As to pharmaceutical and medical device benefits and prices, insurers are obliged to accept nationwide uniform schedules. And most importantly, the “Buy Swiss” principle governs the basic benefits package. This serves to protect domestic service providers and pharmaceutical companies from international competition, which otherwise would keep prices and qualities in line in a small country that relies on imports for almost everything. Admittedly, insurers would have to learn to negotiate, while antitrust authorities would have to learn to effectively prevent collusion and market closure, both on the part of health insurers and health care providers.

Zweifel also argues that the imposition of community rating, which forces price (premium) to differ from marginal cost (expected future health care expenditure), is both inefficient and unnecessary to achieve solidarity in the context of the Swiss system of IRP subsidies. In the absence of community rating, this means-tested subsidy scheme would make rich but sickly persons pay their own premiums, while benefiting citizens who are both sickly and poor, since any premium in excess of eight percent of income would be subsidized away. However, it is at this juncture that concerns about cost reappear. Citizens who finance the premium subsidy through their tax payments are interested in cost control because it keeps these subsidies low (or from rising very fast due to medical innovation). Ultimately, one would have to measure citizens’ willingness to pay for income redistribution designed to grant the poor access to health insurance coverage that also comprises the newest in medical technology.

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167. See *supra* notes 110, 112 and accompanying text.

Some researchers have concluded that Swiss HMOs, at least, save more on costs than the twenty-five percent discount they are allowed to offer on premiums.<sup>168</sup> Perhaps if premium discount restrictions were lifted, HMO premiums would fall relative to traditional coverage and HMOs would garner a greater market share. But, as the FOSI has noted, this might seriously challenge the Swiss devotion to solidarity if enrollment became segregated along income lines, with lower income Swiss concentrated in lower-price managed care products.<sup>169</sup> Whether or not such a segregation, if it were to come to pass, would chip away at Switzerland's track record of low levels of health disparities is an open question. Both authors agree that the answer depends very much on whether the level of premium subsidization will continue to be sufficient to permit lower income beneficiaries to enroll in a conventional plan.

We also agree that the Swiss record on health disparities should give pause to those in the United States who believe that the expansion of public coverage is the only way to ameliorate the condition of the poor and working classes. The Swiss present everyone, rich or poor, with the same menu of choices among competing health insurers, while their system of subsidies makes coverage reasonably affordable for everyone. Both of us agree that this approach is more egalitarian than that of the United States, which consigns those with low incomes to a Medicaid program that pays doctors and hospitals at rates substantially below those paid by either Medicare or commercial insurers.<sup>170</sup>

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168. See LEU ET AL., *supra* note 115, at 17; Hansjörg Lehmann & Peter Zweifel, *Innovation and Risk Selection in Deregulated Social Health Insurance*, 23 J. HEALTH & ECON. 997, 998 (2004).

169. See OFFICE FEDERAL DES ASSURANCES SOCIALES, *supra* note 41, at 65-66.

170. See Zuckerman et al., *supra* note 166, at w510. The ACA will increase the rates Medicaid pays primary care doctors to match the Medicare rates, but does nothing to address disparities in specialist and hospital fee schedules. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1202(a)(1)(C), 124 Stat. 1029, 1052.