

# Health Insurance in Chile

**World Health Organization**

July 1999

Cristian Baeza

Latin American Center for Health Systems Research

# Chile 1998

- ✓ Population: 14.7 mill.
- ✓ GDP/ capita: US\$ 5.600
- ✓ Pop. > 60 : 9.6%
- ✓ % GDP in Health: 6,0 - 7,1%
- ✓ 90% formal insurance coverage
- ✓ Life expectancy 76 (79/74)
- ✓ Infant Mort.: 11 o/oo

# Chilean Health System

(1952-1980)

	Mandatory, Public	Voluntary, Private
Regulation	MoH	
Revenue Collection	MoF (75%), <b>SS (15%)</b> G. Tax: 85% P. R. Tax: 15% Co-Pay : 0%	Providers (10%) Out of pocket : 95%
Pooling	NHS: 75% <b>SS: 15%</b>	
Purchasing	NHS: 75% <b>SS: 15%</b>	
Provision	Public (90-98%) & Private (10-2%)	

## Social Security Reform in the late 70's

- ✓ Significant health sector restructuring, simultaneously with Privatization of the Pension System, reforms of the Financial Market and privatization of most state enterprises.
- ✓ The National Health Service was abolished, decentralizing the management of provision to 26 regional units and separating the “financing administration” (no purchasing) to The National Health Fund--FONASA (Social Health Insurance + GT subsidies for the poor).
- ✓ Contributing /purchasing health insurance was made mandatory but, contributors were allowed to “choose” Private Health Insurance (ISAPRE) or FONASA.
- ✓ Significant Reduction of fiscal expenditures and significant increase in mandatory salary based contributions.

# National Health Fund v/s Private Insurance

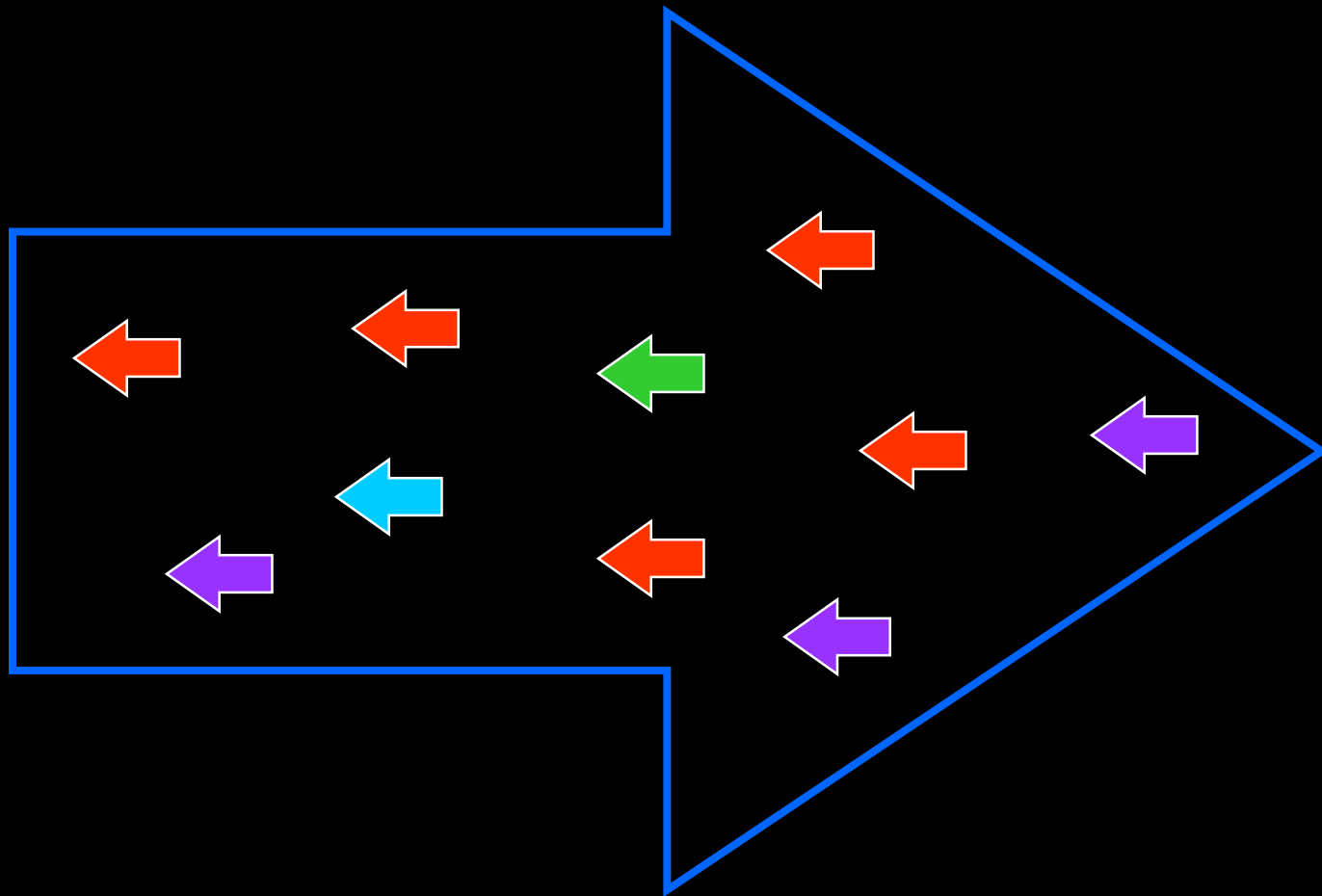
- ✓ **FONASA: population based atypical Social Insurance** (It is an atypical social insurance given that it also receives general taxation to finance services for the poor and the elderly, it can not adjust the premium to the risk or charge more than the pay-role-tax, it is obligated to receive anybody from the ISAPRE system within a month of notice).
- ✓ **ISAPREs: individual risk based private insurance.** It uses the pay-role-tax contribution as the basis for the premium. There is no minimum compulsory coverage and Isapres are allowed to request more contribution for the premium to match an specific benefit package and/or adjust the benefit package to match the premium (pay-role-tax)

# Chilean Health System

(1952-1990)

	Mandatory, Public	Mandatory, Private
Regulation	MoH, MoH	MoH, Regulatory Agency
Revenue Collection	MoF (55%) G. Tax: 20% P. R. Tax: 25% Co-Pay : 10%	ISAPRE (45%) P.R.Tax: 41% Co-payment: 4%
Pooling	FONASA 55% 71%	ISAPRE 45% 15%
Purchasing	FONASA (90% / 10%)	ISAPRE (5% / 95%)
Provision	Public (50-88%) & Private (50-8%)	

# Big Bang during the 80's, small Bangs during the 90's



# Chilean Health System

(1997)

	Mandatory, Public	Mandatory, Private
Regulation	MoH, MoH	MoH, Regulatory Agency
Revenue Collection	MoF (63%) G. Tax: 42% P. R. Tax: 17% Co-Pay : 4%	ISAPRE (37%) P.R.Tax: 33% Co-payment: 4%
Pooling	FONASA 63% 69%	ISAPRE 37% 28%
Purchasing	FONASA (90% / 10%)	ISAPRE (5% / 95%)
Provision	Public (50-88%) & Private (50-8%)	

# Private - Public Interaction

Private, risk related, Market

Public, salary related,  
Command and Control

Insurance

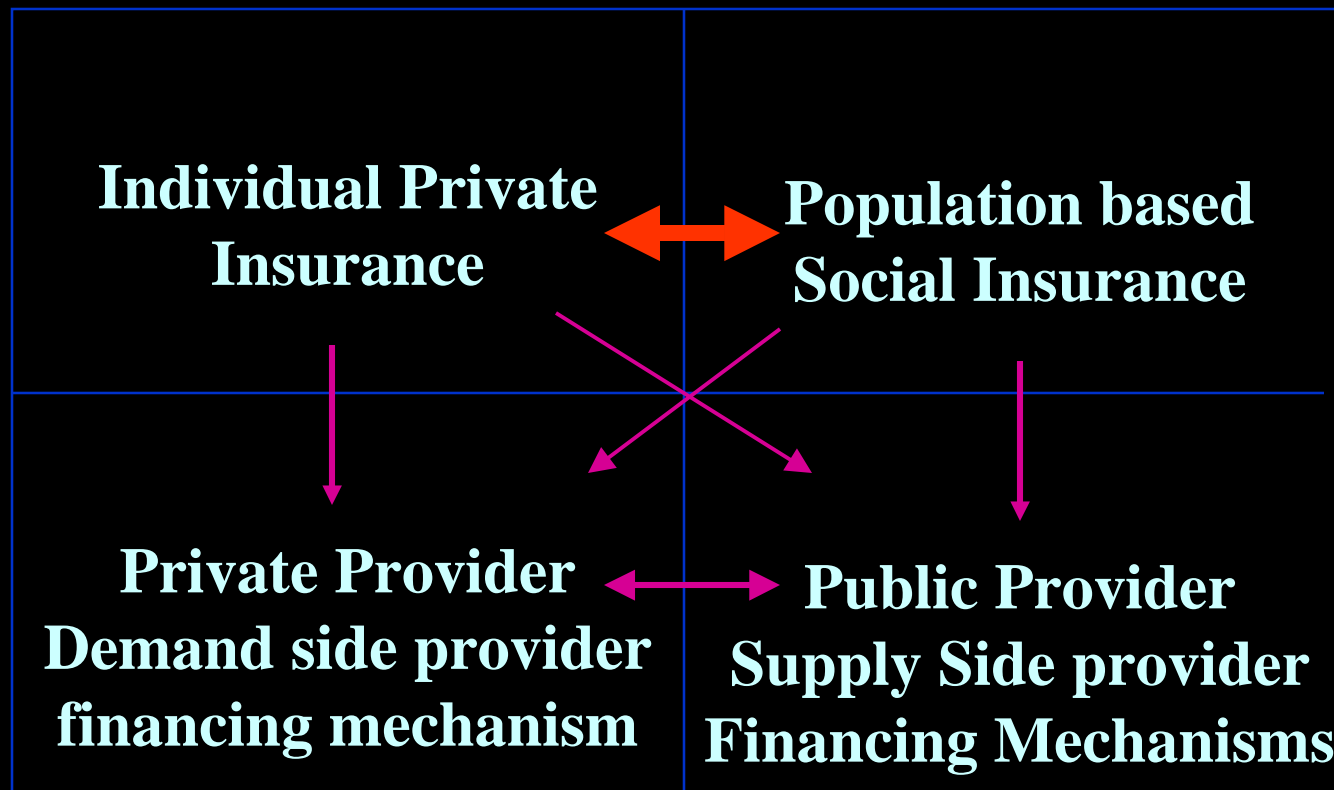
**Individual Private  
Insurance**

**Population based  
Social Insurance**

Provision

**Private Provider**  
**Demand side provider**  
**financing mechanism**

**Public Provider**  
**Supply Side provider**  
**Financing Mechanisms**

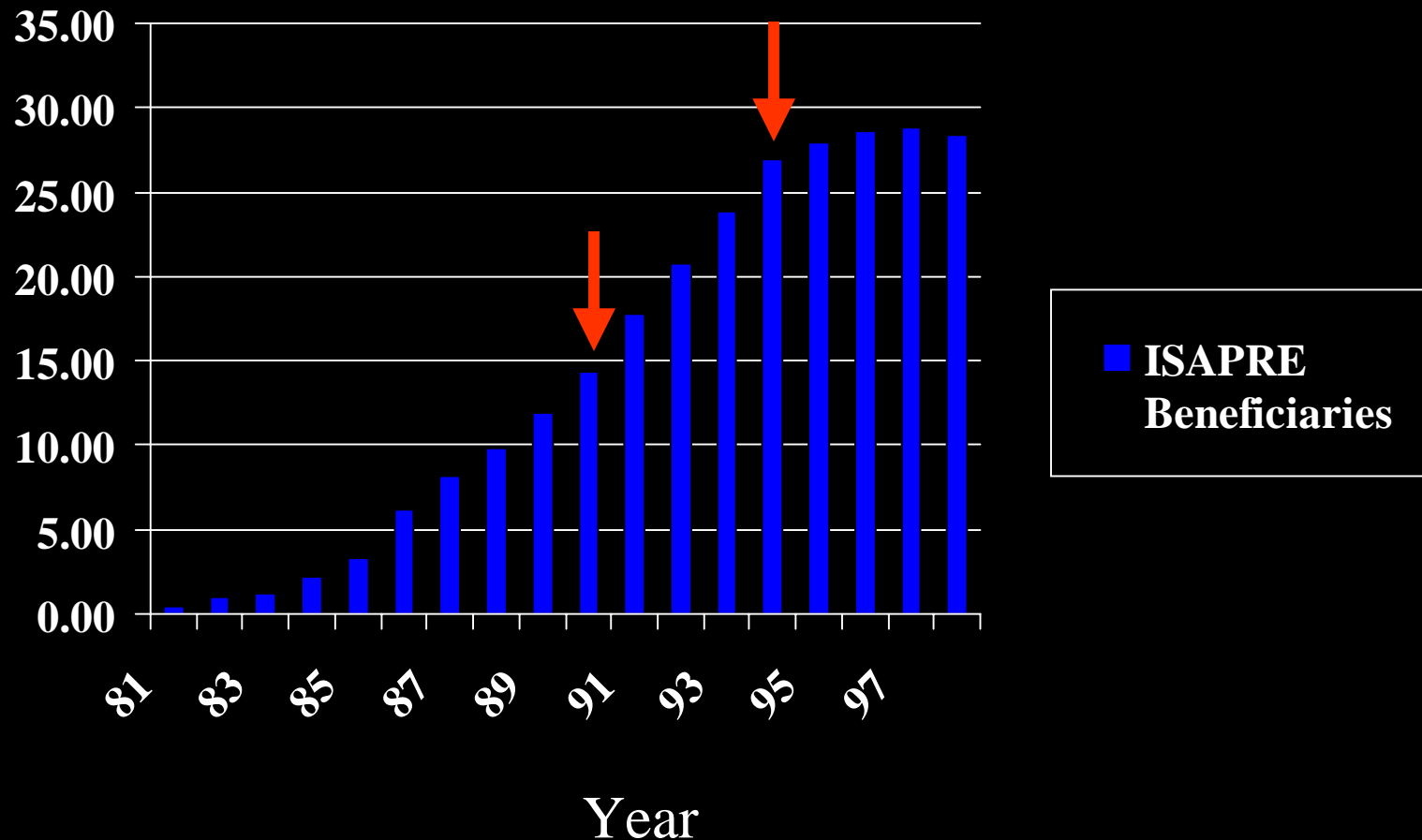


# ISAPRE population

Total beneficiaries as % of total population (1981-1998)

% of total population

Source: ISAPREs Association, 1999.



# Two areas of problems in the Insurance Market

- ✓ Intrinsic insurance competition problems:
  - ❑ Risk selection, particularly in non risk related premium environment
  - ❑ income cream skimming and,
  - ❑ “under service / coverage”, although not exclusive in insurance competition
- ✓ Cost Control

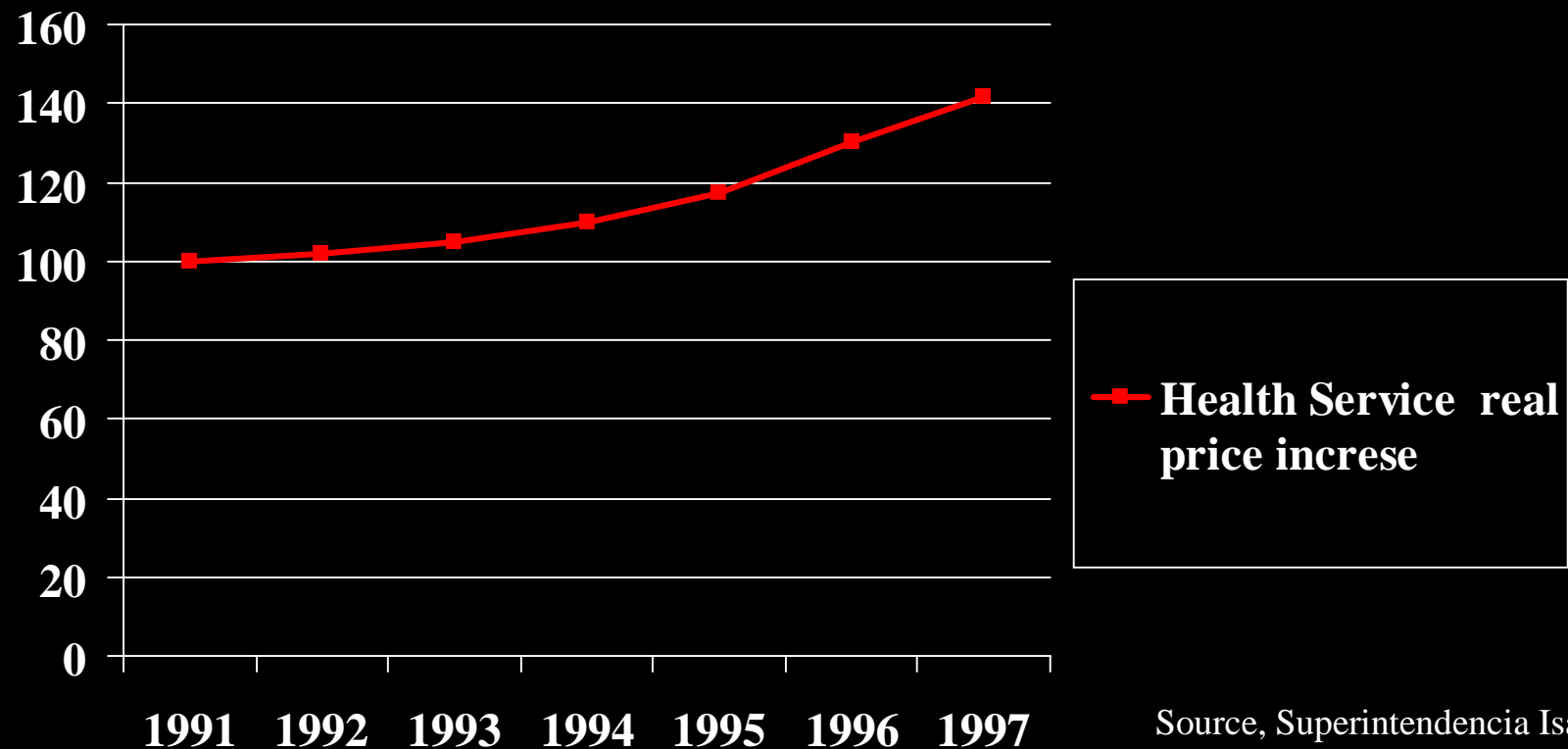
# The cost control problem

- ✓ High administrative costs
  - ❑ Short term contracts (one year), determine the need for significant marketing and commercialization efforts
  - ❑ More than 3500 different insurance plans demand significant contract management efforts
  - ❑ High claim processing costs mainly due the predominance of fee-for-service and lack of investments in technology
- ✓ High financial costs, due to high reinsurance / solvency margins and “guaranties” for small Isapre
- ✓ Health services costs explosion in the last 4 years

# Cost explosion

ISAPREs yearly real increase in health service prices: 1994-97

Relative aggregated technical cost. 1991 = 100



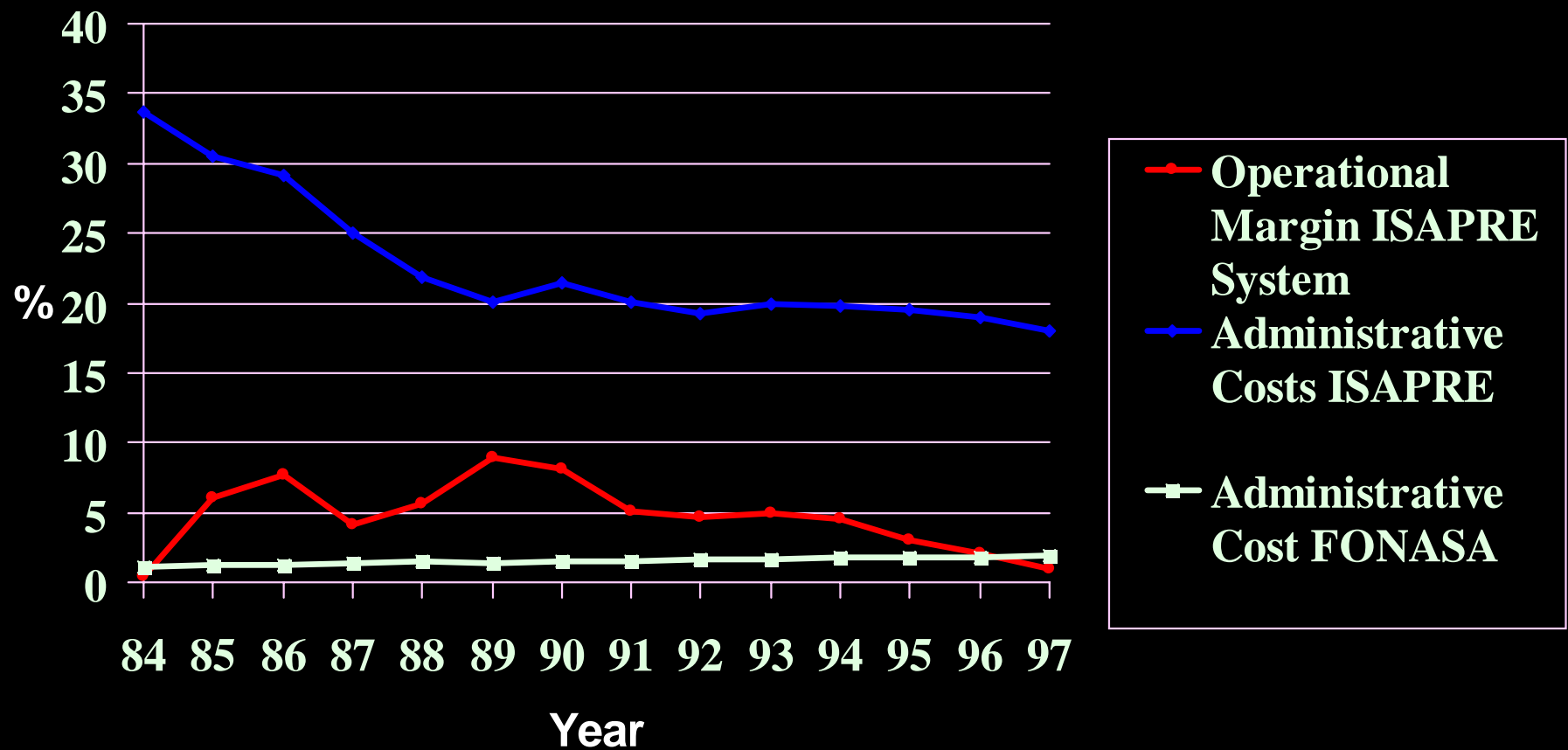
Source, Superintendencia Isapres and FONASA.

1991 and 1992, estimated

# Financial Performance ISAPRES

## 1984 - 1997

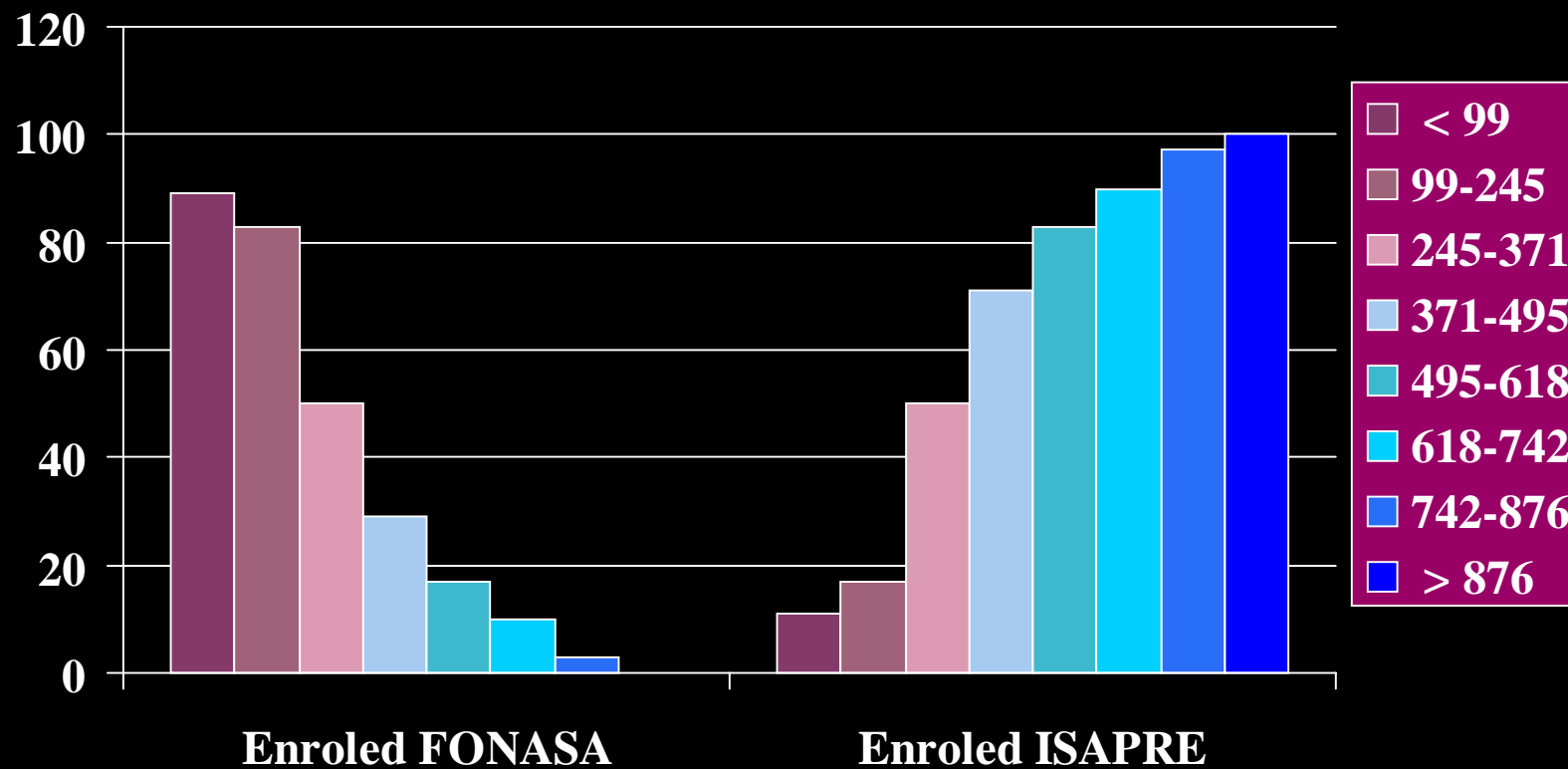
Source: FONASA, Superintendencia y Asociacion de iSAPRES, 1998



# FONASA and ISAPREs Population by income of principal (1994)

Source: ISAPRE Association and FONASA, 1995

% of all formal workers in the income category

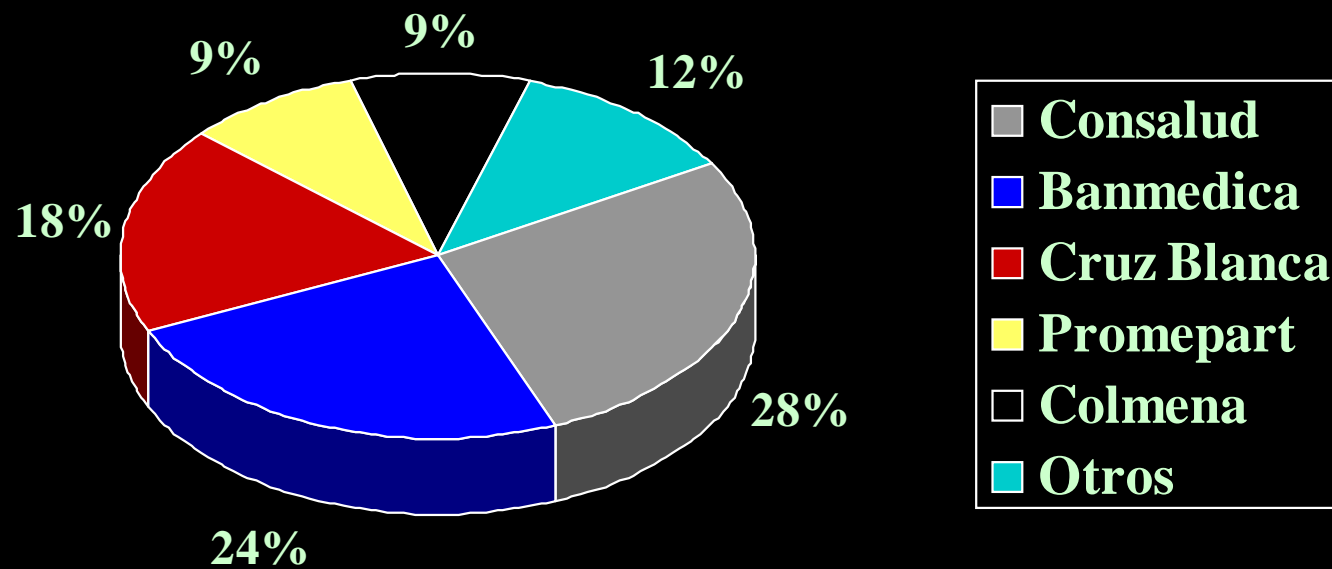


# What to do?

## ✓ Cost Control

- ❑ For more than 15 years ISAPRE responded to technical cost increase through premium increase. Average ISAPRE consumer is paying 9% of salary (in contrast to the mandatory 7%)
- ❑ Isapres already have the incentives to address the problem
- ❑ Will they have the capacity (technical-managerial and political)
  - Significant merging process
  - Introduction of managed care techniques

# Strong Merging Trends and the Introduction of Managed Care



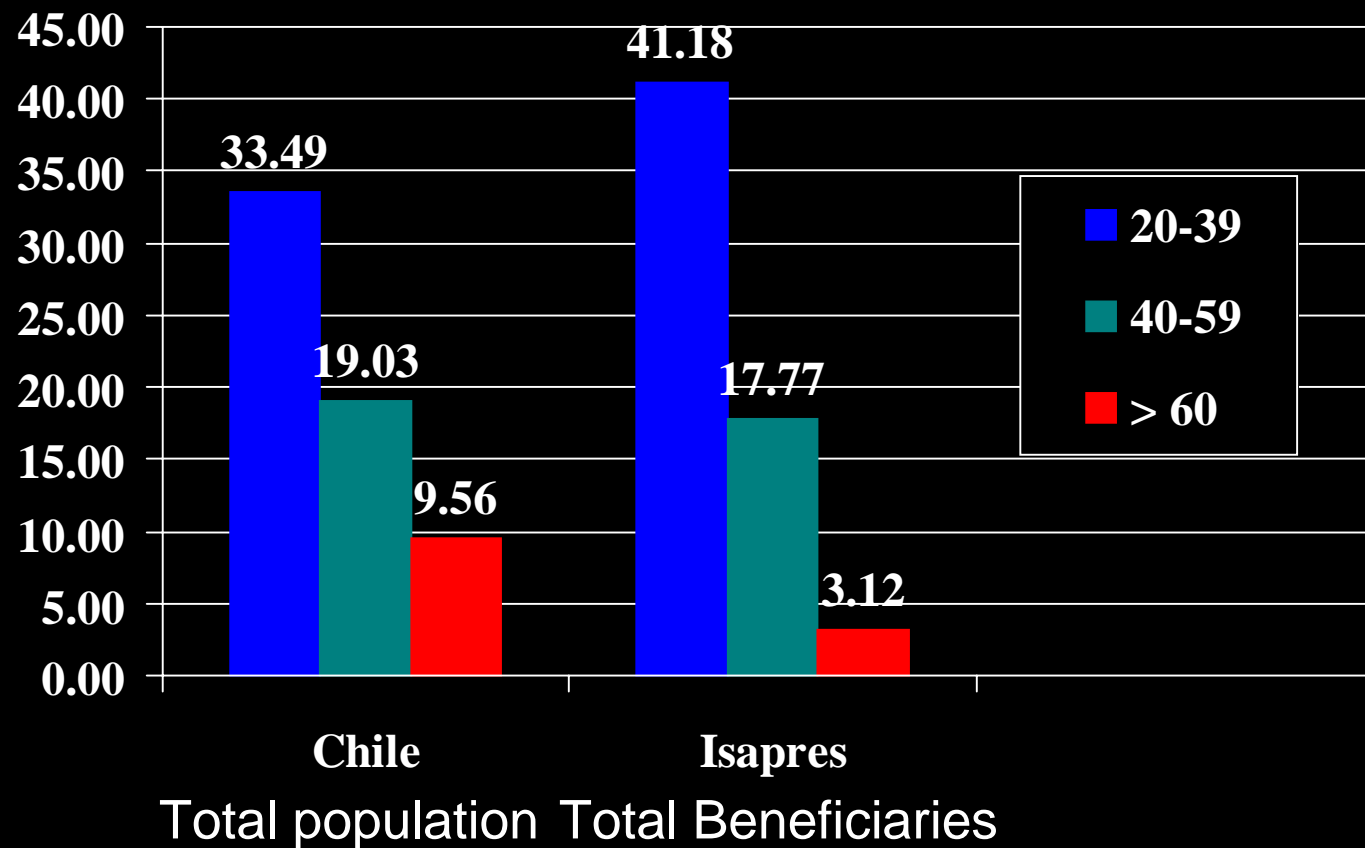
# Intrinsic Competition Problems

- ✓ No regulatory agency except for the MoH until 1990 and very weak regulation regarding consumer protection
- ✓ ISAPREs were allowed to unilaterally terminate the contract and/or introduce pre-existence and exclusions (until 94)
- ✓ The existence of FONASA and its non risk related premium (pay-role-tax) has made easier risk selection and income cream skimming
- ✓ All resulted in significant “Income Cream Skimming”, “Risk Selection” and “under service / coverage” behavior.

# Age structure, Chile and ISAPREs, 1994.

(excluding population under 20 yr.)

% of total



# What to do?

- ✓ Risk Selection, Cream Skimming, Under service
  - ❑ ISAPREs not only do not have the incentives to change this but they have the incentives to oppose significant reforms. This is what has happened in the last 10 years in the system
  - ❑ However, cost control problems, determining premium inflationary pressure is beginning to be a potential threat to labor cost. The threat of losing economic competitiveness might trigger reform.
  - ❑ Aging of ISAPRE cohorts also is creating significant pressure in the ISAPRE system
  - ❑ Roll of FONASA

# Options

- ✓ Maintain multiple competing insurance
- ✓ Mandatory Single Insurance

# Options:

## Maintain multiple competing insurance

- ✓ Accept risk selection and income cream skimming leaving FONASA as the explicit insurance of last resource in the context of the subsidiary role of the state in the Health Sector.
- ✓ Transform FONASA into an Isapre competing in the market and let the state subsidize health insurance premiums for the poor and high risk population. MoF would manage premium subsidies?
- ✓ State premium subsidy for the poor and “medically poor” (high risk), leaving FONASA as a “Premium Subsidy administrator” and possibly, for risk adjustment complexity reasons, as separate pool for catastrophic diseases

# Issues

- ✓ Besides the income identification issues, state premium subsidy for the poor and “medically poor” requires both, the administrator to set right premium and subsidy mechanisms.
- ✓ Introduction of regulation and premium subsidy to reduce “risk selection”, “cream skimming” and “under service” behavior
  - Is it technically feasible? : The complexity of setting effective “risk adjustments” to get the correct premium (not too far lower than the insurer would predict, maintaining the incentive for risk but, not too high that would determine excessive profit by the insurer and probably unaffordable fiscal impact)
  - Can Chile afford it? The administrative and transaction costs involved

# Options:

## Mandatory Single Insurance

- ✓ Reforming FONASA to become the Single Mandatory Social Insurance with or without competing private insurance for voluntary additional coverage.

# Issues

- ✓ Can Chile avoid the traditional problem of Single Social Insurance being captured by vested interests, as seems to be the tradition in LAC?
  - ❑ Fiscal: Social insurance revenues being used for other purposes
  - ❑ Unions: Lobby on prices and payment mechanisms
  - ❑ Politicians: Influence Social Insurance behavior beyond beneficiaries interests
- ✓ Is it possible to set incentives in the absence of competition to minimize monopolistic behavior resulting in lack of innovation, low population satisfaction?
- ✓ Cost containment even under single social insurance will probably require risk sharing agreements with providers. Risk adjustment issues are therefore inevitable
- ✓ Any reform of FONASA either towards single insurance, towards FONASA competing with ISAPREs or towards becoming the “premium subsidy administrator” requires a radical change of the traditional supply side subsidy within the public sector

# What direction will it take?

✓ Depends on Political and Technical issues

✓ ***Political***

- ❑ Will the lobby capacity of ISAPREs block substantial reform as they have managed to do so for more than 8 years?
- ❑ Will the public sector be politically able to implement demand side type of provider financing consolidating FONASA as the purchaser from both, private and public providers, all this seen as a requirement for increasing efficiency and “client” responsiveness?
- ❑ Will it be possible to obtain for FONASA an autonomous status separated from fiscal, political and union interest?
- ❑ Will the idea of an explicit benefit package be accepted politically?

# What direction it will take?

## ✓ **Technical**

- ❑ Is it possible for Chile to design, implement and efficiently manage a risk and income equalization fund/formula containing enough incentives to avoid cream skimming and risk selection?
- ❑ If technically possible, how much it will cost to manage it? Do we have the institutional capacity and financial resources to do so?

# Life has not been easy for Ministers of Health in Chile

- ✓ Just after taking office: “All reforms should have been implemented a long time ago”
- ✓ After the first year in office: “Priority reforms will be implemented during the next months”
- ✓ After the second year in office: “Some reforms will be implemented after the elections”



To be continued...

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**For many years...**