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MANAGED CARE REGULATION: CAN WE LEARN FROM OTHERS? THE CHILEAN EXPERIENCE

Timothy Stoltzfus Jost*

Because the United States relies on private insurance for financing health care to a much greater degree than do other nations, and because managed care as a form of private insurance is further developed in the United States than elsewhere, it is arguable that we have little to learn from other nations about managed care regulation. This Article tests this hypothesis with respect to Chile, a country where private insurance is widespread and managed care is emerging. It concludes that by studying the experience of other nations we might gain a larger perspective on the context of our concerns in regulating managed care, in particular appraising more soberly the difficulties we face in regulating private health insurance markets; understand more fully the importance of attempting the difficult task of regulation; and appreciate more completely our responsibility for sharing with the rest of the world our insights into managed care regulation. We may even find regulatory tools that others have created that might help us with our tasks.

INTRODUCTION

What lessons can we in the United States learn from other nations about how to regulate managed care? At first glance it would appear that there is relatively little to learn. The United States' system of health care finance is so idiosyncratic that the rich experience of other nations in designing health care systems is largely inaccessible to us.

To begin, a nation cannot have regulation unless it has a private sector to regulate. A government manages a national health insurance program; one does not regulate it. While virtually every country in the world has a private health insurance industry, in most places private health insurance plays a very different role than it does in the United States.¹ In countries with universal public

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1. See Deborah J. Chollet & Maureen Lewis, *Private Health Insurance: Principles and Practice*, in *INNOVATIONS IN HEALTH CARE FINANCING: PROCEEDINGS OF A WORLD BANK CONFERENCE*, MARCH 10–11, 1997, at 77, 104–09 tbls.1–2 (George J. Schieber ed., World Bank Discussion Paper No. 365, 1997) [hereinafter *INNOVATIONS IN HEALTH CARE FINANCING*] (describing the role of private health insurance in 10 OECD and 36 non-OECD countries).

health services (the Beveridge model),² persons who purchase private health insurance do so in order to obtain health services more quickly and conveniently, in more pleasant settings, or from more prestigious professionals than is possible under the public system to which they also have access.³ In the United Kingdom, for example, persons rely on private insurance normally to permit queue-jumping for certain kinds of surgery,⁴ while in Australia private insurance pays for hospital care in private facilities.⁵ In some countries with social health insurance systems (the Bismark model),⁶ on the other hand, private health insurance is limited to persons, usually with high incomes, who are not legally obligated to participate in the national social insurance program.⁷ This is the situation, for example, in Germany and the Netherlands.⁸ Finally, in a few countries, such as Canada, private health insurance is only permitted to cover services excluded from coverage under the national health insurance scheme.⁹ In only a handful of countries other than the United States—South Africa, South Korea, and several Latin American countries—is private health insurance extensively relied on by the general population as a primary source of payment for basic health care services.¹⁰

2. The 1942 Beveridge Report on Social Insurance and Allied Services laid out the model for what became the British National Health Service. Under the Beveridge national health service model, health care is funded by general taxation, and services are directly available to patients generally free at point of service. See JUDITH ALLSOP, *HEALTH POLICY AND THE NHS, TOWARDS 2000*, at 24–25 (2d ed. 1995).

3. See Chollet & Lewis, *supra* note 1, at 79.

4. See ALLSOP, *supra* note 2, at 163–64.

5. See Chollet & Lewis, *supra* note 1, at 79.

6. Chancellor Bismark is credited with the creation of the German social insurance system in the 1880s. See RICHARD KNOX, *GERMANY'S HEALTH CARE SYSTEM: ONE NATION, UNITED WITH HEALTH CARE FOR ALL* 26–27 (1993). Under the German system, health care is funded through social insurance funds that are financed through mandatory wage-based premiums and used to pay health care providers for services provided their members. See *id.* at 53–58.

7. See Chollet & Lewis, *supra* note 1, at 79.

8. See I FINANCING HEALTH CARE 427–28, 718–19 (Ullrich K. Hoffmeyer & Thomas R. McCarthy eds., 1994).

9. See Chollet & Lewis, *supra* note 1, at 104.

10. See Chollet & Lewis, *supra* note 1, at 104–08. Since 1989, most Koreans have been required by law to purchase health insurance, which some describe as private insurance, see *id.* at 92, though the insurers resemble the sickness funds of central Europe. See Bong-Min Yang, *Health Insurance in Korea: Opportunities and Challenges*, HEALTH POL'Y & PLAN., June 1991, at 119; Bong-Min Yang, *The Role of Health Insurance in the Growth of the Private Health Sector in Korea*, 11 INT'L J. HEALTH PLAN. & MGMT. 231, 246 (1996); Seung-Hum Yu & Gerard F. Anderson, *Achieving Universal Health Insurance in Korea: A Model for Other Developing Countries?*, 20 HEALTH POL'Y 289, 290 (1992). In South Africa, 16% of the population is covered by private insurance, including 69% of the white and 7% of the black population. See Chollet & Lewis, *supra* note 1, at 108. A national health insurance program is being developed in South Africa under the Constitution. See Department of Health, *White Paper for the*

Managed care also is not well developed outside of the United States. The concept of managed care is notoriously difficult to define.¹¹ One could argue that the high degree of involvement of government payers (usually at the municipal level) in managing the provision of care in the Scandinavian countries resembles the integration of financing and provision functions characteristic of managed care.¹² Some countries with social insurance schemes, notably Switzerland, Germany, and the Netherlands, have also begun to experiment with managed care arrangements that more closely resemble those common in the United States.¹³ Nowhere else in the world, however, can be found the combination of widespread private insurance and vigorous managed care arrangements that characterize the United States.

This is not to say, however, that we are totally alone on this planet as we try to determine how the government should respond to managed care. Other countries do have private health insurance, and most of these nations are attempting to regulate it. Throughout much of the world, moreover, there is in fact interest in managed care arrangements, both because these arrangements are perceived as having been successful in containing the growth of

Transformation of the Health System in South Africa (last modified Mar. 23, 1999) <http://www.polity.org.za/govdocs/white_papers/health.html> (on file with the University of Michigan Journal of Law Reform); Michael A. Simpson, *Reforming Health Care in South Africa*, in REFORMING HEALTH CARE: THE PHILOSOPHY AND PRACTICE OF INTERNATIONAL HEALTH REFORM 101, 111–17 (David Seedhouse ed., 1995) (describing the ANC National Health Plan and the Pan-Africanist Congress health policy, developed during the 1994 democratic elections). In other African countries, particularly former British colonies, private health insurance exists, but few can afford it. See Chollet & Lewis, *supra* note 1, at 92. Latin American countries, particularly Brazil, Argentina, Uruguay, and Colombia, are developing pluralistic models that resemble the Chilean model discussed in this Article. See André C. Medici et al., *Managed Care and Managed Competition in Latin America and the Caribbean*, in INNOVATIONS IN HEALTH CARE FINANCING *supra* note 1, at 215, 218; Karen Stocker et al., *The Exportation of Managed Care to Latin America*, 340 NEW ENG. J. MED. 1131, 1133–34 (1999).

11. See generally Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75 (1993) (providing one of the most successful efforts to describe and classify managed care arrangements).

12. See generally Mats Brommels, *Contracting and Political Boards in Planned Markets*, in IMPLEMENTING PLANNED MARKETS IN HEALTH CARE: BALANCING SOCIAL AND ECONOMIC RESPONSIBILITY 86 (Richard B. Saltman & Casten Von Otter eds., 1995) (describing Scandinavian health care organization).

13. See generally Timothy Jost, *Report from the Field: German Health Care Reform: The Next Steps*, 23 J. HEALTH POL. POL'Y & L. 697 (1998); Dominik Graf von Stillfried, *Schweizer Gesundheitsreform: Vorbild für Deutschland?*, 8 DIE ERSATZKASSE 277 (1996). While these nations have followed United States developments in managed care and managed competition with interest, and their health care reforms in some respects resemble United States models, their reforms are based very much on their own distinctive ideologies and histories. See Lawrence D. Brown, *Exceptionalism as the Rule? U.S. Health Policy Innovation and Cross-National Learning*, 23 J. HEALTH POL. POL'Y & L. 35 *passim* (1998).

health care costs in the United States and because they are being aggressively marketed throughout the world by persons from the United States.¹⁴ Other countries are at least beginning to think about how to regulate managed care if and when it arrives. There may be lessons to learn, therefore, if we look beyond our borders.

If we choose to look beyond our borders, the most productive direction to look is south. In South America private health insurance is becoming increasingly common.¹⁵ One of the most useful South American countries to consider is Chile. Chile is perhaps the only nation in the world whose constitution guarantees its residents a right to purchase private health insurance. Article 19, No. 9 of the 1980 Chilean Constitution provides:

The Right to Health Protection

The State protects free and equal access to actions for the promotion, protection, and recovery of health and for rehabilitation of the individual.

The coordination and control of the activities related to health shall also rest with the State. A primary duty of the State is to guarantee the execution of health activities, whether provided by public or private institutions, in the manner and under the conditions established by law, which may provide for mandatory payments.

Each person shall have the right to choose the health system, whether State or private, that he wishes to join.¹⁶

This right is by no means merely theoretical. Currently 3.8 million persons, about 26% of the Chilean population, and 32% of the workforce, are privately insured by thirty-three Chilean ISAPREs (Instituciones de Salud Previsional), private health insur-

14. See Jost, *supra* note 13, at 705–09; see also JOHANN BEHRENS ET AL., GESUNDHEITSSYSTEMENTWICKLUNG IN DEN USA UND DEUTSCHLAND: WETTBEWERB UND MARKT ALS ORDNUNGSELEMENTE IM GESUNDHEITSWESEN AUF DEM PRÜFSTAND DES SYSTEMVERGLEICHES (1996) (exploring what in the United States experience might be useful to Germany and vice versa).

15. See Chollet & Lewis, *supra* note 1, at 96–97, 106–09; see also Medici et al., *supra* note 10, at 215.

16. Raúl Bertelsen Repetto, *Chile*, in THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY 166, 172 (Hernán L. Fuenzalida-Puelma & Susan Scholle Connor eds., Pan American Health Organization Scientific Publication No. 509, 1989).

ance companies.¹⁷ In 1995, 42% of total Chilean health expenditures of U.S.\$2.653 billion came from the private sector.¹⁸ The ISAPREs are not managed care organizations. Some of them have for some time owned their own health care institutions, however, or have had preferred provider arrangements with doctors.¹⁹ At least two ISAPREs, moreover, have recently begun to develop managed care plans that resemble more closely health maintenance organizations or point of service plans in the United States.²⁰

The ISAPREs have been supervised since 1991 by the Superintendencia de Instituciones de Salud Previsional (SISP), an active and aggressive regulatory agency. The SISP both develops norms for the private health insurance industry and actively supervises compliance with these norms.²¹ It also, as is described below, serves as an arbitrator when beneficiaries come into conflict with their insurers.²²

This Article is about regulation of private health insurance in Chile—about the ISAPREs and the SISP. More broadly, however, it is about the lessons that comparative law and policy may hold for an examination of the regulation of managed care in the United States. For while it is true, as asserted above, that we may have relatively little to learn from other countries regarding managed care, we can learn something. Indeed, we can learn four things.

First, at the macro level, we can gain perspective on the issues that have become the focal points of our national managed care regulation debate. Managed care is, in the end, a form of insurance. Much of the debate regarding managed care regulation, at least at the popular level, has focused on very specific problems, such as gag rules and the definition of an emergency.²³ It may be helpful for us to seek a broader perspective, returning to the fundamental issues of insurance regulation—dealing with moral hazard, cream skimming, insurability, and rate-setting, for

17. See RUBI VALENZUELA MAGAÑA, SUPERINTENDENCIA DE INSTITUCIONES DE SALUD PREVISIONAL, *THE PRIVATE HEALTH SYSTEM IN CHILE* 6, 9 (1996) [hereinafter SISP, PRIVATE HEALTH SYSTEM].

18. See Superintendencia de Instituciones de Salud Previsional, *Chilean Health System Statistics* (1998) (on file with the *University of Michigan Journal of Law Reform*) [hereinafter SISP, Statistics].

19. See *infra* notes 75–89 and accompanying text.

20. See *infra* text accompanying notes 77–83 (discussing the Consalud and Banmédica ISAPREs).

21. See *infra* text accompanying notes 188–91.

22. See *infra* text accompanying notes 206–40.

23. See, e.g., Amy Goldstein & Juliet Eilperin, *Partisan House Swiftly Passes GOP Patients' Rights Bill*, WASH. POST, July 25, 1998, at A4; Todd Pack, *Political Cure for Managed Care's Ills: Lawmakers Don't Agree on a Diagnosis, but They Do Know This: Many Constituents Are Sick of Managed Care, and Election Day Approaches*, ORLANDO SENTINEL, Aug. 10, 1998, at 22.

example. Considering the issues with which Chile is struggling in regulating health insurance may help us to gain perspective on our own issues. In particular, observing the difficulties Chile has faced in regulating private health insurance should help us to be more modest in our expectations of insurance regulation. Most specifically, the Chilean experience cautions us to have modest expectations of what is achievable through the use of regulation as a strategy for expanding insurance coverage.

Second, in contrast, Chile's experience also demonstrates the necessity of health insurance regulation. Some have argued in recent years that health insurance markets would function more efficiently if insurers could sell their products directly to consumers with minimal regulatory oversight.²⁴ Some, including Senator Breaux, the leader of the Bipartisan Commission on the Future of Medicare, have even argued that we ought to replace our public insurance programs with a system under which beneficiaries would be given vouchers with which to shop for private health insurance.²⁵ Chile has essentially done this, allowing Chileans to use their payroll tax contributions to purchase private insurance in what were until recently largely unregulated sales transactions.²⁶ Chile's experience offers little hope to those who see this route as benefiting consumers.

Third, at the micro level, there is always the possibility that when we examine another system we can gain from the transfer of regulatory technology. In constructing our own regulatory systems, we can turn to the regulatory programs of other lands as a craftsman goes to a toolbox, looking for instruments to assist us in getting our job done.²⁷ Chile, like other countries, has developed its own regulatory tools that we might use as we improve the design of our own systems.

Fourth, we may learn where and how we might usefully teach. Our consideration of other nations that are confronting the emer-

24. See RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 121-46 (1997); David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 451-66 (1998).

25. See John Breaux, *Premium Supports Can Help*, USA TODAY, Jan. 13, 1999, at 14A; see also Henry J. Aaron & Robert D. Reischauer, *The Medicare Reform Debate: What Is the Next Step?*, HEALTH AFF., Winter 1995, at 8; Stuart M. Butler & Robert E. Moffit, *The FEHBP as a Model for a New Medicare Program*, HEALTH AFF., Winter 1995, at 47; Gail R. Wilensky & Joseph P. Newhouse, *Medicare: What's Right? What's Wrong? What's Next?*, HEALTH AFF., Jan./Feb. 1999, at 92; Einer Elhauge, *Medi-Choice*, THE NEW REPUBLIC, Nov. 13, 1995, at 24.

26. See *infra* text accompanying notes 90-92.

27. See Timothy Stoltzfus Jost et al., *The British Health Care Reforms, the American Health Care Revolution, and Purchaser/Provider Contracts*, 20 J. HEALTH POL. POL'Y & L. 885 (1995) (developing the notion of technology transfer in health care policy).

gence of managed care might give us a useful perspective on our own enterprise, in this symposium in particular and on the development of regulatory instruments for managed care in general. Though the United States is increasingly an importer of consumer goods, we are just as clearly an exporter of ideas. United States ideological and business entrepreneurs are marketing managed care, both as an idea and as a product, throughout the world.²⁸ To the extent that we can design effective, efficient, and equitable approaches to regulating managed care, we have a responsibility to share these ideas in all corners of the world where United States-style managed care is taking root. Pondering the emergence of managed care elsewhere in the world may remind us of this responsibility.

Before developing these themes further, however, let us first turn to Chile and its health care system.

I. THE CHILEAN HEALTH CARE SYSTEM

A. Some History

We all remember Chile from social studies, that long thin country that runs for 1800 miles down the southern half of the western coast of South America in the narrow strip of land between the Andes and the Pacific. Chile has 14.5 million residents, with 84% of the population living in urban centers, the most important of which is the capital, Santiago, where 4.9 million live.²⁹ Though the disparity of wealth distribution in Chile between the richest and the poorest quintiles of the population is similar to that of the United States,³⁰ the average per capita income is one-seventh that of the U.S.; therefore a smaller proportion of the Chilean population

28. See, e.g., John Covalleski, *U.S. Managed Care in Demand Overseas*, BEST'S REV., LIFE-HEALTH INS. ED., Nov. 1995, at 34; William Gradison, *U.S. Health Insurers Can Export Their Skills; Know-how in Managed Care, Supplemental Products and Technology May Help U.S. Health Insurers Succeed in Expanding Overseas*, BEST'S REV., LIFE-HEALTH INS. ED., July 1994, at 44; Jost, *supra* note 13, at 705. The classic example of ideological entrepreneurship in health care is Alain Enthoven's influence on British health policy in the early 1990s. See Alain C. Enthoven, *Internal Market Reform of the British National Health Service*, HEALTH AFF., Fall 1991, at 60.

29. See THE WORLD ALMANAC AND BOOK OF FACTS 752 (Robert Famighetti ed., 1998).

30. Chile's highest income quintile earned 51.8% of the total income in 1992, the poorest quintile 6.5%. See THE WORLD BANK, CHILE: THE ADULT HEALTH POLICY CHALLENGE, at xvii (1995). In 1992, the United States' highest income quintile earned 44.7% of the total income, the poorest quintile 4.3%. See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES 470 tbl.725 (1997).

lives in relative comfort than in the U.S., and a larger proportion lives in poverty.³¹ Chilean indicators of well being, however, such as nutrition,³² access to potable water,³³ education,³⁴ and adult literacy³⁵ are quite positive. Health statistics are also favorable: Chile's infant mortality rate of thirteen per 1000 and life expectancy at birth of seventy-five years are the best in South America and compare favorably to those of the United States.³⁶ Ninety-seven percent of Chilean children are immunized; 97% of births are professionally assisted.³⁷

Chile has long been a leader in Latin America, and indeed in the world, in public health care. As early as the nineteenth century it established public health institutions to address the problem of communicable diseases.³⁸ It adopted a law providing for health coverage under Social Security along the lines of the German Bismark model in 1924, though coverage under this system was always limited.³⁹ During the 1940s, white collar workers established their own separate social security-type health care system, the Servicio Médico Nacional de Empleados (SERMENA), which by the 1960s had evolved into a preferred provider system under which members could obtain care from private providers who contracted with the system.⁴⁰

31. In 1995 the GNP per capita of Chile in dollars was \$4160, while the GNP per capita of the United States was \$26,980. See WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT, 1998: LIFE IN THE 21ST CENTURY, A VISION FOR ALL 220 (1998) [hereinafter, WHO, VISION]. However, in terms of purchasing power parity, that is, ability to purchase goods and services, Chilean GNP per capita was over one-third that of the United States: \$8890 compared to \$25,880 in 1994. See WORLD HEALTH ORGANIZATION, WORLD HEALTH REPORT, 1997: CONQUERING SUFFERING, ENRICHING HUMANITY 152 (1997).

32. See THE WORLD BANK, *supra* note 30, at xvii (indicating calorie intake per day per capita of 2584 calories in 1990).

33. See *id.* (indicating 95.2% access in urban areas, 73.3% access in rural areas in 1991).

34. See *id.* (indicating 98% primary enrollment rate, 72% secondary enrollment rate in 1991).

35. See WHO, VISION, *supra* note 31, at 224 (95.2% in 1995).

36. See *id.* at 220. In 1997, life expectancy at birth in the United States was 77, and the infant mortality rate was seven per 1000. See *id.*

37. See Jorge Jimenez de la Jara & Thomas J. Bossert, *Chile's Health Sector Reform: Lessons from Four Reform Periods*, in HEALTH SECTOR REFORM IN DEVELOPING COUNTRIES: MAKING HEALTH DEVELOPMENT SUSTAINABLE 199, 206 (Peter Berman ed., 1995).

38. See *id.* at 202 (noting that a board of health was founded in 1805 for small pox vaccination and that a General Sanitary Bureau was created in 1887 to combat the influx of cholera).

39. See *id.* Coverage was limited to workers and their families. See *id.*

40. See *id.* at 205. SERMENA was organized as a separate legal entity under Chile Law 16.781 in 1968. See Mercedes Cifuentes, *Health Care*, in PRIVATE SOLUTIONS TO PUBLIC PROBLEMS 53, 62 (Cristián Larroulet ed., 1993).

In 1952, Chile began to implement a National Health Service, the Servicio Nacional de Salud (SNS), resembling the British NHS, which used social security payroll taxes and general tax revenues to finance a system of public hospitals and clinics, as well as basic public health services.⁴¹ Salvador Allende, a physician who was Minister of Health at the time of the creation of the SNS, led the drive for establishing a health service.⁴²

In 1970, Allende was elected president of Chile as a Socialist. In 1971, the Chilean Constitution was amended to establish the State's responsibility for "medical care, both preventive and curative, [and] rehabilitation in case of accident, illness or maternity"⁴³ By the time President Allende was overthrown in a military coup in 1973, Chile had two established models for public health care financing: SERMENA, which provided curative health services to white-collar workers and their families (25% of the population), and the SNS, which provided preventive services to the entire population and curative services to blue collar workers and indigents.⁴⁴ Chile has always also had, of course, a purely private health care sector, where persons who did not qualify for or chose to seek care outside of a public system could purchase care on a fee-for-service basis.⁴⁵ The country has also long had separate health care systems for the military and the police, as is commonly true in Latin America.⁴⁶

The Pinochet military government that followed the coup settled quickly on a course of reform for the health care system. The military government, heavily influenced by the free market ideology of Milton Friedman and the University of Chicago School of Economics as well as by Pinochet's "Chicago Boys" and with little

41. See Cifuentes, *supra* note 40, at 62; Jimenez & Bossert, *supra* note 37, at 203. The SNS was established under Chile Law 10,383. See Cifuentes, *supra* note 40, at 62.

42. See Jimenez & Bossert, *supra* note 37, at 205.

43. CONSTITUCIÓN (1925), art. 10, § 16, ¶ 1 (1971), translated in GENERAL SECRETARIAT, ORGANIZATION OF AMERICAN STATES, CONSTITUTION OF THE REPUBLIC OF CHILE 1925, at 9 (1972). The original 1925 Constitution, which the 1971 amendment altered, itself provided for the duty of the State to oversee public health and for the maintenance of a national health service. See *id.* art. 10, § 14, ¶ 4. For a discussion of the treatment of health by Chilean constitutions, see Bertelsen Repetto, *supra* note 16, at 169-72.

44. See Brian Cartin, *Chile: The Effectiveness of the Reform*, in DO OPTIONS EXIST? THE REFORM OF PENSION AND HEALTH CARE SYSTEMS IN LATIN AMERICA 205, 206 (María Amparo Cruz-Saco & Carmelo Mesa-Lago eds., 1998). The remaining 15% of the population either received services through the health services attached to the military or police or were uninsured. See *id.* at 206.

45. See Cifuentes, *supra* note 40, at 63.

46. This program covers about 2.5% of the population. See Mathias Kifmann, *Chile: Private Insurance in Chile: Basic or Complementary Insurance for Outpatient Services?*, 51 INT'L SOC. SEC. REV. 137, 139 (1998).

input from public health and medical experts, designed an ideologically-based free-market model for the financing of health care.⁴⁷ Though Pinochet's approach to reform remains controversial, it is generally agreed that the Chilean health care system required reform in the early 1970s.⁴⁸ The system was suffering a huge deficit attributable to overspending by the services and difficulties in collecting payroll taxes from employers.⁴⁹ The government health services were also burdened by a costly, over-centralized, and inflexible administrative structure.⁵⁰ The health services were subject generally to a lack of investment.⁵¹ Moreover, the Pinochet government was not solely concerned with economic efficiency. Its commitment to libertarian ideals was accompanied by a commitment to improving health care for the very poor and to improving preventive and primary care generally.⁵²

The Pinochet reforms were implemented slowly; full implementation did not take place until the early 1980s.⁵³ First, the SNS and SERMENA were eliminated by Pinochet and two new government health care entities were formed in their place (both under the Ministry of Health), the Fondo Nacional de Salud (FONASA) which finances health care, and the Sistema Nacional de Servicios de Salud (SNSS) which delivers health care.⁵⁴ The SNSS is organized in twenty-six regional autonomous services, plus the Environmental Health Service of Santiago.⁵⁵ These services operate hospitals providing curative services and supervise the provision of primary care. Second, in 1980 and 1981, management of public primary care facilities—postas (basic primary health centers) and consultorios (better equipped primary care clinics)—was trans-

47. See Jimenez & Bossert, *supra* note 37, at 207–08.

48. See, e.g., Jimenez & Bossert, *supra* note 37.

49. See Cartin, *supra* note 44, at 207.

50. See *id.*

51. See Cifuentes, *supra* note 40, at 59–60 (identifying stimulation of investment in health care as a motive for privatization of health insurance).

52. See Jimenez & Bossert, *supra* note 37, at 208. Included within this was a commitment to prioritizing care of mothers, children, and high-risk groups. See Cifuentes, *supra* note 40, at 66–67.

53. Chile suffered two serious recessions during the mid-1970s and mid-1980s, delaying the initiation of the reforms until the late 1970s and early 1980s, and full implementation until the late 1980s. See Jimenez & Bossert, *supra* note 37, at 207.

54. See Cartin, *supra* note 44, at 208–09.

55. See Cartin, *supra* note 44, at 209; THE WORLD BANK, *supra* note 30, at 3–4. The SNSS was created through restructuring of the Ministry of Health under Decree Law 2763. See Cifuentes, *supra* note 40, at 69.

ferred to the municipalities.⁵⁶ Finally, in 1981 the reforms were completed with the creation of the ISAPRE system.⁵⁷

B. The Public Health Care System

All employees and self-employed persons who contribute to the social security pension system, as well as indigents, are covered by FONASA, unless they elect private insurance coverage.⁵⁸ All FONASA beneficiaries can choose either to receive services in public facilities (for which they must pay copayments based on a sliding scale related to income ranging from 0% to 50%) or to purchase vouchers that allow them to receive services in FONASA's network of private preferred providers.⁵⁹ Approximately 82% of FONASA services are received in public facilities, and 18% in private facilities under the preferred provider system.⁶⁰ FONASA is financed by payroll taxes (currently set at 7% of income), general revenue funds, fees from the sale of vouchers, and fees from the sale of health care services.⁶¹

FONASA pays for services provided to its beneficiaries by the regional SNSS and municipal primary care centers.⁶² Historically FONASA paid hospitals based in part on budgets which covered labor, investment, and other fixed costs, and in part on a fee-for-service system which covered other operating costs.⁶³ Primary care services were financed on a fee-for-service basis, supplemented by revenues from the municipalities, which in particular covered investment costs.⁶⁴

56. See Cifuentes, *supra* note 40, at 70. This was accomplished through Decree Law 1-3036. *See id.*

57. *See infra* Part I.C.

58. See SISP, PRIVATE HEALTH SYSTEM, *supra* note 17, at 1-2.

59. See THE WORLD BANK, *supra* note 30, at 4-5. The right to obtain health care from private preferred providers, formerly available only to white collar workers under SERMENA, was extended to all FONASA beneficiaries under Decree Law 2575 of 1979. *See* Cifuentes, *supra* note 40, at 69. The statutory provision for subsidies and classification of copayments was established under Law 18.469 in 1985. *See id.* at 71. Private establishments participating in the preferred provider arrangement are classified into three levels based on cost, but reimbursement amounts are established based on the lowest cost level. *See id.* at 71-72. Beneficiaries desiring higher cost (and possibly higher quality) services pay the difference out of pocket. *See id.*

60. See THE WORLD BANK, *supra* note 30, at 4.

61. *See id.* at 5. Payroll taxes and general revenue contributions each account for about 40% of FONASA income. *See id.*

62. *See id.* at 3-5.

63. *See id.* at 5-6.

64. *See id.* at 6.

Chilean public health care finance is currently undergoing a thorough reform, under which primary care is being purchased on a capitation basis and secondary and tertiary care on a diagnosis-related group basis.⁶⁵ Legislation that would further reform the system was before Parliament at the time this Article was written.⁶⁶ An exploration of these reforms is beyond the scope of this Article. The complexity of these reforms, however, and the impressiveness of the thought that has obviously gone into them, demonstrates the seriousness of Chile's commitment to maintaining a public health system as a viable alternative to the private sector. This commitment is also demonstrated by the massive investment in public health expenditures following the end of the military dictatorship in 1991. The national health budget increased 50% in the four years following the restoration of democracy, and U.S.\$500 million was invested in infrastructure and equipment for the public hospitals.⁶⁷ Though the public sector remains subject to criticisms for waste and inefficiency,⁶⁸ and is plagued by shortages and waiting lists,⁶⁹ beneficiaries are relatively satisfied by the services they receive there.⁷⁰

C. The ISAPREs

The ISAPREs that were created in response to the 1981 reforms are private health insurance companies. Most are owned by small groups of investors, though two are public corporations, and one is

65. See RONY LENZ ALCAYAGA & ROBERTO MUÑOZ BUSTOS, FINANCIAL REFORMS IN PUBLIC HEALTH SECTOR: RESOURCE ALLOCATION MECHANISMS *passim* (Fonda Nacional de Salud Work Document No. 1, 1995) (discussing proposed public sector financing and management reforms); CÉSAR OYARZO & SYLVIA GALLEGUILLOS, TOWARDS THE CREATION OF A MUTUAL INSURANCE ON HEALTH: THE REFORM AGENDA OF FONASA *passim* (Corporación de Promoción Universitaria Work Document No. 13, 1995) (discussing FONASA reforms); Ana Sojo, *Potential and Limits of Health Management Reform in Chile*, CEPAL REV., Aug. 1996, at 127 (discussing public health management reform).

66. See Interview with Rony Lenz Alcayaga, Director of Fonda Nacional de Salud (FONASA), in Santiago, Chile (June 23, 1998) (on file with author).

67. See Jimenez & Bossert, *supra* note 37, at 208-09.

68. One-thousand eight-hundred of the 4400 new personnel positions created in the health sector in the early 1990s went to administrative personnel, who now consume 35% of the health sector's total expenditures. See Cartin, *supra* note 44, at 218.

69. See Claudia Villalobos, *El Enfermo Crónico*, TEMAS DE LA EPOCA, May 17, 1998, at 1.

70. In a 1995 beneficiary satisfaction survey, 68% of ISAPRE affiliates preferred their own system while 23% were inclined to FONASA; 66% of FONASA beneficiaries favored their own system, while 29% valued the ISAPRE system more. See Ricardo Bitrán & Francisco Xavier Almarza, *Las Instituciones de Salud Previsional (ISAPRES) en Chile 56* (1996) (on file with the *University of Michigan Journal of Law Reform*).

a cooperative.⁷¹ Seventeen of the currently operational ISAPREs are open to any applicants, while eleven are closed ISAPREs, whose membership is limited to employees of sponsoring companies or industries.⁷² The vast majority of ISAPRE members, 3.7 of 3.9 million, are members of open ISAPREs.⁷³ The market is highly concentrated, with three ISAPREs containing over 60% of the open ISAPRE beneficiaries, and four more containing an additional 24%.⁷⁴

Most of the ISAPREs function as traditional insurers.⁷⁵ A few of the ISAPREs, however, have for some time provided as well as paid for health care, while other ISAPREs have long had preferred provider arrangements.⁷⁶ Consalud, the largest of the insurers, owns thirty-five primary care and dental clinics, two hospitals, and five ambulatory surgical centers.⁷⁷ Although Consalud beneficiaries have free choice of physicians and are not limited to Consalud facilities, about half of the ambulatory care paid for by Consalud is provided in its centers.⁷⁸ Consalud is also able through its centers to assert some control over referrals to secondary and tertiary care—thus maintaining full use of capacity in its own hospitals—and to refer patients to other providers with whom it has agreements with respect to price and quality.⁷⁹

71. See Interview with Franciso Quesney Langlois, Medical Director of Banmédica, in Santiago, Chile (June 18, 1998) (on file with author). Two ISAPREs, Aetna and Cigna, are subsidiaries of United States insurance companies. See Stocker et al., *supra* note 10, at 1133. The largest ISAPRE, Consalud, was originated by the Construction Industry Council as part of its welfare efforts to serve construction workers, and is nonprofit. See Interview with Nicolás Starck Aguilera, Director of Systems and Technologies, Consalud, in Santiago, Chile (June 16, 1999) (on file with author). It is different from the more entrepreneurial ISAPREs in important respects, which will be explored below.

72. See SISP, Statistics, *supra* note 18.

73. See SUPERINTENDENCIA DE INSTITUCIONES DE SALUD PREVISIONAL, BOLETÍN ESTADÍSTICO 34 tbl.2.1.8 (1997) [hereinafter, SISP, BOLETÍN ESTADÍSTICO].

74. See *id.* at 35 tbl.2.1.9.

75. In fact, patients seeking care usually first secure a voucher from their insurer by paying the copayment and take the voucher to the provider, who then bills the insurer for the service based on the voucher. See Interview with Franciso Quesney Langlois, *supra* note 71. The system thus functions quite differently from traditional indemnity insurance in the United States, under which the patient pays the provider first, then seeks indemnity from the insurer.

76. See Interview with Marcelo Maira Carlini, Vice President, and Eduardo Hoyos Lombardi, Director of Health, Consalud, in Santiago, Chile (June 16, 1998) (on file with author) [hereinafter Carlini & Lombardi Interview].

77. See CONSALUD, LÍDER EN SALUD PRIVADA 12–17 (1996) (on file with the *University of Michigan Journal of Law Reform*); Carlini & Lombardi Interview, *supra* note 76.

78. See Carlini & Lombardi Interview, *supra* note 76.

79. See *id.* Promepart, another large ISAPRE, also owns a network of hospitals and primary care clinics. See Interview with Maria Eugenia Salazar, Probenefits, in Santiago, Chile (June 16, 1998) (on file with author).

Banmédica, the third largest ISAPRE, also has an integrated structure, though it is structured differently. While Consalud owns its clinics and other institutions, Banmédica is owned by a parent company, which also owns a share in several health care providers.⁸⁰ Banmédica has historically not attempted to steer its insureds towards its facilities, and only about a quarter of its beneficiaries use its facilities.⁸¹ However, Banmédica has recently formed an HMO in cooperation with a Santiago hospital.⁸² This HMO, which now includes about 8000 members, requires its members to choose a gatekeeper primary care physician (an internist or pediatrician) from a closed panel list and to obtain their care from the hospital (Clínica Dávila) and from three outpatient clinics affiliated with the plan.⁸³

A third managed care possibility is represented by Vida Tres, a small but affluent ISAPRE, which is developing three point-of-service plan type arrangements with a local hospital and two managed care plans.⁸⁴ Vida Tres will pay these plans on a capitated basis for insureds who elect them.⁸⁵ The insured will be required to choose an internist, gynecologist, or pediatrician as a gatekeeper physician.⁸⁶ The insureds will not be limited to care within the plan, but payment for care received outside the plan will be so minimal that few will elect it.

Finally, a number of the ISAPREs have long had preferred provider arrangements, under which insureds have lower coinsurance obligations if they go to professionals or hospitals that have a contract with their plan.⁸⁷ Chile has a strong ideology and tradition of free choice of provider, however, and ISAPREs have been reluctant to place too strict limits on choice.⁸⁸ Moreover, the powerful Chilean Medical Association is reportedly skeptical about managed care, and the ISAPREs, which have always had a strained relationship with the Medical Association, have been reluctant to court

80. See Interview with César Oyarzo Mansilla, Director, and Hector Sanchez Rodriguez, Vice President, Integramedica, in Santiago, Chile (June 14, 1998) (on file with author) [hereinafter Mansilla & Rodriguez Interview].

81. See *id.*

82. See Interview with Eduardo Urrutia Hewstone, General Manager, and Lee Kortmansky, Chief of the Program of Health Administration, Clínica Dávila, in Santiago, Chile (June 24, 1998) (on file with author) [hereinafter Hewstone & Kortmansky Interview].

83. See *id.*

84. See Interview with Gonzalo Simón, Development Director of Vida Tres, in Santiago, Chile (June 19, 1998) (on file with author). One of the MCOs is owned by a partnership of United States investors and Chilean physicians. See *id.*

85. See *id.*

86. See *id.*

87. See Carlini & Lombardi Interview, *supra* note 76.

88. See Hewstone & Kortmansky Interview, *supra* note 82.

further hostility.⁸⁹ More integrated forms of managed care are, therefore, developing slowly and quietly in Chile.

Any employee, pensioner, or other person may purchase a health insurance policy with an ISAPRE using his or her 7% health insurance payroll tax and whatever additional premium may be necessary, if the applicant can find an ISAPRE willing to sell him or her a policy.⁹⁰ ISAPREs are aggressively marketed by in-house sales agents, who are paid on a commission basis.⁹¹ A person who purchases insurance from an ISAPRE is no longer covered by FONASA, the public default program for employees, as of the effective date of the insurance policy—he or she has moved from the public to the private sector of health care finance.⁹²

ISAPREs have no obligation to accept an applicant for insurance.⁹³ Moreover, they may only vary premiums based on age and sex (and coverage of plan) for those applicants whom they insure.⁹⁴ ISAPREs, therefore, often refuse to sell insurance to, or charge high rates to, the elderly or persons with cancer or other costly diseases.⁹⁵ Once a person is insured by an ISAPRE, however, the power balance between the insured and insurer to a degree reverses. After one year an insured can leave an ISAPRE at any time with two months notice, but an ISAPRE cannot terminate an insured who has not otherwise breached the terms of the insurance policy.⁹⁶ An ISAPRE likewise may not raise the rates that it charges any single insured member. If it wants to increase premiums, it must raise the rates equally for all persons insured under a particular plan and must give two months notice of such increases.⁹⁷

A person who chooses to be insured by an ISAPRE must continue to pay 7% of his employment income as the insurance

89. See Stocker et al., *supra* note 10, at 1135.

90. See Law No. 18.933, arts. 29, 34, Feb. 12, 1990, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS 191, 208, 212 (Chile).

91. The commission structure usually takes into account the value of the policy, the length of time the insured remains with the ISAPREs, and the track record of the insured for paying premiums. See Interview with Francis Quesney Langlois, *supra* note 71. Thus, sales agents face an incentive to sign up stable applicants with a relatively high income.

92. See Kifmann, *supra* note 46, at 140.

93. See Bitrán & Almarza, *supra* note 70, at 35.

94. See Chile Law No. 18.933, art. 38, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 215–16.

95. See Kifmann, *supra* note 46, at 147 (explaining that ISAPREs charge higher premiums to elderly persons). ISAPREs do not require medical examinations, which are quite costly, or attempt to identify unhealthy habits like smoking or alcoholism. See Bitrán & Almarza, *supra* note 70, at 34.

96. See Chile Law No. 18.933, art. 38, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 215; Superintendencia de Instituciones de Salud Previsional, Regulation 2500, § 5.3 (on file with author) [hereinafter SISIP, Regulation].

97. See *id.*

premium, up to a ceiling of 4.2 UF a month (equivalent to U.S.\$129 in August of 1998).⁹⁸ Persons insured by ISAPREs may supplement the 7%, and they often pay an additional amount voluntarily if the 7% does not cover all desired benefits.⁹⁹ An employer may supplement the 7% with an additional amount of up to 2% for poorer workers and claim a tax credit for the contribution, resulting in a modest, though symbolically important, public subsidy for the ISAPRE system.¹⁰⁰

The application of a uniform flat percentage premium makes sense in the context of a universal social insurance program, where it permits cross-subsidization of poorer beneficiaries by wealthier beneficiaries.¹⁰¹ This rationale does not apply to the private ISAPREs, however, where cross-subsidies are anathema. If a 7% minimum premium requirement makes any sense in this context, it is to discourage underinsurance. In fact, however, it is just as likely to result in inefficient overinsurance in situations where it results in an excessive payment.¹⁰² It also has in the past caused problems when a beneficiary's income increased temporarily during a coverage period, resulting in increased premium payments without increased benefits.¹⁰³ The insurance statute was amended in 1995 to permit up to 10% of the 7% premium, including any money paid over the premium price, to be placed in a type of medical savings account held by the ISAPREs to be used for payment for health services, including copayments, additional health benefits, or continuation of coverage in case of unemployment or upon retirement.¹⁰⁴ The

98. See SISF, PRIVATE HEALTH SYSTEM, *supra* note 17, at 5. The UF is a unit of measure adjusted automatically for inflation on a monthly basis. It is widely used in Chile for financial transactions and is thus commonly understood. See *id.* at 5 n.2. Though \$129 is a modest sum in terms of United States health insurance costs, it is a significant amount considering that the average income of a member of an open ISAPRE was \$658 monthly in 1995. See *id.* at 13.

99. See Kifmann, *supra* note 46, at 139.

100. The 2% subsidy when added to the 7% premium may not exceed one UF (about \$30.62 in August 1998) for the insured plus .5 UF (\$15.31) for each dependent, so only persons of very modest income are eligible for the subsidy. See Law No. 18,566, art. 8, Oct. 24, 1986, 88 RECOPIACIÓN DE LEYES Y REGLAMENTOS 102, 119 (Chile). This subsidy currently makes up about 2.8% of ISAPRE revenues. See SISF, Statistics, *supra* note 18.

101. See Osvaldo Larrañaga, Eficiencia y Equidad en el Sistema de Salud Chileno 9 (n.d.) (on file with the *University of Michigan Journal of Law Reform*). FONASA presumably uses the 7% contribution in this way, though it is attempting to separate out its indigent members, who pay no premium, into a separate category fiscally to avoid this cross-subsidy between premium payers and non-premium payers. See OYARZO & GALLEGUILLOS, *supra* note 65, at 6-8.

102. See Kifmann, *supra* note 46, at 143.

103. See *id.*

104. See Law No. 18,933, art 32, Feb. 12, 1990, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS 191, 211 (Chile).

ISAPREs are permitted to charge handling fees for these accounts, however, and these fees are often large enough to make the account of little value.¹⁰⁵

Though most ISAPRE policies are purchased by individuals, 35 to 40% are negotiated as collective policies covering a firm's employees as a group.¹⁰⁶ Collective policies tend to offer more favorable coverage for many employees than individual policies because the proportion of the premium devoted to sales and underwriting costs is lower, higher income employees subsidize lower income employees (though there are often several benefit levels within collective plans for different levels of employees), and collective policy negotiators tend to drive a harder bargain with the ISAPREs.¹⁰⁷ Some ISAPREs are unenthusiastic about collective policies, however, because the freedom of movement guaranteed beneficiaries allows higher income employees to opt out of collective plans, undermining the underwriting assumptions on which the plan was based.¹⁰⁸

An ISAPRE policy must cover both the insured and his or her spouse and children.¹⁰⁹ ISAPREs may also agree to cover additional dependents, such as parents, though this is not common.¹¹⁰ Where both spouses work, they may either have separate policies or may purchase marital policies, for which the premium is based on the average wage of the two spouses.¹¹¹ A family may not be split between FONASA and an ISAPRE—if one spouse is privately insured the entire family must be.¹¹²

ISAPREs are required to cover each of the services covered by FONASA and under recent regulations must also cover these services at least to the extent that they would be covered under FONASA.¹¹³ FONASA is subject to high coinsurance, however, for wealthier insureds purchasing private insurance,¹¹⁴ so this coverage requirement is rather minimal. Most ISAPREs exceed it. ISAPREs may only exclude a short list of services or conditions, such as

105. See Kifmann, *supra* note 46, at 143.

106. See Bitrán & Almarza, *supra* note 70, at 34.

107. See Interview with Maria Eugenia Salazar, *supra* note 79.

108. See Interview with Franciso Quesney Langlois, *supra* note 71.

109. See Chile Law No. 18.933, art. 41, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 216–17.

110. See *id.*

111. See Interview with Andrea Muñoz Sanchez, Director, Legal Department, SISP, in Santiago, Chile (June 24, 1998) (on file with author).

112. See *id.*

113. See SISP, Regulation 36 (on file with author).

114. See Interview with Fernando Riveros Vidal, Chief, Audit Department, SISP, in Santiago, Chile (June 22, 1998) (on file with author).

cosmetic surgery (for the purposes of beautification, not of repair of malformation), nursing care at home or in institutions, or services required because of war or criminal conduct.¹¹⁵ They may only impose waiting periods for pregnancy and preexisting conditions.¹¹⁶ Costs associated with pregnancy need only be covered proportionately to the amount of time remaining in the pregnancy at the time of admission to the ISAPRE, i.e. a woman becoming insured with three months remaining in her pregnancy would be covered for one third of her maternity costs.¹¹⁷ Under recently issued regulations, preexisting conditions must be covered fully after eighteen months.¹¹⁸ Prior to the end of the eighteen months, at least one quarter of costs must be covered.¹¹⁹

ISAPRE policies are commonly subject to significant coinsurance obligations, though ISAPREs do offer full coverage policies to those willing to pay for them.¹²⁰ Copayments average a little over 30% for most insureds, though a small percentage of insureds with high costs of care pay almost 50%.¹²¹ More importantly, coverage is almost always subject to caps, both globally and service by service.¹²² Historically, these caps have not been expressed in readily understandable terms of pesos or UFs but by reference to a separate company list of general coverage specifications, which is not readily available. Insurers may have, therefore, only a vague understanding of their coverage.

ISAPREs not only cover medical care, they also pay for sick leave. In fact, ISAPREs spend about 18% to 23% of their claims-related

115. See Law No. 18.933, art. 33(b), Feb. 12, 1990, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS 191, 211 (Chile); Superintendencia de Instituciones de Salud Previsional, Circular No. 025, § 5 (Aug. 3, 1995) [hereinafter SISP, Circular No. 025].

116. See Chile Law No. 18.933, art. 33, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 211-12; SISP, Regulation 2263, § 5.2.1 (on file with author). Treatment related to a nonreported preexisting condition must be covered unless the last medical treatment for the condition took place within the preceding five years and the insured knowingly concealed the existence of the condition. See Chile Law No. 18.933, art. 33(b), 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 211.

117. See Chile Law No. 18.933, art. 33(e), 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 212.

118. See SISP, Circular No. 025, *supra* note 115, § 5.2.1. The regulation only applies to disclosed pre-existing illnesses. Concealed pre-existing conditions need not be covered until five years have elapsed. See *id.* § 5.2.3.

119. See *id.* § 5.2.1.

120. See Interview with Francisco Quesney Langlois, *supra* note 71.

121. See Bitrán & Almaraz, *supra* note 70, at 31-32. Copayments cannot exceed 75% under law. See Chile Law No. 18.933, art. 33(b), 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 211.

122. See Kifmann, *supra* note 46, at 144.

expenditures on medical leave.¹²³ ISAPREs must pay sick leave if a doctor certifies an insured to be unable to work.¹²⁴ Until 1990 the ISAPREs were also responsible for maternity leave, to which a pregnant woman is entitled from forty-two days before the birth until eighty-four days after.¹²⁵ As of 1990, the state took over responsibility for the cost of maternity leave.¹²⁶ Even not considering pregnancy leaves, however, working women request sick leave twice as often as men, contributing to the preference of ISAPREs for insuring men rather than women.¹²⁷ It is also widely believed that fraudulent certification of sick leave presents a significant problem.¹²⁸

Most of the ISAPREs are for-profit entities.¹²⁹ They are, on average, quite profitable. Profits can be evaluated two different ways: as a proportion of income, or as a return on investment. Profits as a proportion of income have been quite modest in recent years, averaging about 5%.¹³⁰ Profit as a return on investment has been much higher, averaging 25% in 1994 and 1995.¹³¹ Profit varies considerably among ISAPREs, however, with larger ISAPREs tending to make much higher profits than smaller ISAPREs.¹³² Because profit is relatively small compared to operating costs, moreover, it is very volatile, with some ISAPREs experiencing large losses in some years.¹³³

ISAPREs have relatively high operating costs, which are smaller for larger ISAPREs and have diminished over time. Between 1985 and 1995 the percentage of ISAPRE revenues actually returned to

123. See SISP, PRIVATE HEALTH SYSTEM, *supra* note 17, at 45. For 1996 the figure was 19%. See NATIONAL ASSOCIATION OF PRE-PAID HEALTH INSURANCE PLANS, ISAPRES, THE PRIVATE HEALTH SECTOR IN CHILE 23 (1996) (on file with the *University of Michigan Journal of Law Reform*).

124. See Chile Law No. 18.933, art. 37, at 214–15. The insurance companies have medical controllers to attempt to identify and deny unnecessary or excessive sick leaves. About 3% of requests for leave are rejected. See Bitrán & Almarza, *supra* note 70, at 40. Beneficiaries whose applications are denied or modified may appeal to a supervisory body, the Comisión de Medicina Preventiva e Invalidez, where they usually win. See Interview with Francisco Quesney Langlois, *supra* note 71.

125. See SISP, PRIVATE HEALTH SYSTEM, *supra* note 17, at 45 n.11.

126. See Chile Law No. 18.933, art. 21, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 202; see generally Law No. 18.469, art. 9, Nov. 14, 1985, 85 RECOPIACIÓN DE LEYES Y REGLAMENTOS 245, 248 (Chile).

127. See SISP, PRIVATE HEALTH SYSTEM, *supra* note 17, at 45.

128. See *id.* at 46; see also Carlini & Lombardi Interview, *supra* note 76.

129. See Interview with Francisco Quesney Langlois, *supra* note 71.

130. See Bitrán & Almarza, *supra* note 70, at 47.

131. See *id.* at 48–49.

132. Banmédica received an 88.4% return on investment in 1995 while Vida Tres received 76.7%. Consalud, the largest ISAPRE is nonprofit and made only 4.6%. See *id.* at 50.

133. See *id.* at 47–49.

beneficiaries in the form of medical reimbursements and sick leave increased from 59.5% to 71.5%.¹³⁴ In 1997, 18.9% of ISAPREs' revenues were spent on sales and administrative expenses.¹³⁵

D. The Effects of the ISAPRE System

Working in tandem, the characteristics of the ISAPRE system described to this point result in the peculiar nature of the Chilean ISAPRE system. First, ISAPRE coverage is skewed towards the wealthier members of society. The average monthly wage of ISAPRE members in 1997 was about U.S.\$700, while the average wage of FONASA beneficiaries (excluding indigents) was U.S.\$250.¹³⁶ Over 33% of ISAPRE members earn more than U.S.\$830 a month, and over 63%, more than U.S.\$400.¹³⁷ This is not surprising; indeed, private insurance is relied on throughout the world to permit persons of means to opt for a higher level of services than that provided through social insurance systems, and the Chilean system in particular was designed to reserve the publicly subsidized health system for the less fortunate. In fact, the remarkable thing about the ISAPRE system is not that it is skewed to the wealthy, but rather that it extends so far down into the population and covers people of such modest means. Over one third of ISAPRE members earn less than US\$400 a month, which means that their 7% premiums equal less than US\$28 a month, unless they are supplemented by the employer or employee.¹³⁸ It is also to Chile's credit that privatizing health insurance for the wealthy has not meant the abandonment of the public health insurance program, which in fact has received relatively generous increases in support in recent years.¹³⁹

A second characteristic, however, is that coverage is skewed toward young, healthy males. ISAPRE coverage drops dramatically upon retirement (indeed, as early as fifty-five). Only 10% of ISAPRE members are fifty-five or over, only 2.7% are sixty-five or

134. *See id.* at 43.

135. *See* SISP, Statistics, *supra* note 18.

136. *See id.*

137. *See id.*

138. *See id.*

139. *See* Jimenez & Bossert, *supra* note 37, at 208–09. These increases in investment, it should be noted, date from the 1990s, after the period of military government, though economic conditions during the 1980s would have made investment difficult during that period in any event. *See id.* at 207.

over, and only 2.7% are pensioners.¹⁴⁰ Some ISAPREs will not accept applicants who are over a certain age, and all charge higher premiums (two to four and a half times the rate of a middle-aged person) to the elderly.¹⁴¹ As noted above, women of child-bearing age also have a difficult time securing ISAPRE coverage in their own right, in part because of their higher use of sick leave. Sixty-nine percent of ISAPRE primary insured individuals are men.¹⁴² Women are much more likely to be insured as dependents of insureds, because dependents cannot receive sick leave, but in the prime child-bearing years between twenty and thirty-five only about 46% of total ISAPRE beneficiaries, including primary insureds and dependents, are women.¹⁴³ Once women reach age thirty-five, they are as likely to be insured by ISAPREs as men.¹⁴⁴

A third characteristic of the ISAPRE system is its bizarre multiplicity of health care plans. A health care plan is a particular policy covering a particular configuration of services, coinsurance, and caps, marketed by a particular ISAPRE.¹⁴⁵ Though it is difficult to discover the number of health care plans that exist within the ISAPRE system, the number is truly enormous. Persons within the Superintendency estimate that 10,000 plans existed, with 1000 or so available at any one time, but individuals affiliated with particular ISAPREs with whom I spoke estimated that their ISAPREs alone have thousands of plans.¹⁴⁶

This great number of plans exists for two primary reasons. First, the multiplicity allows exquisite price discrimination. The statutory 7% premium is a continuous variable, because the level of wages varies continuously. Each ISAPRE, thus, must offer a large number of plans so that at any premium, corresponding to 7% of any given wage level, a variety of choices is available. One expert estimated that if premiums were allowed to vary from 6.5% to 7.5%, 80% of the plans would disappear.¹⁴⁷

The second reason is a peculiar form of indirect experience rating that grows out of the ISAPREs' response to the legal prohibition against direct experience rating. This law, as stated

140. See SISP, BOLETÍN ESTADÍSTICO, *supra* note 73, at tbl.2.1.7. Because only 6.6% of the Chilean population is over 65, these figures are not quite as skewed as they appear. See SISP, PRIVATE HEALTH SYSTEM, *supra* note 17, at 10.

141. See Bitrán & Almarza, *supra* note 70, at 70-72.

142. See SISP, Statistics, *supra* note 18, at tbl.5.

143. See *id.* at tbl.4.

144. See *id.*

145. See Interview with Fernando Riveros Vidal, *supra* note 114.

146. See Interview with Gonzalo Simón, *supra* note 84.

147. See Interview with Francisco Quesney Langlois, *supra* note 71.

above,¹⁴⁸ requires that ISAPREs must raise premiums across the board for an entire plan if they want to raise rates at all, and prohibits raising premiums for individuals who require expensive medical care. It is widely believed that ISAPREs do in fact raise premiums, sometimes dramatically, for plans with which they have negative experiences, but then create new plans that closely resemble the old plan and offer them to persons that have a favorable claims experience under the old plan.¹⁴⁹ Thus high cost insureds pay more or leave the plan while less costly insureds move to new plans, permitting indirect experience rating but also adding to the multiplicity of plans.

Defenders of the ISAPRE system believe that the multiplicity of plans signifies healthy competition and promotes consumer choice. Skeptics believe, however, that the multiplicity of plans makes true comparison among insurers difficult, if not impossible.¹⁵⁰ This is particularly true because coverage limitations are often expressed in terms of internal insurance company schedules that are difficult to locate and understand.¹⁵¹ The fact that health insurance is sold only by agents of particular companies, rather than by independent agents marketing a variety of policies, makes comparison even more difficult.

A fourth characteristic of the system is that it covers primary care services much more effectively than it does catastrophic care. The ubiquitous presence of caps for most services and of overall caps makes ISAPRE insurance coverage of limited use for catastrophic conditions, though ISAPREs also make catastrophic policies available—for a price.¹⁵² ISAPREs are most valuable for covering routine services, and ISAPRE insureds tend to consult doctors more often than those insured by the public sector (3.3 medical visits per beneficiary per year compared to 2.4 visits per year for the public sector).¹⁵³ Indeed, one analyst has argued that private insurance in Chile operates much like private insurance in other

148. See *supra* text accompanying notes 96–97.

149. See Mansilla & Rodriguez Interview, *supra* note 80.

150. See Kifmann, *supra* note 46, at 143.

151. See Interview with Fernando Riveros Vidal, *supra* note 114.

152. See Bitrán & Almarza, *supra* note 70, at 65 (noting that copayments for catastrophic illness reach as high as 56.5%). Catastrophic policies are issued by life as well as health insurance companies. Catastrophic policies often exclude certain diseases or coverage of the elderly. See *id.*; see also URI WAINER K, HACIA UNA MAYOR EQUIDAD EN LA SALUD: EL CASO DE LAS ISAPRES, 29–32, U.N. Doc. LC/L.1036 (1997) (Spanish version) (citing studies finding that a small but significant number of ISAPRE beneficiaries encounter uncovered medical expenses that are catastrophic relative to their income, particularly persons who have low coverage plans and seek care from high cost hospitals).

153. See THE WORLD BANK, *supra* note 30, at 12.

countries that have national health services, i.e., as a supplement to rather than a substitute for the NHS coverage.¹⁵⁴

When ISAPRE beneficiaries require catastrophic care, they always have the option of returning to the public FONASA program by canceling ISAPRE coverage.¹⁵⁵ Indeed, FONASA does not know precisely whom it covers, and it is widely believed that ISAPRE members routinely receive services in SNSS hospitals at FONASA expense once their ISAPRE caps are exceeded, even though this technically is not permitted except in emergencies.¹⁵⁶ FONASA serves, therefore, as a reinsurer for those insured by the ISAPREs.

A final characteristic of the ISAPRE system, therefore, is that a significant cross-subsidization takes place between the public and private sectors. Subsidization clearly flows from the public to the private sector in several respects. The public sector bears the cost of maternity leave and immunization and other public health programs for ISAPRE as well as FONASA beneficiaries.¹⁵⁷ ISAPRE premiums and disbursements are exempt from taxation (as are those of FONASA), but additionally, up to 2% of employer contributions to ISAPREs above the 7% premium can be exempt from taxation for low income insureds, a benefit not available to FONASA members.¹⁵⁸ Moreover, as just noted, FONASA subsidizes the ISAPREs by providing care to their members in catastrophic cases.

On the other hand, the ISAPREs also subsidize the public sector, though the subsidies are less obvious. First, many professionals who work in the public sector also provide care on a fee-for-service basis to ISAPRE beneficiaries.¹⁵⁹ Many of these professionals make the bulk of their income in the private sector and deliver care for much lower compensation in the public sector. In fact, the ISAPREs have generally made a significant contribution to the development of a private health infrastructure in Chile, freeing up

154. See Kifmann, *supra* note 46, at 145.

155. See *id.*

156. See Bitrán & Almarza, *supra* note 70, at 67; Larrañaga, *supra* note 101, at 27; Interview with Giorgio Solimano, President of CORSAPS, in Santiago, Chile (June 19, 1998) (on file with author). FONASA is trying to establish a comprehensive list of its beneficiaries, but currently can identify only 90 to 95%. FONASA, however, is supposed to get lists from the ISAPREs of their beneficiaries, and public hospitals are in the process of developing systems of certification that would require them to verify insurance status at time of admission. Where hospitals discover that a patient is a member of an ISAPRE, they are supposed to bill the ISAPRE and the patient for their respective obligations for the cost of the care. See Interview with Rony Lenz Alcayaga, *supra* note 66.

157. See Larrañaga, *supra* note 101, at 26-27.

158. See *id.*

159. See Interview with Giorgio Solimano, *supra* note 156.

public health facilities to treat public beneficiaries.¹⁶⁰ Second, some believe that the reported higher rates of physician visits by ISAPRE members compared to publicly insured patients may be in part due to fraudulent receipt of ISAPRE benefits by persons who are in fact publicly insured.¹⁶¹ Controls over the receipt of ISAPRE-financed services appear to be quite ineffective.

II. LESSONS TO BE LEARNED FROM CHILE

A. *The Difficult Task of Insurance Regulation*

First, understanding the Chilean experience with regulation of private health insurance can give us a broader perspective on our own task. In particular, it reminds us of the universal nature of the game between the insurer and insured that insurance represents and of the difficult but necessary task that regulators must play to referee that game. Insurance exists because most of us are risk averse. We would rather face a certain but manageable cost in the present than the cost of a much greater but uncertain future risk, even if in the end the amount we pay now to avoid that risk exceeds the cost of the feared risk itself, adjusted for the probability of incurring the risk.¹⁶² We prefer to pay a fixed insurance premium every month and to rest in the certainty that if and when we face major medical bills they will be covered by our insurance.¹⁶³ Insurance companies, on the other hand, are willing to accept premiums from large numbers of insureds in exchange for accept-

160. The percentage of total hospital beds in private hospitals grew from 10% in 1981 to 25% in 1993. See SISP, PRIVATE HEALTH STATISTICS, *supra* note 17, at 32.

161. See Carlini & Lombardi Interview, *supra* note 76.

162. See KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 2 (2d ed. 1995); ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 13-14 (2d ed. 1996).

163. For reasons that are less clear, many people seem quite willing to obtain insurance against high frequency, low cost events such as the use of optical or dental services. See Paul Slovic et al., *Preference for Insuring Against Probable Small Losses: Insurance Implications*, 44 J. RISK & INS. 237 (1977). In the United States this is probably explained in part by the tax subsidy that is available for employment-related insurance. See SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 83-84, 88 (1997) (addressing payment of insurance premiums with pre-tax dollars). In Chile, the relatively low expenditure caps imposed on insurance policies result in most privately insured individuals being better covered for frequent, low cost losses than for catastrophic losses. Undoubtedly this is to a considerable degree due to the presence of FONASA as a reinsurer for catastrophic events. See Kifmann, *supra* note 46, at 148-49.

ing responsibility for the costs of expensive, unpredictable events.¹⁶⁴ The law of large numbers permits insurers to pool a large number of uncertain individual risks into a highly predictable obligation.¹⁶⁵ They can only perform this function, however, if the premiums they collect are sufficient in size to cover the costs of the insured losses, administrative costs (including marketing, underwriting, claims processing, and other costs), and a reasonable profit.¹⁶⁶ The task of insurance rate-setting is to establish a premium that can cover a defined benefit package plus administrative costs and profits for a particular insured.¹⁶⁷

While both parties to the insurance contract benefit from this exchange, the relationship is inherently problematic. First, there is the problem of adverse selection resulting from asymmetry of information.¹⁶⁸ The insured may have a better understanding of his or her risk exposure than does the insurer and thus faces a financial incentive to use this information to secure greater coverage for a given premium than would be actuarially warranted given the actual risk faced by the insured.¹⁶⁹ The woman who suspects that she is pregnant or the man who has recently experienced chest pains may purchase insurance policies without disclosing their current situation, and thus gain the favorable premiums offered to healthy persons.

Health insurers have a fairly standard armamentarium of weapons with which to combat adverse selection. They exclude, either permanently or for a set time, coverage of certain diseases, commonly including conditions that pre-exist coverage, or at least that have resulted in diagnosis or treatment before coverage commences.¹⁷⁰ They insure groups of employees, which are likely to present fairly good risks because group members are working, are

164. That is to say, insurers both accept the transfer of and pooling of risk. See ABRAHAM, *supra* note 162, at 2.

165. See *id.*; JERRY, *supra* note 162, at 14.

166. See ABRAHAM, *supra* note 162, at 106–10. Because risk averse individuals are by definition willing to pay a premium that is larger than the expected value of a potential loss (i.e., the product of the probability of the loss occurring times its magnitude should it occur), insurance companies can in fact charge premiums sufficient to cover these costs. See *id.* at 2. With respect to some types of insurance where payment for a loss occurs sometime after the loss is incurred (e.g., liability insurance), the insurance company also must take into account investment income gained from invested premiums. See *id.* at 107.

167. One of the tasks of insurers, therefore, is risk allocation—determining the level of premium that is proportionate to the degree of risk posed by each insured. See *id.* at 2.

168. See *id.* at 3–4. The classic treatment of this problem is Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 QUART. J. ECON. 629 (1976).

169. See ABRAHAM, *supra* note 162, at 3–4.

170. See Bitrán & Almarza, *supra* note 70, at 34; Chollet & Lewis, *supra* note 1, at 83–84.

unlikely to include many persons seeking insurance solely because of likelihood of illness, are often large enough to spread risk fairly broadly, and cost less to insure than individuals in terms of underwriting and marketing costs.¹⁷¹ Finally, insurers often require disclosure of medical history and medical records or medical examinations by approved physicians to screen out unhealthy applicants.¹⁷²

Two can play at the risk transfer game, however, and insurers often engage in cream skimming, seeking to attract insureds who will cost relatively little given the premiums they are willing and able to pay and to exclude high risk insureds altogether.¹⁷³ Though insurers usually know less about the individuals who seek insurance from them than the individuals know about themselves, insurers can be relatively confident that younger persons are better risks than older persons, that young men are better risks than young women, and that insured employees become riskier over time.¹⁷⁴ Alternatively, insurers set their rates through tiered, experience, and durational ratings to make certain that higher risk insureds pay their own way through higher premiums.¹⁷⁵

Once they obtain insurance, insureds face the temptation to use their insurance coverage to the maximum extent possible to get the full benefit of their policy. This is the problem of moral hazard.¹⁷⁶ The problem of moral hazard takes on peculiar characteristics in the health insurance arena, because there are really two parties that benefit from health insurance: insureds and the providers who care for them. Both face incentives to take advantage of insurers, but providers are often a greater threat to insurers than insureds. Few persons intentionally become ill to take advantage of their health insurer; indeed, most persons would prefer not to have to go to doctors or hospitals.¹⁷⁷ Providers who are paid on a fee-for-service basis, on the other hand, have every reason to want to provide as many and as expensive services for their

171. See Bitrán & Almarza, *supra* note 70, at 34; Chollet & Lewis, *supra* note 1, at 83.

172. See Chollet & Lewis, *supra* note 1, at 82.

173. See *id.*

174. See *id.* at 82–83.

175. See *id.* Tiered rating charges different insureds different rates based on their potential risk; experience rating ties premiums to claims experience; durational rating is charging higher rates for customers who are renewing their policies. See *id.*

176. See ABRAHAM, *supra* note 162, at 4; Chollet & Lewis, *supra* note 1, at 84.

177. See GLIED, *supra* note 163, at 78 (discussing the deterrent effect of noninsurable costs of being ill, such as pain, suffering, and time). Insured persons may take more health risks and are likely to seek more care and more costly care once they become ill, however. See *id.* at 74–76 (addressing the moral hazard of providing health insurance).

insured patients as possible.¹⁷⁸ Again, asymmetry of information problems come into play. The provider often knows more about the insured's condition than does either the insurer or the insured and can use this information to take maximum advantage of both.

Moreover, when, as in Chile and in some other countries with social insurance, the health insurer is responsible for sick leave pay, the insured faces more direct and immediate incentives to take advantage of the insurer.¹⁷⁹ As noted earlier,¹⁸⁰ there is widespread belief that sick leave insurance is widely abused in these countries by employees who are dissatisfied with their work, or simply do not feel like working.¹⁸¹

Health insurers have a range of traditional tools for dealing with moral hazard. Cost-sharing, in the form of deductibles, copayments, and coinsurance, is perhaps the most common.¹⁸² Utilization review of discrete services provided to particular patients is another.¹⁸³ Statistical review of the caseload of particular providers is a third.¹⁸⁴ Caps on coverage, a fourth strategy, place a limit on the insurer's aggregate exposure to the demands of any particular insured, on a service by service basis or in total.¹⁸⁵

Managed care is primarily, from the prospective of the health insurer, a tool for addressing the problem of moral hazard.¹⁸⁶ In less rigorous forms of managed care this is done through utilization review; through the withholding of funds to cover, in part, the cost of tests, referrals, or hospital admissions; or through the granting of bonuses if such costs are avoided. In the strongest forms of managed care, where capitation is used, the provider's incentives are aligned with the insurer to limit the potential of moral hazard on the part of the insured.¹⁸⁷

178. See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 181 (1997).

179. When Bismark originated the German health insurance system in the nineteenth century, its primary purpose was to provide income rather than health care for sick workers. See Peter Rosenberg, *The Origin and Development of Compulsory Health Insurance in Germany*, in POLITICAL VALUES AND HEALTH CARE: THE GERMAN EXPERIENCE 105, 113 (Donald W. Light & Alexander Schuller eds., 1986).

180. See *supra* text accompanying note 128.

181. See MICHAEL ARNOLD, SOLIDARITÄT 2000: DIE MEDIZINISCHE VERSORGUNG UND IHRE FINANZIERUNG NACH DER JAHRTAUSENDWENDE 129 (1995).

182. See Chollet & Lewis, *supra* note 1, at 84-85; see also HALL, *supra* note 178, at 15-61 (evaluating this strategy).

183. See 2 BARRY R. FURROW ET AL., HEALTH LAW 46-53 (2d ed. 1995).

184. This approach is used in Germany, see Jost, *supra* note 13, at 669-77, and by some managed care organizations in the United States.

185. See Chollet & Lewis, *supra* note 1, at 85-86.

186. See *id.* at 84.

187. See HALL, *supra* note 178, at 186-89.

The primary role of insurance regulation has traditionally been to assure that insurers play the game fairly.¹⁸⁸ The specific form that such regulation takes will depend on the basic ground rules under which the insurance system operates. In Chile, for example, the premium for health insurance is more or less fixed at 7% of income, while the benefit package varies widely; in the United States premiums vary widely while the benefit package is more standard. Where, as in the United States, managed care becomes common, underprovision of care becomes a serious regulatory concern. Underprovision is, of course, much less of an issue for insurance regulators in a fee-for-service environment.

The most basic task of regulators is to assure that insurers are able to pay for unexpected events as they occur—that they are solvent.¹⁸⁹ In Chile this is accomplished through requirements that insurers meet minimum capital requirements and deposit a guaranty equaling one month's worth of benefits payments collected with the SISP.¹⁹⁰ The SISP also regularly and frequently audits the ISAPREs to assure their continued financial responsibility.¹⁹¹

The regulator can also attempt to control the use by insurers of various devices that address adverse selection or moral hazard to protect insureds from overreaching or to protect particular insureds or classes of insureds from discrimination. Thus, in Chile, the law prohibits the total exclusion of coverage for most medical conditions, forbids the imposition of waiting periods in most instances, restricts the use of categories other than age and sex for rate setting, and limits the use of preexisting condition clauses and restrictions on the coverage of expenses related to pregnancy.¹⁹²

The first lesson to be learned from the Chilean experience, however, is that as long as one is functioning in a market for private insurance and operating under a basic principle of freedom of contract, there are real limits on how much regulation can accomplish, particularly if the intent of the regulation is to expand insurance coverage. The Chilean experience shows us that if an

188. Chollet & Lewis break this purpose down into three goals: maintaining a stable insurance market, protecting consumers, and maximizing consumer access to insurance. See Chollet & Lewis, *supra* note 1, at 87.

189. See *id.* at 87–89; U.S. GENERAL ACCOUNTING OFFICE, PUB. NO. HRD-94-26, HEALTH INSURANCE REGULATION: WIDE VARIATION IN STATE'S AUTHORITY, OVERSIGHT, AND RESOURCES 8–10 (1993).

190. See Law No. 18.933, arts. 25–27, Feb. 12, 1990, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS 191, 206–07 (Chile).

191. See Interview with Fernando Riveros Vidal, *supra* note 114. The SISP has 15 controllers on staff, who visit each ISAPRE on average four and a half times a year.

192. See Chile Law No. 18.933, arts. 33, 33b, 38, 96 RECOPIACIÓN DE LEYES Y REGLAMENTOS at 211–12, 215–16.

insurance regulator limits the use of preexisting conditions clauses or exclusions of conditions but does not guaranty access to private insurance, insurers can simply refuse to deal with persons who are sick, old, or of child-bearing age. If, as the Chilean experience demonstrates, a regulator requires insurers to guarantee renewability of insurance for persons already insured, insurers will be more selective as to whom they insure and will find ways, if possible, to drive away insureds who are proving to be expensive.¹⁹³

In the end a private insurer will, and must, find ways to limit both whom it insures and the risks that it insures. Though attempts to limit the options available to insurers for doing so may be justified on grounds of fairness, they will also usually result in distortions elsewhere in the market and sometimes be of marginal value to those whom they are intended to protect. This is confirmed not only by the Chilean experience, but also by our own experience with the Health Insurance Portability and Accountability Act¹⁹⁴ and with various state insurance reforms.¹⁹⁵ In the end, private health insurance schemes cannot assure equitable access to health care for all, no matter how they are regulated.

The message here for managed care regulation is that we are likely to meet the same barriers in attempting to regulate insurers' attempts to limit moral hazard that Chile has encountered in attempting to regulate the responses of insurers to adverse selection. There is some truth in what insurers in the United States have been saying loudly and insistently: managed care regulation comes at a cost.¹⁹⁶ If insurers are limited in their ability to control moral

193. This seems to be what is happening with the implementation of guaranteed issue and renewability provisions of HIPAA in the United States. See, e.g., Geri Aston, *Insurance Reform Law Falls Short*, AM. MED. NEWS, Sept. 14, 1998, at 1.

194. 29 U.S.C. §§ 1181-1182, 42 U.S.C. § 300gg-41.

195. See generally U.S. GENERAL ACCOUNTING OFFICE, PUB. NO. T-HEHS-98-114, HEALTH INSURANCE STANDARDS: IMPLICATIONS OF NEW FEDERAL LAW FOR CONSUMERS, INSURERS, REGULATORS (1998) (detailing problems with implementation of HIPPA); U.S. GENERAL ACCOUNTING OFFICE, PUB. NO. HEHS-98-67, HEALTH INSURANCE STANDARDS: NEW FEDERAL LAW CREATES CHALLENGES FOR CONSUMERS, INSURERS, REGULATORS (1998) (same); Robert Kuttner, *The American Health Care System—Health Insurance Coverage*, 340 NEW ENG. J. MED. 163 (1999).

196. The cost of regulation is hotly contested, with industry estimates of the cost of 1998 Democratic proposals ranging from the wildly inflated but still oft quoted estimate of a 23% increase in health insurance costs put out by Millman and Roberts, see Stephen Blakely, *The Backlash Against Managed Care*, NATION'S BUS., July 1998, at 16, to a lower estimate of 2.7 to 8.6% increase from the Barents Group. See *Insurance Regulation: Managed Care Debate Aimed at Public, but Close Look at Polls Show Mixed Signals*, HEALTH CARE DAILY BNA, July 6, 1998. Coopers and Lybrand has estimated that the 1998 House Republican proposal for a point-of-service option would result in premium increases of between \$.58 and \$7.01 per person per month, depending on the rate of cost-sharing that would be allowed. See *id.* Increases in the cost of insurance would in all likelihood result in more persons being uninsured, though the

hazard, the cost of insurance will certainly increase and its availability will certainly decrease. With respect to each proposal for regulation of managed care, and in particular proposals directed at expanding coverage or benefits, we must attempt to discover how much the proposal is likely to cost, on whom the cost will be imposed, and whether the cost will exceed the benefit. Certainly in some instances the benefit will justify the cost, but the calculation cannot be avoided and must always be made.

B. The Necessary Task of Insurance Regulation

While Chile's experience cautions us to be sober and modest in our expectations of regulation, particularly regulation intended to expand access and coverage, it also demonstrates the problems caused by largely unregulated insurance markets. In recent years advocates of free markets have been very effective in convincing the public and policy makers that regulation is more often than not counterproductive.¹⁹⁷ Though it has long been argued that health care markets are more in need of regulation than other markets, free market advocates have recently begun to argue that even here regulation is generally unnecessary and harmful.¹⁹⁸ Some have even argued for the privatization of public programs, by giving program beneficiaries vouchers and then allowing them to use these vouchers to purchase private insurance in private markets.¹⁹⁹

Chile has in fact privatized part of its social insurance programs insofar as Chileans can take the 7% of their wages formerly dedicated to social health insurance and use it to purchase private insurance. Until recently, the insurance purchase transaction itself was largely unregulated. Insurers had to provide a minimum benefit package but were otherwise largely unregulated in their premiums, cost sharing requirements, exclusions, coverage terms, and sales practices.²⁰⁰ The result was a situation in which many con-

estimate of the Lewin Group that 400,000 persons would lose health insurance coverage for every 1% increase in premiums, which again has been widely quoted, is too high. See U.S. GENERAL ACCOUNTING OFFICE, PUB. NO. T-HEHS-99-147, PRIVATE HEALTH INSURANCE: IMPACT OF PREMIUM INCREASES ON THE NUMBER OF COVERED INDIVIDUALS IS UNCERTAIN 69 (1999).

197. See JERRY L. MASHAW, GREED, CHAOS, AND GOVERNANCE: USING PUBLIC CHOICE TO IMPROVE PUBLIC LAW 23-25 (1997) (discussing the effects of deregulatory reform movements).

198. See EPSTEIN, *supra* note 24, at 121-46; Hyman, *supra* note 24, at 451-66.

199. See sources cited *supra* note 25.

200. See Kifmann, *supra* note 46, at 142-43.

sumers were underinsured,²⁰¹ some were overinsured,²⁰² many had large gaps in coverage,²⁰³ and most were thoroughly confused and uncertain as to what their insurance would actually cover. Had the public system not continued as a safety net, many Chileans would undoubtedly have found themselves without resources to pay for needed medical care.

In the recent past Chile has moved toward a form of managed competition, attempting to limit exclusions and cost-sharing through regulation and to produce useful comparative information. The SISP has attempted to assure that insureds have at least the possibility of understanding the contract that the insurer is offering them. It has promulgated regulations requiring insurers to use a common chart to present comparable information as to the extent of their coverage of fifty-three procedures, including services that together account for 80% of the ISAPREs on health services, plus representative, high cost catastrophic services (such as cardiovascular surgery) and common, low cost services (such as urine tests).²⁰⁴ The regulator can also attempt to assure that policies provide at least a basic level of coverage corresponding to the expectations of most insureds. Another recent Chilean regulation requires insurers to cover at least 25% of the cost of any procedure covered by FONASA.²⁰⁵ Though it is too early to judge the effects of these forms of regulation, it is possible to judge from Chile's past experience that largely unregulated markets are highly problematic.

C. The Possibility of Technology Transfers

The United States has developed, in the National Association of Insurance Commissioners (NAIC), a sophisticated and effective mechanism for promoting the sharing of information among the states with respect to approaches to regulating insurance.²⁰⁶ The NAIC acts as a clearinghouse, developing draft statutes and regulations that can be used as models by state legislatures and

201. See *supra* text accompanying notes 155–56.

202. See *supra* text accompanying note 102.

203. See *supra* text accompanying notes 146–50.

204. See SISP, Regulation 2263, § 7 (on file with author); Interview with Fernando Riveros Vidal, *supra* note 114.

205. See SISP, Regulation 2500, § 4.1 (on file with author).

206. See JERRY, *supra* note 162, at 99–100.

regulators.²⁰⁷ It is possible, however, that we can learn not only from approaches developed domestically but also from those developed by other nations with private health insurance industries.

Chile has created its own devices, noted above, for bringing transparency to the insurance market and for limiting the use by insurers of certain contract clauses. Perhaps the most interesting tool developed by the SISP, from a U.S. perspective, is its system for hearing health insurance complaints. A central issue in our debate about managed care has been the crafting of systems for handling complaints and appeals. There is much to learn here from the Chilean system.

Any insured who feels aggrieved by his or her insurer may complain to the SISP. These complaints may be presented in writing, by telephone, in person, or by email.²⁰⁸ During 1997, the SISP received 46,835 complaints and questions from consumers.²⁰⁹ The consumer department of the Audit Division of the Superintendency initially reviews these complaints and questions.²¹⁰ Many of them are either not within the jurisdiction of the SISP (e.g., they pertain to issues such as the level of insurance premiums, over which the SISP has no jurisdiction, or sick leave denials, which are the responsibility of another agency) or are easily clarified misunderstandings.²¹¹

Serious complaints are forwarded to the arbitration division of the legal department.²¹² In 1997, 698 complaints were resolved by the legal department.²¹³ The complaints are first sent to the insurer, who has three business days (or up to five continuous days) to provide the SISP with both its response to the complaint and any relevant documentary evidence.²¹⁴ The burden of proof in complaint cases normally rests with the insurer, so insurers have reason to respond promptly and thoroughly.²¹⁵ Responding to complaints is a major responsibility of the legal departments of in-

207. See generally U.S. GENERAL ACCOUNTING OFFICE, *supra* note 189.

208. See Interview with Fernando Riveros Vidal, *supra* note 114.

209. See SISP, BOLETÍN ESTADÍSTICO, *supra* note 73, at 76.

210. See *id.*

211. See *id.*

212. See Interview with Andrea Muñoz Sanchez, Director, Legal Department, SISP, in Santiago, Chile (June 22, 1998) (on file with author); Interview with Andrea Muñoz Sanchez, *supra* note 111.

213. See SISP, BOLETÍN ESTADÍSTICO, *supra* note 73, at 76.

214. See Interview with Anna Maria Rubio, General Counsel, Banmédica, in Santiago, Chile (June 24, 1998) (on file with author).

215. See Interview with Fernando Riveros Vidal, *supra* note 71.

surers.²¹⁶ Once the SISP receives a complaint, it is assigned to an attorney of the legal department of the SISP for investigation.²¹⁷ In most instances evidence is taken in writing, except when necessary witnesses are interviewed or examined.²¹⁸ Each party may respond to statements of the other party as long as either party has further statements to make.²¹⁹ The complaint and responses are then reviewed by the staff attorney assigned to the complaint, who develops a written analysis of the case and recommended solution.²²⁰ The SISP has three full-time and one part-time physician on staff who assist with medical questions raised by the complaints, such as whether a medical condition preexisted the policy.²²¹ Specialists may also be consulted if necessary.²²²

Once the investigation process is complete, the complaint, response, analysis, and recommendation are reviewed by a committee consisting of the attorney who worked up the case, the physician who assisted (if one did), the head of the legal department, and representatives of the audit and research departments.²²³ This committee comes up with a proposed decision for the complaint. The Superintendent ultimately reviews every complaint personally and may either adopt the proposed resolution or craft his own response.²²⁴

If the complaint is resolved against the insurer, the insurer must comply with the resolution ordered by the SISP. In some cases, the SISP issues small damage awards in the form of "interest" on the amount due the insured.²²⁵ In 1997, 698 cases were resolved through the arbitration process.²²⁶ Twenty-five percent were won

216. The General Counsel of Banmédica estimated that responding to complaints consumed 80% of the time of her three lawyer legal staff. See Interview with Anna Maria Rubio, *supra* note 214.

217. There are five attorneys assigned to this task within the SISP. See Interview with Andrea Muñoz Sanchez, *supra* note 212.

218. See *id.* This is particularly likely to occur where the complainant claims that the insurance salesman made oral misrepresentations. In these cases the salesperson may be interviewed. If oral testimony is taken, the attorneys of the parties may cross-examine, though usually only the insurer will have an attorney. If the salesperson denies the claims, the claimant will usually lose, as the claimant must usually sign the policy application stating that he has read and understood the policy and will be bound by this statement in the absence of admissions that representations contrary to the policy were made. See Interview with Fernando Riveros Vidal, *supra* note 71.

219. See Interview with Andrea Muñoz Sanchez, *supra* note 212.

220. See *id.*

221. See *id.*

222. See *id.*

223. See *id.*

224. See *id.*

225. See Interview with Andrea Muñoz Sanchez, *supra* note 111.

226. See SISP, BOLETÍN ESTADÍSTICO, *supra* note 73, at 76.

totally by the insured, 28% totally by the insurer, 34% partially by the insured, and the remainder were subject to other dispositions.²²⁷ The insurer may contest the decision in court but must essentially prove misconduct on the part of the SISP to prevail.²²⁸ Decisions are in fact rarely appealed.²²⁹ The appellate decisions of the SISP are published annually to inform insurers of the position of the SISP on various issues.²³⁰

The arbitration process is quite time-consuming, lasting six months or more.²³¹ The process is, however, free to the insured and is often the best means of resolving problems with insurers. Moreover, if the complaint is directed at termination of the insured, the insurer must continue coverage until the complaint is resolved.²³²

One of the most important characteristics of this process is that in responding to complaints the SISP is not limited to the strict letter of the statute, regulations, and contract, but has equitable powers to resolve complaints fairly.²³³ Under the law, for example, there is nothing to forbid an insurer from raising the premiums of a particular plan as long as the insurer does so equally for all persons insured under the plan.²³⁴ As noted above, however, insurers can escape this requirement by offering new plans to insureds with favorable claims experience and then raising premiums dramatically for persons insured under the plan with less favorable claims experience who are left behind. Persons whose rates have thus been dramatically increased may complain to the SISP. The SISP has been willing to consider the equity of these rate increases.²³⁵ In a case where an insured is effectively a "captive" to the insurer because her medical condition makes her otherwise uninsurable, the proposed rate increase is substantial, and the financial situation of the insurer does not make an increase necessary, the SISP has been willing to reject the increase and propose a reasonable price increase given the situation.²³⁶ In effect, the regulator has honored

227. See *id.*

228. See Interview with Andrea Muñoz Sanchez, *supra* note 212.

229. See *id.*

230. See generally, SUPERINTENDENCIA DE INSTITUCIONES DE SALUD PREVISIONAL, BOLETÍN DE FALLOS DE LA SISP, PERIODO: ENERO A DICIEMBRE DE 1996 (1997) (on file with the University of Michigan Journal of Law Reform).

231. See Interview with Andrea Muñoz Sanchez, *supra* note 212.

232. See SISP, Regulation 2500, § 5.1 (on file with author).

233. See Interview with Andrea Muñoz Sanchez, *supra* note 212; Interview with Andrea Muñoz Sanchez, *supra* note 111; Interview with Alejandro Ferreiro Yazigi, Superintendent, SISP, in Santiago, Chile (June 15, 1998) (on file with author).

234. See Interview with Andrea Muñoz Sanchez, *supra* note 111.

235. See *id.*

236. See Interview with Andrea Muñoz Sanchez, *supra* note 212.

the "reasonable expectations" of insureds that they would not be singled out for excessive premium increases, just as American courts have often honored "reasonable expectations" to curb insurer overreaching.²³⁷

The complaint procedure is not exclusive, and insureds may go to court if they choose.²³⁸ There is in fact an expedited judicial procedure in Chile for challenging violations of constitutional rights, and insureds have used this procedure effectively to challenge insurance company actions that allegedly violate the constitutional right to health care.²³⁹ Court proceedings are more costly, however, because an attorney is required, and the vast majority of insureds choose to bring their complaints to the SISP.²⁴⁰

There is much to commend this model as a managed care complaint procedure. Particular features of the procedure—the placement of the burden of proof on the insurer, the use of an interdisciplinary team to review complaints, the vesting ultimate decisionmaking power in an official who is both politically accountable and also responsible for assuring the solvency of insurers, the availability of equitable power as well as legal, and the publication of decisions for future consideration—all would be useful in a managed care setting. These ideas should give us food for thought as we craft our own procedures for regulating managed care.

D. Reflecting on Our Responsibility

In his recent movie of the same name, Michael Moore suggests that the United States be renamed "The Big One,"²⁴¹ reflecting our position on the world stage. Though the overall situation of our health care system—the highest health care costs in the world combined with the lowest rate of insurance coverage of any developed nation—gives other nations little to envy, there is a great deal of interest worldwide in our managed care developments. For better or worse, a number of nations are developing various managed

237. See KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 103, 103–32 (1986) (discussing court decisions and rationales honoring an insured's expectations).

238. See Interview with Anna Maria Rubio, *supra* note 214.

239. See *id.*; Interview with Andrea Muñoz Sanchez, *supra* note 212.

240. See *id.*

241. *THE BIG ONE* (Miramax 1998).

care arrangements, often with assistance from United States companies and individuals.

Because Chile has a well-developed private health insurance industry and a strong commitment to a free-market economy, and because it is generally open to new ideas and institutions, it is possible that managed care will develop quickly in Chile. As noted above, some ISAPREs have already begun to develop managed care systems. We have discovered in the United States that institutions that have been developed for regulating fee-for-service insurance are not adequate for responding to the issues raised by managed care. That is the reason for this symposium. In particular, a much more sophisticated capacity for evaluating medical decisions of insurers is necessary when the main threat that an insurance regulator must address is underservice.

At the time this Article was written, Chile was just beginning to think about how to regulate managed care.²⁴² Legislative and regulatory efforts at the federal and state level, as well as a torrent of academic publications and conferences such as this symposium, suggest that we are further along in working through this problem. As we begin to solve this regulatory problem, we need to make our solutions broadly available. We should find ways to involve entities that work with health care systems throughout the world, such as the World Health Organization, the Pan American Health Organization, or the World Bank, in these dissemination efforts.

CONCLUSION

The task of designing institutions and programs to regulate managed care is essential, but formidable. Though comparative law and policy studies may not be able to contribute much to this task, they can contribute something. When tackling such a difficult and important task, we need to accept help wherever we can find it. The experience of other nations, such as Chile, can help us gain perspective both on the context and the importance of our task, and perhaps suggest tools that we can use to accomplish it.

242. See Interview with Andrea Muñoz Sanchez, *supra* note 212.