# ISAPRES
## 1981-2016

**35 years supporting Chile's private health system**

isapres de Chile 35 AÑOS

# PROLOGUE

On the occasion of the thirty-fifth anniversary of the creation of the Social Security Health Institutions (Instituciones de Salud Previsional - ISAPRE), the ISAPRE Trade Union Association (Asociación Gremial de ISAPRES AG) published the book entitled: **"ISAPRES 1981 - 2016: 35 years developing Chile's private health system".**

In its pages it is possible to see a brief historical review of the development of the ISAPRE System and of the regulatory framework that has governed it throughout the years, in addition to institutional and operational aspects that have characterized the Chilean health system. Next, it outlines the challenges faced by the system and presents various proposals submitted by Chile's ISAPRE Association in order to develop and project the system toward a new private social security health care model. Following, it includes a series of statistical data that permit visualizing the health care coverage and benefits delivered by the private system.

It is of particular interest that this book becomes a real contribution to its readers and that its pages may provide a complete picture of the private health care system. The objective, therefore, has been to prepare a document that would become a future contribution toward the improvement of our country's private social security health care system.

# Letter From The Chairman Of The Isapres Association

I have the pleasure of presenting to you the document: "ISAPRES 1981 – 2016: 35 years developing Chile's private health system", which summarizes the main achievements of the private social security health care system and the sector's future challenges.

35 years ago, in 1981, Chileans saw their health choice possibilities expanded via the creation of the ISAPRE System. One of its accomplishments has been to enable access to an increasing number of persons to the private health care system that had no option but to resort to the public system. In this manner, the ISAPRES replaced the State in delivering and financing health care benefits for those workers who freely and individually opted for them. Thus, the creation of the ISAPRE System marked the beginning of Chile's important private health care development; which, in turn, caused the country's significant expansion of the private medical activity, a hospital infrastructure development boom, and ambulatory medical care services benefiting patients of both the ISAPRE System as well as the FONASA public health care system.

All things considered, the ISAPRES today finance the health benefits, including sick leave, of approximately 3.5 million persons in Chile without imposing any economic burden on the State, since the ISAPRES are financed solely by the contributions of their respective affiliate, while helping that more than 7 million FONASA beneficiaries meet their health care needs via private medical services, developed because of the existence of Isapres.

The foregoing drives us to improve the system in order to allow more Chileans to have access to private health care. I am convinced that we should move quickly and decisively in facilitating the affiliates the knowledge of the health care coverages given by ISAPRE´s. To that effect, we propose the creation of a Standardized Health Benefits Plan (Plan de Beneficios de Salud Estandarizado). Likewise, we must migrate from an individual rate-fixing model to a system offering greater solidarity in order to even out gender and age ratings and also to equalize risks via a Risk Compensation Fund. This would minimize differences while permitting the mobility of affiliates with preexisting diseases or of older persons.

The complexity entailed by such changes, however, takes time and prudence to be implemented. However, there is an urgent and pressing problem; i.e. the litigation of the price adjustment of the health plans. There is full technical consensus that such price increases are not arbitrary; instead, they are called for in order to cover the greater costs of an increasingly intensive medicine that looks after a demanding and aging population, all of which, inevitably, generate costs over and above the rate of inflation and economic growth. This problem –currently impacting the system's financial stability - requires an urgent solution and cannot continue to be ignored by the authorities because while we attempt to correct the insurance scheme (model), the increasing wave of lawsuits may jeopardize the viability of any given ISAPRE.

**Rafael Caviedes Duprá**
Chairman - Asociación de ISAPRES de Chile A.G.

# Chapter 1

35 years supporting Chile's private health system

Chile's health care system has undergone a number of transformations ever since the creation of the country's first health care organizations. These modifications have led to structural changes of Chile's health care system, steering it in the direction of what it is nowadays: an all-around mixed health care system that includes the participation of both the public as well as the private sector in all matters concerning its financing, underwriting (social security insurance) and health care delivery services.

The origin of Chile's health care system dates back to the year 1844, with the emergence of the first sanitary organization, hand-in-hand with the creation of the National Welfare Board (Junta Nacional de Beneficiencia). Nevertheless, the concept of insurance appeared for the first time during the first part of the 20th century, with the creation in 1924 of the Ministry of Hygiene, Assistance and Social Security (Ministerio de Higiene, Asistencia y Previsión Social), which subsequently became the Ministry of Health, and with the enactment of the Mandatory Worker's Insurance Act[2] (Ley de Seguro Obrero Obligatorio) (Law N° 4,054 of 1924). This insurance, in addition to health care coverage also incorporated pension payments (old age), labor casualty indemnity payments (disability) and affiliate death payments (until the year 1952). With the Worker's Insurance, a contributory form of health financing system was first installed in our country; namely, the system's contributions came from hired workers, their respective employers, and the State.

Later, in 1942[3] was created the National Employees' Medical Insurance (SERMENA, in its Spanish acronym), merging the former National Public Employees' and Journalists' Fund (CEPP, in its Spanish acronym) with the Private Employees' Social Security Fund (EMPART)

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1. This section is based on: a) the "Presidential Advisory Commission for the study and proposal of a new model and regulatory legal framework for the private health care system" (Comisión Asesora Presidencial para el Estudio y Propuesta de un Nuevo Modelo y Marco Jurídico para El Sistema Privado de Salud) (2014); b) the CEP Report entitled "Challenges and some guidelines for Chile's health care insurance system" (Desafíos y Algunos Lineamientos para el Sistema de Seguros de Salud en Chile) (Velasco, 2014); c) the PUCV Report entitled: "The private health care market in Chile" (Mercado de la Salud Privada en Chile) (PUCV 2012); and, on d) the gathering of data via electronic means.

2. In this case, the word "insurance" is not related to today's current concept of insurance. It was the first step toward the establishment of a social security system in Chile, which established a semipublic social security entity under a "pay-as-you-go" system (sistema de reparto) (i.e. paying the social benefits of its affiliates out of the total funds thus collected).

Until the year 1979, when it merged into the National Health Care System (SNSS, in its Spanish acronym).

thereby incorporating this segment to the social security system and delivering health and dental care services under an administrative or free-choice (boucher) system.

On the other hand, in 1952 (Law N° 10,383 of 1952) was created the National Health Service (SNS, in its Spanish acronym); which, as opposed to SERMENA delivered services to workers and to the rest of the non-covered population (as homeless persons). With the creation of the SNS disappeared the Mandatory Worker's Insurance as such, separating medical from social security functions. On the other hand, social security responsibilities were assumed by the Social Security Service (SSS, in its Spanish acronym) (Law N° 10,383 of 1952[4] , incorporating family allowance and unemployment insurance entitlements into it.

Meanwhile, in 1968, Law N° 16,744 was enacted, laying down regulations governing occupational casualties and occupational diseases, assuming pension and benefit payment commitments, as well as the collection of such insurance premium[5] (Insurance Mutuals (Mutuales de Seguridad), Labor Safety Institute (Instituto de Seguridad Laboral), separating these events from the medical obligations of the National Health Insurance. This insurance exists to this day in our country.

In sum, toward the mid 1970's, Chile's health care system was organized as follows: the Public Health Ministry along with the National Health Service exerted the regulatory and controlling functions. Additionally, the National Health System managed and operated the public health sector; which, as indicated above, provided coverage to workers and homeless persons, none of which had access to free-choice medicine (choice of a health services provider) prior to 1979 and if treated by private sector providers they had to assume the full payment of such services. The SERMENA was dependent from the Public Health Ministry, which at the time was a semi-fiscal institution that financed employees' (white collar) health services and who, in turn, could choose from among a set of registered providers against an on-the-spot copayment. The legislation established that all workers had to mandatory contribute part of their salaries. SNS-registered workers received contributions from their employers in addition to fiscal contributions. On the other hand, SERMENA affiliate workers only received supplementary contributions from their employers.

Moreover, the above-mentioned Insurance Mutuals as well as other health protection schemes associated to the Armed Forces, the Police (Carabineros) and the Universities were already operating.

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### I.1.2 The health reform of the 1980's

The current national health system design originated in the year 1980 (and its modeling extended throughout the entire decade), via the enactment of a new Political Constitution for the Republic of Chile; which, among other

4. En 1980 se crean Administradoras de Fondos de Pensiones (AFP), instituciones privadas encargadas de administrar los fondos y ahorro de pensiones (Decreto Ley N° 3,500 de 1980). Con ello, se reformó el sistema previsional transformándolo en un sistema de capitalización individual de las pensiones de vejez, invalidez y supervivencia. Las cajas previsionales – sistema anterior de reparto por medio de las cuales se cotizaba y entregaban las prestaciones correspondientes – se mantuvo sólo para las Fuerzas Armadas y Carabineros de Chile.

5. Mutuales de Seguridad (privadas sin fines de lucro), Instituto de Seguridad Laboral (ex INP, Estatal) y empresas con administración delegada (Codelco y PUC).

aspects, acknowledged, in its Art. 19 n°9 para 1, the right to the protection of health as a constitutional guarantee. Specifically, said article provided that: "The State protects the free and equal access to actions toward promoting, protecting and recovering the health and the rehabilitation of individuals. Likewise, the State shall be responsible for coordinating and monitoring health-related actions. It is indeed the primary duty of the State to guarantee the execution of health actions, whether provided through public or private institutions, on such terms and conditions as set forth by law; which, may establish mandatory contributions. Each person shall be entitled to choose the health care system of his/her preference, whether public or private".

On health-related matters, the 1980 Political Constitution acknowledged the existence of a private health care sector, underlying the freedom to choose between such private system and the public health system. Thus, such constitutional provisions generated a change on health matters upon understanding that actions toward promoting, protecting and recovering the health and the rehabilitation of individuals can be delegated, thereby permitting private-sector participation in a sphere heretofore practically assigned in exclusivity to the public sector. With respect to health actions -although it is the primary but non-exclusive duty of the State to look after them- they must be performed always honoring the private initiative in this matter, considering that the right of all persons to choose their health care system is guaranteed in the constitution. The law upheld the obligation to contribute (health and pensions); however, it innovated by introducing the worker's right to choose where to do so: i.e. whether to make their contributions in a state or in a private system, without forcing anyone to contribute in one or another system. This constitutional norm originated the Social Security Health Institutions (ISAPRES, in its Spanish acronym) and empowered the law to regulate those private entities that perceive mandatory health contributions; which, in that manner replace the State in the provision and financing of health care services. Thus, all persons since 1980 are entitled, their respective incomes permitting, to choose whether remaining in FONASA or joining an ISAPRE.

This regulatory change ended the discrimination that existed up until the year 1980 between workers (blue collar) and employees (white collar), which could only make use of either the SNS if a worker or the SERMENA if an employee.

Additionally, the 1980 Constitution redefined the role of the Health Ministry and decentralized public health care services. In the case of primary health care, the management of primary health care centers was transferred from the National Health Service to the Municipalities; a process that was carried out between 1981 and 1988. With this, the SNS was dismantled and public health services were decentralized into 27 different autonomous organizations with their own equity capital in charge of the operative, management and development functions of their network and whose jurisdiction remained associated to certain zones.[6]

**1980**

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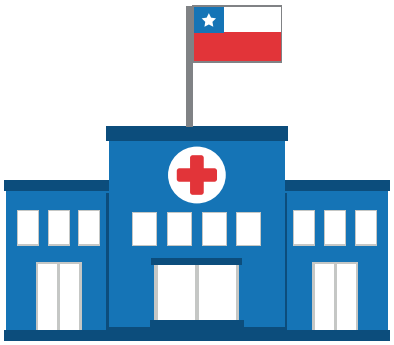
With respect to the collection and management of the resources allocated to state social security health services, the old State dependent underwriters (i.e. SNS and SERMENA) were merged in order to create the National Health Fund – FONASA (Decree Law DL N° 2,763 of 1979), which became a functionally decentralized public service, endowed with juridical personality and its own equity capital.

In sum, the reforms initiated in the early 1980's radically changed the structure and operation of the system with the purpose of separating the policy, operation, control and finance design policies in health, whose main changes were: (i) the creation of the NATIONAL Health Fund (FONASA); (ii) the creation of the Social Security Health Institutions (ISAPRE); (iii) the decentralization of the National Health Service (SNS), transforming it into a National Health Services System (SNSS) through several autonomous health services with their own equity capital and distributed around the country; and, (iv) the transference to Municipal management of great part of primary health care services, with the health services retaining an articulating sanitary policy role. Likewise, expenses were focused on primary health services and on the most cost-effective health actions, with a special emphasis on minimum complexity health centers (postas) and primary health care center (consultorios) networks. In terms of social security, as of the 1980's all legal contributions (health and pensions) became exclusively chargeable to workers[7] , eliminating employer contributions (with the exception of the percentage between 0.9% and 3.5% for labor casualties and professional diseases). In this manner, it was established that health contributions belong to the worker giving them the possibility to choose between a public and a private health care system and that such sense of property ownership over their own contributions would motivate searching for good health service providers.

On the other hand, during the 1980's some state incentives were introduced in order to incorporate more users to the private system, thereby lightening the burden of the public sector. Such was the case of the maternity leave (descanso maternal) subsidy chargeable to the State and the 2% subsidy to low-income workers joining collective ISAPRE plans. This 2% subsidy was discontinued in 1999, which inevitably increased the differentiation between the subsystems, because thousands low-income workers had to abandon their respective ISAPRES, in lack of the 2% subsidy, and join FONASA.

During the 1990's, on the other hand, various laws were promulgated toward strengthening the public health system and better regulate the private activity. Thus, in 1990 the ISAPRE Superintendence (Law N° 18,933 de 1990) was created (it existed until the year 2005, at which time it became the Health Superintendence), the institution that regulates and supervises the health insurance and suppliers' market; likewise, the ISAPRES



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in order to incorporate themselves legally they must register before such Superintendence. FONASA, on the other hand, has been supervised by the Ministry of Health (MINSAL, in its Spanish acronym) ever since its creation and subjected to its policies, norms and plans. During the 1990's, significant efforts were made to improve the public health system, especially with respect to hospital services, in order to recover the sector with greater investments, increased staffing, improved salaries and strong infrastructure and equipment investments.

6. Executive Decree DFL N° 1 of 2005 Art. 16°.
7. From 1981 to 1983, legal contributions went from 4% to 6% of taxable gross salaries and in 1986 it increased from 6% to today's 7%.

### I.1.3 The 2005 health reform

Between 1990 and 2007, Chile confronted a several reforms aimed at acknowledging the right to health, fairness, solidarity, efficiency and social participation. These reforms impacted mostly the ISAPRE Superintendence and the Primary Health Care Statute (Estatuto de Atención Primaria) and replaced the Health Services System with the General Health Guarantees System, incorporating both into the public as well as the ISAPRE systems the obligation to deliver a set of Explicit Health Guarantees (Garantías Explícitas en Salud - GES, in its Spanish acronym).

In regulatory terms, the legislation applicable to the health system was basically contained in the 1980 Political Constitution of the Republic and in Statutory Decree N° 1 of the Ministry of Health, of 2005. The latter established, refurbished, coordinated and systematized the texts of Decree Law N° 2,763[8] of 1979; of laws N° 18,933[9] of 1990, N° 18,469 of 1985 and of Law 19,996. Moreover, in their capacity as economic agents, the ISAPRES began to be governed by Decree Law N° 211, regarding the protection of free market competition.

#### Law N° 19,381 of 1995

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8. Decree Law DL N° 2,763 of 1979: "Restructures the Ministry of Health and the National Health Fund, Chile's Public Health Institute and the Supply Center of the National Health Services System".
9. Law N° 18,933 of 1990; "Creates the Superintendence of Social Security Health Institutions, issues regulations toward the delivery of ISAPRE services and derogates Statutory Decree N° 3, of Health, of 1981".
10. Law N° 18,469 of 1985; "Regulates the constitutional right to health protection and creates a health services system".
11. Non-disclosed preexisting conditions may be excluded from coverage, while disclosed preexisting conditions shall have a grace period of 18 months. Likewise, those services covered by other laws, nursery care, rest hospitalizations, services derived from the beneficiary's participation in acts of war, plastic

## Law of emergencies (1999) and catastrophic coverage (2000).

Law N° 19,650 (Law of emergencies) was enacted in the year 1999, aimed at improving certain health area regulations. By virtue of this regulation, both public and private health facilities were forbidden to require those contributors that they were supposed to look after (either of FONASA or of ISAPRES), money amounts, checks or another financial instruments toward ensuring the future payment of such services or condition services in any other way or form, whenever they face a vital health emergency (i.e. risk of death or serious functional sequel).[12]

In the case of the ISAPRES, these institutions must pay directly to the health facility the value of the services provided to its contributors, until the patient has been fully stabilized and can be transferred onto a different health assistance.

On the other hand, in the year 2000, the ISAPRES proposed (self-regulation) to the Superintendence (of ISAPRES, at the time) to create a catastrophic insurance scheme to be provided to all its contributors in order to financially confront a catastrophic illness, setting a deductible amount[13] over which the full cost of such disease would be fully covered, provided that such services are provided by preferred service providers of the contributor's ISAPRE. This gave rise to the "Catastrophic Illness Coverage" (Cobertura para Enfermedades Catastróficas) scheme, or CAEC (in its Spanish acronym), that was regulated by the ISAPRE Superintendence (subsequently, of Health) via Circular Letter N° 59 dated February 2000. Originally, this started as a voluntary coverage; however, ultimately, all open ISAPRES ended up granting it.[14]

## The ISAPRES solvency law (Law N° 19,895 of 2003) or the "ISAPRES short" law

The reforms to the private health system began with the promulgation of the so-called "ISAPRES short law" (Law N°19,895 of 2003), which sought to safeguard the solvency of the underwriters and the protection of its beneficiaries should the operating permit (registration) of any ISAPRE be revoked[15]. This regulation was subsequently incorporated

# 1999

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surgeries with beauty purposes, ambulatory medications, plus those services not contained in the FONASA Schedule of Health Services shall remain without coverage.

12. Duly accredited by a medical surgeon.

13. This deductible is paid annually, and as of the moment that the catastrophic disease is officially acknowledged the copayments paid out on account of this pathology accumulate in order to conform de deductible amount; which, in turn, is linked to the contributor's economic capacity. It amounts to 30 times the contribution agreed to by each contributor using it, with a minimum of 60 UF and a maximum of 126 UF.

14. During the early years, the ISAPRES charged an additional monthly sum to pay for the CAEC. Later, this charge was incorporated into the base health plan.

15. Following the bankruptcy of ISAPRE Vida Plena in 2003, the government submitted a draft bill to Congress establishing various solvency and protection regulations for persons belonging to ISAPRES, AFP pension funds, and insurance companies all of which culminated with the enactment of Law N° 19,895.

into the 2005 Health Reform and was, therefore, included in Executive Decree Executive Decree DFL N° 1 of 2005.

Special legislation was passed regarding the minimum equity capital requirements at the time of becoming legally incorporated as ISAPRES (5,000 UF along with a 2,000 UF[16] guarantee), the equity capital of ISAPRES (maintain reserves equal or higher than 0.3 times its total debt) and the liquidity of ISAPRES (the ratio between each ISAPRE's current assets and current liabilities may not fall below 0.8), among others.[17]

### Explicit Health Guarantees Act (Law N° 19,996 of 2005 or GES Law) and Statutory Decree N°1 (Executive Decree DFL N° 1 of 2005), establishing the General Health Guarantee System and creating the Health Superintendence. 03) or the "ISAPRES short" law

The Executive Decree DFL N° 1 issued by the Ministry of Health in 2005 comprises the health reform based on the GES pillars and the sanitary authority. Specifically, this law created the General Health Guarantees System. On the other hand, Law N° 19,996 of 2005 provided that such system ought to comprise the Explicit Health Guarantees (GES, in its Spanish acronym). They allude to the Explicit Guarantee of Access, the Explicit Guarantee of Quality; the Explicit Guarantee of Timeliness (Opportunity); and the Explicit Guarantee of Financial Protection, all of which aim at expanding the services to a greater number of persons while covering a greater number of illnesses. In simple terms, the GES Plan comprises a list of pathologies (80 at this time) whose diagnosis and treatment (standardized) have Explicit Health Guarantees (GES) with respect to access, quality, timeliness (opportunity) and financial protection for all citizens (FONASA and ISAPRES).

Thus, this reform compels the delivery of mandatory access coverage for prioritized health events (i.e. those representing the highest illness burden in the population), denominated Explicit Health Guarantees (i.e. guarantees regarding access, quality, financial protection and timeliness/opportunity), in all health care contracts (FONASA and ISAPRES), with a single price for all ISAPRE beneficiaries and the existence of an Inter-ISAPRES Compensation Fund (Fondo de Compensación Inter-ISAPRE) to offset the risks (gender and age) of the different ISAPRE populations.

The GES price or premium is equal for all ISAPRE beneficiaries affiliated to the same Isapre. Contrary to what takes place in the pricing of the health plans, GES prices cannot be discriminated by gender or sex. GES prices change every 3 years, counted as of the date

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16. The "Unidad de Fomento - UF" is an inflation-indexed unit used in Chile in order to keep peso-denominated prices at par with the current rate of inflation. As of November 2016 1 UF was worth USD 40.
17. Likewise, regulations were modified regarding guarantees, payment to providers, creation of a special supervision and control system by the Health Superintendence, appointment of interim managers, revocation of operating permits (registrations) in case of breach of solvency regulations, also regulating portfolio transfers and the priority of ISAPRE-guaranteed payments.
18. Commonly known as AUGE (in its Spanish acronym); i.e. Universal Access System with Explicit Guarantees.

of effectiveness of the respective GES decree or a smaller period if the decree is reviewed before the indicated period, if a health problem and/or illnesses is added.

The health pathologies to be included in the GES are determined by the Ministry of Health, following a procedure established in the law and its regulations, which must also be approved by the country's Finance Ministry . The Finance Ministry[19] sets a frame of reference of resources available in FONASA and the value of the Universal Premium (prima universal), stated in UF, to which said guarantees ought to adjust.[20]

On the other hand, in 2005, the ISAPRE Superintendence was replaced by the Health Superintendence[21], a functionally decentralized entity (linked to the President of the Republic via the Ministry of Health), endowed with juridical personality and its own equity capital, whose main functions are to supervise and control the ISAPRES and FONASA to ensure compliance of their legal obligations, in addition to auditing the accreditation and certification of all public and private health services providers.

The sanitary authority was also modified in order to decentralize certain powers and separate the MINSAL's governing and executory roles. To that effect, the MINSAL was restructured into two Sub secretaries (subsecretarías): of Assistance Networks and Public Health. The Regional Ministerial Secretariats (Secretarias Regionales Ministeriales – SEREMIS, in its Spanish acronym) concentrated the government and regulatory functions. Thus, the health services retained the executory and administrative functions, managing the state centers under their responsibility and articulating the assistance network comprised within their respective area (public and private facilities with FONASA agreements). Each service director, as well as the Health Superintendence must henceforth be screened out and elected via the Senior Public Management System (ADP, in its Spanish acronym).


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19. The Explicit Guarantees Proposal considers undertaking studies aimed at establishing a list of health priorities and interventions (considering the effectiveness of the interventions, their contribution to the quality of life and, whenever possible, its cost effectiveness). With these studies in hand, a list of illnesses and their associated services is prepared. An estimate is made regarding the cost of incorporating them into the System, in line with the public and private supply capacity. The proposal is submitted to an expected cost-verification process per beneficiary of the prioritized GES set, by means of a study coordinated with the Ministry of Health.

20. Law N° 19,966 of 2004 (AUGE Act) establishes that the determined guarantees cannot generate an expected individual average cost of the FONASA or ISAPRE benefit sets, estimated for 12 months, significantly different from the Universal Premium. The changes in the value of the Universal Premium cannot exceed the variation shown by the General Index of Hourly Remunerations (Indice General de Remuneraciones por Hora - IGMO, in its Spanish acronym).

21. Executive Decree DFL N° 1 of 2005, Art. 106.

## Price regulations and Compensation Fund in the ISAPRES for the GES (Law N° 20.015 of 2005 or long ISAPRES Act)

### Price adjustment regulations

The 2005 reform regulated a system for fixing price increases in health plans, establishing those aspects that comprise the schedule (plan) and determining the way in which it could be adjusted annually. Consequently, the "health contract" of the ISAPRES is comprised of: (i) a base price (adjusted by risk factor)[22] ; and, (ii) the GES premium per beneficiary (flat fee). The 2005 reform established that the base price is readjusted via two mechanisms contemplated in the law (Executive Decree DFL N° 1 of 2005): i.e. the "adjustment" of the base price and the application of risk factor tables (gender, age and the condition of contributor or beneficiary). Additionally, health plan prices are stated in UF (inflation index units), which is why they incorporate a monthly inflation restatement

**(i) Adapting the health plans:** Art, 197 of Executive Decree DFL N° 1 of 2005 modified the set of risks to consider for the purposes of adjusting the premiuns (tarifas). The law provided incentives toward expanding risk considerations to cover an ISAPRE's entire portfolio, as a way of pooling (colectivizar) its premiun adjustment among all its beneficiaries (before this law, certain health plans were not readjusted; however, others, with a population with more health problems, suffered higher readjustments).
On the other hand, Art. 198 sets forth the rules to be abided by the ISAPRES[23] ; rules about how the Health Superintendence receives the price of each plan and its price modification proposals; which, in turn, must circumscribe to a price band[24]. The law must ensure that such price increases abide by the law and that there is no discrimination between different affiliates (the law forbids price discounts).

**(ii) Risk factor table:** it is defined under Art. 170 letter n) of Executive Decree DFL N° 1 of 2005. The norm states: "The expression Risk Factor Table refers to that table prepared by the Social Security Health Institution (ISAPRE) whose factors show the price of the health plan for each group of persons according to their age, gender and condition of either contributor or dependent, with respect to a reference group defined by the Superintendence. This table represents an agreed price variation mechanism of the plan throughout its life cycle, which is known and accepted by the contributor or beneficiary at the time of executing the contract and joining it, and that may not vary for as long as the person remains affiliated to such plan". Art. 199 of Executive Decree DFL N°1 of 2005 governs the use of the Risk Factor table.

22. The base price is multiplied by the sum of all the risk factors of all the beneficiaries of such health plan, which gives the monthly price of that plan. Nowadays, the base price also includes the CAEC premium.
23. The law mandates that the price adjustment procedure ought to begin with a letter addressed to the contributor 3 months in advance of that health plan's anniversary date. It states that ISAPRES may once-a-year review their health plans and modify their base price without discriminating between the various contributors of the same plans and pursuant the same terms and conditions in which they are being offered to their new affiliates. Such modifications may solely address the price of the health plan, not its benefits or coverage - which cannot be modified. If the affiliate does not agree with the new price being charged, he/she is entitled to apply for an alternative health plan for the same price that he/she is currently paying; such alternative plans that must be marketed at that time and, if the affiliate is not satisfied with the options thus offered, he/she shall be entitled to disaffiliate (a more complicated option to take for patients with preexisting health conditions, since it is unlikely that he/she will be accepted to join a private insurance scheme offered by competitors. He/she are always accepted to join FONASA).
24. The band goes from 0.7 to 1.3; where 1 is the mean increase of the plans.

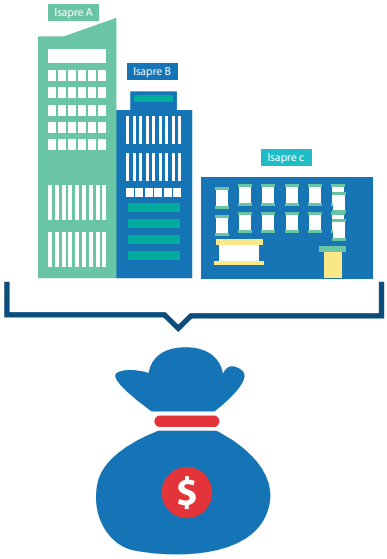
It is important to mention that in 2010, the Constitutional Court ruled to derogate part of the regulations of the Risk Factor Table. It eliminated the application of such table to increase prices to contributors and beneficiaries when overcoming age brackets[25] when in the same plan for the following period. The foregoing, for considering that such practice was contrary to law, to the protection of health, to the principle of equality and to social security entitlements; which, in turn, do not admit any type of discriminatory treatment whatsoever. The Court, additionally, urged the co-legislator (government and congress) to establish a table of risk factors by law, such that said definition is removed from the discretion of the ISAPRES and administrative authorities. The foregoing, however, has not materialized to date.

**(iii) Legal remedies of protection toward restraining base plan price adjustments:** the courts also interfered in base plan price increases via admitting simple lawsuit´s (beginning in 2007) filed by ISAPRE System beneficiaries aimed at stopping the price increase of their health plans. In the majority of cases, judges have ruled in favor of the affiliates against such price increases, grounding such rulings in that such increases constitute arbitrary and unilateral acts on the part of the ISAPRES, leaving aside increasing health cost considerations and that the ISAPRES are indeed empowered by law to annually modify the prices of their health plans.

## Inter-ISAPRES GES-Risk Compensation Fund

The GES Premium per beneficiary is flat. Within this context, and in order to make common cause (to solidarize) with health risks among ISAPRE beneficiaries (related to those health services provided under the GES) a Compensation Fund was created to operate among open ISAPRES[26]. This Fund compensates ISAPRES, among themselves, for any difference between the community premium to be determined for the GES and the appropriate risk-adjusted (gender and age only) premium. The Superintendence determines the sums to be transferred between these institutions[27].

**The GES Premium per beneficiary is flat. Within this context, and in order to make common cause (to solidarize) with health risks among ISAPRE beneficiaries (related to those health services provided under the GES) a Compensation Fund was created to operate among open ISAPRES.**




25. As we grow old, we become more expensive because of our greater health care needs.
26. By applying flat tariffs, there are persons that pay above their expected costs, while others pay below them; thus, the alluded Fund redistributes the income and expenses of each group thereby permitting the proper operation of the flat tariff.
27. The ISAPRES contribute to a virtual fund the GES cost per beneficiary determined by the Health Superintendence and withdraw as appropriate (and determined by the Superintendence) from it according to the gender and age composition of their portfolio

## I.2 CHILE'S CURRENT SOCIAL SECURITY HEALTH STRUCTURE

### I.2.1 Social security health systems and their financing

In Chile, it is legally mandatory to allocate for health purposes 7% of the salary or pension received by a person, with a taxable cap[28]. The institutions legally empowered by law to receive such health contributions in exchange for the delivery or financing of health services, as well as to manage and pay Occupational Disability Subsidies (Sick leave, SIL, in its Spanish acronym) for common illnesses, are the National Health Fund (FONASA), a public institution and the Private Social Security Institutions (ISAPRE), private institutions.

In this manner, Chile's social security health system is indeed a mixed system, since it has both public as well as private participation inasmuch as health insurance is concerned. It is also mixed, at the level of delivery of the various health services. As of today, the health social security sector covers 95% of the country's population; whereas, 76% of them are affiliated to FONASA and 19% to the different ISAPRES. From among the remainder of the population, about 3% is linked to the Armed Forces and the Police, while the rest have coverage that is either different from that offered by the ISAPRES or has no coverage at all[29].

It should be mentioned that, at the health insurance level, there also exist casualty insurance mutuals (Law N° 16,744 of 1968), which are non-profit private institutions[30] aimed at developing labor health risk prevention activities, delivering health services directly, and paying the SIL (In case of occupational casualties or professional diseases, financed by contributions payable by the employers[31]. Nevertheless, as stated above, Chile's social security health is the responsibility of FONASA and the ISAPRES, institutions responsible for collecting and managing the legal health contributions. Consequently, our analysis does not include such mutuals.

**TABLE 1**
**CHILE'S SOCIAL SECURITY HEALTH SYSTEM**

| SYSTEM | MANAGEMENT | FINANCING | PROVIDERS | TYPE | GENERAL FEATURES |
|---|---|---|---|---|---|
| FONASA (SNSS) | STATE | Individual (7% mandatory health contributions) State (Fiscal contributions) | state (MAI) Private (MLE) | State social security Sistem (Bismarck type) | Solidary Coverage: 76% of population |
| Isapre | Private with profit (Open and Closed) | Individual (7% mandatory health contributions plus additional voluntary | Private | Private health Insurance | Non Solidary (Risks) (*) Coverage: 19% of populations |
| Armed Forces | State | Individual and State | State | Social health Insurance | Solidary Coverage: 3% of populations |

(*) The solidarity component of every social security system is represented by the state subsidies, which in Chile are channeled exclusively to the supply of state health providers; namely, to the coverage provided by FONASA. The private system, in the absence of subsidies, is forced to finance itself and, to that effect, the ISAPRES charge premiums based in the individual risks of the population covered by each plan. Nevertheless, there is indeed solidarity in the ISAPRES within a same health plan (the price of each plan is the same for each participant of a same plan) and within a same ISAPRE (price band).

*Source: Presidential advisory commission for the study and proposal of a new model and legal framework for the private health system (2014).*
*Note: The services provided on account of occupational casualties and professional diseases are managed by non-profit entities: the mutuals (private) and the ISL (state).*

Regarding health plans and their premiums, in the case of the ISAPRES the price of each plan depends on the coverage of the plan contracted (credits and copayments), the greater or lesser freedom to choose providers, and the risk of its beneficiaries (gender and age). This is why the ISAPRES offer multiple plans and, therefore, multiple premiums for such plans (the same premium for the same plan, but multiplied by the contributor's own risk factor). On the other hand, the GES premium is identical for all beneficiaries within any given ISAPRE (it varies between ISAPRES).

In FONASA there is a single plan, in which only certain copayments vary for income segments C (10% copayment) and D (20% copayment) under the Institutional Service Mode (MAI, in its Spanish acronym), who also have access to the Free Election Mode (MLE, in its Spanish acronym). In the case of FONASA, the premium corresponds only to the amount resulting from the legal health contribution over taxable salary.

With respect to financing, the benefits delivered to ISAPRE affiliates are solely financed via the contribution of its contributors, which in many cases implies Legal contribution. In effect, it is estimated that ISAPRE contributors pay, on the average, 10% of the taxable salaries. Specifically, 72% of all ISAPRES' collections during 2015 corresponded to legal health contributions, while the remaining 28% came from voluntary contributions.

In the case of FONASA, there is a premium payment calculated in proportion to the payment capacity of each person, although, just like in the ISAPRES, such payment finances only a fraction of the costs incurred by its affiliates, the rest is financed via fiscal contributions from general taxes. According to the 2015 Budget Law, 60% of FONASA's budget is financed via fiscal contributions and the remaining 40% from legal health contributions.

Thus, the systematic and progressive increase of health costs, which affect both FONASA and the ISAPRES, in the case of the former they are financed via increased fiscal contributions and also by means of the rationing health care (waiting lists), while in the case of the latter they translate into premium increases and, consequently, in increased voluntary contributions.

Anticipating the problem of increasing health costs, the 2005 reform of the ISAPRE system authorized ISAPRES to adjust the premiuns (not the coverage) of their base plans (the same for all the beneficiaries of such plan) once a year. However, the operation of the ISAPRE system has had to confront various problems regarding premiun adjustments; the unconstitutionality ruling regarding the risk factor table (2010) and the increasing litigation of premiun adjustments.

TABLE N°2 shows outlines the main distinctive features between both social security health systems; which may be summarized in: (i) how de premium is defined; (ii) the health plan itself; and, (iii) the adjustment of the premium.

**Is estimated that ISAPRE contributors pay, on the average, 10% of the taxable salaries. Specifically, 72% of all ISAPRES' collections during 2015 corresponded to legal health contributions, while the remaining 28% came from voluntary contributions.**

TABLE 2
CHILE'S SOCIAL SECURITY HEALTH S DISTINCTIVE COMPARATIVE FEATURES BETWEEN FONASA AND THE ISAPRES: YSTEM

| SYSTEM | FONASA | ISAPRES |
|---|---|---|
| Affiliation | Automatic, supplementary and pursuant to legal provisions. | Requires contract execution. ISAPRE may reject affiliation application. |
| Affiliation or price or premium | (a) Legal contribution of 7% of taxable income.<br>(b) This "price", as a percentage of income, does not vary over time. | (a) The price of the Health Plan contracted includes the application of a base price and of the table of relative factors (gender and age).<br>(b) The price of the Health Plan changes via annual contract adjustments (the price may be maintained also). Nowadays, only the base price may vary (before 2005 the benefits could vary and before 2010 the risk factor also varied).<br>(c) Flat premium per beneficiary. It is adjusted every 3 years. |
| Plan | Incomes | Multiplicity of plans |
| Relationship between price and plan | Single (with different coverages depending on incomes) | Absolsute. The coverage of Complementary Plans are directly proportional to their respective base prices. |
| Relationsip between price and risk | Non - existent | The price of a Health Plan considers beneficiary risks (GES premiums do not consider gender and age risks). |
| Preexisting conditions | Not considered for the purposes of affiliation or the delivery of benefits. | May trigger the rejection of affiliation and/or deferred or partial coverages. |
| Financing of services | Legal contributin and general taxes. | Legal contribution plus voluntary additional contribution. |

*Source: Prepared by Isapres de Chile, based on Ferreiro A., 2009.*

### I.2.2 The choice to join either Social Security System: Freedom of choice for all?

As indicated above, joining the ISAPRE System is an individual act financed by the worker's legal health contribution (7% of gross taxable salary) plus voluntary contributions. The FONASA Public System, in addition to the workers' legal health contribution, receives significant and increasing fiscal subsidies. If a worker opts in favor of joining an ISAPRE, he/she losses such fiscal subsidy (supply-side subsidy); which he/she would indeed receive upon joining the FONASA System.

On the other hand, the private sector differs from the public sector in terms of a timely and quality delivery of health services; which, given the latter's insurance structure and need of self-financing, discriminates between premiun charges (by risk).

This design does not permit that the entire population may choose an Isapre. Specifically, the constitutionally-established freedom to choose between underwriters is only effective for that population that is able to self-finance its health in the private sector. A person whose legal 7% health contribution is insufficient to cover an ISAPRE health plan may only obtain a subsidy to finance his/her health care in the public sector. Therefore, regardless of a person's desire to access the kind of timely and quality health care provided

by the Isapre, he/she cannot do so if his/her legal health contribution is insufficient to finance such a plan, because health subsidies in Chile are not portable. This explains why the majority of Chile's population is affiliated to FONASA and why this entity concentrates the persons with highest health risks and lower incomes.

In sum, the freedom to choose between Chile's public or private health systems, as indeed guaranteed by our Political Constitution, would only become effective if all FONASA affiliates were entitled to transfer their public health subsidies toward meeting private health sector demands[32].

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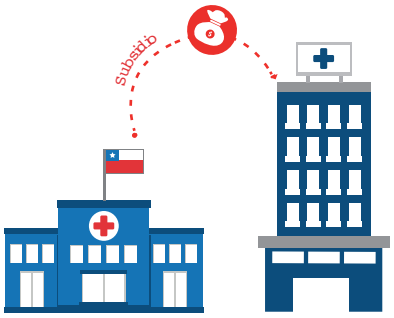



### I.3.1 PROPOSAL OF THE ISAPRES ASSOCIATION TOWARD DEVELOPING A NEW PRIVATE SOCIAL-SECURITY-HEALTH MODEL

The ISAPRES, have stated their will to actively collaborate in bringing about the changes envisaged and they share the idea of making progress toward a system easier to compare, that would enhance stakeholder competition and whose premiun would avoid discriminating by gender, age and preexisting health conditions so that affiliates may move freely within the system (ending the captive affiliate condition). Likewise, implement a price-adjustment system that is accepted by the contributors and by the courts of law.

Within this context, Chile's ISAPRE Association acknowledges that the current private system ought to be improved and solve the above-mentioned aspects. Thus, the grounds of a reform of the ISAPRE system should consider:

**· Increasing transparency by means of comparable health plans; the so-called Social Security Plan (PSS, in its Spanish acronym)[33].**

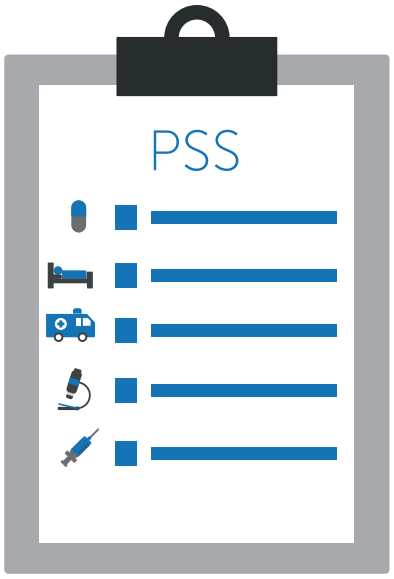
32. Of late, during the 1980's, timid state attempts were made toward promoting the incorporation of more users into the private health system, thereby unburdening the public health sector. Such was the case of the 2% subsidy then granted to those low-income workers who wished to join collective ISAPRE health plans. Such subsidy, however, was discontinued in 1999, thereby inevitably increasing the differentiation between the two health subsystems. In fact, upon their no longer counting with such subsidy, nearly one million low-income ISAPRE-beneficiary workers were forced to abandon their respective ISAPRE health plans to join the ranks of FONASA.
33. It includes health services and the Occupational Disability Subsidy (SIL).

**· Achieving greater health financing solidarity among the affiliates of the ISAPRE system, establishing a community ratings, not individual, without discrimination by gender, age and health condition for tariff-pricing.**

**· Permitting free inter-ISAPRE mobility of all affiliates having a PSS Plan.**

**· Creating an inter-ISAPRE Compensation Fund (FCR), in order to render feasible points 2 and 3, as per above.**

In sum, the ISAPRES propose to move forward toward a standardized and guaranteed social security health plan (PSS) so as to facilitate user comprehension of coverages, regardless of the ISAPRE offering them. Likewise, they propose to migrate from an individual pricing model toward a system that would be more equalitarian and offer greater solidarity, whose premiuns would not discriminate according to individual risks but rather equalize them by means of a Risk Compensation Fund aimed at putting an end to price differentiation by gender, age and also permitting the mobility of persons with preexisting health conditions between private institutions. This would favor competition within the sector and enhance the quality of the services thus delivered.
Additionally, and regardless of whether a full social-security health model is carried out, the Association submits the need to implement, in the short term, a mechanism to regulate the power to adapt the prices of current contracts, incorporating a Panel of Experts to approve such adjustments.




**the ISAPRES propose to move forward toward a standardized and guaranteed social security health plan (PSS) so as to facilitate user comprehension of coverages, regardless of the ISAPRE offering them.**

In the interim, those contracts that contemplate a PSS do not apply a price adjustment mechanism regulated by law (although the adjustment procedure itself is indeed a regulated procedure) because the PSS is equal for all users (with legally-defined coverages) and the certain possibility of inter-ISAPRE personal mobility; all of which would guarantee high levels of competition and the freedom to choose among the best current offerings (supply), in line with the criteria of each contributor.
The foregoing must be also accompanied by a regulatory framework that would enable the orderly transition of current contributors, avoiding both the loss of acquired benefits as well as adverse choices (moral risk) on the part of contributors.
On the other hand, the ISAPRES shall be entitled to offer complementary and supplementary services; namely, products to cover other services not included under the PSS or that would increase the coverage of PSS services.

Additionally, and in order to make progress in terms of the reform, it shall be necessary to introduce the following institutional modifications:

34. We could also explore the alternative of having three (3) age-bracket tariffs: i.e. from 0-8 years of age; from 19-59, and over 60. Such tariff would be multiplied by an X factor in order to reflect increasing health costs among the older population.

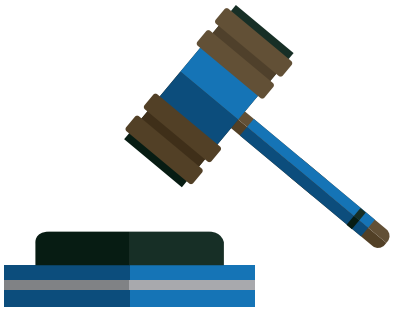
First, a definition should be made regarding a technical institution for the incorporation of new sanitary technologies (ETESA, it its Spanish acronym). This entity should be responsible for analyzing the existing services and the medications to be incorporated or eliminated from PSS plans, as well as for designing medical protocols and provider accreditations (quality measurements).

Second, it would be seemly to separate the health insurance functions, with one of them to cover health services and the other to respond to occupational disability subsidies (SIL), given their distinct nature in terms of health expenses. Specifically, the financing, control and management of medical leave benefits ought to be handled by a specialized institution to not only manage this benefit for FONASA and ISAPRE affiliates, but to also include the occupational casualties and professional diseases. In sum, ideally, a special fund should be established with an independent institution and specific financing for managing medical sick leave and their respective payments, whose financing could be shared between the contributor and the respective employer.

And, third, we ought to promote the use of service procurement mechanisms between underwriters and providers that would point toward integrated, protocoled and/or standardized solutions, more transparent and that would foster greater system efficiency.

We consider that introducing the above-depicted modifications would go a long way toward resolving an important part of the problems that nowadays impact the private social security health sector; which, as we mentioned above, are: its transparency (i.e. the difficulty to compare the various health coverages offered by each ISAPRE, given the multiplicity of existing plans); the price discrimination by gender, sex and health condition; the existence of captive contributors; and, the litigation of price adjustments.
Likewise, these changes would set the bases, so that if in the future the authorities responsible for the country's health policies considered appropriate to move toward a greater integration between the ISAPRES and FONASA, during a second stage FONASA might offer a PSS and join the Risk Compensation Fund (FCR), upon meeting the terms and conditions set for by such fund, which would, in turn, permit the entire population to choose the PSS in the institution of their preference.

The foregoing would enable having an integral health system of competitive multi-insurance schemes, with universal risk compensations allowing for freedom of choice of health insurance, regardless of their income levels, while increasing the effectiveness, efficiency and quality of our country's health sector. All things considered, in order to get to this point, it would be necessary for the public system to raise its service standards, effective timeliness and coverage closer to those of the private sector.



**The foregoing must be also accompanied by a regulatory framework that would enable the orderly transition of current contributors, avoiding both the loss of acquired benefits as well as adverse choices (moral risk) on the part of contributors.**

## I.3.2 CONCLUSIONS

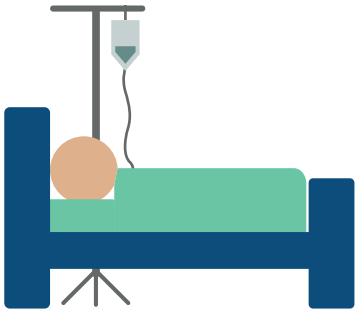
The creation of the ISAPRES, 35 years ago, as an option to public coverage, has permitted an important part of Chile's population (i.e. somewhat less than 3.5 million persons) to receive their medical health care in the private sector. This lightens the pressure on public health services without using fiscal contributions; resources that concentrate in the public network and FONASA.

Likewise, the population has been able to have access to a good level of health, and the private option has contributed to develop health service providers. Ever since their creation, the ISAPRES have helped materialized significant investments in hospital infrastructure and high-quality diagnosis centers, which benefit not only ISAPRE beneficiaries but are also available to the entire population, including over 5 million FONASA beneficiaries. Thus, the private service provider delivers a relevant proportion of all the medical services demanded by all Chileans, all of which testifies irrefutably to the country's public-private collaboration in delivering health care services to the population.

Notwithstanding, the foregoing does not imply the absence of aspects in the country's health system (and particularly in the private underwriting system) that need improvement. In effect, 35 years have elapsed since the reform that created a health system with public and private affiliation in our country, equipped, on the one hand, with individual contracts in private underwritings (ISAPRE) and a solidarity contribution (state contributions from taxes) in the public sector (FONASA).

Mindful of the foregoing, during the decade of the year 2000, the last important changes were introduced into the system, when new sanitary objectives were set for the country, establishing a primary health care model and work in assistance networks in the public health care system as well as a system of guarantied priorities (GES) in both health delivery systems.

With respect to the ISAPRES, they have had to confront difficulties in matters of price adjustments, as well as criticisms for risk selection and the capturing of beneficiaries with preexisting health conditions that prevail within said system. On three occasions, this has driven the government then in power to set up expert commissions (2010, 2011 and 2014) aimed at restructuring the private (and public) health systems; an objective not yet materialized despite the ISAPRES' insistence of the need to do so[35].



**Ever since their creation, the ISAPRES have helped materialized significant investments in hospital infrastructure and high-quality diagnosis centers, which benefit not only ISAPRE beneficiaries but are also available to the entire population, including over 5 million FONASA beneficiaries.**

35. In the year 2011, the Executive submitted before Congress a draft legislation bill (Bulletin N° 8,105-11); which, among other aspects, called for the creation of a guaranteed private sector health plan to be offered at the same price to all beneficiaries. To that effect, an inter-ISAPRE solidarity (conjoined) fund was created to compensate those ISAPRES having riskier portfolios. This draft legislation made some legislative progress during a first stage; however, it subsequently came to a standstill.

The ISAPRES support and believe that it is necessary to move rapidly and decisively toward system modifications. They consider it to be particularly necessary to create a standardized health plan aimed at facilitating user understanding of health coverages, regardless of the ISAPRES offering it. Likewise, they support migrating from an individual pricing model to a community one that would be more equalitarian and offer greater solidarity, that would equal the prices and equalize its risks by means of an inter-ISAPRE Risk Compensation Fund (FCR), so as to put an end to price differentiation by gender and age and permitting the mobility of persons with preexisting health conditions.

Nevertheless, the private system requires an urgent solution to the litigation of the adjustment of base plan prices. This problem cannot continue to be ignored by the authorities, since for as long as the necessary consensus to correct the private social security health model is not agreed to, current regulations will remain in force and if steps are not taken in due course this will, sooner rather than later, jeopardize the viability of any given ISAPRE. This is why a proposal has been submitted to install a panel of experts to approve price adjustments of current contracts, and the premium of the Social Security Plan (PSS) to be fixed annually by each ISAPRE (equally applicable to all the beneficiaries of such plan within an ISAPRE). Thus, it is paramount that future regulatory modifications include temporary provisions toward a progressive adjustment to the new legal provisions.

On the other hand, the Social Security Plan will require an institution, known as ETESA, independent from political powers, to evaluate the incorporation and design of protocols for the medical technologies to be used in said plan and also to evaluate the performance of providers.

Likewise, various health experts and commissions have indicated the need to remove (from the ISAPRES and the FONASA health insurance underwriting schemes) the financing, control and management of medical leave sick benefit (which would also facilitate the FCR operation). To that effect, the creation of a specialized institution has been proposed to manage this insurance for both FONASA as well as ISAPRE affiliates and even to include within such institutions the payment of occupational-casualty and professional-disease leave licenses.

Now then, if we wanted to move forward toward an overall restructuring of our nation's health system (after proving the effectiveness of the PSS and the solvency of the FCR), the next step to take should be to achieve the full integration of both health systems. To that effect, FONASA could participate as an FCR underwriter, financing whatever is appropriate and receiving whatever corresponds, adjusted by risk. This would permit having an integral health system of competitive multi-insurance underwriters and freedom of affiliation for the population.

These changes comprise an integral proposal that intend to modify the access, change the benefits and the manner of financing our health plans. But, above all, it would generate a unique and gigantic political opportunity to move forward in the modernization of the country's health system. Additionally, in the future, it would permit having an integrated multi-insurance system with universal risk compensation, which, in turn, would give way to the user's freedom of choice, regardless of their income level.

All things considered, these changes are complex and require tools (such as the Risk Compensation Fund) about which there is little experience in Chile. Their correct implementation, therefore, would require of time and prudence. In spite of it all, Chile is equipped with a good personal identification system and valuable databases regarding GES pathologies, which may become a valuable source of information upon appropriately designing the Risk Compensation Fund; aspects that were not available in the early stages of many countries that currently apply this system.

Ultimately, it is necessary to improve our institutional design and equip ourselves with more appropriate regulations so as to address and correct existing failures and thereby achieve, in the future, the benefits of a more inclusive, competitive and universal health care system where, ideally, all affiliates would be able to freely and effectively choose between public or private health insurance plans via subsidy models and risk compensations that would meet their needs and decisions regardless of their gender, age, health condition or income.

# Chapter 2

X-raying the isapre system

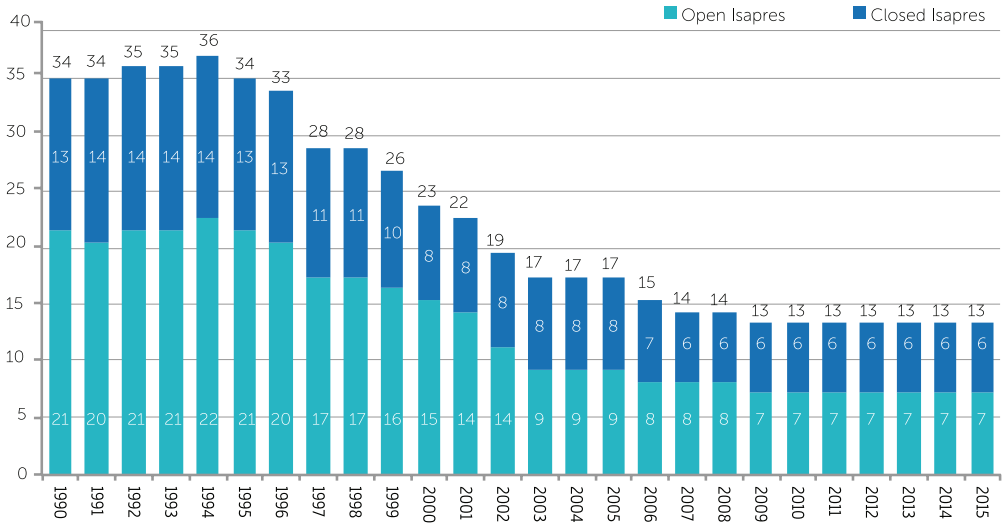
## II. X-RAYING THE ISAPRE SYSTEM

We now turn to submitting the evolution of the main public statistical parameters available for the ISAPRE system; which we grouped into: participating ISAPRES; population coverage; services; medical sick leave benefit; financial performances; and, user opinions. This information was prepared by the ISAPRE Association based on data published by the Health Superintendence (SIS, in its Spanish acronym)[36] , most of which are available as of the year 1990.

## II.1 PARTICIPATING ISAPRES

The number of social security health institutions has diminished during the last decades, due to mergers and acquisitions that took place throughout the years. Specifically, during the 5-year period 1990-1995, the number of ISAPRES remained around 35, dropping to 26 toward the end of 1999. This downward trend continued during the decade of the year 2000, during which the number of ISAPRES dropped from 23 to 13 by the year 2009. Since then, the number of ISAPRES has remained at 13; of which, 7 of them are open and 6 are closed[37].

**TABLE 1**
EVOLUTION OF THE NUMBER OF ISAPRES




*Source: Prepared by ISAPRES de Chile, based on SIS data.*

38. It is urgent to validate the adjustment of base prices before the beneficiaries and the courts of law. To that effect, the ISAPRES have proposed the creation of a regulated adjustment mechanism and a panel of experts to validate the annual price adjustments to which every ISAPRE is entitled by law.

It is not expected the number of ISAPRES to increase in the near future; at least insofar as open ISAPRES are concerned, because the system's development reached a level of consolidation. To the contrary, if there is now change to put an end to litigation[38] or if the country's economic and political conditions worsen, the trend could be toward new mergers in search of economies of scale that would permit continued reductions to the system's management and operating costs.

Actually, upon observing the market share of the various ISAPRES in terms of beneficiaries (TABLE N°3), one may conclude that no industry stakeholder shows a disproportionate market share over the others (Vida Tres is owned by the same holding that owns Banmédica), whereas the market share of the three largest ISAPRES represents around 20%.

**TABLE 3**
2015 MARKET SHARE

| ISAPRES | BENEFICIRIES | AFFILIATION |
|---|---|---|
| Open Isapres | 3.314.427 | 97% |
| Consalud | 666.359 | 20,1% |
| Banmédica | 673.143 | 20,3% |
| Cruz Blanca | 709.204 | 21,4% |
| Masvida | 570.113 | 17,2% |
| Colmena Golden Cross | 535.422 | 16,2% |
| Vida Tres | 138.553 | 4,2% |
| Óptima | 21.633 | 0,7% |
| Closed ISAPRES | 96.060 | 3% |
| System Total | 3.410.487 | 100% |

*Source: Prepared by ISAPRES de Chile, based on SIS data.*
*Note: Vida Tres Belongs to the same corporate holding as Isapre Banmédica.*

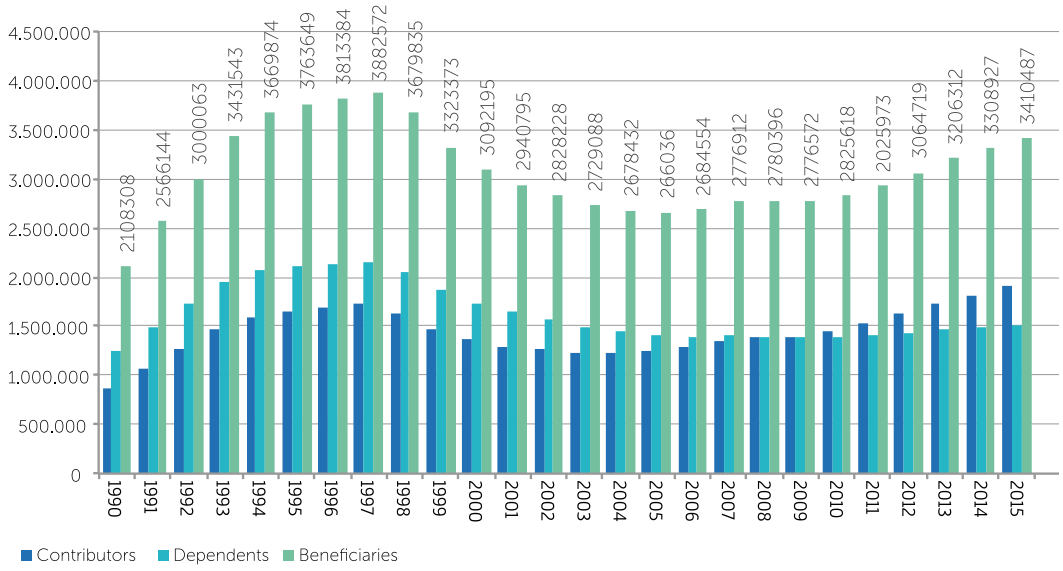
## III.2 POPULATION COVERAGE

Upon analyzing the system's population coverage (GRAPHIC N° 2), one may observe that between the years 1990 and 1997 the ISAPRE system showed a sustained pace of growth. Afterwards, the impact of the 1998 Asian Crisis (unemployment) and the increased prices of health plans for an important percentage of the country's lower-income workers (the 2% subsidy to lower-income workers' salaries joining collective ISAPRE plans was eliminated in 1999), forced a significant number of ISAPRE affiliates out of this system.

Nevertheless, beginning in 2006 and onwards (with the exception of 2008 and 2009 when growth was nil because of the subprime crisis), the system experienced a renewed and sustained dynamism, expanding at an average rate of 4% per year throughout the last 5 years. Specifically, the year 2015 registered the largest number of contributors (1,902,448) ever recorded, while the number of dependents (cargas) (1,508,039) peaked at their highest level since 2002, thereby amounting to a total of 3,410,487 ISAPRE beneficiaries as of the closing of the year 2015; representing nearly 19% of the country's population.

It may also be observed that as of the year 2009, the number of contributors exceeds the number of dependents; a trend that is being annually reinforced. Thus, the number of dependents per contributor dropped from 1.44 in 1990 to 0.8 in 2015.

TABLE 2
EVOLUTION OF ISAPRE PARTICIPANTS




*Source: Prepared by ISAPRES de Chile, based on SIS data.*

With respect to gender, 54% of all ISAPRE beneficiaries are men and 46% women. However, in terms of contributors, 64% correspond to men, while 36% to women; which is consistent with the overall composition of labor affiliation. During the last 25 years, women have gained a meager 4% in contributor affiliation.

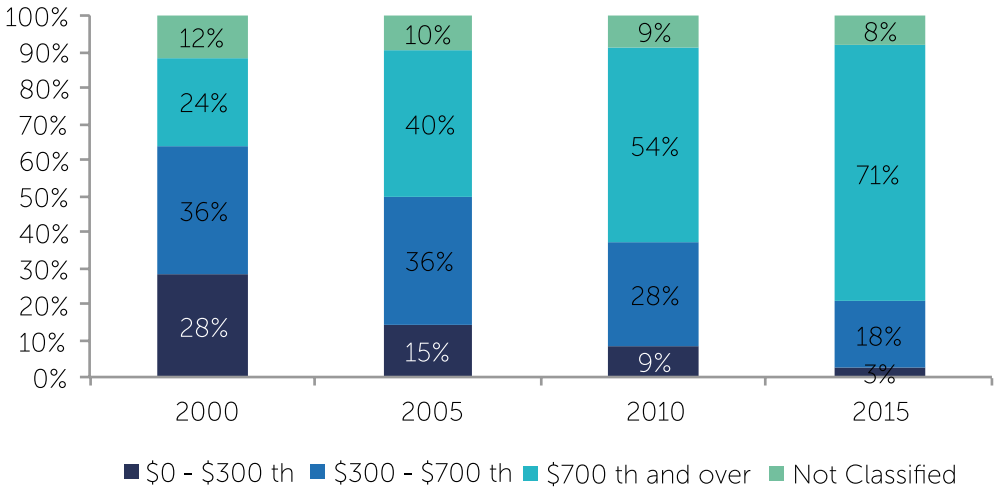
On the other hand, the ISAPRE beneficiary population is mostly concentrated in the Santiago Metropolitan Area (58%); which has evolved somewhat with the passage of time.

Following is the 5th Region (7.4%) and the 8th Region (6.9%).

From the point of view of the social security condition of contributors in 2015, 85% of them were dependent workers; 3% independent workers; 6% retired; and, 6% voluntary contributors. It should be noted that at the outset of the ISAPRE system its contributors were basically dependent workers.

Insofar as taxable incomes are concerned, it must be stated that in the year 2000 those dependent contributors that registered incomes between $ 0 and $ 300,000 represented 28% of total contributors, dropping such participation to just 3% in 2015. Contrariwise, those dependent contributors with incomes higher than $ 700,000 nowadays represent 71% of the total, having represented merely 24% back in the year 2000. (See GRAPHIC N° 3). The foregoing evidences the segmentation suffered by this market ever since its creation, which is partly the consequence of having eliminated the 2% subsidy to lower-income workers in 1999, in tandem with an evolution of health care services toward a more specialized medicine (i.e. greater health costs).

TABLE 3
DEPENDENT WORKERS IN THE ISAPRE SYSTEM, BY TAXABLE INCOME



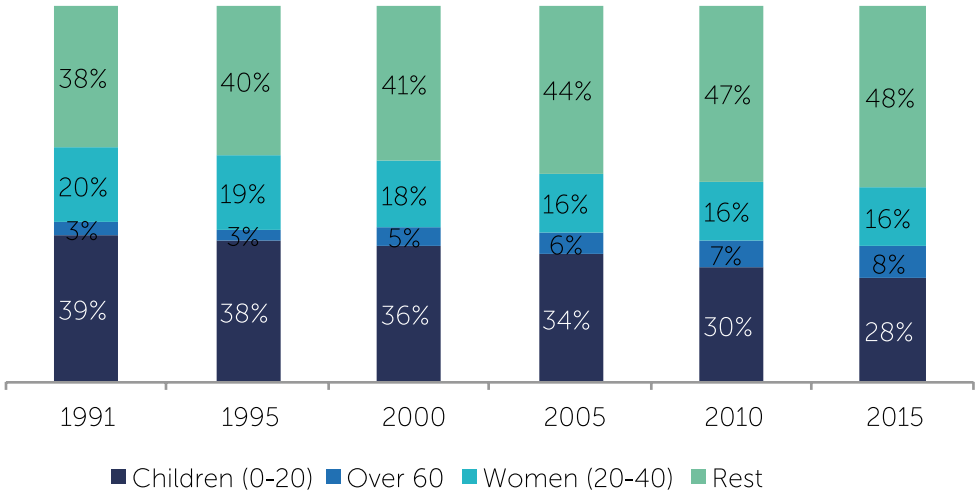

*Source: Prepared by ISAPRES de Chile, based on SIS data.*

With respect to the age profile of system contributors, we observe that the fastest-growing population over 60 years old, while the growth of the children's population as slowed down. In the last 25 years the senior citizen population has tripled, registering 283,873 persons over 60 years of age in the ISAPRE system as of the closing of 2015. The foregoing reflects the fact that the ISAPRE portfolio is aging in tandem with the aging of the country's entire population.

In line with worldwide trends toward lower birth rates and a greater life expectancy of the population, the rate of persons under 20 years of age in relation to those over 60 has dropped sharply in the ISAPRE system. In effect, in the early 1990's that ratio was close to 12 youths for each adult over 60; nowadays, this ratio is 3.3 youths per senior citizen.

All things considered, the aging of the population is a phenomenon that is not alien to the ISAPRE system and that once it begins it becomes difficult to systematically revert it, because those factors that drive such aging process will only continue to deepen (the drop in fertility rates, the sustained drop in mortality rates, and life expectancy). The foregoing becomes manifestly clear in GRAPHIC N° 4, which shows a synthesis of the evolution of the composition of the ISAPRES portfolio and where one may observe that persons under 20 became 39% of the ISAPRES portfolio between the years 1991 and 2015, while senior citizens have gone from 3% of the portfolio to 8%. Likewise, the data shows that the ISAPRES concentrate the largest number of beneficiaries under 60 years old (92% in 2015); which is natural, given the regulations that govern the ISAPRE system that permits contributors to finance their plans with their own resources, and where the retirement age for men is 65 years and that of women 60 years; reason why their permanence in the ISAPRE system will depend on the amount of their pension and savings (and not on subsidies).

TABLE 4
EVOLUTION OF THE COMPOSITION OF THE ISAPRE SYSTEM PORTFOLIO




*Source: Prepared by ISAPRES de Chile, based on SIS data.*

Nevertheless, during the last years, the percentage of persons of the ISAPRE system portfolio in the age bracket of 60 years of age and over has increased, going from 3.3% share of the total portfolio (83.6 thousand beneficiaries) in 1991 to 8.3% (283 thousand beneficiaries) in 2015. See TABLE N° 4.

TABLE 4
EVOLUTION OF ISAPRE SYSTEM BENEFICIARIES, BY AGE BRACKET

| ISAPRES BENEFICIARIES | | | | | |
|---|---|---|---|---|---|
| | Under 60 | % Portfolio | Over 60 | % Portfolio | Total |
| 1991 | 2.482.493 | 96,7% | 83.651 | 3,3% | 2.566.144 |
| 1995 | 3.642.685 | 96,8% | 120.964 | 3,2% | 3.763.649 |
| 2000 | 2.492.211 | 95,4% | 142.631 | 4,6% | 3.084.842 |
| 2005 | 2.499.053 | 94,0% | 160.285 | 6,0% | 2.659.338 |
| 2010 | 2.618.217 | 92,7% | 207.401 | 7,3% | 2.835.618 |
| 2015 | 3.126.127 | 91,7% | 283.837 | 8,3% | 3.410.000 |

*Source: Prepared by ISAPRES de Chile, based on Health Superintendence data.*

The ISAPRE population of senior citizens (8%) is somewhat below the country's population profile (15% of senior citizens of the entire population); which, as indicated above, is the consequence of self-financing in the ISAPRE system and that the premium depends on the risk profile (gender, age) of the user; which is why upon retirement the user's permanence in the system will depend on whether his/her pension or savings is sufficient to continue to finance his/her health. At any rate, the data shows that, contrary to common belief, when ISAPRE contributors retire, a significant number of them decide to remain in the system, in spite of higher premiums. The foregoing because they realize that in the private sector they are bound to receive timely and quality health care services during that stage in their lives when they are likely to need them the most. The permanence of senior citizens in the ISAPRE system was also accentuated with the 2010 Resolution of the Constitutional Tribunal freezing base-plan premium adjustments by risk factors; namely, as of 2010, base plan premiums are not increased as we grow older, it only presents differences according to the contributor's gender.

Although non-discrimination by age is positive for the aging population, it implies that the ISAPRES (and their contributors) will face increasing costs because, as indicated above, the number of senior citizens will continue to increase and the expense incurred in them is indeed significantly greater that in the rest of the portfolio (i.e. 8% of the senior citizen portfolio spends 20% of all medical services invoiced). Consequently, the ISAPRES must find a way to finance such greater costs arising from an aging portfolio.

In sum, it can be said that the ISAPRE beneficiary population is a young population; however, the share of senior citizens has grown rapidly during the last years. It is mostly concentrated in the Santiago Metropolitan Area; there is equilibrium between both genders; it enjoys higher incomes; it is mostly comprised of dependent contributors; and, the number of contributors exceeds the number of dependents.

## II.3 MEDICAL SERVICES

Ever since the outset of the system, the medical services provided by the ISAPRES have had a sustained growth; which is explained not only because of the growth in beneficiaries, but also, because of a greater demand from them and the improved coverage and quality of the health plans offered by the ISAPRES. During the year 2015, the number of medical services provided by the system amounted to over 83 million; of which nearly 31 million corresponded to diagnosis exams and nearly 15 million to medical consultation. All in all, during the year 2015, the system financed an average of 25 medical services per beneficiary.

The annual health service utilization per capita has risen on a sustained basis, since in 1990 the system financed 9 medical services per beneficiary per year, rising to 14 in the year 2000, to 19 in 2010, and to 25 in 2015. Thus, the trend shows that on a year-to-year average beneficiaries use one additional service every year.

On the other hand, out of the 25 medical services used per beneficiary in 2019, 9 corresponded to diagnosis examinations, 5 to clinical and therapeutic support procedures, 5 to additional services (approximately 3 in GES), and 4 correspond to medical consultation.

With respect to the distribution of medical services by age group, in the year 2015, those beneficiaries under 60 years of age used 21 services on the average, while those over 60 years of age used 60 such services; thus averaging the 25 services per beneficiary mentioned above. Insofar as gender is concerned, women used 29 services on the average during 2015, while men used 21.

TABLE 5
SERVICES PROVIDED IN THE ISAPRE SYSTEM

| Nº OF SERVICES PROVIDED IN THE ISAPRE SYSTEM | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Nº Service (in Th.) | 1990 | 1995 | 2000 | 2005 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| N° Medical Service | 6.891 | 11.982 | 13.228 | 10.584 | 11.922 | 12.678 | 13.465 | 14.428 | 14.772 | 14.782 |
| N° Diagnosis exam | 6.306 | 12.978 | 17.144 | 15.436 | 20.653 | 23.855 | 25.566 | 27.901 | 29.408 | 30.931 |
| N° Clinical Terapeutic support procedures | 3.153 | 6.562 | 8.962 | 7.549 | 12.157 | 13.715 | 14.444 | 16.004 | 17.244 | 18.139 |
| N° Surgical Intervention | 157 | 298 | 368 | 269 | 355 | 425 | 446 | 432 | 445 | 441 |
| N°Other Services | 2.133 | 4.697 | 3.760 | 1.142 | 1.785 | 1.936 | 1.986 | 2.253 | 2.296 | 2.321 |
| N° additional services | - | - | - | 4.432 | 6.416 | 8.798 | 10.526 | 12.187 | 13.874 | 15.724 |
| Not Classified | - | - | - | 1.658 | 0 | 0 | 0 | 0 | 4 | 1.305 |
| Total Services | 18.640 | 36.518 | 43.462 | 41.070 | 53.289 | 61.406 | 66.434 | 73.206 | 78.043 | 83.643 |
| Beneficiaries | 2.108.308 | 3.763.649 | 3.092.195 | 2.660.338 | 2.825.618 | 2.925.973 | 3.064.719 | 3.206.312 | 3.308.927 | 3.410.487 |
| N° Services per each beneficiary | 1990 | 1995 | 2000 | 2005 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| N° Medical services | 3,3 | 3,2 | 4,3 | 4,0 | 4,2 | 4,3 | 4,4 | 4,5 | 4,5 | 4,3 |
| N° Diagonis exams | 3,0 | 3,4 | 5,5 | 5,8 | 7,3 | 8,2 | 8,3 | 8,7 | 8,9 | 9,1 |
| N° Clinical Terapeutic support procedures | 1,5 | 1,7 | 2,9 | 2,8 | 4,3 | 4,7 | 4,7 | 5,0 | 5,2 | 5,3 |
| N° Surgical Intervention | 0,1 | 0,1 | 0,1 | 0,1 | 0,1 | 0,1 | 0,1 | 0,1 | 0,1 | 0,1 |
| N°Other Services | 1,0 | 1,2 | 1,2 | 0,4 | 0,6 | 0,7 | 0,6 | 0,7 | 0,7 | 0,7 |
| N° additional services | - | - | - | 1,7 | 2,3 | 3,0 | 3,4 | 3,8 | 4,2 | 4,6 |
| Not Classified | - | - | - | 0,6 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,4 |
| Total Services | 8,8 | 9,7 | 14,1 | 15,4 | 18,9 | 21,0 | 21,7 | 22,8 | 23,6 | 24,5 |

*Source: Prepared by ISAPRES de Chile, based on Health Superintendence data.*

## II.4 CURATIVE MEDICAL LEAVE LICENSES AND OCCUPATIONAL DISABILITY SUBSIDIES (SIL)

Chile's social security system considers various subsidies for employees unable to work, known as Occupational Disability Subsidies (SIL, in its Spanish acronym). Depending on the type of disease the financing varies and its payment is carried out by different institutions. Within this context, in Chile there are three different types of sick leave benefit: (i) those ordered for curative diseases and supplementary maternal leave[39], (ii) maternal leave (pre and post-natal) and serious illness of a children under 1 year of age[40]; and (iii) the SIL derived from occupation casualties and professional diseases[41].

The sick leave arising from curative diseases and supplementary maternal leave, is managed and financed by the public and private social security health systems; namely, by FONASA and the ISAPRES, depending on where the worker makes his/her contributions. It must be stated that, in line with the International Labor Organization (ILO), Chile is equipped with one of the most generous worker disability protection systems, with a salary replacement rate of nearly 100% of the taxable cap, without restrictions regarding the duration of medical leave licenses. It only applies a 3-day deductible when the duration of the license is under 11 days.

In the year 2015, the sick leave benefit represented 25% of the expense over the ISAPRES' legal contribution. This ratio has been observed to increase, and has implied an increasingly burdensome financial expense for the ISAPRES. Thus, TABLE N° 6, below, summarizes the main statistics regarding medical sick leave benefit and the ISAPRES' payments.

39. Pregnancy pathologies and pre and post-natal postponements.
40. The financing for this subsidy is borne by the Single Family Services Fund and Unemployment Subsidy (Fondo Único de Prestaciones Familiares y Subsidio de Cesantía), set up by fiscal contributions.
41. The financing for this subsidy is borne the mandatory contribution established in Law N° 16,744, which is payable by the employer and managed by the Security Mutuals (Mutuales de Seguridad).

**TABLE 6**
MEDICAL LEAVE LICENSES AND SIL PAYABLE BY THE ISAPRES

| | 2001 | 2005 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|
| N° of Benefits rejected | 52.408 | 84.149 | 155.214 | 150.746 | 148.965 | 154.966 | 175.166 | 203.429 |
| N° of Benefitspaid | 908.180 | 867.515 | 1.155.784 | 1.168.320 | 1.265.494 | 1.385.015 | 1.565.075 | 1.696.620 |
| N° of days paid | 6.890.577 | 5.901.939 | 8.932.797 | 8.831.870 | 9.922.444 | 10.819.899 | 12.033.526 | 12.310.568 |
| | | | | | | | | |
| Total Cost (MM$ of 2015) | 178.825 | 177.716 | 282.180 | 281.177 | 317.986 | 380.483 | 416.108 | 420.102 |
| Siil Cost per affiliate year ($ 2015) | 150.195 | 161.306 | 221.775 | 214.844 | 228.894 | 256.320 | 267.608 | 259.093 |
| | | | | | | | | |
| Benefits paid per active contributor | 0,76 | 0,79 | 0,91 | 0,89 | 0,91 | 0,93 | 1,01 | 1,05 |
| Nº of days per active contributor (TII, Q) | 5,8 | 5,4 | 7,0 | 6,7 | 7,1 | 7,3 | 7,7 | 7,6 |
| Benefits cost per day paid (P) | 25.952 | 30.111 | 31.589 | 31.837 | 32.047 | 35.165 | 34.579 | 34.125 |
| | | | | | | | | |
| Active Contributors | 1.190.618 | 1.101.729 | 1.272.373 | 1.308.749 | 1.389.231 | 1.484.404 | 1.554.914 | 1.621.432 |

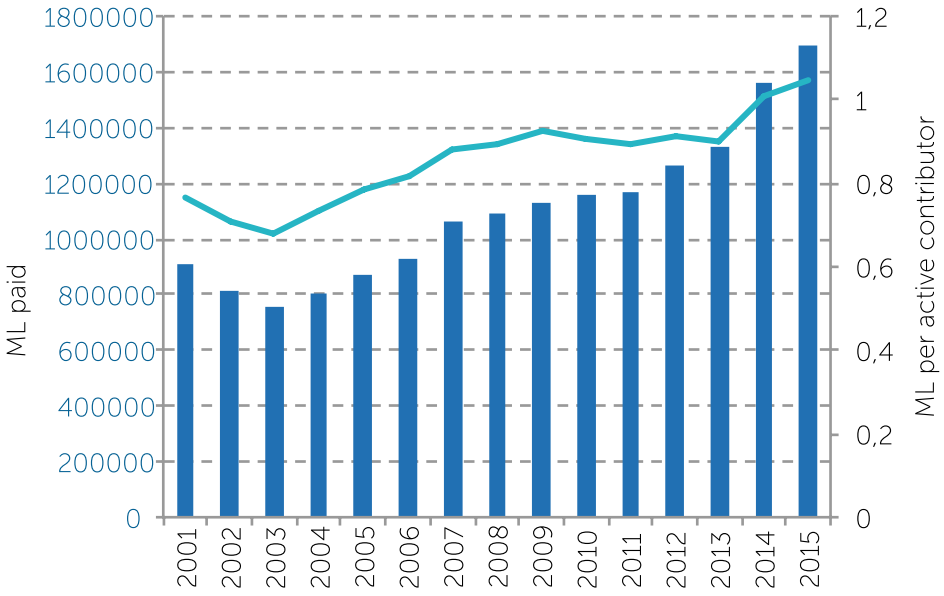
*Source: Prepared by ISAPRES de Chile, based on SIS data*
*Active Contributors: Contributing population comprised of dependent and independent workers subjets to medical licence payments.*

In the year 2015, the ISAPRE system paid out somewhat in excess of 1.6 million sick leave benefits, doubling them as compared to 10 years ago. On the other hand, if we consider that those contributors that are subject to the payment of medical leave licenses (active contributors) total about 1.6 million, one may infer that each active contributor, on the average, makes use of one such medical leave per year; a trend that has increased considerably throughout the years.

GRAPHIC N° 5 expands the information regarding the number of medical leave licenses paid out by the ISAPRES during the last 15 years. It also shows the rate of medical leave licenses per active system contributor during the same period.

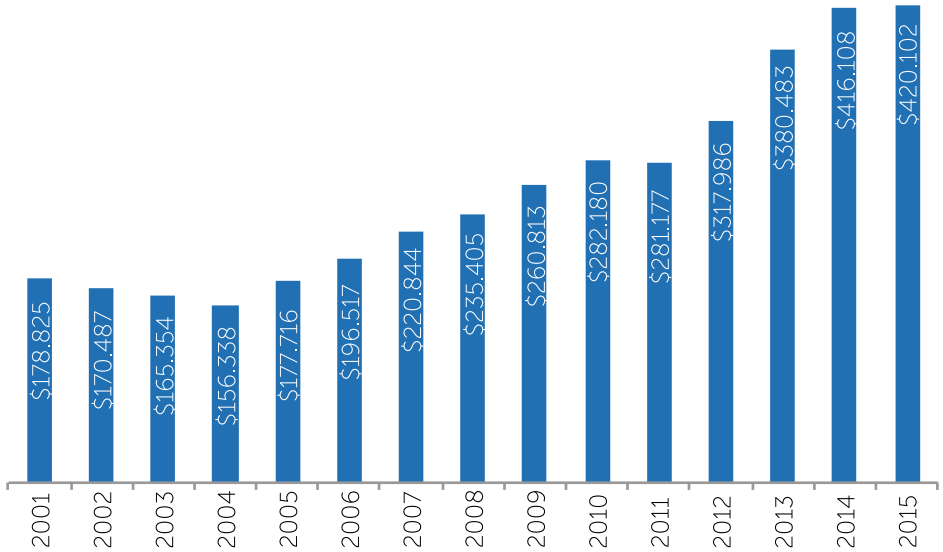
On the other hand, somewhat in excess of 1.6 million medical sick leave benefit paid out during the year 2015 implied expenses of over $ch 420 thousand millions. In real terms, sick leave costs have more than doubled during the last decade, increasing by 136% in real terms between 2005 and 2015 (an average of 9% per year). GRAPHIC N° 6, below, shows expenses payable by the ISAPRES during the last 15 years, stated in currency of 2015.

**TABLE 5**
MEDICAL LEAVE LICENSES PAYABLE AND PAID OUT BY THE ISAPRES AND MEDICAL LEAVE LICENSES PER ACTIVE CONTRIBUTOR




*Source: Prepared by ISAPRES de Chile, based on SIS data*

TABLE 6
SIL EXPENSES PAYABLE BY THE ISAPRES
(IN MILLION PESOS AS OF DECEMBER 2015)




*Source: Prepared by ISAPRES de Chile, based on SIS data*

One of the primary reasons why expenses have increased is the greater use of medical sick leave benefit (quantity impact). However, what has also influenced such increase, albeit in a lower proportion, are salary increases and taxable caps (price impact). In order to analyze the foregoing, one must examine the expense per active contributor, which is the product of multiplying the average cost per days paid (price impact)[42] per number of days paid by the contributor (quantity impact) or occupational disability rate (TIL, in its Spanish acronym)[43].

Upon analyzing expenses per contributor (TABLE N° 7), one may observe that between the years 2005 and 2015 it jumped by 61% in real terms (an average of 5% per year), boosted in large measure by an increased rate of occupational disability (quantity impact), which increased by 42% in real terms (an average of 4% per year), while expenses per subsidy days paid (price impact) increased by 13% in real terms (an average of 1% per year). Specifically, the TIL rate has gone from an average of 5.4 days of license paid by the contributor in 2005 to 7.6 in 2015; namely, it has increased by 2.2 days on the average. On the other hand, the greater increase in the amount paid per day (price impact) obeys to salary improvements and/or to increased taxable caps.

TABLE 7
SICK LEAVE EXPENSE PER CONTRIBUTOR PAYABLE BY THE ISAPRES

| | 2005 | 2012 | 2013 | 2014 | 2015 | GROWTH | Prom. Anual |
|---|---|---|---|---|---|---|---|
| | | | | | | 2005-2015 | |
| Total Sicks leave cost ( Mill $2015) | $ 177.716 | $ 317.986 | $ 380.483 | $ 416.108 | $ 420.102 | 136% | 9% |
| Cost per Contributor years ($ 2015) | $ 161.306 | $ 228.894 | $ 256.320 | $ 267.608 | $ 259.093 | 61% | 5% |
| N° of days per active contributor (TIL,Q) | 5,4 | 7,1 | 7,3 | 7,7 | 7,6 | 42% | 4% |
| Sick leave cost per day paid (P) | $ 30.111 | $ 32.047 | $ 35.165 | $ 34.579 | $ 34.125 | 13% | 1% |

*Source: Prepared by ISAPRES de Chile, based on SIS data*

All things considered, the increase in sick leave expenses explained by the increased number of contributors or of their incomes is indeed unavoidable. Nevertheless, the observed increase in the number of days paid per contributor (quantity impact) is indeed worrisome, because it might me indicating to us that the population is either sicker (or more diseases are being diagnosed) or we are in the presence of abuses heretofore undetected by the ISAPRE controllers' (audit) offices.

With respect to the health of the population, the epidemiological variables have not changed significantly in our country during at least the last two decades; moreover, many health indicators show that they have indeed improved; this is why it is difficult to explain such pronounced increase in medical leave benefits to purely health reasons. What indeed is true is that each day there are better technologies available and a better access to health, which may be allowing a greater number of diagnoses and them, in turn, leading to a greater number of medical leave benefits.

On the other hand, on TABLE N° 7 we may observe that the number of rejected medical leave benefits has more than doubled (an average of 9% per year), having rejected nearly 120 thousand such medical leave during the last 10 years (a little over 28 thousand between 2014 and 2015). Within this context, it is not possible to so easily explain the greater utilization of medical leave to lax institutional controls; although it is indeed important to bear in mind that the objective proof of certain pathologies is more difficult, as is the case with mental health diagnoses or musculoskeletal disorders. Coincidentally, in such pathologies is where we observe a greater utilization rate of medical leave; which, altogether, concentrate 35% of all such benefits.

In such scenario, it is very possible that behind the veritable boost of observed medical leave licenses there might be a misuse component. Specifically, we believe that the sick leave insurance has design problems (100% of the salary replacement rate without any duration restriction) that provide use incentives for purposes other than sick leave. Within this context, changes could be introduced in the design of medical leave benefit aimed at removing bad use incentives. For example, the 3-day deductible could be extended to apply to all such licenses, whatever their duration, thus avoiding their unnecessary extension.

Likewise, the 100% salary replacement rate is too generous, since it provides incentives for misusing such benefits or for their unnecessary use. Reducing the workers' salary replacement rate in other countries has proven to be a good incentive to use such benefit only as needed in case of illness. Within this context, we propose that in the case of demonstrable diseases requiring long periods of treatment (cancer, heart attacks, etc.), the contributor be reimbursed 100% of his/her salary, but to reduce such reimbursements in the rest of cases and to apply a deadline to them.

On the other hand, there ought to be a change in the institutionally of medical leave benefit, so that the (curative) licenses from FONASA, the ISAPRES, and the occupational safety mutuals are managed by a single and specialized underwriter. Upon such changes becoming operative, there could also be progress in the idea that the financing of this benefit be shared between contributors and employers. This would remove labor absenteeism incentives on the part of employers.

Finally, in addition to improving supervision and control measures, we should consider considerably increasing the penalties applicable to fraudulent medical leave benefit, both to their beneficiary contributors as well as their issuing physicians.

In sum, the institutional design for handling occupational disease benefit appears to have generated certain perverse incentives to use this benefit for purposes other than sick leave. This has translated into explosive increase in expenses in the last years (affecting both FONASA and the ISAPRES) and mostly driven by an increase in the number of days paid out per contributor, but also, by a growth in salaries and their taxable caps; all of which has turned into an increasing financial burden for the system.

## II.5 FINANCIAL PERFORMANCE

The expenses of the ISAPRES comprise operational costs (benefits) and administrative and sales costs (A&S expenses, in its english acronym). The benefit costs correspond to those incurred on account of medical service costs and medical sick leave; namely, they are expenses inherent to topics related to the health of contributors. On the other hand, A&S costs correspond to those necessarily incurred in order to operate the ISAPRES and provide health care services to beneficiaries and marketing health plans. In the ISAPRE system, the financing of such expenses comes 100% from the contributions (legal and additional voluntary) of its affiliates; which constitutes the operating income of the ISAPRES.

TABLE N° 8, below, shows the evolution of the income statements of the ISAPRE system as a percentage of operating income. From that Table one may infer that, during the last 25 years, casualties[44] have increased by 13 percentage points, while A&S expenses as a percentage of incomes have dropped by 9 percentage points. Specifically, in 2015, 88% of all the contributions received by the ISAPRES were allocated to financing operating expenses (casualties) or benefits of their users, while 12% of them were allocated to financing A&S expenses. It should be mentioned, however, that out of the 2015 operating costs, casualty claims (rate) from medical services (70% of income) were substantially higher than medical-leave-license payments (17% of income), although both expenses have increased significantly over time.
It is worth highlighting that Chile's private health underwriting system is one of those in which the greatest percentage of its income (coming from contributors) is paid back to affiliates via medical services and health benefits (88%); a circumstance which, in turn, reflects the high levels of casualty claims reached in the system.

| ITEMS | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |
|---|---|---|---|---|---|---|
| Operating income | 100% | 100% | 100% | 100% | 100% | 100% |
| Operating cost | 74,8% | 76,4% | 81,4% | 78,6% | 84,7% | 87,7% |
| Health services | 58,1% | 61,5% | 65,6% | 64,6% | 69,1% | 69,6% |
| Sick leave | 16,7% | 14,9% | 15,8% | 14,0% | 15,6% | 18,1% |
| Margin | 25,2% | 23,6% | 18,6% | 21,4% | 15,3% | 12,3% |
| A&S Expenses | 21,1% | 20,0% | 17,7% | 14,5% | 12,6% | 12,2% |
| Operating margin | 4,1% | 3,6% | 0,9% | 6,8% | 2,7% | 0,1% |
| Not operating margin | 4,3% | 2,2% | 1,2% | 0,2% | 1,6% | 2,1% |
| Income tax | 0,7% | 1,0% | 0,2% | 1,2% | 0,7% | 0,5% |
| Annual balance | 7,7% | 4,8% | 1,8% | 5,8% | 3,6% | 1,6& |

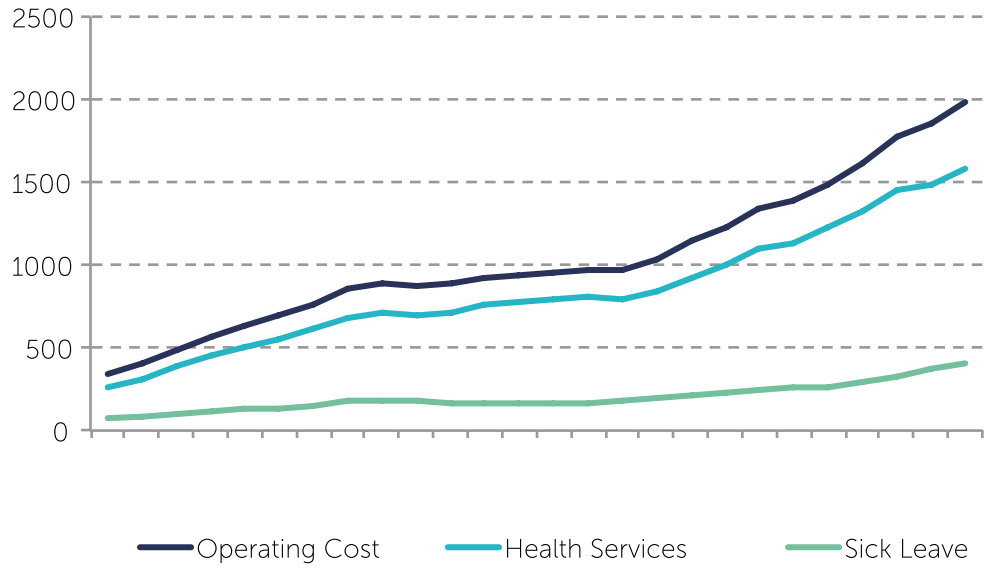
*Source: Prepared by ISAPRES de Chile, based on FEFI'S submitted by the ISAPRES to te SIS.*

The growth experienced by operating costs may be observed in GRAPHIC N°7; which have increased six fold in real terms between 1990 and 2015, going from $ 336 thousand millions in 1990 to $ 1,986 thousand millions in 2015 (in 2015 currency). Out of the 2015 operating costs, 17% corresponded to medical service expenses and the remaining 21% to payments derived from medical leave benefits.

The foregoing has gone hand-in-hand with a greater growth of sick leave payments in later years; which, in fact, doubled during the last decade, growing at an annual average rate of 9%, while medical services grew by 7% per year on average during the same period.

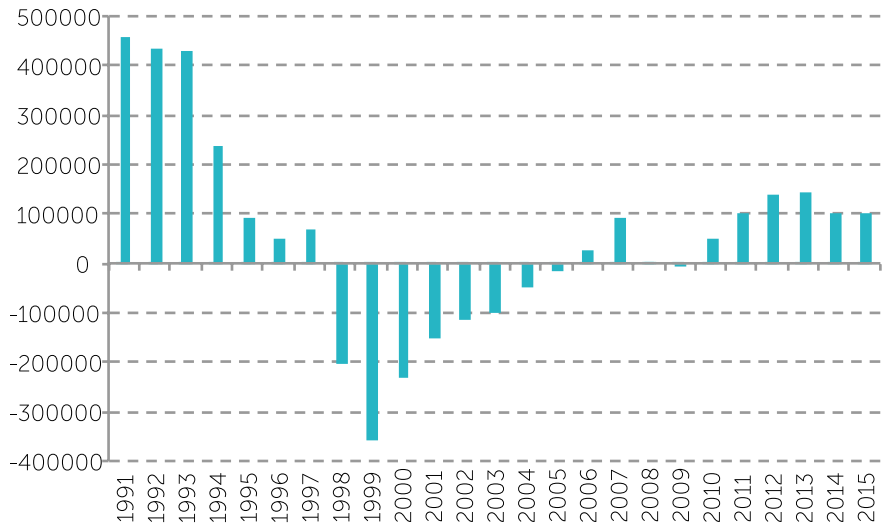
On the other hand, during the years elapsed, the number of beneficiaries has also fluctuated; reason why in order to isolate this impact one would have to show the evolution of benefits costs per beneficiary. Thus, GRAPHIC N° 8, shows annual changes in the number of ISAPRE system beneficiaries; which, in net terms, increased by 1,302,179 between 1990 and 2015.

TABLE 7
OPERATING COSTS OF THE ISAPRE SYSTEM
(IN THOUSAND MILLION PESOS AS OF DECEMBER 2015)




*Source: Prepared by ISAPRES de Chile, based on SIS data*

TABLE 8
ANNUAL FLUCTUATIONS IN THE NUMBER OF ISAPRE SYSTEM BENEFICIARIES
(NUMBER OF PERSONS)

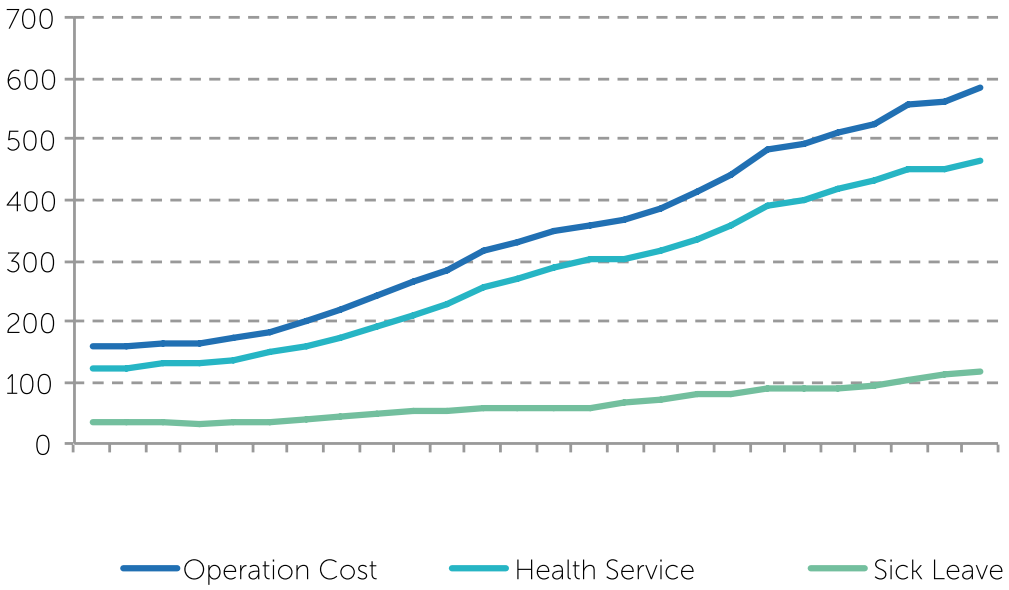



*Source: Prepared by ISAPRES de Chile, based on SIS data*

Having corrected by number of beneficiaries, we observe that the benefits annual costs per beneficiary have quadrupled in real terms between 1990 and 2015, going from $ 159 thousand per beneficiary in 1990 to $ 582 thousand per beneficiary in 2015 (annual real average of 5%); a period during which, as we indicated above, beneficiaries increased by somewhat over 1.3 million (annual average of 2%). On the other hand, between 1990 and 2015, the annual expense in services per beneficiary increased from $ 124 thousand to $ 462 thousand (annual average of 5%), and sick leave payments from $ 36 thousand to $ 120 thousand (annual real average of 5%).

By narrowing down the per-capita analysis to the last 10 years (2005-2015), we may observe that the annual benefits costs per beneficiary increased by 59% in real terms (annual average of 5%). Specifically, annual medical services per beneficiary increased by 54% in real terms (annual average of 4%), while sick leave payments per beneficiary grew by 84% in real terms (6% annual average). This information corroborates how sick leaves expenses (per beneficiary, in this case) have been increasing over and above medical service expenses during the last years.

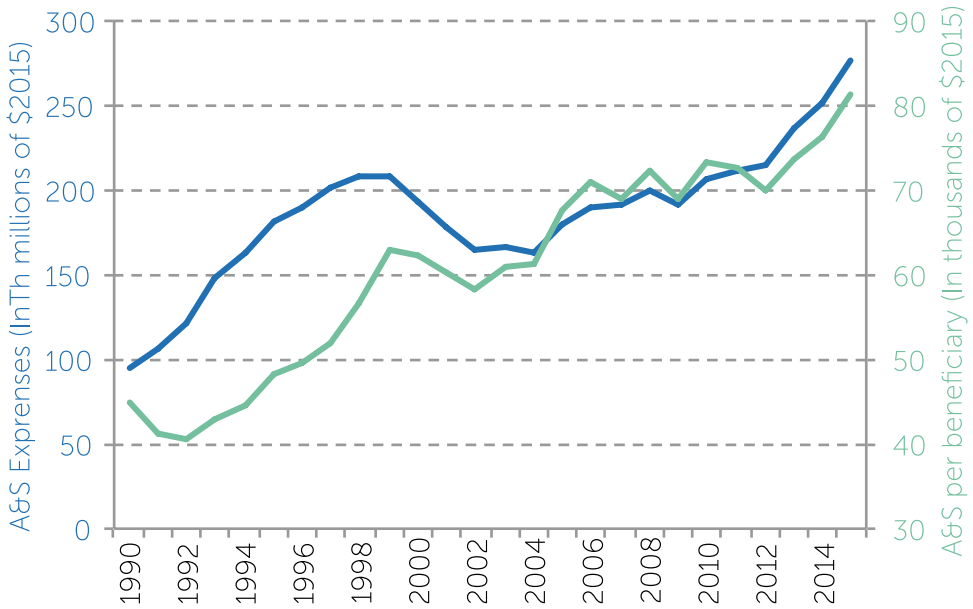
TABLE 9
ANNUAL OPERATING COSTS PER BENEFICIARY IN THE ISAPRE SYSTEM
(IN THOUSAND PESOS OF THE YEAR 2015)




*Source: Prepared by ISAPRES de Chile, based on SIS data*

Administrative and sales expenses, origin that relates to activities regarding the delivery of benefits (such as the operation of customer service offices; telephone services; processing of service orders; and, medical leave benefits, among others); which is why their evolution will, in turn, depend on the development experienced by the number of beneficiaries, medical services and sick leave benefits. In this regard, we observe that during the last 25 years (1990-2015) while the number of beneficiaries increased by 1.3 million, the number of health services per beneficiary increased from 9 to 25 and the use of medical leave benefits per contributor rose from 0.6 to 1.05. This has translated in that the system's A&S expenses tripled in real terms during the last 25 years, going from $ 95 thousand millions in 1990 to $ 277 thousand million in 2015 (in currency of 2015). In per-capital terms, A&S expenses per beneficiary went from $ 45 thousand to $ 81 thousand (in currency of 2015) between 1990 and 2015, increasing an average of 2% annually in real terms (GRAPHIC N° 9). It may be thus observed that real A&S expenses have grown, on the average, less than benefits costs and -as we saw above- the ISAPRES are nowadays more efficient in managing A&S expenses, since A&S expenses as a percentage of income have been consistently dropping (TABLE N° 10).

TABLE 10
ADMINISTRATIVE & SALES EXPENSE TOTALS AND PER BENEFICIARY IN THE ISAPRE SYSTEM
(IN THOUSAND MILLION PESOS OF THE YEAR 2015 AND THOUSAND PESOS OF THE YEAR 2015)




*Source: Prepared by ISAPRES de Chile, based on SIS data*

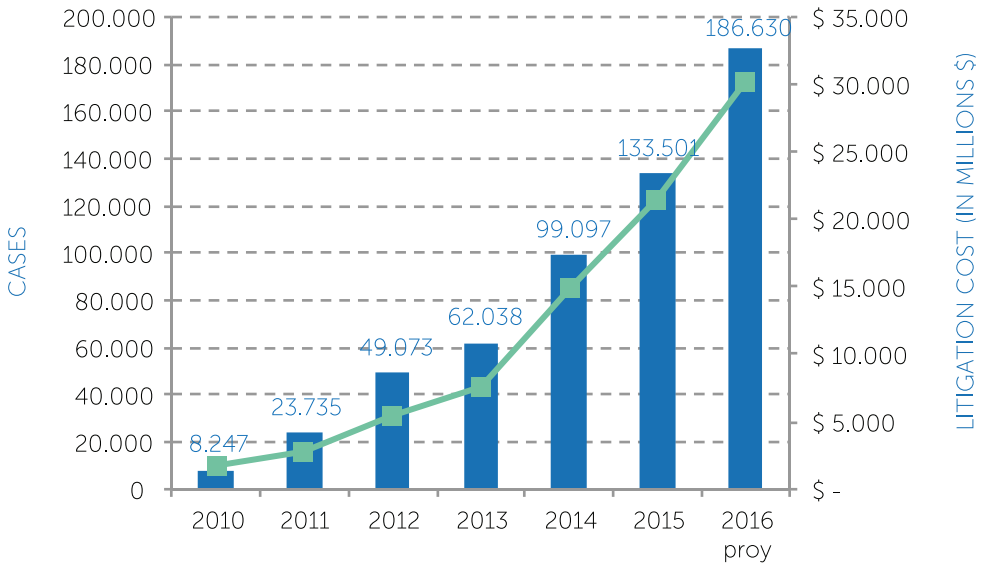
During the last 10 years (2005-2015), A&S expenses grew 54% in real terms (real annual average of 4%), an increment that was heavily influenced by higher personnel expenses (representing more than 50% of A&S), specifically, by an increase in staffing; which, in turn, was the consequence of having to serve more beneficiaries and a greater demand for health services on their part. However, ever since the year 2007, the ISAPRES have had to confront a heretofore non-existent A&S expenses; which, albeit not directly stemming from the operation of the system, they derive from lawsuits filed by contributors. This expense reflects the legal costs derived from the legal remedies filed by contributors in order to deter price adjustments of health plans. Specifically, ever since 2007, these legal costs have been growing at increasing rates and in 2015 they represented 8% of all A&S expenses.

With respect to the litigation, as of the year 2007, and with greater emphasis as of 2011, the Courts of Law began to admit the lawsuits filed by ISAPRE system contributors in order to deter the annual increase of the base price of their plan. For the most part, judges have ruled in favor of the beneficiaries[45] , which have not only stopped the price increase, but also, sentenced the ISAPRES to pay all litigation costs, thereby generating a veritable market of highly-profitable lawsuits for a group of lawyers. This has made litigation to grow exponentially. This situation has decreased the financial resources that ISAPRES require to meet with the contracted benefits; both because of the impossibility of adjusting the prices of their health plans in line with increasing health costs and the payment of lawyers' legal costs.

In the year 2015, the lawsuits amounted to 133,503, entailing costs solely on account of legal costs of nearly $ 21,000 million, to which one has to add the cost on account of the lower income resulting from the frozen premiums. As of September 2016, more than 158,000 lawsuits had been filed, since this year the adjustment of prices came on top of GES premium adjustments, thereby increasing the quantity of lawsuits filed. It is, consequently, estimated that in the year 2016, cases could total some 186,000 filings and that payments on account of legal costs could reach over $ 30,000 million.

45. The reasons invoked by the Courts (Courts of Appeal and Supreme Court) to admit these litigation refer mainly to that, while recognizing the legal right of the ISAPRES to apply these increases annually, such right is being exercised arbitrarily, considering that it is a unilateral hike not based on objective and verifiable parameters, as informed to each affiliate in the price adjustment letter. However, such court rulings fail to recognize that the adjustment mechanism contained in the law hinders the ISAPRES to individually justify the hike and forbids positive discriminations between contributors.

**TABLE 11**
LITIGATION CASES AND LEGAL COSTS FOR ISAPRE PRICE ADJUSTMENTS
**(NUMBER OF REMEDIES OF PROTECTION AND MILLION PESOS OF EACH YEAR)**




*Source: Prepared on the basis of the Altura Management Report*

All things considered, the financial outlook of the ISAPRE system appears increasingly jeopardized, to the point of rendering it non-viable, if such litigation practices are not stopped soon. Within this context, a legal modification of the current legislation could permit overcoming this situation, in a manner such that the courts of law henceforth accept the price adjustments applying considerations established by law, since health cost increases are a worldwide phenomenon[46] of which the private health system cannot escape.

In sum, in the last years, the litigation along with a greater delivery of benefits, have led to a drop in the operating performance of the ISAPRE system and thus with the system's profit; which amounted to $ 37,249 million in 2015 (TABLE N° 9). The average profit recorded per beneficiary per month between 1990 and 2015 amounted to $ 1,130 (in currency of 2015); value that reached $ 910 per beneficiary per month in 2015. The foregoing has also led to a drop in income profitability (TABLE N° 9); which, in 2015 represented 1.6% for the ISAPRE system.

46. Several studies show that, at least during the last three decades, health spending around the world has grown above the expansion of the economies and inflation, thus taking an increasing share of the country's GDP. In the case of Chile, health spending as a percentage of GDP reached 7.8%, having increased 1.3 percentage points during the last 10 years. In any case, although health spending has increased in Chile, it is still below the average OECD spending (9% of GDP). This indicates that health spending in Chile still has room for expansion. In fact, ever since the year 2009, health spending grew faster in Chile than in any other OECD country, according to a study of this same organization. Specifically, we have observed in Chile how the health services demanded by persons increase yearly, as well as the use of medical leave licenses, to which one would have to add the aging of the country's population (and a greater life expectancy) and the progress being made in medical technologies, all of which will continue to add pressure on health costs in the future.

TABLE 9
INCOME STATEMENT OF THE ISAPRE SYSTEM
**(IN MILLION PESOS OF THE YEAR 2015)**

| ITEMS | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| Operating Income | $ 1.640.975 | $ 1.767.445 | $ 1.895.863 | $ 2.025.932 | $ 2.138.113 | $ 2.264.610 |
| Operating Cost | $ 1.389.346 | $ 1.491.524 | $ 1.609.670 | $ 1.780.803 | $ 1.857.389 | $ 1.986.427 |
| Health Services | $ 1.133.354 | $ 1.228.832 | $ 1.320.915 | $ 1.448.447 | $ 1.486.526 | $ 1.576.454 |
| Sick Leave | $ 255.992 | $ 262.692 | $ 288.756 | $ 332.356 | $ 370.863 | $ 409.973 |
| Development margin | $ 251.629 | $ 275.921 | $ 286.193 | $ 245.130 | $ 280.724 | $ 278.183 |
| A&S Expenses | $ 206.740 | $ 212.054 | $ 214.233 | $ 236.314 | $ 252.060 | $ 277.033 |
| Operating results | $ 44.889 | $ 63.866 | $ 71.960 | $ 8.816 | $ 28.663 | $ 1.151 |
| Non operating results | $ 25.899 | $ 33.483 | $ 44.580 | $ 42.307 | $ 52.712 | $ 48.403 |
| Incoming Tax | $ 11.771 | $ 19.689 | $ 24.965 | $ 9.181 | $ 18.843 | $ 12.304 |
| Annual Balance | $ 59.018 | $ 77.660 | $ 91.575 | $ 41.941 | $ 62.532 | $ 37.249 |

*Source: Prepared on the basis of the Altura Management Report*

## II.6 USER OPINIONS

The market research and public opinion company, CADEM, has been carrying out a study about the Perception of the ISAPRE System (2014-2016). In their 2016 survey, 7 out of 10 surveyed ISAPRE affiliates considered the quality of the system to be good or very good and were fully satisfied with the overall services provided by the ISAPRES. Within the satisfaction evaluation, the quality of the services is the main satisfaction variable among users, while health plan prices continue to be the main variable of dissatisfaction. In any case, affiliates perceive that since they belong to an ISAPRE they can access quality health providers and consider it important to belong to one, because, should anything happen to them they have ready and timely access to quality health care; which more than offsets what they pay for their health plan.

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