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Judicial Activism in the Private Health System

The decisions of the Constitutional Court, the Courts of Appeals, and recently the Supreme Court, have defined the operation of the private health system by way of the courts. It is not the role of the Judiciary to define public policies which may be of great technical complexity. A reform to the sector must deal with current problems, many of them caused by their own regulation. Introducing more regulations to the sector is not the solution, since it will probably entail less competition.

The Supreme Court decided against the Isapres (Health Social Insurance Institutions) for adjusting the prices of their plans in accordance with the law. Thus, we are facing a new case – 30 unanimous verdicts in the same line – where the Judiciary assumes the faculty of defining public policies, exceeding the authority granted by the laws and defined by other State powers, imposing its values or beliefs, without necessarily having the technical knowledge of very complex matters, such as health insurances.

With these decisions, the Supreme Court is seemingly endorsing both the judges, who in turn have systematically decided against the Isapres, and all those affiliated to the Isapres who wish to go to trial because the price of their plans have increased. In other words, it is an invitation to strengthen the sector's current judicialization, which is precisely one of the main problems of the Isapre system. There is also the concern and uncertainty that this logic may extend to other sectors of the economy, thus tightening the prices with all the known negative consequences entailed by State price fixing.

These juridical decisions have been presented to the public opinion as aiming to prevent arbitrary unilateral increases that do not consider objective change elements. But this is not so. On the contrary, increases according to the factor tables are attributable to strictly technical factors, and objectives set by the law. In spite of that, the Constitutional Court considered these factors to be excessive for certain age segments.

Therefore, the problem is not that increases are arbitrary in a strictly technical sense, but in relation to a value judgment of the Court and the judges, who have systematically decided against the Isapres, based not on what the law stipulates, but on their own sense of justice, exercising what has been qualified as judicial activism.

Why Reforming the Isapre System?

Although it is not sound that the Judiciary determines how private health should operate beyond the laws, there is a feeling of dissatisfaction towards the system due to specific problems that require a reform. But before that, it is important to have a clearer and agreed diagnosis of the problems needing solutions and what is the right way to do it. Currently, a greater regulation to the system is being proposed, with a strong State presence in the definition of the plans and prices. This is due to the false idea that problems in the private health system are caused by a lack of regulation, when actually it is quite the opposite: problems derive from the excess of bad regulation.

In general terms, the Isapres operate in a reasonable way and most of their affiliates are satisfied with their plans. In Chile, they have allowed many middle-income families to have access to private health services, which are perceived as a better alternative than public ones. However, there are problems which cause dissatisfaction and uncertainty. Among the most important ones are the changes in the affiliates' health status and the price increase of the plans for the elderly, which was precisely the reason for the Constitutional Court's decision.

The affiliates who suffer an expensive chronic condition have no alternative of changing to another company and remain captive in the company where they acquired this condition or undergo a change in their health status. A good system of private insurances must envisage protection against expensive chronic diseases. Nevertheless, its design must be carefully undertaken. The way in which the current regulation implements this insurance is forcing the companies to renew the policies of patients suffering chronic diseases. Isapres cannot legally dismiss an affiliate if his health status changes. Although it seems a reasonable commitment, it entails the undesirable effect of captive affiliates.

A person who catches a high-cost chronic disease means a loss for medical insurers. A new one would not accept him nor does it seem reasonable to force the company to do so. Although the contract signed when the person was healthy envisages a policy renewal without discriminating by health condition, chronic sick persons are no longer attractive customers and the medical insurer gains when they waive their right to renew the policies. This is known as temporal inconsistency of the

contract. There is literature specialized in the design of contracts with alternatives to solve this issue.

John Cochrane of the University of Chicago developed a proposal to solve the temporal inconsistency of health insurance contracts by introducing a “health-status insurance”. In other words, when the health status of the affiliate gets worse, the insurance compensates him for the higher cost he would have to face when hiring a policy at a price that is attractive to any medical insurer.

This would mean that Isapres would have to recognize as loss and cover the estimated cost of the chronic disease’s treatment, and this provision would go along with the patient in case of changing to another Isapre. That is, if the affiliate leaves, he takes his “backpack” along with him, which covers his greater health expenses. Consequently, the affiliate with a chronic disease would still be an attractive customer to any Isapre. The incentives to dismiss him and the captivity issue disappear.

The Constitutional Court’s decision against the factor tables left a legal gap and the need for a reform. Contrary to the interpretation that some people had wanted to give it, this decision validates price discrimination in the plans on the base of objective risk factors such as age and sex, but it considers that the differences of the current tables are excessive.

The factor tables were calculated to reflect the effective average costs per each risk group according to age and sex. In the literature on insurances, these prices are known as “fair prices”, because they reflect the average expense expected both by the insurer and the insured. However, from the regulatory point of view, the “fair price” of the insurance is considered excessive by part of the society, which is perfectly legitimate. The challenge is how to deal with the problem. One alternative is the creation of individual saving accounts. Thus, when the affiliate is young and low-cost, he can save on health to face the higher expenses when he gets older by leveling his effective disbursements throughout his life. We have to take into account that aging is not insurable, since it will certainly occur.

The Bill under Discussion

Today, there are two bills at the Congress dealing with health problems. One is the bill of the Ley Corta de Isapres (“Short Law”), where the law sets a single flat table with a maximum difference of five times among the most and least expensive groups by sex and age. In the current tables, this difference goes up to ten times. Although this bill does not solve the captivity problem, it does fill the legal gap left by the Constitutional Court’s decision and it solves the system’s excessive judicialization. The fact that this bill has not been approved as a short-term solution, while a definitive

reform is being agreed to cope with the private system's problems, is not understandable.

The other bill, rejected at the Chamber of Deputies, created a Guaranteed Health Plan, which sought to introduce a structural change of the Isapre system that strongly increases the sector's regulation and the role of the State. The proposed scheme is known as the Dutch system and it is applied in the Netherlands and Switzerland, among other countries. It is not a plan that has proven to be successful nor is it better than the Chilean one. Schut and Van de Ven (2011) evaluate the Dutch health system, and they stress that it is not a consolidated system, but rather a "work in progress". The authors also highlight that the compensation system does not avoid risk selection. Rosenau and Lako (2008) conclude that the Dutch system is not effective in controlling costs. They note that the insurance prices have increased while the insurers report losses. Furthermore, the users' satisfaction level is low. The authors hope that the Dutch experiment keeps adjusting in the future, since it is not a consolidated system.

In opposition to the Chilean case, the Dutch reforms of the 90's have aimed at an increasingly larger participation of the private sector in the provision of health insurances and giving more freedom to choose to the consumers, from a system that was mainly public. Chile already has a consolidated private system of medical insurers and health care providers.

An agreement between the Ministry of Health and a group of senators from Renovación Nacional (RN) and the Concertación has just been announced and it would allow advancing in this project; the result was to approve the idea of legislating in the Health Commission of the Senate. It has been pointed out that the base of this agreement is to take the necessary steps to prevent discrimination by sex and age, and it improves the possibility of comparing different plans, among other issues that could be added to the bill by way of indications. The problem of the absolute avoidance of the discrimination by age and sex is that it eliminates the insurance concept, since it prevents a differentiated premium from taking into account the risk, also different, among different affiliates. Unfortunately, risks cannot be eliminated; we may only concern ourselves on those who are going to pay them. In this case, for example, we could very well end up with poor young affiliates, by subsidizing older and richer beneficiaries.

What politicians do not tell us is that risks cannot be eliminated, they can only be redistributed. They give people the illusion that someone else (other affiliates or the Isapre) will pay this risk for them. Of course, in the long term, nobody can force someone to pay the risks of somebody else with no limits, and a way of preventing this is to simply get out of the system.

Conclusions

A reform to the sector of private health insurances must deal with the current problems, many of them derived from its own regulation. The solution is not more regulation of the sector, since it will probably entail less competition. There are alternatives to regulate the sector by giving more freedom to private initiatives and more protection to the affiliates. The decisions of the Constitutional Court, the Courts of Appeals, and recently the Supreme Court, have defined the operation of the private health system by way of the courts. It is not the role of the Judiciary to define public policies which may have great technical complexity, as in the design of health insurances. This corresponds to other State powers, which have been elected for this purpose. Let us hope that they do justice to their responsibility.

In brief...

- The problem is not that increases are arbitrary in a strictly technical sense, but in relation to a value judgment of the Court and the judges who have systematically decided against the *Isapres.*
- The absolute avoidance of the discrimination by age and sex is that it eliminates the insurance concept, since it prevents a differentiated premium from taking into account the risk, also different, among different affiliates.
- Unfortunately risks cannot be eliminated; we may only concern ourselves on those who are going to pay them.

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