

The 1983 legislation also provides that a court could consider an individual's Railroad Retirement benefit, other than the tier I benefit, in dividing property in a divorce case. This would treat Railroad Retirement benefits like other pension benefits. The only benefits paid to divorced spouses under the Railroad Retirement system are tier I benefits. Tier I benefits would continue to be immune from garnishment, attachment, assignment, levy, or other legal process, as are OASDI benefits.

### Other Provisions

Public Law 98-76 establishes a Social Security Equivalent Benefit Account effective October 1, 1984. All Social Security equivalent revenues—including tier I taxes, revenues derived from taxation of tier I benefits and amounts transferred to the Railroad Retirement system through, or borrowed against, the financial interchange—will be deposited in this account rather than in the Railroad Retirement Account. All Social Security equivalent benefits will be paid out of this account.

The law placed on a fully current basis the authority of the Railroad Retirement system to borrow from general revenues against amounts due, but not yet payable, from the financial interchange. The Railroad Retirement system will be able to borrow, on a monthly basis, amounts that are due as a result of the financial interchange. (Under prior law, only the amount that would be needed to pay benefits in the following month could be borrowed.) The new law repeals the authority for the Railroad Unemployment Insurance program to borrow from the Railroad Retirement Account effective September 30, 1985. The legislation also provides for transfers from the general fund to the Railroad Retirement Account of amounts due because the full amount necessary to finance dual benefits was not appropriated in past years.

The Railroad Retirement Board is required to submit a report to Congress on the actuarial status of the Railroad Retirement system under various economic and employment assumptions on or before July 1 of each year, beginning with July 1, 1985. The report is to include any recommendations for financing changes. The Railroad Retirement Board is also required to submit an annual report to Congress on the financial status of the Railroad Retirement system over the next 5 years. This replaces the report now required in fiscal years in which the Railroad Retirement system was expected to use 50 percent or more of its borrowing authority.

This legislation establishes a five-member Railroad Unemployment Compensation Committee to review all aspects of the Railroad Unemployment Insurance program. The committee is to submit a report to

Congress no later than April 1, 1984, containing recommendations based on its review of the program and recommendations on repayment of funds borrowed from the Railroad Retirement Account. The latter recommendations are to include adjustments in contributions and benefits that will enable the program to repay all loans from the Railroad Retirement Account by the end of 2000.

## Chile Changes its Health Care System\*

In August 1981, a new law in Chile gave workers<sup>1</sup> the option of remaining under the old government health care program or of joining a new private program intended to provide more comprehensive care than formerly had been available to most persons in that country. The new program is part of a government policy to shift certain social security programs from the public sector to the private sector.

In May 1981, a provident fund type<sup>2</sup> old-age program and a private disability and survivor insurance program were introduced. At the same time, the phasing out of the pay-as-you-go old-age, survivor, and disability insurance (OASDI) program—financed by the employee, the employer, and the government—was begun.<sup>3</sup> The employer's contributions were eliminated—not only for OASDI, but also for health insurance, unemployment insurance, and family allowances. The government covers the entire cost of unemployment benefits and family allowances, and workers are primarily responsible for financing old-age, disability, and health care programs. The government continues its partial subsidy of the old public health program but provides no financing for the new private program.

### Background

In 1924, Chile became the first country in the Western Hemisphere to introduce national health insurance for a large majority of its blue-collar workers. The system

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<sup>1</sup> The terms "workers" and "employees" are used interchangeably in this note to refer to both wage earners (blue-collar) and salaried (white-collar) employees.

<sup>2</sup> A provident fund is a compulsory savings system under which the regular contributions withheld from employees are often matched by those of their employers. These contributions are set aside to the credit of each employee in a special fund for later repayment either in a single lump sum with accrued interest or under some form of deferred payment.

<sup>3</sup> See Barbara E. Kritzer, "Chile Changes Social Security," *Social Security Bulletin*, May 1981, pages 33-37.

gradually evolved into separate coverage for blue-collar and white-collar workers.

The National Health Service (Servicio Nacional de Salud), introduced in 1952, provided insured blue-collar workers and their dependents with medical and dental care, cash sickness benefits, and health care in case of work injury. In 1968, the government established the National Medical Service for White Collar Workers (Sermena), which provided health care facilities offering compulsory services required under the 1938 Preventive Medicine Act: cancer, tuberculosis, syphilis, and heart disease detection and treatment.<sup>4</sup> All other medical services were to be provided by private physicians—at private clinics or hospitals or at specifically designated areas in public hospitals—and paid for by the user.<sup>5</sup> White-collar workers were then to receive reimbursement by Sermena for both medical and dental care at a rate of 50–70 percent of cost, according to minimum fee schedules.

Under an August 1979 law, both blue- and white-collar workers were permitted to use either their own facilities or those of the other scheme. However, it appears that most workers continued to use the same facilities they used before the 1979 reorganization.

In addition, nongovernmental individual funds (cajas) for white-collar workers also provided their own health care plans, with differing contribution and benefit rates, to replace or supplement Sermena. Affiliation with these funds was determined by occupation or employment and the contribution rates and benefits varied from plan to plan. Although these cajas were private agencies by law, in practice they were considered quasi-governmental, since they were heavily regulated by and received a partial subsidy from the government. Furthermore, the health insurance programs for these specialized white-collar groups—the cajas in combination with Sermena—were the equivalent of the government program for blue-collar workers.

## Current Health Care Systems

As a result of the 1981 legislation, two health care systems are now available to employees—the public programs discussed above and the new private program available through private health insurance carriers (Isapres). Under the new program, blue- and white-

collar workers who opt for the private coverage are required to sign a contract for at least 1 year with a private health insurance carrier, with contribution and benefit rates depending on the terms of the contract. The program is open to all employees and participation for the self-employed is optional. Unlike the caja “system,” where affiliation depends on occupation or employment, under the new system, a worker may choose whichever plan suits his or her needs.

## Public System

Under Chile’s government-operated public health system there are more than three dozen cajas for blue- and white-collar workers, and the contribution rates vary from fund to fund. The self-employed are not included in these programs. Two of the largest funds, the Social Security Service (SSS) for blue-collar workers and the Private Employees Fund (EMPART) for white-collar workers, together cover more than 50 percent of the insured population and are representative of the rest of the cajas.<sup>6</sup> The worker contribution rate for the SSS is 5.75 percent of wages; for EMPART it is 6.55 percent of salary. Under these and other programs, coverage is extended to all dependent children of insured persons under age 15, students aged 15–18, and invalids of any age.

To qualify for cash sickness benefits, workers must be currently insured. The cash sickness benefit for both blue- and white-collar workers is 100 percent of net covered earnings during the previous month. All workers may choose between the National Health Service, originally for blue-collar workers, and Sermena, originally for white-collar workers. National Health Service facilities provide full medical coverage, while Sermena offers cash refunds of 50–70 percent of medical costs, according to minimum fee schedules. As previously noted, some individual cajas also provide full medical care either to supplement or to replace the National Health Service or Sermena.

## Private Health Insurance Carriers

By law, a private health insurance carrier (Isapre) must be either (1) an insurance company covering a percentage of medical expenses and permitting the insured a choice of physician, clinic, hospital, or other facility, or (2) a health maintenance organization with designated doctors and/or medical facilities and with partially or fully prepaid medical care. As of May 1982, there were five Isapres insuring about 1 percent of the population.

An Isapre must have a minimum capital of 2,000

<sup>4</sup> The 1938 Preventive Medicine Act established minimum requirements for basic health care for both blue- and white-collar workers: (1) compulsory periodic medical exam to detect tuberculosis, syphilis, heart disease, and cancer; (2) right to preventive rest; (3) payment of benefits during the period of preventive rest at 100 percent of wages or salary, to be continued as long as recovery appeared likely; (4) return to one’s previous job at the end of the period of preventive rest; and (5) security against dismissal during the first 6 months following recovery.

<sup>5</sup> Most physicians in the country were employed part time by the National Health Service and spent a few hours a day in private practice.

<sup>6</sup> There are special funds for railroad employees, bank employees, seamen and port workers, and other groups.

Unidades de Fomento (UF) (US\$42,000)<sup>7</sup> before it is allowed to operate. The National Health Fund, a newly created government entity, approves the formation of all new Isapres and registers and monitors them on a regular basis. An Isapre is required to maintain a reserve equal to 1 month's contributions of all of its affiliates, with a minimum reserve of 600 UF (US\$12,600). In the event that the reserve falls below this minimum, the Fund has the authority to cancel the Isapre's license. The insured can then use the government health system or change to another Isapre.

**Contracts.** An individual signs a minimum 12-month contract with an Isapre, which states in detail the amount of contributions to be paid as well as the type of health benefits provided. An Isapre may break a contract only if the individual fails to pay the required contribution or if the Isapre's license is revoked. On the other hand, the insured may give 30 days' notice to terminate the contract without explanation. If, upon termination of the contract, the insured is receiving cash sickness benefits, the contract is extended until recovery. An insured person may switch freely from one Isapre to another, presumably without limitation, or can return to the public health system.

**Financing.** The amount of the insured's contribution depends on the terms of the contract. The minimum rate is 6 percent of earnings, with a monthly ceiling for contribution purposes set at 60 UF (US\$1,260). Contributions are often expressed in terms of UF's, which means that as the value of the UF changes, usually monthly, so does the contribution rate. In some instances, the contribution is increased for each additional dependent covered, up to a total of eight. An employer may, on a voluntary basis, contribute 5-6

percent of payroll in order to increase the worker's benefit.

**Benefits.** The contract must provide for the following minimum benefits: (1) curative medicine with a reimbursement level of 50-70 percent of the medical costs, according to minimum fee schedules; (2) preventive medicine as previously described in the 1938 Preventive Medicine Law; and (3) cash sickness benefits of 100 percent of net covered earnings. Additional benefits are stipulated in the provisions of the contract. Each Isapre has a variety of plans providing from 50 percent to 80 percent reimbursement of the cost of the care.

Theoretically, under the private program, the worker has access to a wider variety of health care and should be able to choose an Isapre more individually suited to his or her needs. In reality, although the law stipulates that a worker can receive the minimum benefits on the basis of a minimum contribution, the minimum benefits are not available with most of the Isapres. On the other hand, better benefits are available at higher rates. Furthermore, certain benefits call for a minimum amount of contribution under several plans, which means that only those earning above a certain income have access to these particular programs.

The insured may use the state system in cases where there is no private medical help for the particular disease or sickness being treated. The Isapre reimburses the state system for the treatment. At present, only about 10 percent of the hospitals in the country are private hospitals. In other words, the hospitalization portion of the private program is very limited and, in the event of illness, there is a strong possibility that the insured would have to go to a public hospital.

Both health plans are compared in table 1. To date, little information is available as to the enrollment preference of workers under the new private program.

<sup>7</sup> A UF is an indexed unit of value made up of a composite of several indexes including those for wages and prices. In July 1983, 1 UF equalled 1,641 pesos or US\$21.

**Table 1.**—Comparison of public and private health insurance systems in Chile

Item	Type of system	
	Public	Private
Worker	Blue-collar and white-collar are separate. Self-employed excluded.	All workers including self-employed.
Contribution rates	Blue-collar: 5.74 percent of earnings up to maximum of 60 UF. White-collar: 6.55 percent of earnings up to maximum of 60 UF.	6 percent of earnings, up to maximum of 60 UF.
Qualifying conditions	Cash sickness: currently insured, 6 months of insurance including 3 months in last 6 months. Dependents under 15 (18 if student, any age if invalid). Medical benefit: currently insured. Eligibility continues during 3 months of involuntary unemployment. Dependents under 15 (18 if student, any age if invalid).	All workers. Specific conditions depend on individual institution.
Cash benefits	100 percent of net covered earnings during last month.	100 percent of net covered earnings during last month. Anything else depends on contract.
Medical benefits	Blue-collar: includes generalist and specialist care, periodic exams, hospitalization, medicine, dental care, and maternity care. Can use white-collar system. White-collar: cash refunds of 50-70 percent of medical costs, according to minimum fee schedules.	Cash refunds of 50-70 percent of medical costs, according to minimum fee schedules. Anything else depends on contracts.