# Lessons from Brazil: Regulatory changes in the health insurance market

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**Both Brazil and the United States have distinct experiences with reforming their respective healthcare systems. While the two countries have different systems and have pursued different types of reform on different timetables, there are lessons to be learned by looking at the two countries side by side.**

Major healthcare reform has already occurred in Brazil over the past couple of decades. It is possible to draw relevant parallels between some of those changes and what the Patient Protection and Affordable Care Act (PPACA) includes for the United States.

## RECIPES FOR ADVERSE SELECTION

In 1988, Brazil's revised constitution declared that it was the Brazilian government's obligation and duty to provide healthcare for all citizens, with funding through taxes. State and municipal governments are expected to contribute 12% to 15% of their budgets to the health program; in addition, the federal government also contributes money raised from taxes.[1] Secondary taxes, such as those for cigarettes and lotteries, also help fund healthcare. As a result, a basic level of care (i.e., universal coverage excluding dental procedures) is available to all. Over the years, however, a popular trend emerged. People began purchasing private insurance to supplement the publicly provided care, and so the private health insurance sector began to grow.

Brazil's private sector does not have a mandatory requirement for individuals to purchase insurance, nor does it permit underwriting. This combination has resulted in significant adverse selection in the private sector, because primarily those with the greatest need for highly specialized medical care that is not provided by all public hospitals have purchased coverage, which can be obtained with few limitations.

There is much discussion about what will happen in the United States if the individual mandate is eliminated and underwriting remains prohibited. Taking a look at the evolution of Brazil's healthcare system may provide some insight into this possibility. Though its system is different from the one proposed by the PPACA, Brazil's private individual market lacks an individual mandate and does not permit underwriting—two things that have proven to be major drivers in the recent experience in the Brazilian health insurance market.

1 Brazil's march towards universal coverage. (2010). Bulletin of the World Health Organization 88:646-647. http://www.who.int/bulletin/volumes/88/9/10-020910.pdf

## BACKGROUND: HISTORY AND HEALTHCARE RULES IN BRAZIL

Private health coverage in Brazil was originally created by hospital owners in the 1960s. Hospitals were often located near large companies and, in order for these companies to provide basic healthcare for their employees, they paid a fee (premium) per employee each month to the hospital for coverage. Hospitals began partnering together, forming expansive networks that allowed for coverage to reach even more people. The health plan was treated like any other product in the market, without any rules or regulations, and was known as *Plano de Saude*, or "Health Plan."

In the early 1970s, insurance companies began to recognize that health coverage could be a great product for them, too. Insurance companies took a different approach to coverage by reimbursing the hospitals they partnered with on a per-procedure basis. This product was called *Seguro Saude*, or "Health Insurance."

The public health system, *Sistema Único de Saude* (SUS), or "Single Health System," was created in 1988 with the goal of providing universal care to the Brazilian population. This system is still in place today; however, because it is funded by taxes and social contributions, the program has always struggled financially to keep up with demand. For example, in 2010 Brazil's per-capita GDP was $10,800, and only about 3% of GDP was spent on public health; approximately 8% of GDP was spent on healthcare in total, with 60% of healthcare spending privately funded.[2] As a result, many members of the population have chosen to seek private healthcare to supplement the public system's offerings.

2 Shifrin, J. (August 1, 2011). Brazil's health care system. *Healthcare Economist* blog. http://healthcare-economist.com/2011/08/01/brazils-health-care-system/

Central Intelligence Agency. (2011). South America: Brazil. World Factbook. https://www.cia.gov/library/publications/the-world-factbook/geos/br.html

GE. (2012). Health of Nations: Brazil. http://www.healthofnations.com/countries/profile/brazil

Health Care in Brazil: An injection of reality. (July 30, 2011). *The Economist.* http://www.economist.com/node/21524879

Healthcare coverage in Brazil evolved through market forces, and there were very few rules or restrictions regarding the design or limits of coverage. The market (any private plan created before January 1, 1999) included the following limits:

- Typical limits included 30 days for regular inpatient stays or five days for intensive care unit stays.
- Companies could limit the number of doctor appointments.
- Exclusions included preexisting diseases, infectious/contagious diseases, prosthetic and orthotic devices, psychotherapy, fertilization treatments, complex surgery, drugs for outpatient, any aesthetic procedure, professional sports accidents, home care, and cases from cataclysm and war, when declared by the government.

With regard to the technical approach to pricing health insurance, the following rules applied:

- Companies were free to choose their own age bands.
- There was no defined actuarial method for determining premiums.
- There were no mandatory technical reserves.
- Senior citizens and people with preexisting diseases could be underwritten.
- There were no rules regarding annual increases (for premiums).
- Companies could set the waiting period for each procedure.
- Companies were free to cancel any contract that was not profitable.

The delay of any government guidelines for the healthcare market resulted in the majority of both health plans and insurance companies abusing the lack of specific regulation. In 1998, in order to stop exploitation in the market, the government published the Law n. 9656 (Brazilian Health Reform), which applied to all companies offering any kind of health coverage.

Through this healthcare reform, limits of utilization or value can no longer be applied. Post-reform (plans created after January 1, 1999), the number of allowed exclusions was also reduced to include only drugs for outpatient, procedures not accepted by the Physician Union,[3] aesthetic procedures (except for ones required as a result of accidents), home care, cases from cataclysm and war when declared by the government, and any transplants other than kidney or cornea. Rules regarding rate setting for premiums, cancellation of contracts, mandatory reserves, underwriting, and waiting periods were dramatically changed, which we discuss in additional detail in the next section.

3 The Physician Union in Brazil is similar to the American Medical Association in the United States.

## BRAZIL AND U.S. REFORMS: A COMPARISON

One of the most obvious differences in healthcare offered in Brazil and the United States is the use of the public health system in Brazil. Through the SUS, all citizens in Brazil have access to a basic level of care. However, because of the overwhelming need for care and the low funding for this program, about 25% of the population seeks supplemental healthcare through the private health system. The public health systems in the United States, Medicare and Medicaid, are not designed to provide care for a majority of the population. Everyone, except the poor, disabled, and elderly, needs to use the private market to obtain even a basic level of coverage.

The table in Figure 1 on page 3 provides a detailed comparison of the reforms that went into place in 1998 to Brazil's private plans and reforms prescribed in 2010 under the PPACA in the United States.

### *Some key similarities and differences to note:*

The age bands for premium rates in Brazil are limited to a 6:1 ratio between the least and most expensive groups' age bands; in the United States the ratio will be limited to 3:1. In addition, in Brazil there is a requirement that the ratio of band 10 (the oldest age band) and band 7 can be no greater than the ratio of band 7 to band 1 (the youngest age band). Although many are focused on the impact the compression in age rating will have in the United States, the consequence of moving to unisex rates produces a larger impact. In fact, Milliman Health Cost Guidelines™ data show that adult male costs vary by age at a ratio of about 7:1, and the corresponding ratio for females is about 3:1. Even without any compression for age, combining male and female claim costs into a single unisex set of rates by age produces a ratio of 4.2:1.[4]

Brazil has specified rate increase limitations, in the form of an allowed annual percentage increase dictated by the government health insurance regulator, Agência Nacional de Saúde Complementar (ANS). The United States has rate increase limitations, too. However, in some ways the language in the PPACA is less direct: rate increases above 10% are considered "unreasonable"; however, how these restrictions on unreasonable rate increases are enforced and what justifications, if any, are allowed for increases greater than 10% has yet to be determined, so it will be interesting to see how these constraints develop. Either way, limiting rate increases too strictly can endanger an insurer's profitability (and solvency) by creating a large gap in actual costs and charged premiums.

In the United States, a new constraint requires loss ratios of at least 80% for individual carriers. Brazil does not have any loss ratio requirement. Initially, the absence of a loss ratio minimum in Brazil allowed insurers more freedom when it came to setting their rates. However, because of the move from an unregulated to a strictly regulated environment, many companies in Brazil are struggling to stay solvent. Because the loss ratio calculation is indicative of a company's profitability, even though the regulations are becoming

4 Van Der Heijde, M. & Norris, D. (August 30, 2011). The young are the restless: Demographic changes under health reform. Milliman Insight. http://insight.milliman.com/article.php?cntid=7879&utm_source=healthcare&utm_medium=web&utm_content=7879&utm_campaign=Health%2Feature

**FIGURE 1: A COMPARISON OF INDIVIDUAL MARKET REFORMS**

| | BRAZIL<br>PRIVATE PLANS | UNITED STATES (POST-2014)<br>ALL PLANS, EXCHANGES, CO-OPS, ETC. |
|---|---|---|
| **Individual Mandate** | • No, public healthcare is provided for free. Purchasing private health insurance is optional. | • Yes, citizens are required to have some form of health insurance or pay a penalty. |
| **Guaranteed Availability and Renewability** | • Yes | • Yes (may limit enrollment periods) |
| **Underwriting** | • Denial of coverage is not allowed<br>• Preexisting condition or congenital disease exclusions are prohibited<br>• Individual plans cannot be underwritten at all | • Denial of coverage is not allowed<br>• Preexisting condition exclusions are prohibited<br>• Only a select set of factors may vary |
| **Premium Rates** | • Age groups have 6:1 ratio (with an additional constraint so that the oldest groups don't experience significantly higher increases compared to younger age groups)<br>• 10 specific allowed age bands<br>• Unisex rates<br>• No smoking limitations<br>• Maximum percentage increase is designated by ANS<br>• May vary by level of benefits<br>• May vary by rating area | • Age groups limited to 3:1 ratio<br>• Age bands yet to be defined by the National Association of Insurance Commissioners (NAIC)<br>• Unisex rates<br>• Smoking status (1.5:1 ratio)<br>• Additional review will be required to justify premium increases; some plans may be excluded from the exchanges if their premium increases are too high<br>• May vary by level of benefits<br>• May vary by rating area |
| **Limitations** | • Limits not allowed for utilization or value<br>• Coverage can be rescinded only in cases of fraud or failure to pay premiums for more than 60 days over a 12-month period<br>• Can provide coverage to the dependents up to third level of kinship (e.g., grandparents or grandchildren) | • Lifetime limits on dollar value of coverage prohibited<br>• Coverage can be rescinded only in cases of fraud<br>• Must provide dependent coverage for children up to age 26 |
| **Loss Ratio Requirement** | • No requirements | • Minimum 80% loss ratio required for individual and small group business |
| **Decentralization** | • States should be main providers and responsible for delivery of care | • States should be main providers and responsible for delivery of care |
| **Funding** | • Federal and statutory, with an emphasis on statutory regulation | • Federal and statutory, with an emphasis on statutory regulation |
| **Waiting Period** | • Up to 180 days, 300 days for pregnancy | • None, but enrollment limited to open enrollment period or to qualifying life events |
| **Exclusions** | • Drugs for outpatient<br>• Procedures not accepted by Physician Union<br>• Aesthetic procedures, unless need results from involvement in an accident<br>• Home care<br>• Cases from cataclysm/war | • Plans have the option to exclude abortion<br>• Access to coverage is limited to U.S. citizens and legal immigrants that are not incarcerated |
| **Wellness and Preventive Care** | • Not an issue at the forefront of healthcare reform | • Many preventive services now covered without cost sharing |

stricter in the United States, the U.S. market may stand a better chance at retaining active insurers, as this is not an entirely new constraint. Even with the stringent regulations over premium rate increases, the loss ratio will help provide transparency when it comes to a company's financial stability.

### *What happened in Brazil's individual market because of these regulatory changes?*

Prior to Brazil's healthcare reform in 1998, private insurers were subject to very little regulation. As a result, this major reform and overhaul of how the industry operates has brought about significant consequences over the past decade.

Although loss ratios are not necessarily a common measure in Brazil (because there are no specified loss ratio requirements), individual plans are currently achieving a 90% loss ratio on average. This represents a level higher than what is sustainable, which has led to a large premium deficiency reserve for most companies. High premium deficiency reserves are a barometer of financial health for these blocks of business.

The ANS dictates the restricted amount of annual price adjustments for individual plans–at a level less than the rise in medical costs. If this continues, the loss ratios will continue to increase over time and thus the premium deficiency reserve will need to increase as well.

In addition, the following practices have also contributed to the breakdown of the individual insurance market:

- Prohibition of unilateral rescission of contracts and underwriting, leading to an older, lower-quality portfolio
- Increased restrictions from ANS on the allowed annual premium trends increases
- Frequent changes made to the list of covered procedures (applied to all new plans without a readjustment counterpart)

Most companies in Brazil have stopped selling this line of business. From 2005 to 2010, individual plans reduced their share in the market from 24.5% to 20.9%, and this share will most likely continue to decrease.[5]

Time has also revealed that many of the existing companies in Brazil did not possess even the basic administrative or economic infrastructure necessary to survive in a high-risk product market. Because the state established even minimal regulations, these companies have gradually disappeared and continue to disappear from the market. This trend is shown in the table in Figure 2.

**FIGURE 2: NUMBER OF HEALTH PLAN COMPANIES IN BRAZIL, 2000-2010**

| YEAR | # OF COMPANIES |
|---|---|
| 2000 | 2,723 |
| 2001 | 2,709 |
| 2002 | 2,407 |
| 2003 | 2,273 |
| 2004 | 2,178 |
| 2005 | 2,091 |
| 2006 | 2,067 |
| 2007 | 1,930 |
| 2008 | 1,762 |
| 2009 | 1,695 |
| 2010 | 1,618 |

Source: ANS Supplemental Healthcare Information Book

## CONCLUSION

When the public plan in Brazil was formed, the private sector was ill-established and essentially unregulated. The most efficient way to provide universal care was through a government program. However, a private sector, in need of regulation, stayed intact and supported the publicly offered care. The United States currently has public plans (Medicare and Medicaid) in place to help the elderly and those in financial need, and also has a well-established, already regulated private sector that covers the majority of the population. In order to provide universal care for its citizens, the United States has chosen to take advantage of the private insurance sector, which is an active, and in many cases successful, means for providing healthcare. Instead of starting over with a national public plan as in Brazil, the United States has taken a different approach: adapting the structure of the current private plans through stricter regulations and the requirement for every citizen to contribute to the program in order to provide complete access to quality care.

It is possible that the U.S. health insurance industry could face challenges that are similar to the struggles that the Brazil insurance industry has faced, such as restrictions on premium increases that create a growing gap between costs and allowed premiums. Limits on rate increases are a challenge because insurers can become locked into deficiently priced contracts. Adverse selection, however, is probably the number-one concern and driver of the outcome of success or failure for an insurer. Brazil does not have an individual mandate for private insurance, yet the country still requires private care to be provided at affordable rates. Few restrictions on who can access care (no underwriting), when paired with the lack of an individual mandate and strict premium rating regulations, have resulted in serious anti-selection issues and led to the precarious position of the individual insurance market in Brazil. The reason for the individual mandate in the United States is to spread risk evenly over the entire population. By requiring everyone to buy insurance, the hope is that healthy people, who are less expensive to insure and might not otherwise buy insurance, will be entering the market and sharing risk.

5 Agencia Nacional de Saude Suplementar (March 2011). Caderno de Informaçãem Saúde Suplementar, page 29 (last modified April 6, 2011). http://www.ans.gov.br/images/stories/Materiais_para_pesquisa/Perfil_setor/Caderno_informacao_saude_suplementar/2011_mes03_caderno_informacao.pdf

Ultimately, Brazil and the United States share a similar vision: providing universal, affordable healthcare. Because of unique histories and political and social attitudes toward healthcare, the catalysts for reform in Brazil and the United States are different; however, similarities in the actual reforms exist. If an individual mandate is not enforced, the current state of the healthcare system in Brazil may be indicative of the future of healthcare risks facing the United States, especially if an individual mandate is not enforced. It would be prudent to consider the similarities and differences in the two countries' reforms. Looking at and learning from the current outcomes in Brazil could provide insight on how to best define strategies in the United States.

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