BRAZIL

PROGRAM FOR THE REGULATION OF PRIVATE HEALTH PLANS

(TC-98-08-18-2-BR)

EXECUTIVE SUMMARY

Executing agency:	Agência Nacional de Saúde Suplementar (National Supplementary Health Plans Agency) (ANS), through the Program Coordinating Unit (PEU)
Beneficiaries:	Private health plan operators (EOPs) and plan users and consumers
Objective:	To support a new regulatory framework for private health plans, in order to: (i) enhance competition and efficiency in the private health-plan market, promoting a transparent flow of information between consumers and plan operators and encouraging the creation of EOP accreditation bodies; (ii) strengthen consumer protection organizations, devising help tools and information systems for these organizations and promoting improvements in their management structures; and (iii) instill a better understanding and acceptance of the new regulations in Brazilian society and stakeholders, by way of public relations and information strategies and technical events to learn from successful international experiences.

Cost and financing:

Modality:	Grant, funded under the Technical Cooperation Facility (I)	
MIF:	US$1.55 million	50%
Local counterpart:	US$1.55 million	50%
Total:	US$3.1 million	100%

Exceptions to Bank policy or procedures:	None.
Special contractual conditions:	The conditions precedent to the first disbursement of the grant are: (i) entry into effect of the program operating manual, the final text of which is to match the version approved in advance by the Bank; (ii) adoption of all legal measures necessary for the startup of ANS operations; and (iii) creation of the Program Coordinating Unit by virtue of an internal ANS resolution (see paragraph 9.1).

I. COUNTRY AND PROGRAM ELIGIBILITY

1.1 On February 9, 1995, the Donors Committee declared the Federative Republic of Brazil to be eligible for all forms of Multilateral Investment Fund (MIF) financing. The program proposed here is eligible for financing under the MIF Technical Cooperation Facility, its objective being to support implementation of a new legal framework for private health plans and help make Brazil's private healthcare system more efficient and competitive. The program also fits with the Bank's country strategy, inasmuch as it seeks to improve the quality of basic healthcare by instituting various forms of protection for consumers of private health-plan services.

II. BACKGROUND

A. The health sector in Brazil

2.1 As defined in the 1988 Constitution, Brazil's health sector is built upon two central pillars: the **Unified Health System** (SUS) and the **Supplementary Healthcare System** (SMS). In 1998, these systems covered an estimated 90% of Brazilians; the other 10% had no coverage.

2.2 The **SUS** is made up of the network of government-run healthcare establishments plus publicly funded private facilities used by Brazilians with SUS coverage. This decentralized system, administered by the states and municípios, is universal and free, since federal law mandates that every Brazilian citizen have guaranteed access to healthcare. According to 1998 estimates, 98 million people (62% of Brazil's population) were covered by the SUS.

2.3 About 45 million Brazilians had coverage under the **SMS** in 1998 (28% of the country's total population).[1] This system is made up of 1,900 private health-plan operators (EOPs) with about US$16 billion in healthcare outlays a year.[2] Many of these businesses run their own healthcare services; others purchase all services from providers, including private hospitals, some government-run establishments, and university hospitals. Since there is no exclusivity requirement in SUS contracts with providers, many hospitals and health units that deliver services to the SMS also work with the SUS. And since contracts the SMS can sign with private care providers are more attractive in terms of prices, reimbursement schedules, and other

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[1] SMS coverage data are estimates by the consulting firm Towers, Terrin Foster & Crosby. According to indirect estimates based on recent surveys by the Health Ministry's Supplementary Healthcare Department, actual enrollment figures may be lower (between 37.5 million and 40 million).

[2] SMS healthcare spending doubled between 1995 and 1998, whereas enrollments rose only 25%. SMS expenditure per capita climbed from US$275 to US$442, according to estimates, indicating an increase in prices or in the package of services to be covered by the private health plans.

contract terms than SUS-guaranteed contracts, there are vast differences in the quality of care received by SUS and SMS customers.

B. Structure and dynamic of the private health-plan market

2.4 The structural underpinnings of the SMS date back to the late 1950s. After a slow start, this sector began to expand as more and more State enterprise and private-sector employees (particularly in international corporations) and higher-income families joined these plans. Until 1988 the government social-security health system covered only Brazilians who were contributing to social security, most of them formally employed workers and their dependents. The result was a residual demand for an expanded supplementary health-plan market. This structure was bolstered in 1976 when all private companies were given the option of organizing their own health services or hiring providers, to be funded through recoveries of a portion of the companies' social security contributions.

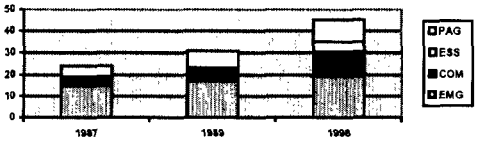
2.5 The SMS consists of four core segments: group health plans (EMGs), medical cooperatives (COMs), health insurance companies (ESS), and employer-sponsored plans (PAGs). Table II-1 gives a breakdown by segment of their enrollments and billings.

Table II-1
Brazil. Breakdown of SMS enrollment and billings, 1998

SMS segment	Enrollment		Billing	
	Users	%	US$bill	%
EMGs	19.3	43	4.0	25
COMs	11.2	25	3.8	24
ESSs	4.5	10	3.3	20
PAGs	10.0	22	5.0	31
TOTAL	**45.0**	**100**	**16.1**	**100**

Note: Customer numbers in millions; billings in billions.

Change in SMS makeup: 1987-1998



2.6 Group health plans (EMGs) operate under different prepaid-care contractual arrangements. Coverage varies with the type of plan. They are the largest of the SMS market segments, accounting for 43% of private plan enrollments and 25% of gross SMS billings. Between 1987 and 1998 their customer base climbed from 15 to 19 million, but their share in the total SMS market dropped from 62% to 43%. Today, these plans tend to be confined to large urban centers, where they are experiencing problems since demand on the part of companies and the middle class has become saturated.

2.7 Medical cooperatives (COMs) have gained considerable market share in the SMS. In 1987 they covered 3.5 million people and held 14% of the SMS market; by 1998 they had 11.7 million enrolled members and a 24% SMS market stake. Based on the model developed in the 1960s, these cooperatives operate through an organized

network of physicians working in clinics and hospitals under contract. This model, a prepaid plan like EMGs, offers fewer health-plan options than the latter and costs less.

2.8 Brazilians covered by health insurance companies (ESSs) can freely choose their providers. As a rule, ESSs are not set up as healthcare businesses, but are part of the financial segment of the economy (banks, insurance companies, etc.). Some EMGs have only recently moved into the insurance business. Traditional indemnity insurance plans make up two thirds of this market; the other third are hybrid insurance/health plan products. This is a fairly selective market, covering at most 4.5 million people (10% of the EMG enrollment figure)—though this is a sizable increase over the 1987 customer base of 700,000. For the most part these companies work on the basis of estimates of individual or family risk profiles, and simply reimburse members for their healthcare outlays after a claims verification process.

2.9 Employer-sponsored plans (PAGs) cover employees of companies that elect to run their own healthcare service or hire outside firms to administer a health plan exclusively for their customers. The most common sponsors of PAGs are State enterprises (which account for over two thirds of PAG customers), private international corporations, and major Brazilian firms. This kind of plan has grown because of the need to manage the sector's high costs, though their management has not been viewed as particularly professional. They are funded through payroll contributions or use employee reimbursement systems ("post-payment"). Member enrollments in these plans rose from 7.5 million in 1987 to 10 million in 1998; they currently account for about 22% of total SMS plan members.

C. The main problems in Brazil's SMS

2.10 SMS growth in Brazil has been largely unregulated. Until the 1990s, the legislative underpinning of the sector was Decree-Law 73 of 1966, which regulated the National Insurance System and made reference to the for-profit healthcare business.[3] The legislation contained no regulations to govern nonprofit segments like medical cooperatives, which came under Ministry of Agriculture regulations. In the mid-1980s the Ministry of Finance began to craft legislation to set out operating rules for health and health insurance plans, to open up the market to foreign capital. This process unfolded slowly until the late 1990s, when the government began to devise a series of interim orders broadly outlining the system's current regulatory framework. To tackle the sector's many problems there is a need for rapid implementation of the recently crafted regulatory framework. Concrete problems are addressed in specific points of the sector regulations, having to do with compiling and disseminating information, incentives to improve

[3] Under this law, the Ministry of Finance's Superintendency of Private Insurance was to regulate private health insurance plans as part of its private-insurance oversight mandate.

competitiveness and quality, and strategies to broaden SMS coverage and protect health plan and health insurance customers.

2.11 *Compiling and dissemination of information*: The SMS is not a transparent system: there is no accurate information on number of users, system costs, adequacy of contracts in terms of coverage and quality of care, number of companies offering health plans and their financial soundness, and qualifications of health plan administrators. The systematic lack of such data has made any public monitoring of contracts impossible, and is the cause of a pronounced information asymmetry between EOPs and their customers and between higher and lower income customer segments. In these circumstances, the health-plan market cannot be truly competitive.

2.12 *Incentives to strengthen competition and improve quality and coverage*: A lack of effective SMS regulation has also held up the development of a fully competitive system. Except for ESSs, which come under financial-sector regulations, SMS segments have no rules to follow as to minimum requirements for setting up business in this sector, a unified chart of accounts, balance-sheet-presentation standards, sector strategies, standardized plans and services to be covered, minimum quality and coverage standards, or assurances of continuity of care. The market thus operates in a highly uncertain and volatile environment, increasing speculative risk in the sector and lessening survival prospects of the best-structured companies.

2.13 *Consumer protection*: In the 1990s Brazil brought in a new Consumer Protection Code that combines recourse to small-claims courts and organized action on the part of consumer advocacy groups. This system has proved to be efficient as far as the filing of complaints is concerned, but has done little to solve the problems raised by health-plan consumers. According to data compiled, customers are very dissatisfied with the system.[4]

D. New SMS regulations

2.14 In 1993, to address the above-described problems, the Brazilian government, by way of the Ministries of Health and Finance, introduced bills in the Senate specifically to regulate private health plans. Table II-2 shows the milestones in this process, culminating in the 1998 passage of Law 9656/98 which lays down guidelines for the new private-plan regulatory model, and in Interim Order 1928 of November 1999 which created the National Supplementary Health Plans Agency (ANS).

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[4] According to special Consumer Protection Services data tabulations for the city of São Paulo in 1994, there were 20,132 complaints filed against the SMS that year, 72% of them relating to excessive monthly premium increases, 24% to nonperformance of contract covenants, and 4% to plans' turning down requests for treatment authorization.

2.15 In the interval between the passage of Law 9656/98 and creation of the ANS, the Ministry of Health's institutional base was strengthened through the creation of the Supplementary Healthcare Department, the Supplementary Health Plans Board, and the National Council on Supplementary Healthcare (CONSU). Sitting on the latter council are representatives of three ministries (Health, Finance, and Justice) whose mandate is to propose and approve policies and rules to further the SMS regulatory process. During this period, CONSU issued rules for creation of a cost-recovery arrangement whereby the SUS could recoup costs from SMS users, and for regulations pertaining to selected points of Law 9656/98, to improve the system's operation.

Table II-2
Recent regulations governing private health plans in Brazil:
A chronology

1993 – First bills introduced in the Senate to expand SMS coverage and provide for SUS cost recovery from private plans.

1997 – Special Committee set up for Senate vote on the bill regulating private health plans.

1998 – Congress passes Regulatory Law 9656/98 giving the Ministry of Health a mandate to regulate the SMS. The Supplementary Healthcare Department and National Council on Supplementary Healthcare are set up in the Ministry of Health.

1999 – Interim Order 1928 of November 25 creates the ANS.

2.16 Interim Order 1928[5] creating the ANS provided for the definitive structure that had been proposed for the operation of the SMS, which thenceforward would consist of CONSU, the ANS, and private health plan operators. The Health Ministry's Supplementary Healthcare Department is abolished. CONSU will expand to include, in addition to representatives of the Health, Finance, and Justice ministries, representatives of the Casa Civil (federal executive office of the President of Brazil) and of the Ministry of Budget and Management. A new advisory body, the Supplementary Health Plans Board, has been set up under the Ministry of Health, its membership drawn from the National Council of State Health Secretaries (CONASS), the National Council of Municipal Health Secretaries (CONASEMS), heath-plan consumer organizations, providers working under contract with health plan operators, and health plan operators. In the Health Ministry, the Health Support Secretariat (SAS) will serve as Executive Secretariat of CONSU.

2.17 The ANS will be the SMS's independently administered executive arm. Its operation will be funded through a sector oversight fee and the proceeds of fines, registration and other fees. In the health sector it will take over the functions now being performed by the Supplementary Healthcare Department and by the Finance Ministry's Superintendency of Private Insurance. Its other tasks will be to: (i) produce rules and regulations and enforce them in accordance with CONSU

[5] Interim orders are legal instruments that the President has authority to issue, whereby the government can approve legislative matters before the Congress formally decides on them. The Congress has 30 days to reach a decision on the order. If no decision is announced, the government can reissue the matter via another interim order, until the Congress's formal decision is made known.

general resolutions; (ii) foster the sector's growth by capturing and disseminating data on its operation; (iii) monitor and assess coverage and quality of medical care being delivered by health plans; (iv) assess EOP financial strength and risk and propose measures to remedy situations in which plan members could sustain losses; (v) produce technical reports; (vi) promote strategies for EOP accreditation and development of human resources specializing in management and operation of the sector; (vii) support the operation of health-plan businesses, striving to maintain a free market and protect SMS consumers; and (viii) foster integration with the public healthcare system in allied areas.

2.18 The new SMS regulatory framework will help resolve the main problems in the sector, generating and disseminating information for health plan users, and establishing basic rules to improve competition and strengthen consumer protection instruments. In addition, the new framework will help eliminate SUS cross-subsidies for EOPs, so that the costs of the public services used by EOPs can be recovered.

2.19 Implementation of the new SMS structure will be coordinated by the Ministry of Health, working with such other agencies as the Ministry of Justice and the Superintendency of Private Insurance. Resources also will have to be mobilized to carry through the regulatory process and provide institution-strengthening for EOPs, to equip them to compete and to operate under transparent rules, pursuant to the new regulatory model. The Health Ministry has sought financial support for this process through two avenues: (a) use of REFORSUS project funds to finance implementation of the new regulatory framework and of ANS; and (b) a MIF operation to finance the up-front work needed for EOP accreditation, publicity and information on the new model, design of information technology for the ANS, and institution-strengthening for EOPs, health plans and consumer protection organizations. The operation proposed here has been prepared in response to request (b).

III. PROGRAM OBJECTIVES AND DESCRIPTION

A. Objectives

3.1 The program's general objective is to support implementation of a new regulatory framework for private health plans in Brazil and to finance activities required to set the ANS in place, with a view to improving competition and efficiency in the private health care system in Brazil.

3.2 Specific objectives are to: (i) support activities that are essential for the regulatory process, to enhance competition and efficiency in the private health-plan market, promoting a transparent flow of information to consumers and healthcare companies, and encouraging the creation of EOP accreditation bodies;

(ii) institutionalize relations between EOPs and consumer advocacy organizations, creating support tools and information systems for these organizations and institutionally strengthening their management structures; and (iii) instill a better understanding and acceptance of the new regulations in Brazilian society and stakeholders, by way of public information and public relations strategies and technical events to learn about, and adopt, successful international experiences.

B. Program components

3.3 The program has three components: (i) institutional strengthening of the ANS; (ii) institutional strengthening of EOPs and consumer protection organizations, and (iii) technical training, promotion and dissemination of the new regulatory framework. Activities to be funded under the program include specialized technical assistance to be delivered by short- and long-term consultants, international and national seminars to train technical officers and disseminate the new model, production and publication of materials in print and magnetic media regarding technical standards and regulations for the sector, software development, purchase of hardware and information technology, and training and development for ANS staff.

1. Component A: ANS institution-strengthening

3.4 Specific objectives of this component are to: (i) construct minimum standards for EOP accreditation and evaluation; (ii) develop models and encourage the creation of EOP accreditation agencies; and (iii) devise a strategic information-technology plan for the ANS.

3.5 To pursue the first of these objectives, funding would be provided for consultants to: (a) systematize the body of knowledge on contractual relations between EOPs, care providers, and health professionals (including international lessons learned); (b) devise a system for official registration and a master health-plan registry, with standards for EOP accreditation, performance benchmarks against which to assess these plans in future, and a timetable for setting such a system in place; and (c) assess the effectiveness of the SMS's current medical audit systems and propose new ones, with due regard to minimum quality assurance requirements for the consumer market and special reporting measures during waiting periods. The consultants' output will be a health-plan registration system and a manual, in print and in electronic form (for the agency's web page), setting out general guidelines for the EOP accreditation process.

3.6 For the second objective, the program would fund consulting work to come up with a pilot accreditation model for health insurance and health plans, indicate how the model could be essayed in a sample of EOPs (at least 50 companies, with control case studies), produce a final health-plan accreditation manual, and design a model organization structure for the accreditation process.

3.7 To achieve the third objective, specialized consultants would be engaged to construct a logical model of the ANS information system, plan network equipment needs, produce terms of reference for the logical design and information technology approach to be used, and draw up terms of reference for software development and purchase of intranet and internet services.

2. Component B: Institutional strengthening of EOPs and consumer protection organizations

3.8 Specific objectives of this component are to: (a) develop software to improve administrative efficiency and obtain and store information on private health plan operators; (b) develop software to support EOP service providers; (c) strengthen avenues for consumer protection; and (d) develop a health-plan costing model for the SMS based on epidemiological and actuarial criteria.

3.9 Program funds for the first of those objectives would pay for consulting services, software development, and training programs to: (i) create a standard EOP chart of accounts; (ii) develop user-friendly software that EOPs of any size can apply in adopting the chart of accounts, and provide training for that process and associated software in EOPs; (iii) set up a telephone help-line system to assist EOPs as they adopt the chart of accounts; and (iv) create a data communication network between EOPs and the ANS for on-line sharing of information collected.

3.10 For the second objective, funds are budgeted for consulting services, software development, and training programs to: (i) establish standards for the reporting of accounting and epidemiological data that EOPs will require in their operations; (ii) develop software for recording, capturing, and transmitting such data to EOPs; and (iii) develop mechanisms within and outside the ANS to give provider establishments access to the use of this software, and promote technical training using distance education techniques.

3.11 Activities planned to attain the third objective are consulting services, software development, and training programs to: (i) devise a regionally based national model for recording complaints, court action, and penalties levied, as inputs for the EOP evaluation system; (ii) establish a data communication network between the ANS and consumer reporting and advocacy organizations, in a secure environment for recording such inputs. This will start off as a pilot project in São Paulo, and then be replicated in other Brazilian states.

3.12 To achieve the fourth objective, the program will pay for consulting services, software development, and training programs to develop an actuarial method for health-plan costing, based on demographic, social, environmental, labor and epidemiological risk factors of EOPs. The plan is for the ANS to apply this model to a sample of 50 companies that volunteer to validate its utilization among the different plan operators.

3. Component C: Technical training, promotion, and dissemination

3.13 The following are the specific objectives of this component: (a) provide advanced technical training for the ANS through a cycle of international seminars and policies on exchanges relating to private health-plan regulation, and (b) promote and publicize the ANS's functions among consumers and EOPs, and raise Brazilians' awareness of the rights of SMS plan consumers and companies that contract for SMS plans.

3.14 Activities to be funded toward the first objective are: (i) an international seminar on health-plan regulation, with Brazilian and foreign specialists in attendance, to look at the ANS's roles, content of regulations, and relations to be established between the different stakeholders; (ii) four regional seminars on private health-plan regulation focusing on the aforementioned elements, with a view to gearing the new regulatory strategy to the circumstances in each Brazilian region; (iii) consulting support and exchanges between Brazilian and international officials to look at critical issues in private health-plan regulation, and (iv) production and dissemination of a series of papers and other literature on key issues relating to efficiency, effectiveness, and social protection in the sector, fostering dialogue and problem-solving and a consensus among stakeholders who have an interest in the sound operation of the sector, consumer advocacy groups, universities, EOPs, etc.

3.15 The program would fund the following activities to pursue the second objective: (i) production of literature for immediate dissemination among users of health plans of SMS operators; (ii) updating, editing, and publication of Guides to the Rights of Health Insurance and Health Plan Consumers (2000 edition); and (iii) events and activities to promote and raise awareness of the new ASN, its mandate, and new consumer rights and avenues for redress.

IV. PROGRAM IMPLEMENTATION

A. Executing agency

4.1 The program will be implemented by the ANS through a Program Coordinating Unit (PCU), adhering to operating guidelines set out in the program operating manual.

B. Execution period and revolving fund

4.2 The program will have an execution period of 24 months and a disbursement period of 30 months. The revolving fund will be in the amount of 5% of the financing.

C. Coordination

4.3 As the program's senior coordination agency, the ANS will be its official representative, oversee PCU activities, approve operating plans, budgets, and reports drafted by the PCU, and appoint and remove the general coordinator.

4.4 The PCU will be responsible for setting up the program and for its administrative management and ongoing liaison with the Bank for technical, operational, accounting, and contractual matters. It will channel the program's information outputs to the Bank and supervise and furnish technical support to consulting firms and others engaged to help execute the program.

4.5 Seven people will work in the PCU, among them four coordinators: a general coordinator (economist, physician or administrator) with a demonstrated track record in the private health-plan market; a specialist in institutional development and/or systems analysis to coordinate component A activities; an economist or administrator with information systems experience and a working knowledge of the private health-plan market, to coordinate component B activities; and, to coordinate the component C activities, a lawyer or media relations specialist with a background in commercial law, consumer protection laws, business administration, or similar areas, and experience in intermediating and improving communications between healthcare organizations and consumers. The expectation is that these professionals would become part of the ANS technical staff when the project ends.[6]

4.6 Another officer to be hired for the PCU will be an accountant or administrator with experience in project implementation for international agencies, to be in charge of producing expenditure reports, conducting and documenting calls for proposals and managing short-lists of consulting firms, producing and conveying program status reports for the Bank, and maintaining the project records. The other two contract employees will be administrative assistants. The terms of reference of all these officials will be spelled out in the program operating manual. Table IV-1 presents the organization chart for PCU operations.

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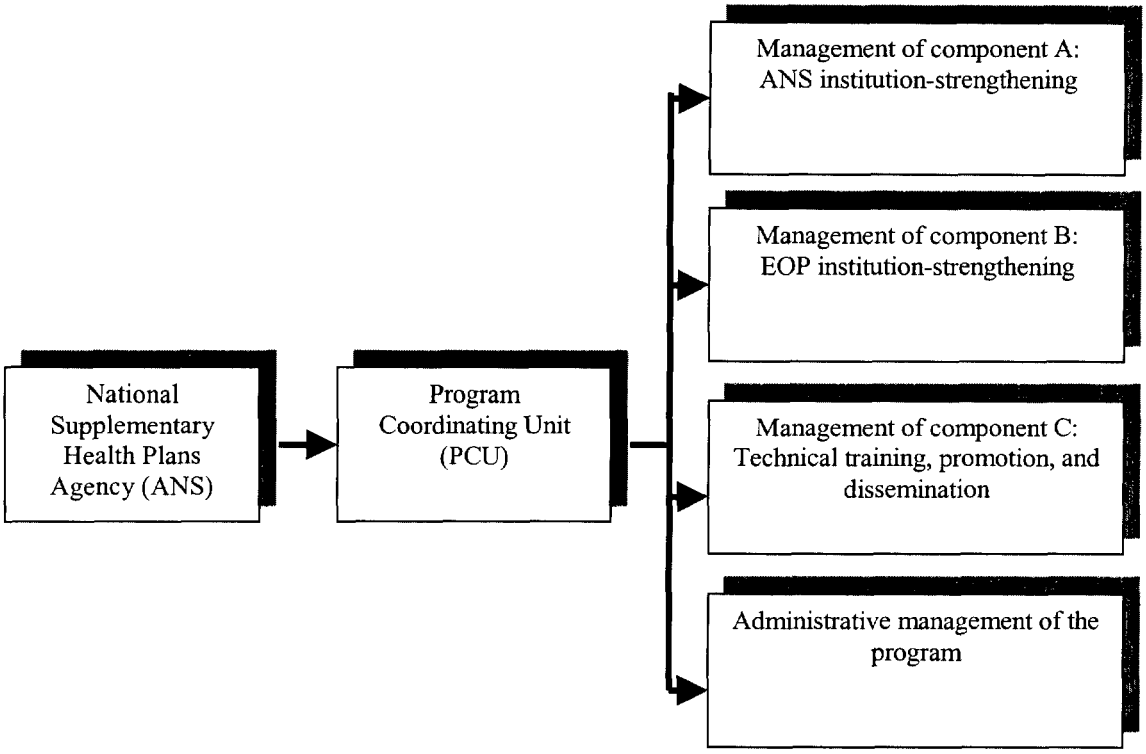
[6] ANS managers could perform these coordinators' functions, since the technical-cooperation activities are an integral part of that agency's functions in its early years of operation.

Table IV-1
Program operating structure



D. Program readiness

4.7 The program was designed and its budget and activities devised jointly by the project preparation team (officers of the Health Ministry's Investment Secretariat and Supplementary Healthcare Department) and the IDB team of officers and consultants. The terms of reference for studies and other activities drawn up by the country's project preparation unit are in the technical files of the Social Programs Division (SO1) under the title "MIF Technical Cooperation Project Proposal", presented by the Ministry of Health. The revised version of this material, with Bank comments, will be included in the program operating manual.

4.8 The operating manual is now being developed by the project preparation team. The government has made the decision to set up the ANS and has issued an interim order to that end.

V. Cost and Financing

5.1 The program's total estimated cost is US$3.1 million, to be funded by a MIF grant of US$1.55 million and a local counterpart contribution of US$1.55 million. Half

the local counterpart would be in cash. Table V-1 shows the program budget; there are cost itemizations of each program-funded activity in the technical files.

Table V-1
Consolidated budget by component (US$000)

Components and cost items	MIF BID	Local contri-bution	Total	%
1. Program Coordinating Unit		453	453	**14.6**
a. Consulting services		398	398	
b. Travel and per diems		38	38	
c. Basic equipment		12	12	
d. Maintenance costs		5	5	
2. Component A: ANS institution-strengthening	423	423	846	**27.3**
a. Consulting services	423	423	846	
3. Component B: Strengthening of EOPs and consumer organizations	632	403	1,035	**33.4**
a. Consulting services		403	403	
b. Software development	434		434	
c. Training	125		125	
d. Equipment	73		73	
4. Component C: Technical training, promotion, and publicity	429	233	662	**21.4**
a. Consulting services	417		417	
b. Seminars		233	233	
c. Papers, other print materials	12		12	
Subtotal	**1,484**	**1,512**	**2,996**	**96.7**
5. Evaluation	60	20	80	2.6
6. External audits	6	18	24	0.7
Total	**1,550**	**1,550**	**3,100**	**100.0**

VI. BENEFITS AND RISKS

A. Benefits

6.1 The project's main benefits will be as follows:

a. for private health-plan members, improved SMS service in terms of the system's coverage and quality, and easier avenues for consumers to file complaints and seek redress through the courts;

b. for health plans and companies, clear and transparent rules governing the operation of the private health-plan market, making for a less volatile environment, creating incentives to reward efficiency, effectiveness, and quality of health care, and improving prospects for long-term investment in the sector; and

c. for the government, the possibility of a transparent border line between actions and customers covered by the public system and those enrolled in supplementary private plans, lowering regressive SUS cross-subsidies and the SMS subsidy and improving chances of targeting the SUS to Brazilians of fewest means.

6.2 Work to implement the new regulations will continue after the proposed technical-cooperation operation ends. Both the ANS and EOPs will need further investments down the road to help put the new legislation and standards into practice. In order to provide continuity to the technical cooperation, Brazil has requested a loan from the Bank (project BR-0325), to be processed when the MIF operation described here concludes. Among the loan's objectives would be to finance work that is essential to fully implement the ANS (identified in the course of this technical cooperation), and a proposed line of credit for EOPs that need funds to revamp their organization or operations to satisfy the new regulatory guidelines.

B. Risks

6.3 The program risks are associated with the following factors:

a. Securing congressional approval of the ANS's organization: the risk that such approval may not be obtained is minimal, given that there is a consensus in the federal government and among most of the political parties and other stakeholders in the SMS regulation process that the ANS is needed as the body that will govern relations in the sector.

b. ANS independence: there is minimal risk in this regard, since the ANS is an independent agency under public law with its own budget obtained from a fee charged on private health plans and collected by EOPs, it has an independent staffing structure, and its management is appointed by the President of the Republic.

c. The patchwork of health plans nationwide: The risk inherent in the different SMS structures and operations and EOP adaptation to the new regulations will be minimized because the structure of the ANS will include regional units that may carry out special functions depending on issues of concern in individual states or regions. Support may be provided under the proposed operation for devising the structure of such units.

VII. PROGRAM MONITORING AND EVALUATION

7.1 The PCU is to provide the Bank with semiannual progress and budget execution reports, within 30 days after the end of each six-month period. These reports are to be viewed as a management tool with which to monitor the program and decide when intervention is warranted to take corrective action. Progress reports must: (i) identify and analyze problems and unforeseen developments; (ii) give a rationale for activities carried out and report on adherence to deadlines; and (iii) report on the timeliness, quantity, and quality of outputs and outcomes.

7.2 Consulting services would be engaged to design a methodology for evaluating the program and to produce a baseline study at the start of the program, a mid-term evaluation 12 months after the first disbursement, and an impact evaluation three months after the program is completed. The performance indicators to be tracked are listed in Annex VI-1.

7.3 The baseline study and mid-term and impact evaluations will measure, inter alia, progress against the following indicators: (i) awareness of health plan consumers of their rights pursuant to the proposed new regulations and their satisfaction with health plans; (ii) percentage of EOPs in the SMS that have adapted to the proposed new legislation and are using instruments developed under the program, such as the chart of accounts and software; (iii) percentage of institutions that are regularly reporting mandatory information to the ANS, and the quality of that information; and (iv) operation of pilot EOP accreditation mechanisms. The terms of reference for the impact evaluation will be drawn up by the PUC and will require IDB approval.

VIII. EXCEPTIONS TO BANK POLICIES

8.1 No exceptions to Bank policies are anticipated.

IX. SPECIAL CONTRACTUAL CONDITIONS

9.1 The special contractual conditions precedent to the first disbursement are: (i) entry into effect of the operating manual for the program, the final text of which is to match the version approved in advance by the Bank; (ii) adoption of all legal measures necessary for the startup of the ANS; and (iii) creation of the Program Coordinating Unit by virtue of an internal ANS resolution.

X. ENVIRONMENTAL AND SOCIAL IMPACT

10.1 The abstract for this operation and the respective eligibility memorandum were reviewed by the Committee on Environment and Social Impact on January 29, 1999. In approving them the Committee made no specific recommendations.

LOGICAL FRAMEWORK

BRAZIL - 2000: PROGRAM TO REGULATE PRIVATE HEALTH PLANS

Objectives	Indicators	Means of verification	Assumptions
implementation of the and operational under- of new regulations to govern ivate health plans.	By the end of the program, 50% of plan operators (or the equivalent of 75% of the consumer population) are producing and forwarding information to the ANS by way of the instruments developed in the proposed technical-cooperation operation.	• Census of private health-plan operators and of their customers, to ascertain precise numbers. • ANS administrative records (Master Private Health Plan Registry).	• The ANS is set up operational, with staff hir physical infrastructure. • Census of plan operato their customers, conducte REFORSUS funds.
E private health-plan market ompetitive and efficient, a transparent flow of n between consumers and tors.	By the end of the program, healthcare consumers are more aware of the private health-plan market and of their options. The information asymmetry between healthcare customers has been reduced.	Two sampling surveys to ascertain what consumers know about the private health-plan market: a baseline survey at the start of the program, and another survey at the end, using the same methodology.	A firm is hired to conduct the using funds budgeted for evaluation (see consolidated bu

LOGICAL FRAMEWORK

BRAZIL - 2000: PROGRAM TO REGULATE PRIVATE HEALTH PLANS

Objectives	Indicators	Means of verification	Assumptions
ENTS titution-strengthening	EXPECTED OUTPUTS • Registration system and master private health-plan registry developed, tested and implemented. • EOP accreditation manual and private health-plan accreditation agency model developed and implemented in a representative sample of EOPs. • Logical model of the ANS information system developed.	PCU semiannual reports to the Bank. Program audits.	Program operating mar is approved and in force
onal strengthening of consumer protection ns	• EOP chart of accounts and associated software developed, tested and implemented. • EOP-ANS data communication system and telephone help line to assist EOPs developed and implemented. • Core information-system requirements for EOP providers and data recording and transmission software implemented. • Model for recording complaints, court action and penalties, for use by consumer protection groups, and associated software for data capture developed. Pilot project implemented in the state of São Paulo. • Actuarial model for determining cost parameters for private health plans and associated software developed. Training program for the model's implementation and software in EOPs designed.	PCU semiannual reports to the Bank. Program audits.	Program operating mar is approved and in force
al training, promotion, y	• International seminar held on health-plan regulation. • Four regional seminars held to discuss ANS roles and content of private health-plan regulations. • Plan for consulting support and exchanges of Brazilian and foreign technical officers designed and implemented, with semiannual completion targets. • Technical and other papers produced for dissemination. • Media publicity plan designed (first three months) and implemented (following 18 months). • Consumer Rights Guide updated, produced and published.	PCU semiannual reports to the Bank. Program audits.	Program operating mar is approved and in force

LOGICAL FRAMEWORK
BRAZIL - 2000: PROGRAM TO REGULATE PRIVATE HEALTH PLANS

Objectives	Indicators	Means of verification	Assump
TIES	BUDGET[1] (US$000)		
ient A: ANS institution-strengthening	**846**	PCU accounting records.	The PCU
nstruct minimum standards for EOP accreditation	185	Quarterly reports.	up.
velop models and foster creation of EOP accreditation agencies	456	External audit reports	
vise a strategic plan for ANS information technology	205		External au services ha been engag
ient B: Institutional strengthening of EOPs and consumer protection organizations	**1,035**		
velop software to improve administrative efficiency and elicit information from private lth-plan operators.	430		
velop software for EOP care providers.	360		
engthen consumer protection avenues.			
velop a model for health-plan costing for the SMS based on epidemiological and uarial criteria.	135		
ient C: Technical training, promotion, and publicity	**662**		
ganize a cycle of seminars and exchange policies.	232		
vise strategies to promote the new regulations and the ANS among consumers and Ps.	430		
on activities: Three surveys: a baseline survey, a mid-term evaluation, and an n at the end of the program, emphasizing user awareness of the SMS market dynamic.	**80**		
l audits: Hiring of an audit firm to product twice-yearly evaluations of program ures and activities.	**24**		
n Coordinating Unit operating costs	**453**		
	3,100		

tation of this budget, grouped by component and activity, differs from the format used in the project cost table in the Donors Memorandum, which is broken do and cost item. There is an itemized budget in the technical files.

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PROPOSED RESOLUTION

BRAZIL. NONREIMBURSABLE TECHNICAL COOPERATION PROGRAM TO REGULATE PRIVATE PLANNING FOR HEALTH ASSISTANCE

The Donors Committee of the Multilateral Investment Fund

RESOLVES:

1. That the President of the Inter-American Development Bank, or such representative as he shall designate, is authorized, on behalf of the Multilateral Investment Fund, to enter into such agreements as may be necessary with the Agência Nacional de Saúde Suplementar (ANS) and to adopt such other measures as may be pertinent for the execution of the plan of operations incorporated in the donors memorandum referred to in Document MIF/AT-____with respect to a technical cooperation for a program to regulate private planning for health assistance.

2. That up to the amount of US$1,550,000 is authorized for the purpose of this resolution, chargeable to the Technical Cooperation Facility of the Multilateral Investment Fund.

3. That the above mentioned sum is to be provided on a non-reimbursable basis.