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SUPPLEMENTARY HEALTH AND CONSUMER PROTECTION: THE SUPERIOR COURT OF JUSTICE AS A PLAYER IN THE CONSTRUCTION OF PUBLIC POLICIES

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ABSTRACT

This paper aims to examine the main controversies faced and precedents set by the Superior Court of Justice in recent years regarding the subject of health insurance or health plan contracts. To this end, this paper analyzed 9 (nine) jurisdictional decisions regarding obligations involving health plans, issued by the STJ between 2023 and 2024, which were highlighted in case law bulletins published by the Court. The study examined the STJ's understanding regarding the following issues related to the subject of research: abusive practices in promoting adjustments in the health plan contract; obligation to supply medicines in consideration of the list of procedures and events of the National Supplementary Health Agency (ANS); obligation to supply medicines for home treatment; healthcare coverage for newborns; and obligation to pay for the cryopreservation of eggs to prevent infertility resulting from cancer treatment. In the end, it was concluded that the Judiciary, and especially the STJ, has a relevant role as a player in the political arena for the construction of public policies for regulating health plans in Brazil, delimiting the scope and limits of the normative frameworks regarding this type of consumer relationship that constantly puts consumer rights and the interests of companies that maintain health plans on a collision course.

Keywords: Health Plans. Contracts. Superior Court of Justice (STJ). Public Policies. Healthcare Coverage.

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INTRODUCTION

O SUPERIOR TRIBUNAL DE JUSTIÇA NA JUDICIALIZAÇÃO DA SAÚDE SUPLEMENTAR

In 2019, the National Council of Justice (CNJ) and the Institute of Education and Research (INSPER), through the "Justiça Pesquisa" series, identified, through empirical diagnosis based on data collection, a scenario of increasing judicialization of demands involving the right to health, with a sharp increase – of approximately 130% (one hundred and thirty percent) – in the number of jurisdictional actions filed in the first instance (State Justice) regarding the topic, in the period between 2008 and 2017 (2019, p. 15). The research also identified that one of the highlighted themes, about the judicialization of health, corresponds to litigation involving health plans, with the Judiciary being an important locus for discussing contracts – consumer contracts, by the statement consolidated by the Superior Court of Justice through Summary 608 ("The Consumer Defense Code applies to health plan contracts, except those administered by self-management entities") – for supplementary health (2019, p. 8). Furthermore, the work carried out by the CNJ and INSPER concluded that there is great regional heterogeneity about the protection of the right to health through the judicial system, both in the types of lawsuits brought to court and in the prevailing grounds in the various courts (2019, p. 15), highlighting the relevance of the role given to the Judiciary, especially the higher courts, in their duty to promote uniformity, integrity and legal certainty in case law (DANTAS, 2011, p. 69) – including under the terms of article 926 of the Code of Civil Procedure (CNJ and INSPER, 2019, p. 15). The scenario of increasing judicialization, described by the institutions, is advancing significantly, and the accumulation of procedural records is worrying: as can be seen from the tool, "Panel Justiça em Números"[2], (Justice in Numbers Panel), also managed by the National Council of Justice, there has been a historical increase in the number of cases pending judgment that deal with supplementary health, and while in January 2020, there were approximately 210,000 (two hundred and ten thousand) cases being processed before the Judiciary, in June 2024 the number was close to 315,000 (three hundred and fifteen thousand).

Considering, therefore, the relevance that the Judiciary's role has in formatting the content and limits of contracts resulting from the consumer relationship between healthcare plan operators and their users, this work aims to visit and analyze some of the main case law precedents formatted, in recent years, on this specific and relevant contractual relationship.

[2] The panel, edited and updated by the National Council of Justice, can be accessed through the following electronic address: < https://www.cnj.jus.br/pesquisas-judiciarias/justica-em-numeros/ >. Accessed in September 2024.

METHODOLOGY

This paper adopts a qualitative empirical methodology, analyzing the approach promoted by the Superior Court of Justice, known to be the Court responsible for standardizing the interpretation of federal law throughout Brazil (by Article 105 of the Federal Constitution), based on the examination of 9 (nine) precedents judged between 2023 and 2024, chosen taking into account that they were included in newsletters published by the STJ itself – periodic editions of the Court's judgments that are selected for their novelty within the Court's scope and for their repercussion in the legal community[3].

The judgments chosen, in turn, provide a relevant overview of the jurisprudential scenario regarding the main topics that are under debate in the judicialization of supplementary health, being segmented by the following subjects: (1) abusive practices in promoting adjustments in the health plan contract; (2) obligation to supply medicines considering the list of procedures and events of the National Supplementary Health Agency; (3) obligation to provide medication for home treatment; (4) healthcare coverage for newborns; and (5) obligation to pay for cryopreservation of eggs to prevent infertility resulting from cancer treatment.

Therefore, the following sections of this work correspond to each of the identified themes, and aim to analyze the precedents established by the STJ in the judgments outlined above, as well as to understand the context in which they were formatted, the respective regulatory panorama and the consequent role of the Judiciary in the construction of public policies to regulate the sector with a view to consumer rights.

RESULTS

DELIMITATION OF ABUSIVITY IN PROMOTING ADJUSTMENT(S) IN THE HEALTH PLAN CONTRACT - PET. 12.602/DF AND RESP 2.065.976/SP

In February 2023, the Second Section of the Superior Court of Justice – which brings together the third and fourth panels – decided, by a majority (six votes to three), that there was no overruling of the precedent set by the Court itself in topic 610 of repetitive appeals. It therefore reaffirmed the thesis set out in 2016, in the sense of understanding that the claim to recognize the nullity of a clause of and the adjustment provided for in health care plan or insurance contracts expires in twenty years, under the legal order in force in the Civil Code of 1916 (art. 177 of the 1916 Civil Code), or in 3 years, under the validity of the

[3] The Superior Court of Justice's case law newsletters are periodically made available at the following electronic address: < https://scon.stj.jus.br/jurisprudencia/externo/informativo/ >. Accessed in September 2024.

2002 Civil Code, applying to the case the hypothesis of three-year limitation provided for in art. 206, § 3º, IV, of the 2002 Civil Code, that is, unjust enrichment).

Specifically regarding clauses for adjusting health plan monthly fees based on the beneficiary's age range, the Superior Court of Justice, in a qualified precedent set in 2016, namely, in topic 952 of repetitive appeals, defined criteria to assess the (in)validity of this review in an individual or family health plan contract (2016a). In this case, the Second Section of the Court understood the feasibility of promoting possible adjustments, as long as there is a detailed contractual provision to this effect, as well as that the relevant regulatory standards are observed and that unreasonable or random percentages are not applied that, specifically and without a suitable actuarial basis, excessively burden the consumer or discriminate against the elderly. Furthermore, it was understood that it was necessary to observe, for contracts signed from 2004 onwards, the requirements outlined in Resolution 63/2003 of the National Supplementary Health Agency, which prescribes the observance of ten age groups for contractual adjustment purposes, the last being at 59 years of age so that the value set for the last age group is not greater than 6 (six) times that set for the first and that the accumulated variation between the seventh and tenth groups is not greater than the accumulated variation between the first and seventh groups.[4-5].

The thesis related to theme 952 was established in 2016, but even today it is common to see health plan contracts that employ abusive levels about annual and age group adjustments, adopting percentages sometimes above those authorized by the ANS, sometimes in disregard of the guidelines established by the STJ, without any standard or even without contractual provision (LIMA, 2024), in clear violation of the basic rights of the consumer, especially the right to adequate and clear, evident and ostensive information, under the terms of art. 6, III, of the Consumer Defense Code.[6].

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[4] In these terms, art. 3 of Resolution 63/2003 of the National Supplementary Health Agency (ANS) states: “Art. 3. The percentages of variation in each change of age group must be set by the operator, observing the following conditions: I - the value set for the last age group may not be greater than six times the value of the first age group; II - the accumulated variation between the seventh and tenth age groups may not be greater than the accumulated variation between the first and seventh age groups; III - the variations due to change of age group may not present negative percentages”.

[5] Although Theme 952 was established for individual and family plans, in Theme 1,016 of repetitive appeals, the STJ extended the validity of adjustments by age group to group health plans as well, following the same requirements adopted in the aforementioned precedent, recognizing the identity in the reasons for deciding (ratio decidendi) for both cases. The established thesis was worded as follows: “(a) Applicability of the theses established in Theme 952/STJ to group plans, except that, about self-management entities, the CDC is inapplicable; (b) The best interpretation of the normative statement of art. 3°, II, of Resolution no. 63/2003, of the ANS, is the one that observes the mathematical meaning of the expression 'accumulated variation', referring to the real price increase verified in each interval, and the respective mathematical formula must be applied for its calculation, with the simple arithmetic sum of readjustment percentages or the calculation of the average of the percentages applied in all age groups being incorrect.” (BRASIL, 2022a).

[6] In these terms, art. 6, III, of the Consumer Defense Code states: “Art. 6 The basic rights of the consumer are: [...]; III - adequate and clear information about the different products and services, with correct specification of

Having resolved the issue regarding the requirements established, within the jurisdictional scope, to determine the nullity of age-based adjustment clauses in health plan contracts, it is necessary to analyze topic 610 of the repetitive appeals of the STJ: also in 2016 and by majority, the Second Section concluded that the claim for judgment arising from the declaration of nullity of an adjustment clause, in these supplementary health contracts, prescribes in three years under the Civil Code of 2002, configuring a case of unjust enrichment (art. 206, § 3º, IV, CC/2002). At that time, the STJ prevailed in the thesis that the three-year prescription for unjust enrichment would be appropriate for the aforementioned situations, considering that (1) the general prescriptive term of ten years would only be applicable when there was no provision for a shorter special term, and its use would not be appropriate "simply because the claim is based on personal law"; (2) there is a specific prescriptive term for claims arising from undue charges made by the supplier, which are directly related to unjust enrichment so that the 2002 Civil Code would have established the institute of unjust enrichment as a primary source of obligations, expressed in a generic and non-exhaustive precept; and (3) the five-year prescription, provided for in art. 27 of the Consumer Defense Code, applies only in cases of compensation for damages caused by the product or service.[7].In this sense, Minister João Otávio de Noronha even recognized in his vote, understanding – in a curious way – that "the incidence of the general limitation period (of ten years, in this case) leads to greater indebtedness of companies that manage health plans and, in a transversal way, only harms the consumer, who is excessively affected by the crisis that is affecting not only the health sector but all economic sectors in the country" (2016b, p. 130). In February 2023, however, Justice Nancy Andrighi submitted a point of order to the Second Section of the STJ (Pet. 12.602/DF), instituting a review procedure for topic 610, and voting, in the end, for the review of this repetitive topic, in the sense of applying the general prescriptive term of ten years (art. 205, CC/2002), to the claims for conviction based on the nullity of the readjustment clause of health plan

quantity, characteristics, composition, quality, applicable taxes, and price, as well as the risks they present (As amended by Law No. 12,741, of 2012).) [...]".

[7] "I also cite a judgment of the Third Panel that established important premises regarding the prescriptive term applicable to the claim for reimbursement of undue payment, also within the scope of a business relationship, arising, in this case, from an educational services contract. Analyzing the issue under the aegis of the 2002 Civil Code, it concluded, in the points that interest us here, that: (I) the general prescriptive term, provided for in art. 205, is intended for ordinary actions and should be applied only when there is no provision for a shorter special term; (II) there is a specific provision for a prescriptive term for claims arising from undue charges made by the supplier, which, being directly related to unjust enrichment, give rise to the three-year time lapse dealt with in art. 206, § 3, IV; (III) the prescription provided for in the Consumer Defense Code should be applied only in cases of compensation for damages caused by the product or service. [...]. With these considerations, more in-depth, at least from a theoretical point of view, I take the opportunity to reiterate my option for the broader doctrine of the concept of cause (theory of division of the institute), and recognize, with this, the interest in filing a lawsuit based on unjust enrichment (lawful; enrichment by provision), even if there has been a prior agreement of wills between the parties (negotiated cause)". P. 59 and 60.

contracts. To this end, the reporting Justice presented, in detail, the following grounds: (1) the Second Section of the STJ, in the judgment of EREsp 1.280.825/RJ, upheld an appealed decision that had applied the ten-year prescriptive term for the exercise of a claim based on contractual breach involving damages caused by non-compliance with the bylaws of an investment club; (2) the Special Court of the STJ, in the judgment of EREsp 1,523,744/RS, decided that the claim for recovery of undue payments due to undue collection of amounts related to services not contracted, carried out by telephone companies, is subject to the ten-year prescriptive term, according to the general rule of art. 205 of the 2002 Civil Code, understanding that the claim for unjust enrichment (action in rem verso) is subsidiary in nature and therefore does not apply to situations in which the prior contractual relationship is the legal cause of the claim; (3) there is no ontological difference between the claim to refund amounts unduly paid in compliance with a health plan contract, a telephone service provision contract, a water and sewage supply contract, or the bylaws of an investment club since all situations describe a type of contractual breach. Thus, the Minister understood that this is not a case of applying the ten-year limitation period "simply because the claim is based on personal law", as established in topic 610/STJ, but in light of the recognition of the differences between contractual and extra-contractual liability, as well as in light of the inadmissibility of the – subsidiary – action in rem verso and the lack of provision for a specific term for the limitation period of the claim related to contractual non-performance, thus attracting the incidence of the general rule of art. 205 of the 2002 Civil Code (BRAZIL, 2023a).

The vote of the reporting Minister, however, was defeated. In this case, the divergence established by the dissenting vote of Minister João Otávio Noronha prevailed, who, in a succinct statement (approximately one page long), highlighted that the precedent indicated by the reporting Minister to support the overcoming of the qualified precedent, related to services not contracted by telephone, would be ontologically distinct from the object of theme 610/STJ, related to the review of a contractual clause that provides for the adjustment of a health plan.[8], and that the issue of the repetition of undue payment would not be exactly the core of the procedural discussion that gave rise to the qualified

[8] In these terms, the reporting Justice acknowledged in her vote: "Indeed, at first glance, one might think that there are signs of disharmony between the two judgments, since, to a certain extent, both concern the recovery of undue payments. However, I understand that the two judgments are distinct in their essence. First, because the Court's judgment concerns contracts with a prescriptive lapse applicable to cases of recovery of undue payments due to undue collection of amounts related to services not contracted by telephone, which, ontologically, is distinct from the subject of Theme No. 610 of the STJ, which deals with the prescriptive term for exercising the claim to review a contractual clause that provides for the adjustment of a health plan. Second, because, even if the recovery of undue payments is, to some extent, included in the discussion of the case that gave rise to the precedent, it is not necessarily the subject in itself" (BRASIL, 2023a, p. 4-5).

precedent. Therefore, it voted to maintain Theme 610, understanding that, even though there are judgments that indicate a path to overcoming the precedent (indicating that the precedent may be subject to future reform), there is not enough maturity of the debate to promote the overruling at this time.

In a critical analysis of the winning vote, however, it is understood that the Second Section of the STJ missed a great opportunity to review the thesis currently under debate, promoting the rights of the consumer, as well as the principles of proportionality and legal certainty. It is understood, in this research space, that there are no ontological differences between the judgments highlighted here (EREsp 1,280,825/RJ, EREsp 1,523,744/RS, and RESP 1,360,969/RS), whose allegation was not even sufficiently addressed in the winning vote. In reality, the causes of action in the cases under discussion are identical, so that, in all of them, it is the breach of contract by the supplier, in consumer relations, that gives rise to the claim for recovery of undue payment, the prescriptive term of which must observe the general rule of art. 205 of the 2002 Civil Code.

The maintenance of issue 610/STJ, moreover, promotes inconsistency in the prescriptive regimes, consolidating a system in which certain nullities, arising from water supply or telephone service provision contracts, can be alleged within a period of ten years, while those arising from health plan contracts would only be admissible within a period of three, to file lawsuits of an equivalent nature (action for recovery of undue payment).

Therefore, it is expected that the judgment of February 2023 will correspond not to the reaffirmation and stagnation of issue 610/STJ, but, on the contrary (as even the winning vote itself recognized), a step towards the maturation and intensification of the debates surrounding the issue in question. May it therefore be an opportunity for the STJ to signal the lack of soundness of the aforementioned qualified precedent, with its overcoming shortly.

In any case, it is important to clarify that the three-year prescriptive term provided for in topic 610/STJ, about health care plans or insurance contracts, is limited solely to claims for recognition of contractual nullity due to the finding of abusiveness in the readjustment clause. As recognized by the Second Section of the STJ itself, in 2020, in REsp 1.756.283/SP, the claim for reimbursement of medical and hospital expenses allegedly covered by the health plan (or health insurance) contract, but which were not effectively paid by the operator, prescribes in ten years, in compliance with the general rule of art. 205 of the 2002 Civil Code. In this case, the Court expressly established a distinguishing to

topic 610/STJ, understanding that the hypothesis consists of an explicit case of contractual breach, to attract, therefore, the ten-year prescriptive term.(BRASIL, 2020, p.23-24[9]).

It remains to be analyzed in this section, the precedent established by the Third Panel of the Superior Court of Justice in REsp 2.065.976/SP, in a ruling published in April 2024, which established a precedent in the sense of recognizing that the health plan operator can only apply the adjustment due to an increase in the claims ratio if it demonstrates, in detail, the increase in the proportion between the assistance expenses and the direct revenues of the plan (BRASIL, 2024a). The unanimous decision was reported by Justice Nancy Andrighi, who, as a preliminary matter, clarified that the STJ case law understands the viability of promoting adjustments to collective health plan contracts when the monthly insurance payment becomes expensive or unfeasible according to the contracting company's standards, either due to cost variation or increased claims, as well as that, in such contractual modalities, there is no identity of adjustment indexes provided for individual plans (BRASIL, 2024a, p. 8). She also highlighted that Law 9.656/1998 does not expressly mention adjustments due to increased claims, but that its concept can be extracted from a document produced by the Institute of Supplementary Health Studies (BRASIL, 2024a, p. 9). In analyzing the specific case that gave rise to the precedent, it is observed that the operator, annually, applied an adjustment for claims, in increasing percentages, without presenting the corresponding justification. Given this, the consumer filed a lawsuit seeking recognition of the abusiveness of the adjustments for claims in the percentages applied, in the period between 2011 and 2021, since throughout the contractual relationship, the operator never forwarded clarifications detailing the actual need for the percentages applied as adjustments for claims. Therefore, he requested the declaration of nullity of the contractual clauses that authorize the annual adjustment based on the alleged claims, given the excessive burden. At the end of the proceedings, the lower court, understanding that the defendant company failed to produce essential evidence to demonstrate the regularity of the adjustment, ruled in favor of the initial requests, recognizing the abusiveness of the adjustment made and ordering the return of the amount paid in excess, corrected and updated, in compliance with the three-year limitation period –

[9] In these terms, the reporting Justice acknowledged in his vote: “In this line of understanding, it should be reiterated: the ratio decidendi of Special Appeals (repetitive) 1,361,182/RS and 1,360,969/RS had as parameters: (a) the review of a contractual clause of a health care plan or insurance considered abusive with the repetition of undue payment of amounts paid (relevant facts of the case); and (b) the logical consequence of recognizing the illegal or abusive nature of the contract is the loss of the cause that legitimized its payment, giving rise to unjust enrichment and the right to reimbursement of amounts unduly paid and, as a result, attracting the incidence of the three-year prescriptive term provided for in art. 206, § 3, IV, of the 2002 Civil Code (determining legal reasons that led to the conclusion). Thus, in this case, it is clear, in my opinion, that there is a distinguishing factor capable of eliminating the incidence of the aforementioned repetitive thesis in cases of reimbursement of medical and hospital expenses due to breach of contract.”.

as provided for in topic 610/STJ itself, analyzed elsewhere. The decision was substantially upheld on appeal.

The Third Panel of the STJ, in turn, upheld the understanding of the state court, understanding that, based on Normative Resolution 565/2022 of the National Supplementary Health Agency[10], The annual adjustment of group plans, including those based on claims, must be justified by the operator, by providing concrete grounds, a calculation report of the adjustment and the methodology used, at least 30 days in advance of the date scheduled for the application of the index review. Thus, the adjustment due to an increase in claims is a complementary modality to “due to cost variation”, and may only be applied if and when a concrete increase in the proportion between healthcare expenses and direct revenues of the plan is demonstrated, in the previous twelve months. The reporting Minister concludes that “prior proof of the increase in claims is, therefore, a condition without which the need to apply the respective adjustment for the actuarial recomposition of the operator’s accounts is not justified” (BRASIL, 2024a, p. 10-11).

At this point, the rapporteur Justice's vote highlights that the case under analysis should not be confused with the requirements for promoting an adjustment by age group (topic 952), which does not require prior justification from the health plan operator (but only compliance with criteria that ensure the proportionality of the indexes) since the increase in risk is presumed due to advancing age. In the adjustment by claims ratio, on the other hand, there is no way to presume an increase in claims, which vary over time according to the frequency of use of the product and the revenues obtained from the considerations, and may even fluctuate downwards, as occurred in some periods during the Covid-19 pandemic – therefore, it is not possible to equate the hypothesis in the case to those contained in topics 952 and 1,016/STJ (BRAZIL, 2024a, p.14-15).

[10] In these terms, Normative Resolution 565/2022 of the National Supplementary Health Agency provides: “Art. 27. Collective plan contracts must provide for the following rules for applying readjustments: I – it must be informed that the value of the monthly fees and the price table for new memberships will be readjusted annually, in accordance with the variation of the index chosen by the operator, which will be determined in the period of twelve consecutive months, and the time in advance of the application of the readjustment in relation to the anniversary base date, considered to be the month of signing the contract; II – in the event that the need to apply the readjustment due to claims is found, this will be reassessed, and the level of claims in the portfolio will be based on the proportion between the assistance expenses and the direct revenues of the plan, determined in the period of twelve consecutive months, prior to the anniversary base date considered to be the month of signing the contract; III – in cases of application of adjustment due to claims, this must be carried out in a complementary manner to that specified in item I of this article.”.

SUPPLY OF MEDICINES AND THE NATURE OF THE ANS LIST OF PROCEDURES – AGINT IN ARESP 1.964.268/DF, AGINT IN RESP 1.941.905/DF AND REsp 2.037.616/SP

There has been a long-standing debate regarding the legal nature – whether exhaustive or exemplary – of the List of Procedures and Health Events of the National Supplementary Health Agency (ANS). The so-called "ANS list", provided for in article 10, paragraph four, of Law 9.656/1998, consists of a list of procedures, consultations, and treatments that health plans are required to cover, depending on the type of plan contracted (outpatient, hospital with or without obstetrics, referral or dental). This list is regulated by Normative Resolution no. 465/2021 of the National Supplementary Health Agency (ANS), which consolidates the coverage obligations in its Annexes I (List of Procedures and Health Events) and II (Guidelines for Use for Coverage of Procedures in Supplementary Health)[11].

However, when establishing mandatory coverage procedures for health plans, the establishment of a list by the ANS resulted in the establishment of a debate, in doctrine and case law, about the nature of this list, questioning whether it should be considered exemplary or exhaustive. This debate arises, in fact, due to the lack of a specific legal provision that determines the nature of the list, leading to different interpretations about the scope of mandatory coverage and the right to supplementary health care (BÔAS, 2022, p. 3).

On the one hand, health plan operators defended the exhaustiveness of this list, arguing that the imposition of strict limits would ensure the safety and stability of the supplementary healthcare market, which would benefit consumers through more affordable prices. In addition, they argued that compliance with the list would ensure the reliability of treatments, not exposing patients to procedures whose safety and effectiveness had not been certified by the regulatory entity. They also stated that failure to observe the list of procedures would imply the emptying of the sectoral regulation itself, established by a technical and specialized entity to promote the evaluation and incorporation of health procedures – so that judicial decisions to the contrary would consequently violate the separation of powers itself (CAVALCANTE, 2021, p. 52-61).

On the other hand, health plan users, their representative entities, and associations understood, due to the exemplary nature of the aforementioned list, that it would be a document with the sole purpose of dispelling doubts and questions about the coverage of certain procedures. According to this position, Law 9.656/1998 provides for exceptions to the mandatory coverage by health plans, and, among them, the absence of the procedure

[11] Available at: < https://www.gov.br/ans/pt-br/acesso-a-informacao/participacao-da-sociedade/atualizacao-do-rol-de-procedimentos >. Accessed in September 2024.

in the ANS list is not included, so the interpretation of exhaustiveness violates the very principle of legality. Furthermore, the regulatory agency would not have the authority to promote a restrictive interpretation of the legal exclusions of art. 10 of Law 9,656/1998, so, according to the caput of this article, mandatory coverage must observe the diseases listed in the International Statistical Classification of Diseases and Related Health Problems (ICD), established by the World Health Organization (WHO) (CAVALCANTE, 2021, p. 42). They further claimed that the decision on whether or not to incorporate procedures is not that democratic, often being the result of networks of influence and political games and a reflection of the health hegemony and liberal predominance that structured the regulatory sector in this area (BAIRD, 2020, p. 45). Finally, the understanding is based on the provisions of the Consumer Defense Code, the recognition of the consumer's vulnerability (art. 4, I), and the need to interpret contractual clauses in their favor (art. 47). Traditionally, the Superior Court of Justice prevailed in its understanding of the exemplary nature of the ANS list, considering that the procedures and events provided for in the resolution would constitute a reference for mandatory minimum coverage, not corresponding to a parameter to support the exclusion of authorization of a procedure indispensable to essential treatment for the patient, prescribed by a doctor or attending physician - as recognized in the Procedural Appeal in the Appeal in Special Appeal (AgRg in AREsp) 169,486/DF and in Special Appeal (REsp) 1,053,810/SP (BÔAS, 2022, p. 3-4). The matter, however, gradually began to raise controversy and disagreements among the STJ's panels, which is why Special Appeal Divergence Appeals (EREsps), numbers 1,886,929 and 1,889,704, were filed by the Second Section of the Superior Court of Justice (STJ), to unify the understanding of the private law panels on the subject.

The divergence appeals were judged in June 2022, after intense participation from institutions and entities linked to both health plan operators and users, as well as consumer rights protection. However, the thesis for the exhaustiveness of the aforementioned list prevailed, understanding that operators, except for exceptions expressly addressed in the judgment, would not be obliged to cover treatments not provided for in the aforementioned list.

The STJ's decision, however, did not end the controversy on the subject. In the same year, the Legislative Branch approved a Bill that resulted in the sanction and publication of Law 14,454, of September 21, 2022, which expressly provides for the possibility of coverage of procedures and treatments that are not included in the list of procedures and events of the ANS. Its approval, in turn, was the result of intense popular rejection of the understanding adopted by the Superior Court of Justice, driven by the movement that

adopted the slogan "an exhaustive list kills". The episode is a clear example of the so-called backlash effect, a concept doctrinal act that refers to the strong reaction, on the part of society or another constituted Power, to an action by the Public Power — in this case, a legislative response to the judicial decision issued by the STJ (ALVARENGA, DUCA and PEREIRA, 2023, p. 20). The new law mainly inserted paragraphs twelve and thirteen into art. 10, to clarify the exemplary nature of the list. It is in this post-Law 14,454/2022 scenario that the STJ precedents, judged between 2023 and 2024 and now analyzed, are inserted. In this section, the objective is to analyze three decisions that deal with an important subject related to the consumer relationship resulting from the provision of supplementary health care services, namely, the refusal of specific procedures and events, given the ANS list and its non-exhaustive nature. The first case concerns AgInt in AREsp 1.964.268/DF, unanimously judged by the Fourth Panel of the Court in June 2023, reported by Min. Raul Araújo, which confirmed the relevant understanding that it constitutes abusive conduct by the health plan to refuse to supply medication, provided that it is registered with ANVISA and prescribed by the attending physician, solely because it is an off-label or experimental use. In this case, the health plan user filed a lawsuit against the healthcare service provider, claiming, in summary, the cost of outpatient treatment carried out using the medication Rituximab, prescribed by the attending physician as a form of treatment for an autoimmune rheumatic disease (Pyelonephritis resulting from complications of Lupus Erythematosus). The health plan operator, however, denied the administrative request, because the off-label or experimental use of the drug would constitute an impediment to coverage, so the intended procedure would not be provided for in the ANS list.

Preliminarily, an off-label drug is one used by its beneficiary in a manner other than that indicated in the package insert, either because it was prescribed for a therapeutic indication other than that approved for the drug, or because it was administered in a manner other than that recommended, or because it was used for patients in age groups other than those for which the drug was tested, or because it was indicated for the treatment of diseases that were not studied or provided for in the package insert (SILVEIRA, 2019, p. 22). An experimental drug, in turn, is a pharmaceutical product in the testing phase, and its use is permitted when accepted by the competent bodies and with the patient's informed consent regarding the situation and possible consequences (SILVEIRA, 2019, p. 24).

In the case under review, the ordinary courts ruled in favor of the consumer's request, ordering the provision of the medication regardless of considerations regarding the experimental nature of the drug. Given this, the operator filed a special appeal, which,

having been rejected at the outset, was subject to an internal appeal by the Fourth Panel of the STJ.

In analyzing the case, the STJ did not agree with the arguments presented by the health plan operator. It initially understood that, with the enactment of Law 14,454/2022, the ANS list of procedures and events constitutes only a basic reference for health plans, allowing coverage, on an exceptional basis, of procedures or medications not provided for in the ANS list, provided that it is supported by technical criteria and analyzed on a case-by-case basis. In this case, even if the medical prescription used the drug for off-label use, the health plan must cover the cost, since (1) the drug (rituximab) is registered with ANVISA and was prescribed by two different medical professionals for the appropriate health treatment; (2) the denial of coverage constitutes an abusive practice, according to art. 37 of the Consumer Defense Code, placing the consumer at an extreme disadvantage; (3) the prescribed treatment is essential to preserving the life and health of the beneficiary, thus reaffirming case law already established within the scope of the Court itself; and (4) it is up to the medical professional, and not the health plan, to define the most appropriate treatment to preserve the physical integrity of the patient. The STJ also stated that the case did not involve, strictly speaking, the dispensing of a drug for home use, but rather outpatient use or a type of assisted medication, since the medication in question consists of an injectable that requires direct supervision by a health professional. And, given all of the above, the Panel unanimously dismissed the internal appeal filed.

The second case to be analyzed in this section is AgInt in REsp 1.941.905/DF, also judged by the Fourth Panel of the STJ, in a judgment reported by Minister Moura Ribeiro and decided unanimously, in May 2023. In this, the Court reaffirmed its already consolidated understanding that it is mandatory coverage by the health plan operator of a medication prescribed by a medical professional for the treatment of cancer, and the nature – exemplary or exhaustive – of the ANS list is irrelevant to the case.

The case consists of an internal appeal filed by a health plan operator against a single judge decision that denied a previous special appeal, and which, in turn, claimed violation of articles 10, paragraph four and 35-F, of Law No. 9,656/98, as well as articles 51, item IV, paragraph one and item II, and 54, paragraph four, of the Consumer Defense Code, by claiming the lawfulness of the refusal to provide medication due to lack of mandatory coverage due to off-label use and that the ANS list is exhaustive.

The Panel, however, did not agree with the operator's argument. On the contrary, it reaffirmed the Court's understanding (already set out in the following precedents: REsp No. 1,733,013/PR and REsp 1949,270/SP) that the discussion regarding the exemplary or

exhaustive nature of the list is irrelevant for certain categories of products, such as medications related to the treatment of cancer for outpatient or hospital use. This is because there is no list of medications indicated for this purpose, either in the list of procedures and events or in the Clinical Protocol and Therapeutic Guidelines (PCDT), and there is only a list of outpatient or hospital oncology drugs in the ANS Usage Guidelines.[12]. Therefore, there is no mention of a minimum coverage list with regard to cancer treatment, and the health plan operator must provide the medication prescribed by the attending physician.

In addition, the ruling highlighted that it is possible for the health plan to establish the diseases that will be covered, but not the type of treatment used, and that the refusal to cover the procedure, treatment, medication or material considered essential for its performance according to what was proposed by the physician is abusive. The third judgment to be analyzed in this section was highlighted in STJ Newsletter 812, and is a judgment handed down by the Second Section of the Court in Special Appeal 2,037,616/SP, which was reported by Minister Ricardo Villas Bôas Cueva and which was judged in April 2024. Highlighting the intertemporal effects resulting from Law 14,454/2022, the Second Section of the STJ concluded that the legal criteria established for the provision of medicines not present in the ANS list of procedures and events must be immediately observed, from the law's effective date, since it has immediate applicability. In summary, the case depicts an action for an obligation to do something combined with a claim for compensation for moral damages, filed by a consumer who uses a health insurance plan, seeking coverage for a PET-CT scan (PET Scan) as a way of evaluating and monitoring the patient's condition, after undergoing surgery to remove a tumor in the intestine (stenosing neoplasia of the sigmoid colon). The ruling in favor of the claims by the ordinary courts, in turn, led to the filing of a special appeal by the health insurance operator, which claimed a violation of article 10, paragraph four, of Law 9.656/1998, given the alleged need to comply with the Guidelines for Use (DUT) contained in the ANS List of Procedures and Events.

[12] In these terms, Resp 1.733.013/PR, tried on 12/10/2019, DJe 2/20/2020, reported by Minister Luis Felipe Salomão “8. However, it is not possible to generalize and confuse things. It is appropriate to highlight the consideration about the ANS list made by judge Ana Carolina Morozowski, a specialist in supplementary health, in a recent seminar held at the STJ (2nd Insurance Legal Seminar), on November 20, 2019, verbatim: On the other hand, there are categories of products (medicines) that do not need to be provided for in the list - and in fact they are not. For these categories, it makes no sense to inquire about the exhaustiveness or exemplarity of the list. The categories are: a) medicines related to cancer treatment for outpatient or hospital use; and b) medicines administered during hospitalization, which is not to be confused with outpatient use. The technologies in item 'a' are not subject to the list, since there is no medication in this category in it, nor in the Clinical Protocol and Therapeutic Guidelines (PCDT). There is only a list of outpatient or hospital oncology drugs in the ANS Usage Guidelines, but with the sole purpose of highlighting the emetogenic risk they imply, so that it is possible to establish which treatment will be used against these reactions (DUT 54, item 54.6)”.

In keeping with the position established by the Court in recent years and already portrayed elsewhere, the Second Section of the STJ decided not to grant the appeal. In this sense, the Usage Guideline (DUT) should be understood only as an organizing element for the provision of pharmaceuticals, supplies and procedures within the scope of Supplementary Health, not prohibiting alternative therapies to the patient, especially when conventional treatments have been exhausted and their effectiveness has been proven.

However, the research is interested in a specific discussion developed in the winning vote of Minister Ricardo Villas Bôas Cueva, regarding the temporal effects of Law No. 14,454/2022. Even if it is considered that the aforementioned legislative change did not actually establish new requirements in § 12 and 13 of art. 10 of Law 9,656/1998, but rather promoted an authentic interpretation of § 4 of the same law, the Minister understood that the meaning intended by the legislator should not be in force retroactively, but only operating ex nunc effects, since it consists of a modifying rule that has an innovative character.

Therefore, in compliance with the Principle of Non-Retroactivity, the requirements imposed by the aforementioned legal provisions for the purpose of supplying a medication not included in the ANS list should not cover past events prior to the enactment of Law 9,656/1998. On the other hand, although they cannot be retroactive, the STJ understood that their effects are instantaneous, applying immediately upon their enactment, including for ongoing treatments initiated at an earlier date.

SUPPLY OF MEDICINES FOR HOME TREATMENT – RESP 2,017,759/MS AND AGINT IN ARESP 2,251,773/DF

Another relevant issue, the limits of which are currently under discussion and development within the Superior Court of Justice, concerns the obligation of health care plans to supply medications for home treatment. At least two judgments on the subject were highlighted in STJ newsletters published between 2023 and 2024, and were included in this research.

The first is REsp 2.017.759/MS, judged in February 2023 in a unanimous decision handed down by the Third Panel of the STJ and reported by Minister Nancy Andrighi, who, in summary, recognized that coverage for home hospitalization, replacing hospitalization (in the home care modality, therefore), must cover the necessary supplies to guarantee effective medical assistance to the beneficiary, including those to which the beneficiary would be entitled if he or she were hospitalized. The second judgment, AgInt in AREsp 2.251.773-DF, in turn, was handed down by the Fourth Panel of the STJ, by a majority of

votes (three votes against two in the opposite direction) and having as rapporteur for the Judgment Minister Marco Bruzzi, and resulted in the conviction of the health plan operator to provide, in a home environment, an orally administered medication prescribed for the treatment of multiple sclerosis, understanding the need for the administration of the drug by the operator when, among other circumstances cias, this is included in the ANS list and is part of a specific stepped treatment that the patient necessarily needs to undergo in order to be entitled to the supply of a mandatory coverage drug. The judgment, up to the date of completion of this research, had not been published in full, however it was highlighted in Informative No. 814, published on June 4, 2024 (BRASIL, 2024c).

Understanding the premises established by the STJ in the judgments above, however, requires a preliminary study, which has been constructed in a contemporary manner, regarding the situations in which the health plan will be required to provide medications for home treatment purposes. The STJ's jurisprudence, based on precedents such as REsp 2.071.955/RS, AgInt in AgInt in REsp No. 2.071.979/SP and AgInt in AREsp No. 1,771,350/PR, in its quest to promote integration and adequate interpretation of the provisions contained in Law 9,656/1998, has consolidated the position that the obligation of operators to promote coverage of treatments or procedures not listed in the ANS list does not, as a rule, extend to the dispensing of medication for home use, with some important exceptions (VITAL, 2024).

Therefore, the understanding formed by the STJ is that, as a general rule, the legislator excluded from the reference health care plan the obligation to provide medication for home treatment (except for contractual provisions to the contrary), given the express exclusion of their coverage promoted by art. 10, VI, of Law 9,656/1998. However, since the publication of Law 12.880/2013, the Health Insurance Law has been reformed to include, in the reference plan, two exceptions: (1) oral home antineoplastic treatments, under the terms of art. 12, item I, letter 'c', of the aforementioned Law, ensuring that cancer patients have access to the necessary medications for due treatment outside the hospital environment, in order to provide greater comfort, reduce the need for hospitalization or constant travel to the hospital, greater autonomy and quality of life; and (2) medications for use in home care, that is, provided in a home hospitalization regime, as provided for in art. 12, item II, letter 'g', of the same Law, and characterized by full-time care for patients with more complex clinical conditions and in need of specialized technology at home (BRASIL, 2023c, p. 10). In addition to the two exceptions presented, a third should be added, corresponding to other treatments included in the List of Health Event Procedures of the National Supplementary Health Agency (Annex II of RN No. 465/2021) for the purpose of

home treatment, such as, for example, specific medications and equipment for respiratory treatment and hyperbaric oxygenation (nebulizers or inhalers), collection and adjuvant equipment, bladder catheters, among others.

It is in this context that the two judgments to be analyzed below are inserted. Specifically regarding treatments provided under a home care regime, the Third Panel of the STJ addressed the issue in Resp 2,017,759/MS, decided in February 2023, which established an important thesis that home coverage must cover all supplies necessary for effective medical care to be provided to the beneficiary, under the same standards to which he or she would be entitled if he or she were hospitalized and in accordance with the prescription made by the attending physician, under penalty of distorting the purpose of home care, compromising its benefits and underutilizing it as a substitute for hospital treatment (BRASIL, 2023c).

The case under analysis concerns a patient suffering from permanent quadriplegia and dependent on specialized home treatment, who, given her clinical condition, filed a lawsuit for an obligation to act against the contracted health plan, aiming to obtain payment for appropriate medical treatment in the home care modality, including the supplies necessary for this purpose. The first instance court partially upheld the claims presented, and the local Court of Justice, denying the appeals filed, confirmed the decision that the operator should only provide the cost of enteral nutrition and infusion pump, consultations or sessions of physiotherapy and motor and respiratory speech therapy, psychological and nutritional therapy, as prescribed by the doctor, for the indicated period. However, the requests that the operator cover the costs arising from geriatric diapers, hospital bed with mattress and nursing supplies were denied, understanding the TJ-MS that such supplies would be the beneficiary's private sphere, with no contractual provision determining their provision. In view of the partial denial, the patient filed a special appeal (BRASIL, 2023c, p. 3-9).

The vote of the reporting Justice, Nancy Andrighi, supported unanimously, was for the provision of the appeal, ending the ruling that the operator must pay for the supplies essential to the appellant's health care, in the form of home care, as prescribed by the attending physician, limited to the daily cost in the hospital. The vote of the reporting Judge was based on the following grounds: (1) the patient, suffering from tetraplegia, is an elderly person, a circumstance that further weakens her already critical health condition; (2) the home hospitalization coverage must include the same supplies that the patient would be entitled to if he were hospitalized, in order to authorize the request for payment of the supplies essential to the appellant's health care, limited to the daily cost in the hospital; (3)

deficient home care would render this type of health care useless, since it will ultimately lead to new hospitalizations, which will inevitably force the operator to pay the full cost of the resulting procedures and events; and (4) failure to cover the costs of supplies resulting from home treatment implies a distortion of the purpose of home care, compromising its benefits, and underutilizing it as a health treatment that replaces hospital stays (BRASIL, 2023c, p. 9-13).

Finally, regarding the Internal Appeal in the Appeal in Special Appeal 2,251,773-DF, the last to be analyzed in this section, it is understood that, despite the lack of full publication of the decision by the time this research was concluded, the information highlighted in Informative 814/STJ is of fundamental analysis to the subject at hand.[13]. This is because, in this case, the Fourth Panel of the STJ, in a decision handed down by a majority, recognized the abusive conduct of the health plan operator that denies essential treatment for the control of a degenerative disease of the nervous system, simply because the medication can be administered orally in the home environment, when it is included in the ANS list and is part of a specific and gradual treatment that the patient must necessarily undergo in order to be entitled to the supply of a drug with mandatory coverage (CARVALHO and HAIDAR, 2024).

The controversy, in this case, concerned the mandatory supply by the operator of the drug “fingolimod”, which is a drug for home use, administered orally and indicated for the treatment of multiple sclerosis, for which there would be no legal or contractual provision for mandatory coverage. Even noting that the STJ case law has established itself in the sense of recognizing the lawfulness of the exclusion of the provision of medicines for home treatment, as a rule, the Panel, in the judgment of the case under analysis, clarified the existence of a distinction that authorizes the application of a different understanding, since: (1) the attending physician recognized the indispensability of the therapy carried out specifically with the medicine fingolimod in a daily dose, orally, clarifying that the patient had previously used injectable therapy, using other drugs in his treatment, without success however; (2) the referred medicine has the due registration with the National Health Surveillance Agency (ANVISA) and is expressly indicated for the treatment of multiple sclerosis, there being no alternatives in the injectable form for his health condition; (3) although the aforementioned drug is not provided for as mandatory coverage, the ANS list contemplates the use of fingolimod as a second or third line of treatment, which the patient

[13] Informative 814/2024 is available at the following electronic address: < https://processo.stj.jus.br/jurisprudencia/externo/informativo/?acao=pesquisarumaedicao&livre=0814.cod.&from=feed >. Accessed in September 2024.

necessarily needs to undergo in order to be entitled to the supply of a drug with mandatory coverage (Natalizumab), when there is therapeutic failure, adverse events or lack of adherence in the previous lines, and it is not appropriate to require the patient to immediately move on to the subsequent stage of treatment, contrary to the technical indications and the attending health professional; and (4) the drug fingolimod is provided by the Unified Health System, and there is information that oral administration is more effective, especially because it provides greater adherence to treatment. In view of the above, the STJ understood, in this case, that it is absolutely unreasonable to subject the patient to a painful injection treatment, performed in a hospital environment, when he or she can use oral treatment, which is more practical, painless and does not involve travel expenses or time expenditure, in addition to representing a lower cost for the health plan operator, which does not affect the contractual balance (BRASIL, 2024c).

The judgment, therefore, constitutes an important precedent by establishing requirements for the provision, by the health plan operator, of medications for home use not provided for in the ANS list of procedures, especially in the case of drugs essential to the patient's health and without equivalent therapeutic substitutes, to be analyzed in even greater detail when the full judgment is published.

CONTOURS ON NEWBORN CARE COVERAGE AND THE MEANING OF ARTICLE 12, III, OF LAW 9,656/1998 – RESP 2,049,636/SP

In April 2023, the Third Panel of the Superior Court of Justice, in a decision reported by Minister Ricardo Villas Bôas Cueva (REsp 2049636/SP), issued unanimously, established an important precedent by recognizing the abusive conduct of the health care plan operator in refusing to enroll a newborn in the health plan owned by the grandfather, whether the mother is a dependent or a beneficiary of an individual or collective plan, as well as the abusiveness in the company's attempt to discontinue paying for the newborn's hospitalization after thirty days of birth.

The specific case submitted for judgment consists of an action for an obligation to do something and compensation for damages, brought in favor of a newborn child, the daughter of a teenage mother, who is, in turn, a dependent beneficiary of a certain health plan with obstetric hospital segmentation, contracted by her father – the newborn's grandfather, therefore. The child, born prematurely (preterm) and with a weight below the expected, required hospitalization for an indefinite period in a neonatal Intensive Care Unit (ICU), but had her request for enrollment in the health plan denied by the operator, on the grounds that the coverage should not apply to children of a potential dependent. In the

action, the following requests were presented: (1) the payment, by the operator, of all medical and hospital expenses in the neonatal Intensive Care Unit (ICU) until the discharge of the newborn; (2) the inclusion of the latter as a pending in the grandfather's health plan; and (3) compensation for moral damages.

The first instance court ordered the defendant company to guarantee all necessary medical care until the final discharge, without any charge for hospitalization or other medical-hospital expenses, in addition to refraining from transferring the child, under penalty of a fine. It also ordered the inclusion of the newborn as a dependent in the health plan. After an appeal by the operator, the state Court of Justice upheld the conviction, which led to the filing of a special appeal by the company.

In the special appeal, the appellant stated that it could not be required to continue to cover the costs of the newborn's treatment and healthcare expenses after the thirtieth day after birth, since only the policyholder's children (natural or adopted) could be enrolled in the health plan, according to article 13, section III, item 'b', of Law 9.656/1998, and there was, furthermore, no contractual provision for including a grandchild either as a dependent or as an aggregate. It also alleged that any broad interpretation in favor of the consumer would cause legal uncertainty and instability in private business relationships, resulting in inappropriate judicial intervention in the economy.

Therefore, the controversy faced by the Third Panel of the STJ was, first, to define whether the operator has the duty to enroll the newborn, the grandchild of the health plan holder, as a dependent, and, second, whether the operator should continue to cover the costs of treatment for the hospitalized newborn, after the thirtieth day after birth.

As for the first controversy, the STJ understood that, despite the apparent imprecision of the legislator, the expression “consumer”, contained in art. 12, III, ‘b’, of Law 9.656/1998, must include both the “consumer holder” and the “dependent consumer”, under penalty of violating the provisions of article 47 of the Consumer Defense Code (CDC), which determines the interpretation of contractual clauses in a manner more favorable to the consumer.[14].Furthermore, as can be seen from the vote of the reporting Minister, it must be considered that the case concerns a hypervulnerable person, in accordance with article 39, paragraph IV.[15], of the CDC, since, in addition to the legal presumption of consumer vulnerability in the consumer relationship, which arises from the provisions of art. 4, I, of the

[14] According to article 47 of the Consumer Protection Code: “Art. 47. Contractual clauses will be interpreted in a manner most favorable to the consumer”.

[15] According to article 39, section IV, of the Consumer Defense Code: “Art. 39. The supplier of products or services is prohibited from, among other abusive practices (Text given by Law No. 8,884, of 6/11/1994): [...]; IV - taking advantage of the weakness or ignorance of the consumer, taking into account his age, health, knowledge or social status, to impose his products or services on him[...].

CDC, in this case, the consumer is a newborn and at risk due to harm to his/her health. Therefore, regarding the aforementioned chapter of the decision, the Third Panel concluded that the operator's conduct in not including a newborn child in the health plan held by his/her grandfather was abusive.

Regarding the second question, the STJ understood that the wording of art. 12, III, 'a', of Law 9.656/1998 does not authorize, in itself, the discontinuation of the cost of medical-hospital treatment of a newborn, starting on the thirtieth day after birth. This position reflects an understanding already adopted by the Superior Court of Justice, in a precedent set in REsp 1,953,191/SP, also judged by the Third Panel in February 2022 and reported by Minister Nancy Andrighi. In this case, it was recognized that, after the thirty-day period, a newborn undergoing therapeutic treatment and not enrolled in the health plan must be considered a user by equivalence, since the operator has the duty to guarantee the continuity of medical assistance in favor of anyone who is hospitalized or undergoing medical treatment essential to their own survival/safety (BRASIL, 2022b). The position adopted by the Panel is also based on repetitive theme 1,082/STJ, when the STJ established a thesis, in a qualified precedent, recognizing that “The operator, even after the regular exercise of the right to unilateral termination of a collective plan, must ensure the continuity of the care prescribed to a hospitalized user or in full medical treatment guaranteeing his/her survival or physical safety, until the actual discharge, provided that the holder fully pays the due consideration” (BRASIL, 2022c).

In reinforcement of the precedents cited, the reporting Minister clarified in his vote that the newborn, as a user by equivalence, must have his/her care coverage guaranteed through the collection of amounts corresponding to monthly payments of his/her category, as occurs with beneficiaries undergoing medical treatment whose plan has been terminated, in compliance with the principles of good faith, the social function of the contract, legal certainty and human dignity.

SEXUAL AND REPRODUCTIVE HEALTH OF WOMEN UNDERGOING CANCER TREATMENT AND EGG CRYOPRESERVATION - RESP 1.962.984/SP

The Third Panel of the Superior Court of Justice, in August 2023, handed down a unanimous judgment, with the reporting of Minister Nancy Andrighi, in REsp 1.962.984/SP, establishing the thesis that the health care plan must cover the egg cryopreservation procedure, as a preventive measure against infertility, for the patient undergoing cancer treatment, even if the contract does not cover assisted reproduction treatment (BRASIL, 2023e). The case brought before the Superior Court of Justice concerns an action for an

obligation to do something, filed by a female consumer undergoing chemotherapy treatment for breast cancer, seeking to have the health plan operator ordered to pay for the egg freezing procedure (cryopreservation), necessary to preserve her reproductive capacity after the prescribed chemotherapy sessions. In view of the plaintiff's claim, the first instance court partially ruled on the claims presented, ordering the operator to pay for the treatment by reimbursing the amounts spent by the plaintiff, a decision that was substantially confirmed and contested by the defendant company, by means of a special appeal. In its appeal, the operator argued, in summary, that the determination to cover the cost of the procedure would be inappropriate, in accordance with the provisions of article 10, item III, of Law 9.656/1998, considering that egg freezing is not included in the list of mandatory coverages of the National Supplementary Health Agency and that the agreed health care contract excludes from coverage all assisted reproduction methods, including in vitro fertilization or artificial insemination techniques.

The Third Panel of the STJ, however, disagreed with the grounds presented by the appellant and substantially upheld the decision handed down by the sentencing court. Initially, the rapporteur Justice's vote highlighted the existence of a distinction (distinguishing) between the case under analysis and the precedent – qualified – consolidated by the Court itself in Theme 1,067/STJ, judged by the repetitive appeals procedure, in which it was recognized that “except for an express contractual provision, health plans are not obliged to cover in vitro fertilization medical treatment” (BRASIL, 2021). This is because what is being discussed in the present case is not simply the provision of infertility treatment, but rather its prevention, taking into account the potential adverse effect of the chemotherapy procedure covered by the plan.

Therefore, the provision set forth in art. 10, III, of Law 9.656/1998, which recognizes that the provision of artificial insemination treatment in the reference health care plan is not mandatory, is of little relevance to the case. In this case, art. 35-F of the aforementioned law should prevail.[16], which, on the contrary, imposes on health insurance companies the obligation to prevent diseases, in order to mitigate the risks arising from the health treatment provided and indicated.

Since infertility is, therefore, an adverse effect of chemotherapy, which is predictable and avoidable, it is mandatory for the health insurance company itself to prevent it. And, in this context, with the aim of better weighing the interests in dispute, namely, the legitimate

[16] According to article 35-F of Law 9,656/1998: “Art. 35-F. The assistance referred to in art. 1 of this Law includes all actions necessary for the prevention of disease and the recovery, maintenance and rehabilitation of health, in compliance with the terms of this Law and the contract signed between the parties (Included by Provisional Measure No. 2,177-44, of 2001)”.

expectations of the consumer and the scope of the restriction established by the legal system regarding the limits of the health insurance contract, the STJ decided, in this case, that the health insurance company is obliged to pay for the cryopreservation of the eggs, but until the patient is discharged from the chemotherapy treatment prescribed to the appellant for breast cancer, from which point it will be up to the latter to bear any costs, at its own expense, if necessary.

The judgment, therefore, represents an important step forward in the promotion and defense of women's rights, especially with regard to the protection of their sexual and reproductive health. By recognizing egg cryopreservation as an essential preventive measure in oncological treatments, the Court reinforces the need to ensure the physical and emotional integrity of patients, expanding the concept of care, especially in its self-care dimension, not only treating diseases, but also preventing their adverse effects, guaranteeing women the preservation of their reproductive capacity, even when facing serious treatments such as chemotherapy..

DISCUSSION

Even though there is discussion about the potential undesirable economic impacts resulting from the actions of the Judiciary in the supplementary health market, which results in costs to be borne by the entire business chain (REZENDE, 2011, p. 105), the fact is that abusive practices and flagrant violations of the rights of consumers are recorded daily, promoted by health care plan operators (under the terms of art. 1, I, of Law 9.656/1998), and which require the action of the Judiciary with the objective of ensuring fundamental rights in the protection of the right to health. Abusive practices often target people in situations of heightened vulnerability (hypervulnerable consumers), affected by other factors of social exclusion in addition to the vulnerability resulting from the consumer relationship, presumed by law under article 4, I, of the Consumer Protection Code, such as illiteracy, racial or gender markers, elderly people, people with disabilities, or people made vulnerable by technical, legal, informational or digital factors (MARQUES, BENJAMIN and MIRAGEM, 2010, p. 198).

CONCLUSION

The analysis of precedents set by the Superior Court of Justice in 2023 and 2024, in judgments highlighted in case law reports, in short, reaffirms the finding drawn up by the National Council of Justice (CNJ) and the Institute of Education and Research (INSPER), in the “Justice Research” series, already reproduced in the introduction to this work: the

Judiciary Branch in fact constitutes an important locus for discussion regarding health care contracts and for affirming the rights of consumers, especially in situations of hypervulnerability, that is, when the user is affected by multiple factors of social exclusion (2019, p. 8). As recognized by the Third Panel of the STJ in Resp 2.049.636/SP, analyzed in section five of this work, the Judiciary Branch is responsible for seeking balance, through weighing and proportionality techniques, between consumer rights and the interests of companies that maintain health plans (BRASIL, 2023d). Both the exploitation of health care by the private sector and consumer protection have constitutional foundations, and therefore there is no hierarchy or prevalence of one legislation over the other. Law No. 9.656/1998 and the Consumer Defense Code, in this normative microsystem, must be applied in a harmonious and integrated manner in health care contracts, since they deal with fundamental goods, such as the preservation of life. These legal provisions aim to ensure that the user can face possible risks to their physical and mental health, ensuring due access to adequate medical treatments. After considering the theses established by the Superior Court of Justice regarding the subject of supplementary health in Brazil, it is understood that the Court has consolidated itself as an important player in the construction of public policies to regulate health plans in the country, in order to interact with the Executive and Legislative Branches and private entities and influence the paths and evolution of the right to health in Brazil (RAMOS, 2022). Its decisions, by delimiting the scope and limits of the regulatory frameworks on the subject, especially in view of the advent of Law 14,454/2022, redefine the supplementary health care market, demanding adaptation by all those involved, especially operators, for the due and adequate observance of precedents and the rights of users of their services.

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