HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

The healthcare economy in the Dominican Republic operates through a combination of public and private sectors, with both playing significant roles in the overall healthcare landscape. The central government is primarily responsible for the formulation and implementation of healthcare policies. The Ministry of Public Health and Social Assistance (Ministerio de Salud Pública y Asistencia Social or MISPAS) oversees public health initiatives, regulates healthcare providers and ensures access to essential health services for the population. Health services are also managed at the municipal and state levels, where local governments may provide direct healthcare services and implement community health programmes tailored to specific regional needs. The private sector includes private clinics and individual practitioners who provide healthcare services, often funded by private insurance or out-of-pocket payments from patients. Private healthcare facilities may offer advanced medical technologies and specialised services that are sometimes lacking in public hospitals.

In accordance with General Health Law No 42-01, the financing of the National Health System is mixed, based on state taxes and social security, with the participation of both public and private insurance providers.

Law No 87-01, which established the Dominican Social Security System (Sistema Dominicano de Seguridad Social or SDSS), aims to regulate the rights and obligations of citizens and the Dominican state regarding the financing of population protection against, among other things, health risks. This law also created the National Social Security Council (Caisse Nationale de Sécurité Sociale or CNSS) as the governing body of the Dominican SDSS. The CNSS is responsible for issuing the list of medications to be financed under the SDSS, which is mandatory and uniformly applicable to all Health Risk Administrators (Administradoras de Riesgos de Salud or ARS).

Regarding the financing of health services, the government ensures access to healthcare for the Dominican population through an autonomous and decentralised public institution responsible for managing the health risks of subsidised, contributory and contributory-subsidised affiliates in the public sector, as well as contributory affiliates in the private sector who voluntarily choose to participate. This institution, known as the National Health Insurance (Seguro Nacional de Salud or SENASA), was established with the enactment of Law 87-01.

Private insurance companies also exist, and offer a range of life and health plans to various

demographics, including higher-income groups who may prefer private healthcare services for improved access and shorter wait times. Private companies offer a variety of life and health insurance plans, which cater to different income levels and needs, and act as a complement to governmental programmes. Competition among these insurers contributes to improving service quality and accessibility.

There are certain limitations with insurance coverage, public or private. Because certain treatments are not fully covered by the government or insurance companies, the remainder of the costs are to be covered by the patient. Certain treatments are not covered by any insurance. There are also many non-governmental organisations (NGOs) and patient organisations that contribute by providing additional funding and resources for patients in need of basic medical treatments.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

The framework regarding healthcare financing and reimbursement in the Dominican Republic is regulated by General Health Law No 42-01, which regulates access to healthcare for the Dominican population. It established the National Health System (SNS) as the overarching structure for healthcare delivery. Additionally, it mandates a mixed financing model combining state taxes and social security contributions, with participation from both public and private insurance providers.

Law No 87-01, which established the SDSS, created the Superintendence of Health and Occupational Risks (Superintendencia de Salud y Riesgos Laborales or SISALRIL) as a regulatory body for the social security system, and includes provisions for healthcare services, contributions and regulations concerning health insurance. Law No 87-01 also introduced the Basic Health Plan (PBS), which outlines the minimum health services to be covered by ARS, and created SENASA, the public health risk administrator.

Various regulations and decrees complement these laws and provide additional details for the implementation of healthcare financing, including rules for reimbursement, management of health services, and obligations of insurers and providers, such as Administrative Ruling No 00251-2023, which regulates healthcare financing and reimbursement through the SISALRIL.

The Regulation for the Organization and Regulation of ARS in the Dominican Republic was established through Decree No 72-03. This regulation governs the organisation and operation of ARS, both public and private, authorised to operate within the SDSS.

Various industry organisations, such as the Association of Health Risk Administrators (Administradores de Riesgos de Salud or ADARS), develop codes of conduct and best practices that influence how private insurers operate and manage healthcare financing. While these codes are not legally binding, they can set higher standards for service delivery and reimbursement practices in the industry. Private healthcare providers and insurers may also create internal policies that govern reimbursement practices, patient interactions and service delivery, which can impact operational compliance with other laws.

The relationships between healthcare providers (hospitals, clinics and physicians) and payors, including public insurers like SENASA and private insurers, are frequently shaped through public and private negotiations. These negotiations determine reimbursement rates, coverage limits and terms of service delivery. Associations representing healthcare providers and insurers often facilitate negotiations, and help develop industry standards. These bodies

advocate for the interests of their members, influence regulatory policies and promote fair practices within the healthcare system.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

The SDSS contemplates supervisory bodies regarding the financing of and reimbursement of healthcare. The SISALRIL is the main regulatory body overseeing health insurance. It establishes regulations for healthcare financing and ensures compliance with health insurance policies. SENASA is a public health insurance entity offering coverage to government employees and the uninsured population. It manages and supervises the provision of services under the subsidised health regime. MISPAS is responsible for overall public health policy, including the regulation and supervision of healthcare services. It plays a role in ensuring quality and access to healthcare, which impacts financing and reimbursement systems. SNS oversees public hospitals and health centres, ensuring they provide services in line with national healthcare standards, which indirectly influences financing and reimbursement processes.

Private Health Insurance Companies (ARS) are private entities that provide health insurance coverage. They are regulated by the SISALRIL and negotiate reimbursement rates with healthcare providers.

4. Has there been a change to healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

Covid-19 has not changed the general system of healthcare financing and reimbursement policies of the Dominican Republic.

To address the pandemic, the Dominican Government invested over DOP 20bn, allocating funds to testing, vaccination, medical personnel and the inclusion of 5.7million Dominicans in the SENASA health coverage programme.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

Access to healthcare is universal, ensuring that all residents, regardless of their economic status or age, have the right to receive public medical services. All residents are entitled to healthcare services, ensuring broad coverage across the entire population. The public healthcare system, managed by MISPAS and SENASA, provides free or low-cost care to the population, particularly to vulnerable groups. Emergency services are available to everyone, including undocumented immigrants, while legal residents and citizens can benefit from a broader range of services.

The SDSS organises healthcare access into three main regimes. The contributory regime that covers formal sector employees and their dependents, with contributions shared by employers, employees and the government. The subsidised regime is fully funded by the government and serves unemployed or low-income individuals without the ability to contribute. The contributory-subsidised regime is aimed at independent workers or professionals with limited income, requiring a partial financial contribution from beneficiaries. Each regime ensures access to the PBS, which provides essential health services

to the population.

Medical service providers, including hospitals, clinics and individual healthcare professionals, must meet specific regulatory requirements to be part of the Dominican healthcare system. These entities are required to obtain a license from MISPAS and register with the SISALRIL. They must comply with health service quality standards and operational guidelines outlined by the CNSS. Medical service providers that participate in the SDSS are required to offer services that are part of the PBS, which is regulated by the SISALRIL, and they must adhere to established tariffs for these services.

Suppliers of medical goods, including pharmaceutical companies, medical equipment providers and distributors of health-related products, also need to comply with strict regulatory requirements to operate within the Dominican healthcare system. They must register their products and health devices with the General Directorate of Drugs, Food, and Health Products (Dirección General de Medicamentos, Alimentos y Productos Sanitarios or DIGEMAPS), ensuring that all medical goods meet safety and efficacy standards. Suppliers must obtain the necessary certifications for importing and distributing medical goods and follow all regulations regarding labelling and quality control. Those wishing to sell products to public healthcare providers must also participate in public procurement processes, which are overseen by relevant government bodies to ensure transparency and fair competition.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Health insurance carriers, including both public and private ARS, in the Dominican Republic are financed through a combination of private contributions, premiums and government subsidies, depending on the type of insurance regime.

The premiums are the primary source of revenue for insurance companies. The government operates a social security system that includes health insurance coverage under the SDSS. This programme is funded through contributions from employers and employees, which help subsidise health coverage for lower-income individuals.

A private health insurance market offers a variety of health plans designed to meet the needs of different population segments. These plans range from basic coverage options for individuals seeking essential healthcare services to more comprehensive packages for those requiring extensive medical care and additional benefits.

Insurance companies evaluate applicants. Higher health risks can lead to higher premiums. The comprehensive nature of the health plan affects premium costs. Plans that offer extensive networks, lower deductibles, and more services typically have higher premiums. Competition among insurance providers can influence pricing strategies. Insurers may adjust premiums to attract and retain customers while balancing financial sustainability.

The government regulates health insurance to ensure certain standards, including minimum coverage requirements.

7. How is the coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

The coverage of medical services by health insurance carriers is regulated by the SISALRIL,

which ensures that ARS comply with the PBS established by the CNSS. This regulation sets the standard for the minimum coverage that must be provided by both public and private insurance providers. The plan outlines the scope of covered services, including general consultations, hospitalisations, surgery and specialised treatments.

There is no significant difference in the coverage for in-person medical appointments and telemedicine appointments under the regulation of the SDSS. The services covered under telemedicine, such as consultations with healthcare professionals via phone or video, are treated similarly to in-person consultations. Both types of appointments must meet the same clinical criteria for reimbursement, making telemedicine a viable option for extending healthcare access.

In cases such as orphan drugs and off-label drug use, coverage may vary. Orphan drugs (medications for rare diseases) are not always included in the standard PBS coverage, and their inclusion often requires special authorisation, negotiation or additional coverage plans. Similarly, the off-label use of medications may not be reimbursed unless there is strong clinical justification, and it often requires pre-approval or negotiation between the ARS and healthcare providers.

In summary, while health insurance carriers in the Dominican Republic have the freedom to define the scope of coverage within their plans, the government plays a significant role in ensuring that essential services are covered and accessible.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Services provided by hospitals in both stationary (inpatient) and ambulatory (outpatient) settings are financed primarily through the SDSS, which includes public and private health insurance providers. ARS, whether public (SENASA) or private, manage the financing and reimbursement of medical services under the system. In the inpatient setting, hospitals are reimbursed for services provided to patients who require hospitalisation, including surgery, emergency care and long-term treatments. This reimbursement is typically based on pre-established tariffs set by the CNSS, which ensures that payments are standardised and reflect the care provided.

For ambulatory (outpatient) services, financing and reimbursement work similarly, with ARS covering consultations, diagnostic tests and treatments that do not require hospitalisation. Outpatient care is reimbursed based on a fee schedule outlined in the PBS and providers must submit claims to the ARS for payment.

Both inpatient and outpatient services are governed by guidelines that ensure the quality of care and control the costs of services rendered. The ARS, whether public or private, reimburses healthcare providers according to the level of coverage that patients have under their respective health insurance plans, ensuring that the costs are covered either fully or partially depending on the patient's regime (contributory, subsidised or contributory-subsidised).

9. How are the prices of such services determined? How is economic efficiency controlled?

The prices of healthcare services, particularly those covered under the SDSS, are determined by a combination of tariffs established by the CNSS and negotiated agreements between ARS and healthcare providers. The tariffs are part of the PBS, which sets standardised prices for a range of services, including consultations, hospital stays, surgery and diagnostic tests. For private health insurance plans, the prices of services may vary, but they are still influenced by the regulations set by the CNSS and competition among private insurers.

Economic efficiency is controlled through a variety of mechanisms. The SISALRIL plays a key role in monitoring the performance of healthcare providers and insurers, ensuring that services are delivered within the established price ranges and that healthcare spending remains within the system's budget. PBS encourages cost-effectiveness by regulating service pricing, promoting standardised care and reducing unnecessary procedures. Audits and monitoring by governmental bodies help to identify areas of inefficiency, while the competitive nature of the private sector pushes healthcare providers to optimise services and reduce costs. These control mechanisms work together to maintain economic efficiency within the Dominican healthcare system.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

Services provided by physicians, therapists, laboratories and other healthcare service providers in the private sector are primarily financed through private health insurance plans offered by ARS or paid directly by patients out of pocket. Private ARS contracts with physicians, therapists, laboratories and other providers to offer a range of services to their insured members. These providers are reimbursed based on pre-negotiated agreements with the ARS or the terms of the insurance plan, which often include a fee-for-service structure. Healthcare providers receive payment for each service rendered, whether it is a consultation, diagnostic test or therapeutic session, according to the fee schedules established by the insurance companies or negotiated individually.

Private health insurance plans, typically aimed at higher-income individuals, determine the scope of coverage and reimbursement rates for various medical services. Reimbursement to healthcare providers is typically based on a set of tariffs agreed upon between the ARS and providers, which may vary depending on the complexity of the service. This reimbursement is subject to the terms of the insured person's plan and may include coverage for outpatient services, such as consultations, laboratory tests and minor procedures, as well as inpatient services, such as surgery or hospital stays.

In cases where the patient has a private insurance plan, the ARS directly reimburses the provider or the patient in the case in which the professional does not have an agreement with the ARS. If the patient does not have insurance, the individual is responsible for paying the full cost of services out of pocket.

The private sector's flexibility allows providers to set their own prices, but these are often regulated and monitored to ensure alignment with market standards and to avoid overcharging.

11. How are the prices of such services determined? How is economic efficiency controlled?

The prices of healthcare services in the private sector are typically determined by ARS, healthcare providers, and the terms of individual health insurance plans. Private health insurance companies negotiate prices with healthcare providers, including physicians, therapists, laboratories and hospitals, based on pre-established tariffs or fee-for-service agreements. These tariffs may vary depending on the type of service provided, the complexity of the treatment, and the agreement between the ARS and the service provider. For patients without insurance, healthcare providers set their own prices, which are often influenced by market conditions and the competitiveness of the sector.

Economic efficiency in the private healthcare sector is controlled through several mechanisms. Regulatory bodies, such as the SISALRIL, monitor the pricing and quality of services to ensure that providers are not overcharging for services or delivering substandard care. While the private sector allows for more flexibility in pricing, it is still subject to certain oversight aimed at achieving fair practices. Competition between private healthcare providers and insurers helps to drive efficiency, as providers aim to attract patients by offering high-quality services at competitive prices.

Audits and reviews of ARS contracts with healthcare providers also help to control costs and ensure that payments to providers are consistent with agreed-upon rates and regulations.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

Pharmaceuticals and medical devices in the private sector are primarily financed through private health insurance plans offered by ARS or paid directly by patients. Reimbursement is typically based on pre-established tariffs or agreed-upon prices between the ARS and suppliers. These tariffs may vary depending on the type of product, its therapeutic use and the insurance plan's coverage.

For patients without insurance, pharmaceuticals and medical devices are paid for directly out of pocket based on the retail price set by pharmacies or medical equipment suppliers. In some cases, individuals may receive discounts or financing options through pharmacies or suppliers, but prices are generally set by the market, influenced by competition and the cost of products.

Patients with government insurance are regulated by the public standards set by SISALRIL and SENASA. The government also maintains a special budget for high-cost medicines, which is administered by MISPAS.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

The pricing of pharmaceuticals and medical devices is primarily influenced by a free pricing system where manufacturers and distributors set prices based on market dynamics. However, there is some price regulation and oversight by the government through the MISPAS and through DIGEMAPS. The government plays a role in regulating the pricing of pharmaceuticals and medical devices, especially those that are included in the public health system's list or are essential for broader public health needs. Certain essential drugs and medical devices may be subject to price controls or tariffs set to ensure affordability and access, particularly for the subsidised sector.

Negotiation between the government and the marketing authorisation holder of the product is common for public procurement, especially for large-volume purchases made by the government or through public health programmes.

Economic efficiency in the private sector is largely controlled through competition, where prices are influenced by market dynamics and supply-demand factors. For products included in public health programmes or those that are critical for public health, price controls and negotiations play a significant role in ensuring that the costs remain manageable while ensuring access to essential medical treatments.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

Litigation concerning healthcare financing and reimbursement in the Dominican Republic is not common, although we are starting to see some, particularly in cases where private healthcare services have been denied.

The public health system has not yet faced significant litigation regarding limits on funding, such as maximum spending per additional life year. However, challenges related to resource allocation and the provision of high-cost treatments have been observed.

While there is no record of important cases directly addressing emergency financing of hospitals or other service providers in financial distress, the financial struggles of public hospitals remain a persistent issue.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes or trends for healthcare financing and reimbursement, and briefly indicate how these may foreseeably affect the medical sector in the near future.

Dominican Social Security Law No 87-01, enacted in 2001, was originally designed to undergo periodic updates, but these modifications have not yet materialised. Discussions around modernising the system are increasingly focusing on expanding coverage, improving reimbursement mechanisms and addressing inefficiencies in fund distribution.

Advocacy groups and patients are pressuring the government and private insurers to ensure broader access to high-cost treatments and innovative treatments. This could lead to regulatory changes and increased investment in specialised healthcare services.

The adoption of digital health technologies is becoming a focal point for improving healthcare delivery and cost management. Innovations such as telemedicine, electronic health records and automated reimbursement systems are important trends in the Dominican Republic.

The healthcare sector is undergoing significant transformation, provided proposed reforms and innovations are successfully carried out.