

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 eyes view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Peru's healthcare system is decentralised, with responsibilities shared among national, regional, and local levels of government. The Ministry of Health, as the national health authority, sets policies, standards, and oversees the quality of healthcare services. Regional governments implement these policies at the regional level, managing health facilities and coordinating with local government. Local government provides primary healthcare services to their communities.

In addition, there is the *Superintendencia Nacional de Salud* (SUSALUD), which is a public entity that protects health rights and the quality of health services. It mainly supervises institutions that provide healthcare services (IPRESS) (mainly, hospitals) and institutions that administrate health insurance funds (IAFAS), such as EsSalud and EPS described below.

Regarding public healthcare insurance, the Social Security of Health (EsSalud) is a public institution that covers dependent workers and their families. Employers are responsible for enrolling their employees in EsSalud and paying the corresponding contributions. Additionally, certain self-employed EsSalud and other groups can voluntarily enrol in ESSALUD. Non-working citizens have access to the Seguro Integral de Salud (SIS), insurance for persons that have no other type of insurance.

Beyond EsSalud, there are private health insurance providers known as *Entidades Prestadoras de Salud* (EPS) in addition to private insurance companies, among others. These entities offer additional health coverage, often complementing the services provided by EsSalud. Employers can choose to provide their employees with coverage through an EPS, allowing for more flexibility and choice in healthcare options.

This decentralised model, with both public and private providers, aims to ensure access to healthcare for all Peruvians, while allowing for flexibility and adaptation to local needs.

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

Peru's legal framework for the financing and reimbursement of healthcare encompasses both public and private insurance. In general terms, the Unique Ordered Text of Law No 29344,

the Law for Universal Insurance (Universal Health Insurance Law), regulates universal access to healthcare for all residents in Peru. It is based on principles of universality, solidarity, and equity, among others, and determines that everyone should have access to the Essential Health Insurance Plan (PEAS). It also establishes the framework for IPRESS and IAFAS.

In addition, Law No. 29946 (Insurance Contract Law), along with other regulations, establishes the foundation for the private health insurance contracts, which must also follow rules set out by SUSALUD, as set out in regulations mentioned in the preceding paragraph, and related regulations.

Regarding mandatory public insurance, the Law No 26702, the General Law of the Financial and Insurance Systems and Organic Law of the Superintendency of Banking and Insurance (the SBS), aims to regulate, strengthen, and modernise Peru's financial and insurance systems. Its primary objective is to ensure system stability, solvency, and transparency while protecting public interests and fostering competition.

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

In Peru's insurance sector, the SBS is the primary entity responsible for regulation and supervision. This constitutionally autonomous institution's main role is to protect public interests and ensure the stability of the insurance system. The SBS operates under the General Law of the Financial and Insurance Systems and Organic Law of the Superintendency of Banking and Insurance (Law No 26702).

Health insurers, particularly those which are not insurance companies (such as hospitals that provide some form of insurance, among others) are supervised by SUSALUD. This entity can also deal with claims made by patients to insurers (or entities that provide some form of insurance) or medical institutions.

Furthermore, the National Institute for the Defence of Competition and Intellectual Property (Indecopi) also exercises oversight within the insurance sector. Indecopi is authorised to sanction anti-competitive practices, including the imposition of abusive clauses in insurance contracts.

In the healthcare field, the Ministry of Health (Minsa) plays an essential role in regulating and overseeing universal health insurance, establishing policies and standards to ensure access to medical care.

Unlike private insurance companies, EsSalud, as a public insurance entity, does not have an external regulator or supervisor in the strict sense. This is because EsSalud is a decentralised public agency attached to the Ministry of Labour and Employment Promotion, with technical, administrative, economic, financial, budgetary, and accounting autonomy, as established in Supreme Decree No 002-2004-TR.

Its internal governance is based on a Board of Directors and an Executive President responsible for its management and oversight. While EsSalud must comply with the general

regulations of the health social security system established by the Ministry of Health/Minsa and the SBS, it is not directly supervised by any external entity.

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

There have not been any changes regarding financing and reimbursement as a consequence of the Covid-19 pandemic.

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?

Peru's healthcare system is structured into two main systems: the public system, comprising the SIS and EsSalud; and the private system, comprising private insurance. Both systems coexist and provide coverage to the population, but they differ in access mechanisms and financing models.

In the public system, EsSalud provides coverage through a contributory scheme. Workers and their employers make mandatory contributions to EsSalud, granting them the right to access its healthcare services. EsSalud also extends coverage to the dependents of the insured, such as spouses, partners, and children. In addition to the contributory scheme, EsSalud offers other health plans, such as the Voluntary Insurance Plan, the Complementary Work Risk Insurance, and the Special Scheme for Independent Professional Drivers. As part of its mission, EsSalud implements social outreach programmes targeting vulnerable populations, such as people with disabilities, the elderly, and those without income. The SIS is intended to be easily accessible, and available to all residents who do not have other forms of health insurance.

The private system consists of private IAFAS (health service providers that provide insurance, insurance companies, etc), which offer private health plans. These plans can complement the Essential Health Insurance Plan (PEAS). The premiums for private health plans are determined in a free market, and in the case of insurance companies, are overseen by the SBS. Access to private healthcare services largely depends on the patient's ability to pay, either through private insurance or direct payment for services.

The conditions for admitting medical service and goods providers also vary between systems. In EsSalud, the recruitment of healthcare professionals and technicians is conducted through public merit-based competitions. EsSalud also has the authority to enter into contracts with public and private entities for the provision of healthcare services. In the private system, insurance companies, hospitals that provide insurance, and other private IAFAS, must be registered and authorised by the National Superintendency of Health Insurance/SUSALUD in order to operate. They are also required to comply with regulations established by SUSALUD regarding service quality, financial protection for policyholders, and timely care.

For medical goods providers, the commercialisation of medicines and other pharmaceutical products requires obtaining a Health Registry from the Health Authority. Companies involved in manufacturing, distributing, and dispensing medicines must implement a quality control system and are subject to oversight by the Health Authority.

It is important to emphasise that access to healthcare is a fundamental right in Peru. While the State has the responsibility to ensure medical care for the entire population, inequalities in healthcare access persist, particularly in rural areas and among vulnerable populations.

HEALTH INSURANCE FINANCING AND COVERAGE

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

EsSalud operates on a model of mandatory contributions from workers and their employers. These contributions are calculated as a percentage of a worker's salary and are collected and managed by EsSalud to fund healthcare services within the contributory system. EsSalud also benefits from other sources of income, such as reserves and returns on its financial investments, which allow it to generate additional revenue through the management of its resources in financial instruments. It also derives income from human risk insurance and health services provided to uninsured individuals, as well as from interest and fines levied on offending employers who fail to meet their payment obligations.

EsSalud offers various insurance schemes, including Regular Insurance, Voluntary Insurance, Complementary Work Risk Insurance, and the Special Scheme for Independent Professional Drivers. Each scheme has specific rules and procedures for determining premiums or contributions.

The private system operates under a free-market model. Insurance companies supervised by the SBS are also free to set the terms of their policies, rates, and commissions, although the SBS oversees these aspects to ensure transparency and consumer protection.

Premiums for private health plans are determined based on several factors, including the scope of coverage offered (plans with more extensive benefits have higher premiums), the age and gender of the insured (as health risks vary by demographic), and the insured's medical history, with pre-existing conditions potentially influencing premium costs. Administrative and operational expenses, as well as the private IAFAS profit margins, are also factored into premium pricing.

The SBS has the authority to approve the premiums and policy terms established by EPS and ensures that information about rates and commissions is publicly accessible. The private system allows users to choose plans that best align with their needs and financial capacity.

It is worth noting that the provided sources primarily focus on the financial regulation of health entities and do not detail the specific premium determination processes for EsSalud's schemes, or private IAFAS. For a more comprehensive understanding, it is advisable to consult the specific regulations governing each institution.

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

Coverage of medical services by health insurers in Peru is governed by the Universal Health Insurance Law, and by Law No 29946, the Insurance Contract Law, and regulations issued

by SUSALUD and the SBS. This framework seeks to balance insurers' freedom to define their policies with protection of policyholders' rights.

Under Article 27 of the Insurance Contract Law, insurers have the authority to determine the content of their policies, including coverage, exclusions, and other conditions, provided they meet the minimum information requirements outlined in Article 26. Article 9 allows insurers to set their rates and commissions freely, while Article 326 ensures that insurance policies and rates operate within a regime of free competition under the Insurance Contract Law.

Insurers must adhere to additional limitations to protect consumers:

- any restriction on the insured's activities must be explicitly stated in the policy;
- coverage, exclusions, risk extension, and beneficiary rights must be interpreted literally;
- policies must uphold good faith and balance the rights of all parties;
- pre-existing conditions must be covered to the extent specified in the original or prior contract, with insurers allowed to apply surcharges for such coverage;
- insurers must comply with consumer protection regulations, which may limit exclusions or coverage restrictions.

Peruvian Regulations do not differentiate between coverage for in-person consultations and telemedicine. However, Law No 30421, the Telesalud Framework Law, and Legislative Decree No 1490, which strengthens telehealth provisions, establish the legal framework for telemedicine in Peru. Article 10 of Legislative Decree No 1490 mandates that IAFAS (healthcare financing entities) fund telehealth services, implying that telemedicine should be included in health insurance plans.

HOSPITAL SECTOR

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

Peruvian regulations do not specifically regulate the way in which insurance companies finance or reimburse services provided by inpatient and outpatient hospitals.

In terms of reimbursement, the most common method in public hospitals is fee-for-service, where providers are paid for each procedure performed. However, capitation and performance-based payment models, which remunerate providers based on the quality and efficiency of care, are being implemented.

The private sector is financed primarily through private health insurance purchased by individuals or companies. Direct payments from patients are also common, especially among the uninsured.

Reimbursement in the private sector is based primarily on fee-for-service, where patients pay for each procedure. Private health insurers typically reimburse providers for services rendered to their members.

The Peruvian healthcare system faces a number of challenges, such as unequal access to quality services, underfunding of the public sector, the high cost of the private system, and fragmentation of the system. To address these problems, the Peruvian government has implemented several reforms, including investment in infrastructure and human resources in the public sector, expansion of health insurance coverage, and implementation of pay-for-performance mechanisms.

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

While there are some regulations regarding pricing in medicine, this does not apply to services provided in private insurance.

Pricing in the public sector is set in the relevant regulations.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

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

Fee for service is most commonly used in the public sector.

In the private sector, patients pay a pre-determined amount (a deductible) and are financed through the corresponding insurance company.

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

Fee for service is most commonly used in the public sector.

In the private sector, patients pay a deductible and are financed through the corresponding insurance company.

PHARMACEUTICALS AND MEDICAL DEVICES

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

Fee for service is most commonly used in the public sector.

Healthcare facilities under the Ministry of Health provide comprehensive services (including the delivery of pharmaceutical products and medical devices) fully financed by the State.

Specifically, the National Cancer Law (Law 31336 and Supreme Decree 004-2022-SA) states that healthcare facilities providing oncological care prioritise the acquisition of pharmaceutical products, including chemical synthesis drugs, biologics, medical devices, or other supplies prescribed by specialist doctors. In the case of healthcare facilities under the Ministry of Health, the acquisition of these products is fully financed by the State.

For healthcare facilities under the Ministry of Health, products intended for the treatment of rare or orphan diseases (Law 31738) follow special internal procedures to approve the acquisition of products fully financed by the public sector.

In the private sector, patients pay a deductible and are financed through the corresponding insurance company.

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

Fee for service is most commonly used in the public sector.

In the private sector, patients pay a deductible and are financed through the corresponding insurance company.

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.

A recurring issue is coverage denial by insurers. Resolution 0265-2024/SPC-INDECOPI addresses a case where an insurance company denied coverage for total, permanent, and definitive disability due to an illness. The litigation focused on the interpretation of the insurance contract clauses and whether the insured's condition qualified for coverage. In another case, Resolution 2279-2023/SPC-INDECOPI (File 0149-2022/CPC-INDECOPI-LAL) involved the denial of family protection insurance coverage because the insured person had a pre-existing condition (hypertension) at the time of purchase, which constituted an exclusion under the policy terms.

Another point of conflict arises from abusive clauses in insurance contracts. Resolution 0963-2023/SPC-INDECOPI (File 0060-2022/CPC-INDECOPI-AQP) mentions SUSALUD's authority to identify such clauses but excludes insurance policies regulated by the SBS.

Inaccurate statements by policyholders can also trigger disputes. Resolution 1244-2024/SPC-INDECOPI (File 0307-2022/CPC-INDECOPI-LAL) describes the case of Mr Aldave, who was denied coverage under a loan insurance policy due to failure to disclose prior medical treatments in his Personal Health Declaration. This was deemed an inaccurate statement, invalidating the coverage.

The obligation of employers to reimburse EsSalud for unpaid contributions is another focal point of litigation. Resolution 0177-2024/SEL-INDECOPI (File 000085-2023/CEB) analyses a case where a company challenged EsSalud's reimbursement request for healthcare services provided to its workers. The controversy centred on the legality of the deadline for rectifying electronic payroll records as a condition for EsSalud to assume the cost of services.

Similarly, disputes arise over the reimbursement of maternity or temporary disability subsidies, particularly regarding the timeframe for filing claims. Resolution 0401-2024/SEL-

INDECOPI (File 000066-2023/CEB) reports a case where a company filed a complaint against EsSalud for requiring that maternity subsidy reimbursement claims be submitted within a maximum of six months. The company argued that this timeframe was not stipulated by law.

Lastly, in insolvency proceedings, the order of priority for payments owed to EsSalud is a source of debate. Resolution 0394-2024/SCO-INDECOPI (File 67-2023/CCO-INDECOPI-02-02) examines the application of Article 42.1 of the General Insolvency System Law, which establishes a priority order that includes debts owed to EsSalud.

In conclusion, the provided sources illustrate the complexity of relationships between insurers, EsSalud, employers, and policyholders in the context of healthcare financing and reimbursement. INDECOPI's resolutions, such as those mentioned above, set critical precedents for consumer protection and the interpretation of applicable legislation.

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.

A main trend is likely to relate to infrastructure. Although technically most Peruvians are insured under some healthcare scheme or other, true access to healthcare is complex and burdensome. We are seeing greater interest from the private sector in investing in insurance, and in the building of public hospitals to meet healthcare needs.

In addition, public providers have limited autonomy and incentives to enhance efficiency and the quality of care. We hope to see a shift in this, to ensure focus on results, although ongoing discussions in the legislative regarding the inefficiency of public health insurance, controlled mostly by EsSalud is at a standstill.