

| 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). |
| <p>In Costa Rica, the healthcare system is composed of both public and private institutions, aiming to improve the wellbeing of the population. The country's Constitution links the right to health with the right to life, and the 1973 General Health Law establishes that health is a public good, making it the state's responsibility to ensure its protection through the healthcare system, which includes medical services, water and sanitation.</p> <p>The main public institution is the Costa Rican Social Security Fund (Caja Costarricense de Seguro Social or CCSS), which is responsible for financing, acquiring and providing health services to the population. The state, through the CCSS, ensures the provision of healthcare services to the majority of the population through a system of mandatory insurance, with a strong focus on health promotion and disease prevention. Additionally, it regulates the healthcare system to ensure quality, safety and access.</p> <p>The CCSS is financed through mandatory contributions from affiliates, employers and the state, and manages three types of insurance: health and maternity, disability, old age and death, and a non-contributory regime.</p> <p>The private sector in Costa Rica includes a diverse network of providers offering specialised and outpatient medical services funded through direct payments or private insurance. The relationship between the public and private sectors is complementary, with the public system covering the majority of the population and the private sector offering alternatives for those seeking faster or more specialised services. However, the public system faces financial and sustainability challenges, which have led to the increased participation of the private sector to alleviate pressure on public system resources.</p> <p>The Ministry of Health is responsible for regulating health policies, supervising services and healthcare products, and promoting research and technological development in this field. It also oversees institutions such as the Centers for Education and Nutrition (Centros de Educación y Nutrición or CEN) and the Institute on Alcoholism and Drug Dependence (Instituto sobre Alcoholismo y Farmacodependencia or IAFA).</p> <p>The National Insurance Institute covers occupational and traffic-related risks, and provides related care. In terms of coverage, Costa Rica has made significant progress, reaching 94.4 per cent of its population under various health insurance regimes.</p> <p>Overall, the government plays a fundamental role in public healthcare, primarily through the</p> |

CCSS, which handles most of the financing and service provision. The private sector complements these services by offering additional healthcare options funded independently. The Ministry of Health supervises the overall functioning of the system and promotes the improvement of public health.

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

In Costa Rica, the financing and reimbursement of healthcare are regulated by a legal framework that encompasses national and sector-specific laws and regulations. This framework focuses on the provision of healthcare services through the CCSS, the public system and private actors that complement or provide additional services.

The legal framework related to healthcare financing and reimbursement in Costa Rica is predominantly public, although there are laws that allow private sector participation in the provision of health services. The main laws and regulations include:

- Law No 17 of the Costa Rican Social Security Fund (1941): This law established the CCSS, which is responsible for managing the country's public healthcare system. The CCSS provides medical and hospital care through social security, covering most workers and their dependents in both the public and private sectors. It also regulates financing through mandatory contributions from workers and employers.
- Law No 5395 General Health Law (1983): This law established the regulatory framework for public health in Costa Rica. It organises the country's health policies. While it focuses on regulating the health system, it also sets guidelines for medical care and services provided by both public and private entities.
- Law No 8634 Development Banking System Law: Although not directly linked to healthcare, this law provides the framework for financing infrastructure and health projects using public resources.
- Regulatory Law of the Insurance Market (Law No 8653): This law regulates the activities of private insurers operating in Costa Rica, establishing the conditions under which they can offer health products.

In Costa Rica, negotiations between healthcare providers and payers (mainly the CCSS and private insurers) are essential to the financing and reimbursement system. These include the following:

- The CCSS establishes contracts and agreements with hospitals and clinics, both public and private, to regulate prices and reimbursements for medical services. It also turns to private providers when public resources are insufficient or waiting times are excessive.
- Private insurers negotiate with healthcare providers to offer services that complement the public system, regulating fees, reimbursements and specialised coverage.
- Associations such as CAMESE and the Costa Rican Association of Insurers actively participate in these negotiations, influencing policies and agreements among regulators, insurers and healthcare providers.

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

and reimbursement?

In Costa Rica, the main regulatory and supervisory body for healthcare financing and reimbursement is the CCSS. This institution, created in 1941, is mandated to ensure universal health coverage through a tripartite financing model, with contributions from employers, workers and the state.

Additionally, the governance and supervision of the healthcare system also involve the Ministry of Health, which is responsible for establishing health policies and monitoring the quality and accessibility of services.

Furthermore, the courts play an important role in resolving disputes and interpreting regulations related to the healthcare system. Below is a detailed analysis of the main regulatory and supervisory entities in this area.

The central government has several agencies and entities responsible for regulating, supervising and managing the financing and reimbursement of healthcare services. These are some of the most relevant:

CCSS

CCSS is the main entity responsible for the provision and financing of medical care in the public healthcare system. Through social security, it manages financing through contributions from workers, employers and the state. It also supervises the provision of services in both public and private hospitals and clinics, regarding payments and reimbursements. The CCSS regulates the conditions under which public and private healthcare providers can receive payments for services rendered to affiliates of the public healthcare system. Through its regulations, it establishes how reimbursement processes should be for private providers contracted to deliver additional services when the public system cannot meet the entire demand.

Superintendence of Insurance (Superintendencia General de Seguros or SUGESE)

SUGESE is the entity responsible for the authorization, regulation and supervision of insurance products.

Specialised bodies and industry organisations

There are also specialised bodies and industry organisations that play an important role in the indirect regulation and supervision of healthcare in Costa Rica.

Superintendency of Pensions (SUPEN)

SUPEN supervises certain aspects related to health insurance linked to private pension plans. The regulation of these plans has implications for the financing of healthcare, especially for individuals who are affiliated with private pension and health funds.

Consejo Nacional de Supervisión del Sistema Financiero (CONASSIF)

CONASSIF has an indirect impact on the regulation of health insurers and other financial actors involved in healthcare, especially concerning the solvency and financial transparency of insurance companies.

Courts

The courts play an important role in the interpretation of laws related to the healthcare

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| system, financing and reimbursement of medical services. |
| 4. Has there been a change to healthcare financing and reimbursement as a consequence of the Covid-19 pandemic? |
| <p>The Covid-19 pandemic caused significant changes in the financing and reimbursement of healthcare in Costa Rica, impacting both the public and private sectors.</p> <p>Public sector</p> <p>The following occurred in the public sector:</p> <ul style="list-style-type: none">• increase in public healthcare spending to strengthen the health response, with more funding directed to hospitals, public clinics and the CCSS;• implementation of rapid financing mechanisms and contracting of private services to address the growing demand;• greater investment in medical equipment and vaccines, prioritising flexibility and speed in reimbursement and payment processes;• promotion of digital technologies such as telemedicine, ensuring continuity of essential services and expanding access to vulnerable populations; and• strengthening of supply chains to ensure medications and home services, especially for chronic patients. <p>Private sector</p> <p>The following occurred in the private sector:</p> <ul style="list-style-type: none">• adjustment of prices and rates for services related to Covid-19, such as diagnostic tests and hospitalisation;• insurers expanded coverage, offered more flexible payment plans and streamlined reimbursement agreements with private providers; and• collaboration with the public sector and adoption of more agile models to address the health emergency. <p>Both sectors adopted innovative and collaborative measures to respond to the health crisis, strengthening the system's capacity to handle emergencies and ensure access to essential services.</p> |
| 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? |
| <p>Access to the healthcare system in Costa Rica, both for patients and providers, is governed by specific regulations that vary between the public and private sectors, and according to the particular circumstances. The main points are as follows:</p> <p>Patient access to healthcare and medications</p> <p><i>Public healthcare system (CCSS)</i></p> |

- Universal access: All residents have the right to healthcare services if they are enrolled in social security, which covers subsidised essential medications.
- Limitations: There are restrictions on non-essential medications, prioritisation based on the severity of the illness and availability issues due to limited resources.

Private healthcare system

The private healthcare system provides access to a wider variety of medications, but the costs are higher and depend on private insurance or direct payment.

Access of healthcare providers to funding and reimbursements

Public providers deal with the following:

- receive direct funding from the CCSS through contributions to social security, without the need to compete for resources; and
- reimbursements to private providers contracted by the CCSS are subject to contracts and pre-established rates.

Private providers deal with the following:

- can receive public funding through agreements with the CCSS to treat insured patients; and
- depend on direct payments or agreements with private insurers, who set the requirements and rates.

Special cases: treatment of non-residents

Medical emergencies

- Everyone is entitled to medical care in emergency cases, regardless of their immigration status, although they must pay later according to CCSS rates.
- Costs for non-residents can be high, encouraging the use of international insurance or private services.

Non-urgent care

Temporary residents and foreigners without CCSS affiliation can only access the public system by paying specific fees or by using private services, depending on their insurance. The system seeks to guarantee basic universal care in the public sector, complemented by broader options in the private sector, with significant differences in costs and accessibility.

HEALTH INSURANCE FINANCING AND COVERAGE

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

The healthcare system in Costa Rica is mainly sustained through a tripartite contribution

scheme involving the state, workers and employers:

- Employers contribute 14.16 per cent of their employees' salary, with 9.25 per cent allocated to the Health and Maternity Insurance (Seguro de Enfermedad y Maternidad or SEM) and 4.91 per cent to Invalidity, Old Age and Death Insurance (Régimen de Invalidez, Vejez y Muerte or IVM).
- Workers contribute 8.25 per cent of their salary, with 5.50 per cent for SEM and 2.75 per cent for IVM.

Additionally, the system is financed through government transfers, capital income and additional sources. The healthcare system has an extensive network of institutions that ensures coverage for the entire population.

Health insurance companies in Costa Rica are mainly financed through premiums paid by their policyholders. These premiums vary based on the terms of the contract, medical underwriting and characteristics of the insured, such as age, gender and associated risks. Furthermore, some private insurers benefit from implicit government subsidies that, although not always explicit, favour their financing.

Premiums in private insurance are freely determined by insurers, based on free-market principles. This approach allows premiums to be adjusted according to risk profiles and contract conditions, offering not only flexibility but also limiting access for lower-income groups or those with higher health risks.

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 regulation of healthcare service coverage in Costa Rica by insurers is based on a regulatory framework that establishes requirements to ensure quality and safety in both public and private services. During the pandemic, telemedicine was promoted, although its access was affected by technological inequalities. The coverage of in-person consultations and telemedicine depends on the conditions of each insurance policy, with in-person consultations being more common in standard policies, while telemedicine continues to establish itself as an alternative.

Insurers have the freedom to define coverage, include limitations, and offer broader plans, while the government, through SUGESE and the Ministry of Health, regulates minimum standards and oversees rates to protect consumers. The government also promotes complementary plans to the public insurance of CCSS. In special cases, such as telemedicine and orphan drugs, insurers have the freedom to decide their inclusion, and in off-label treatments, they may exclude them if there is insufficient scientific evidence. This system aims to balance market flexibility with consumer protection.

| HOSPITAL SECTOR |
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| 8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed? |
| <p>In Costa Rica, according to the General Regulations of National Hospitals, hospital services are financed and reimbursed as follows:</p> <ul style="list-style-type: none">• Patient classification: Patients are divided into free-of-charge (homeless individuals), contributors (those who pay fully or partially), pensioners (those who pay for services in special areas) and those covered by entities such as the CCSS, National Insurance Institute (Instituto Nacional de Seguros or INS) or other entities with specific contracts.• Basis for reimbursements: Reimbursement contracts between hospitals and insurers, such as CCSS or INS, are based on the actual operating costs of the hospitals. If these costs are not available, average costs are used.• Exceptions and fees: In emergency situations, services at facilities without a contract are charged according to the usual fees of the hospital providing the care. |
| 9. How are the prices of such services determined? How is economic efficiency controlled? |
| <p>The prices of hospital services must reflect the actual costs of the facility, and if specific costs are not available, averages based on similar institutions are used. Economic efficiency is monitored through the economic and technical oversight of the General Directorate of Medical-Social Assistance, which has the authority to reduce or withhold funds from state hospitals that fail to comply with regulations. This system ensures the oversight and regulation of financial resources for hospital care, ensuring that services are sustainable and comply with established standards.</p> <p>Insurance companies' and hospitals' associations play a crucial role in negotiating fees and controlling the quality of services.</p> <p>Economic efficiency is controlled in the public sector through the allocation of budgets and production goals, while in the private sector, competition and fee negotiations are used, as well as payment models based on packages or diagnoses to optimise resources and control costs.</p> |
| HEALTHCARE PROVIDERS IN PRIVATE PRACTICE |
| 10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed? |
| <p>In Costa Rica, healthcare providers in private practice (doctors, therapists, laboratories and other providers) are financed and reimbursed through a combination of free pricing, negotiations with insurers and pay-per-service. The system varies depending on whether the service is contracted by direct-pay patients or by private insurers. Below are the most common methods of financing and reimbursement, highlighting whether the prices are fixed</p> |

or individualised and the government's involvement in financing.

Fixed price/flat by treatment category/indication (package payment)

Some medical services in private practice are financed under a package payment model. This model involves negotiating the price for a specific treatment or a set of services related to a diagnosis between the provider (doctor, therapist, hospital or laboratory) and the insurer or patient in advance.

The following exist in this system:

- **Package payment:** A fixed price is established for the set of procedures or services that are offered under a specific treatment. For example, a surgery may have a pre-established cost covering all preoperative consultations, the surgical procedure itself and postoperative follow-up.
- **Negotiation with insurers:** In many cases, hospitals and other private healthcare providers negotiate with insurers fixed or predefined rates for service packages, which facilitates reimbursement for services within health insurance contracts. These packages may be designed for more complex procedures or treatments involving multiple medical services (surgeries, prolonged treatments etc).

Individualised/specified prices (pay-per-service)

In many other cases, medical service providers in private practice in Costa Rica use the pay-per-service model, which means the prices are individualised and determined by the type of specific service or consultation provided. This model applies especially to medical consultations, outpatient treatments and diagnostic tests;

- **Individual prices:** In the pay-per-service model, each medical consultation, laboratory exam or treatment has a specific price, depending on the type of test or diagnosis performed and the geographical location of the provider. For example, a consultation with a general practitioner has a different cost to a consultation with a specialist.
- **Reimbursements through private insurance:** Private insurers offering health coverage in Costa Rica reimburse patients or healthcare providers based on the specified rates for each service. In some cases, insurers set fixed rates or price ranges for certain consultations or procedures, and healthcare providers adhere to these limits.

Government contribution/financing

The government of Costa Rica does not directly finance medical care in private practice, but it does play an indirect role in regulating and controlling the overall healthcare system. The government, through institutions like SUGESE, sets regulations for the insurance sector and monitors that private insurers offer adequate coverage and do not impose excessive prices on patients:

- **Public social insurance (CCSS):** Although the CCSS, which operates public health

services, does not directly finance private providers, some patients who cannot be treated within the public system may seek care in the private sector, where costs vary based on the payment model described above.

- Public financing through private health insurance: The government plays a role in regulating the prices of private health insurance (through SUGESE), establishing a legal framework that seeks to balance premium rates and service fees between private providers and insurers.

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

In Costa Rica, the prices of medical services in private practice (doctors, therapists laboratories etc) are determined by a combination of free pricing and negotiations between healthcare providers and private insurers, with indirect government control. Below is a detailed explanation of how these prices are determined and how economic efficiency is controlled in this context:

Free prices and price setting by the government

Free prices

In Costa Rica's private healthcare sector, medical service providers (doctors, clinics, hospitals and laboratories) are free to set the prices for the services they offer. This means that each private establishment can determine its rates according to various factors, such as medical specialisation, treatment complexity, provider prestige and the operational costs of the facility. For example, the price of a medical consultation with a general practitioner or a specialist may vary depending on the location and conditions of the service.

Price setting by the government

The government of Costa Rica does not directly regulate the prices of private medical services, but it does establish some indirect regulations through SUGESE, which oversees the rates of private health insurance. Additionally, the government sets regulations regarding the minimum coverage that health insurers must offer, which can indirectly influence costs. However, prices for individual medical services remain largely free in the private sector.

Negotiation between the government/insurer and service providers

Although the government does not set prices in the private sector, there are negotiation mechanisms that influence the prices that patients and private insurers must pay.

Negotiation with private insurers

Private insurers play a key role in price setting in private healthcare practice. Insurers negotiate directly with healthcare providers to establish rates and prices for the services they cover. In this context, healthcare providers (eg, doctors and hospitals) agree with insurers on fixed rates or discounts for services or treatment packages for their insured patients.

Insurers can negotiate lower prices for medical services due to economies of scale and

competition among providers. This negotiation process helps to establish a balance between the rates that service providers are willing to accept and the prices that insurers consider reasonable to cover. These negotiated rates are then reimbursed to healthcare providers when an insured patient receives care under a private insurance policy.

Role of associations (insurers and service providers)

Insurer associations

Insurers in Costa Rica are represented by the Costa Rican Health Insurance Association (ACASS), which plays a key role in negotiating rates with healthcare providers. These associations help to define the terms of contracts between insurers and hospitals, clinics or individual doctors. Through these negotiations, agreements are made regarding service prices, coverage and reimbursement procedures. They also promote service quality and the sustainability of the private healthcare system.

Definition of rates

The definition of rates in the private sector in Costa Rica is determined by the College of Physicians and Surgeons of Costa Rica. However, within the price range, several factors influence the definition of rates and flexibility is key in this context.

- **Individualised prices:** Most medical services in private practice are priced individually. This means that the cost of a medical consultation, procedure or specific treatment is determined by the provider based on its specialisation, the complexity of the treatment and the type of service offered. Geographic location may also influence prices, as those in urban areas or in higher-prestige hospitals tend to be more expensive.
- **Market influences:** Although rates are determined by the College of Physicians and Surgeons of Costa Rica, the private market and competition among hospitals, clinics and doctors influence rate definitions. Healthcare providers adjust their prices to remain competitive within a dynamic market but must also take into account their patients' economic capacity and the pre-established rates by insurers.

PHARMACEUTICALS AND MEDICAL DEVICES

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

In Costa Rica, the financing and reimbursement of pharmaceuticals and medical devices are organised as follows:

- **Financing:** The CCSS acquires pharmaceuticals and medical devices through public procurement processes regulated by the Regulations for the Purchase of Medical-Surgical Equipment, Medicines and Others.
- **Reimbursement:** Reimbursement is established according to the policies of the CCSS

and the General Health Law, taking into account safety, cost-effectiveness and quality criteria.

Additionally, the financing and reimbursement of pharmaceuticals and medical devices are carried out through various mechanisms, including public health insurance, private health insurance and out-of-pocket payments by patients. Below are the ways in which these products are financed and reimbursed:

- Public system (CCSS): The CCSS covers a large portion of essential pharmaceuticals and medical devices within its care network, with a rigorous process for accessing orphan drugs or products with early access.
- Private insurance: Private insurers cover pharmaceuticals and medical devices, but patients must make additional payments if the products are not fully covered. Coverage for orphan drugs or products with early access is more limited and subject to special authorisations.
- Out-of-pocket: Patients who do not have insurance or are not covered by their policies must pay directly for the pharmaceuticals or medical devices they need.

This mixed financing model ensures that the majority of the population has access to pharmaceuticals and medical devices, but it also presents challenges in terms of full coverage and access to innovative or rare treatments.

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

The determination of prices for pharmaceuticals and medical devices in Costa Rica is based on costs approved by the Ministry of Health, with evaluations of cost-utility, cost-benefit and cost-effectiveness. The Costa Rican Agency for Quality and Excellence in Health (Accesa) also recommends prices based on added value. Regarding economic efficiency control, Accesa, along with the CCSS and other entities, conducts continuous evaluations of health technologies to optimise health expenditures, prioritising products of higher clinical and economic value. Furthermore, it monitors reimbursement conditions and rates through a budgetary impact analysis, ensuring a sustainable and equitable use of resources allocated to health.

Additionally, the prices of pharmaceuticals and medical devices are determined through a mixed system involving both the public and private sectors.

Prices of pharmaceuticals and medical devices

- Public sector (CCSS): The prices for pharmaceuticals and medical devices are negotiated by the CCSS, which acquires these products through public tender processes. Prices are lower due to large-volume purchases and centralised procurement. The CCSS defines a list of essential medications and covered devices.
- Private sector: Prices are more flexible, with suppliers of pharmaceuticals and medical devices setting prices based on import costs, demand and competition. Private

insurers also negotiate prices with suppliers.

Economic efficiency control

- Public sector: Control is carried out through a system of transparent tenders and centralised purchases, allowing for the procurement of products at competitive prices. The CCSS also establishes rationalisation and prioritisation policies for medications and devices, ensuring that only necessary products are purchased.
- Private sector: Competition between providers and regulation by the SUGESE helps control costs. Private insurers seek to optimise costs through negotiation with suppliers and the management of efficient product portfolios.

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.

In Costa Rica, legal conflicts related to the financing and reimbursement of healthcare are typically addressed in three main areas:

Restrictions in public/compulsory health insurance financing

There are cases where patients file lawsuits against the CCSS due to denial or limitation of coverage for expensive medical treatments, especially when the annual spending limit is exceeded or when long-term high-cost procedures are excluded. These litigations often involve the interpretation of coverage policies and the limits set within the public health system.

Emergency funding for hospitals and providers with financial difficulties

Some hospitals and healthcare providers, both public and private, have faced financial issues, leading to lawsuits for obtaining urgent funding to ensure the continuity of services. In these cases, courts may intervene to ensure that the public or private system covers the necessary expenses to maintain the operability of healthcare centres.

Access to orphan drugs and early access products

Another common issue in litigation is access to orphan drugs or early access products. Patients who require expensive medications to treat rare diseases or in experimental phases often take legal action to gain access to these treatments, either through the public healthcare system or private insurance. These cases may involve the denial of coverage or the exclusion of certain treatments from approved medication lists.

In conclusion, lawsuits in Costa Rica related to healthcare are focused on disputes over the coverage limits of public insurance, emergency funding in hospitals, and access to medications and specialised medical treatments.

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.

In Costa Rica, recent developments and trends in the financing and reimbursement of healthcare indicate a series of changes that could affect the medical sector in the coming years. The following outlines the pending issues, proposed changes and key trends:

The Health Insurance Regulations of the CCSS were reformed in November 2024. The most important modifications are:

- new paid leave types are added (Special Leave, Terminal Phase Leave, Severely Ill Minor Leave and Extraordinary Leave);
- aspects related to the timing of subsidy payments, leave or financial assistance, as well as the procedures for processing them in person or through a third party, were reformed;
- changes in the calculation method for sickness subsidies;
- financial assistance is calculated based on the last 12 reported salaries, excluding disability or leave periods;
- new procedure for investigating doubts regarding the wages earned by a worker;
- multiple births extend maternity leave by one month for each child born;
- paternity leave is granted in cases of the adoption of minors; and
- formulas for calculating maternity and paternity leave.

Regarding the new types of leave, the following definitions are established:

- special leave: a period established by law, granted to the worker for the proper exercise of paternity and maternity in the following situations: birth of the child, legal adoption and death of the mother;
- terminal phase leave: granted to an active salaried insured person for the care of someone in the terminal phase of a disease;
- severely ill minor leave: granted to an active salaried insured person for the care of a minor in a critical condition; and
- extraordinary leave: granted to an active salaried insured person for the care of a dependent person up to 25 years old, in the event of a special or exceptional health condition.

In Costa Rica, lawsuits related to access to orphan drugs are being carried out, where the coverage of specialised treatments is being debated, and the rulings could set precedents

regarding the responsibility of the public and private healthcare systems in terms of unconventional medications. Additionally, there are disputes over the limits of public insurance coverage, especially concerning the annual spending cap and limited coverage, which could influence the state's responsibility to ensure access to high-cost treatments and lead to legislative changes to expand coverage or improve the system's sustainability.

An increase in public health spending is expected due to chronic diseases and an aging population, which could create pressure to redistribute funds and prioritise treatments in the public system. At the same time, private sector growth is anticipated, driven by the increasing demand for private insurance and medical services, which could affect the balance between public and private payers. Additionally, new payment models, such as pay-for-performance or integrated care packages, could be implemented, especially in the private sector, to improve economic efficiency and control costs.