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FINAL REPORT BY THE EXPERT

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Full official name of the advised entity: DKMT Euroregion

Name of the expert contracted for the advice case: Health Connect Partners (subject matter experts: Petra Wilson and Anett Molnar)

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1. Executive summary

The collaboration in the DKMT region on the Hungarian–Romanian–Serbian border started over 25 years ago, with the objective of broadening relationships among local communities as well as to help the region in the process of the European integration. As both Hungary and Romania are now members of the EU and Serbia is a candidate country, they all benefit from various EU funds to facilitate interregional projects within different policy domains. However, EU laws for cross-border healthcare are applicable in Hungary and in Romania only and international agreements govern the relationships with Serbia. The DKMT Euroregion's ambition to pilot a regional health insurance card would be a first of its kind covering an area that is partially beyond the external borders of the EU.

The present report addresses the obstacle that patients in the DKMT region are not always seen in the nearest healthcare institution, which may be on the other side of the border. Despite the fact the Directive on Patient's Rights in Cross Border Healthcare (2011/24/EC) and the Regulations on Coordination on Social Security Systems (883/2004 and 987/2009) afford EU citizens the right to access care in other EU countries and within certain limits to have such care reimbursed, this region demonstrates that it is often difficult for people to take full advantage of these rights, and that there is a need for stakeholder collaboration to develop new solutions to meet these local needs.

The analysis of the legal landscape covers two aspects:
- The EU and international legal instruments applicable among the participating countries
- Complementing national laws

Based on the routes that are available for insured citizens to seek cross-border healthcare services and be reimbursed for treatments (unplanned urgent care, planned care, healthcare services for frontier workers and retired persons), the report lists applicable laws as well as statistical data to illustrate the complexity and challenges of cross-border healthcare insurance in DKMT region.

The report then sets out possible legal solutions to be considered and customised for the rolling out of a DKMT regional health insurance card. The findings are based on best practices and lessons learnt from other European cross-border projects and emphasise that 'one size fits it all' solutions do not work in interregional healthcare collaborations under different jurisdictions. The layers of collaborative actions involve:

- Agreements at various level of the administration to address cross-border healthcare needs in the region;
- Learning from existing cross-border health insurance cards and information tool projects;
- Customising reimbursements to meet the specific needs;
- Integrate future-proof digital health solutions into cross-border healthcare provisions.

To conclude, the establishment of a multilateral agreement among the state departments of Hungary, Romania and Serbia is suggested to adopt special procedures applicable for a designated geographical area to allow locally involved insurers and healthcare providers to implement a system whereby the basket of care, the reimbursement procedures as well as the tariffs are customised for the DKMT Euroregion.

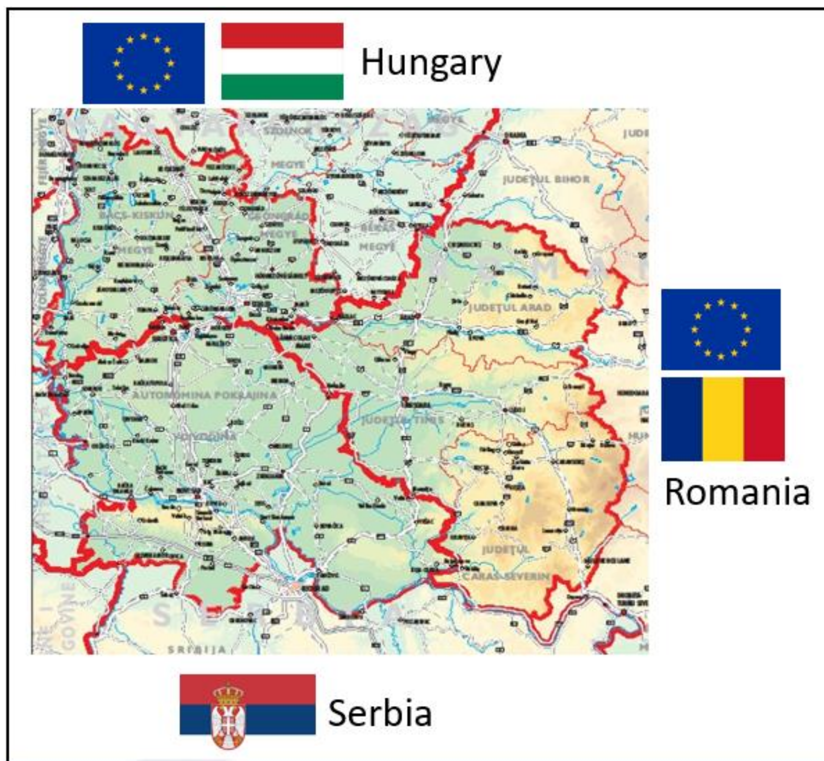
The implementation of the Directive could allow for such flexibility as it does not prevent reimbursement of cost beyond what is required as a minimum, including reimbursement in full and covering extra costs for accommodation or travel across the border. In line with the requirement that Member States shall facilitate cooperation in cross-border healthcare provision at regional and local level, granting additional entitlement for healthcare services for a certain group of people living close to the border would be possible. Serbia could align itself with such a commitment by joining a new multilateral agreement while maintaining the existing international agreements with Hungary and Romania. Adjusting national laws and processes may be necessary in all three participating countries depending on how ambitious the scope of the pilot would be.

A new regional health insurance card based system in the DKMT region could indeed help patients to exercise their rights more easily, especially if it were coupled with digital solutions. Such a system, which would complement access to urgent care accessible through the existing European Health Insurance Card (EHIC), would afford patients living in the border region access to care in locations more suitable to their needs, which could in turn have a positive impact on health in the region, potentially alleviating strain on both patients and the healthcare system created by the financial and time costs of travelling to care providers who are in the same country as the patient, but geographically distant.

2. Background information on the DKMT Euroregion

The DKMT Euroregion is named after four rivers - Danube, Kris, Mures and Tisa - running through its territory in Hungary, Romania and Serbia. It covers an area of approx. 60 thousand km^2 with a population of 4 million in the Carpathian Basin in Central and Eastern Europe. The region is predominantly rural with the largest towns, which have small populations of between 150000–250000 people, serving as regional centres. The national capitals are at least 2 hours' drive from the border, with Bucharest in Romania being the furthest at about 7 hours.

Figure 1: DKMT Euroregion



DKMT Euroregion brings together EU Member States - Hungary and Romania - and Serbia, an EU candidate country which qualifies for Instrument for Pre-accession Assistance (IPA) funding.

It covers:

- three Romanian counties (Arad, Caras-Severin, Timis),
- two Hungarian counties (Bács-Kiskun, Csongrád),
- and the Serbian Vojvodina Autonomous Province.

There is no border-free travel within the Euroregion. Although it includes an internal EU border between Hungary and Romania, Romania is not part of the Schengen Area yet.

The border between Hungary and Serbia as well as between Romania and Serbia are external borders of the EU.

The DKMT Regional Cooperation – currently known as DKMT Euroregion - was founded on 21 November 1997 with the objective to develop and broaden relationships among local communities and local governments in the field of economy, education, culture, science and sports, as well as to help the region to join the process of the European integration. The different bodies of the Euroregion, namely the General Assembly, the Secretariat, the Development Agency and the Working Groups, all play major role in coordinating, implementing and participating in inter-regional development projects and ultimately, they help to strengthen the European way of thinking and collaboration within and beyond the borders of the DKMT.

The regional collaboration proactively paved the way for successful projects in the past, such as the railway link between Szeged (Hungary) and Subotica (Serbia) with the support of Interreg IPA funding, where the collaboration made the case for a unique interregional solution linking Szeged (Hungary) with Subotica (Serbia) and to be continued from Subotica to the other direction to Bácsalmás (Hungary) and Baja (Hungary). The DKMT Euroregion was also engaged in Interreg projects in the healthcare domain, collaborating with University of Maastricht in the 2007 – 2013 programming period to learn about health insurance best practices in border regions as well as taking part in several bilateral projects between Hungarian and Romanian healthcare providers.

3. Description of the Obstacle

This section describes the obstacles challenges that the DKMT Euroregion is currently facing in relation to strengthening the collaboration among healthcare insurers to facilitate local citizens in accessing cross-border healthcare services. It also provides a detailed description of the EU legislative framework, as well as national laws, and sets out data illustrating current patient flows among the three participating countries.

3.1 Overview of the legal challenges

The number of medical doctors relative to population size, as well as the percentage of the population living within 15 minutes' drive from a hospital, are below the EU average across much of the DKMT Euroregion.[1] In interviews, stakeholders confirmed that accessing care and receiving adequate treatment in a timely manner can be challenging for citizens living close to the border, as many local healthcare providers operate under difficult circumstances such as shortage of staff and constrained finances.

The DKMT Euroregion presented a request to B-Solutions to explore the legal possibilities to overcome the obstacle described as a frequent occurrence in the region because "…it is typical that the patient is not sent to the nearest institution, since it may be on the other side of the border, and the settlement between the health insurance companies of the countries does not cover such cases."

DKMT Euroregion indicated that they would like to explore the feasibility of a pilot project that could serve as a test bed for border regions covering internal and/or external EU borders with IPA countries to overcome legal and administrative challenges to facilitate patient mobility for the purpose of receiving certain healthcare services. They envisage the introduction of a special DKMT cross-border health insurance card that could enable patients to benefit from a health insurance scheme that reduces administrative burden for both citizens and insurers. The object of this document is therefore to outline the legal possibilities that exist, and to provide examples of solutions adopted in other EU border regions that might serve as good practice guidance.

It is important to note that although European legislation seeks to address circumstances in which patients may seek some forms of healthcare in another Member State, including in frontier areas where the nearest appropriate facility is on the other side of the border, the border region between Hungary and Romania demonstrates that citizens cannot take full advantage of their rights enshrined in EU laws. Bilateral agreements between Serbia and Hungary as well as between Serbia and Romania cover certain aspects of social security benefits in relation to healthcare, however the scope of these agreements are limited compared to the European legislation applicable in the Member States.

3.2. EU level legislation on Cross-border care

Cross-border healthcare occurs when a patient receives healthcare in a Member State other than the Member State where he or she is insured. Insured persons have two principal routes at their disposal to receive reimbursed cross-border healthcare in the EU. They can seek treatment according to the rules and principles set by the Regulations[2] on the Coordination of Social Security (Regulation 883/2004 and Implementing Regulation 987/2009) *(hereinafter as "Regulations")* or by the Directive[3] 2011/24/EU on Patients' Rights in Cross-Border Healthcare *(hereinafter as "Directive").*

In addition, bi/multilateral agreements or national legislation may also provide local rules to facilitate reimbursed cross-border care. The experiences of other European border regions show that within the framework of the current EU and national law, cross-border healthcare collaborations can flourish and bring real benefits. These typically include adopted procedures, rules and tools specific to their regions to help patients to navigate through various applicable EU and national laws, as well as complimentary agreements among local stakeholders. However, the experience has shown that this demands significant local political engagement to address a local need in the context of more than one jurisdiction.

The Regulations, which predate the Directive, cover a number of social security benefits, including sickness benefits[4] which could be provided either in kind or in cash. What is important from the DKMT health insurance card point of view is sickness benefit in kind: receiving healthcare services in a Member State other than the

[1] Eurostat. Health statistics at regional level.
https://ec.europa.eu/eurostat/statisticsexplained/index.php?title=Health_statistics_at_regional_level#Health_care

[2] Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (Text with relevance for the EEA and for Switzerland) https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32004R0883
Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems (Text with relevance for the EEA and for Switzerland) https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32009R0987&qid=1688745775677

[3] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A02011L0024-20140101

[4] Article 3 of Regulation (EC) No 883/2004 on the coordination of social security systems

one in which the patient is insured – known as the competent Member State. The Regulations apply to three scenarios:

- unplanned cross-border healthcare during a temporary visit in another Member State – see below EHIC,
- planned care in another Member State – see below PD S2 -, and
- persons residing in an EU Member State other than the competent Member State – see below PD S1.

Under the Regulations, healthcare is provided to a patient in accordance with the legislation of the Member State of treatment, however only those treatments which are covered by the care basket of the "home" insurer, the competent Member State, are reimbursed. The reimbursement is provided by the competent Member State at the rate applicable in the country of treatment. The reimbursement is made directly from the competent State to the treating State.

The Directive, often called "Patient Rights" Directive offers an alternative route for planned care for those who are insured in their home Member State The Directive provides r an alternative to PD S2 and covers more types of treatments. Just as with the Regulations, the required treatment is provided in accordance with the legislation of the country of treatment and it must be included in the care basket of the "home" insurer. However, when care is provided under the Directive the rate of reimbursement is that of the competent State. This means that in practice a patient might be out of pocket it the care costs are higher in the treating State than their home State. Furthermore, in most cases the patient will have to pay the bill and then claim reimbursement on returning to their home country. Patients therefore face more differences than similarities between the two routes, as rules for reimbursements are fundamentally different. Important to note the Directive lays down obligations for the Member State on mutual assistance and cooperation[5] as well.

The table below provides a comparative overview of the Regulations and the Directive.

Table 1: Comparative overview of the Regulations and the Directive

	Regulations	**Directive**
Type of care	Planned care (Unplanned under EHIC)	Planned care*
Healthcare providers	Only care providers covered by public insurance	Public and private care providers
Prior Authorisation (PA)	Prior authorisation is requirement Only covers care in "home" insurer's package	Prior authorisation is the exception, usually for care requiring overnight stay in hospital Only covers care in "home" insurer's package
Form to be submitted by the patient	Portable Document - PD - S1 (For border workers / retired border workers for care in the Member State of their residence, if they work/worked as an insured person in another Member State) Portable Document – PD - S2 (For any insured person travelling for planned care to another Member State)	No EU forms *(note: some Member States offer a system of prior notification where a patient can get an indication in advance of the reimbursement they will receive)*
Reimbursement	Based on tariffs of the Member State providing treatment (→ all costs covered) Insurers settle payment, insurer usually pays care provider directly	Based on tariffs of the Member State of insurance affiliation (→ actual costs, only up to what the treatment would have cost in the patient's "home" country) Patient usually pays upfront

* Patient mobility under the Directive is intended to be mainly without prior authorisation for planned care. It may also be used for unplanned care if a patient is visiting a country and finds that they need care that was not foreseen. However, EHIC – under the Regulations - provides a favourable option for patients covering the full cost without the patient having to pay upfront. For the purpose of this paper we only discuss planned healthcare services in relation to the Directive. For cases when unplanned care would occur under the Directive, please refer to the report "Data on cross-border patient healthcare following Directive 2011/24/EU" listed in footnote 13.

[5] Article 10 of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare

Important to note that when the terms of the Regulations are met, treatment should be delivered under the Regulations - not the Directive - unless a patient requests otherwise. It is for the favour of the patient as the Regulations provide reimbursement of the full cost and payment is settled directly by the insurers.

For the purpose of the DKMT cross-border health insurance card pilot project, discussions with stakeholders focused on the planned healthcare scenarios given that unplanned treatment is already partially covered by the EHIC in the region. However, valuable lessons can be learnt from data showing EHIC usage and feedback on how it can be obtained and utilised by EU citizens.

3.3 Cross-border care legislation in the DKMT region

This section covers Hungarian and Romanian national level legislation implementing and complementing the EU laws explained above, as well as bilateral agreements with Serbia in order to establish the legal basis under which Serbian citizens could benefit from healthcare services in Hungary or in Romania and vice versa.

3.1.2 Application of EU laws at national level (Hungary and Romania)

Every action taken by the EU is founded on treaties. There are two main types of EU law – primary and secondary. Treaties are the starting point for EU law and are known in the EU as primary law. The body of law that comes from the principles and objectives of the treaties is known as secondary law; and includes regulations, directives, decisions, recommendations and opinions.[6] The above mentioned Regulations and the Directive are secondary laws.

Regulations apply automatically and uniformly to all EU countries as soon as they enter into force, without needing to be transposed into national law – although changes in national legislation may be needed -, whereas the Directive needs to achieve a certain result and Member States can choose how to achieve the objectives by transposing them into national law. Therefore the application of the Regulations are uniform but the transposition of the Directive may vary from Member State to Member State.

In Hungary, The Government Decree 340/2013. (IX. 25.)[7] on the detailed rules of the healthcare services abroad have been approved to unify the rules regarding cross-border healthcare. According the Decree there are three ways of obtaining healthcare abroad: upon the EU Regulations (that existed before the Directive); upon cross-border healthcare services upon the Directive; and upon the equity process (in case the treatment is not supported by the Hungarian National Health Fund).[8] [9] This piece of legislation determines the list of services that are the exceptions from the general "no PA" rules, as it covers the principles and rules for request and approvals for PA as well as reimbursement for all three ways. A Ministerial Decree 9/1993 (IV.2) NM[10] gives further insight into the classification of healthcare services.

In Romania, Title XVIII "Cross-border healthcare" of Law no. 95/2006[11] on health care reform, partially transposed the Directive into national law. It is supplemented by the Government Decision No 304/2014 for the approval of the Methodological Norms regarding cross-border healthcare[12] which sets the rules such as criteria for PA, as exception from the general rule, and terms of approval and reimbursement.

Comparison between Hungary and Romania regarding the use of the Directive to access care in another country is based on data from 2021[13]:

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[6] https://commission.europa.eu/law/law-making-process/types-eu-law_en
[7] https://njt.hu/jogszabaly/2013-340-20-22
[8] Booklet "Healthcare and patients' rights in the European Economic Area" by Orszagos Betegjogi, Ellátottjogi és Gyermekjogi Dokumentációs Központ. Dowload from https://www.patientsrights.hu/dokumentumletoltes.php?tip=letoltesek_eng&kod=3&file=egeszsegugyi_ellatas_fuzet_eng.pdf
[9] https://www.neak.gov.hu/felso_menu/lakossagnak/ellatas_kulfoldon/tervezett_kulfoldi_gyogykezeles
[10] https://net.jogtar.hu/jogszabaly?docid=99300009.nm
[11] http://www.cnas-pnc.ro/files/1%20-%20Title%20XVIII%20-%20Cross%20border%20healthcare.pdf
[12] http://www.cnas-pnc.ro/files/5%20-%20Government%20Decision%20no%20304%20from%202014.pdf
[13] Data on cross-border patient healthcare following Directive 2011/24/EU. Reference year 2021. Report by Jonathan Olsson, Lynn De Smedt & Frederic De Wispelaere. Published by the EC in February 2023.
https://health.ec.europa.eu/system/files/2023-06/crossborder_2021_patient-healthcare_data_en.pdf

Limitation to patient flow

- HU: No
- RO: Yes

Article 4(3) of the Directive allows that countries may limit access to treatment for visitors from another country where this is justified by overriding reasons of general interest, such as healthcare planning requirements. In Romania, if a provider of medical services does not have the capacity and resources required to cover the amount of medical services requested, the access of Romanian citizen patients to medical assistance shall be given priority[14]. Romania is one of only three countries[15] which indicated in 2021 that they made use of such measures, alongside Denmark and Estonia. However, despite this possibility existing in law, no patients were reported to have has access to treatment limited between 2016-2021[16] on the ground of overriding reasons of general interest.

Healthcare subject to Prior Authorisation (PA)

- HU: PA system in place, requests for PA can be made only per post
- RO: PA system in place, requests for PA can be made only in person

The Directive allows, on certain conditions, that countries set up a system of PA. Eight Member States and Norway had not implemented such a system but the rest of the countries, including Hungary and Romania introduced a PA system. In general terms, there are three types of healthcare that could be subject to PA (care requiring overnight stay, specialised care, high-risk care) and three reasons for refusal for PA (healthcare is available in the Member State of affiliation, healthcare is not included in the basket of care, high risk either for the patient of for the public). There are different ways including in person, post, e-mail, online for making a request for PA across the EU, however both Hungary and Romania offers only limited options, requiring postal or in person requests.

Healthcare not subject to PA

- HU: No prior notification system in place, request for reimbursement can be made only per post
- RO: No prior notification system in place, requests for reimbursement can be made only in person

According to Article 9(5) of the Directive, the purpose of a prior notification system is to allow a patient to receive a written statement of the amount to be reimbursed based on an estimate. This is an optional element and has been adopted by nine countries to support patients who may wish to have greater clarity on the costs they might incur up-front and which they can expect to have reimbursed. Neither Hungary nor Romania has such system in place. Similarly to requests falling under PA, the administrative processes for reimbursements for healthcare not subject to PA are limited in both countries.

3.1.3 Agreements with Serbia

There is an Agreement between the Republic of Serbia and Hungary on Social Security[17] as well as an Agreement on Social Security between the Republic of Serbia and Romania[18] Unplanned care - use of EHIC or equivalent national forms - as well as entitlement for healthcare for border workers and their families - via a quasi PD S1 system - are covered in a reciprocal way both between Serbia and Hungary[19] and Serbia and Romania.

However, there are no provisions for planned care, neither subject to or without PA, to facilitate patient mobility within the sense of the Regulations and the Directive. Seeking care based on private insurance is possible, but for the purpose of this study we focus on public healthcare insurance and laws that govern treatment abroad subject to reimbursement by public insurance in full or partly.

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[14] Article 7 of the Government Decision No 304/2014 for the approval of the Methodological Norms regarding cross-border healthcare http://www.cnas-pnc.ro/files/5%20-%20Government%20Decision%20no%20304%20from%202014.pdf

[15] The other two countries: Denmark and Estonia.

[16] Between 2016 and 2021 only Denmark reported that 14 patients have had their access to treatment limited on the ground of overriding reasons of general interest, while in Estonia and Romania it concerns zero patients over this time period.

[17] 2013. évi CCXXXIV. törvény a Magyarország és a Szerb Köztársaság között a szociális biztonságról szóló egyezmény kihirdetéséről https://net.jogtar.hu/jogszabaly?docid=a1300234.tv

[18] Agreement between the Republic of Serbia and Romania on Social Security https://www.zso.gov.rs/doc/m-ug/RUMUNIJA-e.pdf

[19] https://www.neak.gov.hu/felso_menu/lakossagnak/ellatas_kulfoldon/ellatas_az_eun_kivul/eu_ellatasok_igenybevetele_szerbiai_tartozkodas

Unplanned care (urgent health services during temporary stay)

Citizens of the countries with which Serbia has concluded an international agreement on health insurance receive urgent medical care in Serbia on the basis of health insurance certificate issued in their home countries. Foreign citizens exercise their right to urgent medical care based on certain forms (if such have been prescribed), European Health Insurance Card (EHIC) or on the basis of a document proving their insurance coverage in their home country.[20] Hungary is among the countries whose citizens are entitled to use their EHIC card, however need an additional Serbian health certificate called INO1. Romanian citizens can't use their EHIC in Serbia but can make use of a designated form, called Certificate: Y/R 1.

Bason on the same principles, Serbian citizens who have health insurance in Serbia are entitled for unplanned care during their stay both in Hungary and Romania. For Hungary, they need an additional form (form SRB/HUN 111), although urgent care will be still provided in absence of the form and reimbursement settled between the HU and SRB insurance authorities[21]. For Romania, Serbian citizens are required to have a health insurance certificate/card during their stay in Romania, or private health insurance which needs to be presented at the border crossing upon entering Romania.[22]

Healthcare services for border workers

The Agreement between Serbia and Hungary allows the citizens and their family members of both countries who live in one but work and are insured in the other to healthcare coverage in both countries. The provisions for those who live in one country but entitled to benefits in kind in the other are similar in the Agreement between Serbia and Romania but only at the expense of the competent authority providing insurance. Both agreements introduce a system for prior authorisation for prothesis and other costly benefits in kind unless it cannot be postponed without endangering the life or health of the person concerned.

3.2 Relevant statistical data on cross-border patient mobility

There are several limitations to establish the full picture of the patient flow among Hungary, Romania and Serbia, let alone to attempt to single out comprehensive data covering the DKMT interregional collaboration. The available data has some significant gaps in both the numbers as well as in the commentary setting out the context in reporting from the national level to the European Commission.

It is important to note that cross-border patient mobility data is only available in regards to the different routes that are provided for in the EU legislation. Unless specific local studies are taken, it is not possible to analyse certain healthcare services or groups of patients in a deductible way. To date it seems no such studies have been undertaken in a systematic way, therefore data are anecdotal.

Stakeholders confirmed during our meetings that publicly available data on cross-border healthcare seems to underestimate the actual numbers, even though the direction of the patient flow from Romania and Serbia to Hungary is correct.

We illustrate below the key finding based on the data available in EU level reports, and shared by stakeholders during the interviews. Please refer to Annex II for a detailed overview of national level statistical data.

Key findings based on available national level data as per cross-border patient mobility scenarios

Based on the legal framework, we can illustrate cross-border patient flow relevant for the DKMT Euroregion. For all scenarios below, the following individual circumstances need to be determined: place of residence, place of work (= insurance affiliation), and place of treatment.

Since the EU does not at present collect data from candidate countries, the analysis presented below covers Hungary and Romania. Additional insights into data analytics shared by health insurers involved in the DKMT Euroregion is provided in the subsection on page 11.

[20] Website of the National Health Insurance Fund of the Republic of Serbia. Republic Fund of Health Insurance https://www.eng.rfzo.rs/

[21] https://www.mfa.gov.rs/en/citizens/travel-abroad/visas-and-states-travel-advisory/hungary

[22] https://www.mfa.gov.rs/en/citizens/travel-abroad/visas-and-states-travel-advisory/romania

Cross-border scenario for urgent or unplanned care

Place of residence and place of work are in the same country. The patient lives and works in a country in which health insurance contributions are made. When the patient travels to another country temporarily and seeks urgent care during the visit (place of treatment), the "home country's insurance" covers the cost.
Available route:

- Unplanned care based on EHIC as per the Regulations
  → Cost of treatment covered in full and payment settled by the insurers.

This scenario is already partially covered in the DKMT region by a card between Hungary and Romania for both direction of travel and from Hungary to Serbia with a supplementary form. Additional forms and arrangements are in place in relation to Serbian citizens crossing the EU external border to Hungary or to Romania.

The percentage of insured people having an EHIC card is below the EU average (44%) both in Hungary (22,9%) as well as in Romania (1.8%). In case of Romania, the 1.8% is the second lowest across the EU. These generic numbers do not, however, show how many times EHIC cards were used within the context of the Hungarian-Romanian border, but it is reported that the benefit of EHIC cards is highly appreciated among EU citizens.

Cross-border Scenario for planned care

Place of residence and place of work are in the same country. The patient lives and works in a country in which health insurance contributions are made. When the patient seeks treatment in another county (place of treatment), the "home country's insurance" covers the cost.
Available routes:

- Planned care requiring Prior Authorisation based on PD S2 as per the Regulations
  → Cost of treatment covered in full and payment settled by the insurers.
- Planned care as per the Directive generally without Prior Authorisation
  → Only actual costs covered up to what the treatment would have cost in the "home country". Patient pays upfront and request reimbursement from the insurer at home.

This scenario is only available for Hungary and Romania as Member States of the EU and requires paper forms.

As per the Regulations, the number of patients crossing the border for the purpose of receiving care that have been authorised based on PD S2 are lower than the EU average. It is not unique, as numbers are similarly low along the Eastern border of the EU, especially in relation to neighbouring countries. For instance, Romania reported 22 PD S2 to Hungary, whereas the number was about ten times higher both to Germany and to Italy. Unfortunately, the numbers between Romania and Hungary do not match as Hungary reported 68 S2 from Romania, however the incoming patients to Hungary, Romania would be in the top 5 countries in either way.

Looking at EU level, around three out of four PAs in 2021 have been granted to receive planned cross-border healthcare in an EU-14 Member State. The most prominent flows go from France to Belgium, from Belgium to Luxemburg, from Switzerland to France, from Luxemburg to Belgium, from Luxemburg to Germany, and from Germany to Switzerland. It is found that more than seven in ten PD S2 forms are issued to a neighbouring country, which indicates that geographical proximity plays an important role.[23]

Regarding budgetary implications of treatments based on PD S2 overall, Hungary is a net healthcare provider in the EU, as it received more money in reimbursements (EUR 2.8 M) then it paid out to other Member States (EUR 669 377) to cover for treatment of its own citizens. On the other hand, Romania received only a minimal amount (EUR 1018) for treating patients from other EU countries but paid out a lot more (EUR 10.7 M).

As per the Directive, Romania granted 217 for its citizens who have been treated in Hungary for care not subject to PA. The 217 cases does not look exceptionally high from the Hungarian healthcare providers point of view, however the 217 cases from Romania to Hungary represented 63 % of all reimbursement request not subject to PA in Romania, far more than to any other countries.

Looking at the whole of the EU, the most important flows took place from France as a Member State of affiliation to Spain as a Member State of treatment, from France to Belgium, and from France to Portugal.

[23] EC publication " Coordination on Social Security Systems at a glance. 2022 Statistical report. Download from https://op.europa.eu/en/publication-detail/-/publication/044cf274-b97f-11ed-8912-01aa75ed71a1

However, when leaving out France[24] as a Member State of affiliation, other important flows emerge. For instance, the flows from Poland to Czechia, Denmark to Germany, Sweden to Spain, Finland to Estonia, Slovakia to Czechia, and Slovakia to Poland are of great importance as well.[25]

Frontier (border) worker scenario

Place of residence and place of work are different. The patient lives in one country and works in another, with the latter covering the patient's health insurance. The patient is entitled for healthcare in the country where he/she works, however can register for healthcare in the country of residence. When the patient seeks treatment in the country of residence, the " insurance affiliation" country covers it.

Available route:

- Registering for healthcare via prior authorisation based on PD S1 as per the Regulations
  → Cost of treatment covered in full and payment settled by the insurers.

This scenario is already partially covered in the DKMT region, as Serbia has a similar to PD S2, however there are differences in legal provisions as well as in paper forms.

Unfortunately, reporting to the EU do not list requests for PD S1 forms by sending and receiving countries. Considering that relevance of these data sets are very limited to the DKMT region, all we can observe is that there are six times more people living in Hungary with PD S2 forms then the number of people who are insured in Hungary and living in another Member State. In contrast, the flow is the other way around in Romania.[26]

Complimentary regional data shared by stakeholders

During stakeholder meetings, insurers from Romania and Serbia provided additional insights, confirming that currently the primary direction of patients' flow in the region is towards Hungary. Border branches of the Republic Fund of Health Insurance, the national health insurance fund of the Republic of Serbia reported that in 2022, 433 Serbian citizens benefited from cross-border healthcare services in Hungary, whereas only 19 in Romania[27]. Similarly, the border branch of the Romanian national insurer's office in Arad reported that out of the 181 cross-border health insurance cases it processed in 2022, 165 patients were treated in Hungary which equals to 91%, whereas only 16 were related to other EU Member States.

The health insurance office from Arad explained that the high ratio of cases to Hungary stems from Arad's proximity to the border as well as the quality of hospitals both in Szeged and in Budapest. Also, the transport infrastructure to reach these Hungarian hospitals are better than to Bucharest or to other major cities, such as Cluj-Napoca. Furthermore, patients who can take advantage of these possibilities can afford paying for the Hungarian healthcare services out of pocket and submit reimbursement requests upon returning to Arad. In most cases reimbursements are only granted for part of the costs due to the difference in national tariffs.

Description of the Obstacle in a nutshell

It is typical in the DKMT Euroregion that patients living close to the border are not always seen in the nearest healthcare institution, as it may be on the other side of the border. This region demonstrates that citizens cannot take full advantage of their rights enshrined in EU laws as well as in bilateral agreements.

[24] France does not distinguish between patient flow between the Regulations or the Directive.

[25] see footnote 13

[26] EC publication " Coordination on Social Security Systems at a glance. 2022 Statistical report. Download from https://op.europa.eu/en/publication-detail/-/publication/044cf274-b97f-11ed-8912-01aa75ed71a1

[27] The highest number (186) was to Hungary from Kikinda, a town of 32 000 inhabitants and its neighbourhood located very close to the Romanian border but about 60 km from Hungary. The second highest (156) was to Hungary from Subotica, a town of 95 000 inhabitants which is located on the Hungarian border.

4. Description of possible solutions - towards a DKMT cross-border health insurance card

This section covers possible solutions that the DKMT Euroregion could consider for a pilot DKMT cross-border health insurance card. These are ways in which collaboration among interested stakeholders could be forged and strengthen, as well as suggestions that could be taken into account while designing the scope of such an initiative. We would like to emphasise that these are not stand-alone solutions that could work in isolation, but a tool-kit that can be matched and tailor made over time to tackle the local challenges.

4.1 Agreements to address cross-border care needs in the region

Several Member States have adopted agreements on cross-border care in border regions which address the special needs that arise in their area. Examples listed below cover an intergovernmental framework agreement called *Zone Organisée d'Accès aux Soins Transfrontaliers* (in abbreviated form "ZOAST") that enables local stakeholders to forge micro-regional collaborations along national borders, an interregional medical field agreement, the Mosar Convention, that involves decision-makers, insurers and hospitals and finally, a collaboration between insurers, AOK/CZ, to address cross-border patient needs.

ZOAST

A ZOAST is often seen as a best practise solution to the obstacles that residents living in border regions face when seeking healthcare services near to their home and across national borders. A healthcare treaty, signed on 1 June 2005 by the French and Belgian health ministers on behalf of the two governments, gives the power to the regional authorities in charge of planning, organising and financing the healthcare system to negotiate and validate agreements. The ZOASTs, covering today the whole border, enable the pooling of resources and techniques in order to develop a wide range of care accessible to the population of the defined legal zone without any administrative or financial difficulties. They have become benchmarks for cross-border healthcare cooperation across Europe. [28]

MOSAR

Another type of agreement is the one created by the MOSAR Convention, which operates between France and Germany.[29] Signed in June 2019 by decision-makers and insurers with competence in the region as well as by Eurodistrict SaarMoselle, it materialises the collaboration of three French and two German hospitals that are part of the agreement. It aims to facilitate cross-border healthcare and improve access to care for residents of the cross-border region. This agreement allows residents to access the nearest medical and technical platform and care in the fields of cardiac emergencies, emergencies in the event of polytrauma, and neurosurgical care. Under the framework agreement, the patient will not face any additional administrative procedures and will always benefit from the usual healthcare reimbursement system.

AOK/CZ

On the Dutch – German border, there is a collaboration between the German Health Insurers AOK Rhineland Hamburg and the Dutch Health Insurer CZ Health Insurance[30] to operate a system of a special insurance card which allows patients to access defined healthcare services from defined healthcare providers in the neighbouring country without seeking a prior authorisation. This agreement allows the insurers on each side of the border to agree on special border region tariffs which will be reimbursed to eligible citizens, regardless of the country in which they access care. It could also allow people living in a designated geographic area to access care on the basis of the Regulation without PA.

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[28] See amongst others https://www.ofbs.org/cooperation-franco-belge/zoast/

[29] Please see : http://www.espaces-transfrontaliers.org/ressources/projets/projects/project/show/mosar-convention-sanitaire-transfrontaliere-moselle-saar/

[30] For further detail see https://health.ec.europa.eu/system/files/2022-02/crossborder_patient-mobility_frep_en.pdf

Creating a framework agreement for the DKMT border region that allows for implementing partnerships and mechanisms to be established at lower levels of the authorities and institutions would be essential for the purpose of laying down the foundations of a pilot project for a cross-border health insurance card. Stakeholders involvement from national, regional and local levels would be critical to ensure that competences are fully respected while necessities of the population on all sides of the border are accounted for. The entitlement area could be defined according to the NUTS regional classification system[31] used in the EU, taking into consideration the national administrative divisions at NUTS 3 levels - counties – and local administrative units (LAU) – settlements and municipalities.

Indeed, a recently published study[32] on cross-border healthcare collaborations in Europe between 2007-2017 found that cross-border healthcare emerges especially in situations where there is a need for collaboration, such as in the case of peripheral regions or unmet patient needs. It seem that local understanding of local necessities is a crucial driver and collaborations between healthcare providers and insurers across the border play a key role for success.

The same study confirmed the importance of geographical and cultural factors in driving cross-border healthcare collaboration. Majority of the collaborations that were analysed across Europe took place between countries with similar welfare traditions. Interestingly, Hungary and Romania were listed as the two countries with the most joint projects, either bilaterally or multilaterally, followed by Germany and the Netherlands. [33]

4.2. Examples of cross-border health cards and information tools

The European Commission published its report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare in 2022.[34] Critical points of the report included low level of awareness over patients' rights to cross-border healthcare, inadequate patient information, disproportionate administrative burdens as well as uncertainty over healthcare costs abroad and reimbursement could be addressed by user-friendly manual for patients.

There are online information tools that could make a real difference in raising awareness about cross-border healthcare opportunities and engaging with citizens to help them to make informed choices about their care and assist them if they wish to take advantage of cross-border care. Physical cards go a step further as they assist individual patients to access care easier and ease the administrative burden not just for them but for healthcare providers and insurers as well.

Use of national health cards for cross-border care in the Grande Region on the BE/FR border[35]

The card arrangement is part of a micro-territorial cross-border agreement, one of the 7 ZOASTs mentioned above, within the Grande Region between Belgian and French healthcare and insurance providers. It serves a specific population without any administrative or financial barriers. The legal arrangement leaves the application of European legislation unaltered and provides a localised implementation of the Regulations' PD S2 route and of the Directive without the need for patients to obtain prior authorisation in advance.

<u>How it works:</u> French social security card readers have been installed in Belgian institutions for French patients treated in Belgium. The Belgian institute will recover the funds paid to the Belgian hospital from the French liaison agency.

[31] https://ec.europa.eu/eurostat/web/nuts/background

[32] Cross-border healthcare collaborations in Europe (2007–2017): Moving towards a European Health Union? By Andrea E. Schmidt, Julia Bobek, Stefan Mathis-Edenhofer, Tanja Schwarz, Florian Bachner , Health policy 126 (2022) 1241–1247 https://www.sciencedirect.com/science/article/pii/S0168851022002809?via%3Dihub

[33] See footnote 32

[34] Report from the Commission to the European Parliament and the Council on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, Brussels, 12.5.2022, COM(2022) 210 final, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM:2022:210:FIN#document2

[35] Cross-Border Patient Mobility in Selected EU Regions (Final Report). Prepared by the Association of European Border Regions (AEBR/AGEG) for European Commission, Directorate-General for Health and Food Safety (DG SANTE). Written by Caitriona Mullan, Petra Wilson, Martin Guillermo-Ramirez December 2021 https://health.ec.europa.eu/system/files/2022-02/crossborder_patient-mobility_frep_en.pdf

Cross-border health card in the Meuse-Rhine on the DE/NL border[36]

Two of the health insurers with a strong footprint in the region, AOK Rhineland Hamburg (DE) and CZ Health Insurance (NL), have worked together since 2000 to create a card based system which supports patients who need to regularly use healthcare providers on the other side of the border. This agreement allows the insurers on each side of the border to agree on special border region tariffs which will be reimbursed to eligible citizens, regardless of the country in which they access care.

It allows patients to access defined healthcare services from defined healthcare providers without requesting prior authorisation. This is a card based system, which addresses care services that could be reimbursed under the Directive and Regulations. It simplifies the maintenance of local eligibility requirements, such as requirement for referral by a GP for specialist care, which is required for patients from the NL to receive care in DE, but not vice versa.

How it works: The system operates on the basis of a patient held card, like the EHIC card, and an on-line eligibility verification system. The card also allows for simplification and for maintenance of local eligibility requirements, while allowing patient to access reimbursed care on both sides of the border.

'Guide de Mobilite' in the Upper Rhine FR/DE/CH border[37]

"Guide de Mobilite" is an online information tool that was developed within the TRISAN project in the Upper Rhine region between the French-Germany-Switzerland border. This is a trinational competence centre for cross-border cooperation in the health sector which created it for the purpose to inform patients about their rights and to give advice, particularly with regards to the reimbursement of cross-border care. It serves as a model of good practice in cooperation between National Contact Points and health insurers to provide clear information to meet the specific needs of the patients.

How it works: Online form on the TRISAN website asking basic questions about the patient's country of residence, insurance and place of treatment. It provides patients with an easy to understand downloadable tailor made guide.

The DKMT Euroregion may want to consider incorporating a user-friendly information tool into the DKMT cross-border health insurance card pilot or even run such an initiative as a pre-phase project, which then could be incorporated into the card scheme and upgraded and maintained as a supplementary service. For instance, raising awareness of the benefits, including cost implications, that are currently available to any insured people from all three participating countries could help many to look after their health better. Currently, some may choose a private insurance route or pay out of their pocket for medical expenses across the border without knowing that they are entitled for reimbursement fully or partially.

As the examples of the card based initiatives above demonstrate, building on the existing European legal framework, interregional agreements could provide an extra layer of benefits to a specific population on their border territories by customising reimbursements of cross-border healthcare services to local needs. This could involve making a special insurance basket of care, removing prior authorisation requirements from certain care services, arranging special tariffs, allowing full reimbursement instead of covering part of it as well as introducing reimbursement processes that are more automated. See more on this in Section 4.3.

All of these solutions could be considered in the DKMT Euroregion, however, currently there is no legal basis for planned care in the bilateral agreements with Serbia. Extending these agreements in the future to allow for such local arrangements could be an option for national level decision-makers.

[36] See footnote 45

[37] More details are available at https://www.trisan.org/english

4.3. Customising reimbursements to specific local needs

Cross-border healthcare insurance is a complex domain. EU legislation facilitate collaboration among the Member States in order to provide benefits for the citizens, for instance to improve public health and prevent illness and diseases, however right of the Member States to choose how its healthcare system is financed and organised must be respected. Consequently, healthcare systems, including insurance and care pathways may vary significantly from country to country. This right is enshrined in Article 168 of the Treaty on the Functioning of the EU[38] which states that the organization and finance of healthcare is a Member State power, and the EU's work in public health and healthcare cannot harmonize Member State laws.

As seen in the examples of collaboration agreements, making health insurance arrangements, for instance reimbursements tailor made is at the heart of successful cross-border collaboration. How far these arrangement would stretch and provide additional benefits (if any) compared to the national rules only depends on the circumstances of the specific region and commitment of the stakeholders involved.

The starting point would be to agree on a special DKMT insurance basket of care. As only services that are included in the basket of care of the "home" insurers package would be reimbursed, the pilot project should look at care services that are currently covered or could be added by adjusting relevant laws and/or processes for the benefit of the entitled citizens within the entitlement area.

Based on lessons learnt in other border regions, we suggest considering routine GP, dental and routine hospital services both within usual working hours and extended emergency times (even in a rotating manner designating certain days/times at one side of the border in return for other slots in the neighbouring country), as well as reoccurring appointments for chronic disease patients or treatments in health and wellness centres such as physiotherapy, speech therapy – provided that it can be offered on the patient's own language.

Many chronic diseases require regular medical checks, such as regular podiatrist appointment for diabetes patients. Attendance at such appointments can be compromised if the patient has to travel far, especially for the elderly and those living with multiple conditions. Regular medical checks generally improve adherence to treatment and medication, which prevents deteriorating complications. Indeed, cross-border care could serve not just as a tool for treatment but for prevention too. As Romania is not part of Schengen yet and Serbia in an external border of the EU, border crossing need to be factored in, however Romania might be in a position to join the Schengen agreement very soon.[39]

During the discussion with the stakeholders, it has been noted that treatments not subject to prior authorisation (PA) might be a more feasible option for a pilot card project given that the administrative tasks behind prior authorisations are complex. Given that both Hungary and Romania maintains PA systems defined by their respective national laws based on the Regulations and the Directive, it would be beneficial to remove PA requirements (if they are applicable) from those care services that are flagged for the DKMT basket of care.

The DKMT basket of care could be supported by special tariffs to make estimation of the price abroad as well as reimbursement among insurers more straightforward. Agreeing on special border tariffs is not essential, as reimbursement could be done based on various tariffs just as the current practice, however the price gap between the tariffs of the chosen services is crucial, as working along the same or very similar tariffs would not pose a financial burden on either side of the border. As explained, every country has its own national tariffs which defines the actual prices as well as the pricing structure for healthcare services provided by public healthcare institutions within its territory, however, it is possible to deviate from the national tariffs under special cross-border healthcare insurance arrangements as seen in the practice cases.

Allowing full reimbursement of the cost of care services that are offered within the DKMT basket of care would be a real incentive for patients, especially if they do not need to pay in advance when using the pilot DKMT

[38] Paragraph 7 of Article 168 of the of the Treaty on the Functioning of the European Union states: *Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.* https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX%3A12008E168

[39] European Parliament news: Bulgaria and Romania should be in Schengen by end of 2023, says Parliament https://www.europarl.europa.eu/news/pt/press-room/20230707IPR02431/bulgaria-and-romania-should-be-in-schengen-by-end-of-2023-says-parliament

health insurance card. Just as agreeing on a special cross-border tariff is at the at the discretion of the Member State, reimbursement in full among the insurers for the benefit of entitled patients could be arranged.

Indeed, the more automated, reliable and transparent the reimbursement system, the more encouraging it is for the citizens to use. Processing cross-border cases individually demands lots of human resources and poses a real burden both on insurers and healthcare providers. As a solution, which could also be considered in the DKMT Euroregion, some Member States choose to do bulk purchasing of routine treatments in advance so that healthcare providers can have a budget at their disposal.

Furthermore, it is important to note that care for cross-border patients is provided according to the legislation of the country providing the treatment. Therefore having a clarity on how a certain treatment fits into the patient's care path is key not just from the from the continuity of care point of view but also to manage expectations both for the patient and for the clinicians involved. Similarly, vocabulary and reimbursement nomenclature or codes play an important role, as insurers need to have a common understanding of what they mean by certain healthcare services and match them in their systems accordingly.

The Directive defines 'healthcare' as health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices.[40] Therefore, any basic services suggested above to be included in the DKMT insurance basket could be supported by the dispensation of medication or medical devices to improve continuity of care.

Finally, the capacity and the resources for providing treatment should not be underestimated. Although Hungary did not limit patient flow and Romania has not exercised its right to do so since the introduction of the Directive, the shortage of healthcare professional and staff working in healthcare institution might raise concerns if a newly introduced pilot scheme would not achieve its goal to balance resources across the borders but result in overdemand.

4.4 Integrate digital health solutions into cross-border care

eHDSI, the eHealth Digital Service Infrastructure, is a cross-border infrastructure developed in the EU to ensure continuity of care for European citizens while they are travelling abroad in the EU. It gives EU countries the possibility to exchange health data in a secure, efficient and interoperable way. eHDSI is currently operational for ePresciptions and Patient Summaries among some Member States[41], however not yet in Hungary nor in Romania. The services provided through eHDSI are commonly referred as "MyHealth@EU"[42].

With the European Commission's proposal on the European Health Data Space (EHDS) Regulation[43], it is expected that the EHDS will provide a trustworthy setting for secure access to and processing of a wide range of health data, including ePrescription and Patient Summaries among many other data types across the whole EU. As the proposal for Regulation is still being negotiated in the European Parliament and the Council, legislative and budgetary implications for the Member States are not yet final.

Not yet having a European digital infrastructure available for exchanging data in the region should not prevent the DKMT Euroregion to base its pilot card on currently functioning digital and paper based processes that insurers and healthcare providers use and trust in their everyday dealings. Incorporating European electronic health record (EHR) exchange standards[44], including technical specifications, processes and policies, to a pilot project could ensure future-proofing and conformity with national and European IT systems being developed.

[40] Article 3 of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare

[41] See list of services and EU countries involved: https://health.ec.europa.eu/ehealth-digital-health-and-care/electronic-cross-border-health-services_en

[42] MyHealth@EU flyer: https://health.ec.europa.eu/other-pages/basic-page/myhealtheu-flyer-addressed-patients-and-health-professionals_en

[43] The proposal for a Regulation on EHDS can be found at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A52022PC0197

[44] Commission Recommendation on a European Electronic Health Record exchange format (C(2019)800) of 6 February 2019 https://digital-strategy.ec.europa.eu/en/library/recommendation-european-electronic-health-record-exchange-format

5. Conclusion

Cross-border health initiatives are challenging and sensitive topics that need careful considerations not just because healthcare is a national competence and various laws apply but because it involves the need for trust on behalf all stakeholders who are involved. Patients need to trust healthcare professionals, healthcare professionals the insurers, insurers the decision-makers and vice versa. There is no effective healthcare without a real sense of collaboration, yet alone in a cross-border setting.

What may work as an advantage for the DKMT Euroregion is that its stakeholders already demonstrated that cross-border initiatives can provide real benefits in the region and there is a strong track record of projects among healthcare institutions which could provide a basis for further work to develop a pilot project to address cross-border healthcare needs. There is also cultural familiarity in the region, which would make crossing the border from the patients' perspective at ease.

It is without doubt that introducing a DKMT cross-border health card would be beneficial for citizens of this trination border region, particularly for residents living in smaller towns and villages near the border, where nearby healthcare services may be limited. A regional agreement would also help to address the shortage of healthcare professionals in some areas, as healthcare professionals from neighbouring countries could provide services that are in need on the other side of the border and therefore balance capacities and resources. Furthermore, the importance of focusing on healthcare services that are available, affordable and in demand close to the borders should not be underestimated. In depth consultations with patient and clinicians who are in the best position to know what is needed are equally crucial.

Examples from across Europe demonstrate that the current European legal framework, although complex, but provide a solid ground for interregional collaborations to come up with local solutions to local challenges. The data we have available from the DKMT Euroregion show that there is some patient movement but more could be done to facilitate citizens to exercise their right both under the current legal arrangements as well as in the future with the help of a pilot project that the region is aspiring to do.

In a nutshell, the conclusion is to establish a multilateral agreement among the state departments of Hungary, Romania and Serbia to adopt special procedures applicable for a designated geographical area to allow locally involved insurers and healthcare providers to implement a system whereby the basket of care, the reimbursement procedures as well as the tariffs are customised for DKMT Euroregion.

Annex 1 - List of legal provisions relevant to the case

- Consolidated version of the Treaty on the Functioning of the European Union
  Link (ENG): https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012E%2FTXT

- Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, *O.J.*, L 166/1, 30 April 2004,
  Link (ENG): https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32004R0883. ;

- Implementing Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems, *O.J.*, L284/1, 30 October 2009
  Link (ENG): https://eur-lex.europa.eu/legal content/EN/TXT/?uri=CELEX:32009R0987. ;

- Directive (EU) No 2011/24 of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, *O.J.*, L88/45, 4 April 2011,
  Link (ENG): https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A02011L0024-20140101 ;

- 340/2013. (IX. 25.) Korm. rendelet a külföldön történő gyógykezelések részletes szabályairól; (Hungary) Magyar Közlöny, 2013. Évi 157. szam.
  The Government Decree 340/2013. (IX. 25.) on the detailed rules of the healthcare services abroad; Published in M.K. No 157 in 2013.
  Link (HU): https://njt.hu/jogszabaly/2013-340-20-22

- 9/1993. (IV. 2.) NM rendelet az egészségügyi szakellátás társadalombiztosítási finanszírozásának egyes kérdéseiről (Hungary)
  A Ministerial Decree 9/1993 (IV.2) NM on certain aspects of social insurance financing in relation to specialized health care
  Link (HU): https://net.jogtar.hu/jogszabaly?docid=99300009.nm

- LEGE nr.95 din 14 aprilie 2006 privind reforma în domeniul sănătăţii, Textul actului publicat în M.Of. nr. 372/28 apr. 2006 (Romania)
  Law no. 95/2006 on health care reform, the text of the act published in M. Of. no. 372/28 Apr. 2006
  Link (RO): https://www.cdep.ro/pls/legis/legis_pck.htp_act_text?idt=72105

- Hotararea Guvernului nr. 304/2014 pentru aprobarea Normelor metodologice privind asistenta medicala transfrontaliera a fost publicata in Monitorul Oficial, Partea I, nr. 318 din 30 aprilie 2014.
  Government Decision no. 304/2014 for the approval of methodological norms concerning cross-border healthcare. Official Journal of Romania, 1st part, no. 318/2014, 30 Apr. 2014 (Romania)
  Link (RO):
  https://www.cnaspnc.ro/files/HOTARARE%20Nr.%20304%20din%2016%20aprilie%202014%20-%20pentru%20aprobarea%20Normelor%20metodologice%20privind%20asistenta%20medicala%20transfrontaliera.pdf

- 2013. évi CCXXXIV. törvény a Magyarország és a Szerb Köztársaság között a szociális biztonságról szóló egyezmény kihirdetéséről (Hungary)
  Act No CCXXXIV of 2013 on the Promulgation of the Agreement on Social Security between Hungary and the Republic of Serbia
  Link (HU): https://net.jogtar.hu/jogszabaly?docid=a1300234.tv

- Agreement between the Republic of Serbia and Romania on social security. Done at Belgrade on 28 October 2016.
  Link (ENG): https://www.zso.gov.rs/doc/m-ug/RUMUNIJA-e.pdf

Annex II – Relevant statistical data on cross-border patient mobility

Unplanned care based on EHIC as per the Regulations[45]

Hungary ➢ Insured persons with EHIC card: 22.9 %[46]

Romania ➢ Insured persons with EHIC card: 1.8 %

Planned healthcare requiring Prior Authorisation based on PD S2 as per the Regulations[47]

Hungary
- ➢ HU→RO: HU issued no S2s for treatment in RO (Total from HU to EU/EFTA : 160)
- ➢ HU←RO: HU received 68 S2s from RO (Total from EU/EFTA to HU : 258
  ►RO was highest ranking country to HU, giving 26.4% of all S2s issued to HU
- ➢ HU paid EUR 669377 as competent MS, received EUR 2.8 mill. as MS of treatment.

Romania
- ➢ RO→HU: RO issued 22 S2 for treatment in HU (Total from RO to EU/EFTA: 665)
- ➢ RO←HU: RO received no S2s from HU (Total from EU/EFTA to RO : 16)
- ➢ RO paid EUR 10.7 mill. as competent MS, received EUR 1018 as MS of treatment.

Planned healthcare as per the Directive generally without prior authorisation[48]

There are two types of indicative data we can look at in relation to the Directive: for healthcare subject to PA, data is available for authorised requests for PA; for healthcare not subject to PA, data is available for granted requests for reimbursement.

Hungary ➢ HU→RO: no data available re number of authorised requests for PA from HU to RO

Romania ➢ RO→HU: 0 cases reported re number of authorised requests for PA from RO to HU

Hungary ➢ HU→RO: no data available re granted requests for reimbursement for healthcare not subject to PA from HU to RO

Romania ➢ RO→HU: 217 cases for granted requests for reimbursement for healthcare not subject to PA from RO to HU

► 217 cases from RO to HU represent 63 % of all reimbursement request in RO

[45] Data taken from EC publication " Coordination on Social Security Systems at a glance. 2022 Statistical report. Download from https://op.europa.eu/en/publication-detail/-/publication/044cf274-b97f-11ed-8912-01aa75ed71a1

[46] The number of insured persons applies to insured persons with full social security coverage. However, in total, some 9 258 250 persons are entitled to EHIC and therefore the coverage ratio of EHIC is 10.3 %.

[47] See footnote 45

[48] Data on cross-border patient healthcare following Directive 2011/24/EU. Reference year 2021. Report by Jonathan Olsson, Lynn De Smedt & Frederic De Wispelaere. Published by the EC in February 2023. https://health.ec.europa.eu/system/files/2023-06/crossborder_2021_patient-healthcare_data_en.pdf