Elaboration of an action protocol aimed at simplifying cross-border administrative procedures in the field of health insurance

Final report & action protocol

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This document has been produced with financial support from the European Union. The EGTC Eurodistrict PAMINA is solely responsible for the content, which under no circumstances reflects the position of the European Union.

For reasons of better readability, the male form is used for personal names and personal nouns. In the interests of equal treatment, the corresponding terms apply in principle to all sexes. The abbreviated language form has only editorial reasons and does not include any evaluation.

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This report was written by TRISAN (Euro-Institute) in cooperation with the steering group of the B-Solutions project. In addition to the lead partner, the EGTC Eurodistrict PAMINA, this group includes the INFOBEST network of the Upper Rhine, composed of INFOBEST PAMINA, INFOBEST Kehl/Strasbourg, INFOBEST Vogelgrun/Breisach and INFOBEST PALMRAIN, as well as the Centre for Consumer Protection in Europe in Kehl.

The following bodies and institutions have also contributed to the editorial work through discussions and written feedback:

- Allgemeine Ortskrankenkasse (AOK) Baden-Württemberg
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- Caisse nationale d'assurance maladie (CNAM)
- Centre National des Soins à l'Etranger (CNSE)
- Centre national des firmes étrangères (CNFE)
- Caisse primaire d'assurance maladie (CPAM) du Bas-Rhin
- Caisse primaire d'assurance maladie (CPAM) du Haut-Rhin
- Caisse primaire d'assurance maladie (CPAM) de la Moselle
- Gesetzliche Krankenkasse Spitzenverband – Deutsche Verbindungsstelle Krankenkasse-Ausland (DVKA)
- Kaufmännischer Krankenkasse (KKH) Baden-Württemberg
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- Techniker Krankenkasse (TK) Rheinland-Pfalz
- Union de Recouvrement des cotisations de Sécurité Sociale et d'Allocations Familiales (URSSAF) Alsace

In the course of the drafting process, the parties involved noticed that formal requirements and applicable regulations are not always fully implemented in practice - in some cases the territorial reality does not correspond to the administrative theory. In the report, appropriate formulations were chosen in order to do justice to all actors and to reflect the facts as fairly as possible. In the interests of an understandable presentation and timely completion of the project, however, compromises had to be made at some points which did not necessarily reflect the assessment of all parties involved.

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Introduction

This document has been drafted as part of a European pilot project aiming at overcoming cross-border obstacles in the field of health insurance. The lead applicant of the project is the EGTC Eurodistrict PAMINA[1]. The project followed on a call for proposals under the title "B-Solutions", which was initiated by the European Commission and implemented by the Association of European Border Regions (AEBR). Under this call for proposals, ten pilot projects were selected for EU funding of up to €20,000 and assigned to the following five thematic areas:

1. Employment
2. Health (including emergency care)
3. (Public) Transport
4. Multilingualism
5. Institutional cooperation

For a concrete improvement of the situation in border regions

The innovative solutions developed by the "B-Solutions" projects for overcoming cross-border administrative and legal obstacles should make a concrete contribution to improving the living conditions of the residents of border regions and be transferable to other European border regions, i.e. serve as models for other regions. They fall within the immediate area of application of the European Commission's Communication of September 20th, 2017 on boosting growth and cohesion in EU border regions. In this Communication, the Commission underlines the importance of removing cross-border barriers[2] and lists ten areas of action in line with the thematic areas of the call. It also presents the INFOBEST network of one-stop-shops in the Upper Rhine (co-applicant) as good example in the field of providing reliable and understandable information and assistance.

An action protocol for administrative cooperation between health insurance bodies

The first aim of the project was the concrete improvement of the administrative cooperation of the German and French health insurance bodies to the advantage of frontier workers as well as all inhabitants of the border region using health services in the neighbour country (area 5: institutional cooperation). This part of the project consisted in analysing concrete problem cases encountered at the French-German border (Upper Rhine region) and finding solutions in cooperation with the stakeholders. It resulted in the drafting of a **"Report for the Upper Rhine"** (only available in French and German), providing a reliable framework for the stakeholders in both countries in order to improve the situation.

The second goal of the project was to share the gist of the first part of the project with other border regions in the European Union. This led to the elaboration of the present document called **"action**

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[1] European Grouping for Territorial Cooperation in the Eurodistrict PAMINA (Southern Palatinate, Middle Upper Rhine, Northern Alsace), which according to its statutes is dedicated to the promotion, support and coordination of cross-border cooperation for the benefit of the citizens.

[2] "The Commission has undertaken analytical work exploring the cost of border complexities and the duplication of services. A recent study on the economic impact of border obstacles on GDP and employment levels in internal land border regions suggests that these regions could on average be potentially 8% richer if all current barriers were removed and a common language was used by all. This scenario is neither attainable nor desirable as Europe is built on diversity and subsidiarity. However, if only 20% of the existing obstacles were removed, border regions would still gain 2% in GDP." (COMMUNICATION FROM THE COMMISSION TO THE COUNCIL AND THE EUROPEAN PARLIAMENT: Boosting growth and cohesion in EU border regions, COM(2017) 534 final, Brussels 20.09.2017)

protocol", which also considers existing structures in the Greater Region, covering the other important part of the German-French border.

The starting point for this project was the observation that inhabitants of border regions face a variety of problems when it comes to integration into the health insurance systems and the reimbursement of their health expenses: Long processing times, high complexity of procedures, difficulties in accessing adequate information, additional costs due to incompatible national legislations leading to lack of social security coverage. However, a distinction had to be made between frontier workers on the one hand and the other inhabitants of the border region using health services in the neighbouring country on the other hand.

The populations, which encounter such obstacles, have to invest more time and effort to assert their rights. Ultimately, this leads to negative perceptions of the status as frontier worker and of European integration as a whole.

A network of experienced and motivated stakeholders

The pilot project was carried out by the following organisations:

- the EGTC Eurodistrict PAMINA as lead applicant,
- the INFOBEST network as co-applicant,
- and Euro-Institute/TRISAN (trinational competency centre for cooperation in the field of healthcare) as service provider (analysis of the problem cases, co-moderation of the discussions between the stakeholders, drafting of the two reports mentioned above).

A steering group was set up in which the Centre for Consumer Protection in Europe was involved as an expert on consumer issues, in addition to the above-mentioned organisations. Besides the regular meetings of the steering group, joint meetings with representatives and consultations of the competent entities in the field of health insurance have been organised throughout the project in order to discuss possible solutions for the problem cases and to draft the action protocol.

The "B-Solutions" project also received political support from the members of the EGTC Eurodistrict PAMINA[3] and the INFOBEST network[4]. The Parliamentary State Secretary in the German Federal Ministry of Health, Dr. Thomas Gebhart, Member of the Bundestag for a border region (Southern Palatinate), has assumed the patronage of the pilot project.

Structure of the transferability report

In order to provide an operational tool for other border regions, the report is structured in three parts:

I. A description of the methodology used to draft the action protocol aiming at overcoming existing obstacles at the French-German border. This chapter illustrates how the methodology used throughout the project is transferable to other regions and contexts.
II. The action protocol, which consists in an overview of the problems and obstacles that were dealt with in the first part of the project (French-German border), as well as the solutions found. Although the solutions found are not necessarily fully transferable to other border regions due to their specific circumstances, they may provide inspiration.

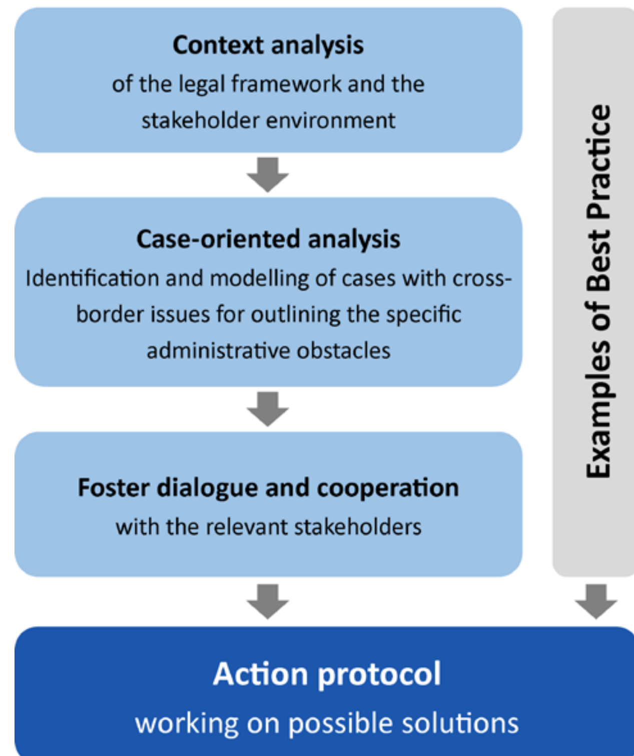
[3] German and French local authorities and regional associations, the Département du Bas-Rhin and the Région Grand Est.
[4] Depending on the location, including the local level as well as the level of the Länder and the French state.

III. An overview of best practices from the French-German border related to cross-border cooperation in the field of healthcare and health insurance, to illustrate that the strategy, which has been followed in the "B-Solutions" project, is only one of several options to tackle cross-border obstacles and to find solutions.

The annex contains an example of a completed analysis grid for one of the twelve problem cases that have been analysed in the first part of the project (French-German border). The detailed analysis of all obstacles may be found in French and German language in the "Report for the Upper Rhine".

I. Methodology used to draft the action protocol

The following chart offers an overview on the methodology, which has been used in order to draft the action protocol for the French-German border. The different steps will be explained in detail in the following subchapters.



The whole method relied on a border-specific approach, which seems to be the most effective way to deal with the issues at hand. Every border region in the EU is confronted with its own specific issues since the obstacles are most of the time due to incompatibilities of two national systems or legislations as far as people crossing borders are concerned.

It is important to underline that certain conditions were provided in the Upper Rhine making it possible to carry out the methodology as described:

- The identification of obstacles was facilitated through the existence of several "front office" structures, which provide information and advice to people confronted with cross-border issues. These structures deal on a daily basis with issues concerning access to cross-border services including healthcare services. Therefore, it was possible to collect problem cases in a short time and to rely on experts who had already a very good comprehension of the existing problems;
- The relevant stakeholders have known each other for a long time. There are in the Upper Rhine Region several well-established cross-border organisations (such as the GECT Eurodistrict PAMINA) which are able to coordinate actions and to bring the stakeholders together. This is why the stakeholders are used to work together (i.e. the working groups "Frontier workers" and "Health" of the Upper Rhine conference). Therefore, it was possible to discuss the problems in a very efficient way, without having to go through the usual prior steps of cross-border cooperation ("identification of the players", "trust-building", "learning how the system of the neighbouring state works", etc.).

- The Upper Rhine region is also characterised by a strong permeability of the border. The number of frontier workers as well as the amount of citizens, who are regularly crossing the border to run errands, use any kind of services or carry out leisure activities is very important. In this context, the number of citizens facing cross-border issues at some point is growing. Thus it is important not only to address these problems, but also to find comprehensive and sustainable solutions.
- The awareness of the issues concerning cross-border healthcare access is growing. For instance, this topic was one of the most discussed themes of the three cross-border citizen dialogues organised by the state of Baden-Württemberg in 2017.
- Due to the importance of the cross-border dimension, there is a clear political commitment in the region to tackle cross-border issues (in the field of healthcare and in others fields). The political support is also important in order to bring all stakeholders around the table.

Based on these observations, it seems appropriate to analyse the specific context before implementing the methodology in another border region:

Legal and administrative framework

- What is the legal and administrative framework in the area? (European, national and regional/local regulations)

Stakeholders

- Which are the relevant stakeholders on each side of the border?
- Are the stakeholders based locally, i.e. in decentralised structures, or located outside the border region?
- What are their spheres of action?

Ability and willingness to cooperate

- Is cross-border healthcare access a topic amongst the relevant stakeholders? Are they willing to tackle the existing obstacles?
- Do the stakeholders from both sides of the border know each other? Are they in regular contact?
- Are there any discussion forums (for instance cross-border working groups) or common structures? Have the forums already been dealing with the topic?

1. Identification of the obstacles

The first step of the process was to identify the obstacles in the field of cross-border healthcare access.

As mentioned before, this first step was mostly carried out by the "front office" structures (INFOBEST network, Centre for Consumer Protection in Europe), which were set up in the Upper Rhine region to provide information and advice to citizens confronted with cross-border issues. These structures are dealing with issues concerning health insurance or healthcare access on a daily basis and were able to establish a list of problem cases. Twelve problem cases were identified.

A first discussion of the problem cases took place among the members of the steering group and led to the following observations and decisions:

- The initial project draft focussed on the issues concerning frontier workers. However, it became clear that the existing obstacles do not only concern frontier workers, but also other inhabitants of the border region, who want or have to use healthcare services in the neighbouring country. Furthermore, these two groups are confronted with different kinds of obstacles: Frontier workers have to deal primarily with problems of registration in the health insurance system. Regarding the second group, the issues concern mostly the access to healthcare services on the other side of the border (and the reimbursement of the costs). The decision was made to widen the scope of the project and to take both groups into account.
- The list of problem cases showed a great diversity of obstacles: Some problems affected a wide range of people, whereas other problems were a lot more specific. Some problems seemed to be relatively easy to solve, whereas others seemed to be very difficult to tackle (particularly the problems that result from incompatibilities of legislation). Finally, it was decided to address all problems and not to prioritise, based on the following reflexions :
    - The B-Solutions call for proposals was clearly designed by the European Commission to reduce identified obstacles in border regions, regardless of the number of people concerned.
    - The people concerned by an obstacle do not necessarily share the information. The number of cases reported to institutions like the INFOBEST network or the Centre for Consumer Protection in Europe is probably only the tip of the iceberg.
    - Even the smallest obstacles might have a negative impact on the citizen's perception of Europe and European integration.

Eurodistrict PAMINA INFOBEST Centre Européen de la Consommation Zentrum für Europäischen Verbraucherschutz e.V. TRISAN Euro Institut

2. Case-oriented analysis

The second step of the process consisted in modelling the problem cases and analysing the obstacles in detail. Euro-Institute/TRISAN drafted an analysis grid which enables to have a common framework to analyse all twelve problem cases.

Topics concerned (keywords)	One or more keywords that allow the case to be easily assigned to one or more larger topics.
Description of the case	A brief description of the problem, which succinctly abstracts and explains the reported case
Case study	Short description of the real case with anonymization of the persons involved.
Legal references	Presentation of the relevant legal framework, both at European and national level.
Target groups concerned by the issue	Indication of the target groups concerned (e.g. cross-border workers, entire population of the border region, etc.).
Negative consequences of the problem	Description of the subsequent negative consequences of the problem.
Suggestions for improvement (to be discussed with the competent entities)	Suggestions for improvement to be discussed with the competent entities throughout the workshops.
Best practices	Listing of best practices (current or past) in the Upper Rhine.
Structure that reported the problem	Indication of contact persons in case of questions.
Sources	Specification of the legal and other sources used to process the case.

For illustration purposes, a fully completed analysis grid is available in the annex to this document.

As part of the analysis, Euro-Institute/TRISAN identified three categories of issues raised in the various cases:

- Lack of information for the populations concerned
- Administrative obstacle / lack of cross-border procedures
- Legal obstacle / incompatibility between national rules and/or European regulation

3. Foster dialogue and cooperation

The third step of the process consisted in discussing the obstacles and the suggestions for improvement with the competent stakeholders on both sides of the border (public health insurance bodies at regional and national level, social security liaison bodies, organizations for the collection of social security and family benefit contributions etc.). The aim of this step was to develop concrete solutions to the identified obstacles in a process of co-construction. It was essential to find solutions, to which all involved stakeholder could agree, since the further implementation depends on them.

This third step resulted in drafting together with the stakeholders an action protocol, which specifies for all twelve problem cases:

- The solutions found (WHAT?)
- The milestones to reach the solutions (HOW?)
- The stakeholders in charge (WHO?)

As stated before, the process initiated in the Upper Rhine region relied on the conviction that solutions must be developed at the local level, taking into account the specific circumstances in each border region (i.e. existing dynamic and institutions of cross-border cooperation, willingness at the state level). Nonetheless, especially when it comes to issues of legislation, it is necessary to invite the relevant stakeholders at the national or European level to join the project.

EU-funded projects, such as B-Solutions can considerably facilitate such initiatives, as they can bring together interlocutors who would otherwise be difficult to reach. Furthermore, they can also show existing approaches to problems and solutions already found (which are not common knowledge). Nevertheless, the challenge consists in the subsequent consolidation of the discussion forums with the aim of establishing an instrument providing sustainable problem-solving capacities.

4. Outline of the conclusions for the Upper Rhine

As stated before, the results found for the Upper Rhine are not fully transferrable to other border regions given the specific context (French-German border, high cross-border dynamism, large number of historically grown institutions, two languages, etc.). Nevertheless, a number of observations is certainly relevant for other border regions and will therefore be presented based on the three problem categories previously identified.

Lack of information

Throughout the project, the high need for information in the field of cross-border healthcare was evident. This applies both to the population itself and to the employees within the competent entities involved in cross-border healthcare.

There was consensus that citizens do not have sufficient information about the possibilities and conditions of cross-border healthcare access. If there is a political will to enhance and facilitate cross-border access to health services, follows the question of how this problem would have to be addressed. What measures can be taken to inform the public? At what level, when and in which context could this sensitisation take place? Who should carry out these actions? There is also the question of the cross-border benefit of such measures: Is it useful, efficient and effective to focus on cross-border (or European) actions or should information be provided in a national context?

The appropriate measures are not self-evident and presumably consist of a combination of all these approaches. Ultimately, the citizen must be "picked up where he/she is": Comprehensive initial information in the national context, further supplemented by coordinated cross-border or European actions, appear to be the most efficient strategy.

In addition to the lack of information among the population, there is often a lack of knowledge among the competent entities' employees (mainly health insurance bodies) about cross-border issues, resulting in citizens not necessarily receiving complete and accurate answers to their questions. This leads to the following conclusions:

- All competent entities – even those who did not participate in the B-Solutions project – need to be informed about the outcome of the project and thus be sensitised for the existing obstacles to cross-border healthcare access.
- Ideally, their employees should receive further training on the topic in order to be better sensitised to potential problems in the future (the need for such training depends certainly on the measures already taken by the various health insurance bodies). Alternatively, the appointment of interlocutors specialized in cross-border healthcare issues could be a temporary solution.
- Possible measures to improve the situation, in addition to providing training for the employees, could include the organization of networking meetings to promote cross-border exchange and cooperation, and the establishment of information and exchange channels to strengthen the capability to tackle new issues in the future.

Administrative obstacles

Administrative obstacles may exist with one or more of the entities involved on either side of the border. Their solution can be complex, as they cannot necessarily be achieved at the local level but must also take into account more extensive interconnections (for instance at the national level). During the analysis for the Upper Rhine, Euro-Institute/TRISAN identified two types of administrative obstacles:

1. Administrative obstacles that can be solved in a purely national context
2. Administrative obstacles, whose resolution require a coordinated approach / cross-border procedures

Legal obstacles

Regarding legal obstacles, two types of action seem conceivable:

1. Report the regulatory incompatibilities and difficulties encountered in applying the legislation at the local level to the responsible authorities (regional level, national states and/or European Union) in order to adapt the legislation and/or introducing exemptions for specific situations.
2. Establish local conventions to develop solutions at the local level, without affecting existing legal texts.

II. Action protocol to overcome obstacles to cross-border healthcare access

After having explained the methodology used in the B-Solution project in a first step, the aim of this chapter is to give a more detailed insight into the concrete cases reported from the Upper Rhine. For each of the twelve problem cases of access to healthcare in a cross-border context, there is:

- a brief description of the case,
- the suggestions for improvement proposed in the ”Report for the Upper Rhine” (before the workshops with the stakeholders),
- some discussion points from the workshops that will help to illustrate the different problems,
- and the solutions proposed during the workshop with the competent entities.

As mentioned beforehand, obstacles to healthcare access in a cross-border context do not only affect frontier workers, but the whole population of border regions. Therefore, we opted for a topical differentiation of the twelve cases into two categories:

- Issues concerning frontier workers
- Issues concerning all inhabitants of border regions

Please note that the following case descriptions are only a summary and do not reflect the totality of context information gathered throughout the whole working process. More information on the different cases, including the respective legal frameworks, is available in the “Report for the Upper Rhine region” (only in German and French language).

1. Action protocol for issues concerning frontier workers

1.1. Case No. 1: Requirement for frontier workers to submit complete applications for health insurance coverage both in their country of residence and in their country of employment

Description of the case

Frontier workers who want to benefit from health insurance coverage both in their country of employment and in their country of residence must submit two complete applications for registration to the competent entities: in their country of employment and in their country of residence. This can mean a certain administrative burden for the insured (large number of forms to be completed, translation costs, language problems etc.).

Suggestions for improvement

- Direct transmission of the S1 form by the legally responsible health insurance body to the health insurance body in the country of residence
- Direct transmission of data by the legally responsible health insurance body to the health insurance body of the neighbouring country
- Use of bilingual registration forms

Discussion points

- From 1 July 2019: S1 forms must be transmitted automatically via the Electronic Exchange of Social Security Information (EESSI)
- Written comment by the German social security liaison body (DVKA): The S1 form is a portable document (PD) and not a structured electronic document (SED), so it cannot be transmitted via the EESSI system. However, after the introduction of the EESSI procedure, the health insurance body in the country of residence may decide to prove the insured person's affiliation by demanding the SED S071 instead of using the S1 form. The legally responsible health insurance body then replies with the SED SO72.
- The registration forms are bilingual in France (French/English) and bilingual (German/English) or multilingual on the German side, depending on the health insurance bodies.
- The required documents are not necessarily the same in both countries → for example, in France, a birth certificate is mandatory in order to be able to assign the social security number
- In Germany, the insured person can freely choose his health insurance body → a frontier worker residing in Germany and working in France needs to inform the CPAM (French health insurance body) to which health insurance body the S1 form should be sent

Solutions

⇒ The problem will be partially solved due to the automatic transmission of S1 forms via EESSI.

⇒ Strengthen EESSI and reinforce the process of setting common standards for transmission.

⇒ The introduction of EESSI could eventually make it possible to avoid having to provide twice the documents required in both countries. However, the question will always arise for documents that are only required in one of the two countries.

1.2. Case No. 2: Problem of affiliation of children in case of divorce or separation of parents

Description of the case

In the case of parents, one of whom is a frontier worker and the other one works in the country of residence, the children are insured with the latter. This also applies in the event of separation or divorce, if the parent working in the country of residence has custody of the child (full or shared custody) and/or until the divorce is final. In the case of residency in France, this can lead to two types of problems:

- Problem 1 : Use of the ex-partner's insurance card
- Problem 2 : Payment by the frontier worker parent, reimbursement of medical costs to the other parent

Suggestions for improvement

- Derogation in the absence of any relationship between the parent residing in France and the child
- French-German agreement at national level to restore the situation before autumn 2017 (double affiliation of the child with both of its parents, which was contested by the German social security liaison body (DVKA) based on Art. 32 of Regulation (EC) No 883/2004)
- Reference to Article 3.1 of the International Convention on the Rights of the Child
- Derogation for issuing the “Carte Vitale” (French insurance card) to children under 12 years
- Cross-border parent keeps the European Health Insurance Card (EHIC) for access to emergency care

Discussion points

- Written comment by the German social security liaison body (DVKA): It has never been the legal opinion of the DVKA that children could be affiliated with both parents. EU regulation states clearly that only one institution can be competent.
- Ad-hoc solutions that currently exist:
    - Individual affiliation of the child based on residency (PUMa) in France if over 12 years old (with reimbursement to the bank account of the frontier worker parent). However, this is only possible by derogation; derogations are issued on a case-by-case basis, depending on the situation.
    - Another pragmatic solution for treatments in the country of residence would be to issue a certificate of eligibility, which would be given to the frontier worker parent by the non-frontier worker parent certifying the child's status as a beneficiary. This presupposes that the treating doctor accepts the certificate. However, this would still not solve the problem of reimbursement of costs on the account of the non-frontier worker parent.
    - Agreement between the parents to authorize the reimbursement on the other parent's bank account. However, this presupposes that the parents are in capacity to reach an agreement.

Solutions

Grant a right of option for the affiliation of the child (possibility of choosing to be affiliated with the frontier worker parent or the non-frontier worker parent), with the possibility of a double affiliation (affiliation with both parents), as it would be the case in a purely national French or German context.

- ⇒ The French-German Treaty of Aachen establishes the possibility of derogatory systems (based on a precise argument). A first solution would be to ask the French-German parliamentary assembly to introduce such a derogatory system allowing the right of option with the possibility of a double affiliation on the French-German border. This would constitute a "standardised" derogatory system, i.e. going beyond the derogations granted currently on a case-by-case basis
- ⇒ Report the administrative obstacle via the European platform (Border Focal Point) in order to introduce in Regulation (EC) No 883/2004 a right of option for double affiliation

1.3. Case No. 3: Refusal to issue the S1 form for family members of the frontier worker

Description of the case

In the case of frontier workers residing in Germany and working in France, family members will be refused the S1 form by the French health insurance body if they do not fall within the definition of beneficiaries in the sense of French regulation.

Suggestions for improvement

The problem originates from the French interpretation of Regulation (EC) No 883/2004. It would be desirable to clarify the application of Article 1(i)(ii) of Regulation (EC) No 883/2004.

Discussion points

The interpretation made by the CNAM of Regulation 883/2004 seems to be contrary to the Regulation.

Solutions

Clarify whether the interpretation of the regulation by the CNAM is in conformity with the regulation.

- ⇒ Report the problem to the European Commission
- ⇒ Contact the French-German parliamentary assembly

1.4. Case No. 4: Loss of French health insurance coverage related to the change of residency (to a foreign country) as part of parental leave

Please refer to the annex for the complete analyse of this problem case.

Description of the case

If a person who lives and works in France returns to their country of origin for the duration of parental leave, he or she loses health insurance coverage in France despite having paid contributions

(possibly for many years).

Suggestions for improvement

This issue needs to be addressed at national level on the French side.

Discussion points

- Since the introduction of PUMa, it is necessary to reside in France for at least 6 months a year in order to be eligible for affiliation based on residency.
- The issue also concerns frontier workers working in France and taking parental leave.

Solutions

Include in European regulations the possibility of an "exceptional exportability" of affiliation rights if the employment contract is maintained.

⇒ Report the administrative obstacle via the European platform (Border Focal Point)

1.5. Case No. 5: Healthcare in the country of residence for persons covered by a private health insurance in Germany

Description of the case

Most frontier workers have two insurance cards (in France and Germany) which allow them access to healthcare under national conditions both in their country of residence and in their country of employment. However, this is not possible for frontier workers who live in France and are insured through a private health insurance body in Germany: they do not have the possibility to register for public French health insurance coverage. This leads to an administrative burden if patients use health services in France.

Discussion points

- Insureds of private health insurance companies in Germany are not entitled to return to the system of legal health insurance bodies. Nor are they intended to be able to return there through a foreign legal health insurance body. PUMa excludes the possibility for privately insured persons to be affiliated based on residency. It should be noted that an agreement has been concluded with Pôle Emploi (French employment agency) to allow privately insured persons who fall into unemployment to be registered despite the fact that they do not have a French social security number.
- This situation effectively forces privately insured persons to pay in advance for their care in France (including in the event of hospitalisation). However, they must also advance the costs for healthcare in Germany, so this does not seem problematic.
- Nonetheless, it is necessary to differentiate according to the target audience: It can be assumed that Germans who choose to be affiliated to a private health insurance company are familiar with the German system and know the implications of their choice. On the other hand, French people who have to choose between a legal health insurance body (GKV) or a private health company (PKV) for the first time in Germany, are not always well aware of the implications of their choice (and in particular the impossibility of returning one day to the GKV).

Solutions

⇒ Strengthen advice/information to French frontier workers who have to be affiliated to a health insurance body in Germany for the first time, and are not under the obligation to be affiliated to the GKV.

1.6. Case No. 6: Certificate of incapacity for work in a cross-border context

Description of the case

The issue of a certificate of incapacity for work may cause two types of problems in a cross-border context:

- Problem 1: Certificate of incapacity for work in a foreign language
- Problem 2: Certificates of incapacity for work transmitted to the wrong health insurance body

Suggestions for improvement

- (Re)-introduce bilingual certificates of incapacity for work
- Information of the insured by the health insurance body in the country of residence
- Direct transmission of certificates of incapacity for work between the health insurance bodies
- Tolerance regarding financial sanctions imposed on the insured, when the delay of the transmission is due to the fact that the insured has sent the certificate to the wrong health insurance body

Discussion points

Concerning the first problem (certificate of incapacity for work in a foreign language):

- Good practice of "bilingual certificates of incapacity for work": This is a purely local initiative of the AOK Breisach (Germany), which approaches French doctors in a very limited geographical area.
- On the French side, it is possible to request the translation of certificates of incapacity for work from the French social security liaison body (CLEISS).
- Written comment by the German social security liaison body (DVKA): German health insurance bodies can contact the DVKA. They have access to translations of French certificates of incapacity for work on the extranet.

Concerning the second problem (certificates of incapacity for work transmitted to the wrong health insurance body):

- The problem is aggravated by the fact that certificates of incapacity for work are more and more often paperless. On the French side, the doctor then automatically sends the certificate to the CPAM (even when the CPAM is not competent).
- Concerning the proposal to systematically inform the patient when he has sent the certificate to the wrong health insurance body: The CPAM indicates that it systematically informs the insured. According to the INFOBESTs, this does not always seem to be the case and/or the

information sent to the insured is not explicit enough (letters stating "We are not competent" but not telling the insured that the competent entity is their health insurance body in Germany).

- Concerning the suggestion to show tolerance when the delay of the transmission is due to the fact that the insured has sent the certificate to the wrong health insurance body: the CPAM indicates that it issues attestations (stating the date of reception), so that nobody is disadvantaged.
- Concerning the proposal that the certificate, when it has been sent to the wrong health insurance body, should be sent directly to the competent entity: The old regulation contained an obligation to forward the certificate to the competent entity. This requirement has been abolished due to the excessive workload.
- On 1 July 2019, the EU's Electronic Exchange of Social Security Information (EESSI) system will be introduced. This system will allow the exchange of European forms in digital form. There is no European form for certificates of incapacity for work, therefore they are not concerned. It would be interesting to see if certificates of incapacity for work can be integrated into the system and/or plan an automatic transmission to the competent health insurance body.
- Another problem has been raised: French certificates of incapacity for work do not mention the diagnosis, unlike German certificates. However, the German health insurance bodies need the diagnosis to proceed with the payment of sickness compensation. In such cases, the health insurance can send a request for information to the medical service of the neighbouring country (via the E 116 form), but the procedure is very time-consuming.

Solutions

Raise awareness among the concerned target groups that the certificate of incapacity for work must be sent to the legally competent health insurance body:

⇒ Inform the insured when the S1 is delivered (welcome letter with list of important information)

⇒ Inform the insured through employers

⇒ Inform the insured online (health insurance bodies, organizations for the collection of social security and family benefit contributions...)

⇒ Inform healthcare professionals through the joint doctor/health insurance committees and a circular to the doctors

Initiate a reflection on the digital cross-border transmission of certificates of incapacity for work:

⇒ This point can only be addressed after the introduction of EESSI. It is specified that in any case, the forms as they are used in the country of healthcare must generally be recognised by the health insurance body in the neighbouring country (for example, since the diagnosis is not specified on the French form, internal arrangements must be found by the German health insurance bodies to derogate from requiring a diagnosis or to follow the procedure laid down in form E 116).

1.7. Case No. 7: Payment of social security contributions in the neighbouring country

Description of the case

Employers of frontier workers may have to pay social security contributions in the neighbouring country. This concerns frontier workers in particular cases of multiple activity in a cross-border context, as well as situations where the frontier worker is teleworking. It is often difficult for employers to obtain the information they need to pay social security contributions in the neighbouring country.

Suggestions for improvement

- Establishment of cross-border procedures, e.g. protocols for calculation and payment of social security contributions in a cross-border context.
- Training/information for employees of the competent entities for the determination and collection of social security contributions.
- Designation of one or more interlocutors by the competent entities for questions related to the determination and the collection of social security contributions in other states.
- Increased communication between the competent entities for collecting social security contributions and employers
- Establishment of an inter-state moratorium allowing a foreign employer to hire a person on a part-time basis who is registered at the employment services of his country of residence to pay social security contributions for him in his country of activity rather than in his country of residence.
- Clarification of the case of persons receiving unemployment benefits in their country of residence, but are also working in another country.

Discussion points

Additional information about the problems:

- Lack of information among companies about legislation. The French body for the collection of social security contributions URSSAF/CNFE has set up a dedicated website (https://www.cnfe-urssaf.eu/index.php/de/) for foreign companies, with information available in several languages. However, companies are not familiar with URSSAF or CNFE.
- Often, the employee does not inform the employer that he or she is in a multi-activity situation
- This is also an important topic for the unemployed: If they start a job on a part-time basis on the German side, Germany becomes the competent state. However, most people do not know this.
- On the German side, a multitude of interlocutors is in charge (each health insurance body is competent)
- It is particularly important to solve the issue of teleworking, as it is developing strongly, particularly in a cross-border context as a solution to traffic jams (i.e. Luxemburg).
- If it is established that the social security contributions have not been paid in the competent state, they must be paid retroactively by the person/company to the competent state. At the

same time, they must request reimbursement in the state which received them wrongly. This procedure is long and complex and should be simplified.

- Written comment by the German social security liaison body (DVKA): With regard to the share of 25 % of working time in the country of residence, Article 14 (10) of Regulation (EC) No 987/09 lays down that a period of 12 months shall be taken into account when determining the applicable legislation.
- Written comment by the German social security liaison body (DVKA): The establishment of a moratorium does not seem comprehensible to the DVKA, since the regulation clearly lays down the applicable legal provisions.

Solutions

Consider setting up a single interlocutor or coordinator on the German side:

⇒ Report the problem to the German social security liaison body (DVKA) which is part of the GKV-Spitzenverband

Raise awareness among the persons/companies concerned:

⇒ Better inform the persons and companies concerned
⇒ Train employees of health insurance bodies

Establish a moratorium on teleworking not being taken into account when determining the competent state (e.g. the state in which contributions are paid):

⇒ Before this can be done, it is essential to start thinking about the definition of “teleworking” in a cross-border context.

1.8. Case No. 8: Lack of information for frontier workers residing in France who already receive a French pension

Problem No. 1: Lack of information on the fact that social security contributions on French pensions must be paid in Germany

Description of the case

French frontier workers receiving a French pension whilst working in Germany must pay all their social security contributions in Germany (including social security contributions for the French pension). They are often unaware of this. Usually, the German health insurance body only obtains the information when the application for payment of the German retirement pension is made. This results in high surcharges to be paid. The reimbursement of contributions paid in France is very difficult to obtain.

Suggestions for improvement

- Systematically inform the employees concerned and their employers
- Facilitate the refund of contributions paid in error in the country of residence

Discussion points

This is a problem of information for the insured. The INFOBEST network and EURES-T Upper Rhine

have developped an information sheet on topics related to frontier workers who receive a pension.

Solutions

⇒ Raise public awareness/information

Problem No. 2: Lack of information on German sickness benefits when receiving a French retirement pension

Description of the case

Under German law, a person is not entitled to sickness benefits if he or she already receives a full retirement pension from a German or foreign pension fund.

According to the recommendations of the German social security liaison body (DVKA), a French retirement pension will only be considered a “full pension” if the legal age limit for pension rights in Germany has been reached (circular of 21.02.2008). Below this age limit, according to the DVKA, the person is therefore entitled to sickness benefits. However, some health insurance bodies do not follow these recommendations. Furthermore, in a recent ruling, the Social Affairs Court of the Land of Rhineland-Palatinate ruled in favour of a health insurance body that refused to pay sickness benefits in this type of situation. The federal court for social affairs ruled about this case on 04.06.2019, however the results haven’t been published yet. There is therefore legal uncertainty and many frontier workers who already receive a French retirement pension are not aware of the risk of non-payment of sickness benefits.

Suggestions for improvement

- Better information for the persons concerned
- Clarification of the legal situation

Discussion points

The challenge is likewise to better inform the insured. However, this is not possible until the legal situation is clarified on the German side.

Solutions

⇒ Raise public awareness/information
⇒ Clarify the legal situation on the German side

Problem No. 3: Lack of information about French pensioners working in a mini-job in Germany

Description of the case

A pensioner residing in France and working in a mini-job in Germany has to become affiliated to a German health insurance body. Very often, the pensioners concerned are not aware of this and remain affiliated on the French side. However, there may be a problem in the event of an accident at work: the employer will notify the competent accident insurance body, which will state that the health insurance affiliation has not been properly executed. Consequently, in order to regularize the situation, the German health insurance body will claim the payment of the contributions

retroactively, while the CPAM will refuse to reimburse healthcare expenses.

Suggestions for improvement

- Better information for employers and the persons concerned
- Clarification of the legal situation

Discussion points

- The issue is not only one of informing the individuals concerned. The legal situation is not clear: According to the German social security liaison body (DVKA), the person must be insured in Germany, even if mini-jobs are exempt from contributions. For the French health insurance, the person must be insured in France, as the French pension entitles them to a permanent right to health insurance and mini-jobs are exempt from contributions. However, it is not possible to decide this question at the moment, because there are also legal issues on the German side concerning mini-jobs (in a purely national context). These questions are currently being clarified at the level of the GKV-Spitzenverband. This includes determining whether the mini-job should be considered as an employed activity. If this is the case, the French frontier worker will have to affiliate to a health insurance body on the German side (his affiliation rights in France will simply be suspended until the end of the activity).
- In the meantime, all frontier workers working in a mini-job must be informed, as they should become affiliated to a German health insurance body (minimum charge per month = 180€).
- Another question is not clear: do people who live in Germany and exclusively receive a French pension have to voluntarily insure themselves on the German side in the event of a professional activity?

Solutions

⇒ Raise public awareness/information
⇒ Clarify the legal situation on the German side

2. Action protocol for issues concerning all residents of border regions

2.1. Case No. 9: Continuity of care after the loss of the legal status as a frontier worker

Description of the case

When a person loses his status as a frontier worker because of the loss of his job or because he returns to work in his country of residence, he loses his health insurance coverage in the country in which he previously pursued his professional activity. This presents a problem for people who have started treatment in the neighbouring country (former country of professional activity) and would like to continue this treatment under the same conditions (i.e. tariff and reimbursement) after their change of status.

This leads to supplementary administrative burdens in the two categories of planned care in the neighbouring country:

- Treatments involving overnight hospital accommodation of the patient in question for at least one night, or requiring the use of highly specialised and cost-intensive medical infrastructure or medical equipment (need for prior authorisation (S2 form) and difficult choice of the applicable rate for reimbursement)
- Planned outpatient care (reimbursement based on the tariffs of the country of affiliation)

Suggestions for improvement

- More flexibility in the delivery of S2 forms, taking into account the issue of continuity of care and/or language in a cross-border context,
- Integrate these two criteria into Directive 2011/24/EU and/or national legislation transposing the Directive as factors to be taken into account when issuing prior authorisations,
- Extend the conditions of eligibility to the S3 form (granting special rights to retired frontier workers in terms of continuity of care).

Discussion points

- This is a question of continuity of care, but also often a question of language skills, for German nationals who have chosen to settle in France. It is recalled that the language criterion is not recognized as a criterion for issuing a S2 form. In practice, on the French side, S2 forms have been delivered in the past for linguistic reasons, in particular for treatments where language plays a particularly important role and even when such treatments do not require prior authorisation under French legislation (e.g. psychiatry). Nowadays, the issuing of S2 forms is much more restrictive on the French side: they are exclusively delivered for treatments requiring prior authorisation (hospital treatments with overnight stay; highly specialised and cost-intensive treatments listed in the 2014 decree on prior authorisations).
- A person who has lost frontier worker status and wishes to continue care in Germany may demand a S2 form, if a prior authorisation is required for the treatment in question (e. g. cancer treatment). Although continuity of care is not a criterion for the delivery of S2 forms, in practice, the S2 form will normally be delivered. However, it is important that the person clearly specifies the pathology and presents his or her case in detail with a letter

accompanying the request for prior authorisation. In general, there is a lack of information on the following points: Need to obtain a S2, need to explain your case to obtain the S2, whom to address the S2 once it has been obtained.

- On the German side, the delivery of S2 forms depends on the different health insurance bodies and is more flexible. In particular, it is not limited to treatments requiring prior authorisation under German law.
- Discussions concerning the suggestions (taking into account continuity of care as a criterion for the delivery of S2 forms; extension of eligibility for S3 form):
  - Given that the question arises mainly on the French side (restrictive policy of issuing authorisations), it could be more effective to change the French regulations, rather than the European regulations.
  - For the CNAM, it is not desirable to make continuity of care a criterion for the delivery of the S2 form. This has been the case in the past, and has led to a deviation of the S2. The S2 forms may be granted for reasons of continuity of care depending on the individual situation, but it is not desired to make this a general principle.
  - The S3 form is dedicated to the issue of continuity of care, but currently limited to retired frontier workers (art. 28 of Regulation 883-2004). An extension of the conditions for granting the S3, at the European level (amendment of the regulation), would be a more effective solution.
  - The AOK points out that this could be problematic regarding Switzerland, due to the tariff disparities. Currently, for people wishing to continue their care in Switzerland, the AOK only provides S2 forms for cancer treatments (proton therapy) and limited to one year.
  - Written comment by the German social security liaison body (DVKA): An extension of eligibility for S3 forms would only be possible by changing EU regulation.

Solutions

Amendment of the Regulation to extend the conditions for granting the S3 form currently reserved to retired or disabled frontier workers.

⇒ Report the proposal via the European Platform (Border Focal Point)
⇒ Contact the French-German parliamentary assembly
⇒ Report the proposal to the French Ministry of Health
⇒ Report the proposal to the German social security liaison body (DVKA)

2.2. Case No. 10: Tariff choice for emergency care abroad

Description of the case

In the case of emergency care during a stay abroad, when the European Health Insurance Card (EHIC) has not (or couldn't) been used, the patient who demands the reimbursement from his health insurance body has the possibility to choose between reimbursement on the basis of the tariffs in the country of care or on the basis of the tariffs in the country of affiliation. In practice, this leads to several problems that mainly concern the insured of the French health insurance body:

- Difficulty in making an informed choice (patient cannot know the different tariffs and does

not know that a reimbursement on the tariff base of the country of care may be very time-consuming)

- Difficulty for the patient to access information (existence of National contact points not widely known, moreover they can only give general advice and not precise tariff rates for instance)
- Impossibility for the patient to change his choice afterwards

Concerning the European Health Insurance Card (EHIC):

Suggestions for improvement

- Set up in France a system identical to the one adopted by Germany, namely integrate the EHIC on the back of the Carte Vitale (national health insurance card).
- Better inform people living in border regions about the importance of always keeping their EHIC on them, even when crossing the border only for short periods of time.

Discussion points

- A lack of information among insured persons on the French side:
  - The EHIC is presented as the "holiday card", while border populations may need it in daily life.
  - Frontier workers are not always aware that their health insurance body in the country of employment issues their EHIC. Also, when moving from one country of employment to another, they may keep the old card.
- On the French side, the incorporation of the EHIC on the Carte Vitale is not planned because of the costs and because of the upcoming dematerialisation of the Carte Vitale, which should take place within 10 years. The dematerialisation test phase of the Carte Vitale (excluding the EHIC) will be launched on January 1, 2021. Specific measures will be taken for people who do not necessarily have a smartphone (especially the elderly): assistance, delivery of a physical Carte Vitale, etc.
- In France, the validity of the EHIC is currently limited to 2 years. In principle, an extension would be possible, as well as reminder messages to the insured to renew it.
- The introduction of the EESSI on July 1, 2019 (which may be postponed) will facilitate the transmission of information between health insurance bodies, in particular with regard to the Provisional Replacement Certificate (PRC) for the EHIC.
- In Germany, the EHIC is often refused by doctors (including for emergency treatments). The problem has already been raised within the French-German-Swiss Intergovernmental Commission. The problem of private billing persists - even if doctors in Germany are, in principle, required to accept the EHIC and apply the legal tariffs.

Solutions

⇒ Better inform insureds in French border areas about the EHIC:
  - Raise awareness of the importance of the EHIC by promoting it rather as a "mobility card".
  - Inform about the validity period and the need to renew it if necessary.

⇒ Increase the validity period of the EHIC for French insureds.

⇒ Remind doctors on the German side that in an emergency they are required to apply the

legal tariffs and to accept the EHIC.

Concerning the choice of the basis for reimbursement if the EHIC is not used:

Suggestions for improvement

- Add the contact details of the French social security liaison body (CLEISS) as an National Contact Point (NCP) in the reimbursement request form (for example in the explanatory note for the french reimbursement request form Cerfa No. 12267*03)
- Give more visibility to the French NCP (dedicated website, hotline, patient communication plan).
- Facilitate information exchange between NCPs to strengthen prior information to patients
- Allow patients to change their choice afterwards if it turns out that the tariff chosen in their demand is unfavourable to them. This is currently not the case.
- Provide local contacts who are informed of local situations regarding the tariff differences.

Discussion points

- On the French side, the explanation of the S 3125 form has changed and now specifies that if the patient does not make a choice regarding the base of reimbursement, the tariff of the country of treatment applies by default.
- Neither the National Contact Points nor the Center for Consumer Protection in Europe are able to inform patients about the choice of the most advantageous tariff, due to the lack of knowledge of the tariffs applied, especially on the German side. The Center for Consumer Protection in Europe says that the only reliable information they can give is that reimbursement will be much faster if the patient chooses the French tariff base. Information on the tariffs applied in the different countries should be improved. It is also indicated that when requests for tariffs are sent to third countries via E 126 form, the delays for an answer are sometimes very long, depending on the country.
- The German tariffs are available in the “Einheitlicher Bewertungsmaßstab” (EBM). However, this information is not easy to understand for the average citizen.
- According to the representative of the MSA (French health insurance body for agricultural workers), the choice of a certain reimbursement basis has in most cases no significant influence on the amount of the reimbursement, with one exception: transportation (in particular helicopter transportation, many cases concerning Austria). On the French side, the reimbursement of emergency transport costs is a flat-rate amount (e.g. 200 € for helicopter transportation) and is significantly lower than the costs charged to the insured). The issue is currently under discussion at the CNAM. According to the representatives of the Center for Consumer Protection in Europe, the differences in reimbursement, depending on the choice of the tariff basis, can be significant even beyond transportation itself.

Solutions

⇒ It would be desirable to improve communication between National Contact Points (NCPs).
⇒ Report the obstacle via the European Platform (Border Focal Point)
⇒ Report the obstacle to the European Social Insurance Platform (ESIP)

2.3. Case No. 11: Difficulties related to the reimbursement of planned care abroad

Problems related to reimbursement demands and their handling

Problem No. 1: Language/Translation

Description of the problem

The Center for Consumer Protection in Europe sometimes registers claims against the French health insurance body for the self-employed / liberal professions (RSI) which requires translations of bills in a foreign language. This is not the case for insured of the regular French health insurance body, since the CPAM can demand the French social security liaison body (CLEISS) for translations.

Can health insurance bodies require the insured to translate foreign documents (such as bills, medical certificates etc.) at their own expense?

Discussion points

- In France: The French social security liaison body (CLEISS) has a translation service, which translates free of charge for people covered by the CNAMTS. The MSA (French health insurance body for agricultural workers) can use this service, but will be charged (without direct billing to the insured).
- Kaufmännische Krankenkasse (KKH): If necessary, insured persons must pay for translation costs from an external office. The costs remain moderate because it is not a certified translation.
- AOK: no translation required for reimbursements within the EU, if necessary use of an external translation agency paid by the AOK.
- Written comment by the German social security liaison body (DVKA): According to Article 76 (7) of Regulation (EC) No 883/04 authorities, institutions and tribunals of one Member State may not reject applications or other documents submitted to them on the grounds that they are written in an official language of another Member State.

Solutions

⇒ Request the German social security liaison body (DVKA) to issue a recommendation to German health insurance bodies to avoid that the insured have to pay for costs of translation.

Problems No. 2 & 3: Differences in tariffs / codification between France and Germany and lack of control / explanation for the reimbursed patient

Description of the problem

2) Understanding foreign medical bills: What about the difference in codification? German doctors are used to codify in detail, while French doctors codify by “block of medical acts” (e.g. dental surgery).

3) The tariffs applicable in France or in other European countries are not public despite the provisions of Article 7(6) of the Directive, which states that: “...Member States shall have a transparent

mechanism for calculation of costs of cross-border healthcare that are to be reimbursed to the insured person by the Member State of affiliation." The Center for Consumer Protection in Europe is regularly contacted by consumers who have doubts about the amount of reimbursement made by their health insurance body asking for explanations.

Recommendation of the Center for Consumer Protection in Europe

- Designate an interlocutor at the central service for the reimbursement of healthcare expenses abroad of the French legal health insurance (CNSE) and, eventually, at the correspondent structures in the other EU member states.

Discussion points

- In the context of doctor's offices, there are major differences in billing between Germany (very detailed bills, list of medical acts) and France (billing by consultation, with four main pricing categories depending on complexity).
- In France: the codifications of acts are available online on Ameli.fr (website of the French health insurance body), the purpose of the codification (including little details) being also the protection of medical confidentiality. However, the information is not easily accessible. In addition, it is difficult to know the costs in advance without knowing the status (convention area 1, 2 or 3) of the doctor. The German rates are available in the "Einheitlicher Bewertungsmaßstab" (EBM). However, this information is not easily understandable for the average citizen.
- In Germany: the main problem remains private billing, which is 3.5 times higher than the legal tariff.
- German health insurance bodies charge administrative fees for the reimbursement of healthcare costs abroad (up to 7.5% of the total amount), which seems to be contrary to the free mobility of patients.
- Efforts are being made at the European level to improve the transparency of the codifications used in the various countries (better knowledge of the codification of the different countries, harmonisation of definitions, definition of equivalences, etc.) according to the CNAM (French health insurance body).

Solutions

⇒ Underline and deepen the efforts already made to ensure the transparency of the codifications.

⇒ It would be useful to be able to provide patients with basic and easily accessible information on tariffs in both countries.

⇒ Report the issue of private billing in Germany to the French-German parliamentary group.

⇒ Request the German social security liaison body (DVKA) to issue a recommendation concerning the abolition of the administrative fees charged by German health insurance bodies for demands for reimbursement of care abroad, which seem to be contrary to the directive.

Problem No. 4: Absence of a "planned outpatient care" checkbox in the French form for claiming reimbursement of medical expenses abroad

Description of the problem

The category “Characteristics of the stay abroad” in the French S3125 form (accessible online) is worded as excluding a situation that is nevertheless classic in the border region, namely that of planned outpatient care. In some cases, demands of patients who had not ticked any box were even sent back.

Recommendation of the Center for Consumer Protection in Europe

- Add a specific box “Planned outpatient care”

Discussion points

- It is pointed out that in French terminology, it is referred to as “outpatient care” (not “planned outpatient care”).
- The form in question is currently being revised within the CNAM.

Solutions

⇒ The form is already being revised.

Problems related to prior authorisation

Problem No. 5: Question of the relevance of the prior authorisation system for certain types of care: The example of MRI in the French-German border region

Description of the problem

Alsatian patients have problems accessing MRI (magnetic resonance imaging) examinations. A report published in 2015[5] by the Center for Consumer Protection in Europe, which is still relevant today, shows that the prior authorisation system is no longer adapted to the current situation, which is characterised by a shortage of this type of equipment. Waiting times for an MRI examination are well beyond “reasonable delays” and delay care by exposing the patient to “loss of opportunity”. The delays from the time an appointment is made can be well over 45 days on the French side while the delay is a few days on the other side of the Rhine.

However, the patient's situation has worsened with the continuing need for prior authorisation for this examination in France. Access to MRI in the border region remains as complicated for the patient as ever, which significantly delays treatment (as well as the reimbursement of costs).

Recommendation of the Center for Consumer Protection in Europe

In accordance with the resolution of 06.11.2015 of the Upper Rhine Council:

- Allow conventions between the French regional health authority (ARS Grand Est) and German radiologists' offices with such equipment and a bilingual medical team, if they apply the French tariffs for sector 1 without exceeding them and write the reports in French language,
- Abolish the system of prior authorisation required by the French authorities in the case of

[5] https://www.cec-zev.eu/fileadmin/user_upload/cec-zev/PDF/themes_conso/sante_allemagne/RapportIRM2015.pdf

MRI examinations carried out in Germany

Problem No. 6: Insecurity related to delays in processing approval for prior authorisation

Description of the problem

In accordance with Directive 2011/24/EU (Article 8), member states may provide for a system of prior authorisation for reimbursement of costs of cross-border healthcare, in particular:

- Treatments involving overnight hospital accommodation of the patient for at least one night
- Treatments requiring the use of highly specialised and cost-intensive medical infrastructure or medical equipment

Member states who apply this system – like France and Germany – "shall set out reasonable periods of time within which requests for cross-border healthcare must be dealt with" (Article 9). While these delays are clear on the French side, in Germany, there is legal uncertainty as to the legal time limits for issuing prior authorisations and how the absence of a reply from a cash register should be interpreted (whether a lack of reply can be considered as an acceptance).

Recommendation of the Center for Consumer Protection in Europe

- Clarification of the legal situation
- Demand recommendations on the interpretation from the German social security liaison body (DVKA)

Discussion points

- AOK & KKH: the delays for prior authorisations are the same as for treatments in Germany, a non-response being equivalent to authorisation.
- Written comment by the German social security liaison body (DVKA): The federal court has ruled that the delays for prior authorisations are the same as for treatments in Germany (BSG-Urteil Az.: B 1 KR 1/18 R).
- Written comment by the German social security liaison body (DVKA): A recommendation by the DVKA is not possible, the GKV-Spitzenverband (Abteilung Gesundheit, Referat Leistungsrecht, Reha, Selbsthilfe) is responsible for all questions concerning the interpretation of the national law.

Solutions

⇒ Request the GKV-Spitzenverband to issue a recommendation to clarify the question of delays to all health insurance bodies.

⇒ On the German side, better information about the delays.

Problem No. 7: Different definition of inpatient care in France and Germany

Description of the problem

Article 8 of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare sets out a regulatory framework for medical treatments that may be subject to prior authorisation. Nonetheless, the wording chosen by the European legislator leaves open the possibility of defining

stationary care, which is subject to prior authorisation. This leads to legal uncertainty for patients and entails the risk of divergent interpretations emerging from European national administrations. This is the case for instance between France and Germany, which is particularly important in the border region.

Recommendation of the Center for Consumer Protection in Europe

- Find an agreement between French and German authorities for the border region, agreeing on a common definition of inpatient care that includes at least one day of overnight hospital accommodation

Discussion points

- The difference probably comes from the historical differentiation in Germany between hospitals and doctor's offices, which are organized through the Kassenärztliche Vereinigung (KV).

Solutions

⇒ In Germany, health insurance bodies will check internally which types of hospital care are subject to prior authorisation. Does this cover, for example, "partially inpatient treatments"?
⇒ Request the French-German parliamentary group to reflect on the definition of hospital care in both countries that is subject to prior authorisation.

2.4. Case No. 12: Healthcare for patients when the medical emergency requires the patient to cross the border for treatment

Description of the case

European regulations distinguish very clearly between emergency care during a stay abroad on the one hand and planned care abroad on the other. They do not adequately cover cases of medical emergency, which force the patient to cross the border to access healthcare services because of the impossibility of rapid care in the country of residence. This concerns both types of medical treatment in the neighbouring country:

- Emergency care in a hospital (e.g. patient's doctor is located in the neighbouring country and diagnoses a serious pathology; recommending urgent hospitalization, the doctor finds a place in a nearby clinic in the neighbouring country.)
- Emergency care in a doctor's office (e.g. because of long waiting lists in the country of residence)

Hospital care

Suggestions for improvement

- Grant reimbursement when the medical emergency justified that the patient did not request prior authorisation

Discussion points

- The problem is not only the time required to issue authorisations: patients often do not know that prior authorisation is required. Even the doctors themselves do not always know.

- When an insured from France has gone to Germany for urgent care without prior authorisation and then makes a request for coverage, the medical service usually grants the S2 a posteriori. At the AOK, it is also possible to obtain retroactive validation if necessary. Nevertheless:
  - The French side indicates a problem with the training of employees: When the person calls to request an S2 while still in hospital or already released, the employee will tend to answer that the S2 cannot be delivered because the S2 is intended for planned care and the person is already in the hospital.
  - In order to enable the reimbursement, it is necessary that the context of the situation be clearly and completely explained in a letter from the insured and/or in the prescription of the doctor. However, few doctors are aware of this necessity. Doctors in the border area need to be better informed (e.g. through the Kassenärztliche Vereinigung and the medical association) about how to act administratively in such cases.
  - Coverage is therefore possible on a case-by-case basis, but it is not possible to make it a general principle, because there would be deviations (because of different interpretations of what is “urgent” or not).
- The CNAM indicates that the situation will improve with the implementation of the EESSI:
  - EESSI will speed up the procedure for issuing the S2 (the maximum processing time being 2 weeks).
  - Thanks to EESSI, the competent institution of the country of treatment will be able to request the S2 as a matter of urgency from the competent institution of the country of affiliation. It should be noted, however, that healthcare providers are not involved in EESSI. It will therefore be necessary for the healthcare provider to first contact the competent institution of the country of treatment
- Possibility of concluding specific bi-national agreements to facilitate access to care?
  - AOK can conclude agreements. An agreement exists, for example, with the children's hospital in Basel.
  - CPAM can conclude agreements within the scope of the framework agreement. There was an attempt to establish an agreement between the children's hospital in Basel and the Clinique des 3 Frontières on the French side, but it was not successful. However, a standardised procedure has been put in place: When a new-born is cared for in Basel, the CPAM medical service is informed and an S2 is automatically delivered.

Solutions

⇒ (Better) inform patients and doctors about the necessity to request a S2 form, and the need to explain the context to justify the treatment. For doctors, information campaigns could be considered in the medical schools.

⇒ Better training of employees of the health insurance bodies regarding retroactive S2 deliveries.

⇒ Conclude specific agreements between health insurance bodies and healthcare institutions when necessary.

Care in doctor's offices

Suggestions for improvement

- Exceptional reimbursement of actual costs, because of the medical emergency and the impossibility of treatment within a satisfactory time in the country of residence.

Discussion points

- Context of lack of doctors, which is generally very marked in (rural) border regions.
- It is possible to designate a doctor established in Germany as "general practitioner" in the sense of French regulation. The doctor living abroad does not have an registration number (ADELI) but a fictional number may be assigned. However, to be recognized as a general practitioner, the doctor must sign the medical agreement, which only exists in French and therefore, very often, the doctor does not follow up.
- The question of language could be taken into account, regarding the delivery of a S2 form in this type of case.
    - From the point of view of a representative of the CPAM, the language question often concerns former German frontier workers who moved to France for purely economic reasons (lower tax/real estate costs). Independently of the question of the continuity of care, it can be assumed that these persons, if they decide to move to France, accept all the inherent consequences. Since the treatment does also exist in France, the issue is consequently not considered a priority.
    - For AOK: S2 forms are delivered on a case-by-case basis. This is a discretionary decision, taking into account all contextual elements (including language, but also other criteria such as family reasons).
    - See also the discussions regarding case No. 9.
- Within the CPAM, a mediator at the departmental level can refer insured persons who have not found a doctor. However, the mechanism may not be sufficiently known, even if the delays are relatively short.

Solutions

⇒ Inform French insureds about the existence of the mediator

2.5. Supplementary Case No. 1: Reimbursement of emergency healthcare

Description

Problems of reimbursement for French insureds that have an accident in Germany and are admitted:

- in a German hospital or
- (by helicopter) in a hospital in Basel.

Healthcare institutions refuse to accept the EHIC, considering the treatment to be "planned" care because it is the result of a consultation or decision by the German emergency services and claim direct payment of costs of treatment from the insured or a S2 form. The CPAM said it was impossible to issue a S2 form, since these transfers are carried out in an emergency situation.

Points of discussion

- There appear to be differences between countries in the definition of “urgent care” and “planned care”, potentially related to differences in the definition of “primary care” and “secondary care”.
- Since the rules for emergency care are based on European regulations, this difference in definitions seems peculiar. Emergency care is defined in EC Regulation 883/2004 as necessary care during a stay in another Member State that cannot be postponed until the patient returns to his country of origin. Whether a doctor is treating first or a transfer is made by decision of the control centre does not change the European definition, which applies to all countries.
- With regard to the case described, the Swiss Health Insurance (KVG) has found a pragmatic solution for this type of case between Switzerland, Austria and Germany.

Solutions

⇒ Request the French-German parliamentary group to reflect on the definitions of “urgent care” and “planned care” in the two countries

2.6. Supplementary Case No. 2: Temporary employment

Description

A French temporary employment agency sends a temporary worker for assignments to Germany. The temporary employment company has its headquarters in France, but the temporary worker pays social security contributions in Germany. The temporary worker has been carrying out missions in Germany for several months without interruption on behalf of this French interim company. However, his contracts only run from Monday to Friday. Following a private accident during the weekend, the temporary worker is refused sickness benefits. The German health insurance body declares that it is not competent since the contract ended on Friday and the new contract did not start until the following Monday. The CPAM also refuses to pay sickness benefits because the person was paying social security contributions in Germany and was not registered as a jobseeker in France during the weekend.

Points of discussion

- In this case, France is competent (even without registration at Pôle emploi / employment agency) on the basis of the residence criterion introduced by the PUMa legislation.
- According to § 19 (2) SGB V, the German health insurance must still cover the former insured for one month after the end of his professional activity if he cannot benefit from the status of a beneficiary (Familienversicherung). French temporary employment contracts also provide weekend coverage if the contract ends on Friday.
- In any case, people in this situation should remain registered at Pôle emploi to avoid problems.

Solutions

Develop platforms for discussion between all relevant stakeholders.

3. Overview of solutions found

Case	Solution(s)
Case No. 1: *Requirement for frontier workers to submit complete applications for health insurance coverage both in their country of residence and in their country of employment*	⇒ The problem will be partially solved due to the automatic transmission of S1 forms via EESSI. ⇒ Strengthen EESSI and reinforce the process of setting common standards for transmission. ⇒ The introduction of EESSI could eventually make it possible to avoid having to provide twice the documents required in both countries. However, the question will always arise for documents that are only required in one of the two countries.
Case No. 2: *Problem of affiliation of children in case of divorce or separation of parents*	Grant a right of option for the affiliation of the child (possibility of choosing to be affiliated with the frontier worker parent or the non-frontier worker parent), with the possibility of a double affiliation (affiliation with both parents), as it would be the case in a "purely national" French or German context. ⇒ The French-German Treaty of Aachen establishes the possibility of derogatory systems (on the basis of a precise argument). A first solution would be to ask the French-German parliamentary assembly to introduce such a derogatory system allowing the right of option with the possibility of a double affiliation on the French-German border. This would constitute a "standardised" derogatory system, i.e. going beyond the derogations granted currently on a case-by-case basis ⇒ Report the administrative obstacle via the European platform (Border Focal Point) in order to introduce in Regulation (EC) No 883/2004 a right of option with the possibility of double affiliation
Case No. 3: *Refusal to issue the S1 form for family members of the frontier worker*	Clarify whether the interpretation of the regulation by the CNAM (French health insurance body) is in conformity with the regulation. ⇒ Report the problem to the European Commission ⇒ Contact the French-German parliamentary assembly
Case No. 4: *Loss of French health insurance coverage related to the change of residency (to a foreign country) as part of parental leave*	Include in European regulations the possibility of an "exceptional exportability" of affiliation rights if the employment contract is maintained. ⇒ Report the administrative obstacle via the European platform (Border Focal Point)
Case No. 5: *Healthcare in the country of residence for persons covered by a private health insurance in Germany*	⇒ Strengthen advice/information to French frontier workers who have to be affiliated to a health insurance body for the first time in Germany and are not under the obligation to be affiliated to the GKV.
Case No. 6: *Certificate of incapacity for work in a cross-border context*	Raise awareness among the concerned target groups that the certificate of incapacity for work must be sent to the legally competent health insurance body: ⇒ Inform the insured when the S1 is delivered (welcome letter with list of important information) ⇒ Inform the insured through employers ⇒ Inform the insured online (health insurance funds, organizations for the collection of social security and family benefit contributions...) ⇒ Inform healthcare professionals through the joint doctor/health

	insurance committees and a circular to the doctors Initiate a reflection on the digital cross-border transmission of certificates of incapacity for work: ⇒ This point can only be addressed after the introduction of EESSI. It is specified that in any case, the forms as they are used in the country of healthcare must generally be recognised by the health insurance body in the neighbouring country (for example, since the diagnosis is not specified on the French form, internal arrangements must be found by the German health insurance bodies to derogate from requiring a diagnosis or to follow the procedure laid down in form E 116).
Case No. 7: *Payment of social security contributions in the neighbouring country*	Consider setting up a single interlocutor or coordinator on the German side: ⇒ Report the problem to the German social security liaison body (DVKA) which is part of the GKV-Spitzenverband Raise awareness among the persons/companies concerned: ⇒ Better inform the persons and companies concerned ⇒ Train employees of health insurance bodies Establish a moratorium on teleworking not being taken into account when determining the competent state (e.g. the state in which contributions are paid): ⇒ Before this can be done, it is essential to start thinking about the definition of “teleworking” in a cross-border context.
Case No. 8: *Lack of information for frontier workers residing in France who already receive a French pension*	
Problem No. 1: *Lack of information on the fact that social security contributions on French pensions must be paid in Germany*	⇒ Raise public awareness/information
Problem No. 2: *Lack of information on German sickness benefits when receiving a French retirement pension*	⇒ Raise public awareness/information ⇒ Clarify the legal situation on the German side
Problem No. 3: *Lack of information about French pensioners working in a mini-job in Germany*	⇒ Raise public awareness/information ⇒ Clarify the legal situation on the German side
Case No. 9: *Continuity of care after the loss of the legal status as a frontier worker*	Amendment of the Regulation to extend the conditions for granting the S3 form currently reserved to retired or disabled frontier workers. ⇒ Report the proposal via the European Platform (Border Focal Point) ⇒ Contact the French-German parliamentary assembly ⇒ Report the proposal to the French Ministry of Health ⇒ Report the proposal to the German social security liaison body (DVKA)
Case No. 10: *Tariff choice for emergency care abroad*	
Concerning the European Health Insurance Card (EHIC):	⇒ Better inform insureds in France's border areas about the EHIC: ○ Raise awareness of the importance of the EHIC by promoting it rather as a “mobility card”.

	○ Inform about the validity period and the need to renew it if necessary. ⇒ Increase the validity period of the EHIC for French insureds. ⇒ Remind doctors on the German side that in an emergency they are required to apply the legal tariffs and to accept the EHIC.
Concerning the choice of the basis for reimbursement if the EHIC is not used:	⇒ It would be desirable to improve communication between National Contact Points (NCPs). ⇒ Report the obstacle via the European Platform (Border Focal Point) ⇒ Report the obstacle to the European Social Insurance Platform (ESIP)
Case No. 11: *Difficulties related to the reimbursement of planned care abroad*	
Problem No. 1: *Language/Translation*	⇒ Request the German social security liaison body (DVKA) to issue a recommendation to German health insurance bodies to avoid that the insured have to pay for costs of translation.
Problems No. 2 & 3: *Differences in tariffs / codification between France and Germany and lack of control / explanation for the reimbursed patient*	⇒ Underline and deepen the efforts already made to ensure the transparency of the codifications. ⇒ It would be useful to be able to provide patients with basic and easily accessible information on tariffs in both countries. ⇒ Report the issue of private billing in Germany to the French-German parliamentary group. ⇒ Request the German social security liaison body (DVKA) to issue a recommendation concerning the abolition of the administrative fees charged by German health insurance bodies for demands for reimbursement of care abroad, which seem to be contrary to the directive.
Problem No. 4: *Absence of a "planned outpatient care" checkbox in the French form for claiming reimbursement of medical expenses abroad*	⇒ The form is already being revised.
Problem No. 6: *Insecurity related to delays in processing approval for prior authorisation*	⇒ Request the GKV-Spitzenverband to inform all German health insurance bodies about the fact that the delays for prior authorisations are the same as for treatments in Germany. ⇒ On the German side, better information about the delays.
Problem No. 7: *Different definition of inpatient care in France and Germany*	⇒ In Germany, health insurance bodies will check internally which types of hospital care are subject to prior authorisation. Does this cover, for example, “partially inpatient treatments”? ⇒ Request the French-German parliamentary group to reflect on the definition of hospital care in both countries that is subject to prior authorisation.
Case No. 12: *Healthcare for patients when the medical emergency requires the patient to cross the border for treatment*	
Hospital care	⇒ (Better) inform patients and doctors about the necessity to request a S2 form, and the need to explain the context to justify the treatment. For doctors, information campaigns could be considered in the medical schools. ⇒ Better training of employees of the health insurance bodies regarding retroactive S2 deliveries. ⇒ Conclude specific agreements between health insurance bodies and

	healthcare institutions when necessary.
Care in doctors' offices	⇒ Inform French insureds about the existence of the mediator
Supplementary Case No. 1: *Reimbursement of emergency healthcare*	⇒ Request the French-German parliamentary group to reflect on the definitions of "urgent care" and "planned care" in the two countries.
Supplementary Case No. 2: *Temporary employment*	⇒ Develop platforms for discussion between all relevant stakeholders.

III. Best Practices from the French-German border: Typology of problem solving methods

The Upper Rhine is characterised by a large number of cross-border organisations, platforms and discussion forums. This strong cross-border dynamic manifests itself in a large number of historically grown institutions (Eurodistricts, Upper Rhine Conference, Upper Rhine Council, etc.) which, through their various instances, working groups and committees of experts, are constantly developing and deepening cooperation. It therefore seems appropriate at this point to illustrate that our approach is only one of several options to tackle cross-border obstacles and to find solutions, and thus to provide an overview of existing Best Practices related to cross-border cooperation in the field of healthcare from the Upper Rhine and, more generally, from the French-German border.

The identified best practices can be divided into four categories:

The first type consists of institutions and projects, which inform the populations, accompany, and support them in their proceedings – the so-called "Front Office". They are in individual contact with the patients who encounter an obstacle before, during or after their medical treatment in the neighbouring country. Their activities are advisory in nature and ideally aim at immediate problem solving – or at best at preventing problematic situations before they appear. If no immediate solution is found, these institutions and projects will then try to clarify the situation and, if necessary, work towards a solution by contacting more specialised bodies.

The "Back Office" institutions complement the work of the "Front Office" and assure further treatment of the issue. Once the existence of an obstacle has been determined, an analysis phase takes place, which then leads to a discussion with the appropriate partners. As far as possible, the information will be disseminated to political representatives at regional, national and European level where appropriate. All "Front Office" institutions also fall into this type.

In addition to Front Office and Back Office, there are two further types of structured approaches that are designed to facilitate access to healthcare in the border region:

- Inter-hospital or partnership agreements that meet local needs on a contractual basis and are based on the willingness of the local partners to cooperate.
- Territorial approaches, which are comprehensive solutions in a limited geographical area offering a broad sustainable response to cross-border healthcare access issues beyond the individual case.

This chapter intends to give an overview of structures, institutions and projects at the French-German border that are involved in overcoming obstacles in the field of cross-border healthcare in the sense of the four types mentioned above – without claiming to be exhaustive.

1. "Front Office" institutions

The mission of the following institutions and projects is to inform the population and to support them in their proceedings.

INFOBEST

Location	INFOBEST PAMINA: Lauterbourg, France INFOBEST Kehl/Strasbourg: Kehl, Germany INFOBEST Vogelgrun/Breisach: Vogelgrun, France INFOBEST PALMRAIN: Village-Neuf, France
Website	www.infobest.eu (German/French)
Description	The INFOBEST network consists of four "one-stop-shops" spread over the entire territory of the Upper Rhine, facilitating the daily life of citizens in the French-German-Swiss border region. It is a public service, bilingual, neutral and free, and follows an integrated approach that covers a wide variety of life situation-oriented information areas: employment, social security, moving, family benefits, imposition and retirement. The main tasks of the INFOBESTs can be summarized in the following points: • Reception / Information of advice seekers. The INFOBESTs dispose of a bilingual and tri-cultural orientation, ensuring a territorial and interdisciplinary overview. • Initial counselling of advice seekers in individual counselling sessions, which enables them to complete the further necessary procedural steps and, if necessary, to be sensitised to possible further problems. • Mediation / Support in case of conflicts with the specialized administrations by providing contact persons as "mediators" or by continuously supporting a complex individual case through several procedural steps In addition, the INFOBESTs are also working in the "back office", clearing up structural problems within the framework of cross-border meetings with the responsible specialized administrations (active feedback and monitoring). Healthcare is one of the most important topics treated by the INFOBESTs, since it is of most personal interest for advice seekers. INFOBESTs provide individual ad-hoc counselling and support (see above) or invite advice seekers to attend one of the regularly held consultation days to speak simultaneously with experts from health insurance bodies from both sides of the border.

Nota bene:

Similar structures equally treating questions of access to cross-border healthcare exist on several internal borders of the EU, for instance:

- *Grenzinfopunkte* in the German-Dutch-Belgian border region (www.grenzinfo.eu/)

- *Infocenter* in the German-Danish border region (www.pendlerinfo.org/)

The INFOBEST network, the *Grenzinfopunkte*, *the Infocenter* and the Task Force "Frontier workers" of the Greater Region also form the European network "Grenznetz" (www.grenzinfopunkt.org/de/grenznetz.shtml), which aims at exchanging knowledge and best practices as well as proposing solutions to overcome obstacles.

Center for Consumer Protection in Europe

Location	Kehl, Germany
Website	www.cec-zev.eu (German/French)
Description	The Center for Consumer Protection in Europe based in Kehl, Germany, is a French-German registered association that reunites the French and German European Consumer Centres (ECC). Its main aim is to provide consumers with information and advice concerning cross-border consumer topics, to inform about consumer rights in the European Union and to support consumers in case of litigations with enterprises and other entities based in the EU, Norway or Iceland. In the field of healthcare, the Center for Consumer Protection in Europe intervenes with several means : • Information regarding access to healthcare and patients' rights in the European Union • Reports and studies on cross-border healthcare issues • Neutral intermediary, helping to settle disputes between patients and (health) companies Additionally, Center for Consumer Protection in Europe also participates in various cross-border working groups and consistently advocates harmonised regulation on both sides of the border.

Nota bene:
« The Centre for Consumer Protection in Europe based in Kehl is part of the ECC-Network, created in 2005 by the European Commission (28 Centres within the EU, plus Iceland and Norway). Goal : providing information, assistance and advice for the extrajudicial resolution of cross-border consumer complaints. A complete list of all centres is available online: https://ec.europa.eu/info/live-work-travel-eu/consumers/resolve-your-consumer-complaint/european-consumer-centres-network_en").

Eurodistricts

Locations and websites	EGTC Eurodistrict PAMINA – Lauterbourg, France www.eurodistrict-pamina.eu (German/French) Eurodistrict Strasbourg-Ortenau – Kehl, Germany www.eurodistrict.eu (German/French) Eurodistrict Region Freiburg / Centre et Sud Alsace – Emmendingen, Germany

	www.eurodistrict-freiburg-alsace.eu Trinational Eurodistrict Basel – Village Neuf, France www.eurodistrictbasel.eu (German/French) Eurodistrict SaarMoselle – Saarbrücken, Germany http://www.saarmoselle.org (German/French)
Description	As cross-border territorial entities, the Eurodistricts are working on a wide range of topics that affect citizens on both sides of the border in daily life. Representing the population on both sides of the border as a whole, they hold a key position as mediator between their citizens and the national, regional and European authorities. In the field of healthcare, the French-German Eurodistricts are involved to varying degrees. Their activities include: • Implementation of concrete projects to inform the border population (e.g. cartography of bilingual doctors in the Eurodistrict Strasbourg-Ortenau) • Implementation of extensive projects to overcome obstacles to cross-border healthcare access (e.g. INTERREG project for the further development of the local healthcare offer in the Eurodistrict PAMINA) • Support for cross-border cooperation projects in the field of healthcare (e.g. French-German cross-border practice for addiction medicine in Kehl, Germany) • Lobbying to improve the access of the population to cross-border healthcare As institutional players, they are also involved in several cross-border committees and similar structures, allowing them to advocate their positions at many different levels.

Nota bene:

Similar structures (Eurodistricts, Euroregions etc.) equally active in treating questions of access to cross-border healthcare exist on several internal borders of the EU.

2. "Back Office" institutions

The mission of the following institutions is to analyse and to structure the discussion concerning obstacles to cross-border healthcare access with and between the relevant stakeholders. Normally, they do not interact directly with the public. Even though the INFOBEST network, the Centre for Consumer Protection in Europe and the Eurodistricts figured already in the first group of "Front Office" institutions, they also fall into this group.

Euro-Institut/TRISAN

Location	Kehl, Germany
Website	www.trisan.org (German/French)
Description	Founded in 2016 as an INTERREG V A project, TRISAN is a trinational competency centre that seeks to optimize transnational and cross-border cooperation through integrated projects in the field of healthcare in the Upper Rhine region. Its primary objective is to develop cooperation efforts in matters of healthcare through structuring cross-border networks, helping partners to build their cross-border projects as well as knowledge production and knowledge management. More specifically, TRISAN… • provides information on healthcare system in the neighbouring country; • identifies opportunities to cooperate in the field of healthcare; • assists healthcare stakeholders in defining and structuring new cooperation projects (e.g. feasibility of a project, territorial analysis ...); • provides a toolbox for the management of cross-border projects and practical advice in the initiation and design of cross-border projects; • offers healthcare stakeholders a platform to present their projects ; • develops synergies and supports the creation of cross-border networks. TRISAN is active in several cross-border committees and working groups, promoting the continual improvement of access to cross-border healthcare.

Nota bene:

With *eurohealthconnect* (www.e-h-c.nl), a similar structure exists in the German-Dutch border region since 2008 (following two INTERREG III A projects beforehand). Another association in this region, the *Gesundheitsregion Euregio* (www.gesundheitsregion-euregio.eu), also aims at improving cooperation between cross-border healthcare stakeholders.

Expert committee "Frontier workers" of the Upper Rhine Conference

Location	Kehl, Germany (Joint Secretariat of the Upper Rhine Conference)
Website	www.oberrheinkonferenz.org (German/French)
Description	The expert committee "Frontier workers" is subordinate to the working group "Economy and Employment" of the French-German-Swiss Upper Rhine Conference, which constitutes the institutional framework for regional cross-border cooperation in the border area. The aim of this expert committee is to offer a discussion forum for developing solutions for current legal or administrative obstacles encountered by frontier workers. Thanks to the cooperation with the INFOBEST network (see above), the expert committee has direct access to the problems encountered by frontier workers in their daily life and may find concrete solutions that can be reported via different channels (members of the Upper Rhine conference, Upper Rhine Council, French-German-Swiss intergovernmental commission). Cross-border healthcare being one of the most important topics for frontier workers – as well as for all citizens of the border region – the expert committee is a strong asset for the sustainable improvement of the patients' situation.

Task Force "Frontier workers" of the Greater Region

Location	Saarbrücken, Germany (Ministry for Economy, Employment, Energy and Traffic Saarland)
Website	www.tf-grenzgaenger.eu/ (German/French)
Description	Founded in 2011 as an INTERREG V A project (followed by a second project running until 2020), the Task Force "Frontier workers" aims at overcoming existing obstacles for frontier workers and improving employment mobility in the Greater Region. For this purpose, it develops solutions for fundamental obstacles encountered by frontier workers, cross-border students and interns, persons in training programmes, as well as companies and institutions who are employing frontier workers. By reporting the solutions to the regional, national and European political level, the Task Force helps to improve the status quo sustainably in all fields, including cross-border healthcare.

3. Inter-hospital or partnership agreements

Due to their specific context and territorial conditions, border regions are particularly likely to develop individual solutions. Local experience may provide the best starting point for exploring potential complementarities and thus creating bilateral (or even multilateral) agreements on a contractual basis between partners that are willing to cooperate.

In the following, two projects on the French-German border will be presented.

SEEK: Cross-border platform in clinical epileptology

Location	Kehl-Kork, Germany & Strasbourg, France
Description	The cooperation between the *Hôpitaux universitaires de Strasbourg* (University Hospitals of Strasbourg) and the *Epilepsiezentrum Kork* (Centre for epilepsy in Kork) aims at the implementation of an innovative model for a binational cross-border epilepsy centre. To that end, the partners trained medical professionals, carried out some research studies, and instigated monthly meetings between the different teams. In 2007, the project obtained funding through the INTERREG IV programme. This funding had a great impact: Technical equipment on both sides of the border can be used mutually, French and German patients are treated by a cross-border team working in both clinics. A first European agreement on cross-border hospital treatment has been signed and still enables cross-border treatment of epilepsy patients today. More specifically, it includes the possibility for German children to be operated at the University Hospitals of Strasbourg and for children and teenagers from Alsace have access to special support centres and the school system operated by the Diakonie Kork on the German side, where they receive appropriate school support and care adapted to their needs. A new cross-border agreement of July 2019 now also opens up the possibility to benefit from the *Heilpädagogische Förderung* (curative education support). Within this framework, adult people from Alsace with severe and multiple disabilities receive individual care and support on the German side.

Convention on cross-border cooperation in the field of cardiology

Location	Völklingen, Germany & Forbach, France
Description	In march 2013, the *C.H.I.C. Unisanté+Forbach* (Forbach hospital), the *HerzZentrum Saar* (cardiology centre of the SHG-Clinics in Völklingen, the *Agence régionale de Santé Grand Est* (French regional health authority) and the local French health insurance bodies (*CPAM Bas-Rhin* and *CPAM Moselle*) signed a cross-border cooperation agreement in the field of cardiology. Its objective is to improve care for patients living in one of the 27 municipalities around Forbach in the Eurodistrict Saar-Moselle and suffering from heart attacks.

The agreement is based on three principal pillars of cooperation:

- The French emergency services can transfer patients suffering from a severe cardiac infarct to the cardiology centre in Völklingen, on the German side of the border.
- For patients' safety and satisfaction, simplified cooperation procedures and tools have been implemented to ensure painless and time-efficient transmissions. Patients can choose the treatment site. Once the patient has been taken in charge and stabilized in the cardiology centre in Völklingen, he is transferred by the French emergency services to the hospital of Forbach on French territory.
- Furthermore, German cardiologists from Völklingen stay permanently on duty in the intensive care cardiology unit of the Forbach hospital, in order to strengthen and support the medical team on-site if needed.

Finally, regular meetings are organized to promote professional and linguistic exchanges, as well as best practices among medical and non-medical staff from both sides of the border (e.g. observation missions or joint specialist events).

4. Territorial approaches

Inter-hospital and other partnership agreements in the field of healthcare are a first step to facilitate access to cross-border healthcare. Nonetheless, due to their thematic focuses, they only have a limited impact on the border region as a whole. In order to go one step further, "territorial approaches" have been developed in limited geographical areas, aiming at giving a comprehensive and sustainable response to obstacles to cross-border healthcare access.

Since no territorial approaches are currently implemented at the French-German border, two examples from France and Germany concerning other border regions will be presented. This digression aims to illustrate approaches that seem possible on both sides of the Rhine, improving access for border populations to planned care in the neighbouring country.

ZOAST – Zone of organised access to cross-border healthcare between France and Belgium

After the conclusion of a framework agreement on health cooperation between France and Belgium in 2005, the regional stakeholders wanted to make even further progress in order to improve patients' access to cross-border healthcare. To meet this goal, seven so-called ZOAST (*Zones organisées d'accès aux soins transfrontaliers*) were set up between 2008 and 2015 along the French-Belgian border.

The creation of the ZOAST aimed at reducing the distances patients need to cover to have access to adequate healthcare. Especially patients living in rural areas at the border, with a low density of healthcare infrastructure on both sides, benefit from synergies created by the intensified cooperation and pooling of resources and infrastructure. The installation of French social security card readers on the Belgian side, in line with the abolition of the requirement for prior authorisation for all treatments and the implementation of simplified cross-border procedures concerning reimbursement of healthcare costs (French patients equally benefit from the Belgian third-party payment system). This means, for instance, that French women can go without any additional costs to the maternity hospital in Givet (Belgium) for giving birth, while they would have spent more than one hour to go to the next French maternity hospital (Charlevilles). To sum it up, the number of obstacles to cross-border healthcare access in daily life is significantly reduced.

European regulation promotes the creation of ZOAST in preamble 50 of the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, especially for border regions.

GRÜZ – Cross-border healthcare cooperation between Germany and Switzerland

Since 2007, the GRÜZ pilot project (*Grenzüberschreitende Zusammenarbeit im Gesundheitswesen*) allows German and Swiss patients from the border area around Basel (district of Lörrach on the German side, Cantons of Basel-Stadt and Basel-Landschaft on the Swiss side) to access healthcare in the neighbouring country. Previously, it was hardly possible for patients without supplementary insurance to carry out planned care on the other side of the border, as the compulsory or statutory health insurance bodies could not reimburse the costs incurred there (apart from emergency care) due to the principle of territoriality. Legal adjustments were necessary for this purpose:

- On the German side, Switzerland holds the same status as country of treatment as any EU member state since 2007.

- On the Swiss side, the principle of territoriality has been relaxed for the pilot project as of 2007 on a trial basis – since 2018, the exception has been included in the law for an unlimited period of time.

The treatments accessible to Swiss patients in the neighbouring country were initially defined in a catalogue of services, whereas in Germany the health insurance bodies and Basel hospitals were responsible for negotiating contractual agreements. As of 2010, the restrictions for Swiss patients were completely abolished and all kinds of treatments are now accessible for them.

The pilot project achieved the objective of controlled cross-border patient mobility, but there have been no significant changes in patient flows: Mostly Swiss patients benefit from rehabilitation treatments on the German side.

IV. Annex

1. Example of a completed analysis grid

Case No. 4: Loss of French health insurance coverage related to the change of residency (to a foreign country) as part of parental leave

Topics concerned (keywords)

Moving to another country as part of parental leave
Loss of health insurance coverage in the country of employment
Continuity of care

Description of the case

If a person who lives and works in France returns to his or her country of origin for the duration of parental leave, he or she loses health insurance coverage in France despite having paid contributions (possibly for many years).

Case study

A woman with German citizenship who has been living and working in France for 15 years wants to get closer to her family living in Germany for a while after the birth of a child. She takes parental leave and returns temporarily to Germany. In doing so, she loses her health insurance coverage in France (reasons explained in the category “Legal references”), with the following consequences:

- As she is no longer affiliated on the French side, she cannot obtain a S1 form that would allow her to benefit from health insurance coverage on the German side. The person concerned is then forced to join the German legal health insurance system on a voluntary basis, which means that he or she must pay contributions (which would not have been the case if she had continued to be covered by her French health insurance body).
- As she no longer has health insurance coverage in France, she cannot continue to consult her gynaecologist, paediatrician or any other doctor she used to consult, at least not under the same conditions as before (problem regarding the continuity of care).
- This also generates a significant lack of understanding in a context where she contributed in France for 15 years.
- If the person is inadequately informed about her rights beforehand, she may find herself in a dramatic situation:
    - Absence of health insurance coverage at a very sensitive moment (birth of a child), and obligation to advance all expenses;
    - Necessity to find a gynaecologist/paediatrician on the German side and difficulty in getting an appointment due to waiting lists.

In a specific case of this type treated by INFOBEST Vogelgrun/Breisach, the young mother had obtained the information at the end of 2015 that her French health insurance coverage would be maintained. The regulations changed on January 1st, 2016 (introduction of PUMa), and the young mother found herself overnight without any health insurance coverage. She was finally able to be affiliated with her spouse to the RSI, but at the cost of long negotiations. In the meantime, she had to advance all expenses.

Legal references

The loss of French health insurance coverage related to the change of residency to a foreign country as part of parental leave is the result of a combination of three elements. Since the introduction of the Universal Healthcare Protection (PUMa) on January 1st, 2016, the French health insurance bodies consider that:

- only persons who work or live in France are entitled to health insurance in France;
- parental leave does not constitute a situation of professional activity (although the employment contract persists); this does not apply to maternity leave, which is considered as professional activity.
- it is not possible to be affiliated with the spouse since the notion of beneficiaries no longer exists for adults.

Target groups concerned by the issue

- Persons living and working in France who choose to move to a third country as part of parental leave.
- Frontier workers living in Germany and working in France, taking parental leave.

It is important to underline that this issue does not only concern frontier workers, nor only border regions.

The problem only arises when the country of employment is France. Indeed, if the country of employment is Germany, the person may remain affiliated to his German health insurance during his parental leave, which is considered on the German side as a professional activity. Persons who are mandatory members of the German legal health insurance are exempt from contributions. On the other hand, persons covered by private health insurance bodies or who are voluntarily affiliated to a German legal health insurance must, in general, pay contributions.

Negative consequences of the problem

- Additional costs (need to join a German health insurance on a voluntary basis; need to pre-finance expenses in the absence of health insurance coverage; significant costs remain, if the person wants to continue the treatment in France)
- Administrative burdens (change of health insurance)
- Problems with continuity of care
- Lack of understanding of how “Europe works in everyday life”
- Restriction of mobility of persons within the European Union

Suggestions for improvement (to be discussed with the competent entities)

This problem cannot be solved by strengthening cooperation between German and French health insurance bodies. This issue needs to be addressed at national level on the French side.

Best practices

Before the introduction of PUMa in France, people could continue to benefit from French health insurance coverage in such situations.