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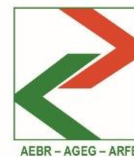

TEMPLATE: FINAL REPORT BY THE EXPERT

Advice case title: Cross-border ambulant therapeutic services

Full official name of the advised entity: Euregio via salina.e.V.

Name of the expert contracted for the advice case: Prof. Dr. Urs Kramer, University of Passau

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Part I

Initiative b-solutions 2.0: Solving Cross-border ambulant therapeutic services

Facts:

The organization Euregio via Salina e.V. reports that inhabitants of highly situated villages in the border region Allgäu-Tirol have problems accessing ambulant therapeutic services such as physiotherapy, occupational therapy, ambulant care and similar services in their respective countries (Germany and Austria) due to the local conditions. An illustrative example for this is the Bavarian city of Balderschwang, which is only accessible from Germany using the winding Riedberg-Pass that is often inaccessible during the winter. Due to this, German inhabitants often use the services of Austrian therapists as they are easier to access via the Bregenzer forest. Additionally, labour shortage, especially in those services providing ambulant patient care, is enhancing difficulties in providing medical care for the inhabitants of this region.

Under normal circumstances, therapists bill their services with the respective national statutory health insurance fund. However, in cases of cross-border services, a direct billing with German insurance funds is not possible. Thus, despite being entitled to German healthcare with their German insurance scheme, German clients often have to pay privately for medical services received in Austria. A subsequent reimbursement of these expenses only seldomly is successful. The only alternative to paying privately is to access the respective German services, which is more expensive and difficult due to longer distances and travel times, especially in winter.

The Austrian side is facing the same problem (an example of this being the city of Kleinwalsertal in Austria, which can only be accessed via German territory): Austrians living in the border region insured by Austrian health insurance funds often access German therapeutic services for which they have to pay privately. Reimbursement for these expenses from their respective Austrian insurance fund is possible in some cases, but not always.

There is no uniform regulation on cost bearing for cross-border therapeutic services. Especially in the border region of Allgäu – Außerfern – Vorarlberg, a rural region with challenging topography, the uncomplicated provision of cross-border services would be useful. Most importantly, healthcare service providers should be able to bill their services provided to foreign persons with their respective health insurance funds directly.

Aim of the project:

1. Identifying legal obstacles to the free access of ambulant therapeutic services in the border region of Allgäu – Außerfern – Vorarlberg.
2. After identifying the legal obstacles, they will be analysed according to their factual consequences as well as their necessity and “validity” in reference to the current legal situation of cross-border cases and Union law.
3. Possible solutions for the analysed problems will be proposed as well as the legal steps necessary to implement them outlined. With reference to the current legal situation, special attention will be paid to the question whether a solution is possible under the current law or legislative change is necessary.

Part II

A. Analysis of the legal situation in Germany and Austria

As a first step, the legal situation in both Austria and Germany will be analysed before influences of EU law and the *Court of Justice of European Union (CJEU)'s* case law will be discussed.

I. The German legal situation

Statutory health insurance as well as further related legal questions are regulated primarily by the Fünfte Sozialgesetzbuch/Fifth Social Code (SGB V). Additional regulations can be found in the First (SGB I) and Ninth (SGB IX) Social Code. Irrespective of provisions in EU law (see below B.), the following SGB V paragraphs are referencing cross-border cases: para. 9(1)(1)(No. 5) (The entitlement to return to national health insurance returning from abroad), para.13(4-6) (The entitlement to reimbursement for self-procured services abroad), para. 16(1)(No. 1, 2), (4) (The suspension of entitlement during time spent abroad), para. 17(1-3) (The benefits of statutory health insurance for those employed abroad), para. 18(1-3) (Meeting costs for medically necessary treatment in countries not being part of the EU or EEA), para. 140e (Contracts with providers of services in non-EU countries), para. 190(2) (The termination of national health insurance memberships for those working abroad), para. 229(1)(2, 1) (Obligation to contribute foreign emoluments), para. 269 (Special rules for those insured abroad), para. 275(2)(No. 2) (Verification of the conditions for the assumption of costs for treatment abroad) and para. 396(1)(No. 2) (Administrative cooperation to combat illegal employment of foreigners).

Due to the focus of this analysis on ambulant at home care, attention must, regardless of the special nature of the cross-border cases, be paid to SGB V para. 37 which generally legislates on ambulant at home care.

Examining all statutes with references to cross-border cases, two regulations must be examined more closely with reference to the facts as presented above:

The first one being **SBG V para. 13(4-6)**, which regulates on the acceptance of medical services within the scope EU or EEA law. It enables those under statutory health insurance to obtain the services of other healthcare providers in EU Member States with reimbursement for expenses by their respective statutory health insurance. This provision can be viewed as consequence of *CJEU* judgements on the acceptance of medical services abroad.[1]

Another important provision regarding cross-border patient care in events of illness is SBG V para. 140e. This provision allows German health insurance funds to contract with foreign providers of services. This provides insured persons with additional entitlement to treatment abroad according to the principle of benefits in kind, which are directly reimbursed by the health insurance fund.[2] The purpose of **SGB V para. 140e** is the extension of the principle of benefits in kind to those service providers situated abroad. With this provision, the German legislator has reacted to the *CJEU* judgements in *Decker* and *Kohll* (see both below at B. I.).[3]

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[1] *Ulmer,* in: *v. Koppenfels-Spies/Wenner*, SGB V, § 13, Rn. 90 und 91.

[2] *Schuler,* in: LPK-SGB V, § 140e, Rn. 10.

[3] *Schuler,* in: LPK-SGB V, § 140e, Rn. 1.

II. The Austrian legal situation

The legal framework for cross-border therapeutic services differs on national scope. Regulations can be found in the Allgemeine Sozialversicherungsgesetz/General Social Insurance Act (ASVG) and social insurance laws paralleling the ASVG such as the Gewerbliches Sozialversicherungsgesetz/Commercial Social Insurance Act (GSVG), the Bauern-Sozialversicherungsgesetz/Farmers' Social Insurance Act (BSVG), the Beamten-Kranken- und Unfallversicherungsgesetz/Civil Servants' Health and Accident Insurance Act (B-KUVG) as well as the Sozialversicherungs-Ergänzungsgesetz/Social Insurance Supplement Act (SV-EG)). The provisions of GSVG, BSVG and B-KUVG are applicable depending on the identity and occupation of the insured person and are of no further relevance here.

The central provisions for cross-border cases (as the one at hand) are: ASVG para-130 (applicable for falling ill abroad), **ASVG paras. 131-131b ASVG** (Reimbursement and cost subsidy claims), **SV-EG para. 7b** (based on Directive 2011/23/EU regulating on medical treatment in another Member State).

Austria uses the so-called "**mixed model**" for public healthcare. Each individual is obligated to be insured with a statutory health insurance fund with their entitlement to treatment being fulfilled by service providers who are privately contracted to the public health insurance fund.[4] On the one hand, the medical associations of the service providers ("Ärztekammern") and the health insurance funds conclude collective contracts. On the other, individual service providers contract with the individual healthcare insurance fund, obligating them to treat the individual insured according to the conditions laid down in the collective contract.[5]

Similar to Germany, healthcare services in Austria are provided as benefits in kind (compare ASVG para. 133(2)(3) ASVG).[6] Primary service providers are doctors with whom the health insurance funds have contracted in accordance with ASVG para. 338 (so-called **contractual doctors**) or contractual facilities owned by the insurance funds themselves.[7] Most of those providing ambulant care are freelance contractual doctors. Those who seek treatment with doctors not under a contractual obligation to the insurance funds (so-called **elective doctors**) must pay for treatment privately but are entitled to partial reimbursement from their insurer. A distinction between domestic and foreign treatment is generally not made. A reimbursement can also be claimed for treatment provided by a foreign service provider.[8]

Depending on the circumstances, entitlement to reimbursement is based on different legal provisions. A distinction between two constellations must be made: (1) the healthcare services provided are already part of a collective contract (including a uniform catalogue of services) or (2) they aren't part of such a contract (resulting in a so-called "contractless state").

In case of the first constellation, claims for reimbursement can be made under **ASVG para. 131**. ASVG para. 131 only applies for expenses in relation to health treatment in accordance with ASVG para. 133, which includes medical aid, medical equipment and

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[4] *Kneihs/Mosler*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 338 ASVG, Rz. 1.

[5] *Kneihs/Mosler, in: Mosler/Müller/Pfeil*, Der SV-Komm, § 338 ASVG, Rz. 7, 12.

[6] There is no enforceable claim for the granting of benefits in kind in health insurance. If the insured person does not receive a therapeutic service on account of the health insurance, they can only claim reimbursement of costs, see *Mosler*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 131 ASVG, Rz. 1, m.w.N.

[7] *Mosler*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 131 ASVG, Rz. 1.

[8] *Mosler*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 131 ASVG, Rz. 3.

remedial aids. Physiotherapy and occupational therapy are treated as such in so far as they are based on a prescription and provided by a certified freelance professional therapist, cf. ASVG para. 135(1)(2) ASVG.[9] A reimbursement is not possible for treatments provided by non-certified therapists or doctors without a professional residence (due to the so-called prohibition of itinerant practice, ÄrzteG para. 45(4)).[10]

In the second constellation, the “contractless state”, ASVG paras. 131a and 131b are applicable. Reimbursement according to **ASVG para. 131a** applies to those cases in which a collective contract on fees has been concluded but later terminated, which caused the contractless state. Reimbursements are made in so far as the reimbursement would have been made had the collective contract not been terminated and only in the amount provided for in the contract which itself is based on ASVG para. 131.

ASVG para. 131b is applicable for those services that have never been covered by a collective contract or are originally contractless (thus dealing with non-contractual benefits). Cost allowance is granted in accordance with each healthcare fund’s guidelines and the fees for such services under the collective agreement. This is of no further relevance for the present case.

For cross-border medical treatment and institutional care, **SV-EG para. 7b** lays down additional rules.

III. Analysis of the national healthcare insurance funds’ statements

As part of this project, German and Austrian healthcare insurance funds have been contacted and questioned on their approaches to cross-border cases.

At least one German health insurance funds has supplied the following information on how cross-border cases are treated:

(1) Austrian therapists consulting patients both living and insured in Germany at their homes act as private service providers, as they are not licensed by German health insurance funds. Consequently, the German patient is paying for treatment privately without the option of having the money refunded by the German health insurance fund.

The only exception to this is a treatment under SGB V para. 13(3), provided that no therapist in Germany is accessible (so-called domestic supply deficit). However, whether this is the case must be determined by the health insurance fund beforehand and in each individual case. For areas in which a general and widespread supply deficit has been found, a contractual agreement between foreign service providers and health insurance funds seems possible. As there are multiple health insurance funds, individual contracts for each fund are necessary.

(2) Another option is the patient, both insured and living in Germany, approaching the nearest Austrian service provider in one of the border regions for ambulant treatment. This leaves two possibilities:

- A refund via so-called benefits in kind, meaning the German health insurance fund provides the patient with a proof of entitlement which the Austrian insurance fund uses for its expenses. This requires the Austrian service provider to be registered in the Austrian health insurance system. Each treatment is directly billed with the Austrian health insurance by the service provider. An

[9] At this point, ASVG para. 135 refers to the Federal Act on the Regulation of Senior Medical-Technical Services para. 7.

[10] *Mosler*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 131 ASVG, Rz. 1/1.

application for proof of entitlement is necessary before accepting treatment and only possible if medical or social reasons require a service abroad.

- According to SGB V para. 13(4-6) acceptance of privately billed healthcare services in the EU/EEA and Switzerland is possible. This requires that the service must be approved in Germany and has been authorised by the German health insurance fund. Services without required authorisation can be accessed directly without prior authorisation. However, these services will be billed privately and reimbursement – if possible at all – must confirm to German contractual fees. As the fees might be lower than the actual costs, some part of the service might have to be paid for privately without further reimbursement.

(3) Cases of ambulant services provided at the residence of the patient are comparable. The EU service provider is required to either be licensed by German health insurance funds or to contract with the respective fund.

Interim results:

The German and Austrian laws on reimbursements for healthcare services provided abroad show many similarities. Both legal systems provide rules for cases in which the insured citizen travels to another country in other to receive medical services. On the other hand, situations – especially typical in border regions – in which the foreign service provider crosses the border to provide care for the insured within the insurer's country, are not regulated. Both countries know the principle of benefits in kind prior to reimbursement. Such reimbursement from German or Austrian healthcare funds for cases of cross-border medical services is only possible if no bilateral agreement provides for benefits in kind.

A reimbursement for receiving ambulant therapeutic or medical care in one's home country by service providers from other Member States is only possible if the service provider and the respective healthcare funds have reached a contractual agreement.

B. Analysis of the influence of EU law

The influence of primary and secondary EU law will be examined more closely.

The basic principle of territoriality (cf. SGB I paras. 30, SGB IV paras. 3 ff. for Germany and ASVG para. 4 in conjunction with para. 3 for Austria) provides that each nation is responsible for social policies within their own territory[11]. This is the explanation as to why there are only few cross-border regulations in Austrian and German social law. The provision or acceptance of healthcare services between at least two different member states also falls within the scope of EU law[12], which tries to enhance social security for cross-border cases by extending the entitlement to the movement and provision of services.[13]

[11] *Schuler,* in: LPK-SGB V, Anh. 1, Rn. 13.

[12] In its case law, the *CJEU* has repeatedly confirmed that all types of medical care fall within the scope of application of the TFEU despite their special features. This was also the case in the *Van Braekel* judgement - *CJEU*, judgement of 12.07.2001 - Ref: C-368/98, NJW 2001, 3397 ff.

[13] *Schuler*, in: LPK-SGB V, Anh. 1 Rn. 13.

I. Influences of EU primary law (with focus on the fundamental freedoms)

EU citizens are entitled to social security under the European fundamental freedoms which grant them individual rights.[14] Consequently, the fundamental freedoms are also relevant for the application of EU law.

Article 56 TFEU concerns the freedom to provide independent, temporary and incorporeal services (normally provided for renumeration) within EU member states.[15] The same principle allows EU-citizens to accept cross-border services.[16] As the *CJEU* decided in the joint cases *Smits contra. Peerbooms*[17], medical services are part of the scope of the freedom to provide services. Each medical service provider is entitled to provide such services in a Member State just as each citizen can receive such services in any Member State without discrimination.

Consequently, for those insured under a statutory healthcare insurance scheme, such freedoms would be pointless if their acceptance of medical services had to be paid for privately. Thus, SGB V para. 13(4)(1, 3) in conjunction with (2)(1) (implementing the EU Directive on Patients' Rights[18]) entitles them to at least some compensation or reimbursement (limited by SGB V para. 13(4)(3)) for services received in other Member States. A similar regulation can be found in the Austrian ASVG para. 131 (in conjunction with ASVG paras. 133, 135) and SV-EG para. 7b. Those insured under Austrian statutory healthcare are entitled to partial reimbursement for services provided by so-called elective doctors (non-contractual partners of their respective health insurance fund) in other Member States.

In addition to regulations on reimbursement, the insured persons are entitled to access healthcare services abroad without prior authorisation by their health insurance funds.[19]

In multiple cases, the *CJEU* itself has confirmed that the freedom to provide services lies at the core of cross-border medical services.[20] This is reflected in the case law constituted of judgements in cases with cross-border elements.

Such a case was ***Kohll***, which the *CJEU* decided on 28.04.1998.[21] In this case the *CJEU* ruled it contrary to EU law that reimbursement for a dental treatment in another Member State was conditional on prior authorisation by the national health insurance fund. The *CJEU* argued that such a requirement had a deterring effect on those insured (cf. guiding principle six of the judgement).

The next case decided on the topic was the joint case of ***Smits/Peerbooms*** (12.07.2001)[22], clarifying that medical treatment was within the definition of services under Art. 56 TFEU (cf. first guiding principle). Additionally, a regulation demanding prior authorisation from a national health insurance fund for stationary hospital treatment was held to be compatible with EU primary law (cf. third guiding principle). This case law is reflected in the German SGB V para. 13(5)(1) as well as the Austrian SV-EG para. 7b(6), (4).

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[14] *Hirsch,* MedR 2000, 586 (588).
[15] *Herrmann*, Examensrepetitorium Europarecht – Staatsrecht III, 7. Aufl., Rn. 97.
[16] *Schuler,* in: LPK-SGB V, Anh. 1 Rn. 53.
[17] *Smits/Peerbooms – EuGH*, Urteil vom 12.07.2001 – Az.: C-157/99, Slg. 2001, I-5437.
[18] Directive 2011/24/EU vom 09.03.2011.
[19] *Kohll – EuGH*, Urteil vom 28.04.1998 – Az.: C-158/96, Slg. I-1931.
[20] *Lorff*, in: ZESAR 2003, 407 (449).
[21] *Kohll – EuGH*, Urteil vom 28.04.1998 – Az.: C-158/96, Slg. I-1931.
[22] *Smits/Peerbooms – EuGH*, Urteil vom 12.07.2001 – Az.: C-157/99, Slg. 2001, I-5437.

A similar decision was reached by the *Court* in ***Müller-Fauré/van Riet*** (13.05.2003)[23], which held that the prior authorisation for dental treatment in another Member State was compatible with EU law: the freedom to provide services had not been breached. However, the *Court* noted that authorisation could only be denied if and in so far as the same kind and quality of treatment could have been provided for by the domestic healthcare services (cf. first guiding principle).

In ***Herrera*** (15.06.2006)[24] the *CJEU* limited the reimbursement for cross-border treatment received abroad to the expenses of the medical treatment itself as well as such expenses connected to a necessary hospitalisation. The insured was not entitled to travelling expenses as well as other expenses connected with their staying abroad (cf. first guiding principle).

Another decision connected to cross-border medical treatment is ***Elchinov***[25]. A Bulgarian citizen applied for treatment in Germany with his national insurance fund as the required treatment was highly specialised and had never been performed in Bulgaria. Due to his rapidly declining health, the Bulgarian citizen decided to move forward with the treatment in Germany irrespective of the not yet received authorisation. The authorisation was subsequently denied. The *CJEU* ultimately decided that a regulation prohibiting all cross-border medical care without prior authorisation was incompatible with EU law. Further, the *Court* clarified that reimbursement was possible for treatment which had never been performed within the country.

In ***Commission v France***[26], the *CJEU* referenced *Kohll* and confirmed that national guidelines requiring prior authorisation for cross-border medical treatments deterred EU citizens from seeking such care. Consequently, these regulations unduly restricted the freedom to provide services.

Even in cases in which medical treatment within the country remained possible, reimbursement for treatment in another Member State remains possible: in ***Petru***[27], the *CJEU* ruled that in cases in which medical treatment was possible but due to inadequate equipment so difficult and dangerous[28] as to limit the chances of success, the national insurance fund had to reimburse their insured for seeking medical treatment in another country.

II. Influences of EU secondary legislation on primary EU law

The relevant European social laws are mainly based on the following secondary legislation: the Regulation of 29.04.2004 on the coordination of social security systems (Regulation (EC) No. 883/2004), the Regulation of 16.09.2009 laying down the procedure for implementing Regulation (EC) No. 883/2004 (Regulation (EC) No. 987/2009) and the Directive of 09.03.2011 on the application of patients' rights in cross-border healthcare (Directive 2011/24/EU).

Regulations (EC) No. 883/2004 and 987/2009 are supposed to close any remaining gaps in cross-border cases and prevent unnecessary superfluous insurances.[29] The regulations are applicable to the insured citizens of a Member State as well as their relatives and citizens of non-EU states with their permanent residence within a Member

[23] *Müller-Fauré/van Riet – EuGH*, Urteil vom 13.05.2003 – Az.: C-385/99, Slg. 2003, I-4509.
[24] *Herrera – EuGH*, Urteil vom 15.06.2006 – Az.: C-466/04, Slg. 2006, I-5341.
[25] *Elchinov – EuGH*, Urteil vom 05.10.2010 – C-173/09, Slg. 2010, I-08833.
[26] *EU-Kommission/Frankreich – EuGH*, Urteil vom 05.10.2010 – Az.: C-512/08, Slg. 2010, I-08833.
[27] *Petru – EuGH*, Urteil vom 09.10.2014 – Az.: C-268/13, Slg. allgemein.
[28] The *CJEU* refers in particular to the absence of necessary medication and basic medical material.
[29] *Schuler*, in: LPK-SGB V, Anh. 1 Rn. 14.

State.[30] The regulations are, however, not applicable to social and medical welfare including and especially preventive treatment abroad (cf. Article 3(5)(a) EC No. 883/2004).

According to **Article 8(1) EC No. 883/2004** bi-or multilateral agreements between two or more Member States regarding cross-border care are only applicable in so far as the terms under the agreement are more favourable than under current EU law. If this is not the case, only the respective EU regulation will be applicable (due to its primacy of application).

Article 17 EC No. 883/2004 determines that EU citizens living in another Member State are entitled to the same benefits (e. g. medical treatment) as the citizens of this Member State with the expenses being carried by the EU citizen's respective insurance fund.

A similar rule can be found in **Article 19(1) EC No. 883/2004**, regulating that EU citizens temporarily staying in another Member State are only entitled to healthcare services if they are medically necessary. If they are deemed such, the statutory health insurance of the insured person will be responsible for any expenses arising from the treatment.

However, this rule is inapplicable in cases in which the insured travels to another country for the purpose of medical treatment, cf. **Article 20(1) EC No. 883/2004**. In such cases, the entitlement to reimbursement is dependent on prior authorisation by the national insurance fund.

If reimbursement is denied by the national insurance fund, **Article 35 EC No. 883/2004** and **Articles 25, 26 EC No. 987/2009** legislate on the subsequent reimbursement between the payer of the state in which treatment occurred and the state of origin of the insured receiving the treatment.

Reflecting *CJEU* case law on cross-border medical care cases, **Directive 2011/24/EU** entitles insured persons and their relatives to medical treatment in other Member States without prior authorisation as well as to subsequent reimbursement of expenses in the height of national reimbursement levels.[31] Member States are free to increase the level of expenses reimbursed by the insurance funds as well as widen the scope of eligible expenses, e.g. to include travel. Only in special cases can the reimbursement be dependent on prior authorisation. Additionally, Member States are required to adjust their legislation to the regulations and *CJEU* case law.

In **German** social law, this was implemented in SGB V para. 13(4-6) (see A. I.). Thus, SGB V para. 13(4)(1) is the implementation of Article 7(1) Directive 2011/24/EU. Article 7(4) of Directive 2011/24/EU is reflected in SGB V para. 13(4)(3). The *CJEU*'s judgement in *Kohll* and *Smits/Peerbooms* (see above) is set out in Article 7(8) and Article 8 of Directive 2011/24/EU and has been implemented in SGB V para. 13(5). SGB V para. 13(4) regulates subsequent compensation only being possible in the height determined by national reimbursement levels.[32]

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[30] Regulation (EU) No 1231/2010 of the European Parliament and of the Council of 24 November 2010 extending Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009 to nationals of third countries who are not already covered by those Regulations solely on the ground of their nationality.

[31] *Baumann*, Patientenrechte in der grenzüberschreitenden Gesundheitsversorgung, SozSi 4/2011, 183 (187).

[32] This provision is based on Entscheidung *Müller-Fauré/van Riet* (vgl. Fn. 24).

Austria passed the EU Patient Mobility Code to conform with Directive 2011/24/EU despite most of the provisions already being implemented in Austrian law beforehand.[33] Only ASVG paras. 131 and 150[34], GSVG paras. 85 and 98a, BSVG paras. 80 and 93 and KUVG paras. 59 and 68a-b are implementing new rules in accordance with the Directive.

For treatment by elective doctors, reimbursement is limited to 80% of the costs of treatment irrespective of whether the doctor was providing services within Austria or another Member State, cf. ASVG para. 131(1), (6) (so-called administrative discount).[35]

SV-EG para. 7b implemented the Directive on reimbursement, adding a paragraph stating that "reimbursement is possible for purchased benefits in kind worldwide without prior authorisation of the statutory healthcare insurance fund".[36] Requiring prior authorisation for reimbursement is the exception, not the norm for stationary treatment, ambulant treatments requiring highly specialised and expensive medical infrastructure and equipment, treatments with a high risk for patients or the population as a whole as well as treatments, which – in some individual cases – give rise to concerns regarding the quality and security of the medical treatment in question. Any requirement for prior authorisation is inapplicable in cases of emergency in which prior authorisation was not obtainable in time or at all as proven by evidence, cf. SV-EG para. 7b(4).

Interim results:

This overview of *CJEU* judgments and EU law illustrates that ambulant medical care in Member States is generally provided without prior authorisation and the requirement of a medical emergency.[37] Permissible exceptions to this being dental treatments[38] as well as high risk treatments and treatments requiring highly specialised and expensive medical infrastructure and equipment. Subsequent reimbursement matching the national reimbursement levels for such treatments is possible and only in exceptional cases dependent on the insurance fund's margin of appreciation.

C. Legal obstacles to free access to cross-border therapeutic treatments in Germany and Austria

The prior analysis illustrates that for some cases, German and Austrian social law is already providing legal solutions for reimbursement of insured persons receiving cross-border medical treatment. SGB V para. 13(1)(4-5) and ASVG para. 31ff., SV-EG para.

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[33] *Müller*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 3b ASVG Rz. 1.

[34] The latter concerns the insurance provider's contribution to care costs in the case of institutional care, which was not the subject of the analysis here.

[35] However, many voices in literature and in practice consider this regulation to be contrary to Union law. In one of its most recent decisions in this context, the *Austrian Supreme Court (OGH)* examined the question of whether the remuneration of only 80% of the cash tariff to an elective doctor in another Member State violates Article 56 TFEU. Since the regulation does not differentiate between domestic and foreign elective doctors, direct discrimination is rejected. However, indirect discrimination against (elective) doctors in other Member States is possible, "because the reduced reimbursement of costs under this provision can potentially make the use of medical services in other Member States [...] less attractive". In the end, however, according to the *OGH*, there are "compelling reasons of general interest relating to public health, which justify the restriction of the reimbursement of costs when using elective doctors also in other Member States of the Union to 80% of the cash tariff according to ASVG para. 131(1)". *OGH*, Urteil vom 26.02.2021 – Az.: 10 ObS 142/20k, Rz. 56 ff., 80. The *OGH* held that no submission to the CJEU was necessary.

[36] Dazu wiederum m. w. N. *OGH*, Urteil vom 26.02.2021 – Az.: 10 ObS 142/20k, Rz. 46.

[37] *Ulmer,* in: v. *Koppenfels-Spies/Wenner*, SGB V, § 13 Rn. 92.

[38] *BSG*, Urteil vom 30.06.2009 – Az.: B 1 KR 19/08 R, SozR 4-2500.

7b provide for reimbursement of such treatments that have been received in other Member States. This rule, however, is only applicable in cases of the insured travelling to another Member State to receive medical care or for hospitalisation in different countries due to medical treatment received there.

In German or Austrian social law, there is no provision dealing with cases of foreign medical service providers travelling to the insured person's residence to provide their services. There are furthermore no laws for situations in which inhabitants of border regions are forced to seek treatment by medical professionals of the neighbouring country at their home to prevent unnecessary long journeys of national healthcare providers due to difficult topography.

Neither German nor Austrian courts have dealt with such issues and consequently no case law is available. This is further evidenced by the "*b-Solutions Cross Border Healthcare Karlovy Vary*" project that questioned cross-border health, mountain safety and patient care teams in the German-Czech border region of Sachsen – Karlovy Vary (Karlsbad). During the Covid-19 pandemic insufficient national and EU law provisions on cross-border medical treatments led to expensive and time consuming transfers of patients to Czech cities to avoid administrative problems connected to patient transfers to closer German hospitals.

The rarity of laws concerning cross-border cases also illustrates that both SGB V and ASVG were written with the focus on domestic cases. Thus, no general rules for cross-border cases were made. Even **Regulation EC No. 883/2004**, which repeatedly has been citied before, only deals with the *CJEU's* judgments regarding the freedom to provide (medical) services and offers no further legal framework.

Whereas the **Directive 2011/24/EU** attempts to summarize and enforce the *Court's* judgement, most of its provisions are not binding on Member States and only have to be executed optionally. This leads to legal uncertainty and no EU wide laws being available.[39]

As a consequence of legal uncertainty in national law, the approaches of health insurance funds towards reimbursement of cross-border cases differ – reimbursement depends on the individual's case with no guarantee for reimbursement for the insured person. This uncertainty deters many inhabitants of cross-border regions from seeking ambulant therapeutic services and has the effect of a passive restriction on the free movement of services.

It is moreover unclear whether insured persons are entitled to claim benefits in kind against their health insurance funds. Presently, only subsequent reimbursement remains possible, meaning that all insured persons must pay for their treatment privately before possibly being refunded by their health insurance fund.

<u>Interim results:</u>

As a conclusion, effective cross-border healthcare is still facing many obstacles. For cases of ambulant medical services in which a foreign healthcare provider travels to the insured's residence, the main issue is the lack of uniform national or EU law provisions on the topic. Neither the EU nor the national legislator took such cases into consideration when laws were made. This leads to a general uncertainty on reimbursement for cross-border medical services.

[39] So *Baumann*, Patientenrechte in der grenzüberschreitenden Gesundheitsversorgung, SozSi 4/2011, 183 (188).

Part III

Possible solutions without legislative action

Legislative action to amend the current legal situation and close existing legislative gaps is only one way to solve the problems in cross-border medical care. Especially an EU Directive obligating all Member States to implement new laws would be the more effective than national legislation.

However, even under the current legal situation, improvements can be made in both Germany and Austria using the existing legal framework and instruments. The success of such alternate measures depends on the health insurance funds and their willingness to cooperate contractually. However, as there are not many affected by cross-border problems, a contractual solution might prove to be unrealistic.

I. Solutions according to German law

A promising approach would be a contractual agreement (SGB V para. 140e) between foreign therapists in cross-border regions providing services to citizens of another Member State and the respective insurance funds of those citizens. By such an agreement, inhabitants of border regions would be entitled to a direct reimbursement without the necessity to forward payment privately: the therapist would receive payment directly from the insurance fund.

SGB V para. 140e requires the therapist to be a suitable provider of services according to SGB V para. 13(4) and the insurance fund to act as care provider for its insureds.

Suitability as a medical service provider is determined by multiple factors: the service provided must be one regulated by EU law.[40] Furthermore, the provider must be registered to provide healthcare for insured persons in their country of residence. This is supposed to ensure the overall quality of the therapeutic treatment as well as that the services provided in different Member States do not differ.

"Care" is defined as the provision of something. As the unique topographic circumstances partially prohibit access from the inland to the border region of Allgäu – Tirol, proper medical care is only possible by consulting therapists in Austria who are more accessible. Consulting German therapists remains both economically and infrastructurally pointless. This situation can be compared to the case of *Petru* (see B. I.) in which the *CJEU* ruled even stationary care provided in foreign Member States to be reimbursable. This judgement, consequently, must apply to border regions such as Allgäu – Tirol as well as for ambulant care. The only, possibly problematic, distinction being that in *Petru* the insured themselves sought care in a foreign hospital whereas in the present case, foreign service providers are providing care at the insured's residences. Therefore, it cannot clearly be said whether the judgement is applicable to the current situation.

Another problem is posed by contractual agreements under SGB V para. 140e being voluntary – there is no obligation for German healthcare insurance funds to enter in such contractual agreements, SGB V para. 140e merely enables them to do so based on their own volition.[41]

Treatments provided by foreign healthcare providers that have not yet been assessed by the Federal Joint Committee are thus not reimbursable as contractually recognised service. This has been confirmed by a ruling of the *Federal Social Court (BSG)* on the

[40] *Ulmer,* in: *v. Koppenfels-Spies/Wenner*, SGB V, § 13 Rn. 95.
[41] *Wenner,* in: *v. Koppenfels-Spies/Wenner*, SGB V, § 140e Rn. 4.

question whether a German healthcare insurance fund had to reimburse the appellant for a CISIS method eye surgery with MyoRing implants in Austria. A reimbursement was consequently refused.[42]

Arguments based on the unique topography of the German-Austrian border region do not necessarily have to be conclusive for the concerned health insurance funds as they are not obligated to contract with each other. On the other hand, it seems contradictory for the insurance funds to reimburse patients for treatments conducted in other Member States but not for treatments at the patient's place of residence. Further arguments regarding treatments provided in other Member States with prior authorisation can be based on the *CJEU's* judgement in *Müller-Fauré/van Riet*[43](see above – e. g. stationary dental treatment): prior authorisation can only be refused in cases in which treatment of similar quality and effectiveness was possible by the domestic healthcare system (cf. first guiding principle). Similarly, the inhabitants of highly situated towns in the border region of Allgäu-Tirol have no access to therapeutic services without the domestic therapists having to make unnecessarily long journeys, with access being impossible during the winter, thus excluding adequate healthcare for inhabitants.

Cross-border services are especially realistic in regions that share the same language and in which cross-border services are already provided on a daily basis. Examples for bilateral contractual agreements ensuring basic healthcare are provided by the "*b-Solutions Cross Border Healthcare Karlovy Vary*" project (see above).

II. Solutions according to Austrian law

Part 6 of the ASVG enables Austrian insurance funds to conclude contracts with healthcare service providers similar to those possible under German law. Contractually obligated therapists can bill their services directly with the Austrian healthcare insurance fund; they are individually entitled and obligated under these contracts.

Additionally, according to scholars, billing agreements could be reached with foreign elective doctors to combat a serious regional shortage of doctors. The foundations for such an agreement are laid down in ASVG para. 131(6) "if despite of best efforts no elective doctor can be found".[44]

However, as in Germany, there is no legal obligation for healthcare insurance funds to agree to such contracts. The insurance funds are under an obligation to try and reach a contractual agreement to the best of their abilities, meaning that agreements cannot be refused on arbitrary or unobjective grounds, but insurance funds are under no obligation to contract at all costs.[45]

III. Guidance by exemplary solutions

A good example for contractual cooperation between German and Austrian insurance funds is the rehabilitation hospital SANARIS in Passau that also treats Austrian citizens who will be reimbursed by their Austrian health insurance funds. Reimbursement by an Austrian health insurance fund works the same as with German insurance funds - in particular, the deductible is the same.[46]

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[42] *BSG*, Urteil vom 26.05.2020 – Az.: B 1 KR 21/19 R; *LSG Bayern*, Urteil vom 14.03.2019 – Az.: L 4 KR 558/17.

[43] Dazu Fn. 24.

[44] Vgl. m. w. N. *Mosler*, in: *Mosler/Müller/Pfeil*, Der SV-Komm, § 131 ASVG Rz. 16/1.

[45] *Kneihs/Mosler, in: Mosler/Müller/Pfeil*, Der SV-Komm, § 338 ASVG Rz. 8.

[46] SANARIS Ambulante Reha-Klinik, https://www.sanaris.de/kostenuebernahme/oesterreich/; zuletzt abgerufen am 02.08.2023.

Further examples can be found in different border regions of Germany, illustrating that cross-border cooperation based on bilateral contracts is working.

In the Czech-German border region, a cooperation agreement between both countries enables cooperation of rescue services. A similar agreement exists between the Bavarian and Czech districts of Pilsen, Karlsbad and Südböhmen with a joint coordination centre for cross-border operations of rescue services.

Concluding a bilateral agreement between Germany and Austria should be even easier than between Germany and the Czech Republic due to the non-existing language barrier. Such an agreement would be a suitable means to influence the discretion of the health insurance funds on both sides without fearing different regulations. However, it should be ensured that the agreement has the same "legal status" in both countries. The cooperation agreement between Germany and the Czech Republic on cross-border rescue services has the problem that in Germany it is below the formal federal and state laws, whereas in the Czech Republic it enjoys priority of application over contrary regulations of the national legislator. In order to avoid difficulties resulting from this, it makes sense for Austria and Germany to commit themselves equally and in particular by means of a cooperation agreement with the same "legal rank" on both sides to cooperate with regard to the reimbursement of costs.[47] Since health insurance in Germany and Austria is partly organised differently, it would have to be checked before a contract is concluded whether it is legally possible to ensure the same "legal rank".

Such cooperation is not limited to healthcare services: in Schwandorf/Petrovice, a bilateral police and customs cooperation agreement instated cross-border facilities for police forces and customs officers.

Final conclusions:

The thorough analysis of the legal situations in Germany, Austria and the EU leads to promising results.

Considering the lack of national and European legislation dealing with the unique situation in border regions, a conclusive European legislation on the topic would be ideal. Consequently, national legislation had to adjust to be compatible with this new EU law. It is, however, unclear whether such a reform can be achieved given the small number of addressees.

Even without legal reform, bilateral agreements can combat the problems posed. As both German and Austrian health insurance funds are granted the power to reach contractual agreements with foreign healthcare providers, such contractual agreements could help ensure medical care in cross-border regions by allowing direct billing with the respective insurance fund. Under Austrian law, these are contracts under private law.[48] German law, on the other hand, provides for the public-law nature of the contract, see § 53 SGB X.[49]

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[47] See the handbook "Rescue Service" on the INTERREG project No. 68, The Common Border Region Bohemia-Bavaria - Overcoming Legal Obstacles in the Areas of Administration, Economy, Social Affairs and Health; https://www.ird.uni-passau.de/kramer/interreg-v-projekt/handbuecher.

[48] See § 338 Abs. 1 S. 1 ASVG; also *Kneihs/Mosler*, in: *Mosel/Müller/Pfeil*, Der SV-Komm, § 338 ASVG Rz. 5 ff.

[49] *Carstensen*, in: BeckOGK, § 140e SGB V Rn. 12; m.w.N. also *Harich*, in: BeckOK SozR, § 140e SGB V Rn. 2.

Part IV
Legal provisions relevant to the case

European Union

Consolidated version of the Treaty on the Functioning of the European Union, OJ C 326, 26.10.2012, p. 47–390 / Konsolidierte Fassung des Vertrags über die Arbeitsweise der Europäischen Union, ABl. Nr. C 326 vom 26.10.2012 S. 47–390.

Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of the social security systems, OJ L 166, 30.04.2004, p. 1–123 / Verordnung Nr. 883/2004 des Europäischen Parlaments und des Rates vom 29. April 2004 zur Koordinierung der Systeme der sozialen Sicherheit, ABl. L 166 vom 30.04.2004 S. 1–123.

Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems, OJ L 284, 30.10.2009, p. 1–42 / Verordnung (EG) Nr. 987/2009 des Europäischen Parlaments und des Rates vom 16. September 2009 zur Festlegung der Modalitäten für die Durchführung der Verordnung (EG) Nr. 883/2004 über die Koordinierung der Systeme der sozialen Sicherheit, ABl. L 284 vom 30.10.2009 S. 1–42.

Regulation (EU) No 1231/2010 of the European Parliament and of the Council of 24 November 2010 extending Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009 to nationals of third countries who are not already covered by these Regulations solely on the ground of their nationality, OJ L 344, 29.12.2010, p. 1–3 / Verordnung (EU) Nr. 1231/2010 des Europäischen Parlaments und des Rates vom 24. November 2010 zur Ausdehnung der Verordnung (EG) Nr. 883/2004 und der Verordnung (EG) Nr. 987/2009 auf Drittstaatsangehörige, die ausschließlich aufgrund ihrer Staatsangehörigkeit nicht bereits unter diese Verordnungen fallen, ABl. L 344 vom 29.12.2010 S. 1–3.

Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, OJ L 88, 04.04.2011, p. 45–65 / Richtlinie 2011/24/EU des Europäischen Parlaments und des Rates vom 9. März 2011 über die Ausübung der Patientenrechte in der grenzüberschreitenden Gesundheitsversorgung, ABl. L 88 vom 04.04.2011 S. 45–65.

Germany

The Fifth Book of the Social Code (SGB V), enacted on 20.12.1988 (Federal Law Gazette I, p. 2477, 2482), entered into force on 1 January 1989, last amended by Art. 2a G of 19 July 2023 (Federal Law Gazette I, 197) / Das Fünfte Buch Sozialgesetzbuch (SGB V) vom 20. Dezember 1988, BGBl. I S. 2477, 2482, in Kraft seit 1. Januar 1989, zuletzt geändert durch Artikel 2a des Gesetzes vom 19. Juli 2023 (BGBl. 2023 I Nr. 197).

Austria

General Social Insurance Act (ASVG), enacted on 9 September 1955 (Federal Law Gazette No 189/1955 in the version of Federal Law Gazette No 18/1956), entered into force on 1 January 1956, last amended by Federal Law Gazette I No 110/2023 / Bundesgesetz vom 9. September 1955 über die Allgemeine Sozialversicherung (Allgemeines Sozialversicherungsgesetz – ASVG), BGBl. Nr. 189/1955 i.d.F. BGBl. Nr. 18/1956, in Kraft seit 1. Januar 1956, zuletzt geändert durch BGBl. I Nr. 110/2023.

Social Insurance Supplement Act concerning supplementary regulations in the field of social security in relation to the European Union, other contracting states and international organizations (Social Insurance Supplement Act – SV-EG), enacted on 4 March 1994 (Federal Law Gazette No. 154/1994), entered into force on 31.12.1996, last amended by Federal Law Gazette I No. 100/2018 / Bundesgesetz betreffend ergänzende Regelungen im Bereich der sozialen Sicherheit im Verhältnis zur Europäischen Union, anderen Vertragsstaaten und internationalen Organisationen (Sozialversicherungs-Ergänzungsgesetz – SV-EG), ausgegeben am 4. März 1994 (BGBl. Nr. 154/1994), in Kraft seit 31.12.1996, zuletzt geändert durch BGBl. I Nr. 100/2018.