Title: The Health Services (Cross-Border Health Care and Miscellaneous Amendments) (Northern Ireland) (EU Exit) Regulations 2019	**Impact Assessment (IA)**
IA No:	**Date: 31 January 2019**
RPC Reference No:	**Stage: Final**
Lead department or agency: DHSC	**Source of intervention:**
Other departments or agencies: DoH NI	**Type of measure:**
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Summary: Intervention and Options

RPC Opinion: N/A

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANDCB in 2014 prices)	**One-In, Three-Out** N/A	**Business Impact Target Status** N/A
0	0	0		

What is the problem under consideration? Why is government intervention necessary?

The Cross-Border Healthcare Directive (CBHD) came into force on 24 April 2011. It sets out a framework of rules which allow patients to seek and pay for treatment in either the state or private sectors in another EEA Member State and have the costs of that treatment reimbursed by their home healthcare system. As we exit the EU, the EU (Withdrawal) Act 2018 will automatically retain these regulations. Following the UK's exit from the EU, the Directive and Treaty rights (Treaty on the Functioning of the European Union) will no longer apply in the UK. The domestic legislation implementing the Directive will no longer be appropriate given that it is based on a reciprocal relationship with the EU which the UK will no longer be a part of.

If the UK leaves the EU without a ratified agreement Government intervention is necessary to provide the appropriate legislative framework for transitionally continuing current EU cross-border healthcare arrangements until 31 December 2020 with those EU Member States where we establish MOUs. If we do not legislate further the regulations would not be coherent or workable without reciprocity by Member States. Legislation is needed to correct deficiencies in retained EU regulations by extinguishing the current arrangements, but continuing to facilitate access to cross-border healthcare for a transition period up until 31 December 2020 with countries with whom we have agreed appropriate arrangements.

What are the policy objectives and the intended effects?

Without amending the policy the EU Withdrawal Act will automatically retain CBHD legislation and the scheme could continue to operate allowing patients to receive reimbursement for overseas healthcare purchases. The process would not be coherent or workable. Should the UK leave the EU without a ratified agreement, the policy objective is to continue current EU reciprocal and Cross-Border Healthcare Directive arrangements until 31 December 2020 (with Member States we have agreed reciprocity) to protect against a sudden loss of reciprocal/cross-border healthcare rights.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1 – static acquis. Impacts of options1 compared against the current situation where the UK is a member of the EU.
Option 2 - Enact the legislation to meet the objectives above
Option 3 – Do nothing. Baseline to which option 2 is compared against.

Option 2 is the Governments preferred option as it best meets the policy objective.

Will the policy be reviewed? It will be reviewed.
If applicable, set review date: Two years after implementation

Does implementation go beyond minimum EU requirements?		N/A			
Are any of these organisations in scope?	**Micro** N/A	**Small** N/A	**Medium** **N/A**	**Large** **N/A**	
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:** **N/A**		**Non-traded:** **N/A**	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Stephen Hammond Date: 07/02/2019

Summary: Analysis & Evidence

Policy Option 1

Description: **Static Acquis - the UK remains part of the EU**

FULL ECONOMIC ASSESSMENT

Price Base Year 2019-20	PV Base Year 2019-20	Time Period Years 10 years	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate: 0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low (Elasticity)				
High (Elasticity)				
Best Estimate	0		0	**0**

Description and scale of key monetised costs by 'main affected groups'

Baseline 'static acquis' position

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low (Elasticity)				
High (Elasticity)				
Best Estimate	0		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

Baseline 'static acquis' position

Other key non-monetised benefits by 'main affected groups'

Key assumptions/sensitivities/risks/uncertainties | **Discount rate (%)** N/A

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m: 0
Costs: **0**	**Benefits:** 0	**Net:** 0	N/A

Summary: Analysis & Evidence

Policy Option 2

Description: Enact the legislation **rules to reflect the UK's departure from the EU**

FULL ECONOMIC ASSESSMENT

Price Base Year 2019-20	PV Base Year 2019-20	Time Period Years 10 years	Net Benefit (Present Value (PV)) (£m)		
			Low:	**High:**	**Best Estimate: 0**

COSTS (£m)	**Total Transition** (Constant Price) Years		**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low (Elasticity)				
High (Elasticity)				
Best Estimate	0		0	**0**

Description and scale of key monetised costs by 'main affected groups'

No financial change to cross-border healthcare arrangements versus the 'static acquis'

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	**Total Transition** (Constant Price) Years		**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low (Elasticity)				
High (Elasticity)				
Best Estimate	0		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

No financial change to cross-border healthcare arrangements versus the 'static acquis'

Other key non-monetised benefits by 'main affected groups'

Enacting the legislation would provide greater clarity for EU and UK nationals on access to the cross-border healthcare, should the UK leave the EU without a ratified agreement.

Key assumptions/sensitivities/risks/uncertainties | **Discount rate (%)** | N/A

An assumption is made that cross-border healthcare arrangements are agreed with Member States after exiting the EU.

BUSINESS ASSESSMENT (Option 2 vs Option 1)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:** 0
Costs: 0	**Benefits:** 0	**Net:** 0	N/A

Summary: Analysis & Evidence

Policy Option 3

Description: Do nothing – The UK retains does not amend existing legislation

FULL ECONOMIC ASSESSMENT

Price Base Year 2019-20	PV Base Year 2019-20	Time Period Years 10 years	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate: 0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low (Elasticity)				
High (Elasticity)				
Best Estimate	0		0	**0**

Description and scale of key monetised costs by 'main affected groups'

Baseline 'do nothing' position

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low (Elasticity)				
High (Elasticity)				
Best Estimate	0		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

Baseline 'do nothing' position

Other key non-monetised benefits by 'main affected groups'

Key assumptions/sensitivities/risks/uncertainties

Other key non-monetised costs by 'main affected groups'

Without amending the policy the EU Withdrawal Act will automatically retain CBHD legislation and the scheme could continue to operate allowing patients to receive reimbursement for overseas healthcare purchases, however the process would not be coherent or workable.

Significant risks and drawbacks associated with this have been identified:

•Redundancy: The same access can largely be delivered through EHIC and S2, both of which the UK is seeking to maintain with Member States.

•Issues of principle: It is odd to operate this scheme when it is not possible for UK patients to obtain reimbursement for private healthcare purchases within the UK (whether for patients within Northern Ireland, England, Scotland and Wales, or patients moving between each part of the UK). There is also a risk of inequalities as patients with financial means to access treatments abroad may be treated more quickly than otherwise and get reimbursement from the NHS, whilst less well-off, vulnerable patients cannot do so.

N/A

•Financial exposure to the NHS: In theory all UK tourists could obtain direct reimbursement from the NHS for any healthcare costs they faced if they travelled without insurance in a Member State where we did not have an arrangement in place similar to EHIC or an MOU with the current cost capping provisions under the CBHD. In theory the costs might be the same as the EHIC scheme, but would be more complex and prone to fraud due to reimbursing individuals directly. For Northern Ireland residents the costs would fall to DoH NI. As Northern Ireland is disproportionally impacted due to the land border with the Republic of Ireland, the CBHD already creates severe pressures on the DoH budget which is viewed as having a negative bearing on the length of waiting lists for those that cannot avail of the CBHD provision. Any further financial exposure would again fall to DoH NI. •WTO / Global Risk: If we maintain reimbursement after leaving the EU, we may over time be challenged as to why we do not reimburse patients who travel to third countries, such as America or India. Discount rate (%)	

BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:** 0
Costs: 0	**Benefits:** 0	**Net:** 0	N/A

Introduction

This is a narrative Impact Assessment that evaluates the costs and benefits of options to address issues raised by the EU (Withdrawal) Act 2018. This Act would retain current legislation surrounding cross-border healthcare in such a way that would no longer be coherent or workable when the UK ceases to be a member state of the EU in the event of no deal. Due to difficulties in accurately estimating the quantifiable impacts of implementing this legislation compared to the option where this legislation is not implemented, this Impact Assessment provides a narrative discussion of the comparative costs and benefits of the options under consideration.

Evidence Base – Cross Border Healthcare Directive (EU Exit) SI

Problem under consideration

1. The domestic legislation implementing the Cross-Border Healthcare Directive clarifies patients' rights to obtain qualifying treatments in another EEA[1] Member State (not Switzerland) and receive reimbursement from their home healthcare system. Reimbursement can be capped at the cost of equivalent state-provided treatment in their home healthcare system. Eligible UK resident patients can receive reimbursement for qualifying private or state-provided treatments up to the amount the NHS would have paid for the equivalent treatment, albeit the patient is charged the price charged to a domestic national in the state of treatment. The obligation to reimburse is limited to treatment which is the same as, or equivalent, to a treatment that would be made available to the person in their home healthcare system i.e. the NHS in relation to the UK.

2. The 'Directive rights' are separate from reciprocal healthcare arrangements under current social security coordination regulations (primarily Regulations 883/2004 and 987/2009). Reimbursement rights under the Directive relate to the fundamental EU principle of the freedom to provide services, whereas the rights under the social security coordination regulations relate to the free movement of people. Payments for reciprocal healthcare under the social security coordination regulations are normally made state-to-state, whereas reimbursements under the 'Directive route' are made to the

[1] EEA is the European Economic Area and includes the EU countries plus Norway, Iceland and Lichtenstein.

individual. The Directive also has a requirement for ‘equal treatment’. This requires that people are not treated differently based on their nationality within the EEA (with respect to pricing and service).

3. In 2013, the UK Government and Devolved Administrations transposed the Directive into domestic legislation. Separate primary and secondary legislation covers England and Wales, Scotland, Northern Ireland and Gibraltar.

4. The EU (Withdrawal) Act 2018 will automatically retain the implementing legislation for the Directive. If we do not legislate further the domestic implementing legislation would be incoherent as the UK would no longer be a Member State and would no longer have an agreement with the EU.

5. The legislation would also be inoperable in its current form without agreements from EEA member states regarding equal treatment. This is because:

   - Without agreement to continue treating citizens equally through MOUs (with respect to healthcare charging), the cost of treatments in the EEA could rise, increasing costs to both the UK and to individuals.

   - Without agreement to continue the current reciprocal healthcare arrangements (under the Social Security Coordination regulations), the NHS in each of the four nations (under the Directive route) could become responsible for unilaterally funding overseas treatment that was previously reimbursed state-to-state by DHSC (e.g. if people choose to use ‘Directive rights’ to claim reimbursement for treatments that were formerly provided under the EHIC scheme and reimbursed state-to-state).

Rationale for intervention

6. Intervention is required to provide a suitable legislative framework for the Directive’s arrangements after we leave the EU in a no deal scenario. It will ensure that the Government can take the necessary steps to transitionally continue the current Directive arrangements, where there is agreement on cross-border healthcare and equal treatment on charging.

7. If we do not legislate further, the relevant domestic legislation would be unclear as the UK would no longer be a member of the EU or have an agreement with the EU. It would be unworkable as it could leave the NHS responsible for funding overseas treatment the cost of which could rise.

Policy objective

8. In a no deal scenario, The Health Services (Cross-Border Health Care and Miscellaneous Amendments) (Northern Ireland) (EU Exit) Regulations 2019 will (using powers under the Withdrawal Act) extinguish the current cross-border healthcare rights under domestic legislation, but at the same time make important savings provisions that do the following:

   - They will enable the UK Government to implement short-term bilateral arrangements with other EU countries (through MOUs). Further legislation will enable the UK to continue to reimburse qualifying healthcare to UK citizens receiving treatments in selected “listed” countries. Countries would be selected and listed by the Secretary of State. We envisage listing countries who reach agreement with the UK to continue the status quo, providing an agreement to continue the current Directive arrangements for a time-limited period until 31 December 2020. This would not apply to countries where there is no reciprocity.

   - It will also protect key groups in a transitional situation on Exit Day, irrespective of any agreements in place. This group has been narrowly defined to cover only those where we have clear legal responsibilities, such as those who have obtained authorisation for planned treatment ahead of Exit Day, though not yet obtained the treatment.

   This includes people who accessed healthcare abroad prior to Exit Day. This will enable the UK to settle its historical liabilities and pay for healthcare obtained by UK residents before the UK leaves the EU.

9. This time-limited measure will balance concerns about the NHS being unilaterally responsible for funding citizens after Exit Day, where there is no MOU in place, with protection against a sudden loss of rights for citizens on Exit Day.

10. The Healthcare (International Arrangements) Bill (HIAB), currently before Parliament, will provide a legislative framework to implement any future longer-term cross-border healthcare arrangements with the EU, individual Member States or countries outside the EU if these are required. The Bill also provides the Government with the ability to respond to further scenarios related to EU Exit, for example making independent arrangements to pay for healthcare, if the UK Government considers it to be necessary in exceptional circumstances.

Description of options considered (including status-quo)

Option 1 – static acquis

11. The current reciprocal and cross-border healthcare arrangements, and their legislative basis, will continue to apply until the UK exits the EU. There would be no change to the current arrangements and therefore no impacts.

Option 2 – Enact the Statutory Instrument – this is the preferred option.

12. Enacting the Cross-Border Healthcare Exit Regulations will (using powers under the Withdrawal Act) correct any incoherent or unworkable aspects of UK domestic legislation (or EU retained legislation) relating to cross-border healthcare in Northern Ireland by extinguishing the current arrangements, but to facilitate Directive rights for certain listed countries until 31 December 2020 where we have entered into a MOU.

13. It is important to enact the legislation to clarify the retained EU legislation (and associated domestic legislation) and to prevent a sudden loss of cross-border healthcare rights

Option 3 – Do nothing

14. If the UK does nothing, the EU (Withdrawal) Act 2018 will automatically retain the domestic legislation implementing the Directive, which would be incoherent as the UK would no longer be an EU Member State.

15. The existing legislation would be unworkable for two main reasons:

- The social security coordination regulations, which would also be retained, are reliant on reciprocity. Without reciprocity, it is unclear whether these rights would continue to apply. If the rights do not continue to apply, then anyone who benefits from current reciprocal healthcare arrangements (e.g. tourists, pensioners or workers) could instead purchase qualifying healthcare in the EEA and claim reimbursement from the NHS as a result of this cross-border healthcare legislation.

- Without MOUs limiting the effect of legislation to situations where equal treatment is maintained, anyone eligible to claim reimbursement from the NHS, for treatments in an EEA country, could be charged more for treatment than a resident of that country after Exit Day. While the amount reimbursed is capped at the cost on the NHS, the amount reimbursed may increase to this amount (if previously below) and the individual receiving treatment would have to pay any costs beyond the cap.

Alternatives to regulation

16. In the absence of regulation, inoperable law will remain in force, creating legal risk. Regulation is further considered necessary to provide a clear legal basis to continue cross-border healthcare arrangements on a time-limited basis, where agreed through MOUs. This will balance concerns about a sudden loss of cross-border healthcare rights.

17. Without regulation, the retention of EU legislation will create legal and operational uncertainty and it will be incoherent and inoperable without MOUs in place.

Summary and preferred option

18. Without legislation to amend the cross-border healthcare legislation, it would be incoherent. This could lead to legal and operational uncertainty. If people are no longer treated equally, due to the incoherence of the existing legislation on cross-border healthcare rights, then this could increase costs to the NHS and to the individual.

19. There may be increased use of the rights under the Directive, which would also increase costs to the NHS and the individual.

20. The UK's preferred option is therefore Option 2, to enact the Cross-Border Healthcare Regulations.

Implementation

21. The regulations are being made and laid in time to come into force on the earliest date the UK can leave the EU (29 March 2019).

Discussion of costs and benefits of options under consideration

Scope

22. The scope of this analysis has been limited to the statutory instrument (SI) covered by this impact assessment.

23. As this is a narrative Impact Assessment we have not decided to quantify or monetise the relative costs and benefits of the options under consideration.

24. The key assumption used in this analysis is that all current cross-border healthcare arrangements continue as-is after the UK leaves the EU. This could also be thought of as arranging 31 bilateral healthcare MOUs with each of the EU Member States[2] on the same basis as the current arrangements. Where the SIs are not enacted, there will be no clear legal basis for implementing these.

25. Any impacts of changes to the cross-border healthcare arrangements between the UK and the EU would be within the scope of other legislation, namely the "European Union (Withdrawal) Act 2018" and (as a 'do nothing' counterfactual) any future "EU (Withdrawal Agreement) Bill".

Monetised and non-monetised costs and benefits of each option (including administrative burden)

Comparison to Option 1 ('static acquis') baseline

26. **Option 1** follows the key assumption that there will be continuing MOUs with the EU Member States. There would be no costs or benefits associated with this option, as changes to the cross-border healthcare agreements are out of scope. For reference, Northern Ireland expenditure on treatment

[2] To reiterate: For ease where we reference EU it also applies to EEA and Switzerland when relating to reciprocal healthcare arrangements provided for under Regulation 883/2004.

under the Cross-Border Healthcare Directive in the 2017/2018 was £1.1m Also, in Option 2 there would be no change to the administrative burden versus the current position.

27. **Option 2**, where the statutory instruments were passed, would have unquantifiable costs and benefits.

Comparison to Option 3 (‘do nothing’) baseline

28. **Option 2** (compared against the ‘do nothing’ baseline) would affect treatment of UK-insured individuals under the cross-border health directive.

29. Passing the Cross-Border Health Directive regulations will provide clarity around the Directive rights that would not be present in the ‘do nothing’ baseline position.

30. Passing the Cross-Border Healthcare Directive regulations is a benefit to individuals compared to the ‘do nothing’ baseline, since it ensures UK residents continue to receive treatment on the same terms as residents of EU countries. Reimbursement under the Directive is capped at NHS tariff, so the regulation avoids individuals bearing any additional cost of treatment if it is more expensive.

Risks and assumptions

31. Given the international nature of the policy, any estimates will inevitably be impacted by the outcomes of negotiations with the EU or with individual Member States on the continuation of existing cross-border healthcare arrangements. As this statutory instrument does not change these cross-border arrangements, and changes to the cross-border healthcare agreements are considered to be out of scope.

32. As a result, there is a high level of uncertainty around the precise value of the costs and benefits.