Title: Combined Impact Assessment for the National Health Service (Charges to Overseas Visitors) (EU Exit) Regulations, Social Security Coordination (Reciprocal Healthcare) (EU Exit) Regulations 2019 and National Health Service (Cross Border Healthcare) and (Miscellaneous Amendments) (EU Exit) Regulations 2019. **IA No: 13014.** **RPC Reference No: N/A** **Lead department or agency:** DHSC **Other departments or agencies:**	Impact Assessment (IA) **Date: 7 February 2019** **Stage: Final** **Source of intervention:** **Type of measure:** **Contact for enquiries:** nhscostrecovery@dhsc.gov.uk

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?

EU regulations currently provide the legal framework for reciprocal healthcare, including the UK's responsibilities to reimburse healthcare costs for UK residents living, working, retired in or visiting the EU (along with Norway, Iceland, Lichtenstein and Switzerland; hereafter 'EU'), as well as our responsibilities to provide healthcare to EU nationals living, working, retired in or visiting the UK (with reimbursement from their home Member State). As we exit the EU, the EU (Withdrawal) Act 2018 will automatically retain these regulations. If the UK leaves the EU without a ratified agreement Government intervention is necessary to provide the appropriate legislative framework to:

- transitionally continue current EU reciprocal healthcare arrangements until 31 December 2020 with those EU Member States where we establish agreements. 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 overseas healthcare for a transition period up until 31 December 2020 with countries with whom we have agreed appropriate arrangements.
- put in place changes to rules for charging overseas visitors and migrants that facilitate on orderly exit, while putting in place the foundation for longer-term cost savings.

What are the policy objectives and the intended effects?

Should the UK leave the EU without a ratified agreement, the policy objective is to:

- ensure that the NHS effectively recovers the costs of NHS services provided to EU visitors and migrants in line with UK Government policy, to support the long-term sustainability of the NHS
- 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 0.1 – static acquis. Impacts of the options 1 and 2 are compared against the current situation where the UK is a member of the EU.
Option 0.2 – Do nothing. Baseline to which options 1 and 2 are compared against.
Option 1 – Enact all legislation to meet the objectives above.
Option 2 – Enact some legislation (relating to charging, reciprocal or cross border healthcare).

Option 1 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 0.1 [Compared to Option 0.1]

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 0.1)

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 1 [Compared to Option 0.1]

Description: Enact all 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 reciprocal 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 reciprocal 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 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 reciprocal healthcare arrangements are agreed with all Member States after exiting the EU.

Any changes to the terms of reciprocal healthcare arrangements with the EU or its Member States, relative to the current arrangements, would be out-of-scope for this analysis.

BUSINESS ASSESSMENT (Option 1 vs Option 0.1)

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 [Compared to Option 0.1]

Description: Enact some legislation (relating to charging, reciprocal or cross border healthcare)

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: N/A

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

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

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

Option 2, where only one or two of the statutory instruments were passed, would have unquantifiable costs. These costs would be a combination of those described in Option 1 and doing nothing, depending on the statutory instruments that passed.

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

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

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

Option 2, where only one or two of the statutory instruments were passed, would have unquantifiable benefits. These benefits would be a combination of those described in Option 1 and doing nothing, depending on the statutory instruments that passed.

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

An assumption is made that reciprocal healthcare arrangements are agreed with all Member States after exiting the EU.

Any changes to the terms of reciprocal healthcare arrangements with the EU or its Member States, relative to the current arrangements, would be out-of-scope for this analysis.

BUSINESS ASSESSMENT (Option 2 vs Option 0.1)

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 0.2 [Compared to Option 0.2]

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	Discount rate (%)	N/A

BUSINESS ASSESSMENT (Option 0.2)

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 1 [Compared to Option 0.2]

Description: Enact all 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: N/A

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

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

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

The Cost Recovery Exit regulations enable EU[1] individuals who have the requisite leave from the Home Office to live and work in the UK to access healthcare in the UK on broadly the same basis as a UK citizen. Where a reciprocal agreement is not in place to recover costs from the relevant EU country, this would be a cost versus the 'do nothing' baseline.

There would be ongoing administrative costs to fund the NHS BSA team who process claims through the EU payment process vs. the 'do nothing' baseline. There would also be an opportunity cost for NHS operational staff to continue to check for chargeable NHS treatment from EU-insured individuals.

Finally, there would be treatment costs for continuing to provide treatments under the S2 scheme (vs. the 'do nothing' baseline).

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

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

Without changes to UK and EU legislation, which would be kept after the UK exits the EU (known as 'retained legislation'), it is unclear whether the reciprocal/cross-border healthcare rights would still exist. The UK would no longer be a member of the EU and the legislation would be incoherent without reciprocity.

Individuals for whom the UK has responsibility for reciprocal healthcare costs under EU legislation are known as 'UK insured'. Those for whom the EU has responsibility are known as 'EU-insured'. If equal treatment provisions no longer applied, EU countries could raise the cost of their healthcare to UK-insured individuals.

If reciprocal healthcare rights continue, this would be a cost to UK Government. If they do not, it would be a cost to individuals and a proportion could seek reimbursement through the Cross-Border Healthcare Directive ('the Directive') instead (which is reimbursed by the NHS). By enacting the legislation, the reimbursement costs would stay with the UK Government (and wouldn't be transferred to NHS commissioners). Keeping reciprocal healthcare rights could also mean UK-insured individuals would not need to pay for private or social insurance instead. There would also be benefits against the 'do nothing' baseline by mitigating a scenario where some individuals return to the UK and increasing the demand for health and social care.

This would be benefits over a ('do nothing') baseline by using reciprocal arrangements vs. charging directly as the total value would be recovered instead of uncertainty around being able to charge. Also, there will be benefits by recovering costs from governments instead of individuals, as this mitigates the risk of non-payment where individuals are directly charged. There would also be benefits from being able to collect income for planned (S2) treatments that are performed.

There may be additional transitional benefits when compared to a 'do nothing' baseline where there could be misinterpretation or inconsistent application of the charging regulations.

[1] 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.

Other key non-monetised benefits by 'main affected groups'	
Key assumptions/sensitivities/risks/uncertainties For the purposes of this analysis, changes to existing healthcare agreements with the EU are out of scope.	**Discount rate (%)** N/A

BUSINESS ASSESSMENT (Option 1 vs Option 0.2)

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 [Compared to Option 0.2]

Description: Enact some legislation (relating to charging, reciprocal or cross border healthcare)

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: N/A**

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

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

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

Option 2, where only one or two of the statutory instruments were passed, would have unquantifiable costs. These costs would be a combination of those described in Option 1 and doing nothing, depending on the statutory instruments that passed.

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

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

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

Option 2, where only one or two of the statutory instruments were passed, would have unquantifiable benefits. These benefits would be a combination of those described in Option 1 and doing nothing, depending on the statutory instruments that passed.

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

Assuming that reciprocal healthcare arrangements are agreed with all Member States after exiting the EU.

Any changes to the terms of reciprocal healthcare arrangements with the EU or its Member States, relative to the current arrangements, would be out-of-scope for this analysis.

BUSINESS ASSESSMENT (Option 2 vs Option 0.2)

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

1. 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 reciprocal healthcare and NHS cost recovery 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 – Social Security Regulations (EU Exit) SI

Problem under consideration

2. Reciprocal healthcare agreements enable people whose state healthcare costs the UK has responsibility for (known as 'UK-insured') to access healthcare when they live, study, work, or travel abroad (and vice versa for people whose state healthcare costs European Union (EU)[2] countries have responsibility for (known as 'EU-insured') when in the UK). They give people more life options, supports tourism and business, and healthcare cooperation.

3. EU social security coordination regulations currently provide the legal framework for reciprocal healthcare, including the UK's responsibilities to:

   - Reimburse healthcare costs for UK-insured individuals living, working, retired in or visiting the EU. This includes healthcare for UK state pensioners living abroad (the S1 scheme), emergency and needs arising healthcare for UK-insured temporary visitors to the EU such as tourists, students and workers (the European Healthcare Insurance Card Scheme (EHIC)) and UK-insured individuals travelling overseas to receive planned treatment in other countries (the S2 scheme). The regulations require the UK to pay the Member State but also, in certain circumstances, provide for direct reimbursement to individuals.

   - Provide healthcare to EU nationals living, working, retired in or visiting the UK (with reimbursement from their home Member State).

4. The EU social security coordination regulations also include the requirement for 'equal treatment', which means that people within the scope of the legislation are not treated differently according to their nationality (with respect to healthcare pricing and service).

5. The EU social security coordination regulations are separate from the Cross-Border Healthcare Directive (the 'Directive'), which provides additional rights (implemented through domestic legislation) to purchase qualifying healthcare in an EEA country and receive reimbursement from the person's home healthcare system, in accordance with specific criteria.

6. When the UK leaves the EU (on the 'exit day'), the EU (Withdrawal) Act 2018 will automatically retain these regulations, and the domestic implementing legislation in UK law if there no further secondary legislation is made. In the event of no deal, if we do not legislate further, the regulations would be incoherent or unworkable without reciprocity by Member States and it would be unclear if patients still had rights to UK funded healthcare in the EU.

7. If they do, this would leave the UK responsible for unilaterally funding healthcare for many UK-insured individuals living and working in the EU and EU-insured individuals in the UK after exit day. However, if these rights are no longer applicable, this would lead to a sudden loss of rights and access to healthcare on exit day.

8. The lack of a clear legal framework would create legal and operational uncertainty and legal risk in relation to the rights that exist and the processes for implementing them.

[2] 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.

Rationale for intervention

9. In a no deal scenario, intervention is required to create a suitable legislative framework for reciprocal healthcare arrangements after we leave the EU. It will ensure that the Government can take the necessary steps to transitionally continue current EU healthcare coordination arrangements, where there is continued reciprocity, and to cease these arrangements where there is not.

10. If we do not legislate further, the retained EU legislation would be incoherent as the UK would no longer be a Member State and would no longer have an agreement with the EU. Reciprocal healthcare arrangements rely on reciprocity and the UK will no longer have reciprocity with the EU (as a whole), or individual Member States in the absence of bilateral agreements.

11. Without further legislation, it would be unclear how, and whether, the rights contained in legislation operated, and it could leave the UK responsible for unilaterally funding healthcare for many UK-insured individuals living, visiting and working in the EU and EU insured individuals in the UK after exit day. For example, UK tourists to the EU could attempt to use their EHICs. Without reciprocity, there would be no mechanisms for the recognition of EHICs or for processing reimbursements. The UK Government may be required to reimburse individuals or institutions in the EU. Alternatively, patients may request reimbursement from the NHS through the Directive.

Policy objective

12. The Social Security Coordination (Reciprocal Healthcare) (Amendment etc.) (EU Exit) Regulations 2019 (the 'Social Security Coordination Exit Regulations') will change aspects of the retained EU social security coordination regulations (e.g. Regulations 883/2004 and 987/2009) that are incoherent and relate to reciprocal healthcare.

13. The reciprocal healthcare elements of these regulations will cease to apply to reciprocal healthcare in the longer term, but be transitionally retained until 31 December 2020, with appropriate modifications, through a time-limited savings provision for a list of countries (to be determined and negotiated).

14. The Department for Work and Pensions will be making separate regulations to correct deficiencies in other social security aspects of the retained Regulations.

15. The Social Security Coordination Exit Regulations extinguish reciprocal healthcare aspects of the social security coordination regulations, but at the same time they make important savings provisions that do the following:

    - The regulations will enable the UK to continue to support the provision of healthcare to UK citizens in selected "listed" countries (as well as receiving reimbursement for healthcare provided in the UK to those countries' citizens). 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 a reciprocal agreement to continue the current arrangements for a time-limited period until 31 December 2020. The saving would not apply to countries where there is no reciprocity.

    - It will also save relevant provisions of the EU social security coordination regulations to preserve, so far as possible, the position of key groups of patients in the course of treatment on exit day, irrespective of any reciprocity in place.

16. These key groups include people who accessed healthcare abroad prior to exit day. This will enable the UK to settle its historical liabilities and pay in arrears for healthcare used by UK residents and expats before exit day (and for claiming costs back from Member States for their own nationals).

17. This time-limited measure will balance concerns about the NHS being unilaterally responsible for funding citizens after exit day, where there is no reciprocity, with protection against a sudden loss of rights for citizens on exit day.

18. The Healthcare (International Arrangements) Bill, currently before Parliament, will provide a legislative framework to implement any future longer-term reciprocal healthcare arrangements with the EU, individual Member States or countries outside the EU. 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 0.1 – static acquis

19. 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 0.2– Do nothing

20. If the UK does nothing, the EU (Withdrawal) Act 2018 will automatically retain the reciprocal healthcare legislation, which would be incoherent and unworkable as the UK would no longer be an EU Member State and the current arrangements are reliant on reciprocity.

21. There would be legal and operational uncertainty as to whether and, if so, how the healthcare rights contained therein would continue to apply. without EU membership underpinning these. One possible interpretation is that the UK would be responsible for unilaterally funding healthcare for many UK-insured individuals living in, visiting and working in the EU and EU-insured individuals in the UK after Exit Day. Where there are no agreements with other countries, there would be no reciprocity. There would be no certainty that UK-insured individuals could continue to receive treatment on the same terms as a national of other EU countries, which could increase costs to the UK Government, the NHS (if they instead make a claim for reimbursement under the Directive route) or the individual. Further EU Member States could refuse to reimburse the UK for the cost of healthcare provided by the NHS to individuals for whom they are responsible.

22. On the other hand, If the rights are interpreted to be no longer applicable, without further legislation amending the existing legislation to clarify the rights and continued arrangements to maintain reciprocity on a time-limited basis, this would result in a sudden loss of reciprocal healthcare rights on exit day. This could have a significant adverse impact on those who are reliant on reciprocal healthcare rights.

23. Without amendments to the Cost Recovery Exit regulations, the UK may be unable to recoup costs from any EU visitors or to exempt relevant EU citizens from charging on the basis of a bilateral agreement. The deficiencies outlined under Option 2 for cost recovery would also be applicable under this option.

Option 1 – Enact all Statutory Instruments – this is the preferred option.

24. Enacting the Social Security Coordination Exit Regulations, in conjunction with the other two statutory instruments, will (using powers under the Withdrawal Act) correct any incoherent or unworkable aspects of EU retained legislation relating to reciprocal healthcare in the UK. It would extinguish the current arrangements, but continuing with these for certain listed countries, with whom we have agreements to maintain reciprocity, for a transition period up until 31 December 2020. Reciprocal healthcare for other countries with whom we have not agreed continued reciprocity would cease (except for transitional provisions).

25. The enactment of the National Health Service (Cross Border Healthcare) and Miscellaneous Amendments etc) (EU Exit) Regulations 2019 (the ‘Cross Border Exit Regulations’) (see section below for further information) would continue these rights where the UK has agreed to maintain reciprocity. This would similarly balance concerns about the NHS being unilaterally responsible for funding citizens after exit day, where there is no reciprocity, with protection against a sudden loss of rights for citizens on exit day.

26. The National Health Service (Charges to Overseas Visitors) (EU Exit) Regulations (the 'Cost Recovery Exit Regulations') would enable the UK to recoup costs of treatments provided by the NHS to EU visitors where we do not have continued agreements.

Option 2 – Enact some legislation

27. The UK could enact the Social Security Coordination Exit Regulations without the other two Exit Regulations, however this is not a viable option.

28. Where there are no reciprocal healthcare arrangements, these rights would cease. If no changes are made to the domestic legislation that implemented the Cross Border Healthcare Directive this could lead to increased costs to the NHS and individuals. For example, if a UK-insured tourist travels to an EU country that the UK no longer has reciprocal healthcare arrangements with, they would no longer be entitled to UK-funded reciprocal healthcare in that country. If they instead make claims for reimbursement under the Cross Border Healthcare Directive route, this could increase costs to the NHS and/or the individual. These costs would currently be met by the Department of Health and Social Care (DHSC) under the EU Social Security Regulations, but under the Cross Border Healthcare Directive route these costs would have to be funded by the NHS. Similarly, in the absence of agreement with the host state to maintain equal treatment, this could increase costs to the individual and the NHS.

29. If the Cost Recovery Exit regulations (see section below for further information) are not enacted, the UK would be unable to recoup costs from EU visitors from countries that the UK no longer has any reciprocal healthcare arrangements with. The scope for some overseas visitors and migrants not making appropriate contribution to the costs of their NHS treatment would remain. The opportunity for this policy area to contribute further towards the financial sustainability of the NHS would be lost.

30. The ability of the NHS (and non-NHS organisations providing NHS-funded services) would be hampered by legal uncertainty as to how references to EU rights in the current charging regulations should be interpreted. This could result in some people not being charged who should be (losing income for the NHS), and some being charged who should not be. While it may be possible to mitigate this to some extent by issuing guidance to providers of NHS-funded services, this does not eliminate all risk of legal challenge.

Alternatives to regulation

31. In the absence of regulation, incoherent law will remain in force, creating legal risk. This approach balances concerns about the UK otherwise being unilaterally responsible for funding UK tourists and EU visitors after exit day with protection against a sudden loss of reciprocal healthcare rights.

32. Without regulation, the retention of EU legislation will create legal and operational uncertainty and it will be incoherent and inoperable without reciprocity.

Summary and preferred option

33. Without the SSC Exit Regulations to amend the social security legislation this would no longer be coherent or workable and would create legal and operational uncertainty. If people are no longer treated equally, then this could increase costs to the UK and to individuals.

34. Without accompanying changes to the Cross Border Healthcare Directive legislation, there may be increased use of the rights under the Directive, which could increase costs to the NHS and the individual.

35. If the Cost Recovery Exit regulations are not enacted, the legislative framework for NHS cost recovery for EU nationals would not function effectively where no reciprocal arrangements are made.

36. The UK's preferred option is therefore Option 1, to enact the SSC Exit Regulations in conjunction with the Cross-Border Exit Regulations and the Cost Recovery Exit Regulations.

Implementation

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

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

Problem under consideration

38. Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare (the Directive) came into force on 24 April 2011 with a transposition deadline of 25 October 2013. It clarified patients' rights to obtain qualifying healthcare in another European Economic Area (EEA) Member State and to receive reimbursement from their home healthcare system.

39. The domestic legislation implementing the Cross-Border Healthcare Directive clarifies patients' rights to obtain qualifying treatments in another EEA[3] 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. However, it provides a broader discretion for relevant UK authorities to pre-authorise treatments which may not be available in the UK.

40. 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 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).

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

42. 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.

43. The legislation would also be inoperable in its current form without reciprocity from EEA member states regarding equal treatment and reciprocal healthcare arrangements with the EU (which impact on cross-border healthcare). This is because:

- Without agreement to continue treating citizens equally through continued reciprocal healthcare arrangements, 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

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

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

44. 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 continued reciprocity on reciprocal healthcare and equal treatment on charging.

45. 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 unilaterally funding overseas treatment (without continued reciprocal healthcare rights under the social security coordination regulations and equal treatment), the cost of which could rise.

Policy objective

46. In a no deal scenario, the National Health Service (Cross Border Healthcare and Miscellaneous Amendments etc) (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 arrangements with other EU countries. 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, so far as possible, key groups in a transitional situation on exit day, irrespective of any reciprocity in place.

47. These key groups include people who accessed healthcare abroad prior to exit day. This will enable the UK to settle its historical liabilities and pay in arrears for healthcare used by UK residents and expats before the UK leaves the EU.

48. This time-limited measure will balance concerns about the NHS being unilaterally responsible for funding citizens after exit day, where there is no reciprocity, with protection against a sudden loss of rights for citizens on exit day.

49. 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.

Description of options considered (including status-quo)

Option 0.1 – static acquis

50. 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 0.2 – Do nothing

51. 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.

52. 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 agreements 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.

53. Without amendments to the Cost Recovery Exit regulations, the UK would be unable to recoup costs from any EU visitors or exempt those EU nationals whose country has agreed a reciprocal healthcare arrangement. The deficiencies outlined under Option 2 for cost recovery would also be applicable under this option.

Option 1 – Enact all Statutory Instruments – this is the preferred option.

54. Enacting the Cross-Border Healthcare Exit Regulations, in conjunction with the other two statutory instruments, 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 by extinguishing the current arrangements, but to facilitate Directive rights for certain listed countries until 31 December 2020 where we have continued reciprocity (on reciprocal healthcare and equal treatment).

55. The enactment of the Social Security Coordination Exit Regulations is important to protect the NHS and individuals from increased costs when using the Directive rights where the UK does not have continued reciprocity.

56. The enactment of the NHS Charging Exit Regulations is important to recoup the cost of NHS treatments provided to EEA visitors from countries that we do not have agreements after EU Exit.

57. It is important to enact all three pieces of legislation to clarify the retained EU legislation (and associated domestic legislation) and to prevent a sudden loss of reciprocal or cross-border healthcare rights and to ensure a fair charging system.

Option 2 – Enact some legislation

58. The UK could enact the Cross-Border Healthcare Exit Regulations without the other two pieces of legislation, however this is not a viable option.

59. Where the UK agrees continued reciprocal healthcare arrangements, the retained social security coordination legislation would be unclear without amendments to reflect the UK's position as a third country and the bilateral nature of the agreement. There would be legal and operational uncertainty about the rights that exist and this could lead to increased use of the cross-border healthcare rights. It may also be unclear whether the equal treatment principle still applies under the new bilateral arrangements, which could lead to some institutions charging more for treatments, increasing costs to individuals and the NHS.

60. If the Cost Recovery Exit regulations are not enacted, the UK would be unable to recoup costs from EU visitors from countries that the UK no longer has any reciprocal healthcare arrangements with. The scope for some overseas visitors and migrants not making appropriate contribution to the costs of their NHS treatment would remain. The opportunity for this policy area to contribute further towards the financial sustainability of the NHS would be lost.

61. The ability of the NHS (and non-NHS organisations providing NHS-funded services) would be hampered by legal uncertainty as to how references to EU rights in the current charging regulations should be interpreted. This could result in some people not being charged who should be (losing income for the NHS), and some being charged who should not be. While it may be possible to mitigate this to some extent by issuing guidance to providers of NHS-funded services, this does not substantially reduce risk of legal challenge.

Alternatives to regulation

62. In the absence of regulation, inoperable law will remain in force, creating legal risk. This approach will balance concerns about the UK otherwise being unilaterally responsible for funding UK tourists and EU visitors after exit day with protection against a sudden loss of cross-border healthcare rights.

63. Without regulation, the retention of EU legislation will create legal and operational uncertainty and as it would be difficult to operate without reciprocity.

Summary and preferred option

64. 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.

65. Without accompanying changes to the Social Security Coordination Exit Regulations, there may be increased use of the rights under the Directive, which would also increase costs to the NHS and the individual.

66. If the Cost Recovery Exit regulations are not enacted, the legislative framework for NHS cost recovery would not function effectively where no reciprocal arrangements are made, either with the EU or individual Member States.

67. The UK's preferred option is therefore Option 1, to enact the Cross-Border Healthcare Regulations in conjunction with the Social Security Coordination Exit Regulations and the Cost Recovery Exit Regulations.

Implementation

68. 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).

Evidence Base – Cost Recovery Regulations (EU Exit) SI

Problem under consideration

69. In the event that the UK leaves the EU on that day without a ratified agreement, the references to EU law within the existing legislative framework for the recovery of costs from overseas visitors and migrants will no longer be clear and the rights of EU citizens derived from that EU law could fall away.

70. The regulations will adjust the rules for charging overseas visitors and migrants to reflect UK government policies under a no deal scenario on access to NHS-funded healthcare for EU citizens residing in, seeking to settle in or visiting the UK. The amendments will make technical changes to ensure the legislation functions effectively from the point at which the UK exits the EU, and provide a foundation for longer-term cost savings.

71. In summary, the amendment regulations will:

- remove references to EU law that are no longer operable following the UK's departure from the EU;
- provide that EU citizens protected by the unilateral Citizen's Rights offer (in a 'no deal' scenario) will remain eligible for free NHS-funded care;
- set out the chargeable status of EU citizens seeking to live, work or visit the UK after exit day;
- provide for transitional arrangements to ensure that EU citizens relying on reciprocal healthcare arrangements over exit day are protected from immediate changes to their eligibility for free NHS-funded care;
- exempt from charges for UK-insured persons currently living in the EU should they return temporary return to the UK; and
- reflect reciprocal healthcare agreements with Member States that are in place following the exit day.

72. In the longer-term, ensuring that the costs of NHS treatment are recovered from eligible persons will contribute to the long-term financial sustainability of the NHS. The money recovered from overseas visitors is reinvested back into frontline services to ensure everyone receives urgent care when they need it.

73. The amendments will form part of a national programme of work to increase the recovery of costs from visitors and migrants who access NHS-funded treatment when in the UK. Alongside other non-legislative policy actions under this programme, DHSC and NHS England have more than quadrupled the income identified from overseas visitors' healthcare over the last four years to a total of £390m per annum.

Rationale for intervention

74. Government intervention is necessary to adjust the charging rules for NHS cost recovery to ensure that they facilitate an orderly exit from the EU, where reciprocal healthcare arrangements with the EU end for the UK, and to provide the foundations for longer-term cost savings that support the sustainability of the NHS.

75. The regulations will be made under Section 175 and section 242 (7) and (8) of the NHS Act 2006, and relate to England only. NHS Charging policy is a devolved matter and the Devolved Administrations are responsible for taking forward any amendments to their own charging regulations.

Policy objective

76. The policy objective is to ensure that the NHS effectively recovers the costs of NHS services provided to EU visitors and migrants in the event that the UK leaves the EU without a ratified agreement. Charging rules will be amended in relation to the rights of EU citizens accessing NHS-

funded healthcare while residing in, seeking to settle in or visiting the UK, to reflect UK Government policies under a no deal scenario, including, for example, the protection of the rights for EU citizens ordinarily resident in the UK before exit day.

77. This objective will be achieved by a combination of legislative and non-legislative policy action to provide the NHS frontline with bespoke and intensive support to improve cost recovery processes. This will include raising awareness of the charging requirements, clearly setting out best practice and enabling NHS trusts to avoid failing to recover income they identify, which would then add to their debt.

Description of options considered (including status-quo)

Option 0.1 – static acquis

78. The current cost recovery, 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 0.2 – Do nothing

79. In the absence of Government intervention, the policy objectives identified above would not be achieved.

80. The scope for some overseas visitors and migrants not making appropriate contribution to the costs of their NHS treatment now and in the future would remain. The opportunity for this policy area to contribute further towards the financial sustainability of the NHS in the longer term would be lost.

81. There would be considerable legal and operational uncertainty as to how references to EU rights in the current charging regulations should be interpreted. As EU Exit legislation is necessarily untested, it is unclear how a court would interpret the validity and operability of references to EU rights. Operationally, the ability of the NHS (and non-NHS organisations providing NHS-funded services) to recover costs effectively from EU visitors may be hampered by similar uncertainties around interpretation. This could result in some people not being charged who should be (losing income for the NHS), and some being charged who should not be. While it may be possible to mitigate this to some extent by issuing guidance to providers of NHS-funded services, this does not substantially reduce risk of legal challenge that the charging regime has been misapplied.

82. If the Charges to Overseas Visitors regulations are not enacted, the UK would be unable to recoup costs from EU visitors from countries that the UK no longer has any reciprocal healthcare arrangements with. The scope for some overseas visitors and migrants not making appropriate contribution to the costs of their NHS treatment would remain. The opportunity for this policy area to contribute further towards the financial sustainability of the NHS would be lost.

Option 1 – Enact all Statutory Instruments – this is the preferred option.

83. The preferred option is to proceed with amending secondary legislation that will amend the charging regulations to:

- remove references to EU law that are no longer operable following the UK's departure from the EU;
- provide that EU citizens protected by the unilateral Citizen's Rights offer (in a 'no deal' scenario) will remain eligible for free NHS-funded care;
- set out the chargeable status of EU citizens seeking to live, work or visit the UK after exit day;
- provide for transitional arrangements to ensure that EU citizens relying on reciprocal healthcare arrangements over exit day are protected from immediate changes to their eligibility for free NHS-funded care;
- exempt from charges UK-insured persons currently living in the EU should they return temporarily to the UK; and
- reflect reciprocal healthcare agreements with Member States that are in place following exit day.

Option 2 – Enact some legislation

84. If in this option, the Cost Recovery Exit regulations are enacted, the results will be the same as Option 1 above. Otherwise, the 'do nothing' option (Option 0.2) would apply.

Alternatives to regulation

85. No alternatives to regulation have been considered. Regulation is considered necessary to drive a culture in the NHS to embed identifying and charging overseas visitors and migrants not eligible for free NHS healthcare, and to clarify the rights to healthcare of EU-insured individuals should the UK leave the EU without a ratified agreement.

86. These regulatory changes lie outside the scope of the Better Regulation Framework and as such no OI3O or EANDCB assessments are presented.

Summary and preferred option

87. Without legislation to amend the cross-border healthcare directive, and the domestic legislation that implements it, these 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.

88. Without accompanying changes to the Social Security Coordination Exit Regulations, there may be increased use of the rights under the Directive, which would also increase costs to the NHS and the individual.

89. If the Cost Recovery Exit regulations are not enacted, the legislative framework for NHS cost recovery would not function effectively where no reciprocal arrangements are made, either with the EU or individual Member States.

90. The UK's preferred option is therefore Option 1, to enact the Cross-Border Healthcare Regulations in conjunction with the Social Security Coordination Exit Regulations and the Cost Recovery Exit Regulations.

Implementation

91. 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

92. The scope of this analysis has been limited to the three statutory instruments covered by this impact assessment. However, as these instruments also are in the environment of exiting the EU, there are other changes that are occurring that will affect any resulting outcome but are out-of-scope of this impact assessment.

93. 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.

94. The key assumption used in this analysis is that all current reciprocal healthcare arrangements continue as-is after the UK leaves the EU.

95. Any impacts of changes to the reciprocal 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) the "EU (Withdrawal Agreement) Bill" and the Healthcare (International Arrangements) Bill.

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

Comparison to Option 0.1 ('static acquis') baseline

96. **Option 1** follows the key assumption that there will be continuing agreements with the EU Member States. There would be no costs or benefits associated with this option, as changes to the reciprocal healthcare agreements are out of scope. For reference, UK income via the current EU reciprocal healthcare arrangements was £66m in 2016-17 and UK expenditure was £630m in 2016-17. Expenditure on treatment under the Cross-Border Healthcare Directive was £2.2 million in 2017. Also, in Option 1 there would be no change to the administrative burden versus the current position.

97. **Option 2**, where only one or two of the statutory instruments were passed, would have unquantifiable costs and benefits.

Comparison to Option 0.2 ('do nothing') baseline

98. **Option 1** (compared against the 'do nothing' baseline) would affect the elements listed below (but the value of costs and benefits is dependent on a number of aspects):

- Care currently provided via the S1 scheme;
- Planned treatment currently provided via the S2 scheme;
- Needs arising care currently provided via an EHIC;
- Patients whose course of treatment spans exit day;
- Treatment of UK-insured individuals under the cross-border health directive;
- Potential returners to the UK; and
- Cost of private or social insurance.

99. Passing the Social Security Coordination Exit Regulations and Cross-Border Health Directive Exit Regulations will provide clarity around the reciprocal healthcare and Directive rights that would not be present in the 'do nothing' baseline position.

100. After exit day, UK-insured individuals in the EU will continue to receive treatment paid for by the UK Government under the reciprocal healthcare regulations, so far as possible in those countries who agree reciprocity. Compared to the 'do nothing' baseline this provides clarity; it maintains reciprocity of the current arrangements, ensures reimbursements are made to Member States rather than institutions and individuals, and it avoids individuals seeking alternative treatment and claiming healthcare costs through the Directive instead. This also ensures costs of treatment stay with the UK Government rather than transferring to the NHS commissions in each of the four nations, as would be the case if individuals claimed on the Directive.

101. Passing the Social Security Coordination Exit Regulations will mean that UK-insured individuals continue to receive treatment on the same terms as a resident of EU countries, so far as possible in those countries who agree reciprocity, which is a potential benefit compared to the 'do nothing' baseline where EU countries could increase charges for treating UK-insured individuals. This is a benefit for both the UK Government and for individuals, even those who would otherwise claim treatment costs through the Directive since reimbursement under the Directive is capped at NHS tariff.

102. Compared to the 'do nothing' baseline, passing the Social Security Coordination Exit Regulations is a benefit to individuals as it avoids a sudden loss of rights on exit day, so far as possible in those countries that agree reciprocity, which could otherwise have a significant adverse impact on those who are reliant on reciprocal healthcare. Passing the regulation mitigates against UK-insured individuals returning to the UK due to losing their healthcare rights, so costs of treating these individuals stay with UK Government via the reciprocal healthcare agreements, instead of transferring to the NHS commissions in the four nations. This is also a benefit to Local Authorities,

who could otherwise have to provide care to any people returning to the UK. Another benefit to individuals is not being required to take out private health insurance or social insurance.

103. Passing the Cross-Border Healthcare Directive Exit 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.

104. Passing the Cost Recovery Exit Regulations will provide clarity around the regulations relating to charging of overseas visitors and migrants that wouldn't be present in the 'do nothing' baseline position.

105. After exit day, EU insured individuals in the UK who would have formerly been treated under the S1 scheme or using an EHIC (where the costs being recouped from their competent country) would continue to be covered by reciprocal healthcare agreements that are in place and costs would be recovered by governments instead of individuals. This would have benefits over a ('do nothing') baseline as the total value would be recovered instead of uncertainty around being able to charge. Also, there will be benefits by recovering costs from governments instead of individuals, as this mitigates the risk of non-payment where individuals are directly charged

106. As the S2 scheme entitles the holder to a specific plan of care in another EU country (with the costs recovered from the country that insures the individual), then passing the Cost Recovery Exit regulations would allow this to continue. This would have costs to the UK (as there is a cost to the UK for providing this treatment) as well as benefits of the same amount (as the UK could continue to recover the treatment costs from the competent country). This is compared against the 'do nothing' baseline, where S2 treatments would cease, as patients would seek treatment in another country which still accepts S2 arrangements.

107. The Cost Recovery Exit regulations enable EU[4] individuals who have the requisite leave from the Home Office to live and work in the UK to access healthcare in the UK on broadly the same basis as a UK citizen. Where a reciprocal agreement is not in place to recover costs from the relevant EU country, this would be a cost (versus the 'do nothing' baseline) as it is compared to directly charging these individuals for their healthcare whilst in the UK (albeit with the same risk of non-payment as above).

108. Option 1 (versus the 'do nothing baseline') would result in additional costs for NHS operational staff after EU exit day and from the central team processing claims for DHSC (a part of NHS BSA).

109. Passing the Cost Recovery Exit Regulations would result in an administrative cost to fund NHS operational staff who identify, process and charge patients not eligible for NHS-funded care. This is compared to a situation where EU-insured individuals are not chargeable and so there would be a reduction in the workload of these operational staff. This means this cost is essentially an opportunity cost, as these staff would not be able to work on other projects.

110. Passing the Social Security Coordination Exit Regulations would result in ongoing administrative costs to fund the NHS BSA team (who claim reimbursements for treatment provided EU-insured individuals and pay for treatment in Member States for UK-insured individuals). These are costs over the 'do nothing' baseline, where the team could be wound down after four years once processing the outstanding claims (that accrued before exit day) was completed.

111. Comparing the above potential scenarios in Option 1 against the 'do nothing' baseline make the costs and benefits difficult to quantify for the three instruments.

112. **Option 2**, where only one or two of the statutory instruments were passed, this would have unquantifiable costs and benefits and would depend on which statutory instruments were passed. Against the 'do nothing' baseline, there would not be an administrative cost for NHS operational staff if the Cost Recovery Exit regulations were not passed and there would not be the ongoing

[4] 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.

administrative cost for the NHS BSA team if the Social Security Coordination Exit Regulations were not passed.

Risks and assumptions

113. 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 reciprocal healthcare arrangements. As these statutory instruments do not change these reciprocal arrangements, changes to the reciprocal healthcare agreements are considered to be out of scope.

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

Wider impacts

115. This impact assessment has been combined for three statutory instruments to account for the wider interactions of each individual element.