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Healthcare for Pensioners

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Contents

1 Introduction – The European Commission's brief
2 Policy background
3 Context: Mobility of pensioners
4 Member States' healthcare systems
5 Community competence for healthcare
6 Regulation (EEC) 1408/71
7 Regulation (EC) 883/04
8 Impact of deleting Articles 23 – 30 of Regulation 883/04
9 Recommendations

List of Tables

Table 1: Corresponding articles for healthcare for pensioners in Regulations 1408/71 and 883/04

Table 2: The impact of deleting Articles 23-30 of Regulation 883/04

1. INTRODUCTION: THE BRIEF FROM THE EUROPEAN COMMISSION

This paper analyses the consequences for pensioners and the members of their families if their right to healthcare were to be based solely on Article 11(3)(e) of Regulation 883/04.

According to the provisions on applicable legislation in Regulation 883/04, Article 11 (3) (e) provides that the economically non-active person, in principle, is subject to the legislation of only one Member State, which shall be the Member State of her or his residence.

However, provisions in Articles 23-30 of Regulation 883/04 provide an exception to this rule for pensioners and members of their families with regard to their right to sickness benefits in kind. The purpose of this exception is to make sure that these insured pensioners receive sickness benefits when they move within the European Union (EU) on behalf of a State which pays a pension.

With the introduction of the provisions in Article 11 (3) (e) of Regulation 883/04 on applicable legislation for economically non-active persons and the reinforcement of the provisions on equal treatment in Articles 4 and 5, the European Commission considers that it is timely to investigate and analyse whether this exception is still valid.

The TRESS think tank has therefore been asked to examine what the situation for pensioners and members of their families would be should the right to healthcare be based solely on the provisions in Regulation 883/04 on applicable legislation in Article 11 (3) (e) read in conjunction with Articles 4 on equal treatment and Article 5 on the equal treatment of benefits, income, facts or events.

This report identifies the role of Articles 23-30 of Regulation 883/04 (and the corresponding articles of Regulation 1408/71) in protecting the social security rights of pensioners and their families and whether their deletion would improve or impair the protection of those rights; and secondly what the impact of their deletion would be on the distribution of costs between Member States. Section 2 sets out the policy background; while section 3 looks at the policy focus - free movement of pensioners. Section 4 briefly outlines the basic principles of the Member States' healthcare systems; section 5 sets out Community competence for healthcare; and section 6 the principles of coordination; while sections 7 and 8 examine the relevant provisions of Regulation 1408/71 (and the associated case law) and Regulation 883/04 respectively. Section 9 identifies the impact of deleting Articles 23-30 of Regulation 883/04 on pensioners and the distribution of costs between Member States. Section 10 considers issues outstanding if that scenario is rejected; and finally section 11 presents recommendations.

2. POLICY BACKGROUND

The background to the issue and the statement of the problem is set out in the *Note from the Secretariat to the Administrative Commission on Social Security for Migrant Workers* of 25 November 2008 in which it is observed that under Article 13 (2) (f) of Regulation 1408/71 non-active people are by default subject solely to the legislation of the Member State of residence. This will no longer be the case under Article 11 (3) (e) of Regulation 883/04 which fully integrates non-active people into the scope of the new regulation.

The Community legislature has, however, taken a different approach to coordination for pensioners under Regulation 1408/71 (see section 7 below). This approach has been retained by Regulation 883/04 where it is set out in Articles 23 – 30 (this is discussed in section 8 below).

The context to the question is framed by concerns expressed about the fair distribution of the burdens associated with the costs of benefits for pensioners which "*was at the root of the Commission's initial proposal to bring Regulation 1408/71 up to date … and played a major role when Regulation 883/2004 was being drawn up*" (Note from the Netherlands of 2 April 2008, CA.SS.TM. 152/08).

During the examination in the Working Party on Social Questions of the chapters on sickness and financial provisions (sickness) in the proposal for a Regulation to implement Regulation No 883/04, the French Delegation had stated that it was:

> "*in favour of a fairer distribution of the burden of benefits in kind provided to pensioners and members of their families where those concerned receive pensions from more than one Member State*".

It added that:

> *"while it did not seem possible to reopen the dossier when examining these two chapters, it did appear necessary for the Administrative Commission to be able to re-examine this question as soon as possible, and announced its intention to prepare a note to open the debate."* (Note from France of 8 June 2007 CA.SS.TM 184/07).

In its Note to the Administrative Commission of 8 June 2007 France pointed out that under both Regulation 1408/71 and Regulation 883/04, if a pension is provided by the State of residence and the pensioner acquires entitlement to benefits in kind in that State, then the total cost of healthcare falls to the State of residence. If, on the other hand, the pensioner does not receive a pension from his (or her) State of residence or there is no entitlement to benefits in kind in the State of residence, the cost of healthcare falls on the other Member State paying a pension that provides entitlement to healthcare within its territory, or, if there is more than one, on the State to whose legislation the pensioner has been subject for the longest time.

The note continued:

> *"This basic rule is simple in principle and generally requires only a rapid examination of the person's dossier in order to decide upon and establish competence.*"

However, the note from France argued that this rule:

> "*does not guarantee a sufficiently fair distribution of the burden of benefits between the States liable to pay pensions, as it is sufficient for the State of residence to be liable to pay a small pension (in accordance with the legislation on either capital payments or reimbursement of contributions) for the entire burden to fall upon it, even though the person concerned may have been active almost entirely in another State and be entitled to a commensurate pension from that State"* (Note from France of 8 June 2007, CA.SS.TM 184/07).

The French Note then went on to consider the subsidiary rule of apportioning the responsibility in line with the longest insurance history, thus making it possible to distinguish between debtor States other than the State of residence where this State is not the competent State. As the French Note points out this is almost as simple in principle as the primary rule, except that it requires a comparison of the various histories. France considered that this approach is fairer as it cannot lead

to the allocation of responsibility to a State that is only paying a very small pension based on a brief insurance history rather than a State where the person has a longer insurance history. Nevertheless, France considered that this approach is not entirely fair as it is sufficient to have one month more insurance under one legislation rather than another over a whole working life in order for the entire responsibility for healthcare costs to be transferred from one State that is liable to pay a pension to another.

As the French Note points out the initial proposal by the Commission to modernise Regulation 1408/71 took this scenario into account by proposing a distribution of the burden of benefits in kind "*among all the States paying a pension, in proportion to the periods completed in each of the said States and in so far as the person involved would have been entitled to the benefits pursuant to the legislation of each Member State concerned if he resided in their territory*."

The French note concluded that

> *"in principle, such a distribution of the burden appears to be a good solution for ensuring financial fairness, in that it distributes the burden between the States concerned proportionately and with no threshold effect. While other distribution criteria remain possible (relative amounts of pensions, relative values of average costs, etc.), the criterion of the length of time spent subject to one legislation has the advantage of being objective, easily determinable (in principle, the data are already in the pension dossier of the person concerned) and directly linked to the aim sought."*

The Netherlands responded to France's submission to make the point that while the note from France:

> *"looked solely at a fair distribution of the burdens associated with the costs of benefits where public authorities are involved, it is important that any changes being considered should be compatible with the member countries' national implementing arrangements and that any discussion of a fair distribution of burdens should not be undertaken without also taking account of the position of the insured persons themselves."* (Note from the Netherlands of 2 April 2008, CA.SS.TM 152/08).

3. CONTEXT: MOBILITY OF PENSIONERS

Economic, social, demographic and political changes that have been taking place in Europe over the past 50 years have impacted on patterns of retirement migration. When the coordinating regulations were conceived in the 1950s and when they were first 'modernised' in the early 1970s cross border pensioner-related healthcare costs were in the main connected to migrant workers who were returning to their countries of origin after having worked for many years in the host country and reaching retirement age. However, the patterns of retirement migration have changed dramatically since 1971 and rather than returning permanently to their home country on retirement after a life-time's work as was anticipated when the regulations where designed, a growing number of people today command the necessary financial resources – often, at least in part, in the form of State and occupational pensions - and enjoy sufficiently good health to migrate to another member country, generally from north to south to enjoy a warmer climate, on or after retirement.

Retirement migrants, however, are a diverse group of people who move to another member country at various ages and for different reasons. Some retirement migrants may move permanently and fully integrate into the host society, others may retain their centre of interest in the country where they lived and worked and consider themselves to be a resident of that country while they share

their time between two or more Member States. In the event of illness, many will want or indeed need to be treated where they are. However, in some cases the decision to retain residence in their 'country of origin' may be a conscious decision so as to be able to return in the event of serious illness, need of long-term care, or disability because they believe that the quality of healthcare is better, better understand the language, system and procedures, and can be close to family who may provide comfort and necessary support. In many cases retirement migrants will feel a 'natural' affinity with their country of origin not for any reason of personal advantage but because they believe that their centre of interest is where their personal history is and, for many, where their children and grandchildren live.

However, although an increasingly important issue, the demand for healthcare amongst mobile pensioners is not known due to lack of good quality data at national and European levels. The data on pensioners 'residing' or 'staying' in other Member States are limited and unreliable owing to the lack of detailed statistics being kept in many Member States. Estimates are also difficult because the distinction between 'residence' and 'stay' is not clear and in many countries the number of pensioners from abroad (and, in particular, from other Member States) is not known because there is no requirement to register.

As regards the number of pensions paid to non-nationals, there is often no distinction made between pensions paid to pensioners from other Member States who reside in the competent State and national pensioners residing in another Member State (or in a third country), while the number of 'E 121' forms - which entitles a pensioner who has taken up residence in the host country to receive healthcare cover from the State of insurance at the same level as a pensioner of the host country - issued and received is not known in some Member States (for example, because of large numbers of autonomous sickness funds). The introduction of the EHIC did not improve this information as it allows access to healthcare in a member country during a visit providing a person retains their residence in their competent State (and it does not record the quantity of healthcare consumed).

Neither is the number of pensioners receiving scheduled healthcare in another Member State known, although it is likely to be relatively small based upon the estimated total amount of scheduled cross border healthcare which is currently believed to average only about one per cent of overall public expenditure on healthcare according to European Commission estimates.

In spite of these uncertainties, patient mobility is an issue that will remain on Europe's agenda for the foreseeable future, and indeed is likely to increase in importance as people in Europe are living longer and remaining active into later life.

In moving from one member country to another on retirement pensioners are crossing the boundaries of healthcare systems. The next section looks briefly at the main principles of the different healthcare systems of the Member States.

4. THE MEMBER STATES' HEALTHCARE SYSTEMS

At their meeting in June 2006 the Council of Health Ministers agreed that Member States' healthcare systems are based on the common values and principles of universality, solidarity, equity and quality of care.

However, Member States have taken different approaches to realising these common values. With the (partial) exception of the Netherlands the six founder members of the European Economic Community – Belgium, France, Germany, Italy, Luxembourg and the Netherlands – shared a similar 'philosophy' of social security based on the contributory insurance principle and their healthcare

systems, while containing differences in, for example, the categories of people insured and the lists of benefits provided, were nevertheless all based on the principle that the right to sickness benefits and healthcare is linked to work-based social insurance. Consequently, sickness benefits and healthcare were almost entirely financed from contributions and provided by public health insurance institutions, either as benefits in kind or in the form of – total or partial – reimbursement of costs incurred.

The accession of Denmark, Finland, Ireland, Sweden and the UK introduced a different 'philosophy', namely residence based systems financed from general taxation. The healthcare systems of the EU 27 today are hybrids and contain a mix of these principles and elements in different measures.

Nevertheless, it is possible to identify criteria by which to distinguish different approaches to the provision of healthcare for pensioners amongst the Member States in order to construct a rudimentary typology of healthcare 'regimes' for mobile pensioners.

These criteria are:

A Finance of healthcare systems

B: Legal basis of entitlement to healthcare

C: Pensioners' contribution to the financing of healthcare

Taking these in turn:

A: Finance of Member States' healthcare systems

There are two broad methods of financing healthcare systems in the EU with many systems being hybrids:

- Tax-based
- Contribution-based
- 'Mixed' systems (tax-based systems, supplemented by contributions, co-payments, etc.; and contribution-based systems, supplemented by tax-financed subsidies, co-payments, etc.)

B: Legal basis of entitlement to healthcare

Four basic principles of legal entitlement can be identified:

- Resident pensioners entitled to healthcare without any additional requirements
- Entitlement to healthcare on condition that contributions are paid
- Entitlement to healthcare if special requirements are met (e. g. residence permit)
- Entitlement to healthcare in specific situations (e. g. urgent need of treatment)

C: Pensioners' contribution to the financing of healthcare

In contribution-based schemes there are four different approaches for pensioners to contribute to financing healthcare. These are:

- Obligatory for pensioners to pay contributions for healthcare
- Contributions are obligatory only for pensioners with income above a certain amount
- Obligatory contributions are paid on behalf of pensioners out of public funds
- No obligatory contributions for pensioners

These distinctions are significant for the healthcare provided to mobile pensioners as well how the costs of that healthcare are distributed amongst the Member States.

5. COMMUNITY COMPETENCE FOR HEALTHCARE

While Article 152 of the EC Treaty gives the Community a limited right to act in the field of public health, according to Article 152(5), Community action should fully respect the responsibilities of the Member States for the organisation and delivery of health services.

Thus the competence for action in the field of health is held mainly by Member States, but the EU has the responsibility, set out in the Treaty, to undertake certain actions in support of Member States, for example in relation to cross border health threats, reducing health inequalities, and patient mobility.

On 23 October 2007 the European Commission adopted a new Health Strategy, *'Together for Health: A Strategic Approach for the EU 2008-2013'*. The Strategy aims to provide, for the first time, an overarching framework that contains both principles and strategic themes for improving health in the EU. The strategic themes include 'Fostering Good Health in an Ageing Europe'.

5.1 Cross border healthcare

More specifically the Community has competence for cross border healthcare. There are two sources in the Treaty: Freedom of movement of persons under Articles 21, 45, 49 TFEU (ex Articles 18, 39 and 43 EC) and Freedom to provide services under Article 56 TFEU (ex Article 49 EC).

5.1.1. Free movement of persons

The drafters of the Treaty of Rome recognised that the different social security systems and the restrictions on benefits and entitlements to healthcare which they contained could present a deterrent to workers moving between Member States and therefore be a barrier to the right to free movement enshrined in the Treaty.

Thus Article 48 TFEU (ex Article 42 EC and 51 EEC) specifies that the Council shall adopt measures in the field of social security that are necessary to provide freedom of movement for workers. Two approaches to solving the problems of social security were considered: One was to harmonise the different social security systems of the Member States, and the other was to coordinate them. The drafters of the Treaty adopted the more cautious and politically acceptable method of coordination.

Coordination adjusts social security systems in relation to each other to protect the entitlements of migrant workers and citizens while leaving the national schemes intact in other respects.

The necessary coordinating measures were initially provided by Regulations 3/58 and 4/58. These were replaced by the current Regulations 1408/71 and 574/72, which in turn will be replaced by Regulation 883/04 and 987/09 from 1 May 2010.

The European legislator believes inter alia that it is important that pensioners who exercise their right to free movement to live in another member country are able to enjoy their retirement, which includes having access to healthcare. Conversely a failure to be able to access healthcare in retirement would be a barrier to free movement. The provisions of the coordinating regulations that provide healthcare, and specifically healthcare for pensioners, are set out in sections: 6 (principles of coordination); 7 (Regulation 1408/71); and 8 (Regulation 883/04).

5.1.2. Freedom to provide services

Article 56 TFEU (ex Article 49 EC) prohibits restrictions on the freedom to provide and receive services across borders within the Community. Healthcare is a service covered by Article 56.

The right of patients from EU Member States to travel to another Member State to receive healthcare is a principle that has been confirmed and defined by a series of European Court of Justice (ECJ) cases commencing with *Kohll* (C-158/960) and *Decker* (C-120/95) and continuing via *Smits/Peerbooms* (C157/99), *Vanbraekel* (C-368/98)[1], *Inizan* (C-56/01)[2], *Ioannidis* (C-326/00)[3], *Müller-Fauré* (C-385/99)[4], *Leichtle* (C-8/02)[5], *Keller* (C-145/03)[6], *Watts* (C-372/04)[7], *Acereda Herrera* (C-466/04)[8] to, most recently, *Stamatelaki* (C-344/05)[9].

Thus, patients' rights in cross border healthcare have evolved through the courts rather than the legislator, leading to some uncertainty over how those rights should operate in practice. In 2008, in order to codify the ten years of ECJ case law and to clarify patents' rights, the Commission published its proposal for a Directive on the application of patients' rights in cross-border healthcare which, however, did not get the approval of the Council under the Swedish Presidency. [10]

6. THE PRINCIPLES OF COORDINATION

Regulation 1408/71 and from 1 May 2010 Regulation 883/04 coordinate social security and healthcare for people who exercise their right to free movement in the Community through four key principles, namely:

- equal treatment: discrimination on grounds of nationality is prohibited to guarantee that a person residing on the territory of a Member State is subject to the same obligations and benefits from the same rights as the citizens of that Member State;

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[1] Cases C-368/98, Vanbraekel, [2001] ECR I-5363 and C-157/99, Smits and Peerbooms, [2001] ECR I-5473
[2] Case C-56/01, Inizan, [2003] ECR I-12403
[3] Case C-326/00 Ioannidis v. IKA [2003] ECR I-1703
[4] Case C-385/99, Müller-Fauré, [2003] ECR I-4509
[5] Case C-8/02 Leichtle [2004] ECR I-2641
[6] Case C-145/03, Keller, [2005] ECR I-2529
[7] Case C-372/04 Watts (2006) ECR I -4325
[8] Case C-466/04 Acereda Herrera [2006] ECRI-5341
[9] Case C-344/05 Stamatelaki (2007) ECRI-3185
[10] COM(2008) 414

- rules are laid down to determine which member country's legislation the person is subject to;

- rights in the course of acquisition are protected through aggregation of periods of insurance, residence or employment spent in each of the respective countries to establish a right in another Member State; and

- rights already acquired are protected by allowing certain benefits to be exported.

6.1. The material scope

Regulation 1408/71 and 883/04 apply to all legislation concerning the 'classical' branches of social security enumerated in ILO Convention No. 102, including sickness benefits. Title III, Chapter 1 of both Regulation 1408/71 and Regulation 883/04 set out special provisions relating to sickness benefits.

In the context of coordination, sickness benefits can be distinguished into 'benefits in cash' and 'benefits in kind' with the concepts having a specific interpretation under Community law.[11] Under Community law the term 'benefits in kind' applies to medical provisions even if these are set out in legislation on other social risks, for example, invalidity.

Long-term care benefits that are designed to support the independence of people who are reliant on care also fall within the provisions of the regulation concerning sickness benefits. Long-term care benefits may be either benefits in cash or benefits in kind depending on national legislation.

Long-term care benefits consisting in the direct payment or reimbursement of care home costs fall within the definition of benefits in kind within the meaning of Title III of the Regulations.[12] Accordingly, benefits which provide in-patient care, although they may consist of the payment of a sum of money by way of reimbursement of costs, are considered to be benefits in kind under EC coordination law.[13]

Long-term benefits are qualified as sickness benefits in cash when the payment of that allowance is periodical and not subject either to certain expenditure having already been incurred, or a fortiori to the production of receipts for the expenditure incurred. The amount of that allowance is fixed and independent of the costs actually incurred by recipients in meeting their daily requirements, and the latter are, to a large extent, unfettered in their use of the sums thus allocated to them.

6.2. The principles of '*lex loci laboris*' and '*lex loci domicilii*'

The scenario examined in this report of deleting Articles 23-30 of Regulation 883/04 is that responsibility for the healthcare of mobile pensioners – both delivery and meeting the costs - becomes the exclusive responsibility of the Member State of residence (*lex loci domicilii*). Although it

[11] Case C- 466/04 Herrera [2006] ECR I-5341 and Case C-208/07 Von Chamier-Glisczinski – n. y. r. (Judgment of 16 July 2009).

[12] Case C-160/96 Molenaar [1998] ECR I-84; joined Cases C-502/01 and C-31/02 Gaumain-Cerri and Barth [2004] ECR I-6483

[13] Case C-208/07 Von Chamier-Glisczinski – n. y. r. (Judgment of 16 July 2009)

has very recently been suggested that *lex loci domicilii* is in fact the default position[14] in practice it is the principle of *lex loci laboris* that has in the main determined the applicable legislation for employed and self-employed people since the inception of coordination and that will continue to be the case under Regulation 883/04. Nevertheless, in several instances the regulations depart from the principle of *lex loci laboris* to link entitlement to the person's State of residence. This is the case for economically active persons who work simultaneously in more than one Member State, mariners and for economically non-active persons by default under Regulation 1408/71 and by design under Regulation 883/04.

However, with respect to pensioners there are specific rules to prevent the State of residence in which a pensioner has never worked having to bear the costs of providing family benefits (Article 77 of Regulation 1408/71 and Articles 67 and 68 of Regulation 883/04) and sickness benefits in kind based on the principle in the latter case that the former State of employment meets the costs of medical treatment for its former workers that must in many cases necessarily be delivered for pragmatic reasons in the State of residence. This arrangement is to avoid the latter State having to bear the costs of these benefits, when either their nationals worked in another Member State when they were young and healthy and then return to their country of origin when they became old and sick and dependent or if the case of nationals of other Member States who have not contributed in their new host country.

7. REGULATION (EEC) 1408/71

7.1. Applicable legislation

Title II of Regulation 1408/71 sets out the rules for determining the legislation that is applicable to mobile workers and citizens. Article 13 (1) provides that, subject to Articles 14c and 14f, persons to whom the Regulation applies shall be subject to the legislation of a single Member State only. Article 13 (2) provides that employed and self-employed persons are in principle subject to the legislation of the State of employment (principle of '*lex loci laboris*'). Article 13 (2) (f) determines the competent Member State for people who are no longer professionally active. Article 13 (2) (f) provides that a person to whom the legislation of a Member State ceases to be applicable, without the legislation of another Member State becoming applicable, is subject to the legislation of the Member State in whose territory s/he resides.

7.2. The right to healthcare

Chapter 1 of Title III of Regulation 1408/71 sets out special provisions relating to sickness benefits. Article 19 provides that when a person is resident in a Member State other than the competent State the competent institution pays benefits in cash in accordance with its legislation, whereas healthcare services are provided on behalf of the competent Member State by the competent institution of the place of residence in accordance with its legislation, even if the person is insured in another Member State.

Article 20 provides special rules for frontier workers and members of their family.

[14] S. Van Raepenbusch 'The Regulations as seen by the ECJ' Presentation to the conference 'Modernized EU Social Security Coordination – Preparation for the application of the New Regulations on the Coordination of Social Security', Stockholm, 25-27 November 2009.

Article 21 provides for a stay in or transfer of residence to the competent State. Persons not residing in the competent Member State are also entitled to healthcare in the competent State when they are staying there. Thus they can choose in which State they wish to receive medical treatment.

Article 22 provides for a stay outside the competent State. Article 22 allows nationals of one Member State to travel to another for treatment, at the cost of the relevant authority in the home State, as long as they have been authorised to do so. However, authorisation may not be refused where the treatment is amongst the benefits normally provided within the home Member State and where the treatment cannot be provided within a medically justifiable time limit, taking into account the state of health and probable course of the condition.

7.3. Healthcare for pensioners

Articles 27 – 33 of Regulation 1408/71 contain special provisions for pensioners and members of their families.

The general rule is that pensioners are insured for sickness benefits in their State of residence, if they are entitled both to a pension from the State of residence and to medical care according to its legislation (Article 27).

Where a pensioner receives a pension from one or more Member States where there is no right to benefits in the Member State of residence s/he is entitled to healthcare (benefits in kind) from the Member State from which s/he draws a pension, provided s/he would be entitled to such benefits if residing in that State. Thus a pensioner receives healthcare in the Member State of residence and the costs incurred are reimbursed by the State where s/he is entitled to healthcare (Article 36). However, the healthcare that is provided is determined by the legislation of the State of residence alone.

If a pensioner is entitled to healthcare in two or more Member States, but not in the Member State of residence, the general rule is that the Member State to whose legislation the pensioner has been subject for the longest period of time is responsible. If this does not provide a solution, the costs are borne by the institution which administers the legislation to which the pensioner was last subject (Article 28).

When Article 28 applies, the pensioner and members of their family are entitled to healthcare in the Member State of residence as if they were pensioners under the legislation of that State and were entitled on that legal basis to those benefits. It follows that the Member State of residence becomes, for those insured persons, by reason of this legal fiction, the competent State as regards the granting of health benefits. This means that it is the Member State of residence which is responsible for granting authorisation to receive medical treatment in another Member State, including the Member State which is liable to pay a pension.[15]

Allowing a person to go to the Member State that is liable for payment of the pension for the purpose of receiving from the competent institution of that State the benefit provided for by the legislation would imply that that Member State must assume the costs of the healthcare for a second time which it has already financed by means of a lump-sum payment to the Member State of residence.

[15] Case C-156/01, van der Duyn.

Pensioners not residing in the Member State which pays a pension are however entitled to benefits in cash (including long-term care benefits in cash) to be paid by the Member State which pays the pension (competent Member State).

Article 28(a) provides a special rule for pensioners who reside in the territory of a Member State under whose legislation the right to receive benefits in kind is not subject to conditions of employment or insurance. If a pensioner resides in such a Member State and is not entitled to a pension from that State, the costs of healthcare provided to her or him and to the members of her family are borne by the institution from which s/he receives the pension if s/he would have been entitled to healthcare from that Member State had s/he resided there. Without this provision, Member States in which the right to receive benefits is not subject to conditions of employment or insurance, would not have the costs reimbursed from a Member State where the claimant receives her or his pension, because s/he would already be entitled to medical care on the basis of her place of residence.

Article 31 governs the provision of healthcare which becomes necessary during a "stay" in another Member State. This provision does not contain any '*lex specialis*' in relation to Article 22, both in terms of the category of people concerned (pensioners) and of the situation covered, i.e. stay in another Member State. However, if the treatment abroad is planned by the patient, it is not Article 31 but Article 22 that applies.

7.4. The right of the Member States to levy contributions on pensions

Article 33 regulates the question of liability for contributions deducted to cover sickness benefits and healthcare services provided to pensioners. Only the Member State paying a pension and actually bearing the cost of the benefits provided to the pensioner is authorised to deduct contributions from that pension. The aim is to prevent someone being liable for contributions levied by a Member State that does not bear the costs of the healthcare which s/he receives. Thus, there is a link between the obligation to finance the healthcare benefits and the authority to deduct contributions.

In this respect Article 36 of Regulation 1408/71 provides that the Member State, which under the provisions of the Regulation has to bear the costs of sickness benefits, shall fully refund the cost of the healthcare provided by the institution of another Member State. Refunds are based either on real costs or determined on the basis of lump-sum payments.

However, whether, and how many, contributions have to be paid is not determined by the amount or quality of healthcare that a pensioner is entitled to or receives under the legislation of the Member State in whose territory s/he resides, but solely on the legislation of the Member State which will eventually bear the costs.

Article 33 of Regulation 1408/71 does not make any distinction between benefits in kind or benefits in cash.

The general principle is that the Member State which bears the costs of sickness benefits in cash, which in practice means that it pays these benefits directly to the pensioner concerned, may levy contributions on the pension(s) if the legislation it applies allows it to do so. This might be particularly relevant for long-term care benefits.

As described in section 4 above, some Member States make direct payments to the competent institution on behalf of pensioners or supplement the pension with a healthcare subsidy to be paid by recipients as a contribution towards their sickness insurance. In *Movrin (C-73-99)* the ECJ held

that these payments are part of the pension itself and are therefore governed by the rules on the payment and the calculation of pensions. These payments must therefore also be made if the pensioner resides in another Member State and/or is liable to pay contributions for health insurance in another Member State. [16]

The ECJ held in *Rundgren (C-389/99)*[17] that it follows from Article 33 that the regulation does not authorise the Member State in whose territory the pensioner resides to require her or him to pay the contributions for sickness insurance prescribed by its domestic legislation and calculated by reference to the income from a pension paid by another Member State. Article 33 (1) merely authorises, in cases in where it applies, the relevant institution of a Member State to make deductions in order to cover, inter alia, sickness benefits from the pension paid by it. Accordingly the responsibility for making deductions from pensions lies with the Member State that actually pays the pension. A Member State which merely offers the *possibility* of paying a pension but does not *actually* pay it cannot rely on the provisions of the regulation to demand payment of social security contributions.

However, in *Nikula (C-50-05)*[18] the ECJ denied the principle that a Member State cannot assess social security contributions on the basis of pensions paid by another Member State. In circumstances where an institution of the Member State in whose territory a person resides pays a pension to that person and a social security institution of the same Member State is responsible for payment of her or his sickness insurance expenses, the Court confirmed that no provision of Regulation 1408/71 hinders that Member State from calculating the amount of that person's contributions on the basis of her or his total income, whether it comes from pensions paid by the Member State of residence or from pensions paid by another Member State. On the other hand there is no provision of the regulation that requires the competent Member State to do so.

Nevertheless, whatever the method of calculation adopted, the amount of the contributions may not exceed that of the pensions paid by the institutions of the Member State of residence as according to Article 33 (1) of Regulation 1408/71 contributions may only be deducted from the pensions or annuities paid by the Member State of residence. The limitation is derived from the actual wording of the Regulation "*from the pension payable"* by the Member State that is competent to provide the benefits.

As a result, there is a risk of creating an imbalance to the detriment of the Member State that is competent to provide the benefits. That State may find itself, on the one hand, compelled by the regulation to provide healthcare as though the person concerned were entitled to a pension solely under its legislation and, on the other, being unable to deduct contributions on the basis of that person's whole income in circumstances in which, as a result of the method of calculation adopted, those contributions exceed the amount of the pensions paid. This could lead to a situation in which an insured person who only receives a minimal portion of their pension from the competent Member State enjoys advantages that may be considered to be unfair.

8. REGULATION 883/04

Regulation 883/04 will replace Regulation 1408/71 from 1 May 2010. Regulation 883/04 retains the basic principles of coordination, namely: equal treatment; rules to determine the legislation applicable; aggregation; and export of certain benefits, although the application of these principles is

[16] Case C-73/99 *Movrin* [2000] ECR I-5625
[17] Case C-389/99 *Rundgren* [2001] ECR I-3731
[18] Case C-50/05 *Nikula* [2006] ECR I-7029

modified and developed in some important respects. One important development concerns the extension of the principle of equal treatment which is strengthened in two ways:

Firstly, Article 4 provides that people covered by the regulation enjoy the same benefits and are subject to the same obligations under the legislation of any Member State as the nationals of that State. According to Article 4 the prior condition of residence on the territory of a Member State is no longer required. Thus people who come within the personal scope of the regulation will be able to invoke the right to equal treatment with regard to social security irrespective of their residence.

The principle of equal treatment has been further strengthened by the insertion of a provision providing for the cross border recognition of facts or events (Article 5) which provides that:

> *"(a) where, under the legislation of the competent Member State, the receipt of social security benefits and other income has certain legal effects, the relevant provisions of that legislation shall also apply to the receipt of equivalent benefits acquired under the legislation of another Member State or to income acquired in another Member State;*
> *(b) where, under the legislation of the competent Member State, legal effects are attributed to the occurrence of certain facts or events, that Member State shall take account of like facts or events occurring in any Member State as though they had taken place in its own territory."*

This provision is in line with ECJ case law and has enabled the legislature to eliminate numerous provisions that exist in Regulation 1408/71 which are aimed at achieving this objective for specific situations.

A second important development concerns the personal scope of the new regulation. While Regulation 1408/71 was initially confined to employed and self-employed persons, (i.e. to persons who are economically active), and was later extended to non-workers, for example students, Regulation 883/04 covers all EU nationals who are insured under national law, including non-active people, as well as their family members and survivors. Thus, coordination is no longer limited to economically active persons and specific categories of non-active people.

The principle of only one legislation applicable is strengthened and *lex loci laboris* is maintained for economically active people (with exceptions) who continue to be subject to the legislation of Member State of work.

However, Regulation 883/04 provides a new general principle for determining the legislation applicable to people who are no longer economically active. Article 11 (3)(e) provides that:

> *"any other person to whom subparagraphs (a) to (d) do not apply shall be subject to the legislation of the Member State of residence, without prejudice to other provisions of this Regulation guaranteeing him/her benefits under the legislation of one or more other Member States."*

Thus people who are no longer active are subject to the legislation of the Member State of residence. 'Residence' in this context means the place where a person 'habitually' lives (Article 1 (j)). However, some categories of economically inactive people are assimilated under the new regulation with active people insofar as persons receiving cash benefits as a consequence of their activity as an employed or self-employed person are considered to be pursuing that activity (Article 11 (2)).

TABLE 1: Corresponding articles for healthcare for pensioners in Regulations 1408/71 and 883/04

		Article							
	1408/71	26	27	28	28a	29	30	31	33
	883/04	22	23 29	24 29	25 29	26	33	27 29	30

Articles 23 – 30 retain and in some respects modify the special rules for healthcare for pensioners and members of their families that already exist in Regulation 1408/71.

The new regulation maintains the rules for establishing the competent Member State in Regulation 1408/71 where pensions are payable under the legislation of several Member States. Thus, the period of insurance is the main criterion to be taken into account when determining the competent State. According to Article 24 (2) (b) of Regulation 883/04 the costs of benefits in kind shall be borne by the competent institution of the Member States to whose legislation the pensioner has been subject for the longest period of time.

However, Regulation 883/04 has introduced some modifications with respect to *pensioners'* sickness benefits. While maintaining the general approach of Regulation 1408/71, some of the changes introduced by Regulation 883/04 and, in particular Regulation 987/09, complicate the procedures applied for pensioners who are temporarily staying in a Member State other than their Member State of residence.

On the other hand, the new provisions provide more rights in the case of a temporary stay in the competent Member State as well as for retired frontier workers (Articles 27 (2) and 28).

Article 27 (2) of Regulation 883/04 offers the possibility for Member States that have opted to be listed in Annex IV to grant more rights to their pensioners when they are staying temporarily in the competent State as if they were residents in and at the expense of this State.

Article 28 of Regulation 883/04 provides more rights for former frontier workers and members of their families in the Member State where the pensioner had last been active as a frontier worker. Regulation 883/04 - as is the case in Regulation 1408/71- entitles retired frontier workers to benefits in kind in Member State of residence; but in addition under Regulation 883/04 they are also entitled to continue to receive investigation, diagnosis and treatment that has already begun in the Member State of former employment until it is completed. Furthermore, a former frontier worker who during the five years prior to retirement has worked for at least two years as a frontier worker is also entitled to benefits in kind in a Member State where s/he worked as a frontier worker, if this Member State and the Member State bearing the costs for healthcare in the Member State of residence are listed in Annex V.

The situation of the pensioner in the Member State of residence does not change with respect to benefits in kind. The legislation of the Member State of residence is applicable and pensioners of other Member States are treated as nationals of this State. (Articles 23 and 24)

With regard to a temporary stay in a Member State other than the Member State of residence, the European Health Insurance Card (EHIC) is no longer issued by the Member State of residence but instead by the competent Member State (Article 27 (1)).

The rules on the provision of scheduled healthcare for pensioners in a Member State other than the Member State of residence are clarified and the scope of application broadened. Authorisation is always required (for both hospital and non-hospital treatment). However, as is the case in Regulation 1408/71, authorisation must be given if the treatment is provided for by the competent Member State and where the treatment cannot be given within a medically justifiable time limit, taking into account the state of health and likely course of the condition. The procedures, however, are more intricate under Regulation 883/04 and depend on the method of calculating costs. Where costs are reimbursed through a lump sum payment the rule is that the Member State of residence is the competent State to issue authorisation. However, where reimbursement is calculated on the basis of real costs, the competent Member State remains responsible for authorisation. When authorisation is granted, that person is entitled to the benefits in Member State of stay in accordance with legislation of that Member State, as though s/he were insured in that Member State. The cost of the treatment is borne by competent Member State according to the rates applicable in Member State of stay (Article 27 (3)(4)(5).

In addition, under Article 26(7) of Regulation 987/09, in line with the *Vanbraekel* Judgment, the insured person will be entitled, upon request, to the difference (if any) between the reimbursement rates applied in the Member State of stay and the rates applied for the same treatment in the competent Member State.

No changes have been introduced as regards the assumption of the costs of healthcare provided by the Member State of residence and reimbursed to it by the competent Member State (Article 35). Benefits in cash continue to be paid directly by the latter (Article 29).

However, the rules on the liability for contributions deducted to cover sickness benefits provided to pensioners have been redrafted. Article 30 of Regulation 883/04 contains some differences compared to Article 33 of Regulation 1408/71.

The new regulation no longer requires a link between the deductions and the amount of pension paid by that institution. (The wording of the provision only refers to "*deductions*" and not to "*deductions from pensions*", and it refers to "*request and recover such deductions"* and not "*deductions … from the pension payable by such institution*".)

It would appear from this that the institution, which under the legislation of that Member State is responsible for making deductions in respect of contributions for sickness benefits in cash and in kind, may fully deduct or recover these deductions calculated in accordance with the legislation it applies. As a result, these deductions may first be calculated on the income determined as the basis for the calculation under the legislation of this institution.

Secondly, the deduction may be higher than the amount of pension actually paid by the institutions of that Member State. The word '*recover*' appears to indicate that the contributions to be paid are not just to be '*deducted'* from the pension paid, in which case they cannot be higher than the amount of pension actually paid by institutions of that Member State, but that the contributions may also be '*recovered*' in a way other than by deduction from the pension.

However, Article 30 of Regulation 987/09 specifies that:

"If a person receives a pension from more than one Member State, the amount of contributions deducted from all the pensions paid shall under no circumstances be greater than the amount deducted in respect of a person who receives the same amount of pension from the competent Member State."

This provision obliges the competent Member State to calculate the maximum amount of contributions to be paid by a pensioner as if this pensioner receives one pension only, thus preventing the calculation of a maximum amount on each pension received from other Member States.

The same principles apply to the healthcare costs for the members of the family of pensioners who do not reside in the same Member State as the pensioner. According to Article 26 these costs also fall to the competent institution that is responsible for the costs of healthcare provided to the pensioner in the Member State of residence. (Except in the cases referred to in Article 27 (5)).

9. THE IMPACT OF DELETING ARTICLES 23 – 30 OF REGULATION 883/04 ON PENSIONERS AND THE FAIR DISTRIBUTION OF COSTS BETWEEN MEMBER STATES

This section identifies the impact of deleting Articles 23-30 of Regulation 883/04. Section 8.1 discusses Table 2 below, which compares the outcome of deleting Articles 23-30 of Regulation 883/04 to the current provisions of Regulation 1408/71 and Regulation 883/04; specifically, section 8.2 examines the impact of deleting Articles 23-30 on the position of the pensioner; section 8.3 examines the impact on the issue of fair distribution of costs between Member States; and section 8.4 the related issue of the right of Member States to levy contributions on pensions.

TABLE 2: The impact of deleting Articles 23-30 of Regulation 883/04

	REGULATION 1408/71	**REGULATION 883 / 04**	**STATE OF RESIDENCE SCENARIO**
Competent State	Member State which allocates the pension or in case there are two or more Member States which allocate pensions, the Member State which allocates for the longest period of time	Member State which allocates the pension or in case there are two or more Member States which allocate pensions, the Member State which allocates for the longest period of time	Member State of residence will always be the competent State
Benefits in kind	State of residence, reimbursed by the competent State	State of residence, reimbursed by the competent State	No reimbursement to the Member State of residence

Benefits in cash	Competent State	Competent State	Member State of residence has to pay all benefits in cash provided for by its legislation (including long-term cash benefits where relevant)
Temporary stay in a Member State other than the State of residence	State of residence EHIC	Competent State EHIC	State of residence EHIC
Temporary stay in the competent State	No special provisions	Supplementary benefits if the Member State is listed in Annex IV	No special provisions
Pensioner frontiers workers	No special provisions	Special provisions with more rights	No special provisions
Members of the family residing in a Member State other than the State of residence of the pensioners	Competent State	Competent State	State of residence of the pensioner (see by analogy Article 17 of 883/04; depends on definition of 'Member of the family') or State of residence of the pensioner's family (see discussion in section 9.1 below)
Scheduled treatment	State of residence	Competent State if reimbursement to State of residence is made with real cost/ State of residence if reimbursement is made with lump sums	State of residence
Scheduled treatment for members of the family unit residing in a Member State other than the Member State of	Competent Member State	Competent State if reimbursement to State of residence is made with real cost/ State of residence if reimbursement is made with lump sums	State of residence of the pensioner (see by analogy Article 17 of 883/04; depends on definition of 'Member of the family') or State of residence of the pensioner's family (see discussion in section 9.1

residence of the pensioner			below)
Scheduled treatment for pensioners (frontier workers)	No special provisions	Special provisions	No special provisions
Payment of contributions by the pensioner	Competent Member State	Competent Member State	Member State of residence

9.1. The impact of deleting Articles 23-30 of Regulation 883/04

- The ***rules to determine the competent Member State*** are the same under Regulations 1408/71 and 883/04. Under both Regulation 1408/71 and 883/04 the Member State which allocates the pension is competent. Where a pensioner receives pensions from two or more Member States it is the Member State in which entitlement is for the longest period of time that is the competent State. However, under the scenario of deleting Articles 23-30 the Member State of residence will always be the competent State.

- For ***benefits in kind*** under Regulations 1408/71 and 883/04 the State of residence which provides the healthcare will be reimbursed by a State that pays a pension. However, if Articles 21-30 are deleted there will be no reimbursement from the State that pays the pension to the State of residence.

- With regard to ***benefits in cash*** the competent State which pays the pension pays cash sickness benefits. However, if Articles 21-30 are deleted the Member State of residence pays all benefits in cash provided for by its legislation (including long-term cash benefits).

- For a ***temporary stay in a Member State other than the State of residence***, under Regulation 1408/71 it is the State of residence that issues the EHIC and covers the costs. However, this changes under Regulation 883/04 where it will be the competent State i.e. the State that pays the pension (or the greatest proportion of the pension) that issues the EHIC and covers the costs. However, if Articles 21-30 are deleted responsibility for issuing the EHIC and covering the costs for treatment during a temporary stay in a State other than the State of residence reverts back to the State of residence.

- For a ***temporary stay in the competent State*** there are no special provisions under Regulation 1408/71. However, under Regulation 883/04 a pensioner may be entitled to additional benefits if the Member State that is competent is listed in Annex IV of the Regulation**.** If Articles 21-30 are deleted the competent State will be the State of residence so that temporary stay is not possible in that State.

- There are no special provisions under 1408/71 for ***pensioner frontiers workers***; while, there are special provisions with more rights under 883/04**.** However, if Articles 21-30 are deleted the situation reverts back to that of Regulation 1408/71 (no special provisions).

- Where a ***member of the pensioner's family is residing in a Member State other than the pensioner's State of residence*** it is the competent State under both Regulation 1408/71 and 883/04 that is responsible for reimbursing costs to the State that provides the healthcare. It is not entirely clear what the situation would be if Articles 21-30 are deleted. On the one hand it could be argued that it would be the State of residence of the pensioner that is responsible for meeting the costs of healthcare. The general rule in Regulation 883/2004 would appear to support this position. Article 17 states:

  "An insured person or members of his/her family who reside in a Member State other than the competent Member State shall receive in the Member State of residence benefits in kind provided, on behalf of the competent institution, by the institution of the place of residence, in accordance with the provisions of the legislation it applies, as though they were insured under the said legislation."

  This provision guarantees the member of the family of an insured person, in the event that this member of the family resides in a Member State other than the Member State that is competent for the insured person, continuation of coverage for healthcare in the Member State of his or her residence on behalf of the Member State which is competent for the insured person. In the scenario being discussed the insured person is the pensioner insured by the legislation of the Member State in which s/he resides. As the scenario does not propose to delete Article 17 this article would continue to apply to members of the family of pensioners as insured persons.

  On the other hand it could be argued that a consistent application of the principle that non-active people are insured in the State of residence requires that members of the pensioner's family, as non-active persons, must be treated in the same way and be insured in the State of residence.

- For ***scheduled treatment*** it is the State of residence under 1408/71 that grants authorisation; whereas under Regulation 883/04 it is the competent State if reimbursement to the State of residence is made with real costs and the State of residence if reimbursement is made with lump sum payments. If Articles 21-30 are deleted it reverts to the State of residence

- ***Scheduled treatment for members of the family unit residing in a Member State other than the Member State of residence of the pensioner*** is the responsibility of the competent State under both Regulation 1408/71 and 883/04. If Articles 21-30 are deleted the same arguments apply as discussed above in the case where a member of the pensioner's family is residing in a Member State other than the pensioner's State of residence.

- While there are no special provisions with regard to ***scheduled treatment for pensioner frontier workers*** under Regulation 1408/71, there are special provisions under 883/04. However, the situation reverts to that of Regulation 1408/71 (no special provisions) if Articles 21-30 are deleted.

- While it is the competent State under both Regulation 1408/71 and 883/04 that is authorised to collect ***payment of contributions from the pensioner*** if Articles 21-30 are deleted it would be the State of residence.

The following three sections consider whether in the light of the above analysis deleting Articles 23-30 of Regulation 883/04:

a) enhances the right to free movement for pensioners, and
b) makes the distribution of costs amongst Member States 'fairer'?

9.2. The impact of deleting Articles 23-30 on the position of the pensioner and the members of her/his family

As demonstrated in section 9.1 above, the scenario that Articles 23-30 of Regulation 883/04 are deleted would mean that the pensioners themselves would potentially lose out in several ways. One concerns a temporary stay in the competent Member State where a pensioner would lose entitlement to the additional benefits provided by a competent Member State listed in Annex IV of Regulation 883/04.

Pensioners who have been frontiers workers would lose both the special provisions with more rights provided under Regulation 883/04 and the special provisions with regard to scheduled treatment.

The scenario of deleting Articles 21-30 may also, in practice, be less advantageous for the pensioner with regard to cash benefits as the Member State of residence – rather than the State of former insurance - would then have to pay all benefits in cash provided for by its legislation (including long-term care benefits, where relevant).

The effect of the scenario of deleting Articles 21-30 where a member of the pensioner's family is residing in a Member State other than the pensioner's State of residence and for scheduled treatment for members of the family unit residing in a Member State other than the Member State of residence of the pensioner is unclear. As discussed in section 9.1 above, it could be argued that a consistent application of the principle that non-active people are insured in the State of residence requires that members of the pensioner's family, as non-active persons, must be treated in the same way and be insured in the State of residence.

However, if members of the pensioner's family are considered to be independent persons and subject in all circumstance to the legislation of the Member State in which they reside, even if the parent/pensioner is residing in another Member State, then they will lose their status of member of the family. This could even mean that, as a consequence, they will not be covered in some cases for health care by the Member State of residence.

9.3. The impact of deleting Articles 23-30 on the issue of fair distribution of costs between Member States

In its note to the Administrative Commission France argued that the current rules that allocate the financial responsibility for pensioners' healthcare costs do not guarantee a sufficiently fair distribution of costs between the States liable to pay pensions.

However, as identified in section 8.1 above, deleting Articles 23-30 of Regulation 883/04 would not address these concerns as the responsibility for costs would shift further in the direction of the pensioner's State of residence. While under both Regulation 1408/71 and 883/04 the Member State which allocates the pension is responsible for a pensioner's healthcare costs and where a pensioner receives a pension from two or more Member States it is the Member State in which entitlement is for the longest period of time that is responsible, under the scenario of deleting Articles 23-30 the Member State of residence will always be the competent State. This is a move in the opposite direction to that argued for by the French note.

This is also the case with regard to benefits in kind where, if Articles 21 – 30 are deleted, there will no longer be any reimbursement from the State which pays the pension to the State of residence.

Furthermore, if Articles 21-30 are deleted, the Member State of residence must pay all benefits in cash provided for by its legislation (including long-term care benefits, where relevant).

And finally, as discussed above, where a member of a pensioner's family is residing in a Member State other than the pensioner's State of residence, if Articles 21-30 are deleted, once again, it would be the State of residence of the pensioner that is responsible for meeting the costs of healthcare by analogy to Article 17 of Regulation 883/04 or perhaps the State of residence of the family members.

Thus the scenario of deleting Articles 23-30 and the application of Article 11 (3) (e) to pensioners would mean that the Member State where the pensioner resides also has to bear, as the sole Member State, the cost of the sickness benefits and healthcare. This scenario does not therefore address the concerns expressed in the note from France; indeed it runs in the opposite direction and makes the situation – from that perspective – less equitable.

9.4. The impact of deleting Articles 23-30 on the right of Member States to levy contributions on pensions

The additional burden of costs that would fall on the State of residence under the scenario of deleting Articles 23-30 may be compensated to a greater or lesser extent by the State of residence also becoming the sole State authorised to collect contributions from the pensioner. The impact of deleting Articles 23-30 on the payment of contributions if Article 11 (3) (e) applies to sickness benefits for pensioners would mean that the Member State of residence alone is financially responsible for rendering benefits and recovering contributions. In *Noij* the ECJ stated that Article 33 of Regulation 1408/81 constitutes the application of a general principle according to which a pensioner cannot be required to pay compulsory insurance contributions to cover benefits payable by an institution of another Member State.

Thus if the application of Article 11 (3) (e) to pensioners means that the Member State where the pensioner resides also has to bear, as the sole Member State, the cost of healthcare, the general principle referred to in *Noij* would mean that only this Member State could apply its legislation on deductions and recovery in respect of contributions for sickness benefits.

The case law on Article 33 of Regulation 1408/71 analysed in section 7 above shows that such deductions may be calculated on the income as determined by the national legislation of the competent institutions. Indeed, Community law does not prevent a Member State from taking into account the income from pensions paid by other Member States. This conclusion is also supported by Article 5 of Regulation 883/04 on the equal treatment of benefits, income, facts or events. As described in section 8, according to these provisions:

> "*where, under the legislation of the competent Member State, the receipt of social security benefits and other income has certain legal effects, the relevant provisions of that legislation shall also apply to the receipt of equivalent benefits acquired under the legislation of another Member State or to income acquired in another Member State*".

Therefore, even on the basis of these provisions the competent Member State would be allowed to take into account pensions paid by another Member State or any other income acquired in another Member State for the calculation of the contributions to be made for sickness benefits.

Moreover, on the basis of the wording of Article 30 of Regulation 883/04 there seems to be no legal obstacle to allowing this Member State to make such deductions, not only from the pension payable by its institutions, but also to recover contributions that would be higher than the amount of pensions actually paid by that Member State.

It would appear that under the scenario of the application of Article 11 (3) (e) combined with Articles 4 and 5 *Rundgren* would no longer be relevant. Indeed, even if the Member State of residence is not paying a pension itself, the principle of equal treatment with non-migrant residents in that State and the principle of recognition of income would mean that for the calculation and recovery of contributions from pensioners the Member State of residence could take into consideration all relevant incomes of the pensioner including the income coming from other Member States.

In this case, the Member State of residence would be permitted to recover contributions on the income of the pensioner according to its own legislation. This Member State must of course respect the principle of non-discrimination on grounds of nationality under Article 4 of Regulation 883/04, which means that for the calculation of deductions and the determination of the income on which deductions are made, this Member State has to apply the same rules it would apply to its own nationals in a purely internal situation. The provisions of Article 30 of Regulation 987/09 outlined in section 8 above are a demonstration of this principle.

Member States deduct only limited contributions on pensioners' income for the financing of sickness benefits. As noted in section 4 above, many Member States finance their system either by taxes or by a mixed system of taxes and contributions in which pensioners only pay a limited amount of contributions, if any at all. It seems likely that the philosophy behind this is that financing the healthcare system is primarily seen as the responsibility of the working part of the population whose (generally higher) income is subject to higher contributions than that of pensioners. In view that, on the whole, pensioners cost the health system more than working people, the cost of healthcare is mainly borne by the working portion of the population. If a pensioner spent only a small part of her or his active life - or indeed no part of at all - in the Member State of residence, the application of Article 11(3)(e) would mean in practice that this Member State nevertheless has to bear the costs for that pensioner's healthcare, without having been able to rely on his or her previous contributions.

Taking into account the principle of the sole legislation applicable described in section 6, and the principle that only the Member State which bears the cost of the sickness benefits may levy contributions to finance these benefits, it would not be permitted for other Member States to make deductions from pensions or from any other income to finance sickness benefits. This would also be the case if the pensioner had spent part or even all of his or her professional life in another Member State. Neither under this system could other Member States be obliged to pay compensation to the Member State of residence.

Thus the scenario of deleting Articles 23-30 and the application of Article 11 (3) (e) to pensioners would mean that only the Member State where the pensioner resides may recover contributions for the financing of health care on the pensioner's income. This Member State will probably not benefit from previous contributions paid by the pensioner in other Member States during his/her active life.

10. ISSUES THAT REMAIN OUTSTANDING IF THE SCENARIO OF DELETING ARTICLES 23-30 IS REJECTED

The scenario of deleting Articles 23-30 of Regulation 883/04 would neither be to the advantage of the pensioner nor would it introduce a more equitable distribution of costs between Member States. Therefore, in our opinion, it does not seem appropriate to delete these articles. This conclusion

leaves the question whether the rules that will become applicable under Regulation 883/04 on 1 May 2010 are indeed the best possible approach to meeting the healthcare needs and associated costs of mobile retirement pensioners or whether a better set of arrangements can be envisaged?

This question goes beyond this Think Tank's mandate but nevertheless we think it appropriate to identify some of the outstanding issues that need to be considered both in this section and the final section which presents our recommendations. The issues that remain open include the substantive and operational definition of residence, and administrative complexity including, for example, the complicated procedure to get authorisation for scheduled care in another Member State.

10.1. Determining the State of residence

With respect to the concept of 'residence' in the coordination regulations the ECJ has established that it must be common and mandatory, and has stated that the term 'State of residence' in Regulation 1408/71 refers to the Member State in which the person concerned 'habitually resides' defined as the "habitual centre of his interests". The length of residence is not considered to be an intrinsic element of this concept.[19]

As described in section 3 above the concept of habitual residence and determining a pensioner's habitual centre of interest is far from straightforward and while there are elaborate rules to determine which Member State should be considered to be the competent State of employment when a person works in different Member States, there are no corresponding rules for persons with two or more 'residences' or 'residence connections' in different Member States.

Indeed, the notion of 'habitual residence' cannot function in all situations as a coordination rule in practice because, as described in section 3 above, retirement migrants who make use of the freedom of movement in order to move to another Member State will often not know whether their presence in the other country will be a short-term, long-term or permanent. This may imply that in many cases mobile pensioners will not have a clear 'habitual centre' of interests in either their former home country or in country that they have moved to in which, as described in section 3, the concepts of 'stay' and 'residence' may themselves be blurred.

The problem is addressed in the new Regulation from an administrative perspective only. According to Article 11 - 'Elements for determining residence' - of the new implementing Regulation 987/09 Member States should cooperate in determining the place of residence of persons to whom Regulations 883/04 applies.

Article 11 of Regulation 987/09 provides that where there is a difference of views between Member States they should establish by common agreement the centre of interests of the person concerned, based on an overall assessment of all available information relating to relevant facts. The relevant facts may include the:

- duration and continuity of presence on the territory of the Member States concerned,
- person's situation, including the nature and the specific characteristics of any activity pursued, in particular the place where such activity is habitually pursued,
- exercise of any remunerated activity,
- stability of this activity and the duration of any work contract, family status and family housing situation, in particular how permanent it is,
- Member State in which the person is deemed to reside for taxation purposes.

[19] ECJ, Case C-90/97 *Swaddling* [1999] ECR I-1075

Where the consideration of these various criteria does not lead to agreement between the institutions concerned, the person's intention, as it appears from the facts and circumstances, and especially the reasons that led the person to move, are be considered to be decisive for establishing the actual place of residence.

It is of course too early to evaluate the impact of Regulation 883/04 on pensioners' healthcare but it is already clear that the definition of pensioners' residence is not self evident - even in the light of the new Article 11 the new implementing Regulation 987/09.

This is problematic because as reported in section 3, pensioners for a variety of reasons, which may include being able to access healthcare in their country of origin, may themselves decide where the most advantageous place is to designate as their place of residence. It is not clear that this is the intention of the legislator and the legal consequences of not living where the pensioner's residence is designated risks complications, misunderstanding and even in some cases the possibility of fraud and abuse.

The proposed Directive on the application of patients' rights in cross-border healthcare is likely to further complicate matters.

10.2. Administrative complexity

The procedure to get authorisation for scheduled care for which the pensioner must apply to the Member State of residence for the assessment of need and confirmation that treatment is not available within a medically defined reasonable period of time, following which the request is referred to the competent State for authorisation and then back again to the State of residence to communicate the decision to the patient risks delaying essential treatment.

11. RECOMMENDATIONS

Retain Article 23-30 of Regulation 883/04

The scenario that Articles 23 – 30 of Regulation 883/04 are deleted would reduce mobile pensioners' healthcare rights. Specifically pensioners on a temporary stay in the competent Member State and pensioner frontier workers would lose supplementary benefits in the case of the former and additional rights in the case of the latter. Moreover, pensioners would only be entitled to cash benefits, including long-term care benefits, provided for by the legislation of the Member State of residence, which might be less advantageous than the cash benefits provided for by the legislation of the Member State which pays a pension. Therefore, the recommendation is to retain Articles 23-30 so as not to reduce pensioners' existing rights. (If, on the other hand, Articles 23-30 were to be deleted, it would be necessary to introduce transitional provisions to maintain the existing status of pensioners who are already resident in a State other than the competent Sate.)

Review determination of residence

The determination of residence for mobile pensioners lacks clarity and can lead to ambiguity. The recommendation is to develop clear rules to determine pensioners' residence.

Provide choice for pensioners

The question of choice for pensioners is a complex issue as pensioners may have different preferences that the legislator needs to take in to account. As described in section 3, mobile pensioners may wish to return to their home country in the event of sickness, need of long-term care or disability because they believe the quality of healthcare to be better, better understand the

language and procedures, and can be close to family who may provide necessary support. Others will want or indeed need to be treated where they are. The recommendation is to offer pensioners a choice of where they wish to receive healthcare between the State of residence and the competent State that is administratively simple.

This could be achieved for a temporary stay in the competent State by extending Annex IV rights to every State. However, this would not address the issue of scheduled care.

Implementation

The complicated procedure to get authorisation for scheduled care for which a pensioner must apply to the Member State of residence for assessment of need and confirmation that treatment is not available within a medically defined reasonable period of time, then be referred to the competent State for authorisation and back to the State of residence to communicate to the patient risks delaying what by definition is necessary and could be vital treatment. The recommendation is that the procedures of prior authorisation are reviewed with a view to their simplification.

Revisit the question of fair distribution of costs with up to date data

The French Note to the Administrative Commission raised and discussed the fair distribution of costs amongst Member States. The deletion of Articles 23-30 of Regulation 883/04 would not address the concerns expressed by France – indeed it would make the situation less equitable from that point of view.

On the other hand the two scenarios discussed by the French Note - the scenario originally proposed by the Commission that the criterion for distribution of healthcare costs for pensioners should be based on the ratio of insurance periods spent in the different Member States and the current subsidiary rule of apportioning responsibility in line with the longest insurance history would both potentially improve equity of distribution of costs between Member States. However, the Commission's proposal was rejected. One difficulty with this scenario is that having several competent institutions responsible for the cost of benefits in kind provided to the pensioner in her or his Member State of residence would introduce greater administrative complexity which might, at least in part, reduce the gains from a fairer distribution of costs.

However, the introduction of Electronic Exchange of Social Security Information (EESSI) would make the administrative complexities of this approach more manageable. Therefore, the recommendation is that the two approaches - that originally proposed by the Commission that the criterion for distribution of healthcare costs for pensioners should be based on the ratio of insurance periods spent in the different Member States and that of apportioning responsibility in line with the longest insurance history - be re-examined in the light of empirical evidence of patterns of pensioner mobility and actual costs and distribution of costs between Member States, and the possibilities introduced by EESSI.

Evidence based policy making

The effectiveness of policies is in part determined by how they are implemented. Regulation 987/09 demonstrates the intent of the Council, the European Commission and Parliament to improve service delivery to customers of coordinated benefits throughout the EU. Recital 2 of the Preamble to Regulation 987/09 states that closer and more effective cooperation between social security institutions is a key factor in allowing the persons covered by Regulation (EC) No 883/04 to access their rights as quickly as possible and under optimum conditions. However, effective policy making must be based on evidence. Unfortunately, as noted in section 4, the demand for healthcare amongst mobile pensioners is not known for several reasons. Statistical data about cross-border healthcare are scarce, at both a European and a national level, and the data on pensioners 'residing'

or ‘staying’ in other Member States is limited and unreliable as there is a lack of detailed statistics in many Member States.

Nevertheless increasing longevity and wealth amongst Europe’s pensioners suggests that retirement to another member country is likely to increase, especially – but not only - in regions which are already attracting large numbers of elderly retirement pensioners. While many people are moving in their early retirement, others are retiring abroad in old age. This combined with the general ageing of the European population can be expected to create a growing need for healthcare and long-term care facilities for the mobile pensioner population. This has implications for the development of social protection and for the coordination rules for retirement migrants raising important questions about the design of national social protection schemes, quantifying healthcare demand, capacity planning and service delivery as well as questions about equity at the European level.

The recommendation is that Member States collect common data to enable a clear picture of pensioner mobility and cross border healthcare costs in Europe. This could be supported at EU level by a requirement for Member States to establish systems to collect and share data on patient mobility, healthcare pricing and contracting, and national, regional and local capacity planning.

Information for pensioners

Access to and availability of good quality information is not only essential for rational evidence based policy making at the European, national, regional and local level but also for European citizens to make informed choices about where they wish to spend their retirement and to exercise their rights to healthcare. With particular reference to the right to sickness benefits, Article 22 of Regulation 987/2009 obliges the competent authorities and institutions to ensure that all necessary information is made available to insured persons regarding the procedures and conditions for the granting of benefits in kind where such benefits are received in the territory of a Member State other than that of the competent institution.

This requires Member State cooperation and once again a supporting function at EU level. In this respect Regulation 987/09 establishes Community competence. Article 89(1,3) provides for transparency, tasking the Administrative Commission with ensuring that the parties concerned are aware of their rights and the administrative formalities required to assert them. In addition to this it would also be advantageous for Member States and the European Commission to provide an information service such as a web portal with information for pensioners on other Member States’ healthcare systems, provider quality, administrative formalities etc.

Many of the problems faced both by competent institutions in the Member States and pensioners who have migrated after retirement arise due to lack of adequate preparation by the pensioner, and institutions giving poor information. Thus there is a need at all levels for effective information and advice to assist people in deciding whether to emigrate and to assist those people in integrating into the society of their host country. Pensioners need good quality information both from sending countries before departure and receiving country on and after arrival. The opportunity for coordinated national and EU online ‘One stop shops’ for pensioners could be explored. The recommendation is for Member States and the European Commission to explore the information needs of mobile pensioners and identify the most effective methods of meeting those needs.

Support for mobile pensioners to engage with services in the host country

There is a need for mobile pensioners to be supported to engage with policy and service provision in the host country. In this respect cooperation between Member States should be developed, especially in relation to sharing experience and expertise in meeting the special needs of mobile pensioners while they live in another member country. The recommendation is for a structured

framework of financial and other support to be directed by the Member States to those who can best inform healthcare policy and service delivery for pensioners at European, national, regional and local levels such as the competent authorities and NGOs representing pensioners.

Identification and sharing of good practice

Patient mobility should be worthwhile for all stakeholders, including the pensioners, competent institutions and healthcare providers. Those treating mobile pensioners must be reimbursed appropriately and without unreasonable delay and, where relevant, taking account of the extra work-load and any additional costs involved.

Recital 6 of Regulation 987/09 states that certain procedures should be strengthened to ensure greater legal certainty and transparency: *"For example, setting common deadlines for fulfilling certain obligations or completing certain administrative tasks should assist in clarifying and structuring relations between insured persons and institutions."*

Article 89(1) of the Regulation 987/09 establishes Community competence to monitor the quality of service provided to customers of coordinated benefits. The technical support to meet the requirements introduced by Article 89(1) is greatly enhanced by the forthcoming introduction of EESSI in response to Article 4(2) of Regulation 987/09. EESSI opens up several possibilities for managing case work and contains the potential to collect a wide range of management information. The recommendation is for the introduction of appropriate performance indicators and an EU-wide network to identify and disseminate best administrative practice.