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Health insurance-related rules of EU law and their implementation into Hungarian national law

I. CHALLENGES ARISING FROM THE CURRENT STATE OF EU LAW

At the EU level, patient mobility refers to situations in which patients receive healthcare in a Member State other than the one in which they are affiliated (insured) based on residence or gainful activity.

The classical form of patient mobility occurs when a patient voluntarily chooses a healthcare provider in another Member State and personally covers the costs. In this case, the patient purchases healthcare services and acts as a service recipient in the host Member State.¹ As with any other economic service, the patient is entitled to equal treatment in the host country under the Treaty on the Functioning of the European Union (TFEU).² The healthcare provider is obligated to grant access to treatment under the same professional and personal conditions and at the same prices as those applicable to the host Member State's own citizens. The patient pays for the service, receives an invoice, and then returns to their home country – essentially mirroring the consumption of any other service. This form of mobility does not involve the movement of healthcare professionals³ or healthcare services. However, its scope remains limited, as not all individuals are sufficiently informed or in a financial and personal position (e.g., due to language barriers) to take advantage of this option.⁴

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¹ Joined cases 286/82 and 26/83, *Graziana Luisi and Giuseppe Carbone v Ministero del Tesoro*, [ECLI:EU:C:1984:35].

² W. Palm and I. A. Glinos, Enabling patient mobility in the EU: between free movement and coordination, in E. Mossialos, G. Permanand, R. Baeten and T. K. Hervey (eds), *Health Systems Governance in Europe – The Role of European Union Law and Policy* (Cambridge University Press, Cambridge, 2010) 509–560.

³ Kovács R., Az Európai Szakmai Kártya bevezetésének első hazai tapasztalatai (Initial Domestic Experiences with the Introduction of the European Professional Card), (2020) (2) *Munkajog*, 20–27.; R. Kovács, Health professionals on the move: analysing Brexit's influence on diploma recognition and the employment of health care workers, (2023) 62 (1) *Annales Universitatis Scientiarum Budapestinensis de Rolando Eötvös Nominatae. Sectio Iuridica*, 163–188.

⁴ A. De Ruijter, *EU Health Law & Policy. The Expansion of EU Power in Public Health and Health Care* (Oxford University Press, Oxford, 2019).

Another form of patient mobility occurs when a patient receives healthcare services in another Member State and obtains reimbursement from their own insurer. These cases are governed by the EU social security coordination regulations [Regulations (EC) No 883/2004 and No 987/2009] and Directive 2011/24/EU.⁵

The main rule under the EU social security coordination regulations is that an EU citizen and their family members may receive health insurance services from a publicly funded provider in another EEA Member State – whether as medically necessary care or as pre-authorised treatment that is also covered under their own insurance package – and the competent institution of the Member State of affiliation reimburses the full cost to the institution of the Member State providing the treatment. According to these regulations, prior authorisation is required for all planned treatments. Third-country nationals are also covered by these regulations if their situation involves more than one Member State and they have residency in an EEA country.⁶ Though the scope of this provision remains contested, particularly in light of the *Balandin* case.⁷

Since 2013, following the transposition deadline of Directive 2011/24/EU, Member States must recognise the right of their insured individuals to access healthcare services in another EU Member State based on the Directive.⁸ Under the Directive, reimbursement is not full but is limited to the internal tariff.⁹ The term “internal tariff” refers to the amount that the treatment would have cost in the individual’s home Member State, with the reimbursement not exceeding the actual cost of the treatment.¹⁰ Under the directive, healthcare services may be obtained from any provider, including private healthcare providers.

Both the EU social security coordination regulations and the Directive have been interpreted in hundreds of CJEU cases. Additionally, as a form of soft law, Member States apply the decisions of the Administrative Commission for the Coordination of Social Security Systems.¹¹

⁵ Király M. (szerk.), *Az Európai Unió gazdasági joga I. (Commercial Law in the EU I.)* (ELTE Eötvös Kiadó, Budapest, 2021) 145–150.

⁶ Regulation (EU) No 1231/2010 of the European Parliament and of the Council of 24 November 2010 extending Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009 to nationals of third countries who are not already covered by these Regulations solely on the ground of their nationality, OJ L 344, 29.12.2010, p. 1–3.

⁷ Case C-477/17. *Balandin* [ECLI:EU:C:2019:60]. Amendments to the regulations have been under discussion since 2016, but their adoption has been delayed.

⁸ G. Berki, *Free Movement of Patients in the EU* (Intersentia, Belgium, 2018).

⁹ Gellérné Lukács É. and Gyeney L., *Élesedő kontúrok – gyakorlati kihívások a határon átnyúló egészségügyi ellátás területén* (Sharpening Contours – Practical Challenges in the Field of Cross-Border Healthcare), (2014) (15) *Pázmány Law Working Papers*, 1–3.

¹⁰ Article 7(4): The costs of cross-border healthcare shall be reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare received.

¹¹ The complete list can be downloaded from here: <https://ec.europa.eu/social/main.jsp?catId=868&langId=en> (last accessed: 31.12.2024.).

EU law cannot function without national implementation and enforcement. This principle is reinforced by Article 35 of the Charter of Fundamental Rights, which, in the field of healthcare, refers exclusively to national laws without mentioning EU law: “Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices.”

The social security sector is therefore unique in that, despite extensive EU legal instruments, numerous national competences remain.¹² The design and operation of social security systems fall under the exclusive competence of Member States,¹³ and even the European Union, despite its broad legal powers, lacks competence in these matters. EU law does, however, establish certain rules,¹⁴ such as those governing the European Health Insurance Card (EHIC),¹⁵ while Member States also seek to provide social protection to their citizens beyond their borders through bilateral agreements.¹⁶ EU law and international agreements take precedence over national law. This means that the applicable rules of either EU law or bilateral agreements determine which state’s national regulations must be applied. When a specific Member State’s law becomes applicable, it must be applied in its entirety, covering both insured status and entitlement to benefits in accordance with the designated national legal framework.

The challenges of EU law are twofold. First, it is difficult to pinpoint the exact content of EU law due to the complexity of secondary legislation, CJEU case law, Administrative Commission decisions, and interpretative documents. Second, once

¹² Hungler S., Gellérné Lukács É., Petrovics Z. and Dudás K., *Az Európai Unió szociális és munkajoga (Social and Labour Law of the European Union)* (ELTE Eötvös Kiadó, Budapest, 2020).

¹³ Berke Gy., Kajtár E. and Bankó Z., *Bevezetés a társadalombiztosítási jogba (Introduction to Social Insurance Law)*, (JPTE Állam- és Jogtudományi Kar, Pécs, 2018); Hajdú J. and Homicskó Á. O. (eds), *Bevezetés a társadalombiztosítási jogba (Introduction to Social Insurance Law)*, (Patrocinium, Budapest, 2012).

¹⁴ Hoffman I., *Az Európai Unió jogának és politikáinak hatása a szociális személyes szolgáltatásokra (The Impact of European Union Law and Policies on Social Personal Services)*, (2019) (3) *Munkajog*, 46–50.; Fazekas M., *Szociális kérdések az Európai Unióban (Social Issues in the EU)*, in Forgács I. (szerk.), *Gazdasági szektorok és jogharmonizáció (Economic Sectors and Legal Harmonisation)*, (Osiris, Budapest, 2000) 473–539.; É. Gellérné Lukács, *Benefit-related interpretation issues in social security coordination*, in J. Bergham and P. Schoukens (eds), *The social security of moving researchers*, (Acco, Den Haag, 2011) 59–74.

¹⁵ SI. Határozat (2009. június 12.) az európai egészségbiztosítási kártyáról (2010/C 106/08). Kristó K. and Borbás Sz., *Külföldi egészségügyi ellátások az európai uniós és a magyar szabályok tükrében (Healthcare Services Abroad in Light of European Union and Hungarian Regulations)*, (2021) (3) *Acta Humana*, 141–154. DOI: <https://doi.org/10.32566/ah.2021.3.6> (last accessed: 31.12.2024.); Kristó K. and Malustyyk B., *A tervezett külföldi gyógykezelés engedélyezése Magyarországon: Az elektronikus ügyintézés egy lehetséges útja (Approval of Planned Foreign Medical Treatment in Hungary: A Possible Path Through Electronic Administration)*, (2021) (2) *Új Magyar Közigazgatás*, 15–25.

¹⁶ Mészáros Á., *Magyarország szociális biztonsági egyezményei, és az azokban alkalmazott főbb szabályozási elvek (Hungary’s Social Security Agreements and the Main Regulatory Principles Applied in Them)*, (2019) (4) *Munkajog*, 30–39.

this content has been identified, the next challenge is the interpretation and application of the designated national law to the specific legal situation (e.g. who is qualified as insured or employed under the national legal framework¹⁷). This requires familiarity with the principles and fundamental concepts of the national legal system, the substantive and procedural rules of EU health insurance law, and the ability to integrate national and EU law effectively.

The following discussion first addresses fundamental concepts, then examines specific issues related to EU social security regulations and the Directive, and concludes with *de lege ferenda* proposals.

II. HUNGARIAN HEALTH INSURANCE PRINCIPLES IN THE LIGHT OF EU PRINCIPLES

In my habilitation thesis, I analysed the fundamental principles of Hungarian social security and health insurance within the framework of EU principles, identifying the implications that arise from the intersection of Hungarian and EU law.

One fundamental reference point is the 2006 Council Conclusions, which state that “The health systems of the European Union are a central part of Europe’s high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development”.¹⁸ However, the same document emphasises that “All health systems in the EU aim to make provision, which is patient-centred and responsive to individual need. However, different Member States have different approaches to making a practical reality of these values.” It further asserts that “Whilst it is not appropriate to try to standardise health systems at an EU level, there is immense value in work at a European level on health care.” These statements indicate that while existing European principles are acknowledged by the Member States and remain the subject of continuous discourse, their core aim is to ensure healthcare systems respond to individual needs.

A second key point is that although Member States recognise these fundamental principles, they retain full autonomy over their practical implementation. The exclusive competence of Member States in shaping and operating their health policies and health insurance systems extends to determining the fundamental principles governing these systems.

¹⁷ I would refer here to my recent article, which relates to this issue, namely the effect of national definitions of ‘social insured’ under EU law, see É. Gellérné Lukács and T. Gyulavári, Social rights of EU mobile workers: limitations through the concepts of ‘worker’ and ‘insured person’, (2025) *Transfer: European Review of Labour and Research*, DOI: <https://doi.org/10.1177/10242589251315852>

¹⁸ Council Conclusions on Common values and principles in European Union Health Systems (HL C 146., 2006.6.22., 1. o.). Common values and principles.

Given this autonomy, the question arises as to the extent to which EU principles – such as universality, solidarity, equal treatment, access to high-quality care, and patient participation – should be applied to Hungarian social security and health insurance principles. In my view, as an EU Member State, Hungary must take into account the explicit or implicit expectations derived from the European value system, even when these expectations do not carry binding legal force, as they ultimately aim to improve citizens' lives. There must be European benchmarks, even if they are not mandatory, as they serve to guide participating states within the Union. Accordingly, periodic assessments of the extent to which these principles are being upheld are necessary. This is not about creating an idealised, infinitely funded, publicly financed healthcare system, but rather about determining the principles the state conveys to its citizens in shaping social consciousness. It concerns the direction of policy efforts and how available human, financial, and other resources are utilised to achieve specific objectives.

In Hungary, for several decades, the dominant narrative has centred on the distinction between the 'public' and 'private' healthcare systems. Before the COVID-19 pandemic (2017–2019), it appeared that the state was gradually withdrawing from financing the publicly funded healthcare system in favour of a private insurance-based model reliant on private healthcare providers, which would reduce public expenditure on healthcare services.¹⁹ This shift suggested that the population had the financial capacity to bear these costs – after all, if the state withdrew, healthcare financing would have to be assumed by either private insurers or patients themselves. During this period, no new pharmaceutical substances were added to public health insurance coverage for four consecutive years, waiting lists grew, capacity limits were reduced, hospitals and healthcare centres were closed, and private healthcare providers proliferated.

However, a shift has been noticeable since the post-COVID period, peaking in 2023. It appears that policymakers have, at least temporarily, abandoned plans for a fundamental transformation of the publicly funded healthcare system. The primary reason for this is that the vast majority of the population is neither able nor likely to be able to afford private healthcare services or private insurance policies that provide comprehensive coverage, which are increasing in cost each year. Even major private healthcare providers primarily rely on contracts with companies that offer limited outpatient care packages for their employees, as individual patients alone do not represent a sufficient market, especially in rural areas. Additionally, continuous inpatient care in the private sector is practically non-existent at present, with most private facilities closing on weekends and discharging patients. A relevant example is Slovakia's 2013 decision to renationalise two private health insurers through

¹⁹ L. Cs. Dózsa, *Restoring the Appeal of the Publicly Funded Healthcare System*, (2021–2022) (1) *Medicina Yearbook*, 22–24; Cs. Dózsa, *Regulation of Public and Private Services*, (2020) *Medicina Yearbook. Hungarian Healthcare in Numbers: Provision, Economy, Innovation*, 116–117.

expropriation, as private insurers ultimately failed to provide adequate healthcare services under the financial constraints imposed on them.²⁰

The Hungarian state appears to have resigned itself to the notion that no fundamental conceptual changes can be implemented; instead, the existing system must be adapted to the available financial resources. Consequently, continuous reforms are being introduced.²¹ While this inevitably entails certain sacrifices, it is my view that the present system should be maintained, as it serves the majority of society, making consideration of entirely new structures unnecessary. Signs of this commitment to continuity are evident in recent policy decisions, such as the centralisation of emergency services,²² regulations on in-vitro procedures, and the precise definition of conditions for the use of high-value diagnostic equipment.²³

A key objective of the current healthcare policy is also to ensure that public healthcare does not serve as a safety net for correcting professional errors in the private healthcare sector.²⁴ Instead, the goal is to optimise the utilisation of the substantial financial resources that are available. In this regard, governmental efforts should be supported. This does not imply the marginalisation of the private sector, as private providers have been incorporated into service provision (e.g., in laboratory diagnostics). However, it is essential for the state to prioritise private healthcare services that maintain exceptional quality and demonstrate a professional standard at least equivalent to public healthcare. As Zsombor Kovács aptly stated, “Neither total state control nor the extreme free market approach is the optimal solution in healthcare”.²⁵

Following this introductory discussion, it is my contention that the Hungarian healthcare system, in both its foundational principles and the detailed measures

²⁰ D. Futej and D. Grigel, *Expropriation of health insurance companies in Slovakia*, (20 February 2013), <https://www.iflr.com/article/2a63733ixysbvcl0rovfv/expropriation-of-health-insurance-companies-in-slovakia> (last accessed: 31.12.2024.).

²¹ Barzó T., *Reformlépések az egészségügyben: Hálapénz tilalom, kirendelés és összeférhetetlenség kontra illetményemelés (Reform Steps in Healthcare: Ban on Gratuities, Assignments and Conflicts of Interest vs. Salary Increase)*, (2022) 17 (2) *Miskolci Jogi Szemle*, 53–66.

²² In accordance with Section 6/A of Act CXXXIII of 2015, as amended by Act LXXIII of 2022, the gradual introduction of the new, unified on-call system began in Hungary after January 2, 2023.

²³ The provisions amending the Health Insurance Act (Ebtv.) in Act LIII of 2023, which underpin Hungary’s 2024 national budget (Sections 30–37), forecast cardinal changes in the field of outpatient specialist care. Section 30(1b) of the Ebtv. stipulates that diagnostic imaging procedures, including computer tomography (CT) and magnetic resonance imaging (MRI), must be carried out within the framework of health insurance under a financing agreement with a state, church, or municipal institution, and financing agreements with privately owned healthcare providers can only be made for supplementary state services. The new subsections (21)–(27) of Section 82 and Section 82/X of the Ebtv. contain the regulations ensuring the implementation of these provisions.

²⁴ Danó A., *Kulcsszerepet kap a műhibák “beárazásában” az Egészségügyi Tudományos Tanács (The Health Science Council plays a key role in the “pricing” of medical errors.)*, (20 February 2024), https://nepszava.hu/3225961_egeszsegugy-neak-muhiba-maganegeszsegugy (last accessed: 31.12.2024.).

²⁵ Kovács Z., *Elfekvő – Gyógyítható az egészségügy? (Dormant – Can Healthcare Be Healed?)*, (Noran Libro Kiadó, Budapest, 2020) 10.

implementing those principles, remains committed to European values. Furthermore, I would argue that the current system even exceeds the expectations set forth in EU soft law guidance. The health insurance framework is needs-based, ensuring extensive coverage that encompasses almost the entire population under various legal entitlements. No distinction is made between individuals with different eligibility statuses regarding access to healthcare services, meaning that all patients receive care based on their medical condition rather than their legal classification. Moreover, this care is not only comprehensive but is also provided free of charge to those entitled. The principle of responsiveness to individual needs is upheld, as patients receive diagnostic and therapeutic interventions tailored to their specific medical conditions until they can be declared recovered.

These principles ensure that a financially disadvantaged or socially vulnerable citizen has the same opportunity for recovery as an individual in more favourable circumstances who could afford to pay for care out of pocket. Given that health is both a value and an investment, this also signifies that the Hungarian state has, for decades, been investing in the health of nearly all its citizens. In this regard, Hungary surpasses, for example, the United States. Despite President Obama's efforts, only a minimal universal healthcare package was successfully enacted in the American legislature, covering only a small fraction of the population,²⁶ an implicit indication that the U.S. government only partially assumes responsibility for safeguarding the health of disadvantaged social groups. The contrast between these two approaches is clear.

This fundamental message is what is truly at stake when discussing healthcare principles. In this context, it can be argued that the Hungarian system exceeds expectations by incorporating almost the entire population into the mandatory risk-sharing framework, ensuring that everyone has a chance at recovery. Naturally, a pivotal role is played by healthcare professionals, who constitute the backbone of the system. Although my habilitation thesis does not address their situation – due to both thematic and scope limitations – the employment conditions of the latter have been significantly influenced by numerous legal changes in recent years.²⁷

During my lectures, students frequently raise the question of why, in Hungary, the cost of healthcare for „others” is primarily borne by those who pay contributions (those engaged in gainful employment or self-employed). They argue that a system in which those who contribute more receive better access and greater benefits would be preferable. In other words, they question why Hungary adheres to a needs-based and

²⁶ T. Luhby, *Here's why it would be even harder now to kill Obamacare*, (7 December 2023), <https://edition.cnn.com/2023/12/07/politics/obamacare-affordable-care-act-repeal/index.html> (last accessed: 31.12.2024).

²⁷ See Horváth I. and Kártyás G., *Látélet: Az egészségügyi szolgálati jogviszonyról és a szabályozás kérdőjeleiről* (A Report: On the Healthcare Service Relationship and the Questions of Regulation), (2021) (1) *Munkajog*, 1–17.

comprehensive healthcare model rather than shifting toward a contribution-based approach. In response, it is worth reconsidering the significance of the broader societal message embedded in the current system, as previously discussed. Additionally, it is crucial to recognise that healthcare is not a static snapshot reflecting an individual's health status or financial ability at a given moment. Rather, the healthcare system functions as an ongoing narrative – akin to a continuously running film – where the central question is whether a person can be assured that they will always be able to afford necessary medical care throughout their lifetime. No one can predict whether they will eventually find themselves in a position where they cannot pay for care at the „end of the film”.

Moreover, as implied by the expectation of high-quality healthcare services, maintaining a comprehensive health insurance system is an inherently costly endeavour. The system operates under continuous pressure to integrate new technologies, medical devices, and pharmaceuticals into publicly funded care. Certain treatments can cost millions of forints, and while a small number of individuals may indeed be able to cover any medical expense for themselves and their families, such individuals are in the minority.

Many place great faith in the omnipotence of private healthcare providers. However, certain highly specialised medical fields – such as traumatology, cardiology, and oncology – continue to fall outside the scope of private healthcare in Hungary. This is partly because such procedures are not cost-effective for private providers and partly because the volume of surgeries required to maintain a high standard of expertise is not feasible in private institutions. Complex procedures, such as open-heart surgery or organ transplantation, require the infrastructure, technical capacity, and professional expertise that only major public hospitals (university clinics) possess and will likely continue to possess.

As a result, it is in the interest of both the economically disadvantaged majority and the wealthier elite to preserve a strong publicly funded healthcare system. The former relies on this because they cannot afford private care, while the latter may require it when specialised treatments are unavailable in the private sector due to cost considerations. A fundamental issue arises if the publicly funded system deteriorates to the point where even private providers cannot offer the necessary treatments, as no service will exist to purchase, regardless of financial means.

Another argument frequently raised is that comprehensive coverage and equal treatment „soften” individuals, and that there should be sanctions for those who do not lead a healthy lifestyle. Actually, such a mechanism already exists in the system and is enshrined in Constitutional Court Decision 3132/2013. (VII. 2.) AB,²⁸ commonly

²⁸ Constitutional Court of Hungary, Decision 3132/2013. (VII. 2.) AB on the rejection of the petition seeking the establishment of the unconstitutionality and annulment of certain provisions of Decree

known as the „patient compliance rule.” This principle allows the restriction of healthcare subsidies if a patient’s non-compliance is deemed inadequate, even when the request for financial support would otherwise be justified by their medical condition. The Constitutional Court ruled that it is not unconstitutional for authorities to condition the full reimbursement of analog insulin treatment on the patient maintaining appropriate metabolic control, as measured by their HbA1c levels. In other words, adherence to prescribed dietary guidelines can determine the extent of state-funded treatment for diabetes patients.

It is likely no coincidence that this is the only sanction embedded in the system. First, it is worth considering the logical options available for evaluating patients. If access to publicly funded healthcare services were made contingent upon adherence to a healthy lifestyle, someone would need to monitor whether each patient meets the relevant health criteria. In a (perhaps not-so-distant) future dominated by artificial intelligence, such oversight might become easily feasible. However, under current administrative conditions, such a system is not practically implementable. At present, the millions of doctor-patient encounters that take place cannot begin with physicians reviewing data on patients’ eating habits, exercise routines, sleep patterns, and overall lifestyle choices before determining whether they qualify for treatment.

A second approach could involve restricting the examination of healthy lifestyle habits to specific treatments. However, this raises the question of who would conduct these evaluations, what criteria would be assessed, and at what point in the treatment process such assessments would occur. This approach also lacks a solid foundation. Consider, for instance, a hypothetical policy where smokers are denied treatment for lung cancer, or excessive alcohol consumers are refused care for laryngeal cancer. In response, smokers and alcohol consumers might question why smoking or drinking should be treated more harshly than excessive eating, which can lead to obesity-related cardiovascular diseases. Such distinctions are difficult to justify.

A third option would be to shift from punitive measures to incentives, rewarding individuals who maintain a healthy lifestyle. This could take the form of preferential treatment, such as moving up on waiting lists for medical services. However, even in this scenario, challenges arise regarding how to verify and track patients’ adherence to a healthy lifestyle. If artificial intelligence could be leveraged in this area, it could provide societal benefits, though it would also entail significant risks.

Additionally, in the Hungarian system, the implementation of the needs-based and comprehensive healthcare model is supported by several complementary legal mechanisms. These include the right to freely choose a physician, the right to seek a second medical opinion, and the option to receive treatment at a provider other than

the one designated by territorial service obligations, including the possibility of receiving medical care abroad with financial support from Hungarian social security. Additionally, treatment protocols are standardised through professional guidelines to ensure equal treatment for all patients. The system also incorporates built-in equity measures that provide temporary assistance in special cases.

In conclusion, based on the above considerations, it can be stated that the fundamental principles of Hungarian health insurance align with key EU requirements, including universality, solidarity, equal access to healthcare, and quality treatment (the latter understood strictly from a legal perspective, as an in-depth quality analysis falls beyond the scope of the habilitation and the author's expertise). Indeed, ensuring nearly universal access to healthcare based on equal treatment is a socially valuable proposition that conveys an important positive message. The adequacy of the principles does not inherently mean that they are implemented at an outstanding level in practice in Hungary. In fact, implementation faces considerable criticism, including issues such as regional disparities in access, long waiting lists, and shortages of professionals and nurses. However, it is important to emphasise that the existence of these problems does not warrant a response that seeks a solution in the dismantling of the fundamental principles. From this perspective, the continuous reforms and modifications of the system are necessary adjustments, and it is to be hoped that the structural foundations of this system will not only be preserved but also strengthened in the future

III. THE PERSONAL SCOPE OF THE SOCIAL SECURITY COORDINATION REGULATION AND HUNGARIAN LAW

As discussed earlier, EU law establishes numerous mandatory rules, and states also seek to provide extraterritorial protection to their citizens through bilateral agreements. The binding international obligations primarily rest on two pillars: EU law and the system of treaties composed of bilateral agreements. These international obligations take precedence over the application of Hungarian law. According to the rules of the Tbj. (Social Security Act) and the Ebtv. (Mandatory Health Insurance Act),²⁹ they enjoy primacy over Hungarian legal provisions. This means that EU law or the provisions of a bilateral agreement determine whether Hungarian rules should be applied at all or whether the laws of another state are applicable.

If Hungarian law is applicable, it must be applied in its entirety, meaning that all Hungarian provisions related to insured status, benefits, or their financing become mandatory. Hungarian law, in a sovereign manner, determines who qualifies as eligible,

²⁹ Section 3. of Act CXXII of 2010 on Social Security and Section 8/A. of Act LXXXIII of 1997 on Mandatory Health Insurance.

meaning who is insured and entitled to healthcare services. However, the relevant provisions of EU law must also be applied in this context. This requirement is explicitly stated in Section 6(3) of the Tbj., which provides that: „An insured person is also a natural person who performs work outside the territory of Hungary for a foreign employer and falls under the scope of this Act based on the Community regulation on the coordination of social security systems or a bilateral social security agreement concluded by Hungary”. Consequently, EU law mandates the application of Hungarian law (the Hungarian Tbj.) even in cases where an employee works outside Hungary for a foreign employer and has no other connection to Hungary besides their residence.

A Hungarian residence is required for this provision to apply. In such instances, EU law bases the insurance relationship on the place of residence of the economically active insured person, which would not otherwise occur under the Hungarian Tbj., because if economic activity is present, the place of activity shall determine the applicable law, not residence.

Regarding the challenges arising from the implementation of the regulation, it is also necessary to examine the situation of third-country nationals. Regulation 1231/2010/EU states that “Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009 shall apply to nationals of third countries who are not already covered by those Regulations solely on the ground of their nationality, as well as to members of their families and to their survivors, provided that they are legally resident in the territory of a Member State and are in a situation which is not confined in all respects within a single Member State”.³⁰

This article was the subject of the Balandin case and its subsequent Hungarian counterpart, the *Koppány 2007 Kft. case*.³¹ A common feature of both cases is that the third-country national workers involved had undeniably travelled to multiple locations and worked in different Member States. Thus, they met the requirement of involvement in more than one Member State, with only the issue of lawful residence remaining as a condition to be fulfilled.

In the *Koppány 2007 Kft. case*, based on Balandin, the CJEU established that it was undisputed that truck drivers working in the international freight transport sector were in a situation involving multiple Member States. The Court further ruled that, despite not having a registered address in Hungary, they were lawfully resident in Hungary due to their employment, making them eligible for an A1 certificate for posted workers. The A1 certificate confirms that workers are subject to Hungarian social security rules, meaning they contribute to and are entitled to benefits under Hungarian regulations.³²

³⁰ Article 1 of Regulation (EU) No 1231/2010.

³¹ Case C-477/17. *Balandin* [ECLI:EU:C:2019:60] and Case C-523/20. *Koppány 2007 Kft. and Vas Megyei Kormányhivatal* [ECLI:EU:C:2021:160].

³² Case C-523/20. *Koppány 2007 Kft.*, para 29.

It is noteworthy that in the Balandin case, the Advocate General opined that Ukrainian and Russian figure skaters did not meet the requirement of lawful residence and were therefore not covered by the Regulations.³³

For Hungarian legal practice, the issuance of an A1 certificate should not be in question, as it must be granted following the *Koppány 2007 Kft.* case. However, there may be some discretion regarding the issuance of the EHIC to third-country nationals, since the requirement of multiple Member State involvement may not be met by a third-country national who resides and works exclusively in Hungary. This calls for caution in extending the eligibility for the EHIC to third-country nationals who are only temporarily residing in Hungary. Such an extension could put case officers in a difficult position when assessing applications, as it would be challenging to determine which third-country nationals have connections to multiple Member States and which do not. Without the criterion of lawful residence as a decisive factor, this would become the key question in deciding whether an individual falls within the scope of the Regulation.

IV. PRIOR AUTHORISATION UNDER THE EU PATIENT RIGHTS DIRECTIVE

According to the Directive, authorisation cannot be refused if the requested treatment is included among the benefits provided for under the legislation of the Member State where the insured person resides and if, considering the patient's current health condition and the probable course of the illness, the treatment cannot be provided within a medically justifiable timeframe in the Member State of residence.³⁴

Before the adoption of the Directive, in the *Elchinov* case,³⁵ the CJEU addressed the issue of whether a Member State could be obliged to reimburse treatment costs in cases where prior authorisation had been requested but not granted at the time of treatment. It ruled that a national rule that systematically excludes reimbursement for hospital care received without prior authorisation deprives insured persons who were prevented from applying for such authorisation due to their health condition or the urgency of the required hospital treatment – or who could not wait for the competent institution's decision on their request – from obtaining reimbursement, even if the conditions for reimbursement were otherwise met.³⁶ Since the Bulgarian system categorically excluded the possibility of reimbursement in such cases, the CJEU considered this an unjustified restriction on the freedom to provide services.³⁷

³³ Opinion of the Advocate General in Case C-523/20. *Koppány 2007 Kft.* [ECLI:EU:C:2019:60] para 45.

³⁴ Article 8 of Directive 2011/24/EU.

³⁵ Case C-173/09. *Elchinov* [ECLI:EU:C:2010:581].

³⁶ Case C-173/09. *Elchinov*, para 45.

³⁷ Case C-173/09. *Elchinov*, paras 45–47., 51., 75.

The ruling established that reimbursement cannot be denied if the insured person was prevented from submitting a request due to their health condition or the urgent need for hospital treatment, or if they could not wait for the competent institution's decision, provided that the EU legal conditions for authorisation were otherwise fulfilled. Notably, the concept of obstruction ('akadályoztatás') was introduced in the ruling, even though the *Elchinov* case did not actually involve such a situation, as Elchinov had submitted a request. Nevertheless, the introduction of obstruction as a valid justification became part of the ruling and significantly narrowed the grounds for refusing prior authorisation in subsequent cases.

However, this principle was not incorporated into the Directive.

The first case in which the CJEU had to rule on authorisation in light of the Directive was the *WO and Vas County Government Office* case, which had a Hungarian connection.³⁸ In this case, no request for authorisation was submitted before the treatment was carried out. Upon returning home, the patient submitted a reimbursement claim, citing obstruction. However, the authority did not examine the claim on its merits but rejected it on formal grounds, arguing that the absence of prior authorisation per se excluded the possibility of reimbursement.

In its ruling, the CJEU held that a national regulation that categorically excludes reimbursement for planned medical treatment obtained in another Member State due to a lack of prior authorisation – despite all other legal conditions being met – cannot be justified by overriding reasons of public interest, fails to meet the requirement of proportionality, and constitutes an unjustified restriction on the freedom to provide services.

Accordingly, the insured person (patient) is entitled to directly claim reimbursement from the competent institution for an amount equivalent to what would have been covered if prior authorisation had been obtained. In paragraph 83 of the ruling, the CJEU stated that if a patient is unable to wait for a decision or is obstructed from obtaining authorisation, then requiring prior authorisation for ophthalmic surgery cannot be justified on planning grounds or for maintaining the financial balance of the social security system.

The CJEU unequivocally established that reimbursement cannot be automatically refused solely on the formal ground that the patient did not request prior authorisation. Instead, every reimbursement request must be examined on its merits. The core principle is clear: an inquiry must be conducted to determine whether the

³⁸ É. Gellérné Lukács, Prior and Subsequent Authorization of Cross-Border Healthcare under Directive 2011/24/EU, The Significance of the WO Case for EU Law and for Hungarian Law, (2023) 11 (1) *Hungarian Yearbook of International Law and European Law*, 50–73. DOI: <https://doi.org/10.5553/HYIEL/266627012023011001005>

patient was obstructed from obtaining prior authorisation and whether the medical conditions for granting authorisation and covering the costs were otherwise met.³⁹

The key difference between *Elchinov* and *WO and Vas County Government Office* lies in the extent of the CJEU's ruling. In *Elchinov*, the CJEU effectively decided the case, declaring that authorisation should not have been refused, as the refusal violated EU law, and therefore reimbursement was due. However, in *WO and Vas County Government Office*, while applying the same legal principles, the CJEU did not rule on the substantive merits of the case but left it to the national court to assess whether the conditions for reimbursement under Article 8(1) of the Directive were met.

Horizontally, the Directive, building upon the *Elchinov* case, took a stance on the topic of the solidarity-individualistic approach, reinforcing the latter. The CJEU further emphasised the individualistic direction and, in the case of *WO and Vas County Government Office*, went as far as weakening the prior authorisation requirement. When the CJEU ruled that the Hungarian regulation was incompatible with EU law because it did not provide a possibility for reimbursement in the absence of a prior application, stating that the patient was obstructed or could not have awaited the authorisation, it essentially moved beyond the formal requirement of prior authorisation. The concept of obstruction, as used by the CJEU, was not aligned with the approach under Hungarian national law but rather an EU interpretation, which seems to have a relatively broad scope, particularly in the *WO and Vas County Government Office* case.

*Tacconi*⁴⁰ criticised the CJEU in the *Watts* case⁴¹ for glossing over the factual elements, and this occurred again in the present case. It cannot be definitively stated that the patient was indeed obstructed from requesting prior authorisation, since (i) when traveling for the treatment, they likely knew the surgery would take place the following day, and (ii) upon returning home, they did not request authorisation or provide supporting documents but rather submitted a reimbursement claim.

The CJEU clearly based its ruling on the freedom to seek services, seeking to make a statement beyond the specific individual case about the condition of prior authorisation for reimbursement. With a permissive spirit, driven by supporting the rights of individual patients, the CJEU effectively rendered the prior authorisation requirement outdated and left its scope broader (since more individuals might now consider themselves 'obstructed' from submitting an application). The CJEU

³⁹ The CJEU has left considerable leeway for national courts to decide whether a patient is entitled to reimbursement under the scope of Regulation 883/2004/EC, which is clearly more advantageous for the patient, as full reimbursement is the general rule in this context.

⁴⁰ F. Tacconi, Freedom of Health and Medical Care Services within the European Union – Recent Jurisprudence of the European Court of Justice, with Particular Reference to Case C-372/04 Yvonne Watts, (2008) 68 (1) *ZaöRV*, 195–207. https://www.zaoerv.de/68_2008/68_2008_1_b_195_208.pdf (last accessed: 31.12.2024.).

⁴¹ Case C-372/04. *Watts* [ECLI:EU:C:2006:325].

horizontally weakened the gatekeeper function of national authorities. Without a prior request, the national authority – the responsible body for the insured individual, which is in charge of reimbursement – would not even be aware that expenses are likely to arise. This could negatively impact the planning objectives previously accepted by the CJEU. Previously, the CJEU had affirmed that for both hospital and non-hospital treatments, the need for prior authorisation is justified by planning reasons: The aim of planning is, on one hand, to ensure adequate and constant access to quality and balanced hospital care within the Member State. On the other hand, planning contributes to ensuring cost-efficiency and preventing the waste of financial, technical, and human resources.⁴²

In the *WO and Vas County Government Office* case, the national authority cited planning needs as a justification for requiring prior application, arguing that post-treatment authorisation would undermine the system both financially and in terms of human resources. The CJEU, using the concept of obstruction, overruled the argument based on planning needs, which might be grounded in the fact that obstruction is considered more of an individual case issue.

There exists an approach that views patients asserting their cross-border rights in national courts as explorers in the context of the national health insurance system.⁴³ As a result of the case law they induce, the situation of those who would not have been able to travel abroad for treatment could improve, thereby contributing to solidarity within the healthcare system of the Member State in which the insurance is based. The *WO and Vas County Government Office* case marks another step in this direction, further expanding the rights of cross-border healthcare seekers. An open question for the future remains whether this will strengthen solidarity within the national system or whether more resourceful patients will gain better positions in cross-border healthcare contexts.

V. FINANCIAL AND DATA PROTECTION ASPECTS OF EU LAW IMPLEMENTATION IN HUNGARY

1. Financial Aspects

The habilitation thesis also addresses the costs arising from EU legal obligations. The main rule in EU social security coordination regulations is reimbursement between Member State institutions. According to Article 35 of Regulation 883/2004/EC, health insurance services provided in another Member State are reimbursed at full

⁴² Case C-372/04. *Watts*, paras 109–110.

⁴³ B. Van Leeuwen, *The Patient in Free Movement Law: Medical History, Diagnosis, and Prognosis*, (2019) 21 *Cambridge Yearbook of European Legal Studies*, (162–186) 164., “Through the exercise of their free movement rights, moving patients acted as explorers for their national healthcare systems.”

cost. The accounting is based on actual costs, meaning that Member States invoice each other for the actual services rendered. The EU Patient Rights Directive contains several provisions allowing patients to seek healthcare in another EU Member State without prior authorisation, provided certain administrative formalities are met, with costs covered by the Member State of the patient's insurance. However, the Directive does not contain rules for inter-State accounting, as such rules are absent; the patient settles accounts directly with the service provider and later with their insurer. In this case, the Member State of insurance reimburses a portion of the cost to the patient, without any inter-State accounting. The reimbursement is generally based on internal tariffs, meaning the patient's insurer reimburses an amount equivalent to the cost of the treatment in the Member State of insurance (or the actual cost if it is lower than the domestic cost).⁴⁴ According to the Directive, prior authorisation is required for reimbursement in certain cases, such as costly or hospital treatments that require overnight stays.⁴⁵ However, even with prior authorisation, reimbursement cannot exceed the domestic cost.

Due to the binding nature of EU law, Hungary must bear the costs associated with its obligations. The decision on how to bear and cover these costs is within the competence of each Member State, including Hungary. Cost planning is included in the annual Budget Act under the chapter of the National Health Insurance Fund ("E-Alap"). Healthcare financing in Hungary follows a mixed funding model, where contributions are made through payroll taxes by employers and insured individuals, while the state assumes financial responsibility through budgetary allocations. The financial coverage of healthcare services primarily relies on three pillars: the contribution obligations of the insured individuals and employers, the employer's solidarity tax obligation (social contribution tax), and the state's liability from the central budget when expenditures exceed revenues.

No separate financing or coverage is allocated for international obligations; costs are paid from the National Health Insurance Fund. It could be said, somewhat exaggeratedly, that every insured person paying contributions participates in the financing of their fellow insured citizens' foreign healthcare, whether planned or unplanned (but legally entitled). This aspect is partly criticised in the literature, described as a kind of solidarity deficit,⁴⁶ although in reality, it represents an advanced extraterritorial legal protection for the insured. Financial data analysis indicates that the use of the EU Directive by Hungarian insured individuals is rather limited to medication reimbursements, and beyond that, Hungarian insured individuals do not

⁴⁴ Article 7 of Directive 2011/24.

⁴⁵ Article 8 of Directive 2011/24.

⁴⁶ See N. N. Shuibhne, *The Coherence of EU Free Movement Law. Constitutional Responsibility and the Court of Justice*, (Oxford University Press, 2013), "incompleteness of reasoning and the selective citation of existing authority", 66.

make use of the opportunities provided by the Directive.⁴⁷ The Hungarian Medical Chamber regularly monitors statistical data, and it seems that their 2018 conclusion, stating that „with the entry into force of the EU Directive, the number of planned foreign treatments has not increased significantly”,⁴⁸ still holds true today.

In conclusion, based on the above, it can be established that an increasing number of Hungarian insured individuals are benefiting from the advantages offered by EU law, with more people using the EHIC or the card-replacement form, i.e., participating in EU patient mobility. Three clarifications must be made: firstly, the increase only relates to those extraterritorial protection situations where insured individuals do not need to pay upfront, as the full cost is covered by the Hungarian health insurer based on the financial rules of the EU regulations. Secondly, the use of the EHIC is still considered very low compared to the EU average. Thirdly, the process exhibits regional and local network characteristics, as both Austria and Germany are among the top three partners, with Slovakia appearing as the third most significant partner for expenditures and Romania as the third most significant for revenue.

2. European Health Data Space

The proposed regulation on the European Health Data Space (EHDS)⁴⁹ aims for revolutionary changes: experts in the field have long agreed that „the regulation and standardization proposed by the EHDS are necessary steps towards a harmonized, forward-looking, data-driven research-supported digital health space”.⁵⁰ However, it is crucial how this is implemented, as it will be necessary to gain the trust of EU citizens for the project to succeed. A comparison of the original version of the regulation with the Council mandate shows that the Council has significantly improved the draft by retaining the original objectives while adding stronger data protection guarantees and better access conditions.

It is important to note that the regulation does not mandate Member States to introduce electronic systems, as the EU does not have the competence to do so. It only

⁴⁷ Gellérné Lukács É. and Paragh B., A magyar biztosítottak részvétele az európai uniós szintű betegmozgásokban – tervezett egészségügyi szolgáltatások igénybevétele (The Participation of Hungarian Insured Persons in European Union-Level Patient Mobility – Utilization of Planned Healthcare Services.), (2020) (4) *Munkajog*, 27–36.

⁴⁸ <https://mok.hu/hirek/lapszemle/nem-akarunk-kulfoldon-gyogyulni> (last accessed: 31.12.2024.).

⁴⁹ Commission welcomes political agreement on European Health Data Space https://ec.europa.eu/commission/presscorner/detail/en/ip_24_1346 (last accessed: 31.12.2024.), [https://www.consilium.europa.eu/en/meetings/mpo/2024/3/coreper-1-permanent-representatives-committee-\(342717\)/](https://www.consilium.europa.eu/en/meetings/mpo/2024/3/coreper-1-permanent-representatives-committee-(342717)/) (last accessed: 31.12.2024.).

⁵⁰ R. Raab et al., Federated electronic health records for the European Health Data Space, (2023) (5) *Lancet Digit Health*, (840–847) 846., <https://www.thelancet.com/action/showPdf?pii=S2589-7500%2823%2900156-5> (last accessed: 31.12.2024.).

stipulates that if a Member State has or creates such a system, it must function with the appropriate exchange formats. For example, Bulgaria currently has no electronic system, but if it were to establish one, it would need to comply with this regulation. This is indicated in Article 5(1) of the Council mandate, stating that „if the data is exchanged electronically...”,⁵¹ and only under this condition (i.e., if the Member State continues to use paper-based systems, the regulation does not apply).

Another noteworthy aspect is that, in addition to regulating the cross-border data exchange format, there are provisions in the regulation that influence national internal regulatory frameworks. Thus, there is an indirect harmonisation trend, which was ultimately accepted by the Member States in the Council. For example, the regulation specifies the contents of patient files registered at the national level. The original Article 3 was restructured by the Council and placed after Article 8, but its main elements remain unchanged.⁵² It stipulates, for instance, that by the end of the transitional period, medical imaging results (not just medical opinions about them) must be uploaded into the accessible patient file. This will significantly increase storage capacity requirements, but substantially improve the availability of diagnostic tools. For example, an MRI viewed by a doctor conveys more information than simply reading a colleague's medical opinion on an MRI result they have not seen themselves.

VI. DE LEGE FERENDA PROPOSALS

The analysis of EU law and Hungarian law in the field of health insurance necessarily leads to improvement proposals that may be worthy of consideration. At the end of the habilitation thesis, three specific proposals are presented, two of which concern Hungarian law, and one EU law.

1. Rethinking the appeals structure of the Health Insurance Act

Sections 77–78 of Act LXXXIII of 1997 on Mandatory Health Insurance (Ebtv.) regulate appeals. The current text was established by Section 32 of Act CX of 2019, which amended several laws in order to simplify the functioning of capital and county government offices, effective January 1, 2020. According to the justification of Section 32, „Due to the general exclusion of appeals in the case of government office and district office matters, it is necessary to repeal the provisions concerning appeals”. In Hungary, the primary remedy is an administrative lawsuit, which, as a general rule,

⁵¹ Council Mandate, Article 5(1): “For the purposes of this Chapter, where data is processed in electronic format, the priority categories shall be...”.

⁵² Council Mandate Article 8/A.

results from a one-step administrative procedure. In the case of health insurance benefits, the court with jurisdiction is the one located within the area of the plaintiff's domestic residence or, in the absence of such, the location of the employer's headquarters and the relevant health insurance authority.⁵³

The rules applicable to such cases are contained in Act I of 2017 on Administrative Procedure. According to this, a court can alter an administrative action if it occurred within a multi-level administrative procedure, or if it was part of a single-level procedure, only if another law specifically permits it and (as a cumulative condition) if the nature of the case allows, the facts are sufficiently clarified, and the available data enable a final decision on the legal dispute.⁵⁴ The Ebtv. does not expressly authorise alteration, thus, such changes are only possible in multi-level or repeated procedures.⁵⁵ However, by generally excluding appeals, the majority of cases are one-step procedures, meaning judicial alteration is not possible.

I propose an amendment to Section 77 of the Ebtv. to allow judicial alteration of decisions made in international matters under Sections 26(3) and (6) of the Ebtv., based on three main reasons:

a) Standardizing different national approaches

A one-step procedure is applied in reimbursement cases, but a multi-level procedure applies to cases concerning authorisation, where, based on Government Decree 340/2013 (IX. 25.), the National Hospital Directorate-General is the second-instance authority. Therefore, the appeal system for reimbursement cases related to the 2011/24/EU Directive differs for cases with or without authorisation requirements. In the first case, judicial alteration is not possible, while in the second case, it is. Neither the volume nor the nature of the cases justifies this distinction.

⁵³ Section 84(2) of the Social Security Act – In the case of a decision made during an inspection regarding the subsequent determination or cancellation of entitlement to insurance or healthcare services, the provisions of the Health Insurance Act (Ebtv.) and the Administrative Procedure Act (Art.) must also be applied accordingly for legal remedies.

⁵⁴ Case C-556/17. *Alekszij Torubarov és a Bevándorlási és Menekültügyi Hivatal ügy* [ECLI:EU:C:2019:626] resulted in the amendment of Act I of 2017. In the *Torubarov* case, the CJEU stated that if the Hungarian court, due to the lack of the power to amend, does not have the right under Hungarian law to grant refugee status to an asylum seeker, and if the authority fails to do so despite the court's guidance, then, in order to ensure effective legal remedy, the court is authorized to grant refugee status with a 'sanctioning' character, even if it would otherwise not have the power to amend. [Explanation of Section 90 of the Administrative Procedure Code.]

⁵⁵ Barabás G., F. Rozsnyai K. and Kovács A. Gy. (szerk.), *Kommentár a közigazgatási perrendtartáshoz – Kommentár a közigazgatási perrendtartásról szóló 2017. évi I. törvényhez. Magyarázat a Kp. 90. §-ához (Commentary on the Administrative Procedure Code – Commentary on Act I of 2017 on the Administrative Procedure Code. Explanation of Section 90 of the Administrative Procedure Code)*, (Wolters Kluwer Hungary Kft., Budapest, 2018).

b) Reducing the financial and administrative burden on the parties involved

As seen in the WO case, the theoretical exclusion of judicial alteration in the field of health insurance can lead to prolonged litigation and significant burdens for both the plaintiff and the health insurer. The plaintiff may have to submit the statement of claim twice, and the insurer faces an administrative burden that could be avoided. Therefore, it would be beneficial for all parties involved if the court were not barred from altering the administrative decision, leading to quicker resolution of the case. Naturally, this would only occur if the nature of the case permits it, the facts are sufficiently clarified, and the available data allows a final determination of the legal dispute.

c) Introducing judicial alteration would not be an unprecedented solution

The possibility of judicial alteration would not be an unusual innovation, as this rule is also present in Act III of 1993 on Social Administration and Social Benefits.⁵⁶ The aim of judicial intervention is to provide quick assistance to a deserving applicant if the court finds it appropriate. Naturally, one might argue whether the court is in a position to make appropriate decisions in administrative matters, which often involve technical details or calculations requiring specialised expertise.

An example of anticipating judicial alteration can also be found in Act CXCI of 2011 on the Benefits for Persons with Reduced Working Capacity and Amendments to Certain Laws, which is based on the provisions of Act CL of 2016 on the General Rules of Administrative Procedure (Ákr.), albeit without special provisions. However, there is a reference to judicial alteration. According to Section 19(2) of the law: „If during the review, the rehabilitation authority determines that the qualification category under Section 3(2) differs from the qualification category established before the review (change in condition), the benefits for persons with reduced working capacity shall be determined with regard to the new qualification category – unless the court’s decision in a repeated procedure states otherwise – from the day following the decision”. This provision assumes that in a repeated procedure, there may be a judgment that differs, but not in the original procedure.

I believe that granting the possibility of judicial alteration does not imply that judges will necessarily exercise it when they do not have the necessary information. However, when they do have such information, the time spent on the process could seem like unnecessary delay: it starts with the annulment of the decision and issuing

⁵⁶ According to Section 11. (1) In an administrative lawsuit aimed at challenging the decision of the authority exercising social jurisdiction, the court, upon the request of a party, may order interim measures, particularly regarding:

a) the payment of normative monetary social benefits;
b) the provision of social services in kind;
c) the referral to a social institution providing personal care.

instructions to the administrative authority, and if the authority does not comply with the instructions, the process continues with an administrative decision made contrary to the instructions in the repeated procedure, which is concluded with the judicial decision altering the original decision. This situation could result in the applicant being in an uncertain position for years, simply because the legislator believes that the court should not be trusted to resolve the dispute in the original procedure.

2. Amendment of Government Decree 340/2013 (IX. 25.)

As previously discussed, although the CJEU unequivocally allowed for retroactive claims for reimbursement even in the absence of a prior authorisation request and approval, Hungarian law has not yet incorporated this legal conclusion. I have also pointed out that, while CJEU rulings are binding on Member States *erga omnes*, the conclusions of these cases are typically formalised in secondary legislation (regulations, directives) to actually produce an *erga omnes* effect. This has not been the case following the Elchinov and WO rulings.

It is important to clarify that the CJEU does not obligate Member States to provide reimbursement in every case if the request for authorisation and reimbursement is delayed. The obligation relates to examining the conditions following the treatment abroad and making decisions in light of this examination. A decision can be made in favour of the patient, but it could also involve the rejection of authorisation and reimbursement. What is crucial is the existence of a retroactive mechanism and the establishment of a procedure that effectively addresses the subsequent evaluation of medical criteria. Currently, the medical decision regarding prior authorisation is under the jurisdiction of the Health Science Council (ETT).⁵⁷ Professionally, the ETT or a similar independent evaluating body could be competent to act in the case of retroactive authorisation.

It might be worthwhile to consider developing a standard within domestic law, as the principle established in the Elchinov and WO cases is final: all requests for reimbursement concerning cross-border healthcare, citing obstruction, must be addressed by the authorities. These cannot be automatically rejected simply due to the absence of prior authorisation. Therefore, both medical and formal conditions must be examined, and a procedure must be devised by the authorities to handle this challenge. Naturally, any decision will be subject to the usual legal procedures, including appeals and judicial review if contested.

⁵⁷ Section 14/A of Government Decree 340/2013. (IX. 25.) on Detailed Rules of Medical Treatments Abroad.

3. Amendment of the EU Patient Rights Directive regarding retroactive authorisation

In connection with the above point, I believe that the implementation of the conclusions from the *Elchinov* and *WO* cases is necessary within Directive 2011/24/EU. The legal concepts of urgency and obstruction established in *Elchinov* and *WO*, could serve as a solid basis for amending the existing legal framework, particularly Article 8 of the Directive, to further narrow (or slightly relax) the legal scope of prior authorisation for cross-border healthcare. Aligning the legal provisions in this area could help prevent unforeseen legal uncertainties and unjust outcomes for patients lawfully seeking medical treatment abroad.

Without this, it is unlikely that Member States will consistently apply the rules regarding retroactive authorisation. The amendment of the Directive should address the preambles, as they all refer to prior authorisation, as well as Article 8, which currently deals with prior authorisation for healthcare services. I recommend including the conclusion of the *Elchinov* case in the preamble.

The current title of Article 8 is “Health care subject to prior authorization”, which should be amended to “Health care subject to authorization”, removing the word “prior”. It is suggested that the word „prior” be deleted from the entire article. Furthermore, I propose adding a new paragraph (8) to Article 8 regarding the possibility of requesting retroactive authorisation, in line with the *Elchinov* case. Its content should correspond to the conclusion of the case, which stated: “the reimbursement of hospital care received without prior authorisation should not be excluded by national regulations if the insured person was unable to submit the request for authorisation due to health reasons or, as in the case of *Elchinov*, could not wait for the response of the competent institution”.⁵⁸ Additionally, no Member State’s regulations can exclude the reimbursement of hospital care received without prior authorisation in another Member State.⁵⁹

The CJEU has clearly stated that such reimbursements would not jeopardise the objectives of hospital planning, would not severely affect the financial balance of the social security system, and would not impact the provision of balanced and universally accessible hospital care, capacity, or medical competence. With this, the CJEU has essentially excluded the possibility of Member States lawfully invoking any exceptions in these cases, making the retroactive reimbursement examination mandatory.

⁵⁸ Case C-173/09. *Elchinov*, para 45.

⁵⁹ Case C-173/09. *Elchinov*, para 49.