Brussels, 15 December 2022
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Norwegian Ministry of Health and Care Services
Postboks 8011 Dep
0030 Oslo
Norway

Dear Sir or Madam,

Subject: Letter of formal notice to Norway concerning the reimbursement of costs related to cross-border healthcare

1 Introduction and correspondence

By a letter dated 30 September 2020 (Doc No 1152080), the EFTA Surveillance Authority ("the Authority") informed the Norwegian Government that it had received a complaint on the Norwegian legislation and administrative practices relating to the reimbursement of costs for cross-border healthcare.

Directive 2011/24 on patients' rights ("the Directive")[1] provides an extensive legal framework for cross-border healthcare, including provisions on the reimbursement of costs, the administrative responsibilities of the EEA States, and cooperation among national authorities. It aims at promoting patient mobility throughout the EEA, whereby patients may receive medical care in another EEA State than the one in which they are socially insured.

Section 5-24a of the National Insurance Act[2] ("NIA") forms, together with the relevant implementing regulation ("IR")[3], the legal basis under Norwegian law for the reimbursement of costs related to cross-border healthcare. A distinct administrative circular sets out how those provisions are to be applied by the national authorities.[4] Claims for reimbursement are handled by the Norwegian Health Economics Administration ("Helfo").[5]

In its letter of 30 September 2020, the Authority invited the Norwegian Government to answer a series of questions for the purposes of examining the issues raised by the complainant. The reply was received on 30 October 2020 (Doc No 1160689). A further set of questions was sent to the Norwegian Government by way of a letter dated 23 September 2021 (Doc No 1227746). The answer was received on 21 October 2021 (Doc No 1237151). The issues at hand were subsequently discussed at the package meetings in 2021 and 2022.

[1] Directive 2011/24 on the application of patients' rights in cross-border healthcare, which entered into force in the EEA on 01.08.2015.
[2] LOV-1997-02-28-Lov om folketrygd (*folketrygdloven*).
[3] FOR-2010-11-22-1466 Forskrift om stønad til helsetjenester mottatt i et annet EØS-land.
[4] Rundskriv til forskrift om stønad til helsetjenester mottatt i et annet EØS-land (F22.11.2010 nr 1466).
[5] See however the Authority's reasoned opinion to Norway of 20 October 2022 in Case 72376 concerning the general rules and the system in place in Norway for access to hospital treatment in other EEA States (Doc No 1311515), where the Authority, in Section 3.2.2.3, took note that, according to Section 7-2(1) of the Patients' Rights Act (LOV-1999-07-02-63-Lov om pasient- og brukerrettigheter (*pasient- og brukerrettighetsloven*), complaints regarding Chapter 2 of the Patients' Rights Act, including Section 2-4a(1)a regarding *inter alia* the Patients' Rights Directive, shall be made to the County Governor, and not to Helfo.

The Authority considers that certain elements of Norwegian legislation and administrative practice are in breach of EEA law. This letter of formal notice delineates the scope of the infringement as follows:

- According to the national administrative practice, the reimbursement of costs related to cross-border healthcare is limited to 80 % of the relevant national "diagnosis-related-group" ("DRG"), in breach of Article 7(4) of the Directive, c.f. Article 7(1) thereof.

- The national legislation's generic deadline is applied strictly to claims relating to cross-border healthcare, in breach of the principle of proportionality as expressed by Article 9(1) of the Directive and the principles of equivalence and effectiveness.

- The translation requirements applicable to claims relating to cross-border healthcare amount to a breach of Article 9(1), Article 9(2) and/or the freedom to provide services c.f. Article 36 EEA and create a state of ambiguity and legal uncertainty contrary to Article 3 EEA.

2 Relevant national law

2.1 Reimbursement level

Section 5-24a of the NIA provides that:

> *"§ 5-24a. Financial assistance for healthcare received in another EEA State*
>
> *Financial assistance is provided to cover expenses incurred by the member for healthcare services received in another EEA State pursuant to provisions determined by the ministry by means of an implementing regulation.*
>
> *The implementing regulation may set out provisions concerning:*
>
> *[…] "*

Section 7 of the IR concerns the calculation of the financial assistance for healthcare received in another EEA State and appears to, *prima facie*, accurately transpose the relevant provisions of the Directive.

Referring to the "diagnosis-related-group" ("DRG") classification system, the administrative circular clarifies how the above provisions are to be interpreted and applied in practice.

> *"The DRG is an average cost which does not only encompass treatment costs, but also the hospital's other costs (such as service, administration, emergency preparedness, education etc). In order for the amount to be reimbursed in accordance with Section 5-24a of the National Insurance Act to reflect, to the greatest extent possible, only the actual treatment costs, a percentage reflecting other costs shall be deducted from the DRG. This deduction is set to 20%, but is subject to later amendment (any such amendment will appear in this circular).*
>
> *This entails that a patient seeking treatment in another EEA State shall be able to receive a reimbursement of up to 80% of the DRG-cost which would have been applied had the treatment taken place at a public, Norwegian hospital.*

If the treatment abroad is more expensive than the estimated DRG-cost for a similar treatment in Norway, the patient must cover the exceeding amount himself.

When patients affiliated with other EEA States invoke the patient rights' Directive to received planned treatment in Norway, the hospital shall invoice the patient 80 % of the DRG-cost.

2.2 Claim deadline

Section 10(1) of the IR provides that:

> *"§ 10. Procedural provisions, claim submission and complaint*
>
> *Reimbursement claims shall be submitted after the healthcare has been received and paid. The claim deadline is calculated in accordance with the provisions in Section 22-13 of the National Insurance Act."*

Section 22-13 (2) of the National Insurance Act provides that:

> *"Claims for benefits which are disbursed as a one-time payment, c.f. Section 22-10 first paragraph and fourth paragraphs letters a,b and c, must be submitted within six months from the moment the claim could have been submitted at the earliest."*

The administrative circular clarifies what point in time is considered as the earliest for which a claim could have been submitted:

> *"The claim deadline corresponds to that applicable to other situations covered by chapter 5; six months from the moment the claim could have been submitted at the earliest, c.f. Section 22-13(2) of the National Insurance Act. Six months will be counted from the day of the treatment."*

2.3 Translation requirements

Section 11 of the IR provides that:

> *"§ 11. Documentation, claim form and translation*
>
> *The reimbursement claim must be submitted by the designated form.*
>
> *[…]*
>
> *The claim must include the information necessary to decide whether the healthcare qualifies for financial assistance. Necessary documentation demonstrating that the conditions are fulfilled, must be attached.*
>
> *The expenses must be documented by original and specified invoice from the healthcare provider and original receipt or other documentation demonstrating payment.*
>
> *The member must pay for and provide translation of necessary documentation if that documentation is not available in Norwegian, Danish, Swedish or English. The translation shall, as a main rule, be made by a state authorised translator. The translation requirement may be waived if it is considered that there is no such need for translation.*

HELFO may, if necessary, require the member to produce additional information or documentation. HELFO may also collect additional information."

3 Relevant EEA law

Article 7 of the Directive is entitled "general principles for reimbursement of costs" and provides that:

"1. Without prejudice to Regulation (EC) No 883/2004 and subject to the provisions of Articles 8 and 9, the Member State of affiliation shall ensure the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation.

[…]

3. It is for the Member State of affiliation to determine, whether at a local, regional or national level, the healthcare for which an insured person is entitled to assumption of costs and the level of assumption of those costs, regardless of where the healthcare is provided.

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.

6. For the purposes of paragraph 4, Member States shall have a transparent mechanism for calculation of costs of cross-border healthcare that are to be reimbursed to the insured person by the Member State of affiliation. This mechanism shall be based on objective, non-discriminatory criteria known in advance and applied at the relevant (local, regional or national) administrative level.

9. The Member State of affiliation may limit the application of the rules on reimbursement for cross-border healthcare based on overriding reasons of general interest, such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources

11. The decision to limit the application of this Article pursuant to paragraph 9 shall be restricted to what is necessary and proportionate, and may not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of goods, persons or services. Member States shall notify (…) of any decisions to limit reimbursement on the grounds stated in paragraph 9."

Article 9 of the Directive is entitled "administrative procedures regarding cross-border healthcare and provides that:

"1. The Member State of affiliation shall ensure that administrative procedures regarding the use of cross-border healthcare and reimbursement of costs of healthcare incurred in another Member State are based on objective, non-discriminatory criteria which are necessary and proportionate to the objective to be achieved.

2. Any administrative procedure of the kind referred to in paragraph 1 shall be easily accessible and information relating to such a procedure shall be made publicly

available at the appropriate level. Such a procedure shall be capable of ensuring that requests are dealt with objectively and impartially.

[…]"

4 The Authority's assessment

4.1 Reimbursement level – 80 % of national DRG

4.1.1 Financing of the Norwegian health care system, activity-based funding linked with national DRGs and "guest settlement" between regions[6]

Norway has a universal, nationalised health care system. The system is semi-decentralised: the central government is responsible for specialist care, which is delivered through four regional health authorities (RHAs), which own twenty hospital trusts. The municipalities are principally responsible for primary care.[7]

The four RHAs fund public hospitals and contracted, private hospitals. The latter are regulated by contracts concluded following competitive tenders.

Funds for public hospitals are allocated to the four RHAs, which are free to decide how the hospitals are paid. For somatic care, funding comprises block grants and activity-based funding (in roughly equal shares). The block grant for each RHA is based on the number and age of inhabitants in the regions, health indicators and cost level etc. The activity-based funding is based on the Nordic diagnosis-related groups (DRG) system to classify patients.[8]

There are approximately 980 DRGs for inpatients and outpatients in Norway. Each DRG has a calculated cost weight. These cost weights are used as a basis for the calculation of refunds to the RHAs within the activity-based financing mechanism. The cost weight attributed to each DRG expresses the average cost for all patients in that group. Defined cost groups in the system are operations, intensive care, radiology, laboratories, cytostatics, radiations, dialysis, direct care and basic costs (administration etc.). Length of stay is a key factor. Capital and research costs are not included in the cost weights.

The cost weights are updated annually to reflect changes in medical practice and other cost-related changes in hospitals. They are based on reported cost per patient data from all public hospitals in Norway.

For a patient treated in another region than that of residence, there is a "guest settlement" between the RHAs, which entails a payment amounting to 80% of the DRG-cost. This practice assumes that the marginal cost is lesser than the average cost when using available capacity. In other words, the payment for a guest-patient shall cover costs related to treat one more patient (the marginal cost), whereas the average cost expressed by the relevant DRG covers all types of costs as mentioned above.

4.1.2 Reimbursement of costs related to cross-border healthcare within the EEA – Norway's administrative practice

As reflected by the administrative guidelines, c.f. point 2.1 above, the current Norwegian practice consists of limiting the reimbursement of costs related to cross-border healthcare to 80 % of the relevant, national DRG. The rationale behind this practice is that the

[6] This point is largely based on the overview provided by the Norwegian Government in its letter of 30 October 2020.
[7] Health Systems in Transition, WHO, Vol. 22 No. 1 2020, p. 64.
[8] Idem.

reimbursement should reflect only the treatment costs themselves, excluding other costs such as service, administration, education etc.

Indeed, referring to the *guest settlement* mechanism applicable between the domestic RHAs and described above, the Norwegian Government has confirmed that it "found it rational" to adopt the same approach to the reimbursement of costs related to healthcare received in another EEA State.[9]

Based on the above, the Authority observes that the application of the same rationale to two distinct situations, entails significantly different outcomes for the patient. Thus, while a patient resident in Norway but being treated in another region than his or her region of residence sustains no financial disadvantage – as he or she will in any event, not be obliged to pay for the treatment - a patient resident in Norway who seeks healthcare in another EEA State will potentially have to cover a part of the expenses him- or herself.

4.1.3 Assessment – Article 7(4) of the Directive

The question is whether the Norwegian administrative practice at issue complies with Article 7(4) first paragraph, which provides that the costs of cross-border healthcare shall be reimbursed *"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".*

First, the Authority notes that the wording "without exceeding the actual costs of healthcare received" cannot serve as a basis for limiting the reimbursement to what might be conceived as the alternative, marginal cost on the part of the EEA State of affiliation. This leg of the provision merely makes clear that if the costs of the healthcare received were in fact lower than what would have been assumed by the EEA State of affiliation, the latter's responsibility is reduced accordingly.

Second, and of particular importance to the issue at hand, the provision requires reimbursement up to the level of costs "that would have been assumed *by the Member State* (…)". This entails, the Authority contends, that the relevant benchmark is what costs the EEA State of affiliation – as a whole – would have borne had the treatment taken place in its territory.

While the rationale underpinning the practice of applying a "guest settlement" between the national RHAs might certainly make sense due the Norwegian financing model, the Authority cannot see that the provision in Article 7(4) of the Directive allows for it to be transposed to the cross-border situations safeguarded therein. Rather, as argued above, the wording of Article 7(4) first paragraph refers to the costs carried by the EEA State of affiliation altogether, pointing to the total average costs as determined by the applicable DRG in any given reimbursement claim.

The Authority contends that its interpretation of Article 7 of the Directive, as set out above, finds support in the judgement by the European Court of Justice in *Veselības ministrija*, in which it held that[10]:

> (75) "The reimbursement provided for by Article 7 of Directive 2011/24 may, therefore, be subject to a twofold limit. First, it is calculated on the basis of the fees for healthcare in the Member State of affiliation. Secondly, if the cost of the healthcare provided in the host Member State is lower than that of the healthcare provided in the Member State of affiliation, that reimbursement does not exceed the actual costs of the treatment received.

[9] Letter of 30 October 2020 (Doc No 1160689), p. 2.
[10] Case C-243/19, *A vs. Veselības ministrija*, paras. 75-76.

(76) Since reimbursement of that healthcare under Directive 2011/24 is subject to that twofold limit, the healthcare system of the Member State of affiliation is not liable to be faced with a risk (…) of additional costs linked to the assumption of the cross-border healthcare costs."

The Authority notes that in its interpretation of Article 7 of the Directive, the CJEU focussed on "the healthcare system" (as such) of the "Member State of affiliation" (as a whole). Moreover, the Authority cannot see how the Norwegian administrative practice at issue purports to avoid a risk of additional costs linked to the assumption of the costs related to cross-border healthcare.

In its judgment, the CJEU clarified that the reimbursement provided for by Article 7 of the Directive shall be calculated *"on the basis of the fees for healthcare in the [EEA] State of affiliation."* Applied to the Norwegian healthcare system, the Authority finds that the national DRG costs must be considered to constitute "fees for healthcare" for the purpose of reimbursement under the Directive. More generally, the Authority contends that all costs must be borne by the EEA State of affiliation, regardless of whether they emanate from the central authority, one regional authority or another regional authority that is making a guest settlement.

In further support of its interpretation of Article 7(4) first paragraph and its application to the Norwegian practice at hand, the Authority observes that the provision contained in Article 7(1) of the Directive is centred on the duty of the EEA State of affiliation to ensure that "the costs incurred by an insured person who receives cross-border healthcare are reimbursed". Thus, while the expenditure-component is directly joined with the costs sustained by the healthcare recipient, the limitation of the EEA State of affiliation's responsibilities relates to what treatments are available in its territory.

In light of the above considerations, the Authority concludes that the Norwegian practice at issue amounts to a breach of Article 7(4) of the Directive, c.f. Article 7(1).

4.2 Claim deadline

4.2.1 The national rules applied to claims relating to cross-border healthcare

Pursuant to Section 10(1) IR, claims for reimbursement relating to cross-border healthcare shall be submitted after the healthcare has been received and paid. The claim deadline is to be calculated in accordance with the generic provisions set out in Section 22-13 NIA.

The general rule set out in Section 22-13(2) NIA stipulates that claims for benefits disbursed as a one-time payment shall be submitted within six months from the earliest moment in time that a claim could have been submitted. The provision does not specify further what constitutes the "earliest moment in time".

The Authority observes that, for the purposes of applying that generic provision of national law to claims for reimbursement relating to cross-border healthcare, the relevant administrative circular demands for a specific, strict application: the earliest moment in time that a claim could have been submitted shall, as regards claims relating to cross-border healthcare, be counted from the day of treatment.[11]

4.2.2 Assessment – Article 9(1) of the Directive / principle of effectiveness

The Authority recalls that Article 9(1) of the Directive requires that administrative procedures regarding the use of cross-border healthcare and reimbursement of costs

[11] Rundskriv til forskrift om stønad til helsetjenester mottatt i et annet EØS-land, § 10 (R05-24A-FOR, as revised per 1 July 2022).

incurred in another EEA State be *"based on objective, non-discriminatory criteria which are necessary and proportionate to the objective to be achieved"*.

According to the complainant, invoicing practices vary within the EEA entailing various degrees of efficiency. Concretely, the Authority notes, counting the deadline from the day of treatment becomes an issue where the invoice is only received at a later stage. Moreover, the difficulties ensuing thereof are reinforced by applying the national legislation's general deadline of six months also to claims pertaining to cross-border healthcare.

The Authority is not aware that the generic provision set out in Section 22-13(2) NIA has been given a similarly strict application in other areas or whether this concerns singularly claims relating to cross-border healthcare. Moreover, the Authority has not been presented with any arguments as to why such a specific and strict application is considered necessary.

Furthermore, the Authority observes that the principle of equivalence requires that the protection of rights within a national system of EEA-law based rights must not be less favourable than in the case of individual rights based on national law.[12]

The Authority further recalls that the principle of effectiveness entails that national procedural rules governing actions for safeguarding rights, which individuals and economic operators derive from EEA law, must not render practically impossible or excessively difficult the exercise of rights conferred by EEA law.[13] Moreover, that principle precludes national provisions which deprive directives of their effectiveness.[14]

In light of the above considerations, the Authority concludes that the Norwegian practice at issue amounts to a breach of Article 9(1) of the Directive, the principle of equivalence and the principle of effectiveness.

4.3 Translation requirements

4.3.1 The obligation to provide translations of necessary documentation – Article 9(1) of the Directive

Pursuant to Section 11(3) IR, the claim must include the information necessary for Helfo to decide whether the healthcare received qualifies for reimbursement. Section 11(5) IR stipulates that the claimant must pay for and provide translations of necessary documentation if that documentation is not available in Norwegian, Danish, Swedish or English. This requirement may be waived if Helfo considers that there is no need for a translation.

According to the complainant, Helfo does not in practice make use of the possibility to waive the translation requirement. The complainant claims that it is not necessary to translate, for example, an epicrisis drawn up in Spanish in order to understand it. The complainant stresses that the translation requirement entails substantial costs for those claiming reimbursement of costs related to healthcare received abroad.

In its letter of 21 October 2021, the Norwegian Government informed the Authority of what criteria Helfo applies when deciding whether to actually require translation of documents deemed necessary. Helfo will consider in each individual case whether there is a need for translation. This depends on *inter alia* the monetary value of the claim and whether requiring translation would entail unreasonable costs for the claimant, as specified in the relevant circular. Accordingly, the Norwegian Government has assured

[12] Case E-7/13, *Creditinfo Lánstraust*, para 45.
[13] Case E-10/17, *Nye Kystlink*, para. 110.
[14] Case E-08/07, *Celina Nguyen*, para 24.

that Helfo will rarely require translations if the monetary value of the claim is low. In such situations, Helfo will attempt to make use of other means of translation, mainly internal lingual competence and online translation services.

The Authority notes that the Norwegian Government provided anonymised examples both of cases where translation had been deemed necessary and one example of a case where that requirement had been waived. The latter concerned a claim for reimbursement of EUR 2 900, supported *inter alia* by an invoice in Italian and relevant DRG codes. The healthcare concerned in-patient treatment at a maternity ward and the applicant had applied for and was granted prior notification prior to going abroad.

With reference to the explanations and examples provided by the Norwegian Government, the Authority does not find sufficient indications that the obligation to provide translations of necessary documentation is applied restrictively and consistently in such a manner to constitute a breach of Article 9(1) of the Directive.

4.3.2 The requirement that translations shall be undertaken by a state authorised translator – Articles 9(1) and (2) / freedom to provide services

Pursuant to Section 11(5) IR, translations shall as a main rule be undertaken by a "state authorised translator" (*statsautorisert translatør*). The Authority recalls that this refers to a specific, Norwegian certification system governed by a national regulation,[15] which does not necessarily exist in all other EEA States. In order to be authorised as a state authorised translator in Norway, it is necessary to either pass a specific exam or ask for recognition of foreign qualifications. Both tracks are administered by the Norwegian School of Economics.[16]

In its letter of 21 October 2021, the Norwegian Government clarified that the objective of this requirement is to ensure a minimum level of quality of translations in order to avoid necessary information being lost. As such, this requirement was not to be perceived as a predisposition towards a specific Norwegian classification system, but as an indication of the qualitative level required of translations of documents accompanying a claim for reimbursement.

The Norwegian Government went on to state that, being aware of the principle of non-discrimination under EEA law, translations would be accepted "provided the level of translation is sufficient." In the same vein, the Authority was informed that Helfo "may accept" translations performed by individuals exercising the profession of translator in another EEA State.

In that respect, the Authority welcomes the recent amendments to the relevant administrative circular, whereby the requirement to make use of a state authorised translator has been removed. The Authority observes that the circular now states that, as a main rule, a "professional translator" shall be used.[17]

[15] FOR-2005-12-01-1391, Forskrift om bevilling som statsautorisert translatør.
[16] The Authority has duly taken note of the commitment on the part of the Norwegian Government, expressed during the package meeting of 27 October 2022, to consider amending Section 11(5) IR to the effect that the requirement to use a state authorised translator would no longer figure in national legislation. At the time of issuing this letter of formal notice, no amendments have been made.
[17] Rundskriv til forskrift om stønad til helsetjenester mottatt i et annet EØS-land, § 11 (R05-24A-FOR, as revised per 1 July 2022).

Furthermore, the Authority observes that the explanatory text accompanying the relevant application form[18] still reflects the requirement, set out in Section 11(5) IR, to make use of a state authorised translator. The explanatory text, which serves to guide the claimants, states that:

> *"All documentation must be in Norwegian, Danish, Swedish or English. You should therefore try to get the documentation issued in one of these languages.*
>
> *If the documents are in another language, Helfo may ask you to provide a state-authorised translation. You must pay for the translation yourself."*

While the Authority certainly recognises the need to ensure that Helfo receives translations of sufficiently high quality, it cannot see why that objective could only be reached by requiring, as a main rule, that such translations are undertaken by a state authorised translator. While the Norwegian Government has reassured that this requirement is not strictly applied in practice, the Authority recalls that by virtue of Section 11(5) IR and the explanatory text accompanying the application form, Helfo is ultimately left with the discretion to decide whether to accept translations performed by individuals legally established in another EEA State and exercising the profession of translator.

A less onerous approach would be, for example, to establish as a main rule that translations undertaken by professionals legally established in other EEA States should be accepted by Helfo.

In light of the above, the Authority contends that the national legislation and ensuing practice are in breach of Article 9(1) of the Directive and constitute an unjustified restriction on the freedom to provide services safeguarded by Article 36 EEA.

Moreover, the Authority recalls that the adjusted administrative practice, as reflected in the revised circular, is not reflected in Section 11(5) IR nor echoed in the application form.[19] This inconsistency gives rise to an unclear and ambiguous legal situation.

On those grounds, the Authority takes the view that Norway is in breach of Article 9(2) of the Directive, which requires that administrative procedures relating to the reimbursement of costs shall be easily available and that relevant information shall be made publicly available at the appropriate level

Moreover, it is settled case-law that maintaining in force national legislation, which is in itself incompatible with EEA law, even if the EEA State concerned in practice acts in accordance with EEA law, gives rise to an ambiguous state of affairs by maintaining, with respect to individuals subject to the legal provisions concerned, a state of uncertainty as to the possibilities available to them of relying on EEA law.[20] Administrative practices alone cannot be regarded as constituting the proper fulfilment of an EEA State's obligations under the EEA Agreement when elsewhere, individuals who seek to determine what their rights and obligations may be, by consulting the relevant legal provisions, informed that the situation is different to that reflected by the administrative practice of the EEA State in question.[21] The Authority recalls that the principle of loyalty as expressed in Article 3 EEA requires EEA States to take all measures necessary to guarantee the application and effectiveness of EEA law.[22] In this respect, the principle of

[18] "Application for reimbursement of healthcare services received in an EEA country/Switzerland", Helfo 05-24a.10, see the last page, available here.
[19] The Authority in this respect notes that, according to the Norwegian legal hierarchy of norms, the IR prevails over the circular.
[20] See e.g. C-307/89, *Commission v France*, paras 13-14.
[21] Case E-15/12, *Jan Anfinn Wahl*, para. 53.
[22] Case E-7/97, *EFTA Surveillance Authority v Norway,* paragraph 16.

loyalty and sincere cooperation, as provided for by Article 3 EEA, requires that conflicting legal provisions are revoked or amended.

5 Conclusion

Accordingly, as its information presently stands, the Authority must conclude that,

- by adopting an administrative practice whereby the reimbursement of costs related to cross-border healthcare is limited to 80% of the relevant national DRG, Norway has failed to fulfil its obligation arising from Article 7(4) of Directive 2011/24, c.f. Article 7(1) thereof.

- by adopting an administrative practice whereby the national legislation's generic deadline is applied strictly, to claims relating to cross-border healthcare, Norway has acted in breach of the principle of proportionality as expressed in Article 9(1) of Directive 2011/24 and the principles of equivalence and effectiveness.

- by maintaining in force translation requirements applicable to claims relating to cross-border healthcare, such as those set out in Section 11 IR, Norway has acted in breach of Articles 9(1) and 9(2) of Directive 2011/24 and/or the freedom to provide services, c.f. Article 36 EEA, as well as created a state of ambiguity and legal uncertainty by maintaining in force Section 11 IR, contrary to Article 3 EEA.

In these circumstances, and acting under Article 31 of the Agreement between the EFTA States on the Establishment of a Surveillance Authority and a Court of Justice, the Authority requests that the Norwegian Government submits its observations on the content of this letter *within three months* of its receipt.

After the time limit has expired, the Authority will consider, in the light of any observations received from the Norwegian Government, whether to deliver a reasoned opinion in accordance with Article 31 of the Agreement between the EFTA States on the Establishment of a Surveillance Authority and a Court of Justice.

For the EFTA Surveillance Authority

Arne Røksund President	Stefan Barriga Responsible College Member	Árni Páll Árnason College Member

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This document has been electronically authenticated by Arne Roeksund, Melpo-Menie Josephides.