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THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* EMPLOYMENT & SOCIAL SECURITY

SCHEME FOR THE FUNDING OF MEDICAL TREATMENT FOR GUERNSEY AND ALDERNEY RESIDENTS TRAVELLING IN THE UK

The States are asked to decide:

Whether, after consideration of the Policy Letter entitled 'Scheme for the funding of medical treatment for Guernsey and Alderney residents travelling in the UK', dated 10th February 2020, they are of the opinion:

1. To agree that a scheme for the funding of medical treatment for Guernsey and Alderney residents travelling in the UK should be implemented as soon as possible during 2020, as outlined in section 4 of that policy letter, and to agree that:

   a) the scheme will only be available to those individuals who can demonstrate, in the manner and with the evidence required by the Committee *for* Employment & Social Security, their inability to obtain medical insurance for travel to the UK, either at all, or at a reasonable cost;

   b) individuals who are approved, under the terms of the scheme set out by the Committee *for* Employment & Social Security, will be issued with documentation that can be provided to a UK hospital, should they require proof of ability to pay for NHS secondary care;

   c) individuals will be required to pay the first £250 towards their medical costs, should they require NHS secondary care, that is compliant with the terms of the scheme, as set out by the Committee *for* Employment & Social Security;

   d) States expenditure shall be limited to a maximum of £250,000 per incident for an individual's medical treatment under the scheme;

   e) the scheme will include the cost of repatriating a person, who was approved as being covered by the scheme, by medevac transport, should a medical professional confirm this as a necessary means of transport, and if it would

be more cost effective for the States to continue, or complete, the patient's treatment in Guernsey, than it would for them to remain in the UK.

2. To direct the Committee *for* Employment & Social Security and the Committee *for* Health & Social Care to agree the practical arrangements for the implementation of the scheme set out in section 4 of that policy letter.

3. To note that it remains the responsibility of the Policy & Resources Committee to pursue the negotiation of a Reciprocal Health Agreement between Guernsey and the United Kingdom.

The above Propositions have been submitted to Her Majesty's Procureur for advice on any legal or constitutional implications in accordance with Rule 4(1) of the Rules of Procedure of the States of Deliberation and their Committees.

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COMMITTEE *FOR* EMPLOYMENT & SOCIAL SECURITY

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The Presiding Officer
States of Guernsey
Royal Court House
St Peter Port

10th February 2020

Dear Sir

1. Executive summary

1.1. The Committee *for* Employment & Social Security ('the Committee') has explored extensively, the options for the provision of a scheme of insurance, or funding, for Guernsey and Alderney residents who require medical treatment while travelling in the UK. The primary aim of the scheme is to assist those who struggle to afford or access medical insurance for travel to the UK, and protect them from exposure to prohibitively high medical bills, should they require treatment during a visit to the UK. This has been a gap for the population since April 2009, when the UK ended the former reciprocal health agreement (RHA) that Guernsey had with the UK, although, there was an opportunity to negotiate a more limited version of an RHA in 2010, which was deemed unsuitable for Guernsey by the States at the time.

1.2. A full investigation into the options available to Guernsey commenced following a successful amendment by Deputy Fallaize in October 2015[1]. The Committee proposes that a States-operated scheme is put in place for those who struggle to obtain insurance at a reasonable cost, funded through the Guernsey Health Service Fund ('the Fund'), and subsequently, the Guernsey Health Service Allocation, when the Fund moves to General Revenue, as directed by the 2019 policy letter on the reform of healthcare funding[2]. Subject to approval by the States, the Committee's intention is that the new

[1] Benefit and contribution rates for 2016 (Billet d'État XVIII of 2015, Article VIII, Resolution 32)
[2] Reform of health care funding (Billet d'État X of 2019, Article VII)

scheme will be implemented during 2020, as soon as possible following debate.

1.3. This policy letter is concerned only with the options for providing cover for Guernsey and Alderney residents who require medical treatment while travelling in the UK. The scope of the new scheme is not in relation to those residents who are referred to the UK to receive treatment that cannot be provided locally. Anyone referred off-island for medical treatment on this basis is already covered under States of Guernsey insurance for any unexpected medical treatment that they may need while in the UK, from the day before until the day after their appointment. It is also not concerned with the feasibility, negotiation, detail, or costs of a new reciprocal health agreement between Guernsey and the UK. Following an unsuccessful amendment to the Policy & Resource Plan in June 2019[3], from Deputy Prow, and a similar successful amendment from Deputy Le Tocq, this responsibility now falls to the Policy & Resources Committee.

1.4. The anticipated cost of the scheme proposed in this policy letter is in the region of £160,000. This is based on estimated claims costs, which were calculated using data and assumptions on travel patterns, the extent of private medical cover, and average claims costs.

1.5. Regardless of the outcome of the debate on this policy letter, the Committee wants to make it clear that any residents travelling overseas should always obtain relevant information and advice about the cost to them of medical services in their destination country. Appropriate travel or medical insurance should be sought and obtained by Guernsey residents, where possible, regardless of whether there is an RHA in place with that country, or any cover provided by the destination country. This is due to the limited coverage provided by RHAs, and the potential cost that individuals could incur, should they require medical treatment or repatriation while off-island.

2. Background

2.1. This section outlines the background to the circumstances that have led to the publication of this policy letter. This includes the former Reciprocal Health Agreement between Guernsey and the UK, the successful amendment from Deputy Fallaize, and work streams that have contributed to the development of this policy letter.

[3] The Policy & Resource Plan – 2018 review and 2019 update (Billet d'État IX of 2019, Article I, Resolution 1A)

Former Reciprocal Health Agreement

2.2. The States of Guernsey had a reciprocal health agreement (RHA) with the United Kingdom until April 2009. The RHA had been in force in various forms since 1948, when the National Health Service (NHS) was established in the UK. The decision to end the arrangement was made unilaterally by the Secretary of State in the UK. While the handling of this notification, without consulting the Crown Dependencies, was a matter which the States of Guernsey objected to, the States did recognise at the time that the agreement was outdated and no longer fit for purpose.

2.3. Following representation made by the authorities in Guernsey, Jersey, and the Isle of Man, the UK Government offered a new form of RHA, which differed in terms from the agreement that ended in 2009. The revised RHA offered to the Islands was much narrower in scope than the previous agreement. It covered a narrower range of services and excluded treatment for individuals with pre-existing medical conditions. In line with the old RHA, the arrangement would not have covered repatriation. In addition, the agreement would have had an estimated cost to Guernsey of over £500,000 a year (in 2008 terms), as the States would have had to absorb the cost of treating UK patients in Guernsey, because no money would have changed hands.

2.4. Due to the limited benefits of that proposed agreement, and the estimated costs that Guernsey would have incurred, the States of Guernsey could not justify entering into a revised RHA with the UK at that time. Jersey and the Isle of Man were both able to accept the agreement on offer, as their health funding model operates on a different basis to Guernsey's.

2.5. Under the former RHA, money changed hands on both sides for costs incurred. It was the complex administrative and financial arrangements that were one of the main considerations for the UK Government in deciding to end the RHA. If a future RHA followed the same model as the revised RHAs that the UK now has with Jersey and the Isle of Man, it would have no such arrangement. However, it would create a financial liability for the UK and for Guernsey, albeit the revised RHA is much narrower in scope than the former Agreement, and would operate on a 'when in Rome' basis[4]. Appendix 1 shows the funding arrangements for treatment under the former RHA. This was correct when it was produced in 2011, however, some of the exclusions in the UK have changed since.

2.6. While the benefits of the revised RHA with the UK had limitations for Guernsey, it was a matter that remained under review by the former Health

[4] A 'When in Rome' model means that the patient would be treated as though they were a resident of the jurisdiction that they were in. For example, UK visitors to Guernsey would pay for primary care services, as Guernsey residents do, but would not pay for secondary care.

and Social Services Department for a number of years, until there was evidence to suggest that the chances of obtaining such an agreement with the UK in the near future would be difficult. For example, the NHS implemented further funding restraints for overseas visitors in 2015[5], and the fact that 40% of the UK RHAs were ended by the UK Department of Health, as at 1st January 2016. Any case for entering into a revised RHA would be required to demonstrate benefits for UK tax payers and be truly reciprocal in nature. However, the States could push to negotiate from a constitutional angle to provide another argument to secure an RHA with the UK, especially given the fact that Jersey and the Isle of Man have one.

2.7. More recently, in September 2018, the UK Department of Health indicated that it would be open to the possibility of discussing the potential to negotiate a new RHA in the future, in light of the arrangements that the UK may need to put in place with EU countries as a result of Brexit. However, any discussions with Guernsey will not be a priority for the UK, until post-Brexit. The responsibility for pursuing these discussions rests with the Policy & Resources Committee, who have a duty to report back to the States on progress in the 2020 update to the Future Guernsey Plan, as directed by the States in resolution 1A b) of 28th June 2019, following the 2018 P&R Plan Review and 2019 Update. This work will be undertaken in conjunction with the Committee *for* Health & Social Care. Representatives from both Committees have already begun discussions with the UK on this matter.

<u>The current situation for Guernsey and Alderney residents requiring medical treatment while travelling in the UK</u>

2.8. Since the removal of the RHA in 2009, local residents visiting the UK have been required to pay for any secondary care that they had received. It should be noted that, at the time of writing, visitors to the UK, including Guernsey and Alderney residents, were not charged by the UK for access to primary care, although it is expected that this could change in the future. Primary care constitutes treatment and consultations received from General Practitioners or at emergency departments, and ambulance costs. Secondary care is the treatment received after a patient is admitted to a hospital, such as operations and specialist consultations and treatment.

2.9. A patient who is not entitled to free NHS secondary care would be asked to pay the full cost of treatment in advance, unless emergency treatment was required. If proof of the ability to pay cannot be provided, for example travel insurance, health insurance, or personal funds, treatment will be refused. However, emergency medical treatment that stabilises a life-threatening

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5 The National Health Service (Charges to Overseas Visitors) Regulations, 2015

condition would not be refused, but a patient would be expected to return home for it to be completed, once the emergency was over.

2.10. If there was no emergency, but treatment has to start immediately, an undertaking to pay would be requested from the patient. If it was not urgent and the patient could not afford to pay, then they would be able to refuse treatment and wait until they returned home to receive it there instead.

2015 Fallaize Amendment

2.11. During the October 2015 debate of the Policy Letter on the Benefit and Contribution rates for 2016[6], Deputy Fallaize placed a successful amendment, on which the States resolved on 30th October 2015:

> '32. To agree that the Committee for Employment & Social Security shall investigate the merits of including within the ambit of the Guernsey Health Service Fund the costs of healthcare and medical treatment incurred by Guernsey residents while travelling to the United Kingdom which would previously have been within the ambit of the States' reciprocal health agreement with Her Majesty's Government, or alternatively of the States entering into partnership with one or more private insurance providers to ensure that such insurance cover can be made available to Guernsey residents at reasonable cost; provided that such investigation shall be undertaken on the presumption that any such insurance scheme would most probably require any claim to be subject to both maximum and minimum conditions in relation to cost coverage; and further to agree that the Committee for Employment & Social Security shall report to the States thereon by no later than October, 2017; and further to note that, for the purposes of Rule 15(2)(a) of the Rules of Procedure of the States of Deliberation, carrying into effect the proposals in this amendment, i.e. the carrying out of such an investigation, will not increase the expenditure of the States.'

2.12. In response to the resolution resulting from the successful Fallaize amendment, the Committee has investigated the options for the provision of a scheme of funding for Guernsey and Alderney residents who require medical treatment while travelling in the UK. This has included contracting an independent insurance consultant to scope the initial options available, conducting a soft market test and formal tender exercise to further refine the options and identify a potential insurance provider, and the consideration of

[6] Benefit and contribution rates for 2016 (Billet d'État XVIII of 2015, Article VIII, Resolution 32)

options that are not insurance-based, to reach a final proposal. All options that were considered are outlined in Appendix 2.

Independent Report

2.13. The former Social Security Department contracted with an independent insurance consultant to identify the options available to the States, which would provide cover for Guernsey and Alderney residents in broadly the same circumstances as would have been covered by the former RHA with the UK. This report was then considered by the newly formed Committee *for* Employment & Social Security in 2016.

2.14. The report outlined five options, and recommended that the Committee pursue a Group Travel Medical Insurance scheme. The recommendation offered a solution to the issue of the unavailability, or high cost, of medical insurance for islanders visiting the UK. The Committee looked to further refine the option presented, and to identify a suitable company who could provide a formal quote. The scheme proposed by the Committee, which is outlined in section 4, varies from the scheme presented in the independent report. The other options that were considered are outlined in more detail in Appendix 2.

Soft market test and formal tender exercise

2.15. Following the consideration of the independent report by the newly formed Committee in late 2016, a tender process was undertaken to seek an insurer who could provide a scheme of medical insurance, which suitably covered the needs of the population, and limited exposure to the risk of high value claims for the States. A soft market test was conducted initially, to gauge interest and inform the formal tender exercise.

2.16. There was one response to the formal tender exercise, which came from a local insurance broker, who would engage with a local insurer, to deliver the scheme. Initially, the company that responded seemed suitable for the Committee's requirements.

3. Insurance based options

3.1. Discussions continued with the company who had provided a quote through the formal tender exercise, including negotiations to refine the insurance model to best suit the needs of the population and balance that with the possible costs of the scheme. The discussions detailed the operation of the new scheme, including the claims handling process, as well as the contract and payment options. The Committee obtained quotes for a number of variables, including restricting eligibility criteria for accessing the scheme,

including or excluding repatriation costs, and changing the level of risk that the States would assume for low value claims.

3.2. The Committee considered its preferred option from those available from the insurers, noting that the potential cost of the scheme could not be known, due to its demand-led nature. However, using assumptions based on travel patterns, claims data, and existing private medical insurance cover, it was estimated that the maximum cost to the States could be £890,000, if the worst case scenario claims volume and cost was experienced. The minimum cost would be the premium of £90,000 that the insurer would charge to the States, regardless of whether any claims were received in the insurance period.

3.3. The Committee's findings were presented to the Policy & Resources Committee in March 2018. That Committee had significant concerns about the wide scope and potential cost of the scheme, and that there would be an upper limit on the costs that the insurer would be willing to provide cover for. The Policy & Resources Committee suggested that the option of establishing a captive insurance scheme should be researched and considered. Details of how this could work, including the potential costs, risks and benefits involved, were obtained through discussions with two independent local captive insurance experts. Both advised that setting up a captive insurance scheme would not be suitable for the States, due to the ongoing cost of regulatory and administrative requirements that apply to captives, which would not be offset, due to the small size of the scheme. In essence, what the Committee was trying to do was not profitable, and therefore commercially difficult for a private insurer to be involved with, and the cost and complexity of setting up a captive scheme did not appear to represent value for money for the States.

3.4. Further, in order to restrict the cost of the scheme, the Committee considered the appropriateness of implementing eligibility criteria, so that the scheme would only be open to people who struggled to obtain insurance, either due to age, pre-existing conditions, or prohibitively high policy premium costs. Further work was also undertaken in order to scope the feasibility of charging individuals to participate in the scheme, but it was noted that there was a regulatory requirement to have a licence to sell insurance policies. The States would have been required to pay a premium for this service, which would also include claims handling, emergency assistance, the service of an insurance manager, access to the reinsurance market, and a potential reduction in the risk of high cost claims. However, none of the insurers contacted were willing to offer this service.

3.5. Two insurers who specialise in insuring older people were also contacted to scope the possibility of them providing a bespoke scheme that would meet the Committee's preferred terms, especially focusing on affordability for

people. The outcome of those discussions was that the insurers would not be able to provide any kind of stop-loss scheme without any previous claims data on which the underwriters could base the potential risks, claim numbers and premium income. While they did offer travel medical policies to people over pension age and who had pre-existing medical conditions, those people had to be assessed on a case by case basis. This is because many of the situations are complex, and therefore had to be individually screened and rated. For that reason, they would not be able to insure those people through a group scheme, which is what the States scheme would be.

3.6. After extensive investigations and detailed discussions with insurers, the Committee unfortunately reached the conclusion that there were no suitable insurance based options available that would address the scope of the 2015 Fallaize amendment. The Committee therefore had to reconsider the options of doing nothing or implementing an in-house scheme that would cover the costs of medical treatment only for those who needed it most, which was the original intention of the 2015 Fallaize amendment. The Committee's preferred option for implementation, to run an in-house scheme, is outlined in section 4 below.

4. Proposed scheme for implementation

4.1. The Committee is proposing that an in-house scheme is developed, which is targeted at those who struggle to obtain medical insurance for travel to the UK, either due to age, a pre-existing medical condition, or prohibitively high cost. This is in line with the aim of the 2015 Fallaize amendment, and will minimise expenditure by limiting the scheme to those who need it most. In simple terms, Social Security will pay medical bills received by individuals pre-approved by Social Security, who require NHS secondary care and/or repatriation while travelling in the UK. Repatriation will cover the cost of travel to Guernsey via a medevac/air charter transfer for the patient. This would be done in the event that it would be more cost effective for the States of Guernsey to bring the patient back to Guernsey and continue their treatment locally. If the person is declared medically fit to travel on a commercial flight or ferry, this must be done at their own expense. In the event of a person's death while in the UK, the repatriation of their body would not be covered by this scheme.

4.2. Measures will be put in place to ensure that the scheme targets those with no alternative, is proportionate to the issue that this policy letter aims to address, and recognises the Committee's responsibility to limit unnecessary expenditure of public money.

4.3. Individuals who want to access the scheme will need to demonstrate that they had enquired with two or more insurers, including insurers who

specialise in complex cases, policies for older people, and for those with pre-existing medical conditions. The individual would then contact Social Security with this evidence, and it would be assessed whether the person was eligible to access the scheme. If approved, the individual would be issued with documentation confirming Social Security's commitment to pay any bills that the individual may incur, subject to the limitations set out in paragraphs 4.7-4.9 below. This would be presented to the UK hospital when they asked how the patient was going to pay for their treatment. Alternatively, confirmation could be obtained from the office during normal office hours. As the UK treats emergency cases, regardless of the ability to pay, it is not deemed necessary that a 24hr emergency phone number would need to be set up to provide confirmation that a person was covered by the scheme.

4.4. It is difficult to say what is reasonable or affordable, as people have different circumstances and financial situations. Therefore, to ensure that the assessment of eligibility is consistent, a benchmark of being able to answer the following questions will be set, and officers will take a common-sense approach to assessing eligibility:

- Has the individual obtained evidence from at least two different insurers?
- If the individual can obtain medical insurance for travel to the UK, but considers it to be prohibitively high in cost, does the individual have savings of less than £100,000?
- Is the individual over pension age, and/or does the individual have complex needs or pre-existing medical conditions?
- Has the individual been quoted for medical insurance that is not prohibitively high in cost, but excludes treatment for their pre-existing medical conditions?

4.5. Even when individuals are approved as being able to access the scheme, should they require medical treatment while travelling in the UK, the Committee recommends that they obtain a travel insurance policy to cover the risk of travel delays, and lost baggage, etc. Further, the Committee recommends that individuals obtain limited cover for medical expenses and repatriation if they are able to, which may exclude treatment for particular pre-existing health conditions, as the policy they obtain would provide much more extensive coverage than the emergency cover provided by the scheme proposed in this policy letter. The proposed Social Security scheme would then agree to pay the costs of any treatment required in relation to any conditions excluded from their private insurance policy.

4.6. Notwithstanding the possibility of Guernsey being able to negotiate a new RHA with the UK in the future, which the Policy & Resources Committee now has responsibility for investigating, the Committee considers an in-house

scheme to be the most appropriate option. This approach is simple to administer and understand, and is also practical and proportionate to the issue. What the Committee is proposing is not a formal insurance scheme, as it would be too costly to register as an insurer compared with the size of the scheme. The Committee's proposed approach is based on the assumptions that claims volume and costs would be quite low. This option would have no upfront policy premium costs and would not involve an external provider. The Committee therefore considers the risk of high expenditure to be low.

Limitations of the scheme

4.7. One way that the Committee proposes to limit the number of people relying on the scheme, and therefore the risk of increasing expenditure, is to require that anyone who does access the scheme pays the first £250 of any medical bill they receive from the UK NHS for secondary care. It is anticipated that £250 would not be prohibitively expensive a risk for individuals relying on the scheme to take, but also high enough that it would deter those who could obtain medical insurance at a reasonable cost from taking the risk. Medical insurance policies available in the market are far more comprehensive than the emergency cover that this option would provide, so the Committee wants to encourage people to opt for that, if they are able to. In practical terms, the individual would be required to submit their bill to Social Security within one month of receiving it, unless there were any extenuating circumstances that Social Security considered acceptable. Social Security would then pay the NHS and invoice the patient for £250.

4.8. This option ensures that a safety net is provided for those who were truly unable to obtain medical insurance at a reasonable cost, as the 2015 Fallaize amendment intended, but does not include those who choose not to purchase insurance. It also will not include people who thought that their existing medical or travel insurance policy would cover secondary care in the UK, but in fact does not, as it should be the individual's responsibility to understand their insurance policy. This restriction of the scheme is considered reasonable by the Committee, and intends to limit potential expenditure, which the Committee hopes will be reassuring to the States. To ensure that people are not caught out by assuming that the proposal in this policy letter will cover the whole population, the Committee intends to widely publicise, online and in the media, exactly what the scheme will cover and how people can opt in, if they think that they may be eligible.

4.9. The Committee proposes that:

- cover would be restricted to UK NHS secondary care medical expenses and repatriation costs via a medevac charter only;

- cover would not apply if the travelling resident had personal or business travel or health insurance in place that covered the treatment that they required[7];
- treatment or the cost of continuing prescription and administering of drugs in the Channel Islands, or elsewhere, would be excluded;
- UK primary care would be excluded (primary care is still free for foreign visitors to the UK);
- any costs associated with a medical condition where a trip to the UK is made for the purpose of obtaining medical treatment for that condition would be excluded;
- elective care would be excluded;
- there would be no age limit on eligibility to access cover;
- there would be no exclusion for pre-existing medical conditions, however, death, bodily injury, or sickness resulting from a trip to the UK undertaken against the advice of a qualified medical practitioner would be excluded; and
- cover would be limited to £250,000. Any medical expenses in excess of that amount would need to be covered by the individual.

5. Costs of the scheme

5.1. This section sets out the costs of the proposed scheme to the States and to the individual participating in the scheme.

Cost to the States

5.2. Based on 2015 data, it has been estimated that the likely cost of medical treatment currently payable personally by local residents travelling in the UK with no insurance is approximately £160,000 annually. This equates, on average, to approximately 160 travel claims of £1,000 each. If a £250 excess was applied to each claim, this would reduce the estimated total cost by £40,000 (£250 multiplied by 160), to £120,000.

5.3. The cost of bringing people back to Guernsey, who are unable to travel on a commercial flight or ferry, but who are well enough to travel back to Guernsey for the remainder of their treatment via medevac, needs to be added to this, as the Committee proposes that repatriation is included in the scheme. Repatriation referred to here would not include a person's body, in

[7] This could be a possibility if a person holds an insurance policy that covers some medical treatment, but not a pre-existing condition. Social Security would only pay the bill for something that they could not obtain insurance for.

the event of their death in the UK. The inclusion of the costs of repatriation in this scheme is especially important, as it is quite likely that it would be cheaper for the States to provide treatment in Guernsey, than to pay the UK to provide it. In addition, repatriation can be very expensive, and would not be likely to be covered by any form of RHA that Guernsey may be able to negotiate with the UK in the future. This is because it was not included in the former RHA between the two jurisdictions, and is not included in the model that Jersey and the Isle of Man currently operate with the UK. Based on average repatriation costs in 2015, this is likely to cost in the region of £30,000, which gives a total estimated annual cost to the States of £150,000. As these assumptions were based on 2015 data, the total anticipated claims cost of £150,000 has been uprated by inflation to £160,000, in 2019 terms.

5.4. The costs quoted above are based on an assumption, calculated by an independent insurance consultant, that approximately 30% of the population do not hold an employment or personal travel or medical insurance policy that would cover them for NHS secondary care treatment in the UK. A further assumption is made based on an analysis of the travel patterns of Guernsey and Alderney residents, and the average duration of stays in the UK. These costs are assumptions based on anticipated use of the scheme. There is no benchmark available, as there is no similar scheme identifiable that Guernsey could base its assumptions on. The costs are also based on 100% of the cost of medical treatment in the UK, however, since 2015, the UK has charged overseas visitors a tariff at the rate of 150% of the cost of their treatment. The Policy & Resources Committee and Committee *for* Health & Social Care are still negotiating this issue with the UK, so dependent on the outcome of that, there is a small chance that the proposed costs of this scheme may need to be increased by 50%, which would be £240,000 per year.

5.5. The Committee proposes that one of the limitations of the scheme, as outlined in paragraph 4.9 above, is that the maximum cost that the States would cover is £250,000. Any bill in excess of that amount, although extremely unlikely, would need to be funded by the individual, in addition to the first £250 of their medical treatment costs. The Committee hopes that this provides reassurance to States Members that expenditure is not open-ended, but also to the population, that they would be able to travel to the UK and not incur a large medical bill, should they require medical treatment.

5.6. The other cost to the States would be in terms of administering the scheme. With low volumes anticipated, it is expected that all of the processing would be handled by existing staff, notwithstanding the forthcoming transfer of health benefits staff to the Committee *for* Health & Social Care.

Cost to the individual

5.7. Individuals approved by Social Security who require medical treatment, which is covered by the terms of this scheme will be required to pay the first £250 of their medical bill. The reason for this approach is two-fold. Firstly, it encourages those who could easily obtain insurance at a reasonable cost to continue to do so, as the majority of the population are able to obtain a medical policy for the UK for substantially less than £250 per year, often with more substantive insurance cover than this scheme would provide. This deters people from relying on the scheme if they do not need to do so, and reduces potential claims, where an insurer could bear the cost instead of the taxpayer. Secondly, the requirement for the patient to pay the first £250 of their medical bill is set at a low enough level for those who struggle to obtain medical insurance to be able to afford to pay it, should they require medical treatment while travelling in the UK. This would not deter people from travelling to the UK to visit friends and family, should they wish to do so.

5.8. The Committee will continue to monitor the costs of the proposed new scheme during the first few years of implementation, as will the Committee *for* Health & Social Care when the responsibility for funding health services transfers to that Committee in the future. While this Committee is still responsible for the scheme, it will consult with the Committee *for* Health & Social Care on any recommended adjustments to the scope and eligibility criteria of the scheme, if necessary in order to reduce expenditure. The Committee is aware that health costs can be volatile, and that the sustainability of the Guernsey Health Service Fund, soon-to-become the Guernsey Health Service Allocation, needs to be monitored to ensure its availability for future generations and higher priority spending on health services.

6. Implementation

6.1. Subject to the States approval of the propositions, the Committee envisages that the scheme could be implemented during 2020, and endeavours to do so as soon as possible following debate.

6.2. Section 1(3)(a)(ii) of the Health Service (Benefit) (Guernsey) Law, 1990, allows for a pilot scheme to be implemented under the Guernsey Health Service Fund. In addition to the ability to implement the scheme sooner, another reason for conducting a pilot would be because the costs of the scheme are unknown. It would be useful to trial and review the process and model, and have an understanding of the costs involved, before making a commitment in legislation to fund the scheme on an ongoing basis.

6.3. Section 4(d) of the Law allows for categories of benefits to be added to the Law by Ordinance, so a policy letter would need to be brought back to the States following the end of the pilot, making the recommendation for this to be done, if the pilot is successful. However, it should be noted that, by the time this pilot is completed, it is likely that responsibility for services currently funded by the Guernsey Health Service Fund will have transferred to the Committee *for* Health & Social Care, who may take a different view on the future of the scheme and whether it should be developed into a statutory scheme. It was therefore important that that Committee was consulted during the development of this policy letter. The Committee *for* Health & Social Care expressed some concern about the uncertainty around volumes and administrative overhead. It was noted that its preference would be for a new Reciprocal Health Agreement to be established between Guernsey and the UK.

6.4. It is anticipated that the pilot would operate for a minimum of two years, which should be sufficient time to collate data which can inform the Committee, or the Committee *for* Health & Social Care, of whether the approach is appropriate to the population's needs and whether expenditure levels from the Guernsey Health Service Fund, or it's replacement, are acceptable to the States.

7. Conclusions

Compliance with Rule 4 of the Rules of Procedure

7.1. Through the drafting of this policy letter, the Committee has consulted with the Policy & Resources Committee, the Committee *for* Health & Social Care, independent insurance advisers, and representatives of the UK's Department for Health and Social Care.

7.2. The Committee has also consulted with the Law Officers' Chambers regarding the legal implications and legislative drafting requirements resulting from the propositions set out in this policy letter.

7.3. Throughout this policy letter, the Committee has set out its proposals for a funding scheme for Guernsey and Alderney residents who require medical treatment while travelling in the UK. The Committee seeks the States' support for the propositions, which are based on the Committee's purpose:

> 'To foster a compassionate, cohesive and aspirational society in which responsibility is encouraged and individuals and families are supported through schemes of social protection relating to pensions, other contributory and non-contributory benefits, social housing, employment, re-employment and labour market legislation.'

7.4. The propositions are aligned with the priorities and policies set out in the Committee's Policy Plan, which was approved by the States in June 2017[8]. The Committee's Policy Plan is aligned with the States objectives and policy plans. This policy letter would discharge a 2015 Resolution that the Committee has been working on for a number of years.

7.5. In accordance with Rule 4(4) of the Rules of Procedure of the States of Deliberation and their Committees, it is confirmed that the propositions have the unanimous support of the Committee.

Yours faithfully

M K Le Clerc
President

S L Langlois
Vice-President

J A B Gollop
E A McSwiggan
P J Roffey

M J Brown
Non-States Member

A R Le Lièvre
Non-States Member

[8] Policy & Resource Plan – Phase Two (Billet d'État XII of 2017, Article I)

APPENDIX 1

8. Funding arrangements for the former Reciprocal Health Agreement between the States of Guernsey and the UK

WHO PAYS?
II = INDIVIDUAL OR INSURER
UK = UK GOVERNMENT
SoG = STATES OF GUERNSEY

	UK RESIDENTS VISITING GUERNSEY - WHO PAYS			*GUERNSEY RESIDENTS VISITING THE UK - WHO PAYS		
	FORMER RHA	NEW RHA	NO RHA (CURRENT)	FORMER RHA	NEW RHA	NO RHA (CURRENT)
PRIMARY CARE (SURGERY)						
• G.P. CONSULTATION	II	II	II	UK	UK	II
• PRESCRIPTION	II	II	II	UK	UK	II
• DRUGS	SoG	SoG	II	UK	UK	II
AMBULANCE	II	II	II	UK	UK	UK
A & E						
• PRIMARY CARE CONSULTATION	II	II	II	UK	UK	UK
• PATHOLOGY	UK	SoG	II	UK	UK	UK
• RADIOLOGY	UK	SoG	II	UK	UK	UK
• DENTIST	II	II	II	UK	UK	UK
• PHYSIOTHERAPY	II	II	II	UK	UK	UK
IN PATIENT (SECONDARY CARE)						
• HOSPITAL TREATMENT	UK	SoG	II	UK	UK	II
• PATHOLOGY	UK	SoG	II	UK	UK	II
• RADIOLOGY	UK	SoG	II	UK	UK	II
• PHYSIOTHERAPY	UK	SoG	II	UK	UK	II
ELECTIVE TREATMENTS	II	II	II	SoG	SoG	SoG
RENAL DIALYSIS	II	II	II	II	II	II
REPATRIATION	II	II	II	II	II	II

***Exemptions for Guernsey residents visiting the UK with no RHA (i.e. Current Position):**

- IN RECEIPT OF UK STATE PENSION
- FULL TIME COURSE OF STUDY > 6 MONTHS
- SELF EMPLOYED WORKING FOR A UK COMPANY
- LICENCE HOLDERS < 5 YEARS RESIDENCY & > 10 YEARS CONTINUOUS LAWFUL RESIDENCE IN UK AT ANY TIME
- IMMEDIATELY NECESSARY TREATMENT FOR CONTAGIOUS DISEASES

NOTES:

- A & E treatment in Guernsey is provided by Primary Care and is chargeable to all who access it.
- Repatriation (£3K to £15K) between both territories was always chargeable & insurance for this reason alone was always recommended.

APPENDIX 2

9. Options considered while developing the preferred option

Option 1: Do nothing

9.1. The Committee is aware that the status quo should always be considered when investigating options for change, however, it agrees that 'do nothing' is not an acceptable solution.

9.2. The RHA with the UK ended in April 2009. Given that it has been more than 10 years, it could be argued that there is no need to implement a scheme at all, as the population has managed without any form of cover provided by the Government since 2009. However, it has become apparent that there is a group of people who are unable to travel to the UK to visit relatives, as they are unable to obtain medical insurance at a reasonable cost.

9.3. At present, there is no financial risk faced by the States of Guernsey associated with the cost of secondary medical treatment, hospital care and repatriation provided to local residents travelling to the UK. That risk is currently borne either by local residents themselves or, where they are able to obtain travel or health insurance, transferred to an insurance company. The risk currently borne by the States of Guernsey is one of reputational damage in that the local public may expect that, in the absence of an RHA, the States of Guernsey should be responsible for meeting such costs.

9.4. In recent years, there has been continued public and political pressure to find an alternative solution to the lack of an RHA with the UK. While the Policy & Resources Committee has been directed by the States to negotiate a new RHA with the UK, this may not be possible. Even if the UK is open to discussion on the matter, it would not be for some time that a solution could be negotiated and implemented, as the UK prioritises Brexit issues for the foreseeable future. The Committee therefore discounted this option.

Option 2: Optional individual travel insurance

9.5. The second option is for the States to promote the need for local residents to buy travel or health insurance, and provide information on suitable levels of cover and where such insurance cover can be bought. This could be achieved through marketing, and working with the local travel industry.

9.6. While this may be a suitable option for those who can easily obtain insurance, but choose not to, it would not address the issues faced by the target group set out in the 2015 Fallaize amendment. The Committee therefore discounted

this option, however, it will always recommend that people obtain suitable travel or medical insurance, wherever possible.

Option 3: Group travel medical expenses insurance

9.7. The insurer who submitted a response to the tender exercise, provided two options for a group travel medical expenses insurance scheme. The policy details proposed by the insurers for the first option, would have meant that the States would pay a minimum of £270,000, regardless of claims experience. Additional charges would also be applied for claims costs, and age-related excesses, where the States would pay £5,000 and £10,000 excesses for claims from people over the age of 80 and 85 respectively.

9.8. The second option quoted for a group travel medical expenses insurance scheme had a minimum cost of £90,000 in the form of a premium, but costs to the States could escalate up to a cap of £890,000, as the reduction in premium cost compared with the first option would be reflected in additional claims experience risk for the States.

9.9. The benefit of these options would be that some of the catastrophe risk could be borne by the insurer. However, the disadvantages include the potential cost involved, even if there is no claims experience. With cover arranged on an annually renewable basis, premiums at renewal could fluctuate substantially in the event of an expensive year for total claims costs, a high number of claims, or a large individual claim.

Option 4: Establishing a cell in a protected cell company

9.10. A 'captive' has conventionally been defined as a subsidiary company set up to insure the risks of its parent or owner. In reality, a captive is not a conventional insurance company, but rather a risk-retention vehicle. It issues policies, collects premiums, and pays claims. What fundamentally distinguishes a captive, and makes it alternative to commercial insurance, is the form of ownership and who keeps any profit. In a traditional commercial insurance arrangement, insurance premiums are paid to an insurance company, and the profits of that insurance company stay with that insurer. With a captive, premiums are paid to a company that you own and any profits can be returned to you. This relationship allows a captive the ability to customise its insurance programme to best serve the needs of its owners. While captives require capitalisation and incur administrative costs, for suitable organisations they can provide the greatest possible return for the assumed risk.

9.11. Alternatives to a full captive that could be considered are a cell in a Protected Cell Company or an Incorporated Cell Company, owned by an insurance

company or a captive insurance company manager, for example. A cell company is a company that has the ability to create one or more cells with assets and liabilities that are distinct from the assets and liabilities of other cells, and the cell company itself. These cells can be used to carry out separate and distinct businesses. However, there are fees and annual costs associated with a cell in a third party sponsored Protected Cell Company, when operating as a registered insurance entity.

9.12. While there could be a number of benefits to this option, the captive insurance experts consulted both said that the size of the scheme that the Committee was proposing would not make a captive or cell an appropriate option for the States.

Option 5: Negotiate a new Reciprocal Health Agreement with the UK

9.13. Members considered the possibility of entering into a new RHA with the UK, however, this was not an option available at the time of the Fallaize amendment. Now that there is some scope for a new RHA to be considered, the States has directed the Policy & Resources Committee to pursue this.

9.14. Further, the cover available under the RHA that was on offer by the UK would not do what the 2015 Fallaize amendment directed, as it would not include repatriation.

Option 6: Extension of Specialist Medical Benefit

9.15. This option was to amend the legislation to extend the Specialist Medical Benefit scheme to cover those currently eligible to treatment while in the UK, on the same terms as secondary care is provided while at home. This is the simplest option for the population to understand and the States to administer, however, there is no limit on the costs that the States could incur. All Guernsey and Alderney residents would be covered for the costs of secondary care treatment in the UK, however, private insurance would take precedent. Individuals who received treatment would be billed directly by the NHS and would submit the bill to Social Security for payment. At that point, they would be required to sign a declaration stating that they did not hold a form of insurance that could pay the medical bill.

9.16. Guernsey and Alderney residents would receive primary care treatment free of charge, which they do not receive in Guernsey, as the UK did not charge visitors for this, at the time of writing. If the UK implemented a primary care charging model for UK visitors during the lifetime of this scheme, the Committee could legitimately argue that the individual should be liable for any primary care costs, including GP, ambulance and Emergency Department treatment, as they would be charged for those services at home.

9.17. The Committee also considered that individuals incurring a medical bill in the UK could be charged £250 towards their treatment costs.

9.18. Given that the scheme is intended to be an interim measure until a new Reciprocal Health Agreement can be negotiated with the UK, it could be an appropriate option for the States to consider. Although the costs of the scheme are unknown, the timeframe is a finite period, on the assumption that an RHA would replace it within a few years.

9.19. The Committee discounted this option, due to the open-ended nature of potential States expenditure.