

Comments Template on CEIOPS-CP 50 Consultation Paper on the Draft L2 Advice on SCR Standard Formula – Health underwriting risk		Deadline 11.09.2009 4 p.m. CET
Name of Company:	AMICE	
Disclosure of comments:	CEIOPS will make all comments available on its website, except where respondents specifically request that their comments remain confidential. Please indicate if your comments should be treated as confidential:	
The numbering of the paragraphs refers to Consultation Paper No. 50 (CEIOPS-CP-50/09).		
Reference	Comment	
General Comment	<p>These are AMICE´s views at the current stage of the project. As our work develops, these views may evolve depending in particular, on the other elements of the framework which are not yet fixed.</p> <p>The comments outlined below constitute AMICE´s primary areas of concern:</p> <p>The Health activity is a complex area and AMICE members welcome the progress done by this consultation paper in the analysis and understanding of this activity. However we do not share some of its conclusions.</p> <p>Health is not a homogenous risk; Health insurance covers multiple risks such as life/non life, worker´s compensation, etc. As a consequence, the segmentation proposed in this consultation paper between <u>accident, sickness and worker´s compensation</u> line of business is arbitrary and not appropriate to properly carry out health activities.</p> <p>Given the particular divergences in this area, undertakings should be allowed to use national specific parameters and entity specific parameters to calibrate the standard deviation of premiums and reserves (e.g. the standard deviation for reserve risk of health is very low in those jurisdictions where health is a complementary-type insurance, which does not cover heavy-fat tail risks).</p> <p>As a general rule, CEIOPS should develop tables by products and per country as part of the Level 3 supervisory guidance. AMICE members still find it difficult to set in a single module standard stresses and correlations, which appropriately recognise the different types of health insurance products existing in different jurisdictions.</p> <p>Finally, we believe that the standard formula should recognize the insurer´s ability to increase</p>	

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	premiums in order to absorb a shock. It is unclear whether changes to future premiums rates would be allowed where the policy contract permits.	
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3.18.	Health covers loss of income or medical expenses caused by illness (sickness), accident or disability. In Germany however, disability and accident are not covered under health. Disability is covered in life and accident, in non-life.	
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3.21.	AMICE members agree with the CEA that "workers compensation insurance" and "annuities related to workers compensation insurance" should be classified as Health SLT insurance (for the disability and death part) and Health non-SLT for the (P&C) accident part. We also agree that unemployment guarantees should not be included in the health category.	
3.22.	AMICE members are of the opinion that mortgage insurance (both covering housing financing and consumer credit) should be classified as Health SLT insurance.	
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3.27.	CEIOPS provides a list with different categories by which health risk may be segmented. These categories have a direct impact on the nature of risk. AMICE members welcome the segmentation defined in this paragraph. However, some of the categories defined are no longer deemed appropriate as possible options for the LoB definition.	

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	Proposed segmentation should be included in the options discussed with regards to the definition of lines of business considered to the assessment of the Non SLT Health premium and reserve risk (paragraph 3.209).	
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3.65.	AMICE members believe that calibration should be adapted to a more granular segmentation of the health insurance business. The deficiency in the segmentation, in particular in the Non-SLT sub module and the lack of consistency which derived from it, leads to an inadequate calibration of the module. As a consequence we suggest CEIOPS redefine the segmentation and work on an alternative calibration (see our proposal in paragraph 3.209).	

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3.87.	Given that life and health products have different features, the same lapse rates cannot be applied. In this regard, a specific calibration applicable to "Health SLT" should be developed by CEIOPS.	
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3.89.	<p>As pointed out in the AMICE response to CEIOPS on Health Catastrophe Risk, standard scenarios should be developed by CEIOPS and designed as a result of a European consensus, with the help of the industry, their professional organizations dealing with the topic and the reinsurers. We also consider that scenarios might be broken down by country according to specific regulations or geographical specificities of each country. However, undertakings may, on an optional basis, be allowed to use personalized catastrophe scenarios according to the classes of business written and geographic concentration.</p> <p>AMICE would be interested in contributing to the calibration of the standard catastrophe scenarios such as influenza pandemics for Health and Life insurance business.</p>	
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3.118.	See our comments to paragraph 3.209	
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3.124.	CEIOPS' Advice does not explain how health insurance obligations should be classified. We suggest adding to the advice the classification defined in the paragraph 3.24.	
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3.126.	CEIOPS suggests splitting Health underwriting risks into 2 categories: SLT Health & Non-SLT Health. We believe that there are still many uncertainties on how to classify some categories of health products. In our opinion, this uncertainty arises from an insufficient segmentation of the health activities	
3.127.	Segmentation into existing modules could be difficult to carry out. AMICE members therefore suggest setting tables by product for each country as part of the Level 3 guidance.	
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3.130.	We agree with the CEA that the correlation of 1 between sub-modules is too high. The underlying factors of accident and sickness are not the same. Additionally, an accident occurs independently of any other factors. As such, we expect a very low correlation between accident and sickness for example.	
3.131.	CEIOPS provides the following formula for the capital charge for $nSCR_{Health}$: $nSCR_{Health} = nHealth_{SLT} + Health_{NonSLT}$ <ul style="list-style-type: none"> In our opinion the capital charge for SLT Health and Non-SLT Health should be aggregated using a correlation matrix. 	
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3.135.	We agree with the CEA that the health underwriting correlation matrix should be the same as the one used for the Life Underwriting risk module. In this regard, we suggest to amend the following sentence as follows: "The calibration is for illustrative purposes, it should eventually be the same as the one used for the Life underwriting risk module"	
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3.142.	The mortality stress (15% permanent increase in rates) and longevity stress (25% permanent decrease in rates) applied as a one-off permanent step change is a contentious area. We agree with the CEA that a one-off shock for mortality/longevity is appropriate only as a simplification. We also agree that a <u>trend base table</u> and <u>trend stress</u> is the most appropriate method.	
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3.146.	AMICE members are in favour of extending the definition of disability risk in order to include the risk to switch from short term disability to long term disability.	
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3.150.	AMICE members believe that the correlation between medical and income disability /morbidity risk should eventually not be fixed to 1.	
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3.157.	<p>AMICE members believe that calibration should be adapted to a more granular segmentation of the health insurance products. We suggest to redefine the segmentation and to work on an alternative calibration.</p> <p>AMICE members believe that consistency with the valuation approach for technical provisions will need to be considered.</p>	
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3.168.		
3.169.	<p>CEIOPS proposes the calculation of <u>SLT Health disability/morbidity risk for income insurance</u> to be computed as defined in the "<u>Life disability-morbidity risk</u>". The Life disability-morbidity risk does not recognise the possibility to absorb shocks by an increase in premiums whereas this possibility is allowed for medical insurance (see paragraph 3.158). The same possibility should be recognised for SLT Health disability/morbidity risk for income insurance.</p>	
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3.181.	<p>CEIOPS considers that the CAT risk exposure for both SLT Health and Non-SLT Health should be treated in the same way as Non-life CAT risk module. As pointed out in the AMICE response to CEIOPS on Health catastrophe risk, standard scenarios should be developed by CEIOPS and designed as a result of a European consensus, with the help of the industry, their professional organizations dealing with the topic and the reinsurers. We also consider that scenarios might be broken down by country according to specific regulations or geographical specificities of each country.</p>	

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3.186.	CEIOPS includes the loss absorbing capacity of technical provisions in the capital charge for SLT Health underwriting risk but not in the capital charge for Non-SLT Health underwriting risk. We believe that non-life contracts with profit sharing mechanism should also benefit from such absorbing effect.	
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3.196.	<p>CEIOPS includes in the volume measure for the premium formula a new element : C_{LOB}^{PP} (defined as the expected present value of net claims and expense cash out-flows which are related to claims incurred after the year and covered by the existing contracts)</p> <p>We understand from this definition that this element is only appropriate for multi-year contracts. However, more clarification on the purpose of such parameter should be provided.</p>	

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3.209.	<p>CEIOPS proposes three options with regards the definition of the lines of business that should be considered in the assessment of the Non-SLT Health premium and reserve risk. The segmentation between accident, sickness and worker´s compensation is arbitrary and neither convenient nor sufficient to adequately carry out the wide range of health activities. We claim for a wider range of segmentation that allows taking into account the different nature of risk carried out in each country. In this regard Non-SLT health risk may be segmented as follows:</p> <ul style="list-style-type: none"> - <u>Accident</u> - <u>Sickness</u> - <u>Worker´s Compensation</u>(for the accident part) - <u>Complementary Health</u>: Line of business which covers Non-occupational 	

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	<p>insurance, Payment of medical care, Accident and Sickness, and Revisable Premiums.</p> <ul style="list-style-type: none"> - <u>Providence Revisable</u>: Line of business which covers Non-occupational insurance, Wage compensation, Accident and Sickness and Revisable Premiums. - <u>Providence Non Revisable</u>: Line of business which covers Non-occupational insurance, Wage compensation, Accident and Sickness and Non Revisable Premiums. <p>If further segmentation is not feasible at European level, national segmentation should be actualized. For example the existing segmentation in France is as follows:</p> <ul style="list-style-type: none"> - <u>SLT Health and Non-SLT Health</u>: This criterion may be seen in France as justifying the segmentation of the risk of long term disability and the risk of dependence risk, from the risk of short term disability and the risk of complementary health - <u>Wage compensation /Payment of medical care</u>: these activities give rise to a separate administration. Note that payments of medical care are pooled ,even thought the risk should eventually be split between hospital, dental goods, etc since each category of payment generate one different risk (and different volatilities therefore) - <u>Accident/Sickness</u>: accident and sickness are pooled. - <u>Professional insurance/non-occupational insurance</u>: professional insurance comes in addition to social security and is marginal compared to the non-occupational insurance. Since these amounts are small, they are pooled with non-occupational insurance. - <u>Revisable premiums/Non revisable premiums</u>: (Revision of premium available/non available.) When disability or dependence insurance contracts are distributed through individual insurance the health risk is not annually revisable. It may be revised annually for complementary health contracts and for group contracts. <p>AMICE members believe that the calibration should be refined since it is the result of an inadequate</p>	

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segmentation of the Non-SLT Health (i.e. Non-similar to Life Techniques) sub module (as an example, the standard deviation for reserve risk of the Sickness line of business is in practice very low in the jurisdictions where health is a complementary insurance not covering high-tail risks). Our proposal is as follows:

Market volatilities (1)	Premiums	Reserves
Accident	5%	15%
Sickness	3%	7,5%
Worker's Compensation	7%	10%
Complementary Health	x%	x%
Providence (revisable)	x%	x%
Providence (non revisable)	x%	x%

(1) Source: Database from FNMF / SFG, which represent 55% of market share of the lob "complementary health" in France during the year 2008. From this basis, we kept the stakeholders covering exclusively complementary health, which consist in x mutuals from all sizes and which represent x% of market share. The study covers the period 2005-2008 (to exclude the impact of the change in accounting norms in 2004). The calibration for premium risk is the result of the average P / C of each mutual weighted by the amount of premiums.

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Annex A		
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