Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk	CEIOPS-SEC-113-09

CEIOPS would like to thank AAS BALTA, AB Lietuvos draudimas, AMICE, Association of British Insurers, Belgian Coordination Group Solvency II (Assuralia/, Bupa, CEA,

ECO-SLV-09-445, Centre Technique des Institutions de Prévoyance (C, CRO Forum, DENMARK: Codan Forsikring A/S (10529638), Dutch Actuarial Society – Actuarieel Genootschap (, European Union member firms of Deloitte Touche To, FFSA, German Insurance Association – Gesamtverband der D, GROUPAMA, Groupe Consultatif, Investment & Life Assurance Group (ILAG), Legal & General Group, Link4 Towarzystwo Ubezpieczeń SA, Lloyd\39s , Munich RE, NORWAY: Codan Forsikring (Branch Norway) (991 502 , OAC Actuaries and Consultants, PKV, (German) Association of Private Health Insure, PricewaterhouseCoopers LLP, RSA Insurance Group PLC, RSA Insurance Ireland Ltd, RSA\32\45\32Sun Insurance Office Ltd., SWEDEN: Trygg-Hansa Försäkrings AB (516401-7799), and Unum Limited

The numbering of the paragraphs refers to Consultation Paper No. 50 (CEIOPS-CP-50/09)

No.	Name	Reference	Comment	Resolution
1.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	General Comment	It should be clarified that the segmentation of the Health insurance business into a part working on a non-life basis and another one based on life techniques does not mean that Health insurance undertakings are composite ones. The split into a variety of underlying risks seems to be exaggerated. The grouping of risks in QIS4 was adequate both to mirror the risk exposure and still to be handled. Too often reference is made to the CP49 for the life underwriting module. Application of life techniques in health insurance does not mean that the underlying risk leads to the same consequences as it would in life insurance. So an own approach for the valuation for the capital charges in health insurance is necessary. The special treatments in QIS4 for small and young enterprises were not only necessary. The period of development of a health portfolio until reaching a stable state is even longer and could	Agree (see revised CP) Disagree Noted (see CP on undertaking specific parameters)

			therefore even be stretched. Instead of doing this, it disappeared completely in this CP.	
2.	AMICE	General Comment	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. The comments outlined below constitute AMICE´s primary areas of concern: 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. 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 accident, sickness and worker's compensation line of business is arbitrary and not appropriate to properly carry out health activities. 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). 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.	Noted Noted (see CP on undertaking specific parameters) Noted

			Finally, we believe that the standard formula should recognize the insurer´s ability to increase premiums in order to absorb a shock. It is unclear whether changes to future premiums rates would be allowed where the policy contract permits.	Agree (see CP on management action)
3.	Association of British Insurers	General Comment	The draft Level 2 advice does not allow for the use of entity specific parameters for life underwriting risk in the standard formula. Typically, the larger the life portfolio is, the less uncertain the assumptions for the best estimates become and this would be recognised through, for example, the use of credibility weighted entity specific parameters. Care will be needed in identifying comparable products, as there is a significant variation across the EU. Some examples of UK product types not included in the current table are set out in paragraph 3.21. We believe that the health module deserves its own calibration There are two main reasons for a new calibration: - The motivations of the policyholder are different, thus different lapse behaviour is to be expected. - Even if a sub-module in life and health has the same name it might refer to something different. For example the disability -morbidity risk in health will be driven by increases in medical expenses and not by a slower recover rate from severe accidents or illnesses.	See CP on undertaking specific parameters Noted
4.			Confidential comment deleted	
5.	Bupa	General Comment	The handling of the Health underwriting risk module, as challenging a sit is, does seem to be moving in the right direction. We encourage CEIOPS to continue to tease out and address the nature	Noted

			of the risks in the health sector. To that the treatment is fair, sensible, but adequately protective to policyholders.	
6.	CEA, ECO-SLV-09-445	General Comment	Introductory remarks: The CEA welcomes the opportunity to comment on the Consultation Paper (CP) No. 50 on SCR Health UW risk module. It should be noted that the comments in this document should be considered in the context of other publications by the CEA. Also, the comments in this document should be considered as a whole, i.e. they constitute a coherent package and as such, the rejection of elements of our positions may affect the remainder of our comments. These are CEA's views at the current stage of the project. As our work develops, these views may evolve depending in particular, on other elements of the framework which are not yet fixed. The CEA proposes: - To stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" cover. - The following definition for health insurance: Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or short or long term care, providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance. The above definition at this stage seems flexible enough for all European markets to have a separation of the three different branches (Non Life, Health, Life) with respect to their business	Noted Disagree (see health definition in CP) Disagree

			written and the principle "substance over form". However we are aware that the types of coverage exiting in the different countries differ significantly and the CEA suggests pursuing further analysis of this issue. Consequently, disability risk should be covered by life insurance, and accident risk should be covered by non-life insurance. Nevertheless, undertakings will be in the best position to classify such products based on their underlying risks and after a proper implementation of the proportionality and materiality principles.	
			The CEA proposes in addition to Ceiops that the life risk module supports the development of separate stresses for disability which would take into account the specific features provided by disability products.	Noted
			Furthermore, the CEA proposes to Ceiops that the life risk module supports also the development of separate stresses for workers compensation which would take into account the specific features provided by such products.	Disagree
			It is very important to notice and take into account the specificities of the different public/private health systems in the EU. Such specificities would be best captured by the allowance for country and/or entity specific parameters in the calculation of the health UW risk charge.	Noted (See CP on undertaking specific parameters)
			We welcome the change from factor-based to scenario-based approaches for determination of the capital charge for the health insurance obligations pursued on a similar technical basis to that of life insurance (SLT Health). But in our opinion it is not enough only to use the sub-modules of the life underwriting for SLT Health underwriting risk. Technical distinctions must be taken into account in an appropriate way, especially the risk exposure as well as the	Noted

			calibration.	
7.	CRO Forum	General Comment	50.A The health module deserves its own calibration (priority: high) The Health long term business is now modelled precisely as the life module. Because both use the same actuarial techniques it makes perfect sense to use the same structure. However, it seems improbable that the same stress and correlation calibration can be used for life and health and this should be kept in mind when the calibration paper is developed. 50.B An appropriate segmentation in Health is key (priority: medium) The CRO Forum believes the health risk module is very specific for most EU countries and hence an appropriate segmentation where all country specific products "fit" is of significant importance. National guidance will be essential for insurers to understand how to classify/segment their health portfolios. The country specific parameters should be taken into account as health insurance is very dependant on individual country regulations and practices. It is however, important that the large number of different products can be segmented appropriately. As a result, we believe that more sub-classes rather than less are preferable. By "building in" more sub-classes in the standard formula, makes the formula more flexible. 50.C Geographic diversification should be allowed for (priority: high) The CRO Forum disagrees that there should not be an allowance for geographic diversification.	Noted Noted (see CP on undertaking specific parameters) Disagree (see CP on non-life underwriting risk)

			50.D Undertaking specific parameters (USPs) should be introduced (priority: medium) The CRO Forum believe it is of important for Health insurers to be able to use USP's given the specific nature of Health insurance products. The Directive (Article 104 paragraph 7) allow for the use of a USP. 50.E The definition of health insurance is crucial for an appropriate calculation of SCR (Priority: high) The definition of health insurance is either possible via the event covered or the causing factor. The CP seems to take favour of differentiating by the causing factors. We would suggest a definition via the covered event which seems to fit better to the complex health insurance market. "Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or short or long term care (medical insurance), providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance." Inherent risks of health insurance can be best assessed by analysing the dependency from covered event and risk factors. 50.F Early engagement of industry in QIS5 with respect to calibration is required (priority: high)	See CP on undertaking specific parameters Noted Noted
8.	Dutch Actuarial Society – Actuarieel Genootscha	General Comment	This paper is a large improvement for the Dutch disability insurance companies. The issues we are confronted with in this paper for the disability business are quite the same as the issues mentioned in CP 48. For the Health insurance companies some issues are still under construction, like the counterparty default risk, so at the	Noted

	p (		moment we cannot give a complete opinion on that part. One can discuss that the disability insurances should be part of the Life Insurance instead of Non-Life due to the similarity in characteristics. We want to stress that at the moment in the Dutch Supervisory Report the disability insurances are categorised as Non-Life. A discussion on the mapping of the Short Term Health insurance is different, because in the Dutch Supervisory Report they are already mapped as Non-Life at the moment.	Noted Noted
9.	European Union member firms of Deloitte Touche To	General Comment	We are supportive of the advice that CEIOPS has put forward, and have no further comments or observations in respect of this paper. We believe further guidance may be required at Level 3 to foster homogeneous classification of health insurance products according to the decision tree provided on para. 3.32. This would improve harmonisation between undertakings and across markets.	Noted
10.	FFSA	General Comment	FFSA thinks that the approach of splitting Heath in two main categories: life and non-life is interesting, but would like calibration to be carefully tested in QIS5 as this was not the case in QIS4 and also would probably need more clarification on classification. CEIOPS has based the calibration of the SLT Health disability/morbidity risk for medical insurance on the German health insurance undertakings (see 3.173). FFSA thinks that this calibration may not apply to all the European industry, and that this calibration should be refined based on a larger basis. Indeed, claims volatility depends also on the national health care system. Therefore, FFSA believes that the use of country specific / entity specific data should be allowed. Furthermore, CEIOPS is doubling the calibration of the risk to allow for other risks (e.g. model risk, risk of change, random error). FFSA	Noted Noted (See CP on undertaking specific parameters) Noted

			strictly disagrees with CEIOPS calibration of other risks. Indeed this calibration results from observations of the German market (3.166). Also CEIOPS did not provide any rational explanation for the capital charge of 5% of these other risks FFSA thinks that it should be based on a sounder basis	
11.			Confidential comment deleted	
12.	German Insurance Association – Gesamtverband der D	General Comment	GDV appreciates CEIOPS' effort regarding the implementing measures and likes to comment on this consultation paper. In general, GDV supports the detailed comment of CEA. Nevertheless, the GDV highlights the most important issues for the German market based on CEIOPS' advice in the blue boxes. It should be noted that our comments might change as our work develops. Our views may evolve depending, in particular, on other elements of the framework which are not yet fixed – e.g. specific issues that will be discussed not until the third wave is disclosed. The GDV proposes: - To stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" cover. - The following definition for health insurance: "Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or by short or long term care (medical insurance) or by providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance." The definition of health insurance is either possible via the event covered or the causing factor. CEIOPS seems to take favour of	Noted Disagree (see revised CP)

			differentiating by the causing factors. We would suggest a definition via the covered event which seems to fit better to the complex health insurance market. The above definition seems flexible enough for all European markets to have a separation of the three different branches (Non Life, Health, Life) with respect to their business written and the principle "substance over form". Disability risk should be covered by life insurance, and accident risk should be covered by non-life insurance. The GDV proposes in addition to CEIOPS that the life risk module supports the development of separate stresses for disability which would take into account the specific features provided by disability products. It is very important to notice and take into account the specificities of the different public/private health systems in the EU. Such specificities would be best captured by the allowance for entity specific parameters in the calculation of the health UW risk charge. We strongly support the classification of "Long term care insurance" to Health insurance obligations, because long term care insurance is calculated on the same calculation principles as health insurance.	See CP on undertaking specific parameters Noted
13.	GROUPAMA	General Comment	Groupama has two major points dealing with the Health risk module: - We think that the standard formula should recognize the insurer's ability to increase premiums (for income insurance, for instance) to absorb a shock. (3.169) - We suggest allowing the undertakings using entity-specific parameters, or at least national-specific parameters, to calibrate their shocks. For instance, the standard deviation	Agree (see CP on management action) See CP on undertaking specific parameters

			for reserve risk of Sickness seems too high for French business, as Health insurance is a complementary insurance which does not operate on heavy risks. At least, we should be allowed to use national-specific parameters. Moreover, we suggest reintegrating a size factor which allows the volatility to be decreased (as in the QIS 2). (3.209) - Segmentation into modules could be difficult to carry out. We suggest that CEIOPS establish tables by products per country at Level 3. (3.127)	Disagree (see revised CP)
14.	Groupe Consultatif	General Comment	We suggest that CEIOPS should consider whether a separated health module is really necessary. All health specific risks can be naturally and adequately mapped to the life or. non-life modules. The life module should be used for long-term health business (with actuarial reserve), with the adjustment of the new risk driver "morbidity risk" (modelled as described in 3.1.6) instead of "disability risk". The life model must be slightly enhanced in a straight forward way to incorporate health's policyholder participation and premium adjustment rule. The non-life modules should be used for short-term health business. In general there are still some residual concerns as to the consistency of the treatment of health insurance across Europe. For example, in the Netherlands and Germany health insurance recent reforms have meant that the health insurance sector is structurally becoming closer to that provided in Ireland and the United Kingdom but from the proposed framework they may still be treated as long-term classes of insurance and therefore could be argued to be covered under the life insurance module. Given the experience under previous Quantitative Impact Studies it	Disagree (see Level 1 text) Noted

			is important that supervisors in different countries as consistent in their treatment of health insurance lines of business. Healthcare insurance is very diverse and varies significantly by Member State as noted by CEIOPS itself paragraph in Section 3 of CP50. It is important that the standard formula is not biased towards one country. There needs to be an adequate balance between "standard parameters" and "user specific parameters". A potential way of accommodating this balance is for the wording in paragraph 3.213 to consider "Market-specific parameters (MSP)" rather than just "Undertaking-specific parameters (USP)". Alternatively, CEIOPS could classify short-term health insurances based on the nature of their risk profiles, policyholder claim probability distributions, and settlement speeds, and use these benchmarks to make the SCR more specific to each market. We understand that the correlations presented in the paper are for illustration only and that they are still under review. We would welcome the opportunity to provide input on these parameters.	See CP on undertaking specific parameters Noted
15.	Investment & Life Assurance Group (ILAG)	General Comment	Many of the SCR standard formulae proposed in this paper are more onerous than under QIS4. We are disappointed at the lack of justification presented in this paper for the increased onerousness of the various SCR components, particularly as CEIOPS did not express any doubt as to the adequacy of the QIS4 calibration at the time that the QIS4 results were released.	Noted
16.	Lloyd's	General Comment	Overall, We agree with the approach that this paper takes. We note that the Framework Directive article 104 requires a health underwriting risk module. Otherwise we believe that it would be preferable for the classes of business within the health module to be dealt with in the non-life and life underwriting risk modules. Nevertheless, we have commented on the basis that a separate Health underwriting risk module is part of the Basic SCR.	Noted

17.	Munich RE	General Comment	We fully support all of the GDV statements and would like to add the following points: a) We appreciate the new scenario based approach! b) A meaningful QIS5 is vital given the divergence of views with respect to the calibration of the standard formula. We would urge CEIOPS to engage with the industry at an early stage to discuss the respective specification and calibration. c) The definition of health insurance is crucial for an appropriate calculation of SCR: The definition of health insurance is either possible via the event covered or the causing factor. CEIOPS seems to take favour of differentiating by the causing factors. We would suggest a definition via the covered event which seems to fit better to the complex health insurance market. "Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or short or long term care (medical insurance), providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance." Inherent risks of health insurance can be best assessed by analysing the dependency from covered event and risk factors.	Noted
18.	PKV, (German) Association of Private Health Insure	General Comment	PKV appreciates CEIOPS' effort regarding the implementing measures and likes to comment on this consultation paper. In general, PKV supports the detailed comment of CEA. Nevertheless, the PKV highlights the most important issues for the German market based on CEIOPS' advice in the blue boxes. It should be noted that our comments might change as our work	Noted

			develops. Our views may evolve depending, in particular, on other elements of the framework which are not yet fixed – e.g. specific issues that will be discussed not until the third wave is disclosed. The PKV proposes: - To stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" cover. - The following definition for health insurance: "Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or by short or long term care (medical insurance) or by providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance." The definition of health insurance is either possible via the event covered or the causing factor. CEIOPS seems to take favour of differentiating by the causing factors. We would suggest a definition via the covered event which seems to fit better to the complex health insurance market. The above definition seems flexible enough for all European markets to have a separation of the three different branches (Non Life, Health, Life) with respect to their business written and the principle "substance over form". Disability risk should be covered by life insurance, and accident risk should be covered by non-life insurance. The PKV proposes in addition to CEIOPS that the life risk module supports the development of separate stresses for disability which would take into account the specific features provided by disability	Noted Disagree (see revised CP)

			products. It is very important to notice and take into account the specificities of the different public/private health systems in the EU. Such specificities would be best captured by the allowance for entity specific parameters in the calculation of the health UW risk charge. We strongly support the classification of "Long term care insurance" to Health insurance obligations, because long term care insurance is calculated on the same calculation principles as health insurance.	
19.	PricewaterhouseCoopers LLP	General Comment	We welcome the additional clarity provided in this consultation paper relative to that in QIS4 in respect of the scope of the health underwriting risk sub-module. However, throughout our comments we note areas where further clarity is still required.	Noted
20.	Unum Limited	General Comment	Care will be needed in identifying comparable products, as there is a significant variation across the EU. Some examples of UK product types not included in the current table are set out in paragraph 3.21.	Noted
21.	CEA, ECO-SLV-09-445	2.	In order to consider the Dutch equalisation system, article 101, paragraph 5 should be included as well.	Noted
22.	CEA, ECO-SLV-09-445	3.1.	In the QIS 4 technical specifications a special Annex was included to cover the specific treatment of the Dutch Health insurance (TS.XVII.G Annex SCR 5: Dutch health insurance). In this draft advice no mention is given to this annex. Two important features of the Dutch health insurance system are: (a) compulsory health insurance for all Dutch citizens for a standard health insurance policy; and (b) a mandatory equalisation system for health insurance companies offering the standard health insurance policy.	Noted

			Both features cannot be captured in the current SCR module as envisaged in this draft advice. As seen during QIS 3 the results of not amending the parameters will lead to unjustifiable high capital charges for the Dutch health insurers, not reflecting the actual risk profile of the Dutch health insurer. In QIS 4 the parameters were amended and gave a better reflection of the underwriting risk. A requirement to build an internal model to amend this onerous situation for the whole Dutch health industry is not the solution as this measurement should be applied by the supervisors by exception. The requirement to use a partial internal model throughout the health industry will lead to higher costs and to the introduction of market entry barriers and will have serious market distorting and political effects.	
23.	Association of British Insurers	3.3.	We believe that the treatment of Health Insurance in QIS4 was an improvement over QIS3 by including Short-term health & accident insurance.	Noted
24.			Confidential comment deleted	
25.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.7.	The suggestion of some undertakings to treat health and disability in the morbidity risk module of the life insurance module seems not to be adequate, because of the application of life and non-life techniques in the health insurance business. No. 3.54 of CP49 (life underwriting) states more clearly that the morbidity-"sub-module of the life underwriting risk module is therefore likely to be applicable only in cases where contracts cannot be unbundled".	Noted/disagree
26.			Confidential comment deleted	
27.	ACA – ASSOCIATION DES	3.8.	The lack of clarity rises also the question whether health insurance is formally "composite" or not. If it is, this would immediately implicate (by way of CP42 nr. 3.42) that the absolute floor for	Noted (See revised CP)

	COMPAGNIES D'ASSURANCES DU		health insurers is 5.4 million €, which seems absolutely not reasonable.	
28.			Confidential comment deleted	
29.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.11.	The long-term care risk is not always part of the health insurance cover. It should therefore not automatically be seen as a part of health insurance. Maybe one should treat it as an own LOB?	Not clear/Noted
30.			Confidential comment deleted	
31.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.12.	This absence of a clear separation leads again to the question "composite or not?" (cf 3.8)	Noted (See revised CP)
32.			Confidential comment deleted	
33.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.13.	This seems to be the right way to treat health.	Noted
34.			Confidential comment deleted	

35.	Legal & General Group	3.13.	The clarity provided by this section is extremely helpful. In the context of the UK our interpretation of "Mortgage insurance" is as a non-life insurance obligation given its short term, annual renewal nature.	Noted
36.			Confidential comment deleted	
37.	CEA, ECO-SLV-09-445	3.15.	Health insurance typically covers medical costs and wage losses due to illness, but it is indifferent to the causes of the medical treatment/illness (e.g. disability, accident). So neither disability nor accident risk is covered by health insurance. Disability risk should be covered by life insurance, and accident risk should be covered by non-life insurance (P&C). The reference to "accident" should be removed from this paragraph.	Disagree
38.	German Insurance Association – Gesamtverband der D	3.15.	Note – no text in original comment	
39.	Groupe Consultatif	3.15.	Disability risk is covered normally by life insurance and accident risk by non-life insurance (P&C).	Disagree
40.	PKV, (German) Association of Private Health Insure	3.15.	Note – no text in original comment	

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
41.	CEA, ECO-SLV-09-445	3.16.	The CEA proposes to stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" covers.	Noted
42.	AMICE	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.	Noted
43.	Association of British Insurers	3.18.	This definition of health insurance is more restrictive and so may help to clarify what to model as life and non-life. However, attention needs to be paid on not moving products between life and non-life by changing defintions, given the Directive is quite restrictive on this (see Art.72) and forces companies to manage these business separately, as per existing Solvency I approach, which may cause a significant impact for some companies.	Noted
44.	CEA, ECO-SLV-09-445	3.18.	Health insurance typically covers medical costs and wage losses due to illness, but it's indifferent to causes of the medical treatment/illness (e.g. disability, accident). So neither disability nor accident risk is covered by health insurance. Disability risk is covered by life insurance, and accident risk is covered by non-life insurance (P&C). The reference to "disability" should be removed from this paragraph. Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses caused by medical treatment (medical insurance), or supplementary insurance underwritten in addition to medical insurance. The above definition is flexible enough for all European markets to have a separation of the three different branches (Non Life, Health,	Disagree Disagree (see revised CP)

			Life) with respect to their business written and the principle "substance over form".	
45.	AAS BALTA	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
46.	AB Lietuvos draudimas	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
47.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.19.	This definition illustrates one more time the problem of the long term care risk. It should be included in the health module as indicated in the list of insurance products (3.21)	Noted
48.			Confidential comment deleted	
49.	Belgian Coordination Group Solvency II (Assuralia/	3.19.	The definition should make a clear distinction between Accident and Sickness.	Disagree
50.	CEA, ECO-SLV-	3.19.	The CEA proposes clearly distinguishing between Accident and Sickness and amending the definition for health obligations.	Disagree

	09-445		The references to "accident" and "disability" should be removed. Health insurance typically covers medical costs and wage losses due to illness, but it's indifferent to causes of the medical treatment/illness (e.g. disability, accident). So neither disability nor accident risk is covered by health insurance. Disability risk is covered by life insurance, and accident risk is covered by non-life insurance (P&C).	
51.	CRO Forum	3.19.	It is not clear that the definition covers products that provide cash payments such as hospitalisation benefits or those that do not 'compensate or reimburse losses' such as critical illness. CEIOPS should clarify.	Noted
52.	DENMARK: Codan Forsikring A/S (10529638)	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
53.			Confidential comment deleted	
54.			Confidential comment deleted	
55.	Link4 Towarzystwo Ubezpieczeń SA	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
56.	NORWAY: Codan Forsikring	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of	Noted

	(Branch Norway) (991 502		benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	
57.	RSA Insurance Group PLC	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
58.	RSA Insurance Ireland Ltd	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
59.	RSA - Sun Insurance Office Ltd.	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
60.	SWEDEN: Trygg-Hansa Försäkrings AB (516401-7799)	3.19.	We think the scope of this definition might be interpreted as being wider than CEIOPS intend. For example in many countries motor or liability policies provide, at least in part, precisely the type of benefits listed in the definition. We think CEIOPS intend the definition to apply to business where claims are payable on a "no fault" basis. If so this would be a useful clarification.	Noted
61.	CEA, ECO-SLV-	3.20.	Disability risk should be covered by life insurance.	Disagree

	09-445			
62.	Groupe Consultatif	3.20.	Characteristically, disability risk is covered by life insurance.	Disagree
63.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.21.	Long term care: see 3.19	Noted
64.	AMICE	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.	Noted
65.	Association of British Insurers	3.21.	We suggest CEIOPS to add a new column clarifying whether a health obligation is SLT or non-SLT, in order to avoid arbitrage. In the definitions under 3.21, precautionary costs should be included too where this is the case in practice. Critical illness. Under this product different types of covers may exist (creditor insurance, individual protection and so on). We believe that such different covers may need classification under SLT or non-SLT, depending on the underlying risks and would welcome CEIOPS view on such a classification. Critical Illness/Accelerated Critical Illness – due to their consideration under different modules, we ask for more clarification on the differences between such products.	Noted Noted (see revised CP) Noted (see revised CP)

			Our product definitions are set out below for PHI/IP and PMI, as they were not included in the current table for these products. Permanent Health Insurance (PHI)/Income Protection (IP) – pays you a monthly income if you become unable to work because of illness or accidental injury for a prolonged period. Private Medical Insurance (PMI) – pays for treatment for curable short-term illness or injury (commonly known as acute conditions). Cover is generally renewed annually. Mortgage insurance. We further believe that heath insurance obligations relating to illness, accident and disability as defined under 3.19 that apply to mortgage insurance should be treated in the same manner as income protection for any other loan product. We believe that the benefits offered are fundamentally the same in nature. Supplementary insurance underwritten in addition to life insurance are covered by the definition of Health insurance since the health risk can be unbundled, though is immaterial. However, the definition in CP27 3.21 uses the proportionality principle, which implies that unbundling is not required and therefore this product would be classified as Life insurance. We would suggest that the most pragmatic approach would be to adjust the classification so that where health obligations are immaterial even if they can be unbundled they should do not need to be covered in the health module.	Noted (see revised CP) Noted (se revised CP) Noted (see revised CP)
66.			Confidential comment deleted	
67.	Belgian Coordination Group Solvency II	3.21.	We think that it is not realistic to artificially separate a rider from his subjacent contract. The risk bearer being the same person, a rider contract should always be treaded in the same module as the main contract. (also applies to point 3.32.)	Noted

	(Assuralia/		We would advise to change table 3.21 accordingly: Critical illness insurance = dread disease insurance If the insurance policy exists as a stand alone contract, it should be treated as Health insurance obligations for SCR purpose. However, if the contract is a rider attached to a main Life contract, it should be treated as Life insurance obligations for SCR purpose. Supplementary insurance underwritten in addition to life insurance Those products are directly linked to the life insurance contracts and should therefore be treated as Life insurance obligations for SCR purpose.	
68.	CEA, ECO-SLV-09-445	3.21.	Health insurance typically covers medical costs and wage losses due to illness, but it's indifferent to causes of the medical treatment/illness (e.g. disability, accident). So neither disability nor accident risk is covered by health insurance. We suggest Ceiops to add a new column clarifying whether a health obligation is SLT or non SLT, in order to avoid any arbitrage. The table aims to clarify problematic cases but for clarity Ceiops should add the treatment of disability income insurance and premium waiver (including pension contribution waiver) sold as attachments to life contracts, stand alone by life companies and by non life companies. Accidental death cover – individual protection should also be added and classified under life insurance for SCR purposes. We strongly support the classification of "Long term care insurance" to Health insurance obligations, because long term care insurance is calculated on the same calculation principles as health insurance. In the definitions under 3.21, precautionary costs (e.g. dental	Disagree Noted Noted Agree (see revised CP)

			examination costs for the youth, preventive medicine and prophylaxis) and availability costs (e.g. in Holland: the allowance per insured person for general practitioners, irrespective of the actual visits of an insured person) should be included too. In general, costs to prevent medical expenses, covered by the policy of the health insurer, should be part of this table as well as health insurance. Critical illness. Under this product different types of covers may exist (creditor insurance, individual protection and so on). The CEA believes such different covers may need classification under SLT or non SLT, depending on the underlying risks and would welcome Ceiops view on such a classification. - "Disability" should be removed from the definition of critical illness. Critical Illness/Accelerated Critical Illness – due to their consideration under different modules, the CEA asks for more clarification on the differences between such products. ABI product definitions are set out below for PHI/IP and PMI as they were not included in the current table for these products. Permanent Health Insurance (PHI)/Income Protection (IP) – pays you a monthly income if you become unable to work because of illness or accidental injury for a prolonged period. Private Medical Insurance (PMI) – pays for treatment for curable short-term illness or injury (commonly known as acute conditions). Cover is generally renewed annually. Income maintenance in case of disability insurance for "ordinary sickness" should be added in the life obligations class. Workers compensation.	

			The CEA argues for classifying "workers compensation insurance" and "annuities related to workers compensation insurance" as life insurance obligations for the disability and death part and non-life insurance obligations for the accident part. Unemployment guarantees, for which the techniques are similar to life, should be treated as life obligations. Mortgage insurance. Mortgage insurance" should be excluded from health and classified as life insurance obligations. Supplementary insurance underwritten in addition to life insurance "This type of insurance should be classified as "life insurance obligations" except when it covers accident. For such a case it belongs to "non-life insurance obligations".	Noted Disagree (see revised CP) Disagree (see revised CP)
69.	CRO Forum	3.21.	The examples are welcome. Although its treatment is clear, to avoid confusion we suggest that CEIOPS adds disability income to the examples given. The treatment of accelerated critical illness is appropriate and gives necessary clarification as the chart in 3.32 is open to interpretation. In the Guidance on the classification of specific insurance contracts Workers' Compensation is classified partly in "Annuities related to Workers' Compensation", and partly in "Workers' compensation insurance". "Annuities related to Workers' Compensation" are categorized as health insurance obligations pursued on a similar technical basis to that of life insurance (SLT Health). It is not clear whether "Workers' compensation insurance" is	Noted Noted

			categorized in part (or in total?) as health insurance obligations not pursued on a similar technical basis to that of life insurance (Non-SLT Health). From 3.118, where Workers' Compensation is treated in relation to the Non-SLT Health underwriting risk sub-module, one could conclude that "Workers' compensation insurance" is at least in part seen as Non-SLT Health. In order to avoid arbitrage, it would be preferable to clearly split the risks into risks arising from health insurance obligations not pursued on a similar technical basis to that of life insurance (Non-SLT Health) and risks from health insurance obligations pursued on a similar technical basis to that of life insurance (SLT Health). If risks cannot be unbundled, preference should be given to risks arising from health insurance obligations as belonging to one and the same category: SLT Health. To "Mortgage insurance" could be added "Consumer credit insurance" (payment protection insurance products). Despite the strong effort to give a precise definition of health risks, it's still not obvious how to affect some products to SLT (Similar to life techniques) or non-SLT insurance obligations (eg medical insurance). We would welcome further guidance on the following problematic products for the classification under SLT and non SLT: - Workers compensation and long term care insurance - Critical illness insurance - Accelerated critical illness insurance - Mortgage insurance: Does it mean Creditor Insurance?	Noted (see revised CP) Noted (see revised CP) Noted

			- Accidental Death cover – Individual Protection	
70.	Dutch Actuarial Society – Actuarieel Genootschap (	3.21.	Supplementary insurance underwritten in addition to life insurance (Dutch market: premium compensation in case of disability) are covered by the definition of Health insurance. On the other hand, in paper 27 3.20 they are also covered by the definition of Life insurance. This could lead to discussion. We advise to classify these as Life insurance.	Disagree (see revised CP)
71.	FFSA	3.21.	CEIOPS provides guidance on the classification of potentially problematic products. FFSA would like more guidance for the following products: - Workers compensation and long term care insurance: What is the classification under SLT and non SLT? - Critical illness insurance: CEIOPS proposes it would be classified as Health insurance. FFSA would like CEIOPS to clarify if it will be admitted that, depending on the underlying product (creditor insurance or individual protection) it will be treated either as SLT or as Non SLT? - Accelerated critical illness insurance: We would life CEIOPS to clarify what is exactly the difference between this product, to be classified as Life, and the previous one, to be classified in Health even though critical illness would be a rider to a life or health contract. - Mortgage insurance: Does it mean Creditor Insurance? FFSA would like CEIOPS to clarify this point. Creditor insurance products are not always related to housing financing: a wide range of products corresponds to consumer credit covers. Risk drivers, structure of the guarantees, quotation and reserving technics are the same, only the cover duration	Noted (see revised CP)

			differentiates the products. - Accidental Death cover – Individual Protection: FFSA would like to know how to classify this module. - FFSA would like more guidance on the income maintenance in case of disability insurance for "ordinary sickness". FFSA suggests CEIOPS mentions explicitly the terms "ordinary sickness	
72.			Confidential comment deleted	
73.			Confidential comment deleted	
74.	German Insurance Association – Gesamtverband der D	3.21.	Note – no text in original comment	
75.	Groupe Consultatif	3.21.	Disability risk is covered by life insurance and accident risk by non-life insurance (P&C). '- For "critical illness insurance": Remove "disability". "Guidance on the classification of specific insurance products" - we would suggest that this section be further expanded to better reflect the different nature of risks across the range of healthcare products - one specific point on terminology - Permanent health insurance ("PHI") is not just available in the UK and Ireland. It is just another term referring to disability insurance. It is also referred to as income protection ("IP").	Disagree Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
76.	PKV, (German) Association of Private Health Insure	3.21.	Note – no text in original comment	
77.	Unum Limited	3.21.	Could add a clarification point on which types of contracts fall into Health SLT or non SLT. Supplementary insurance underwritten in addition to life insurance are covered by the definition of Health insurance since the health risk can be unbundled, though is immaterial. However, definition in CP27 3.21 uses the proportionality principle which implies that unbundling is not required and therefore this product would be classified as Life insurance. We would suggest that the most pragmatic approach would be to adjust the classification so that where health obligations are immaterial even if they can be unbundled they should do not need to be covered in the health module.	Noted Noted/Agree (see revised CP)
78.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.22.	Mortgage: From a technical point of view the so called "Restschuldversicherung" which pays in case of medical necessary treatment of an illness is clearly health insurance	Noted (see revised CP on mortgage insurance contracts)
79.	AMICE	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.	Noted (see revised CP on mortgage insurance contracts)
80.	Association	3.22.	Undertakings will be in the best position to classify such products	Disagree

	of British Insurers		based on their underlying risks and after a proper implementation of the proportionality and materiality principles. In UK, where mortgage insurance is more common, it should be possible to classify such covers according to the underlying risks: critical illness, PHI etc. In some cases, creditor insurance provides for the following guarantees: death guarantee, accidental death guarantee, disability/critical illness. Consequently it should be possible to classify the creditor insurance product accordingly: life module for the first two covers, health module for the last one. In some markets, credit insurance is offered in connection with trade credits and insures against default of the debtor. It is usually purchased by companies and not individuals. The insurance pays in case of default: - Independent of the cause of default (subject to any restrictions mentioned in the insurance contract). Therefore, it seems reasonable to assign this to the non-life module. - Dependant on the employment state. Again, non-life module could be used as risk class. In other cases, creditor insurance provides for mixed guaranteed: death and permanent disability, unemployment, hospitalization and critical illness. Following the principles of proportionality and materiality undertaking will be able to classify such products accordingly. Residual debt insurance can refer to both consumer credits and personal loans. - For consumer credit, it usually insures against death,	Noted (see revised CP on mortgage insurance contracts)

			morbidity/disability and possibly unemployment. The mortality component is priced using life methodologies, whereas other components tend to be priced using non-life methodologies (but could also be based on life methodologies). Unbundling of the components should be possible. For personal loans, the insurance covers mostly mortality risk (so that it is actually a term insurance with varying death benefit) and should therefore be assigned to life underwriting risk. However, it is also possible to add morbidity/disability protection etc as for consumer credits.	
81.			Confidential comment deleted	
82.	CEA, ECO-SLV-09-445	3.22.	Undertakings will be in the best position to classify such products based on their underlying risks and after a proper implementation of the proportionality and materiality principles. For the cases where the premiums can't be unbundled between guarantees, we suggest that it is possible to gather the package in the category corresponding to the leading risk of the package. In UK, where mortgage insurance is more common, it should be possible to classify such covers according to the underlying risks: critical illness, PHI etc. In some cases, creditor insurance provides for the following guarantees: death guarantee, accidental death guarantee, disability/critical illness and unemployment. Consequently it should be possible to classify the creditor insurance product accordingly: life module for the first two covers, health module for the last one. However in some cases the premium may not be uniquely split and proportionality and materiality will be important. In some markets, credit insurance is offered in connection with	Disagree Noted Noted (see revised CP on mortgage insurance contracts)

			trade credits and insures against default of the debtor. It's usually purchased by companies and not individuals. The insurance pays in case of default: - Independent of the cause of default (subject to any restrictions mentioned in the insurance contract). Therefore, it seems reasonable to assign this to the non-life module. - Dependant on the employment state. Again, non life module could be used as risk class. In other cases, creditor insurance provides for mixed guaranteed: death and permanent disability, unemployment, hospitalization and critical illness. Following the principles of proportionality and materiality undertaking will be able to classify such products accordingly. Residual debt insurance can refer to both consumer credits and personal loans. - For consumer credit, it usually insures against death, morbidity/disability and possibly unemployment. The mortality component is priced using life methodologies, whereas other components tend to be priced using non-life methodologies (but could also be based on life methodologies). Unbundling of the components should be possible. - For personal loans, the insurance covers mostly mortality risk (so that it is actually a term insurance with varying death benefit) and should therefore be assigned to life underwriting risk. However, it is also possible to add morbidity/disability protection etc as for consumer credits.	

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
83.	CRO Forum	3.22.	Mortgage might be treated similar to income protection, although the risks depend more on macroeconomic parameters than in other health insurance products. Mortgage insurance, respectively Consumer credit insurance, can in most or all cases be unbundled in: Life insurance obligations (term insurance), Health insurance obligations (disability insurance) and Non-Life insurance obligations (unemployment insurance, assistance). Risks should be categorized according to the type of obligations. If risks can't be unbundled, preference is to treat all risks as Life insurance obligations.	Agree (see revised CP on mortgage insurance contracts) Noted
84.	FFSA	3.22.	CEIOPS would appreciate suggestions as to the adequate treatment for mortgage insurance In the case of Mortgage insurance corresponds to Creditor insurance, the following elements could be taken into account: Creditor insurance provides the following guarantees, to be classified in several modules : - Death guarantee in Life module - Accidental death guarantee - Disability, hospitalization, Critical Illness in Health module SLT - Unemployment (to be defined, cf. General Comments) In some contracts or countries, the premiums can't be unbundled between guarantees. We then could gather the package in the category corresponding to the leading risk of the package. This could be the case with	Noted (see revised CP on mortgage insurance contracts)

			- Death and Permanent Disability - Unemployment, hospitalization and critical illness FFSA thinks this kind of insurance should be treated within SCR health underwriting risk. However, it can be difficult to split termination causes for the disabled claimants of these contracts between death and recovery. In such a case, a recovery shock could be applied for the N first years in a disabled state (eg. N=3) and a longevity shock afterwards on populations where it is not possible to differentiate temporarily disabled claimants from permanently disabled claimants.	
85.			Confidential comment deleted	
86.	Munich RE	3.22.	Mortgage might be treated similar to income protection, although the risks depend more on macroeconomic parameters than in other health insurance products.	Agree (see revised CP on mortgage insurance contracts)
87.	PricewaterhouseCoopers LLP	3.22.	We understand "mortgage insurance" to mean insurance to cover mortgage repayments in the event of illness, accident or disability. As such, we consider this to be a form of income protection and thus to fall under the definition of a health insurance obligation (SLT Health).	Noted (see revised CP on mortgage insurance contracts)
88.	Association of British Insurers	3.24.	The classification for immaterial riders seems unnecessarily tight. Our preference would be for immaterial health risks to have the option to bundle or unbundled. Naturally as part of the ORSA the appropriateness of the treatment will need to be justified. Although there may be concerns about perceived "cherry picking" where options exist, in this case the immateriality makes this unlikely. It will be practicalities that drive the choice made.	Agree (see revised CP on scope of the health underwriting risk module)
89.			Confidential comment deleted	

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
90.	Belgian Coordination Group Solvency II (Assuralia/	3.24.	Classification of insurance obligations We would suggest that where obligations can be unbundled, but are not material then unbundling should not be required, to be in line with the general principle of proportionality.	Agree (see revised CP on scope of the health underwriting risk module)
91.	CEA, ECO-SLV-09-445	3.24.	Classification of insurance obligations We would suggest that where obligations can be unbundled, but are not material then unbundling should not be required, to be in line with the general principle of proportionality.	Agree (see revised CP on scope of the health underwriting risk module)
92.	CRO Forum	3.24.	It is unclear why the rider needs to be separated from the base policy as described in this advice. What if health risk IS material but CANNOT be unbundled? This scenario is not included in the summary. It seems reasonable to add this to the second bullet.	Noted (see revised CP on scope of the health underwriting risk module)
93.	FFSA	3.24.	See 3.124	
94.			Confidential comment deleted	
95.	Legal & General Group	3.24.	The classification for immaterial riders seems unnecessarily tight. Our preference would be for immaterial health risks to have the option to bundle or unbundled. Naturally as part of the ORSA the appropriateness of the treatment will need to be justified. Although there may be concerns about perceived "cherry picking" where options exist, in this case the immateriality makes this unlikely. It will be practicalities that drive the choice made.	Noted (see revised CP on scope of the health underwriting risk module)
96.	PricewaterhouseCoopers	3.24.	Further clarification is needed on the criteria that should be used to determine whether the health component of a contract can be	Noted (see revised CP on scope of the health underwriting risk

	LLP		unbundled from other components. In many cases it is not practical to unbundle contracts, as the cash-flows from different components are interdependent. It would be helpful if, where practical and relevant, the requirements for unbundling are aligned with those in IFRS. It would also be useful to consider how to assess the level of materiality of the health risk.	module)
97.	Unum Limited	3.24.	We would suggest that where obligations can be unbundled, but are not material then unbundling should not be required, to be in line with the general principle of proportionality.	Agree (see revised CP on scope of the health underwriting risk module)
98.	PricewaterhouseCoopers LLP	3.25.	Clear guidelines for the appropriate risk classification of material health obligations which cannot be unbundled from life and non-life insurance obligations would be particularly important to avoid cherry-picking.	Noted
99.	CRO Forum	3.26.	"As part of the governance system and the ORSA, the insurance undertaking will be required to justify the appropriateness of the specific treatment" It is not clear how the classification needs to be justified in the ORSA. Classification is part of the standard approach. We think CEIOPS is offering flexibility which will be useful given the very wide range of product variations that exist across Europe and even within each market. Classification is part of the standard approach and firms following rules or guidance from their supervisor should not be burdened with justification. Where there is more than one permitted outcome or the rules/guidance is unclear then firms should be free to choose an appropriate treatment, and where material at entity level to justify it.	Noted Noted

			Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk	CEIOPS-SEC-113-09
100.	AMICE	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. 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).	Noted Noted
101.	CEA, ECO-SLV-09-445	3.27.	Type of cause "accident" should be removed.	Disagree
102.	Belgian Coordination Group Solvency II (Assuralia/	3.29.	Given the social impact of health insurance, it is very important that the risks underlying health contracts are adequately evaluated in the standard capital requirements for insurance undertakings. The techniques used in the Health Insurance industry are very specific and cannot simply be described as "Similar to Life" and "Non similar to life". (also applies to points 3.31 to 3.35) We would like to propose a clear two axis segmentation for Health contracts. The two axis of the segmentation are the length of the engagement from the Insurer's point of view, and the type of insurance cover. Length of the engagement We choose to make a segmentation based on the fact that the insurance contracts allows or not the insurer to put the contract to an end if the risk becomes too high, like it is the case for other non-life products, for example Motor third-party liability. This	Noted Noted

possibility for the insurer is a very efficient way of reducing the risks compared to a similar contract where this opportunity does not exist. We therefore think that this distinction is crucial and should be reflected in the segmentation.

If the Insurance Company has the opportunity to put the contract to an end, the risks related to the contracts are short term risks and will be treated as Short Term Policies. If the Company is not free to remove the risk from her portfolio, the risk has to be kept on the long term and will be treated as Long Term Policies.

Type of insurance cover

We have identified two main Lines of Business for the health insurance based on the type of insurance cover:

- Income insurance: Health insurance obligations compensating or reimbursing losses (e.g. loss of income) caused by illness, accident or disability.
- Medical insurance: Health insurance obligations compensating or reimbursing medical expenses caused by illness, accident or disability.

Proposed segmentation:

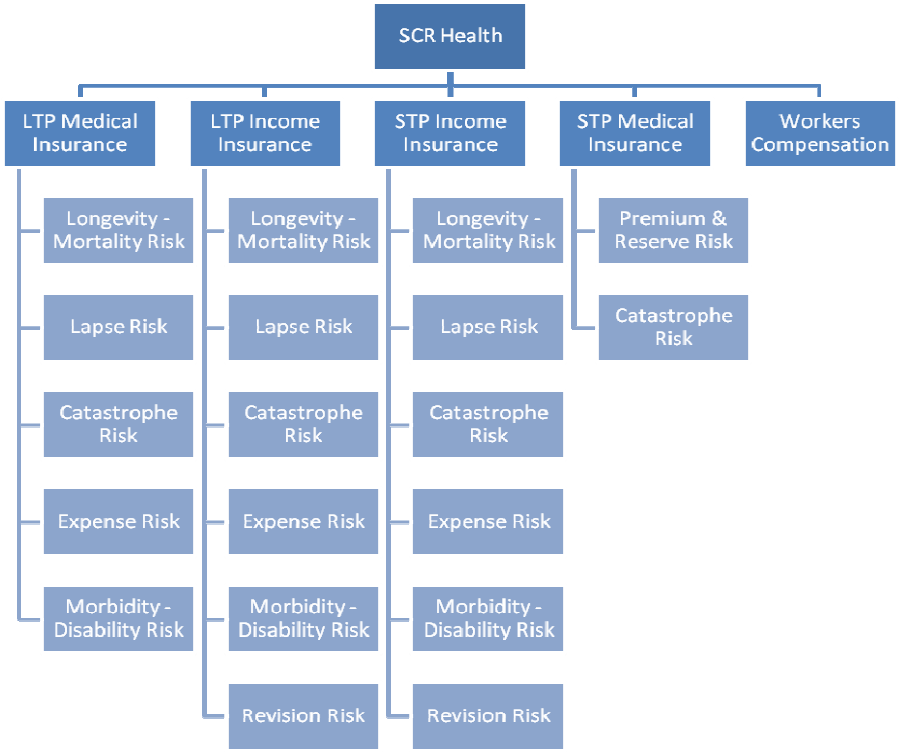
Long Term Policies Medical insurance	Long Term Policies Income insurance
Short Term Policies Medical insurance	Short Term Policies Income insurance

Noted

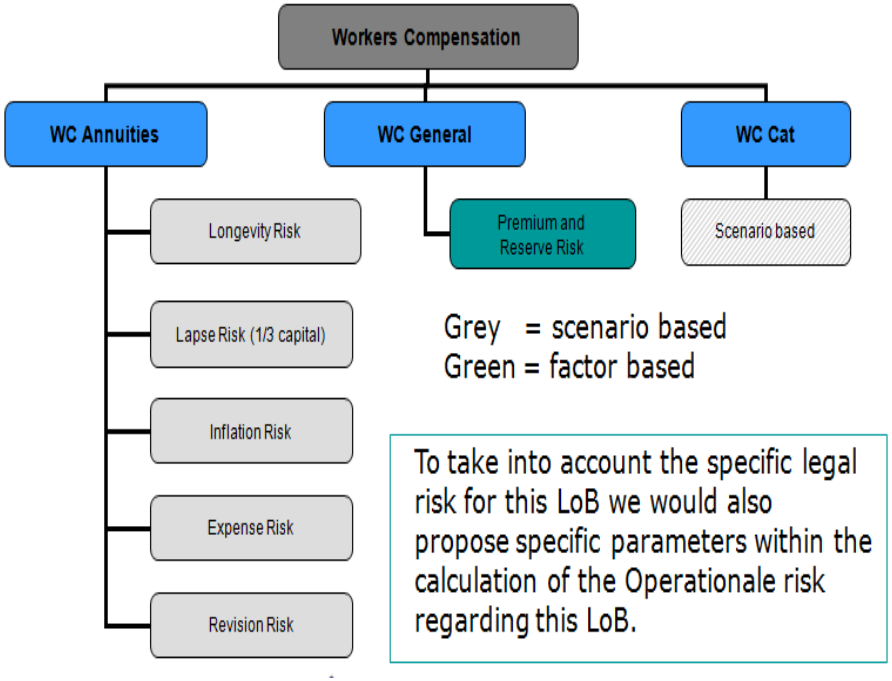
			Workers compensation being a very specific business, it should be treated in a separate module. To reflect this Segmentation, we propose a new structure for the Health Module as described in point 3.35.	
103.	Lloyd's	3.29.	Lloyd's agrees that the health underwriting module should be split into two sub-modules where the calculation is similar to that for either life or non-life insurance.	Noted
104.	Association of British Insurers	3.30.	We agree that it should be up to the firm to decide on the most appropriate sub-classification.	Not clear
105.	Association of British Insurers	3.31.	We believe that the classification of health obligations based on the type of methodology used to value the best estimate is not sufficiently robust. The non-life industry is divided with some insurers adopting purely "non-life techniques" (e.g. triangular projections) for ASU/MPPI business and some adopting more hybrid methods encompassing so-called "life" techniques (e.g. recovery rates and annuities) in combination with triangular projections of claim numbers. We agree that further work needs to be done on "mortgage insurance" and this issue will need to be investigated further.	Noted
106.	Legal & General Group	3.31.	We believe that the classification of health obligations based on the type of methodology used to value the best estimate is not sufficiently robust. The non-life industry is divided with some insurers adopting purely "non-life techniques" (e.g. triangular projections) for ASU/MPPI business and some adopting more hybrid methods encompassing so-called "life" techniques (e.g. recovery rates and annuities) in combination with triangular projections of claim numbers. We agree that further work needs to be done on "mortgage insurance" and this issue will need to be investigated	Noted

			further	
107.	Belgian Coordination Group Solvency II (Assuralia/	3.32.	As mentioned in point 3.21, we think that a rider should always be treated in the same module as the contract it is attached to. So the point in the decision tree asking "Stand alone or easily unbundled or risk materiality" should be replaced by "stand alone or rider?". Stand alone leads to SCR Health and Rider leads to a choice between SCR Life and SCR Non-life depending on the type of contract the rider is attached to. Also, the choice between two sub-modules based on the method used to estimate the BE should be replaced by a choice between the four sub-modules described on point 3.21 based on the Length of the Engagement end the type of insurance cover.	Disagree
108.	CEA, ECO-SLV-09-445	3.32.	We welcome the guidance provided in this paragraph.	Noted
109.	Belgian Coordination Group Solvency II (Assuralia/	3.33.	See point 3.21.	
110.	CEA, ECO-SLV-09-445	3.33.	Note – no text in original comment	
111.	German Insurance Association – Gesamtverb	3.33.	Note – no text in original comment	

	and der D			
112.	PKV, (German) Association of Private Health Insure	3.33.	Note – no text in original comment	
113.	Belgian Coordination Group Solvency II (Assuralia/	3.34.	See point 3.21.	
114.	AMICE	3.35.	Note – no text in original comment	
115.	Belgian Coordination Group Solvency II (Assuralia/	3.35.	Based on the segmentation presented on point 3.21, we propose a new module as follows: (also applies to points 3.36. to 3.46.	Noted



In addition to the health risk classification, we hereafter also propose the following segmentation for workers compensation:



Segmentation:

➔ Category « Annuities »:

All provisions for the guarantees with life characteristics and a long term perspective.

➔ Category « General »:

All provisions for the guarantees with non-life characteristics and a short term perspective.

			Description of the risks in the new proposition – Annuities: 1. Longevity Risk: should captur.e the uncertainty in the mortality rates used for the calculation of the BEL of the annuities. 2. Lapse Risk: should capture the uncertainty in the lapse rates used for the calculation of the BEL of the annuities. This option generates a positive result for the insurer so the risk is a decrease of these lapse rates. 3. Expense Risk: should capture the uncertainty in the expense rates used for the calculation of the BEL of the annuities. 4. Inflation Risk: should capture the uncertainty in the inflation (indexation) rates used for the calculation of the BEL of the annuities. Most annuities are indexed and this inflation risk is one of the major risks for these liabilities. • Diversification with the interest rate risk should be taken into account • We also think an inflation reference should be imposed for the calculation of the BEL of those indexed liabilities, as it is the case for the interest rate. 5. Revision Risk: should capture the uncertainty in the amount of the annual allocation (degree of disability and earnings)	

			used for the calculation of the BEL of the annuities. Description of the risks in the new proposition – General: • Reserve Risk: • We agree with the methodology used in QIS 4 for these kind of liabilities. • We think the parameter (σ) used for the reserve risk is too high . • Premium Risk: • The premium Risk concerns all type of guarantees as mentioned in TS of QIS 4. Description of the risks in the new proposition – Operational risk: Instead of introducing specific sub module within the Workers Compensation module, we would propose specific parameters within the calculation of the Operational Risk for this LoB.	
116.	CEA, ECO-SLV-09-445	3.35.	"Disability" in the sub-module "disability - morbidity risk" should be removed. The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". 16.	Disagree disagree
117.	German Insurance	3.35.	Note – no text in original comment	

	Association – Gesamtverband der D			
118.	PKV, (German) Association of Private Health Insure	3.35.	Note – no text in original comment	
119.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.36.	Why is there no element "$nHealth_{nonSLT}$"?	Noted
120.			Confidential comment deleted	
121.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.38.	The correlation between $Health_{nonSLT}$ and $Health_{SLT}$ in QIS4 was 0, here it is 1. It should be equal to 0 or at least nearer to 0 than to 1 in order to reflect the different kind of doing the underlying business.	Noted
122.	Association of British Insurers	3.38.	The calibration is for illustrative purposes only, but we find the correlation of 1 between the sub-modules too high.	Noted
123.	CEA,	3.38.	The calibration is for illustrative purposes only, but we find the	Noted

	ECO-SLV-09-445		correlation of 1 between the sub-modules too high. In important markets for example Health Non-SLT is mainly travel health insurance while Health SLT mainly covers medical treatment. A correlation of 1 between them would be too high.	
124.	CRO Forum	3.38.	Even though the correlation matrix shown is for illustrative purposes, for completeness, we would like to emphasise that it seems reasonable to expect diversification benefits between Health SLT and Health Non SLT. In Germany for example Health Non SLT is mainly travel health insurance while Health SLT mainly covers medical treatment in Germany.	Noted/Disagree
125.			Confidential comment deleted	
126.	Munich RE	3.38.	The correlation between HealthSLT and HealthNon-SLT has changed from 0 to 1 without a comment. While the risks are certainly correlated 1 seems too high, because usually the type of insurance policies is different. In Germany for example HealthNon-SLT is mainly travel health insurance while HealthSLT mainly covers medical treatment in Germany.	Noted/Disagree
127.	Unum Limited	3.38.	The calibration is for illustrative purposes only, but we find the correlation of 1 between the sub-modules too high.	Noted
128.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.39.	In view of remark 3.36 the $nSCR_{Health}$ should be calculated correspondingly	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
129.	Association of British Insurers	3.39.	The same correlation matrix as in 3.38 should be used for aggregation. It seems unlikely that the gross risks are only partially correlated while the net risks are fully correlated.	Noted
130.	CEA, ECO-SLV-09-445	3.39.	The same correlation matrix as in 3.38 should be used for aggregation. It seems unlikely that the gross risks are only partially correlated while the net risks are fully correlated.	Noted
131.			Confidential comment deleted	
132.	Unum Limited	3.39.	The same correlation matrix as in 3.38 should be used for aggregation. It seems unlikely that the gross risks are only partially correlated while the net risks are fully correlated.	Noted
133.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.41.	It should be considered whether the split into mortality and longevity risk is necessary. The QIS4-split into 3 blocks of underlying risks seemed to us being sufficient.	Disagree
134.	CEA, ECO-SLV-09-445	3.41.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". "Disability" should be removed out of the design, as stated above.	Disagree Disagree
135.			Confidential comment deleted	
136.	ACA –	3.43.	In view of 3.41 the whole correlation matrix should be reviewed. At	Noted (see CP on health

	ASSOCIATION DES COMPAGNIES D'ASSURANCES DU		least the values in the cells of the correlation matrix are surely to be reviewed and their assignment by CEIOPS should be disclosed. The consequences of the different risks in health insurance are different from the ones in life insurance, so the cells and the entries of the matrix should be appropriate to the health business and cannot be taken unchanged from the life scheme.	calibration)
137.	Association of British Insurers	3.43.	We encourage CEIOPS to review this illustrative correlation matrix in the light of the specificities of health business and disclose the methodology and results of their research. For example, correlations are independent of the direction of the stress for disability/morbidity risk (medical insurance) and for lapse risk.	Noted (see CP on health calibration)
138.	Belgian Coordination Group Solvency II (Assuralia/	3.43.	We encourage CEIOPS to review this illustrative correlation matrix in the light of the specificities of health business and disclose the methodology and results of their research. For example, correlations are independent of the direction of the stress for disability/morbidity risk (medical insurance) and for lapse risk.	Noted (see CP on health calibration)
139.	CEA, ECO-SLV-09-445	3.43.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". Unfortunately, no explanation for this correlation matrix is given. The correlation between expense and disability/morbidity as well as lapse seems too high. In particular, as all three risks are considered for increased and decreased rates. Thus this may well be a correlation between decrease in cost and an increase in lapse. In addition, in important markets the costs for claim settling are	Disagree Noted (see CP on health calibration)

			included in the claim expenses thus there is only a more remote connection between expenses for claim settling and the "general expenses". There are other correlations which are difficult to understand in certain increase/decrease combinations. The correlation coefficient between SLT Health expense risk and SLT Health lapse risk seems to be too high. A certain degree of negative correlation should be established between SLT Health morbidity risk and SLT Health lapse risk. In an important market SLT Health insurance premium adjustments have the main influence on the lapse behaviour of policyholders. And premium adjustments are mainly caused by an increase of claims. This means higher medical expenses imply higher lapse rates. But the relevant lapse risk of SLT Health insurance is the decrease of lapse rates. Due to observable distinctions it should be possible to determine correlation coefficients distinguished between lines of businesses. In respect of 3.21 remove "disability".	Noted (see CP on health calibration) Disagree
140.	CRO Forum	3.43.	Even though the correlation matrix shown is for illustrative purposes, for completeness we would like to emphasise that the correlation between expense and disability/morbidity as well as lapse seems too high. In particular, as all three risks are considered for increased and decreased rates. Thus this may well be a positive correlation between decrease in cost and an increase in lapse. In addition, It is not adequate to simply follow the life matrix.	Noted (see CP on health calibration)
141.			Confidential comment deleted	

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
142.	Munich RE	3.43.	Unfortunately, no explanation for this correlation matrix is given. The correlation between expense and disability/morbidity as well as lapse seems too high. In particular, as all three risks are considered for increased and decreased rates. Thus this may well be a correlation between decrease in cost and an increase in lapse. In addition, in Germany the cost for claim settling are included in the claim expenses thus there is only a more remote connection between expenses for claim settling and the "general expenses". There are other correlations which are difficult to understand in certain increase/decrease combinations.	Noted (see CP on health calibration)
143.	Unum Limited	3.43.	We encourage CEIOPS to review this illustrative correlation matrix in the light of the specificities of health business and disclose the methodology and results of their research. For example, correlations are independent of the direction of the stress for disability/morbidity risk (medical insurance) and for lapse risk.	Noted (see CP on health calibration)
144.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.45.	The consequences of the different risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
145.	CEA, ECO-SLV-09-445	3.45.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". In respect of 3.21 remove "disability".	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
146.			Confidential comment deleted	
147.	Munich RE	3.45.	Probably the comments in brackets are switched, see 3.54-	Agree/Noted
148.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.47.	It should be considered whether the split into mortality and longevity risk is necessary.	Noted
149.	Belgian Coordination Group Solvency II (Assuralia/	3.47.	(Also applies to points 3.48. to 3.53.) Mortality & Longevity risks are mutually exclusive events and should be treated in the same sub-module (like it is the case for interest rate risk and lapse risk for example). Two shocks can be applied to the Qx in respect with mortality risk, one up and one down, and one providing the highest capital charge is used for SCR purpose. Regarding the longevity risk, we refer to the progressive shocks as mentioned under CP 49 para 3.39.	Noted
150.			Confidential comment deleted	
151.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.48.	Unlike to life insurance, we cannot figure out that the described effect could be material for health insurance.	Noted
152.	CEA, ECO-SLV-	3.48.	The risk driver "death risk" is typically not relevant for health insurance. The CEA suggest removing the "death risk" or	Noted

	09-445		alternatively asks Ceiops to develop a simplified methodology.	
153.			Confidential comment deleted	
154.	German Insurance Association – Gesamtverband der D	3.48.	Note – no text in original comment	
155.	PKV, (German) Association of Private Health Insure	3.48.	Note – no text in original comment	
156.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.50.	The consequences of the different risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
157.			Confidential comment deleted	
158.	PricewaterhouseCoopers LLP	3.50.	While it is reasonable to use the same approach for calculating the risk charge as for the life underwriting module, it may be appropriate to define separate stress tests for critical illness, income protection and long term care obligations. It would also be useful to consider research from undertakings in several countries to support any stresses adopted. These comments also apply to paragraphs 3.53, 3.80, 3.83 and	Noted

			3.87.	
159.	CEA, ECO-SLV-09-445	3.51.	The risk driver "longevity risk" is typically not relevant for health insurance. The CEA suggest removing the "longevity risk" or alternatively asks Ceiops to develop a simplified methodology. For example, income products often have a certain end age in the contract. Main risk drivers are disability/morbidity and recovery rates.	Noted
160.	PricewaterhouseCoopers LLP	3.53.	See paragraph 3.50	
161.	CEA, ECO-SLV-09-445	3.54.	In respect of 3.21 remove "disability".	Disagree
162.	CEA, ECO-SLV-09-445	3.55.	In respect of 3.21 remove "disability" and "accident".	Disagree
163.	CEA, ECO-SLV-09-445	3.56.	In respect of 3.21 remove "disability". Input information for disability/morbidity risk. Typo - "income" and not "medical".	Disagree
164.	CRO Forum	3.56.	Definition of $nHealth_{income}$: "medical" should be replaced by "income"	Agree
165.	Munich RE	3.56.	Definition of nHealth(income): "medical" should be replaced by "income"	Agree
166.	CEA,	3.57.	In respect of 3.21 remove "disability".	Disagree

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167.	Belgian Coordination Group Solvency II (Assuralia/	3.59.	This risk should be introduced more obviously; it is not clear what exactly is covered by this definition and what isn't. It's also not clear what the connections of this risk are with expense and revision risks, since the calculation is based on claims inflation and changes in claims amount. We understand it as follows: SLT Health Morbidity & Disability risk = the risk of loss, or of adverse change in the value of insurance liabilities, resulting from changes in the level, trend or volatility of the frequency or the initial severity of the claims, due to changes : - In the disability, sickness and morbidity rates; - In the medical inflation. The Morbidity & Disability risk includes the recovery which is the risk of loss, or of adverse change in the value of insurance liabilities resulting from fluctuations in the level, trend, or volatility of the recovery rates where a decrease in the recovery rate (moving from sick or disable to full revalidation) leads to an increase in the value of insurance liabilities.	Noted Agree (see revised CP)
168.	CEA, ECO-SLV-09-445	3.59.	In respect of 3.21 remove "disability". This risk should be introduced more clearly within 3.41 and 3.45. It's also not clear what are the connections of this risk with expense and revision risks, since the calculation is based on claims inflation and changes in claims amount.	Disagree
169.	CRO Forum	3.59.	It seems that a new sub-risk is defined: disability / morbidity risk	Noted/Disagree

			for medical insurance. This is not described in 3.41 and 3.45. See also definition of disability/morbidity risk in article 105 3.b of the level 1 text (page 5 of CP50): " (…) c. The risk of loss, or of adverse change in the level of insurance liabilities, resulting from changes in the level, trend or volatility of disability, sickness and morbidity rates (disability / morbidity risk). (…)" This risk should be introduced more clearly within 3.41 and 3.45. It would be preferable to classify this risk as part of non SLT Health. It would then be part of reserve / underwriting risk.	
170.	PricewaterhouseCoopers LLP	3.59.	We note that paragraph 3.21 specifically provides a separate category for "private medical insurance (as sold in the UK)" and classifies it as non-SLT Health. We query whether this category is a subset of the more general "medical insurance" referred to in this section. Given the explicit non-SLT classification of UK medical insurance, and the apparent non-SLT nature of medical insurance more generally throughout this section, we query whether it is appropriate for it to be included within the calculation of "SLT Health disability/morbidity risk for medical insurance". These comments apply to all paragraphs from 3.59 to 3.74.	Noted
171.	CEA, ECO-SLV-09-445	3.60.	In respect of 3.21 remove "disability".	Disagree
172.	CEA,	3.61.	In respect of 3.21 remove "disability".	Disagree

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173.	CEA, ECO-SLV-09-445	3.62.	In respect of 3.21 remove "disability".	Disagree
174.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.63.	The complex calculation of the technical provision in a scenario model and as a consequence of the NAV gives reason to the use of simplifications (holds also for 3.66)	Noted
175.			Confidential comment deleted	
176.	CEA, ECO-SLV-09-445	3.64.	In respect of 3.21 remove "disability".	Disagree
177.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.65.	By all means the calibration should take into account the specific situation of the respective local market (depending on the underlying social system!) but also the specific situation of the undertaking (age, size of portfolio).	Noted (see CP on the use of undertaking specific parameters)
178.	AMICE	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	Noted/Disagree

			suggest CEIOPS redefine the segmentation and work on an alternative calibration (see our proposal in paragraph 3.209).	
179.	Belgian Coordination Group Solvency II (Assuralia/	3.65.	We agree that the proposed scenario based method is relevant. But more guidance is needed in order to apply the inflation shock appropriately. Question: Should the value resulting from the shock be reduced if the asset-side also is inflation-dependent? Question: Should the value resulting from the shock be reduced if the premium adjustment is inflation dependent? Question: How are we supposed to take into account the future management actions taken in order to react to the shock on the inflation? Question: How should all those impact be taken into account in the calculation of both the SCR and the nSCR? In Belgium, some health insurance premiums adjustments are directly linked to inflation (Law Verwilghen) but it is still possible to make a higher adjustment with the authorization of the regulator. Question: How should those two possibilities be taken into account in the calculation of the SCR? Further, the claim risk depends on the size of the portfolio; undertakings should be able to use specific data.	Noted See CP on the use of undertaking specific parameters
180.	CEA, ECO-SLV-09-445	3.65.	We agree that the proposed scenario based method is relevant. However there should be the possibility to distinguish between lines of businesses and to check whether they are exposed to the risks described. For example daily benefit insurances pay a fixed amount while the insured person is in a defined state. These products are calculated with expected annual medical expenses (German Term:	Noted

			"Kopfschäden") instead of inception rates. These kinds of daily benefit insurances are not subject to claim inflation, but to permanent relative changes of claims. For these contracts a shock factor of 10% is too high. Such a high value could not be deduced from historical data of the German market. We would welcome a distinction between lines of businesses. Further the claim risk depends on the size of the portfolio and the type of benefits; insurance specific data should be used here. An increase of 10% together with 1% inflation seems rather high; in particular, as an increase of 3-4% is already expected and therefore included in the best estimate. A distinctive feature of Austrian health insurance contracts under this regime is the right of the insurer to regularly change (increase) premiums in certain nationally different but legally defined/restricted ways. The proposed scenarios "permanent absolute change of claims inflation" and "permanent relative change of claims" allow (may even require) management actions, i.e. to increase future premiums of existing insurance contracts. As this management action is certainly not instantaneous (because of a permanent stress) it is not subject to CP54 – so HealthSLT and nHealtSLT are identical in this case (except of discretionary profit sharing) However, technical provisions vary considerably, depending on the extent as these management actions which compensate a permanent absolute/relative change of claims are taken into consideration. As the prognosis of future premium increases under stressed scenarios (which would require a recalculation of premiums under 1st order assumptions) is beyond the scope of efficient and reasonable calculability – we propose the following	

			relaxation(explanation) of the scenario (which is currently under test in Austrian QIS 4.5): The national supervisor shall have the ability to specify the duration of the "permanent" stress (e.g. 3 years/5 years). This duration should reflect the timeframe that is normally required given the nationally different premium change regimes until a permanent stress is offset. In respect of 3.21 remove "disability". Finally, should the value resulting from the shock be reduced if the asset-side also is inflation-dependent?	Disagree
181.	CRO Forum	3.65.	The claim risk depends on the size of the portfolio; insurance specific data should be used here. An increase of 10% together with 1% inflation seems arbitrarily prudent. In particular, as an increase of 3-4% is already expected and therefore included in the best estimate.	Noted (see CP on the use of undertaking specific parameters)
182.			Confidential comment deleted	
183.	Munich RE	3.65.	The claim risk depends on the size of the portfolio and the type of benefits; insurance specific data should be used here. An increase of 10% together with 1% inflation seems rather high. In particular, as an increase of 3-4% is already expected and therefore included in the best estimate.	Noted
184.	Unum Limited	3.65.	We agree that the proposed scenario based method is relevant. But more guidance is needed in order to apply the inflation shock appropriately. Should the value resulting from the shock be reduced if the asset-side also is inflation-dependent? Further, the claim risk depends on the size of the portfolio; undertakings should be able to use specific data.	Noted

185.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.66.	The complex calculation of the technical provision in a scenario model and as a consequence of the NAV gives reason to the use of simplifications.	Noted
186.			Confidential comment deleted	
187.	CEA, ECO-SLV-09-445	3.69.	Typo in formula – final row should have SLT, not down as the header for the second Health. This comment is dependent on the definition of gross Health SCR (see CP 54). It may be that for same shock Health and nHealth have opposite signs, in which case the formula needs further refinement. Example: a health contract with premium adjustments and increase in medical expenses. Following CP54 which for gross health does not allow adjustments, we have a negative gross health. However, in nSCR premium adjustments are allowed. Thus after a short period of loss there may be additional profit due to the higher premium which outweighs the loss. For a decrease in medical expenses the situation is reversed. Ceiops may wish to reconsider its definition of gross SCR.	Noted
188.	CRO Forum	3.69.	Depending on the definition of gross Health SCR (see cp 54). It may very well be that for the same shock, Health and nHealth have opposite signs! In this case the formula is inconsistent. Consider for example a health contract with premium adjustments and increase in medical expenses. Following CP54 which for gross health does not allow adjustments, we have a negative gross health. However, in nSCR premium adjustments are allowed. Thus,	Noted

			after a short period of loss there may be additional profit due to the higher premium which outweighs the loss. For a decrease in medical expenses the situation is reversed. CEIOPS may consider to review its definition of gross SCR.	
189.	Munich RE	3.69.	Depending on the definition of gross Health SCR (see cp 54). It may very well be that for same shock Health and nHealth have opposite signs! In this case the formula makes no sense. Consider for example a health contract with premium adjustments and increase in medical expenses. Following cp54 which for gross health does not allow adjustments, we have a negative gross health. However, in nSCR premium adjustments are allowed. Thus after a short period of loss there may be additional profit due to the higher premium which outweighs the loss. For a decrease in medical expenses the situation is reversed. CEIOPS may wish to reconsider its definition of gross SCR.	Noted
190.	CEA, ECO-SLV-09-445	3.70.	In respect of 3.21 remove "disability".	Disagree
191.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.73.	As mentioned in the remark to 3.65 specific data of the local market as well as the undertaking should be used because of the differences in the underlying social system.	Noted (see CP on the use of undertaking specific parameters)
192.	Association of British Insurers	3.73.	Undertaking specific data should be allowed in this risk module.	Noted (see CP on the use of undertaking specific parameters)
193.	Belgian	3.73.	Undertaking specific data should be allowed in this risk module.	Noted (see CP on the use of

	Coordination Group Solvency II (Assuralia/			undertaking specific parameters)
194.	CEA, ECO-SLV-09-445	3.73.	Undertaking specific data should be allowed in this risk module.	Noted (see CP on the use of undertaking specific parameters)
195.	CRO Forum	3.73.	Undertaking specific data should be allowed in this risk module.	Noted (see CP on the use of undertaking specific parameters)
196.			Confidential comment deleted	
197.	Munich RE	3.73.	Undertaking specific data should be allowed in this risk module.	Noted (see CP on the use of undertaking specific parameters)
198.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.74.	The simple doubling of the value of 5% shows how difficult for example the validation and assessment process will be (cf CP45).	Noted
199.	CEA, ECO-SLV-09-445	3.74.	A simple doubling of the shock factor from 5% to 10% seems to be inappropriate.	Noted
200.			Confidential comment deleted	
201.	CEA, ECO-SLV-09-445	3.75.	This risk should be introduced more clearly within 3.41 and 3.45. In respect of 3.21 remove "disability".	Noted Disagree

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
202.	CRO Forum	3.75.	A new sub-risk is defined: disability / morbidity risk for income insurance is defined. It seems more appropriate to have this combined within the SLT Health disability/morbidity risk as introduced in 3.54 If Health insurance obligations arising from medical insurance are categorized as Non-SLT Health (see 3.59) it seems no longer necessary to distinguish SLT Health disability/morbidity risk for income insurance as a separate risk category within "ordinary" SLT Health disability/morbidity risk.	Noted
203.	CEA, ECO-SLV-09-445	3.76.	In respect of 3.21 remove "disability".	Disagree
204.	CRO Forum	3.76.	Definition of nHealth(income): "medical" should be replaced by "income".	Agree
205.	Munich RE	3.76.	Definition of nHealth(income): "medical" should be replaced by "income"	Agree
206.			Confidential comment deleted	
207.	CEA, ECO-SLV-09-445	3.77.	The majority of health insurance contracts covering loss of income cover short term losses of income, for example during the treatment in a hospital. Thus their nature differs from the ones in the life module and should be calibrated differently. In respect of 3.21 remove "disability". For the shock scenarios the Consultation Paper refers to CP49, Life underwriting risk. It is agreed that recovery rates are included for the disability/morbidity risk. The calibration however needs attention as it can be questioned whether the Swedish disability data can be considered representative for the European market.	Noted

			In some markets, insurance contracts compensating loss of income are usually calculated with expected annual medical expenses instead of inception rates. Therefore necessary and appropriate adjustments for health insurance have to be done.	
208.	CRO Forum	3.77.	The majority of health insurance contracts covering loss of income cover short term losses of income, for example during the treatment in a hospital. Thus their nature differs from the ones in the life module and should be calibrated differently. Furthermore, it is not clear how representative the Swedish disability data are for the European market.	Noted
209.	Munich RE	3.77.	The majority of health insurance contracts covering loss of income cover short term losses of income, for example during the treatment in a hospital. Thus their nature differs from the ones in the life module and should be calibrated differently.	Noted
210.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.80.	The consequences of the risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
211.			Confidential comment deleted	
212.	PricewaterhouseCoopers LLP	3.80.	See paragraph 3.50	

213.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.81.	This seems to double count with the disability/morbidity risk for medical expenses.	Disagree
214.	Association of British Insurers	3.81.	We question CEIOPS on how this risk relates to the premium and reserve risk and disability/morbidity risk and if there is double counting of risk capitals consequently.	Noted
215.	Belgian Coordination Group Solvency II (Assuralia/	3.81.	This risk should only be used for income insurance policies.	Disagree
216.	CEA, ECO-SLV-09-445	3.81.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". The risk connected to reopening (or indeed the total difference between reported incurred claims and projected ultimate claims cost) is covered by the IBNR reserve and not the annuity reserve, the IBNR being based on paid to ultimate and/or incurred to ultimate triangles. One therefore cannot use the reopening frequency and severity for annuities as a basis for evaluating the strength of the annuity reserve; the annuity reserve is only meant to cover the structured payments of already settled claims whereas any reopening or re-evaluation of reported claims, as well as unreported claims, is covered already in the IBNR reserve. Therefore we can't see any reason for adding revision risk (i.e. the state of health of the person insured) as this risk is already	Disagree

			reflected in the premium and reserve risk.	
217.	Dutch Actuarial Society – Actuarieel Genootschap (	3.81.	We have some doubts concerning the interpretation of the revision risk. Two points of discussion: - It seems that (uncertain) future inflation of benefits can now be seen as revision risk. It seems curious that two completely different issues (inflation and rehabilitation) are both covered by the same revision risk. - In the Netherlands it is also possible to go from the state fully disabled to partial disabled. On a total level this means that part of the loss due to an adverse change in the state of disability is offset by a gain due to less disability of some of the persons insured. The revision risk is the biggest issue for the Netherlands. The definition is still a bit unclear as we mentioned above. However it do seems to tackle the two issues (inflation of benefits and rehabilitation) that we missed in QIS 4.	Noted
218.			Confidential comment deleted	
219.	CEA, ECO-SLV-09-445	3.82.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk".	Disagree
220.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURAN	3.83.	The consequences of the risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted

	CES DU			
221.	CEA, ECO-SLV-09-445	3.83.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk".	Disagree
222.			Confidential comment deleted	
223.	PricewaterhouseCoopers LLP	3.83.	See paragraph 3.50	
224.	CEA, ECO-SLV-09-445	3.84.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". The annuity reserve doesn't include any inflation risk if you have pay-as-you-go scheme.	Disagree
225.			Confidential comment deleted	
226.	Belgian Coordination Group Solvency II (Assuralia/	3.85.	The lapse risk for disability products may not be material. Therefore to maintain a complex calculation method as proposed in the Life risk CP (CP 49) seems unjustifiable. CEIOPS should verify the extent of this risk and suggest a simpler risk factor method instead.	Noted
227.	CEA, ECO-SLV-09-445	3.85.	The lapse risk for disability products may not be material. Therefore to maintain a complex calculation method as proposed in the Life risk CP (CP 49) seems unjustifiable. Ceiops should verify the extent of this risk and suggest a simpler risk factor method instead.	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
228.	CRO Forum	3.85.	The lapse risk for disability products is not as material as for life products. Therefore to propose a complex calculation method as proposed in the Life risk CP (CP 49) seems to add unnecessary complexity. A simple risk factor method could be used instead.	Noted
229.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.87.	The consequences of the risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
230.	AMICE	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.	Noted
231.	Association of British Insurers	3.87.	We do not agree. Rules in the UK allow lapses to be taken into account when setting reserves, and reserves may be materially sensitive to lapse assumptions.	Noted
232.			Confidential comment deleted	
233.	Belgian Coordination Group Solvency II (Assuralia/	3.87.	In some markets, there are major differences between life and health contracts with regard to the lapse risk. A different calibration from life is therefore needed or undertakings should be allowed to use entity specific data.	Noted
234.	CEA, ECO-SLV-09-445	3.87.	In some markets, there are major differences between life and health contracts with regard to the lapse risk. For example, in Germany everybody must have a health insurance, thus cancelling an insurance contract means getting a new one with	Noted

			another insurance company. Because the policyholders do not have the option of having no insurance at all, the lapse rates will be less volatile. A different calibration from life is therefore needed or undertakings should be allowed to use entity specific data.	
235.	CRO Forum	3.87.	There are major differences between life and health contracts with regard to the lapse risk. For example, there are states where everybody must have health insurance cover, e.g. Germany. Because the policyholder does not have the option of the having no insurance at all, as in life, the lapse rates will be less volatile. A different calibration from life is therefore appropriate.	Noted
236.			Confidential comment deleted	
237.	Munich RE	3.87.	There are major differences between life and health contracts with regard to the lapse risk. For example, in Germany everybody must have a health insurance, thus cancelling an insurance contract means getting a new one with another insurance company. Because the policy holder do not the option of the having no insurance at all, the lapse rates will be less volatile. A different calibration from life is therefore needed (allowing for a market/product specific shock).	Noted
238.	PricewaterhouseCoopers LLP	3.87.	See paragraph 3.50	
239.	AMICE	3.89.	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	Noted/Agree (see revised CP)

			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. AMICE would be interested in contributing to the calibration of the standard catastrophe scenarios such as influenza pandemics for Health and Life insurance business.	
240.	Association of British Insurers	3.89.	It is unclear why the catastrophe risk should follow the non-life module for risks related to SLT Health. Ability of the non-life module to assess the CAT exposure for impact on disability/morbidity inception rates, for instance, is not clear. A different calibration from life is therefore needed.	Noted
241.			Confidential comment deleted	
242.	CRO Forum	3.89.	It is unclear why the catastrophe risk should follow the non-life module for risk related to SLT Health. Ability of the non-life module to assess the CAT exposure for impact on disability/morbidity inception rates, for instance, is not clear. A different calibration from life is therefore appropriate.	Noted
243.	Legal & General Group	3.89.	We note the proposal to pick up all CAT risks in this module through the non-life CAT risk module as outlined in CP 48/09 and will be monitoring developments with interest, especially in relation to SLT-Health products.	Noted
244.			Confidential comment deleted	
245.	CEA, ECO-SLV-09-445	3.91.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that Ceiops will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore the possibility to use own scenarios in the standard	Noted Disagree

			model should be provided too.	
246.	CRO Forum	3.91.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it should always be taken into account that entities know what their CAT risk is, since they also have reinsurance contracts custom made for the CAT risk they encounter. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted Disagree
247.	PricewaterhouseCoopers LLP	3.91.	Including the catastrophe risk sub-module in the health sub-module and applying the same methodologies as the non-life catastrophe risk module (rather than in the life CAT sub module, applying life CAT stresses) seems a more appropriate treatment.	Noted/Disagree (see revised CP)
248.	Legal & General Group	3.94.	The various drivers for non-SLT Health underwriting risk follow the Non-life underwriting risk module in CP48 (this applies to 3.94 - 3.122)	Noted
249.	CEA, ECO-SLV-09-445	3.95.	Compared to the other correlation matrices there is a non-zero calibration between Cat risk and another risk. The CEA asks Ceiops to disclose the reasons for this calibration.	Noted
250.	Legal & General Group	3.95.	As per 3.94	
251.	Munich RE	3.95.	Compared to the other correlation matrices there is a non-zero calibration between Cat risk and another risk. Why here?	Noted
252.			Confidential comment deleted	
253.	CEA,	3.96.	In The Netherlands, the Dutch basic health insurance has certain	Noted (see revised CP)

	ECO-SLV-09-445		specific features. In its current form the equalisation system consists of two stages. The first, ex ante, stage results in payments from insurers with a relatively healthy population to insurers with less healthy customers. The second balancing stage leads to ex post (partial) payments from insurers with relatively good stochastic results in a given year to insurers with less favourable outcomes. It is self-evident that this equalisation system results in a substantial smoothing of the results of an individual insurer. In other words, the underwriting risk of Dutch health insurers is less volatile and consequently its business can be considered less risky. A system based on historical data (i.e. results after equalisation) automatically makes the volatility reduction due to equalisation visible and, if insurers have sufficient historical loss data, the Solvency II requirements will automatically produce an appropriate, risk based outcome. Without sufficient available data, however, insurers will be required to fall back on the prescribed parameters of the standard formula. These parameters do not take into account the risk mitigating effect of equalisation schemes. Because the equalisation system has been operational since 1 January 2006, there is insufficient data available to use undertaking-specific data. The cover for the basic health insurance is changing time and again with sometimes a significant distorting effect on historical data. Therefore it is envisaged that undertaking-specific data probably will be unavailable in the future as well.	
254.	Legal & General Group	3.96.	As per 3.94	

255.	Legal & General Group	3.97.	As per 3.94	
256.	Legal & General Group	3.98.	As per 3.94	
257.	Legal & General Group	3.99.	As per 3.94	
258.	CEA, ECO-SLV-09-445	3.100.	It is not clear whether "new premiums" consider existing contracts only.	Noted
259.	CRO Forum	3.100.	"New premiums may be written at inadequate rates". This is not clear. With 'new premiums' are only the future premiums of existing contracts meant?	Noted
260.	Legal & General Group	3.100.	As per 3.94	
261.	Legal & General Group	3.101.	As per 3.94	
262.	Legal & General Group	3.102.	As per 3.94	
263.	PricewaterhouseCoopers LLP	3.102.	Given the acknowledgement that expense risk can be quite material for some lines of business, we query whether it is appropriate to make an implicit, rather than explicit, allowance for it.	Noted

264.	Legal & General Group	3.103.	As per 3.94	
265.	Legal & General Group	3.104.	As per 3.94	
266.	Legal & General Group	3.105.	As per 3.94	
267.	Lloyd's	3.105.	This paragraph appears to suggest that PCO and C are not provided by the participant, but there is no further comment made as to where these would come from. Clarification is required on this point.	Agree (see revised CP)
268.	Legal & General Group	3.106.	As per 3.94	
269.	Legal & General Group	3.107.	As per 3.94	
270.	Legal & General Group	3.108.	As per 3.94	
271.	Legal & General Group	3.109.	As per 3.94	
272.	Legal & General Group	3.110.	As per 3.94	

273.	Dutch Actuarial Society – Actuarieel Genootschap (	3.111.	This approach seems rather crude: more prudent rates seem to be punished. In our view the formula should be based on $P^{t,earned}$ in all cases: last year's written premium is not driving current year's premium volume and if the written premium is higher than the earned premium there is an increased unexpired risk, This unexpired risk is captured in C^{PP}, so taking the maximum over the written premium would double count this risk. We also like to stress that for the Dutch Short Term Health insurance business the coverage can change from year to year, which makes it sometimes impossible to use P^{t-1} as a Volume Measure for this year's premium risk.	Noted
274.	Legal & General Group	3.111.	As per 3.94	
275.	Dutch Actuarial Society – Actuarieel Genootschap (	3.112.	See also 3.27. How can an insurer commit to its regulator that its actual premiums will not exceed its estimated volumes? We suggest to eliminate this article.	Noted
276.	Legal & General Group	3.112.	As per 3.94	
277.	Legal & General Group	3.113.	As per 3.94	
278.	Legal & General Group	3.114.	As per 3.94	

279.	Legal & General Group	3.115.	As per 3.94	
280.	Legal & General Group	3.116.	As per 3.94	
281.	Legal & General Group	3.117.	As per 3.94	
282.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.118.	Workers compensation is going immaterial in our local market. We would therefore opt for only 1 LOB.	Noted
283.	AMICE	3.118.	See our comments to paragraph 3.209	Noted
284.	Association of British Insurers	3.118.	We would prefer segmentation where workers compensation is a LoB on its own and where sickness and accident are put together.	Noted
285.	Belgian Coordination Group Solvency II (Assuralia/	3.118.	- We prefer the segmentation with three different LoB (Sickness, Accident and Workers Compensation). - The provided sigma's should depend on the size of the reserves and be country-specific.	Noted
286.	Bupa	3.118.	Option 3 is necessary. The volatility and "tails" of these classes are totally different, especially so when policy benefits are based on when the treatment is received, rather than when an episode of	Noted

			sickness first started. Combining accident, sickness, and workers compensation and then parameterising them as one would lead to policyholders being exposed to under-capitalised higher risk undertakings whose SCRs have been subsidised by those who write more sickness business.	
287.	CEA, ECO-SLV-09-445	3.118.	Following the proposals above to remove accident and workers compensation out of the health module, the line of business still to be treated under this module would be medical treatment/illness. Critical illness due to disability and workers compensation should have their own calibration under the life or non life modules. For medical treatment/illness, depending on the size of the portfolio, it should be possible to derive company specific standard deviations. These should be net of reinsurance.	Noted
288.	CRO Forum	3.118.	Segmentation is key We believe the health risk module is very specific for most EU countries and hence an appropriate segmentation where all country specific products "fit" is of significant importance. National guidance will be essential for insurers to understand how to classify/segment their health portfolios. Making a distinction by "technical basis" allows insurers to model the Health risk either using Life techniques or Non-Life techniques, which makes sense. It is however, important that the large number of different products can be segmented appropriately. As a result, we believe that option 3 (in 3.118) is the most appropriate option as it allows for health products pursued on a non-life technical basis, to be segmented by 3 different sub-classes. Potentially even more sub-classes should be	Noted

			"built in" the standard formula, given the wide variety of Health products which may exist within one country. We believe that Level 3 guidance should clarify the number of sub-classes required within the health risk module, given the diversity of the products across the EU. By "building in" more sub-classes in the standard formula, makes the formula more flexible.	
289.			Confidential comment deleted	
290.	Legal & General Group	3.118.	As per 3.94	Noted
291.	Lloyd's	3.118.	We believe that option 1 – a single line of business to cover all Non-SLT health insurance obligations – is preferable. It is common for business to be categorised as Accident & Health and it would be difficult to segment this down to accident and sickness separately. The parameters suggested for this class seem reasonable. Lloyd's does not believe it is necessary to have a separate Workers Compensation line of business because this cover is incorporated within the legal classifications of non-life insurance classes 1 (accident) and 2 (sickness).	Noted
292.	Munich RE	3.118.	Depending on the size of the portfolio it should be possible to derive company specific standard deviations. These should be net of reinsurance.	Noted
293.	PricewaterhouseCoopers LLP	3.118.	In respect of the calibration of the standard deviations for reserve and premium risks, segmentation of health insurance obligations into three lines of business will capture differing experiences at a product level and may be more appropriate. However, we note that this may present practical difficulties as not all firms will maintain their data split to the appropriate level.	Noted

294.			Confidential comment deleted	
295.	Legal & General Group	3.119.	As per 3.94	
296.	Legal & General Group	3.120.	As per 3.94	
297.	Legal & General Group	3.121.	As per 3.94	
298.	Belgian Coordination Group Solvency II (Assuralia/	3.122.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore, the possibility to use own scenarios in the standard model should be provided too.	Noted Disagree (see CP on the use of undertaking specific parameters)
299.	CEA, ECO-SLV-09-445	3.122.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that Ceiops will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted Disagree (see CP on the use of undertaking specific parameters)
300.	CRO Forum	3.122.	This article refers to the Non Life Underwriting risk module (CP 48).	Noted

			This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it should always be taken into account that entities know what their CAT risk is, since they also have reinsurance contracts custom made for the CAT risk they encounter. Therefore the possibility to use own scenarios in the standard model should be provided too.	Disagree (see CP on the use of undertaking specific parameters)
301.	Legal & General Group	3.122.	As per 3.94	
302.			Confidential comment deleted	
303.	CEA, ECO-SLV-09-445	3.123.	The CEA encourages Ceiops to develop the use of undertaking specific parameters.	Noted (see CP on the use of undertaking specific parameters)
304.	CRO Forum	3.123.	Undertaking specific parameters should be introduced CEIOPS will study at a later stage whether undertaking specific parameters (USP) will be introduced in the Health underwriting risk module. We believe that this is of significant importance for Health insurers to be able to use USP's, especially given the specific nature of Health insurance products. In addition, the Directive (Article 104 paragraph 7) allows for USP.	Noted (see CP on the use of undertaking specific parameters)
305.	Dutch Actuarial Society – Actuarieel Genootschap (	3.123.	Like in the comments on CP 48, Non-Life underwriting risk, we would welcome the use of company specific parameters. We want to stress that this year the Dutch supervisor studied the parameters for CAT risk for the Dutch Short Term Health business in the so-called Dutch RiSK study. We advise to bring the CAT risk parameter for the Dutch market in line with this study.	Noted (see CP on the use of undertaking specific parameters)

306.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.124.	This definition illustrates one more time the problem of the long term care risk. It should be included in the health module as indicated in the list of insurance products (3.21)	
307.	AMICE	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.	Noted
308.	Association of British Insurers	3.124.	See also comments to 3.18.	Noted
309.			Confidential comment deleted	
310.	CEA, ECO-SLV-09-445	3.124.	The CEA proposes: - To stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" cover. It's then up to the business of the company whether accident is part of non life insurance or part of health. - The following definition for health insurance: Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses caused by medical treatment (medical insurance), providing services (medical assistance), or supplementary insurance underwritten in addition to medical insurance.	Noted Disagree

| | | | The above definition seems flexible enough for all European markets to have a separation of the three different branches (non life, Health, Life) with respect to their business written and the principle "substance over form".
Further, for supplementary health insurance guarantee (a rider) underwritten in addition to non-health insurance contracts:
- If the health risk is material then the health insurance obligations are covered in the health underwriting risk module;
- If the health risk is not material, then:
o where Health insurance obligations are underwritten in addition to Non-life insurance obligations, Health insurance obligations are covered in the Non-Life underwriting risk module;
o where Health insurance obligations are underwritten in addition to Life insurance obligations, Health insurance obligations are covered in the Life underwriting risk module. | Noted (see revised CP on 3.35) |
| | | | Health insurance typically covers medical costs and wage losses due to illness, but it's indifferent to causes of the medical treatment/illness (e.g. disability, accident). So neither disability nor accident risk is covered by health insurance.
Disability risk is covered by life insurance and accident risk by non-life insurance (P&C).
The references to "accident" and "disability" should be removed. | Disagree
Disagree
Disagree |

311.	CRO Forum	3.124.	We make the same comment on Segmentation as for P&C: Segmentation is currently risk-oriented and not product-oriented, which may be disconnected with the way companies monitor their business (bundled contracts).	Noted (Solvency II is risk oriented)
312.	FFSA	3.124.	CEIOPS proposes in 3.24 that riders are unbundled if they are material OR if they can be unbundled. FFSA suggests the following change of wording: "For supplementary health insurance guarantee (a rider) underwritten in addition to non-health insurance contracts: - if the health risk is material then the health insurance obligations are covered in the health underwriting risk module; - if the health risk is not material, then: o where Health insurance obligations are underwritten in addition to Non-life insurance obligations, Health insurance obligations are covered in the Non-Life underwriting risk module; o where Health insurance obligations are underwritten in addition to Life insurance obligations, Health	Noted Noted (see revised CP on 3.35)

			insurance obligations are covered in the Life underwriting risk module."	
313.			Confidential comment deleted	
314.	German Insurance Association – Gesamtverband der D	3.124.	The GDV proposes - To stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" cover. - The following definition for health insurance: "Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or by short or long term care (medical insurance) or by providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance." The definition of health insurance is either possible via the event covered or the causing factor. CEIOPS seems to take favour of differentiating by the causing factors. We would suggest a definition via the covered event which seems to fit better to the complex health insurance market. The above definition seems flexible enough for all European markets to have a separation of the three different branches (Non Life, Health, Life) with respect to their business written and the principle "substance over form". Disability risk should be covered by life insurance, and accident risk should be covered by non-life insurance.	Noted Disagree Noted Disagree
315.	GROUPAMA	3.124.	CEIOPS' Advice doesn't explain how to classify Health insurance obligations as well as the paragraph 3.24. does.	Noted

			We suggest to complete the CEIOPS' Advice with the classification detailed in the paragraph 3.24.	
316.	Groupe Consultatif	3.124.	Definition of healthcare - the current wording of the definition would not pick up certain healthcare products in the UK; for example, hospital cash plans, long-term care (when support services are offered) and critical illness which pays a lump sum benefit upon contracting one of a list of critical illnesses.	Noted
317.	PKV, (German) Association of Private Health Insure	3.124.	The PKV proposes - To stick to point A of the Annex I of framework directive which clearly distinguishing between "Accident" and "Sickness" cover. - The following definition for health insurance: "Health insurance could be understood as a generic term applying to all types of insurance indemnifying or reimbursing losses or expenses caused by medical treatment or by short or long term care (medical insurance) or by providing services (medical assistance) or supplementary insurance underwritten in addition to medical insurance." The definition of health insurance is either possible via the event covered or the causing factor. CEIOPS seems to take favour of differentiating by the causing factors. We would suggest a definition via the covered event which seems to fit better to the complex health insurance market. The above definition seems flexible enough for all European markets to have a separation of the three different branches (Non Life, Health, Life) with respect to their business written and the principle "substance over form". Disability risk should be covered by life insurance, and accident risk	Noted Disagree Noted

			should be covered by non-life insurance.	
318.	Unum Limited	3.124.	Certain insurances are not covered by this definition – e.g. Critical Illness which pays a lump sum on illness As in the comment to paragraph 3.24, we would suggest that where obligations can be unbundled, but are not material then unbundling should not be required, to be in line with the general principle of proportionality.	Noted Agree (see revised CP on 3.36)
319.	AMICE	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	Noted
320.			Confidential comment deleted	
321.	CEA, ECO-SLV-09-445	3.126.	The CEA is ready to further work with Ceiops on fully clarifying the split of underwriting risks between SLT Health and non SLT Health. Uncertainties still relate to the items like medical expenses, long term care insurance, which could be considered as SLT when calculating in France a "Provision Pour Risques Croissants " (it is a similar reserve to mathematical reserves for long term care insurance in France), and others. Since the calibration has never been tested on these products, the CEA advises Ceiops to test the impact during QIS 5.	Noted
322.	CRO Forum	3.126.	CEIOPS requires splitting Health risks into 2 categories (SLT and non-SLT modeling), which is globally welcomed by the CRO Forum	Noted

			members. However the calibration has never been tested on these products, and we would suggest to test the impact during QIS 5. In addition, we need more guidance to determine whether a risk is SLT or non-SLT, as already expressed in §3.21	
323.	FFSA	3.126.	CEIOPS requires splitting Health risks into 2 categories (SLT and non-SLT modeling). FFSA thinks the approach of splitting between SLT and Non SLT is interesting. However the calibration has never been tested on these products. FFSA advises to test the impact during QIS 5. Moreover FFSA notices there is no precise guidance to determine whether a risk is SLT or non-SLT, for instance: - Medical expenses could be modeled by both (and for both UW risks and CAT risks. Eg. Pandemic). - Long term care insurance could be considered as SLT when calculating a "provisions pour risques croissants" (Reserve similar to mathematical reserves for Long term care insurance in France) - In France, shall the undertakings distinguish temporary disability ("Incapacité") from definitive disability ("Invalidité"), like it is today?	Noted
324.	GROUPAMA	3.126.	CEIOPS suggests to split Health underwriting risks into 2 categories: SLT Health & Non-SLT Health. We think it could be useful to precise that "Health insurance obligations pursued on a similar technical basis to that of life insurance (SLT Health)" deal only with muti-year contracts.	Noted
325.	Groupe	3.126.	Despite scepticism as to whether a separate health module is	Noted

	Consultatif		needed, we support the split of underwriting risks within the module as between SLT health and non SLT health and feel that it is much clearer.	
326.	AMICE	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.	Noted
327.	Association of British Insurers	3.127.	It seems helpful to review the risk drivers/correlation matrix to assess whether these categories are relevant to health business. It may be also useful to ask CEIOPS to provide a list of common products (like the one under 3.21) to illustrate the inherent risk of specific product features, which they intend for the insurance company to consider.	Noted
328.	CEA, ECO-SLV-09-445	3.127.	Segmentation into modules could be difficult to carry out. We suggest Ceiops establishing tables by products per country at Level 3. We note it might not be easy to differentiate the termination cause for disabled claimants between recovery and death. So, when not possible, a recovery shock may be applied to temporarily disabled claimants and a longevity shock to permanently disabled claimants (according to the proportionality principles). We think an allowance for the risk absorbing effect of the technical provisions should be made in the Non SLT Health sub-module where profit sharing applies. "Disability" in the risk driver "disability - morbidity risk" should be removed. The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk" In respect of 3.21 remove "disability".	Noted Noted (See CP on non-life underwriting risk) Disagree Disagree Disagree

			In respect of 3.21 remove "accident".	
329.	FFSA	3.127.	Segmentation into modules could be difficult to carry out. FFSA suggests CEIOPS establishing tables by products per country at Level 3. FFSA notes it might not be easy to differentiate the termination cause for disabled claimants between recovery and death. So, when not possible, a recovery shock may be applied to temporarily disabled claimants and a longevity shock to permanently disabled claimants (according to the proportionality principles). FFSA thinks an allowance for the risk absorbing effect of the technical provisions should be made in the Non SLT Health sub-module where profit sharing applies.	Noted Noted (See CP on non-life underwriting risk)
330.	GROUPAMA	3.127.	Segmentation into modules could be difficult to carry out. We suggest that CEIOPS establish tables by products per country at Level 3.	Noted
331.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.128.	Why is there no element "$nHealth_{nonSLT}$"?	Noted (see CP on non-life underwriting risk)
332.			Confidential comment deleted	
333.	CEA, ECO-SLV-09-445	3.128.	Ceiops allows the possibility of calculating the impact of loss absorbing capacity of technical provisions. We agree with the principles, notwithstanding the definition of this loss absorbing capacity provided in a specific consultation paper.	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
334.	FFSA	3.128.	CEIOPS allows the possibility of calculating the impact of loss absorbing capacity of technical provisions. FFSA agrees with the principles, notwithstanding the definition of this loss absorbing capacity provided in a specific consultation paper.	Noted
335.			Confidential comment deleted	
336.	Unum Limited	3.128.	Loss absorbing capacity of technical provisions – does this cover reviewable premiums – where premiums can be varies during the term of the contract and management decisions would be part of the assessment	Noted (see CP on non-life underwriting risk)
337.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.130.	The correlation between $Health_{nonSLT}$ and $Health_{SLT}$ in QIS4 was 0, here it is 1. It should be equal to 0 or at least nearer to 0 than to 1 in order to reflect the different kind of doing the underlying business.	Noted
338.	AMICE	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.	Noted
339.	Association of British Insurers	3.130.	The calibration is for illustrative purposes only, but we find the correlation of 1 between the sub-modules too high. For example, the correlation between Long Term Care and Private	Noted

			Medical is not 1.	
340.			Confidential comment deleted	
341.	CEA, ECO-SLV-09-445	3.130.	The calibration is for illustrative purposes only, but we find the correlation of 1 between the sub-modules too high. For example, the correlation between Long Term Care and Private Medical is not 1.	Noted
342.	CRO Forum	3.130.	Even though the correlation matrix shown is for illustrative purposes, for completeness, we would like to emphasise that it seems reasonable to expect diversification benefits between Health SLT and Health Non SLT and that. In Germany for example Health Non SLT is mainly travel health insurance while Health SLT mainly covers medical treatment in Germany.	Noted
343.			Confidential comment deleted	
344.	Unum Limited	3.130.	The calibration is for illustrative purposes only, but we find the correlation of 1 between the sub-modules too high. For example, the correlation between Long Term Care and Private Medical is not 1.	Noted
345.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.131.	In view of remark 3.128 the $nSCR_{Health}$ should be calculated correspondingly.	Noted (see CP on non-life underwriting risk)
346.	AMICE	3.131.	CEIOPS provides the following formula for the capital charge for $nSCR_{Health}$: $nSCR_{Health} = nHealth_{SLT} + Health_{NonSLT}$ In our opinion the capital charge for SLT Health and Non-SLT	Noted

			Health should be aggregated using a correlation matrix.	
347.	Association of British Insurers	3.131.	The capital charge (including loss absorbing) is calculated as the sum of the capital charge of the two categories – It is not clear why is the correlation matrix approach not applied, as for the pre loss absorbing capacity SCR result?	Noted
348.	CEA, ECO-SLV-09-445	3.131.	The capital charge (including loss absorbing) is calculated as the sum of the capital charge of the two categories – It is not clear why is the correlation matrix approach not applied, as for the pre loss absorbing capacity SCR result?	Noted
349.	FFSA	3.131.	CEIOPS does not take into account a possible diversification via a correlation matrix between Health SLT including loss absorbing capacity and Health non SLT. FFSA wonders why the capital charge for nSCRHealth is not calculated using a correlation matrix.	Noted
350.			Confidential comment deleted	
351.	GROUPAMA	3.131.	CEIOPS gives the following formula for the capital charge for $nSCR_{Health}$: $nSCR_{Health} = nHealth_{SLT} + Health_{NonSLT}$ We wonder why the capital charge for $nSCR_{Health}$ is not calculated using a correlation matrix.	Noted
352.	Unum Limited	3.131.	The capital charge (including loss absorbing) is calculated as the sum of the capital charge of the two categories – It is not clear why is the correlation matrix approach not applied, as for the pre loss absorbing capacity SCR result?	Noted
353.	ACA – ASSOCIATION DES COMPAGNIES	3.133.	It should be considered whether the split into mortality and longevity risk is necessary. The QIS4-split into 3 blocks of underlying risks seemed to us being sufficient.	Disagree

	D'ASSURANCES DU			
354.	CEA, ECO-SLV-09-445	3.133.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk" In respect of 3.21 remove "disability".	Disagree Disagree
355.			Confidential comment deleted	
356.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.135.	In view of 3.133 the whole correlation matrix should be reviewed. At least the values in the cells of the correlation matrix are surely to be reviewed and their assignment by CEIOPS should be disclosed. The consequences of the different risks in health insurance are different from the ones in life insurance, so the cells and the entries of the matrix should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
357.	AMICE	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"	Noted
358.	Association of British Insurers	3.135.	It would be helpful to review the risk drivers/correlation matrix to assess whether these categories are relevant to health business.	Noted
359.	CEA, ECO-SLV-09-445	3.135.	The calibration should not be the same as the one used for Life underwriting risk module, because the risk nature in Health insurance differs from the one in Life insurance.	Noted

			The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". In respect of 3.21 remove "disability". We encourage Ceiops to review this illustrative correlation matrix in the light of the specificities of health business and disclose the methodology and the results of their research.	Disagree Disagree Noted
360.	CRO Forum	3.135.	If the correlation matrix of Life underwriting risk should apply eventually, why is this correlation matrix then not reported? Or is it, and is that matrix yet to be calibrated? The calibration is for illustrative purposes only, although most factors seem too low. Even though the correlation matrix shown is for illustrative purposes, for completeness we would like to emphasise that the correlation between expense and disability/morbidity as well as lapse seems too high. In particular, as all three risks are considered for increased and decreased rates. Thus this may well be a positive correlation between decrease in cost and an increase in lapse. It is not adequate to simply follow the life matrix.	Noted Noted Noted Noted
361.			Confidential comment deleted	
362.	Groupe Consultatif	3.135.	Correlation matrix - we would suggest that the healthcare correlation matrix will not necessarily be the same as the life one. We do however realise that the correlation matrices provided in the	Noted

			paper are for illustration only. We support the fact that more work needs to be done on this issue.	
363.	Unum Limited	3.135.	Is this correlation matrix just an example – you would not necessarily expect it to be the same as for Life module	Noted
364.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.137.	The consequences of the different risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
365.	Association of British Insurers	3.137.	The status of critical illness under the disability/morbidity module (income insurance) is not clear.	Noted
366.			Confidential comment deleted	
367.	CEA, ECO-SLV-09-445	3.137.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". In respect of 3.21 remove "disability".	disagree
368.			Confidential comment deleted	
369.	Groupe Consultatif	3.137.	Under the 3rd bullet point, "SLT Health Disability-morbidity risk (only income insurance)", we would suggest that this be changed to "SLT Health Disability-morbidity risk (income and lump sum insurance)" to allow for critical illness in the UK market (as noted above under 3.124).	Noted
370.	Unum Limited	3.137.	It is not clear what is the status of critical illness under the disability/morbidity module (income insurance).	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
371.	Association of British Insurers	3.138.	Loss absorbing capacity of technical provisions Is any allowance made for premium adjustments in the stress scenarios? In general, allowance should be made for premium adjustment mechanisms, which are mandatory in some markets with some management discretion. Proper consideration should be given on the time lap until premiums can actually be adjusted in practice (based on regulatory and legal requirements). We would suggest that further clarification of allowance for premium adjustment should be considered. As detailed in CP49, the revaluation should allow for any relevant adverse changes in option take-up behaviour of policyholders (in particular lapse and reduction of coverage); this could be clarified here again.	Noted (see CP on non-life underwriting risk) Noted
372.	CEA, ECO-SLV-09-445	3.138.	Loss absorbing capacity of technical provisions It should be made clear that the loss absorbing capacity of technical provisions is related to instantaneous actions that are at the discretion of management (such as the declaration of a different amount of profit sharing in a single stress scenario). Regular (or legally required) management action (such as premium increase within legal boundaries in e.g. Austrian or German Health insurance under a permanent stress) needs to be captured in both SCR and nSCR.	Noted (see CP on non-life underwriting risk)
373.	Unum Limited	3.138.	Loss absorbing capacity of technical provisions	Noted

			Is any allowance made for premium adjustments in the stress scenarios? In general, allowance should be made for premium adjustment mechanisms, which are mandatory in some markets with some management discretion. Proper consideration should be given on the time lap until premiums can actually be adjusted in practice (based on regulatory and legal requirements). We would suggest that further clarification of allowance for premium adjustment should be considered. As detailed in CP49, the revaluation should allow for any relevant adverse changes in option take-up behaviour of policyholders (in particular lapse and reduction of coverage); this could be clarified here again.	(see CP on non-life underwriting risk)
374.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.139.	It should be considered whether the split into mortality and longevity risk is necessary.	Noted
375.			Confidential comment deleted	
376.			Confidential comment deleted	
377.	Groupe Consultatif	3.139.	SLT health mortality risk - we have assumed that these are "healthy deaths", ie death from a healthy status. Can you please confirm.	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
378.	Unum Limited	3.139.	Is Health mortality in relation to deaths of policyholders prior to becoming a claim, where there is a claim payment on death – i.e. an accelerated payment on death?	Noted
379.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.140.	Unlike to life insurance, we cannot figure out that the described effect could be material for health insurance.	Noted
380.	CEA, ECO-SLV-09-445	3.140.	The risk driver "death risk" is typically not relevant for health insurance. The CEA suggest removing the "death risk" or alternatively asks Ceiops to develop a simplified methodology.	Noted
381.			Confidential comment deleted	
382.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.142.	The consequences of the different risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
383.	AMICE	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 trend base table and trend stress is the most appropriate method.	Noted

384.	Association of British Insurers	3.142.	We agree that for most of the risks under SLT health module, the methodologies from Life UW module can be used.	Noted
385.	CEA, ECO-SLV-09-445	3.142.	For the CEA comments to the life methodologies please see CEA answer paper to CP49.	Noted
386.	FFSA	3.142.	CEIOPS is referring to life SCR underwriting risk for the calculation of SLT health risks (except for disability/morbidity risk). FFSA agrees with the principles, notwithstanding the definition of these calculations provided in a specific consultation paper.	Noted
387.			Confidential comment deleted	
388.	Unum Limited	3.142.	We agree that for most of the risks under SLT health module, the methodologies from Life UW module can be used.	Noted
389.			Confidential comment deleted	
390.	CEA, ECO-SLV-09-445	3.143.	The risk driver "longevity risk" is typically not relevant for health insurance. The CEA suggest removing the "longevity risk" or alternatively asks Ceiops to develop a simplified methodology. For example, income products often have a certain end age in the contract. Main risk drivers are disability and recovery rates.	Disagree
391.	Unum Limited	3.143.	Is health longevity risk the risk for currently Health claimants of ceasing from all causes rather than just ceasing from death?	Noted
392.	Association of British Insurers	3.145.	It should be emphasised that SLT Health longevity risk specifically applies to mortality only since the recovery risk (for PHI and LTC) is now covered under SLT Health Disability-morbidity risk. Also it	Noted

			should be clarified whether mortality and recovery together should both be covered in the disability stress for PHI and LTC. One could question the rate of 25% to be too high today for longevity risk charge. The rate is based on historical improvements in mortality rates over 15 years from 1992 to 2006 and more moderate improvements might be supposed during the next years.	
393.	CEA, ECO-SLV-09-445	3.145.	One could question the rate of 25% to be too high today for longevity risk charge. The rate is based on historical improvements in mortality rates over 15 years from 1992 to 2006 and more moderate improvements might be supposed during the next years.	Noted
394.	FFSA	3.145.	See 3.142	
395.	Unum Limited	3.145.	It should be emphasised that SLT Health longevity risk specifically applies to mortality only since the recovery risk (for PHI and LTC) is now covered under SLT Health Disability-morbidity risk. Also it should be clarified whether mortality and recovery together should both be covered in the disability stress for PHI and LTC. One could question the rate of 25% to be too high today for longevity risk charge. The rate is based on historical improvements in mortality rates over 15 years from 1992 to 2006 and more moderate improvements might be supposed during the next years.	Noted
396.	AMICE	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.	Noted (see revised CP on 3.159)
397.	Association	3.146.	SLT Health disability/morbidity risk	Noted

	of British Insurers		In some markets, when a insured person is in disability state, at claim reserve level the following distinction exists between the short term disability from the long term disability reserve: - The latter is composed by the product of probability of passing from short-term to long term and is a sum of probabilised annuities - A person with 3 years of short term disability is automatically switched to long term disability This mechanism implies that the real risk driver of this risk is not a major inception rate in short term disability but a major probability rate to switch from short-term to long term (in the latter state there are two causes of exit: death or pension). The definition of disability risk should be extended to include this risk. So the standard formula should include for the disability risk: - A major inception rate for short term disability, this applies for insured person which are in a healthy state - A major inception rate from short term to long term disability, this applies for insured persons which are in a short term disability state	
398.	CEA, ECO-SLV-09-445	3.146.	In respect of 3.21 remove "disability". SLT Health disability/morbidity risk In some markets, when a insured person is in disability state, at claim reserve level the following distinction exists between the short term disability from the long term disability reserve:	Disagree Noted

			- The latter is composed by the product of probability of passing from short-term to long term and is a sum of probabilistic annuities. - A person with 3 years of short term disability is automatically switched to long term disability. In this structure the real risk driver of increased long term disability is reflected not by a major change in the inception rate in short term disability but a major change in the probability rate to switch from short-term to long term (in the latter state there are two causes of exit : death or pension). The definition of disability risk should be extended to clearly deal with such a structure. So in addition to the existing inception/termination model the standard formula should include for the disability risk: - A major inception rate for short term disability, this applies for insured person which are in a healthy state. - A major inception rate from short term to long term disability, this applies for insured persons which are in a short term disability state. This section and those that follow are specified in terms of medical and Income. Neither appears to allow for critical illness. In addition to specifying how this should be treated Ceiops will need to consider that it will exhibit different 'correlations' and is a source of diversification effects.	
399.	CEA, ECO-SLV-09-445	3.147.	In respect of 3.21 remove "disability". In respect of 3.21 remove "accident".	Disagree Disagree
400.	CEA,	3.148.	In respect of 3.21 remove "disability".	Disagree

	ECO-SLV-09-445		There is a typo in last row of table - should refer to "income" not "medical".	Agree
401.	CRO Forum	3.148.	Definition of $nHealth_{income}$: "medical" should be replaced by "income".	Agree
402.	CEA, ECO-SLV-09-445	3.149.	In respect of 3.21 remove "disability".	Disagree
403.	AMICE	3.150.	AMICE members believe that the correlation between medical and income disability /morbidity risk should eventually not be fixed to 1.	Noted
404.	Association of British Insurers	3.150.	Capital charge of SLT Health disability/morbidity risk Correlation seems too high. It seems overly prudent to assume full correlation between income insurance and medical insurance regarding disability/morbidity risk. Furthermore, correlations with other risks may differ between income insurance and medical insurance (e.g. higher correlation with expense risk for medical insurance compared to income insurance; also for lapse risk, higher correlation may be observed for medical insurance (e.g. due to premium adjustment mechanism)).	Noted
405.	CEA, ECO-SLV-09-445	3.150.	In respect of 3.21 remove "disability". Capital charge of SLT Health disability/morbidity risk Correlation seems too high. It seems overly prudent to assume full correlation between income insurance and medical insurance regarding disability/morbidity risk.	Disagree Noted

			Furthermore, correlations with other risks may differ between income insurance and medical insurance (e.g. higher correlation with expense risk for medical insurance compared to income insurance; also for lapse risk, higher correlation may be observed for medical insurance (e.g. due to premium adjustment mechanism)).	
406.	Unum Limited	3.150.	Furthermore, correlations with other risks may differ between income insurance and medical insurance (e.g. higher correlation with expense risk for medical insurance compared to income insurance; also for lapse risk, higher correlation may be observed for medical insurance (e.g. due to premium adjustment mechanism)).	Noted
407.	Association of British Insurers	3.151.	This risk should be introduced more clearly within 3.41 and 3.45. It's also not clear what are the connections of this risk with expense and revision risks, since the calculation is based on claims inflation and changes in claims amount.	Noted
408.	CEA, ECO-SLV-09-445	3.151.	In respect of 3.21 remove "disability". This risk should be introduced more clearly within 3.41 and 3.45. It's also not clear what are the connections of this risk with expense and revision risks, since the calculation is based on claims inflation and changes in claims amount.	Disagree Noted
409.	CRO Forum	3.151.	It seems that a new sub-risk is defined: disability / morbidity risk for medical insurance. This is not described in 3.41 and 3.45. See also definition of disability/morbidity risk in article 105 3.b of the level 1 text (page 5 of CP50):	Noted

			" (…) c. The risk of loss, or of adverse change in the level of insurance liabilities, resulting from changes in the level, trend or volatility of disability, sickness and morbidity rates (disability / morbidity risk). (…)" This risk should be introduced more clearly within 3.41 and 3.45. It would be preferable to classify this risk as part of non SLT Health. It would then be part of reserve / underwriting risk.	
410.	CEA, ECO-SLV-09-445	3.153.	In respect of 3.21 remove "disability".	Disagree
411.	CEA, ECO-SLV-09-445	3.154.	In respect of 3.21 remove "disability".	Disagree
412.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.155.	The complex calculation of the technical provision in a scenario model and as a consequence of the NAV gives reason to the use of simplifications (holds also for 3.158)	Noted
413.			Confidential comment deleted	
414.	CEA, ECO-SLV-09-445	3.156.	In respect of 3.21 remove "disability".	Disagree

415.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.157.	By all means the calibration should take into account the specific situation of the respective local market (depending on the underlying social system!) but also the specific situation of the undertaking (age, size of portfolio).	Disagree/Noted (see revised CP on 3.17)
416.	AMICE	3.157.	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. AMICE members believe that consistency with the valuation approach for technical provisions will need to be considered.	Noted
417.	Association of British Insurers	3.157.	We agree that the proposed scenario based method is relevant. But more guidance is needed in order to apply the inflation shock appropriately. Should the value resulting from the shock be reduced if the asset-side also is inflation-dependent? Further, the claim risk depends on the size of the portfolio; undertakings should be able to use specific data. A clear distinction is necessary between the claims cost (medical expenses reimbursed to policyholders) and servicing costs (internal expenses of the insurance company). Both are exposed to inflation (medical inflation vs. general price/salary inflation, which are correlated). In the expense risk stress, the claims cost should remain unchanged. Similarly, servicing costs should remain unchanged in the disability/morbidity risk stress. This would avoid double counting. Some clarification in the CP seems advisable (3.160 and	

			3.170). In both cases, the impact on policyholder behaviour should be taken into account. E.g., if medical inflation is much higher than salary inflation in the disability/morbidity stress, then the resulting premium adjustments may not be bearable by the ph and the ph may decrease coverage to partially make up the difference (for example, by increasing deductibles).	
418.	CEA, ECO-SLV-09-445	3.157.	In respect of 3.21 remove "disability". We agree that the proposed scenario based method is relevant. However there should be the possibility to distinguish between lines of businesses and to check whether they are exposed to the risks described. For example daily benefit insurances pay a fixed amount while the insured person is in a defined state. These products are calculated with expected annual medical expenses (German term: "Kopfschäden") instead of inception rates. These kinds of daily benefit insurances are not subject to claim inflation, but to permanent relative changes of claims. For these contracts a shock factor of 10% is too high. Such a high value could not be deduced from historical data of the German market. We would welcome a distinction between lines of businesses. Further, the claim risk depends on the size of the portfolio; undertakings should be able to use specific data. An increase of 10% together with 1% inflation seems rather high; in particular, as an increase of 3-4% is already expected and therefore included in the best estimate. A clear distinction is necessary between the claims cost (medical expenses reimbursed to policyholders) and servicing costs (internal expenses of the insurance company). Both are exposed to inflation	Disagree Noted

			(medical inflation vs. general price/salary inflation, which are correlated). In the expense risk stress, the claims cost should remain unchanged. Similarly, servicing costs should remain unchanged in the disability/morbidity risk stress. This would avoid double-counting. Some clarification in the CP seems advisable (3.160 and 3.170). In both cases, the impact on policyholder behaviour should be taken into account. E.g., if medical inflation is much higher than salary inflation in the disability/morbidity stress, then the resulting premium adjustments may not be bearable by the ph and the ph may decrease coverage to partially make up the difference (for example, by increasing deductibles). In Austria the private health insurance is dominated by the inpatient treatment additional to public (compulsory) health insurance (supplementary/additional cover). This has the effect that most of the basic costs of inpatient treatment is paid by public health insurance. Furthermore the Austrian health insurance companies (under lead of the Austrian Insurance Association) negotiate prizes and conditions with the care providers (doctors and hospitals). Therefore the stress of permanent relative change of claims should be reduced to 3 years and to 5% for the Austrian situation. Finally should the value resulting from the shock be reduced if the asset-side also is inflation-dependent?	
419.	CRO Forum	3.157.	The claim risk depends on the size of the portfolio; insurance specific data should be used here. An increase of 10% together with 1% inflation seems arbitrarily prudent. In particular, as an increase of 3-4% is already expected and therefore included in the best estimate.	Disagree

420.			Confidential comment deleted	
421.	German Insurance Association – Gesamtverband der D	3.157.	Note – no text in original comment	
422.	PKV, (German) Association of Private Health Insure	3.157.	Note – no text in original comment	
423.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.158.	The complex calculation of the technical provision in a scenario model and as a consequence of the NAV gives reason to the use of simplifications.	Noted
424.			Confidential comment deleted	
425.	CEA, ECO-SLV-09-445	3.161.	Typo in formula – final row should have SLT, not down as the header for the second Health. It may be that for same shock Health and nHealth have opposite signs, in which case the formula needs further refinement. Example: a health contract with premium adjustments and increase in medical expenses. Following CP54 which for gross health does	Noted

			not allow adjustments, we have a negative gross health. However, in nSCR premium adjustments are allowed. Thus after a short period of loss there may be additional profit due to the higher premium which outweighs the loss. For a decrease in medical expenses the situation is reversed.	
426.	CRO Forum	3.161.	Depending on the definition of gross Health SCR (see cp 54). It may very well be that for the same shock, Health and nHealth have opposite signs! In this case the formula makes no sense. Consider for example a health contract with premium adjustments and increase in medical expenses. Following cp54 which for gross health does not allow adjustments, we have a negative gross health. However, in nSCR premium adjustments are allowed. Thus, after a short period of loss there may be additional profit due to the higher premium which outweighs the loss. For a decrease in medical expenses the situation is reversed. CEIOPS may wish to reconsider its definition of gross SCR.	Noted
427.	CEA, ECO-SLV-09-445	3.162.	In respect of 3.21 remove "disability".	Disagree
428.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.165.	As mentioned in the remark to 3.65 specific data of the local market as well as the undertaking should be used because of the differences in the underlying social system.	Disagree (see revised CP on 3.18 on CP on the use of undertaking specific parameters)
429.			Confidential comment deleted	
430.	CEA,	3.165.	The calibration should be verified against a larger European basis.	Disagree (see CP on the use of

	ECO-SLV-09-445		Alternatively undertaking specific data should be allowed in this risk module.	undertaking specific parameters)
431.	CRO Forum	3.165.	Undertaking specific data should be allowed in this risk module.	Disagree (see CP on the use of undertaking specific parameters)
432.			Confidential comment deleted	
433.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.166.	The simple doubling of the value of 5% shows how difficult for example the validation and assessment process will be (cf CP45).	Noted
434.			Confidential comment deleted	
435.	CEA, ECO-SLV-09-445	3.166.	Doubling the calibration of the risk to allow for other risks (e.g. model risk, risk of change, random error) is rather crude and inappropriate. The CEA disagrees with this proposal due to the fact that Ceiops based the calibration of this risk on the German health insurance undertakings. We think that this calibration may not apply to over the whole European industry, and that this calibration should be refined based on a larger basis.	Noted
436.	CRO Forum	3.166.	CEIOPS based the calibration of this risk only on the German health insurance undertakings. We believe that this calibration should be refined based on a larger basis. CEIOPS is doubling the calibration of the risk to allow for other risks (e.g. model risk, risk of change, random error), only based on the observations of the German market, and calibration factors should	Noted

			be based on a sounder basis.	
437.	FFSA	3.166.	CEIOPS based the calibration of this risk on the German health insurance undertakings. (see 3.173) FFSA thinks that this calibration may not apply to all the European industry, and that this calibration should be refined based on a larger basis. CEIOPS is doubling the calibration of the risk to allow for other risks (e.g. model risk, risk of change, random error). FFSA strictly disagrees with CEIOPS calibration of other risks. Indeed this calibration results from observations of the German market. Also CEIOPS did not provide any rational explanation for the capital charge of 5% of these other risks FFSA thinks that it should be based on a sounder basis.	Noted
438.			Confidential comment deleted	
439.	CEA, ECO-SLV-09-445	3.167.	In respect of 3.21 remove "disability". This risk should be introduced more clearly within 3.41 and 3.45.	Disagree Noted
440.	CRO Forum	3.167.	A new sub-risk is defined: disability / morbidity risk for income insurance is defined. It seems more appropriate to have this combined within the SLT Health disability/morbidity risk as introduced in 3.54 If Health insurance obligations arising from medical insurance are categorized as Non-SLT Health (see 3.59) it seems no longer necessary to distinguish SLT Health disability/morbidity risk for income insurance as a separate risk category within "ordinary" SLT Health disability/morbidity risk.	Noted

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
441.	CEA, ECO-SLV-09-445	3.168.	In respect of 3.21 remove "disability". Since in Austria the private health insurance has only few contracts providing "full cover" (as an alternative to public health insurance) most high risks are covered by the public health insurance. The stress scenarios and risk factors should reflect the different risk exposure caused by different market and legal conditions between Austria and other countries where private health insurance has a higher relative degree of "full cover" insurance (like e.g. Germany).	Disagree Noted
442.	CRO Forum	3.168.	Definition of nHealth(income): "medical" should be replaced by "income".	Agree
443.	AMICE	3.169.	CEIOPS proposes the calculation of SLT Health disability/morbidity risk for income insurance to be computed as defined in the "Life disability-morbidity risk". 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.	Noted
444.			Confidential comment deleted	
445.	Belgian Coordination Group Solvency II (Assuralia/	3.169.	Note – no text in original comment	
446.	CEA, ECO-SLV-	3.169.	In respect of 3.21 remove "disability". The CEA commented previously in QIS4 feedback that the disability	Disagree

	09-445		risk stress of an increase of 35% in year one and 25% for all subsequent years applied in QIS4 was deemed to be too high by many of its members. The disability stress has now increased to an increase of 50% in year one and a 25% for all subsequent years. This increase in the level of stress seems to have been largely based on research carried out by the Swedish FSA but this does not provide a sound justification for the increase in the stress (and is not entirely in line with the research carried out by the UK Actuarial Profession Healthcare Reserving Working Party). The fact that the stress could be absorbed by the insurer's capacity to modify premiums should be taken into account in the calculation of SLT Health disability/morbidity risk for income insurance too, as for medical expenses. The CEA has the view that the stress is too high. We believe that it may be more appropriate to define separate stress tests for critical illness, income protection and long term care obligations. Also insurance contracts compensating loss of income are usually calculated with expected annual medical expenses (Germen term: "Kopfschäden") instead of inception rates. Therefore necessary and appropriate adjustments for health insurance have to be done.	Noted
447.	CRO Forum	3.169.	The majority of health insurance contracts covering loss of income cover short term losses of income, for example during the treatment in a hospital. Thus their nature differs from the ones in the life module and should be calibrated differently. Furthermore, it is not clear how representative the Swedish disability data are for the European market.	Noted

448.	FFSA	3.169.	CEIOPS proposes that the calculation of SLT Health disability/morbidity risk for income insurance is computed as set in Life disability-morbidity risk. The Life disability-morbidity risk doesn't take into account the fact that the shock could be absorbed by the insurer's capacity to increase premiums as the paragraph 3.158 describes for the calculation of Health disability/morbidity risk for medical insurance. ☐ The fact that the shock could be absorbed by the insurer's capacity to modify premiums might be taken into account in the calculation of SLT Health disability/morbidity risk for income insurance too.	Noted
449.	GROUPAMA	3.169.	CEIOPS proposes that the calculation of SLT Health disability/morbidity risk for income insurance is computed as set in Life disability-morbidity risk. The Life disability-morbidity risk doesn't take into account the fact that the shock could be absorbed by the insurer's capacity to increase premiums as the paragraph 3.158 describes for the calculation of Health disability/morbidity risk for medical insurance. We think the fact that the shock could be absorbed by the insurer's capacity to modify premiums should be taken into account in the calculation of SLT Health disability/morbidity risk for income insurance too.	
450.	Groupe Consultatif	3.169.	Calibration of the mortality-disability stress: - the Institute of Actuaries' paper on "Healthcare Reserving" is referred to in this section. It is important to note that the survey results presented in this paper are based on input from very early on in the FSA's ICA regime. The figures for the stress tests were companies' initial views on the level for these tests and they have more than likely refined these	Noted

			views over time. - stress test on recoveries - the 20% appears reasonable. We are assuming that this covers recoveries and deaths from a disabled status. Can you please confirm. - we would suggest that it would be more appropriate to have different stress tests by product line (eg critical illness, income protection, long-term care) to reflect the different nature of the underlying risks involved. - the level of these stress tests also needs to be considered in conjunction with the work being carried out by the newly formed CEIOPS Catastrophe Task Force to ensure there is no double counting.	
451.	Investment & Life Assurance Group (ILAG)	3.169.	We are particularly concerned about the onerousness of this test. We have estimated that this test has the effect of doubling the present value of claims in the SCR scenario compared to the "best estimate" in the technical provisions, and we fear that such a high capital requirement will result in large increases in costs to consumers and leaves insurers faced with the prospect of raising significant additional capital.	Noted
452.	Unum Limited	3.169.	QIS4 feedback was that the disability risk stress of an increase of 35% in year one and 25% for all subsequent years applied in QIS4 was deemed to be too high. The disability stress has now increased to an increase of 50% in year one and a 25% for all subsequent years. This increase in the level of stress seems to have been largely based on research carried out by the Swedish FSA but this does not provide a sound justification for the increase in the stress (and is not entirely in line with the research carried out by the UK Actuarial Profession Healthcare Reserving Working Party).	Noted

			The fact that the shock could be absorbed by the insurer's capacity to modify premiums might be taken into account in the calculation of SLT Health disability/morbidity risk for income insurance too, as for medical expenses. As such it is still our view that this stress is too high for income protection products. We believe that it may be more appropriate to define separate stress tests for critical illness, income protection and long term care obligations. Does the stress test on recoveries relate to relate to all types of recvoereis from a disabled status – including recovery from death?	
453.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.170.	The consequences of the risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
454.			Confidential comment deleted	
455.	CRO Forum	3.170.	The lapse risk for disability products is not material. Therefore to maintain a complex calculation method as proposed in the Life risk CP (CP 49) seems unjustifiable. A simple risk factor method could be used here to reflect the lapse risk.	Disagree/Noted
456.			Confidential comment deleted	

457.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.171.	This seems to double count with the disability/morbidity risk for medical expenses.	Noted/Disagree
458.			Confidential comment deleted	
459.			Confidential comment deleted	
460.	CRO Forum	3.172.	There are major differences between life and health contracts with regard to the lapse risk. For example, there are states where everybody must have health insurance cover, e.g. Germany. Because the policyholder does not have the option of the having no insurance at all, as in life, the lapse rates will be less volatile. A different calibration from life is therefore needed.	Noted
461.	FFSA	3.172.	See 3.142	
462.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.173.	The consequences of the risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	Noted
463.	Association of British Insurers	3.173.	Note – no text in original comment	
464.			Confidential comment deleted	
465.	Belgian	3.173.	The calibration of the SLT Health disability/morbidity risk for	Noted

	Coordination Group Solvency II (Assuralia/		medical insurance was based on the German health insurance undertakings. This calibration may not apply to all the European industry because claims volatility depends also on the national health care system. Therefore, the use of specific data (country data) should be allowed.	Noted
466.	CEA, ECO-SLV-09-445	3.173.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk". SLT Health Revision risk The CEA is uncertain about Ceiops' view as to what is meant to be covered by revision risk. How does this risk relate to the premium and reserve risk and disability/morbidity risk? Is there double counting of risk capitals consequently? The change of legislation (notably the push back of the age retirement) is a great risk for worker's compensation in Europe. We encourage Ceiops to consider this risk in the development of the specifics of workers compensation under the life (for death and disability) and non life modules (for accident), respectively. It seems that (uncertain) future inflation of benefits can now be seen as revision risk. Is this correct? Linked to this issue, we attract attention to the fact that the annuity reserve doesn't include any inflation risk if you have a pay-as-you-	Disagree Noted

			go system. The risk connected to reopening (or indeed the total difference between reported incurred claims and projected ultimate claims cost) is covered by the IBNR reserve and not the annuity reserve, the IBNR being based on paid to ultimate and/or incurred to ultimate triangles. One therefore cannot use the reopening frequency and severity for annuities as a basis for evaluating the strength of the annuity reserve; the annuity reserve is only meant to cover the structured payments of already settled claims whereas any reopening or re-evaluation of reported claims, as well as unreported claims, is covered already in the IBNR reserve. Therefore we can't see any reason for adding revision risk (i.e. the state of health of the person insured) as this risk is already reflected in the premium and reserve risk. The increase in disability degree in the Netherlands is seen as negative rehabilitation. This way the rehabilitation rates (that were not covered until now) seem to be covered by the revision risk. But is the possibility of less (positive) rehabilitation than expected also covered by the revision risk definition? It seems curious that two completely different issues (inflation and rehabilitation) are both covered by the same revision risk. We recommend that such rehabilitation issues which are part of the normal claim assessment process are included in the disability/morbidity risk.	

Summary of Comments on CEIOPS-CP-50/09 Consultation Paper on the Draft L2 Advice on SCR Standard Formula - Health underwriting risk				CEIOPS-SEC-113-09
467.	CRO Forum	3.173.	Critical illness does not fit under the description 'disability/morbidity module (income insurance)' nor does it appear to be covered elsewhere. Note: we believe different calibrations are appropriate for CI and disability income.	Noted
468.	FFSA	3.173.	See 3.166	
469.			Confidential comment deleted	
470.	Unum Limited	3.173.	What is meant to be covered by revision risk?	Noted
471.	CEA, ECO-SLV-09-445	3.174.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk".	Disagree
472.	CEA, ECO-SLV-09-445	3.175.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk".	Disagree
473.	FFSA	3.175.	See 3.142	
474.	CEA, ECO-SLV-09-445	3.176.	The risk driver "revision risk" is typically not relevant for health insurance or it is handled in connection to other risks. The CEA suggest removing the "revision risk".	Disagree
475.			Confidential comment deleted	
476.	CEA, ECO-SLV-09-445	3.177.	The lapse risk for disability products may not be material. Therefore to maintain a complex calculation method as proposed in the Life risk CP (CP 49) seems unjustifiable. Ceiops should verify the extent	Noted

			of this risk and suggest a simpler risk factor method instead.	
477.	CRO Forum	3.177.	The lapse risk for disability products is not as material as for life products. Therefore to propose a complex calculation method as proposed in the Life risk CP (CP 49) seems to add unnecessary complexity. A simple risk factor method could be used instead.	Disagree
478.	Investment & Life Assurance Group (ILAG)	3.177.	This paragraph sets out the particular policyholder options that should be considered in the SCR lapse risk module are lapse, termination, renewal and surrender. However, the advice then goes on to state that the SCR lapse risk module should be calculated in the same way as for the life SCR lapse risk module. The Life SCR lapse risk module states that all policyholder options should be taken into account, and gives as examples options to increase or decrease cover. Many of these options can be applied equally well to a health insurance policy as to a life insurance policy. There is therefore an apparent conflict here between the advice in this paragraph to consider only lapse, termination, renewal and surrender, and the advice given later to follow the same process as for life SCR lapse risk, which would involve considering all policyholder options.	Noted
479.	Unum Limited	3.178.	The lapse risk for disability products may not be material. Therefore to maintain a complex calculation method as proposed in the Life risk CP (CP 49) seems unjustifiable. CEIOPS should verify the extent of this risk and suggest a simpler risk factor method instead.	Noted
480.	ACA – ASSOCIATIO	3.179.	The consequences of the risks in health insurance are different from the ones in life insurance, so the risks end the calculation of the	Noted

	N DES COMPAGNIES D'ASSURANCES DU		corresponding capital charge should be appropriate to the health business and cannot be taken unchanged from the life scheme.	
481.	Association of British Insurers	3.179.	In some markets, there are major differences between life and health contracts with regard to the lapse risk. A different calibration from life is therefore needed or undertakings should be allowed to use entity specific data.	Noted
482.	CEA, ECO-SLV-09-445	3.179.	In some markets, there are major differences between life and health contracts with regard to the lapse risk. A different calibration from life is therefore needed or undertakings should be allowed to use entity specific data.	Noted
483.	FFSA	3.179.	See 3.142	
484.			Confidential comment deleted	
485.	Investment & Life Assurance Group (ILAG)	3.179.	Assuming that the intention of the advice given in this paragraph is that all policyholder options (not just those stated in paragraph 3.177) should be considered in the Health SCR lapse risk component (as is the case for the Life SCR lapse risk module), we consider that the following comments are relevant: We are concerned at the resulting complexity of the calculation if the SCR lapse risk module is intended to cover the impact of every conceivable policyholder action. In addition to the conventional options of surrender and termination, we must consider all policyholder options explicitly stated in the contract (e.g. renewability, convertibility, exercise of a guaranteed annuity option) and other options suggested in CP 49 including increase or decrease in cover.	Noted Noted

			One of the most difficult aspects of implementing this module will be the how to assess the rates of take-up of each of the options available to the policyholder at each time period. In addition to rates of take-up assessed independently for each option, an assessment of the correlations between take-up rates of each option will be required, and variation in take-up of other options following the take-up of a particular option will also need to be assessed (for example, following an increase in cover, lapse experience is likely to be quite different than for an equivalent policy of the same duration that has not converted to paid-up status). Furthermore, for options such as increase or decrease in cover, the amount of increase or decrease will be another variable to be estimated or parameterised. A further concern regarding the setting of assumptions is the concept that any change in lapse rates (or rates of take-up of any policyholder action) can be broken down into a component that is "organic" and a component that is in response to changes in other economic or demographic variables will greatly increase the complexity of setting assumptions for the rates of take-up of each policyholder action. For example, if using historical data to derive an assumption for lapse rates to be used in the SCR lapse risk module, it will be necessary to strip out the effects that changes in other demographic or economic circumstances brought to bear on lapse rates over the period for which you are analysing the data. We are doubtful that the effects of the "non-organic" components of changes in lapse rates could be stripped out in a credible manner, and thus the "organic" component of the lapse rate cannot be properly assessed. We consider that only a stochastic calculation could possibly take	

			into account all possible policyholder actions and their probability of occurrence in each future time period. We assert that a model of such complexity is beyond the resources of all but the largest insurers, and we question whether this is CEIOPS's intention. We are also concerned that the requirement to assess the direction of the strain for each possible policyholder option for each contract in each time period adds an extra dimension of computational difficulty to the calculate.	
486.	OAC Actuaries and Consultants	3.179.	We consider that the calculation recommended for lapse risk in CP 49 is unnecessarily complicated. We do not consider it necessary to make allowance for risks, other than the normal lapse stress, since any attempt to do so makes the calculation unnecessarily complicated, and the differences are unlikely to be material. For any firm where this is a material risk the actuary should make an appropriate allowance as part of the normal prudent reserving process.	Noted
487.	AMICE	3.181.	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.	Noted
488.	Association of British Insurers	3.181.	Inclusion of morbidity catastrophe stress in the health underwriting module We support the inclusion of the Health CAT risk in the health sub-	Noted

			module (rather than in the Life CAT sub-module), which is now more appropriately treated according to the same methodologies as the non-life CAT risk module, where a number of pan European catastrophe scenarios will be developed.	
489.			Confidential comment deleted	
490.	CEA, ECO-SLV-09-445	3.181.	Inclusion of morbidity catastrophe stress in the health underwriting module The CEA supports the inclusion of the Health CAT risk in the health sub-module (rather than in the Life CAT sub-module), which is now more appropriately treated according to the same methodologies as the non-life CAT risk module, where a number of pan European catastrophe scenarios will be developed.	Noted
491.	CRO Forum	3.181.	It is unclear why the catastrophe risk should follow the non-life module for risk related to SLT Health. Ability of the non-life module to assess the CAT exposure for impact on disability/morbidity inception rates, for instance, is not clear. A different calibration from life is therefore needed.	Noted
492.	FFSA	3.181.	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. The Consultation Paper does not precise the way to deal with a CAT scenario which leads to a benefit (like pandemic risk for a dependence insurance contract).	Noted
493.	GROUPAMA	3.181.	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.	Noted

			The Consultation Paper doesn't precise how we should deal with a CAT scenario which lead to a benefit (like pandemic risk for a dependence insurance contract).	
494.	Groupe Consultatif	3.181.	We support the inclusion of Health CAT risk in the health sub-module (rather than the Life CAT sub-module, applying life stresses) and are now more appropriately treated according to the same methodologies as the non-life CAT risk module, where a number of pan European catastrophe scenarios will be developed. As noted above under 3.169, the CAT risk and stress tests need to be considered together to ensure there is no double counting.	Noted
495.	Legal & General Group	3.181.	We note the proposal to pick up all CAT risks in this module through the non-life CAT risk module as outlined in CP 48/09 and will be monitoring developments with interest, especially in relation to SLT-Health products.	Noted
496.	Unum Limited	3.181.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted
497.	Association of British Insurers	3.183.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore the possibility to use own scenarios in the standard	Noted

			model should be provided too.	
498.	CEA, ECO-SLV-09-445	3.183.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that Ceiops will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted
499.	CRO Forum	3.183.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it should always be taken into account that entities know what their CAT risk is, since they also have reinsurance contracts custom made for the CAT risk they encounter. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted
500.	Association of British Insurers	3.184.	For SLT Health products one can allow for the "risk absorbing effect of the technical provisions". Similar allowance in Non SLT Health products should be done where there is an element of profit sharing as well.	Noted (see CP on non-life underwriting risk)
501.	CEA, ECO-SLV-09-445	3.184.	For SLT Health products one can allow for the "risk absorbing effect of the technical provisions". Similar allowance in Non SLT Health products should be done where there is an element of profit sharing as well.	Noted (see CP on non-life underwriting risk)
502.	FFSA	3.184.	For SLT Health products one can allow for the "risk absorbing effect of the technical provisions". FFSA thinks that a similar allowance in Non SLT Health products	Noted (see CP on non-life underwriting risk)

			should be done where there is an element of profit sharing.	
503.	AMICE	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.	Noted (see CP on non-life underwriting risk)
504.	GROUPAMA	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 think that non-life contracts with profit sharing mechanism should benefit of such absorbing effect too.	Noted (see CP on non-life underwriting risk)
505.	CEA, ECO-SLV-09-445	3.187.	Compared to the other correlation matrices there is a non-zero calibration between Cat risk and another risk. The CEA asks Ceiops to disclose the reasons for this calibration.	Noted
506.	CEA, ECO-SLV-09-445	3.188.	In The Netherlands, the Dutch basic health insurance has certain specific features. In its current form the equalisation system consists of two stages. The first, ex ante, stage results in payments from insurers with a relatively healthy population to insurers with less healthy customers. The second balancing stage leads to ex post (partial) payments from insurers with relatively good stochastic results in a given year to insurers with less favourable outcomes. It is self-evident that this equalisation system results in a substantial smoothing of the results of an individual insurer. In other words, the underwriting risk of Dutch health insurers is less volatile and consequently its business can be considered less risky.	Noted

			A system based on historical data (i.e. results after equalisation) automatically makes the volatility reduction due to equalisation visible and, if insurers have sufficient historical loss data, the Solvency II requirements will automatically produce an appropriate, risk based outcome. Without sufficient available data, however, insurers will be required to fall back on the prescribed parameters of the standard formula. These parameters do not take into account the risk mitigating effect of equalisation schemes. Because the equalisation system has been operational since 1 January 2006, there is insufficient data available to use undertaking-specific data. The cover for the basic health insurance is changing time and again with sometimes a significant distorting effect on historical data. Therefore it is envisaged that undertaking-specific data probably will be unavailable in the future as well.	
507.	CEA, ECO-SLV-09-445	3.192.	It is not clear whether "new premiums" consider existing contracts only.	Noted
508.	CRO Forum	3.192.	"New premiums may be written at inadequate rates". This is not clear. With 'new premiums' are only the future premiums of existing contracts meant?	Noted
509.	AMICE	3.196.	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) 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.	Noted

510.	Association of British Insurers	3.196.	We support the following changes: $P_{LOB}^{t+1,written}$ = Estimate of net written premium for the forthcoming year (for the individual LOB) $P_{LOB}^{t+1,earned}$ = Estimate of net earned premium for the forthcoming year (for the individual LOB) $P_{LOB}^{t,written}$ = Net written premium for the current year (for the individual LOB)	Noted (see consistency with CP on non-life underwriting risk)
511.	CEA, ECO-SLV-09-445	3.196.	We think that the definition of years in this paragraph needs clarification and suggest the following changes: $P_{LOB}^{t+1,written}$ = Estimate of net written premium for the forthcoming year (for the individual LOB) $P_{LOB}^{t+1,earned}$ = Estimate of net earned premium for the forthcoming year (for the individual LOB) $P_{LOB}^{t,written}$ = Net written premium for the current year (for the individual LOB)	Noted (see consistency with CP on non-life underwriting risk)
512.	FFSA	3.196.	FFSA thinks that the definition of years in this paragraph needs clarification. FFSA suggests the following changes: $P_{LOB}^{t+1,written}$ = Estimate of net written premium for the forthcoming year (for the individual LOB) $P_{LOB}^{t+1,earned}$ = Estimate of net earned premium for the forthcoming year (for the individual LOB) $P_{LOB}^{t,written}$ = Net written premium for the current year (for the individual LOB) CEIOPS is introducing in this paper the notion of C_{LOB}^{PP} (Expected present value of net claims and expense cash out-flows which are	Noted (see consistency with CP on non-life underwriting risk)

			related to claims incurred after the year and covered by the existing contracts). FFSA interprets the presence of this notion as adequate for multi-year contracts only, as in the non-life underwriting risk. In that case that should be clearly stated.	
513.	GROUPAMA	3.196.	CEIOPS includes in the volume measure for premium formula a new element : C_{LOB}^{PP} (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) We understand from this definition that this element is appropriate only for muti-year contracts. We think that this should be specified more clearly.	Noted
514.	Association of British Insurers	3.206.	CEIOPS proposal to use a credibility mix of undertaking specific and market wide standard deviations has been suppressed compared to the draft paper. We believe that the possibility of using a credibility mix of undertaking specific and market wide standard deviations is necessary for the calculation of the non-SLT health modules.	Noted (see CP on the use of undertaking specific parameters)
515.	CEA, ECO-SLV-09-445	3.206.	Ceiops proposal to use a credibility mix of undertaking specific and market wide standard deviations has been suppressed compared to the draft paper. The CEA believes that the possibility of using a credibility mix of undertaking specific and market wide standard deviations is necessary for the calculation of the non SLT health modules.	Noted (see CP on the use of undertaking specific parameters)
516.	FFSA	3.206.	CEIOPS proposal to use a credibility mix of undertaking specific and market wide standard deviations has been suppressed compared to	Noted (see CP on the use of undertaking specific parameters)

			the draft paper. FFSA believes that the possibility of using a credibility mix of undertaking specific and market wide standard deviations is necessary for the calculation of the non SLT health modules.	
517.	ACA – ASSOCIATION DES COMPAGNIES D'ASSURANCES DU	3.209.	Workers compensation is going immaterial in our local market. We would therefore opt for only 1 LOB.	Noted
518.	AMICE	3.209.	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: - Accident - Sickness - Worker´s Compensation(for the accident part) - Complementary Health: Line of business which covers Non-occupational insurance, Payment of medical care, Accident and Sickness, and Revisable Premiums. - Providence Revisable: Line of business which covers Non-occupational insurance, Wage compensation, Accident and	Noted

			Sickness and Revisable Premiums. - Providence Non Revisable: Line of business which covers Non-occupational insurance, Wage compensation, Accident and Sickness and Non Revisable Premiums. If further segmentation is not feasible at European level, national segmentation should be actualized. For example the existing segmentation in France is as follows: - SLT Health and Non-SLT Health: 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 - Wage compensation /Payment of medical care: 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) - Accident/Sickness: accident and sickness are pooled. - Professional insurance/non-occupational insurance: 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. - Revisable premiums/Non revisable premiums: (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.

AMICE members believe that the calibration should be refined since it is the result of an inadequate 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.

519.	Association of British Insurers	3.209.		
520.			Confidential comment deleted	
521.	CEA, ECO-SLV-09-445	3.209.	Following the proposals above to remove accident and workers compensation out of the health module, the line of business still to be treated under this module would be medical treatment/illness. Critical illness due to disability and workers compensation should have their own calibration under the life or non life modules. For medical treatment/illness, depending on the size of the portfolio, it should be possible to derive company specific standard deviations. These should be net of reinsurance.	Noted
522.	Centre Technique des Institutions de Prévoyance (C	3.209.	Even though the overall structure Health SLT / Health non SLT can be agreed, none of option 1, 2 or 3 does represent the real diversity of Health LoB with a sufficient precision regarding their specific volatility, even for the standard formula. The Health classification should include specific parameters for each of the LoB: - Disability / morbidity (for any cause) - Medical insurance complementary to a legal medical insurance - Medical insurance (not complementary to a legal medical insurance), short term - Medical insurance (not complementary to a legal medical insurance), long term	Noted

			- Workers'compensation (exclusively occupational injuries and diseases) - Disability / morbidity (exclusively accidental) - (other) We are working on a proposal of appropriate calibration.	
523.	CRO Forum	3.209.	Segmentation is key We believe the health risk module is very specific for most EU countries and hence an appropriate segmentation where all country specific products "fit" is of significant importance. National guidance will be essential for insurers to understand how to classify/segment their health portfolios. Making a distinction by "technical basis" allows insurers to model the Health risk either using Life techniques or Non-Life techniques, which makes sense. It is however, important that the large number of different products can be segmented appropriately. As a result, we believe that option 3 (in 3.118) is the most appropriate option as it allows for health products pursued on a non-life technical basis, to be segmented by 3 different sub-classes. Potentially even more sub-classes should be "built in" the standard formula, given the wide variety of Health products which may exist within one country. We believe that Level 3 guidance should clarify the number of sub-classes required within the health risk module, given the diversity of the products across the EU. By "building in" more sub-classes in the standard formula, makes the formula more flexible.	Noted
524.	FFSA	3.209.	CEIOPS is providing 3 options on segmentation of accident,	Noted

			sickness and worker's compensation. FFSA thinks that it would seem appropriate to retain option 3 as the three lines of business can have very different developments. Indeed, it is not obvious whether the choice between these options could be different for each entity or if it has to be settled for the whole market place. It could be difficult in some cases to separate all the lines of business.	
525.			Confidential comment deleted	
526.	GROUPAMA	3.209.	CEIOPS proposes 3 options with regards to the definition of lines of business considered to the assessment of the Non-SLT Health premium and reserve risk. In each option, the standard deviation for premium risk and the standard deviation for reserve risk are clearly defined. We suggest allowing the undertakings using entity-specific parameters, or at least national-specific parameters, to calibrate their shocks. For instance, the standard deviation for reserve risk of Sickness seems too high for French business, as Health insurance is a complementary insurance which does not operate on heavy risks. At least, we should be allowed to use national-specific parameters. Moreover, we suggest reintegrating a size factor which allows the volatility to be decreased (as in the QIS 2).	Noted
527.	Groupe Consultatif	3.209.	Lines of business ("LOB") - what level of granularity will be required? For example, can all PMI products be combined or do they have to be separated out? We would view "Option 3" as the bare minimum.	Noted
528.	Bupa	3.211.	Because of the great variation seen within the EU health sector that CEIOPS itself notes several times in CP 50, these scenarios should be defined in a great level of detail (by CEIOPS). Firms should be expected to evidence in detail their exposures, impacts, and	Noted

			management actions accordingly. Otherwise, the responses and assessments would not be comparable across Member States. Such an exercise would certainly drive out transparency on these risk exposures and cultivate more meaningful CAT risk management. This objective and comprehensive scenarios therefore do seem appropriate. On the other hand, providing a high degree of scenario specificity (whether for pandemics, terrorism, macro-economic shocks, or any other catastrophes) might be require undertakings go further down the internal model path more than CEIOPS may wish. Moreover, specifying scenarios in detail would result in more reconciliation issues (e.g., SCR versus internal model) and within the ORSA. It is the variety of types of health insurances that makes parameterisation and standardisation difficult but all the more necessary to avoid disadvantaging firms on the one hand, and not leaving policyholders under-protected on the other hand. On a separate point, future consultations should probably begin to tease out diversification assumptions within the CAT modules to at least clarify CEIOPS thinking on multiple events, negatively correlated risk factors, positive factors, etc. This point about consistency checking extends across CAT modules within the SCR. If too much correlation is assumed without a good reason in the calibration process , the CAT module could have a significant effect in overstating the SCR.	
529.			Confidential comment deleted	
530.	Bupa	3.213.	Linking the Health CAT (non-SLT) module to the non-life module should not be a problem. Given that the nature of some CAT scenarios in health-non-SLT are strongly related to life, the health CAT module should be designed –	Noted

			or at least reviewed – in parallel with other CAT modules (health-SLT CAT, life, or non-life).	
531.	CEA, ECO-SLV-09-445	3.213.	With reference to CP48 (Non-life underwriting risk) Ceiops will provide standard scenarios to calculate Health CAT risk. In the standard model it should be possible to use own scenarios in accordance with existing reinsurance contracts on catastrophe risk.	Noted
532.	CRO Forum	3.213.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that CEIOPS will provide standard scenarios that should be calculated for the Health CAT risk. However, it should always be taken into account that entities know what their CAT risk is, since they also have reinsurance contracts custom made for the CAT risk they encounter. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted
533.	Groupe Consultatif	3.213.	We understand that a new CEIOPS Catastrophe Task Force has been set up (on which we are represented) covering both SLT Health and Non-SLT Health. At this stage we would however like to capture the fact that catastrophe risk is one of the biggest issues for Non-SLT Health. One specific point to note is that the catastrophe risk will vary between countries with a national healthcare system and those without.	Noted
534.	Bupa	3.214.	Because of the variety of forms that health insurance takes and for the additional reasons that CEIOPS notes in for example section 3 and 3.220 of CP 50, undertaking specific parameters (USP) should be an inherent part of the health underwriting risk SCR, particularly so for those classes where insurance benefits depend or are closely related to local healthcare systems and economies. If USP is considered too unreliable, especially for smaller undertakings, CEIOPS should consider developing market specific	Noted

			parameters (MSP) where "markets" are based on categorising Member States where the nature of the risk, and in particular the nature of the policy level claim probability distribution, are of a similar statistical nature. Allowing USP or creating an MSP structure would still be appropriate even with the option to develop internal models since it is the risk sensitive nature of the SCR that is brought into question without either USP or MSP.	
535.	CEA, ECO-SLV-09-445	3.214.	This article refers to the Non Life Underwriting risk module (CP 48). This implies that Ceiops will provide standard scenarios that should be calculated for the Health CAT risk. However, it always should be taken into account that entities know what their CAT risk is. Therefore the possibility to use own scenarios in the standard model should be provided too.	Noted
536.	CEA, ECO-SLV-09-445	Annex	It is a remarkable that two very important discussions in the Netherlands between the national supervisor and the Dutch health insurance-industry are not mentioned: 1. Depending on the terms of the insurance policy prepayments to hospitals and other suppliers of care, should be deducted from the technical provisions, as is custom for all prepayments on claims. Also see CP 28, paragraph 3.78. Explanation: For many treatments in hospital payments will take place after the treatment. To prevent financing problems for hospitals bigger insurance companies have to arrange prepayments. In case of default of a hospital we must distinguish between: - Insurance in kind. Prepayments by insurance	Noted

			companies can be deducted from technical provisions. - Indemnity insurance. The insurance company will arrange prepayments to hospital, hospitals will have a debt-claim on the insured and the insured will receive compensation from the insurance company. Those three elements cannot be settled, despite the fact that in many cases the insurance company will pay to the hospital directly. In those cases prepayments to hospitals must be treated as a kind of investment. 2. Because of the Dutch equalisation system and additional legislation, specific on catastrophes, according to the industry, there is no significant catastrophe-risk for the basic health insurance. The same goes for the supplementary health insurance because of the terms of the insurance-policies. The fact that these discussions are not mentioned could be due to the fact that the comments arisen after QIS3 where solved by applying the Annex (TS.XVII.G, Annex SCR 5: Dutch health insurance). However the QIS3 remarks are still very much valid if no attention is given to the Dutch health insurance contracts.	