	Comments Template on Consultation Paper on EIOPA's second set of advice to the European Commission on specific items in the Solvency II Delegated Regulation	Deadline 5 January 2018 23:59 CET
Name of Company:	FNMF	
Disclosure of comments:	Please indicate if your comments should be treated as confidential:	Public
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Reference	**Comment**	
General Comment	First of all, FNMF federates more than 400 insurance mutual undetakings (of all size, specialized in health insurance) representing EUR 20 billions of premium and more than 50% of the private health insurance market in France. Our members are really affected by : • the recalibration of standard parameters of premium health medical expenses risk • the definition of FP_{future} According to Article 145 of the Solvency II Delegated regulation, the capital requirement for NSLT	

health medical expenses premium risk sub-module shall be equal to the following :

$$SCR(NSLT\_HME,pr)=3*\sigma_{NSLT\_HMEh}*V_{NSLT\_HMEh}$$

Where

- σ_{NSLT_HMEh} denotes the standard deviation for NSLT health medical expenses premium (EIOPA suggests σ_{NSLT_HMEh} = 6%)
- V_{NSLT_HMEh} denotes the volume measure for NSLT health medical expenses premium (EIOPA suggests to include N+2 earned premiums in this volume)

FNMF stresses out EIOPA that a accumulation of conservative modelisations leads to an overestimated capital and deviate forme the original definition of a Value-at-Risk with a 99,5% confidence level.
Indeed, all components of the NSLT health medical expenses premium risk defined by the standard formula are more important than it really is.

Hence, according to our assessment[1] (with conservative assumptions) :

- The factor 3 is overestimated by 16%
- The standard deviation sigma is overestimated by 50%
- The subscription year N+2 risk included in volume premium by option 1 (FP_{future}) or option 2 is overestimated[2]

Eventually, health medical expenses premium capital requirement defined by EIOPA is at least (conservative assumptions) between 70% et 90% higher[3] than a Value-at-Risk with a 99,5% confidence level.

Therefore, FNMF recommends to use a global concistency approach to perform an adequate

[1] Our studies are available on demand
[2] For an annually renewable 1-year insurance contract (health medical expenses insurers sell only annually renewable 1-year insurance contracts).
[3] The level of overestimation depends on the option chosen in the premium volume

	recalibration of NSLT health module.	
Introduction	We have assessed for our members (which represent more than 16 billion € on medical expense insurance), that the effect of EIOPA proposals regarding the definition of V(prem,s) and NSLT health premium calibration lead to an increase of 0.9 billion € of SCR. • On the one hand, this increase is not technically justified, as a study based on data representing more than 40% of the French Health Insurance market shows that the current calibration is accurate • On the other hand, the new proposals would increase the present capital requirements by more than 10%, causing significant solvency issues to some mutual which are not able to raise easily their Own Funds or diminish their capital requirement beside costly reinsurance solutions.	
1.1	According to Article 145 of the Solvency II Delegated regulation, the capital requirement for NSLT health medical expenses premium risk sub-module is equal to the following : $SCR(NSLT\_HME,pr)=3*\sigma_{NSLT\_HMEh}*V_{NSLT\_HMEh}$ Where • σ_{NSLT_HMEh} denotes the standard deviation for NSLT health medical expenses premium (EIOPA suggests σ_{NSLT_HMEh} = 6%) • V_{NSLT_HMEh} denotes the volume measure for NSLT health medical expenses premium (EIOPA suggests to include N+2 earned premiums in this volume)	

First of all, "SCR shall be calibrated using a Value-at-Risk measure, with a 99,5% confidence level, over a one-year period"[4].

Besides, a normal parametric model was used by EIOPA for recalibration of standard parameter σ_{NSLT_HMEh} of health medical expenses premium risk.

We remind a theoretical property of a Normal Distribution (named Y) : $VaR_{99,85\%}(Y) = 3*\sigma^{5}(Y)$

Consequently, medical expenses premium capital requirement seems to be calibrated using a Value-at-Risk measure, with a 99,**8**5% confidence level, over a one-year period which does not appear consistent with the Solvency II Directive principle previously mentioned.

In fact, we have :

$VaR_{99,5\%}(Y) = 2.58*\sigma(Y) < 3*\sigma(Y)$

Consequently, medical expenses premium capital requirement must be equal to :

$$SCR(NSLT\_HME,pr)=2.58*\sigma_{NSLT\_HMEh}*V_{NSLT\_HMEh} < 3*\sigma_{NSLT\_HMEh}*V_{NSLT\_HMEh}$$

Thus, standard formula seems to be more conservative than mathematical theory. It overestimates health medical expenses premium capital requirement of 16%[6].

We are aware that the overall architecture of the standard formula must not be modified. Therefore, we recommend including this conservative approach by lowering the standard parameter by 14%[7].

[4] Source : Article 104 of Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009.
[5] σ=standard deviation
[6] With a Lognormal assumption, the overestimation is almost 9% (standard deviation of 6%).

NB : The same should be applied to health medical expenses reserve risk.

In addition we would like to point out your attention to the fact that the capital requirement for NSLT health premium wording doesn't refer explicitly to the loss in basic own funds (unlike life risk, market risk etc). So, the capital requirement for NSLT health does not respresent a own funds shock. For example, French "Réserve Générale" and "Réserve de stabilité" which[8] can absorb highly future losses are not currently taken into account in the calculation of the SCR. In fact, these reserves can't be use as risk mitigation for NSLT health contract because of the formulae (it is note the case for life or SLT Health, because the SCR shock is based on a delta NAV).
Consequently, we suggest to modify the formulation of the first paragraph of Article 146 of the Solvency II Delegated regulation as follows :

"*According to Article 145 of the Solvency II Delegated regulation, the capital requirement for NSLT health medical expenses premium risk sub-module shall be equal to the loss in basic own funds of insurance and reinsurance undertakings that would result from an increase of claims and expenses following* "

Moreover, the volatility of health insurance technical results is mainly driven by the AMSB and results in particular from strategic decisions (price war, launch of new products, cross-selling, loss leader etc) in response to market upheavals (regulatory or competition). So, the volatility is mainly driven by the AMSB decisions.

At least, for the niche insurers, the change in health medical expense standard parameters leads to a significant narrowing of the margin of maneuver that is otherwise constrained by their nature (monoline, no alternative to raise easily and quickly own funds, small commercial scope etc).

[7] For example, if standard deviation equals 6%, the final standard parameter must be 5% to obtain an exact SCR valuation.
[8] Belongs to the contract (thus it's a liability) but allows to cover adverse loss-ratio.

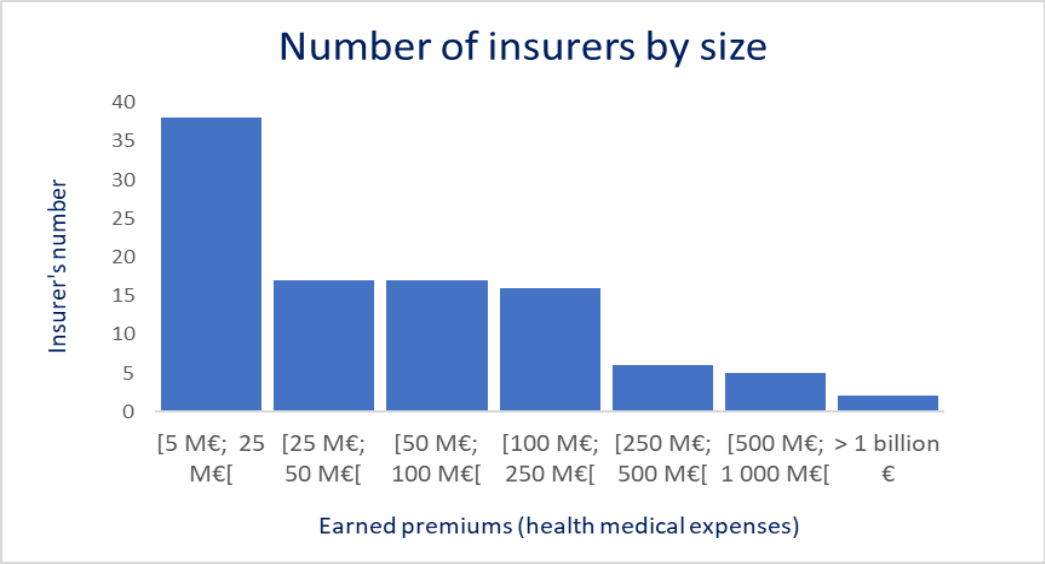
1.1.1		
1.2.1		
1.2.2		
1.2.3	In our comprehension, representativeness of health medical expenses (HME) data collected in 2017 seems to be worse than the previous study performed by the JWG in 2011. Indeed, the number of submissions is more important this year but only in countries with low weights (used by EIOPA to aggregate the country sigma in 2017). In fact, submissions are less important of 8% in 2017 from France and from the Netherlands which generates less overall representativeness :	
1.2.4		
1.3		
1.3.1	For a better transparency in the Solvency II review, we ask EIOPA to expose why final calibration	

Country	Number of HME submissions used in 2011	Number of HME submissions used in 2017	Weights used by EIOPA in 2017 to aggregate the country sigma	Evolution of the weight size of the sample
Netherlands	21	20	48%	-5%
France	51	37	32%	-27%
Other	197	224	21%	14%
Overall	269	281	100%	**-8%**

	suggested for health medical expenses premium risk is based on a normal distribution and not on a lognormal distribution[9]. In addition, we would like to draw your attention to the impact of this assumption on the formula[10] for calculating capital requirements [11].	
1.3.2		
1.3.3	For a better transparency in the Solvency II review, we ask EIOPA to expose kappa factor calculation method and kappa value.	
1.3.4	As indicated in the paragraph 1.4.1, the weight of the Netherlands in the sample used to recalibrate standard parameter of health medical expenses risks seems to be overestimated[12].	
1.3.5	According to a study[13] carried out on more than 100 health medical expenses insurers, less than 0.07% (respectively 0.04%) of the insurers[14] present a health medical expenses underwriting specific parameter upper than 5% (respectively 6%). Consequently, current calibration and EIOPA's proposition calibration seems to be high.	
1.4		
1.4.1	FNMF conducted a study[15] to valuate itself the standard parameter of health medical expenses premium risk. A calculation of the USP for more than 100 health medical expenses French insurers[16] was performed. We used the prescribed legal methodology[17] described in Annex XVII of the Delegated Regulation.	

[9] Which results in an average standard deviation of 5.5%
[10] The multiplicative factor applied to the standard deviation and the volume of premiums change
[11] For more information, see 1.1
[12] For more information, see 1.4.1
[13] For more information, see 1.4.1
[14] Weighted by earned premiums
[15] Available on demand
[16] Whose gross premium income exceeds EUR 5 million

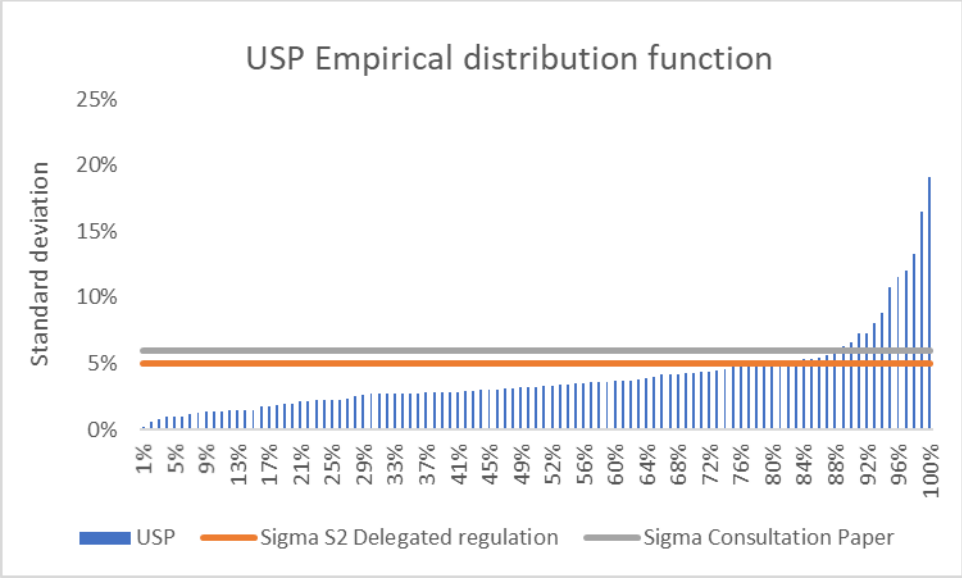
The studied sample consists of more than 50% of health medical expenses earned premiums French market[18]. It includes the latest available observations[19] (earned premiums, expenses and claims paid in 2016). It is composed of small, medium and big insurers :



The portfolio size heterogeneity warrants a calibration at the appropriate level.

[17] To further represent reality, the credibility factor was set equal to 1.
[18] French insurers using Internal Model are excluded.
[19] Unlike the EIOPA study

We obtain the following results :



We observe that currently (respectively suggested by EIOPA in 2017) standard parameter of

health medical expenses premium risk is overestimated for more than 80% (respectively 88%) of insurers.
Less than 0.07% (respectively 0.04%) of the insurers[20] present an underwriting specific parameter upper than 5% (respectively 6%).

In summary, we have :

USP	Standard deviation
Weighted average earned premium	3,3%
Average (without any weighting)	4,0%
$Q_{65\%}$ (company approach[21])	3.9%
Median	3,2%

Consequently, the recalibration of standard deviation of health medical expenses premium risks must not be higher than 4,0%. By taking a conservative approach, FNMF recommends to set this parameter to 4%. Although French insurers present an intrinsic risk 20% lower than the current regulatory requirements, EIOPA plans to increase the capital requirements by 20%. Thus, if EIOPA's proposal would be transposed into the regulation, the health medical expenses parameter of premium risk applied to French insurers would be overestimated by 50%.

We also remind that the health medical expenses premium capital requirement is overestimated[22] by the currently standard formula. So, if the overall architecture of the standard formula is not

[20] Weighted by earned premiums
[21] At least 65% of portfolios sould be covered with a security level of at least 99.5% (definition given by the JWC in 2011).
[22] Standard deviation is multiplied by 3 (see for more information 1.1) which is not consistency with a $VaR_{99.5\%}$

modified, FNMF recommends to lower standard parameter of health medical expenses premium to 3.5 %.

Moreover, EIOPA advice on recalibration of standard parameter of health medical expenses premium risks is based on method 2. This method uses following weights to aggregate the country sigma :

Country	Weight
Netherlands	47.8%
France	31.7%
Other	20.5%
Sum	100%

Health medical expenses premiums are in France EUR 35 billion [23].

The Dutch health insurance system combines two types of insurance :

- A mandatory health insurance public insurance (turnover = EUR 39[24] billion)
- An optional health insurance (turnover = EUR 4[25] billion).

We don't know if data used by EIOPA to recalibrate health medical expenses premium risk includes or not public insurance. For a better transparency in the Solvency II review, we ask EIOPA to clarify this point.

Anyway, the weight of the Netherlands seems to be overestimated. Besides, if data used by EIOPA to recalibrate health medical expenses premium risk does not include Dutch public healthcare

[23] Fore more information, see p.26 of http://www.cmu.fr/fichier-utilisateur/fichiers/Annuaire_statistique_10-2017.pdf
[24] Fore more information, see p.78 of https://www.verzekeraars.nl/media/3545/verzekerd-van-cijfers-2016-eng.pdf
[25] Fore more information, see p.78 of https://www.verzekeraars.nl/media/3545/verzekerd-van-cijfers-2016-eng.pdf

	insurance, the weight of France should be more important. Assuming that the France standard deviation of health medical expenses premium risk is 4%, the Netherlands standard deviation of premium risk is 6%, it would be necessary for the weighted average standard deviation of the other European countries to be 9% to obtain an overall weighted average standard deviation of 6%. If this is the case, the methodology for calibrating premium risk is not suitable because of much too many disparities within European Union. It would then be necessary, like the catastrophe risk, to consider a health medical expenses parameter specific to each country. Eventually, as explained in point 1.2.3, the new calibration of standard parameter of health medical expenses premium risk proposed by EIOPA is based on data that are less representative of reality than in the previous study[26].	
1.4.2	FNMF considers that the current standard parameter[27] of health medical expenses reserve risk is suitable. So, the recalibration of this parameter does not seem to be useful.	
2.1		
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2.4.1	In our opinion, the two different options considered by EIOPA don't reflect the risks supported by the insurers. They generate volatility over time, distortions of competition and unfair disparities between one year and multi-year contracts : - On the one hand, the first option creates an unjustified theoretical gap in the premium volume exposures. In addition, aggregation[28] method for N+1 year risks and beyond year	

[26] Performed by the JWG (2011)
[27] Equals to 5%
[28] Summing up the risks

N+1 risks leads to overestimate solvency capital requirements. It is not consistent with the Solvency II risk measure[29] .

- On the other hand, the second option seems to overestimate NSLT Health underwriting premium beyond year N+1 risk. Indeed, FP_{future} is not fully exposed to unexpected risk 1[30] (abbreviated UR 1). In fact, a permanent rise in costs does not occur suddenly. It often comes from market shocks which take a long time to come into effect and which are usually debated for several months. Thus, the AMSB has enough time to properly raise insurance prices.

- In particular, for 1-year contracts, insurers can almost always increase[31] year N+2 health insurance prices to compensate for any losses due to the occurrence of UR 1 so this risk is not significant. This also applies to multi-year contracts premium where the risk is overestimated.

- FNMF shares the EIOPA view on unexpected risk 2[32] (abbreviated UR 2) which does not affect earned premiums beyond year N+1. Besides, like EIOPA said, UR 2 explain much of the premium risks. Thus, a corrective coefficient (less than 1) should be applied to earned premiums beyond year N+1 (FP_{future} *and* $FP_{existing}$[33]).

- Nevertheless, the method used by EIOPA to calibrate the adjustment factor seems to be unjustified and not fully transparent.

[29] SCR equals to Value-at-Risk measure, with a 99,5% confidence level, over a one-year period
[30] Unexpected risk 1 is defined by EIOPA as an undertaking experiences higher payments than the premiums due to permanent rise in costs (e.g inflation, change in legal environment).
[31] During N+1 year
[32] Unexpected risk 2 is defined by EIOPA as an undertaking experiences higher payments than the premiums due to temporary rise in costs (e.g large event).
[33] Unfair disparities between one year and multi-year contracts are not compliant with recital 43 of the Delegated Regulation : "to avoid restructuring long-term contracts as short-term renewable contracts".

- Besides, as shown in the study[34] presented in point 1.4.3, for an annually renewable 1-year insurance contracts, P_{future} is insignificant. Thus, FNMF recommends to set $FP_{existing}$ and FP_{future} to zero for an annually renewable 1-year insurance contracts.

In addition, EIOPA's definition of initial recognition date does not seem to be appropriate. This approach is not consistent with the premium risk calibration method. The latter is based on the annual loss ratios by accident year which includes only earned premium of the year.
Moreover, NSLT Health underwriting premium risk should not be in contradiction with recital 43 of the Delegated Regulation and with substance over form principle. To illustrate this last point, let's consider two insurance companies exposed to the same risk period (renewable 1-year insurance contracts from 1st April to 31 March) with different advance notices (3 months minus 1 day versus 3 months). We have[35] :

	Vprem	
Advance notice	Option 1	Option 2
3 months minus 1 day	15 months	12,9 months
3 months	18 months	18.6 months
Differences	3 months	5.7 months

In the two options proposed by EIOPA, there are significant gaps of capital requirements (between + 20% and + 44 %) which are not consistent with level playing field and substance over form principles.

Moreover, the definition of initial recognition date creates significant volatility in capital requirements during the year. It generates also unexpectedly large increase of health capital

[34] Available on demand
[35] Balance Sheet as of 31/12/N

	requirements which may be detrimental to the European insurance market. It could threaten the ability for the European citizens to take care of their own health[36]. Besides, it creates an inconsistency between Balance Sheet and SCR. Indeed, for renewable 1-year insurance contracts, profitability of insurance business beyond year N+1 is not included in Balance Sheet (and in Net Asset Value) whereas NSLT Health underwriting premium beyond year N+1 risk generates capital requirements. To solve the issues identified above, we suggest to modify the formulation of the third paragraph of Article 147 of the Solvency II Delegated regulation as follows : *"For all segments set out in Annex XIV, the volume measure for premium risk of a particular segment s shall be equal to the following :* $V(prem,s) = Max(P_s ; P_{last,\ s}) + 30\% \times FP_{(existing,\ s)} + 50\% \times FP_{(future,s)}$ *With* $FP_{(existing,\ s)} + FP_{(future,s)}$ *set to zero for an annually renewable 1-year insurance contracts"*	
2.4.2		
2.4.3	FNMF did a study[37] to assess the global risk (including that relating to the earned premiums year N + 2) for an annually renewable 1-year health medical expenses insurance contract. For information, French health medical expenses insurers sell only annually renewable 1-year	

[36] Indeed, capital increase may result in health medical expenses premiums increases.Some of them may not be able to pay health medical expenses insurance.
[37] Available on demand

	insurance contracts. The main assumptions are : • Expenses and claims follow a lognormal distribution[38] (mean = 99% and standard deviation = 5%[39]). • Years N+1 and N+2 are correlated (conservative approach) • Stability in earned premiums between year N+1 and year N+2 • Earned premiums of year N+1 are higher than earned premiums year N • Health medical expenses premium capital requirement is calibrated using a Value-at-Risk measure, with a 99,5% confidence level, over a one-year period. With conservative assumptions, we obtained an overall Solvency II health medical expenses premium capital requirement[40] equals to 16% of earned premiums N+1. This result is very close to our interpretation of the current regulations (15% of earned premiums N+1). Moreover, assuming a normality of expenses and claims year N + 2 or assuming a standard deviation of 4%, the year N + 2 risk-related risk supplement (in proportion to the year N + 1 risk) is of the same order as normal modelling with a standard deviation of 5%. Thus, FNMF recommends to set $FP_{existing}$ and FP_{future} to zero for an annually renewable 1-year insurance contracts.	
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[38] This assuption is frequently made by EIOPA
[39] Currently standard parameter of health medical expenses premium risk
[40] At the end of the year N

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7.4.3	EIOPA proposes two options which generates more complex calculations, while EIOPA recommended also simplifications to the calculation of SCR standard formula. These two options also will generate disproportionate development costs. They can significantly change the asset allocation of insurers which may threaten financial stability. FNMF is uncomfortable with changes in the standard formula resulting from short-term issues (low interest rate environment) and	

	creating too much instability for the insurance industry. FNMF recommends to not modify currently formula calculation.	
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15.1	Insurance regulation shoud accompany the ecological transition process. That's why, the sustainability and the long terme nature of responsible investments should be taken into account in the SCR valuation.	
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15.4.1		
15.4.2		
15.4.3	FNMF considers that EIOPA's advice does not simplify enough the look-through approach. Indeed, the look-through approach does not seem to be useful. It generates also disproportionate costs for insurers. FNMF recommends to remove the look-through obligations.	
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17.4.3	FNMF recommends to standardize the National Supervisory Authorities approaches (level playing field principle) especially on the subject of loss-absorbing capacity of deffered taxes.	
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