ECO-SLV-12-076 10 February 2012	**Comments Template on** **the Proposal for Guidelines and Recommendations on Health issues**	**Deadline 10.02.2012**
Name of Association/Stakeholder:	CEA	

Please follow the following instructions for filling in the template:

- ⇨ Do **not** change the numbering in the columns "reference" or "Question number".
- ⇨ Please fill in your comment in the relevant row. If you have no comment on a paragraph, keep the row empty.
  - If your comment refers to multiple paragraphs, please insert your comment at the first relevant paragraph and mention in your comment to which other paragraphs this also applies.
  - If your comment refers to sub bullets/subparagraphs, please indicate this in the comment itself.

Please send the completed template to Marjan.Trobina@eiopa.europa.eu and Hugues.MAIGNAN@acp.banque-france.fr;

The numbering of the paragraphs refers to the Proposal for Guidelines and Recommendations on Health issues

Reference	Comment	resolution
General Comment	The CEA welcomes the opportunity to comment on the Pre-consultation Paper on the Proposal for Guidelines and Recommendations on Health issues. We appreciate the opportunity to discuss these issues in advance of the formal public consultations.	

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	We are generally satisfied with these guidelines, although we do still have some comments below. For the calculation of CAT risks, if within the contract boundary, **the risk-mitigating effects of premium adaption clauses should be taken into account**.	
1.		
2.		
3.1.		
3.2.		
3.3.		
3.4.		
3.5.		
3.6.		
3.7.	We question whether so much detail is necessary (e.g. on the demographic characteristics).	
3.8.	We question whether so much detail is necessary and ask for "*to be able to justify these assumptions*" to be removed from the wording.	
3.9.	We question whether so much detail is necessary.	

3.10.		
3.11.		
3.12.	If within the contract boundary, the economic effects of **premium adaption clauses** should also be taken into account.	
3.13.	Our interpretation of "10 years disability" and "12 months disability" is, that this is not a part of the sum insured of permanent disability, but a special coverage which is not always available, depending on the Member State.	
3.14.	If within the contract boundary, the economic effects of **premium adaption clauses** should be taken into account.	
3.15.	Which kind of accidents should be considered? The "normal average accident"? There have been only a few mass accidents in the past years, thus there is no reliable estimate for the "average mass accident claim" based on this experience. The average claim will be mostly based on expert judgment. In addition, the kind of mass accident should be specified, e.g. plane crash or mass panic in a stadium. The resulting injuries will differ depending on the type of accident and even differ from the ones of a "normal average accident".	
3.16.		
3.17.		
3.18.		
3.19.	This may not add much value to the draft Level 2 text.	

3.20.	We welcome the clarification on the counting of the different contracts. However, for some of our members, for health insurance contracts the work place of the insured person is typically unknown, because **the insurance cover does not depend on the work place**. **Thus the proposed calculation seems to be impossible**.	
3.21.		
3.22.		
3.23.	If within the contract boundary, the economic effects of **premium adaption clauses** should be taken into account.	
3.24.	Further guidance may be needed, e.g. by specifying which kind of infectious disease events should be considered. Moreover, in our opinion –although we know this might not be easy to do– when considering a pandemic we should try to take into account the effect of deferral of "normal health consumption". As a pandemic takes place many people will defer their non-critical health care in order not to run the risk of any exposures. This has happened with the "Mexican flu". Next to this calculation an assessment should be made whether all the necessary healthcare treatment is able to be provided by the health care providers. Within each country there is a certain maximum number of treatments able to be provided because for example hospitals cannot take more patients for treatment because they have reached their maximum capacity or the number of specialist able to treat the population affected by the infectious disease event is limited. One could even argue that these specialists could also be affected by the pandemic and that the "natural" boundary is too high.	

	We would propose to add that each Member State would provide an assessment of this natural boundary and an assessment of the current capacity already in use e.g. this would provide an assessment of what the maximum loss could be for the health insurance industry in the specific Member State or geographical area.	
3.25.		
3.26.		
3.27.		
3.28.	When no formal medical is sought, self-medication often may not be covered by the health insurance contract and therefore will have a cost of zero for the insurer.	
3.29.		
3.30.		
3.31.		
3.32.		
3.33.		
3.34.		
4.1.	"located at the corner of streets Y and Z": If this is the only problem which guideline 4 is trying to resolve, then maybe it could be deleted. Moreover we are not sure that undertakings can address this due to data availability.	
4.2.		
4.3.		

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Q1	We consider the lapse risk as immaterial for the NSLT Health business. If the lapse risk module should apply for NSLT Health insurance companies, we would welcome some clarifications. Most importantly, reinsurance companies should have a possibility to use simplifications while calculating the lapse risk of the underlying insurance contracts based on the principle of proportionality.	
Q2	We see the need for some guidelines and recommendations in the Health SLT SCR calculation, especially for the disability-morbidity risk of income protection. Instead of disability rate and recovery rate, some short-term income protection insurers use the average claims and average length of disability in days for pricing purposes. Since the usual length of such business is much more shorter than one year, it is difficult to translate the increase in the yearly recovery rate into an increase in the length of disability in days. Therefore, we see a need for more guidelines on how the risks defined in the Article 129 of the draft level 2 text can be translated for short-term income protection insurance.	
Q3	Yes, there is a need for further clarification: **Is the calculation of SI(e,i) correct in the following examples?** **Example 1:** Sum insured in case of death by any cause: 100.000€ Additional sum insured in case of accidental death: 50.000€ Resulting SI(e,i) = 50.000€ plus costs of settlement **Example 2:** Sum insured in case of death by any cause: 100.000€ Additional sum insured in case of accidental death: none Resulting SI(e,i) = 0€	

	Are the two examples correct also if "death" is replaced by "invalidity"? **Are the two examples correct also if "death" is replaced by "medical treatment" and "sum insured" by "expected insured costs of medical treatment"?**	
Q4	We don't think that further issues on mass scenario need to be treated in the guidelines.	
Q5	The explanation linked to the building having several postal addresses clarifies the concept of 'same building' for the Accident concentration scenario. However, this type of information is not always easy to check.	
Q6	What's the meaning of "the largest exposure": large in the sense of the largest risk capital amount or the highest number of insured persons. The latter could be difficult to assess.	
Q7		
Q8		
Q9	**Yes: Which infectious diseases are meant here?** A list of examples would be helpful. We would also need more clarification of the definition of a pandemic. In our opinion, a pandemic takes place when the following 3 conditions are met: - Emergence of an infectious disease new to a population, - Agents infect humans, causing serious illness, - Agents spread easily and sustainably among humans.	

	We think there are two types of pandemic: 1) influenza, e.g. Spanish flu in 1918-1919 and Swine flu in 2009-2010; 2) non-influenza infectious disease, e.g. smallpox in the 16th century and SARS. For the influenza type, we suggest to consider the WHO early warning system to define when this is considered as a pandemic. In addition, we have some other questions: - For hospitalization, how should we proceed for intensive care unit costs? - For consultation, does it correspond to the consultation with a general practitioner only or does it apply to the linked medication also (pharmaceutical costs)? Could we get some more explanations on the last healthcare utilization type (no formal medical care sought)? Why could this type add costs in case of a pandemic (vaccines are only available through prescription, so only state, hospital or doctor consultation would trigger its use)?	
Q10		
Q11	The assessment of the potential cost seems to be spread between low and medium impact.	