	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:	Zorgverzekeraars Nederland (umbrella organisation of health insurers in the Netherlands)	
Disclosure of comments:	Please indicate if your comments should be treated as confidential:	Public
	Please follow the following instructions for filling in the template: ⇨ Do **not** change the numbering in the column "reference"; if you change numbering, your comment cannot be processed by our IT tool ⇨ Leave the last column empty. ⇨ Please fill in your comment in the relevant row. If you have no comment on a paragraph or a cell, keep the row empty. ⇨ Our IT tool does not allow processing of comments which do not refer to the specific numbers below. **Please send the completed template, in Word Format, to CP-17-006@eiopa.europa.eu** **Our IT tool does not allow processing of any other formats.** **The numbering of the reference refers to the sections** of the consultation paper on EIOPA's second set of advice to the European Commission on specific items in the Solvency II Delegated Regulation. Please indicate to which paragraph(s) your comment refers to.	
Reference	**Comment**	
General Comment		
Introduction		
1.1	The recalibration of the standard parameters is done by the same methodology as in 2011. This results in a 1:200 recalibration based on the current volume measure. If EIOPA decides to amend the volumefactor for premium risk, we expect a revised recalibration of the standard parameter to remain the 1:200 calibration.	

	The SCR formula suggests that HME can increase without a maximum. But if shocks appear, non-emerging healthcare treatments will be postponed or cancelled, so medical expenses before shock decreases at that moment. Also for a part of the medical expenses in the Netherlands, there is a maximum expense per insured per year.	
1.1.1	Following sections 20 and 22 HME does not classify for a recalibration. What is the reason for taking HME as a part of the parameter recalibration? The initial calibration in 2011 is the starting point for the recalibration. However, this neglects the developments in Solvency II (concept) legislation in the period 2011-2017. Has EIOPA examined if the calibration method of 2011 is still appropriate?	
1.2.1		
1.2.2		
1.2.3		
1.2.4		
1.3	See also 1.1.1 that EIOPA used the same method as in 2011. Has EIOPA examined if the calibration method of 2011 is still appropriate?And what was theoutcome of this assessment?	
1.3.1		
1.3.2		
1.3.3		
1.3.4		
1.3.5		
1.4	Indication of the impact applying the recalibration only to the supplementary health in the Netherlands results in an impact in the range between 2% to 5%-points decrease in Solvency ratio on group level. On entity level the impact is in the range between 15% to 45%-points decrease.	

	Due to the Dutch Health Risk Equalisation System, the recalibration will have no impact on the Dutch Basic health calculations.	
1.4.1		
1.4.2		
2.1	The main objective is a reassessment of the appropriateness of the volume measure for premium risk. The proposal for adjustment of the volumefactor although is based on a technical reason and not based on the appropriateness / experience. Can EIOPA show the evidence that the current volumefactor does underestimate the premiumrisk? In our opinion the number of one-year contracts is much larger than the number of long-term contracts. See the remark in 1.1 that If EIOPA decides to amend the volumefactor for premium risk, we expect a revised recalibration of the standard parameter to remain the 1:200 calibration. See the remark in 1.1 that if this consultation results in a volumemeasure which includes the period between initial recognition and the start of the coverage periode, we expect a revised calibration of the standard parameters to remain the 1:200 calibration.	
2.2	Par. 80: see the remark in 1.1 that the SCR formula suggests that HME premium risk can increase without a maximum, which is not the case for supplementary health in the Netherlands. Par 78, Recital 43:“In order to avoid giving the wrong incentive to restructure long-term contracts as short term renewable contracts…”. Can EIOPA show in how many cases this has been done? And If insurance companies restructure long-term contracts to one-year contracts, it means that the current volume measure is not the correct parameter for both kinds of contracts. The aim of the guidance (77) is to reflect the risks of the contracts as good as possible. And risks differ between long-term and short term contracts. So in our opinion the volume factor for both types of contracts has to be different.	

| | In the Dutch Health Care System it is restricted by law that contracts are one-year contracts, renewable only at the beginning of the calenderyear. So for Dutch Health Care no incentive exists to restructure long-term contracts as short-term renewable contracts.

Par 78, Recital 43: "… the volume measure for non-life and NSLT health premium risk used in the standard formula should be based on the economic substance of insurance and reinsurance contracts rather than on their legal form."
Policyholders see one year contracts as for one year with the choice to buy or not to buy a new one year contract in one year. So after this one year contract this contract ends as well as premium risk ends after one year. This leads to a volumefactor of 12 months for one year contracts, without influence of options for renewals.

Renewals for a one year contract always follow a new proposal from the insurer in which terms and pricing are set at that time and will be influenced by the risks and conditions of the new policy. Therefore the insurer does have impact on the pricing and the risks in the proposed renewal policy. Therefore in our opinion the volumefactor for one year contracts can not be higher than 12 months.

In our opinion the volumefactor should be in line with the contractboundary, both for one year contracts and long-term contracts. This means that the volumefactor will differ between both types of contracts.

If the insurer can change the future pricing and/or terms for new business policies, there should be no capital requirement for these kind of new business policies. But if the insurer can not reflect the changed circumstances in the terms of the policy and/or in the pricing, there should be a capital requirement for these new business policies giving a better reflection of the risk of the insurer.
This idea is equal for one year contracts and long-term contracts and is in our opinion in line within the definition of the contract boundary. | |

	In our opinion the volumefactor should therefore be based on the actual period over which the insurer has the premium risk. For a one year contract, that is one year.	
2.3	We refer also to paragraph 2.1 & 2.2. Par 83. Although we recognize the gap in the definition for multi-year contracts, this gap is not present for one-year contracts. We understood that the vast majority of non-life insurance contracts are one-year contracts. So this gap only exists for a small portion of European non-life insurance contracts. The proposed fix through option 2 for all contracts (one-year and multi-year) results in a very significant increase in the volume measure for one-year contracts. This increase does not match with an experienced larger premium risk for one-year contracts. A volume measure of 12 months for one-year contracts is suitable and corresponds to the calibration of the premium risk. Par 89. In the Netherlands all health insurance policies (both Basic and Supplementary) run from the 1st of January to the 31st of December. This results in a saw pattern of the volume measure for the premium risk during the year. To be able to manage the capital position by the insurer, it is not desirable to have a fluctuating (saw pattern) volumefactor. Only the passing of time and doing nothing will result in a significant (20%-points of SCR ratio) improvement of the capital position. It is clear that this is undesirable.	
2.4.1		
2.4.2	Par 145. For one-year contracts the insurer can reprice or change the terms of the contract every year. The proposed change of the volume measure results in a volume measure of 12 months or more, depending on the recognition date. Therefore the proposal overestimates the premium risk of the insurer for one-year contracts. The impact of the proposed change in the definition leads to an estimated increase of the SCR for HME in the Netherlands of ca. 1 billion euro's on a total of 7 billion euro's at the end of 2016. On the SCR ratio the impact will be a decrease of ca. 20%-points. This will have a large negative impact on the public opinion on the semi-public Basic health insurance in the Netherlands.	

Par 146. The introduction of an adjustment factor (30%) is introduced for FPfuture. The explanation of the calibration of this alpha is not very clear. Can you give more insights / clearity about the calibration of the alpha? And can more information be given about the number of one-year contracts versus the number of long-term contracts in the calculations?

Par 151. In Dutch HME all contracs have a renewal date of 1-1 and contracts are bounded just before year end. The proposed introduction of the saw pattern results in a volumefactor increase from 12 months to 15.6 months, a 30% increase. As can be seen in appendix 25 the Netherlands has an enormous weight in HME. Can you explain how it is possible that on average the volumefactor HME has only 3% increase in table 151?

Par 172 shows a graph with the saw pattern in volume measure which is representative for Dutch HME. As mentioned before this saw pattern is undesirable since it has a significant impact on the SCR ratio of ca. 20%-points.

Par 158-161. Even if the definition of the volume measure for premium risk is not changed (as proposed in option 1), the given definition of the initial recognition date will affect Dutch HME significantly. Dutch health insurers all apply a volume measure of 12 months. As mentioned before, Dutch HME insurance contracts run from the 1st of January to the 31st of December and are recognized ca. 1.5 month before, due to the binding offer. When we calculate the SCR for premium and reserve risk at the end of the year, we include the premium of the contracts which are already bounded but for which the coverage period has not started. In the Dutch case this would generally lead to an increase of the volume measure for premium risk from 12 months to 13.5 months.

We have three objections to this proposal.

1. First, as mentioned before, in our opinion the volume measure for one-year contracts can not be higher than 12 months. A volume measure of 13.5 months will significantly overestimate the premium risk.
2. Second, even if there is a small risk, it is not clear that this risk should be quantified by the

	same parameters as the risks for the contracts for which the coverage period will start immediately after the valuation date. 3. The calibration of the parameters has been done with a volume measure of 12 months. This means that the parameter has to be recalibrated before it is possible to use the parameter for a period of 13,5 month. The use of the calibration of the parameters in the consultation document does overestimate the premium risk.	
2.4.3	We have a strong preference for option 1. If a change will be made it should in our opinion be a change to the volumefactor of long-term contracts and not for one-year contracts. In our opinion the number of one-year contracts is much larger than the number of long-term contracts. In option 2 the one-year contracts are punished for the undesired behaviour of the long-term contracts. The calibration and the volumefactor are not aligned anymore in option 2. The saw pattern in option 2 is undesirable as well as it is difficult to manage and decreases the comparability of the capital position of the insurers. The proposal of option 2 is not in line with the definition of the contract boundary, where expected (and not bounded!) new business is not within the boundary of the contract. As insurers are able to reset terms and pricing for the new business contracts. In our opinion the volumefactor for one-year contracts can not be higher than 12 months. Option 2 will have an impact of on average ca. 20% decrease on the solvency ratio for health insurers in the Netherlands. But in a range of 15% - 45% for individual health insurers. The SCR will increase with ca. 1 billion euro’s on 7 billion euro’s. This will mean a large overestimation of the riskprofile of the Dutch healthcaresystem. This is a very undesired effect as the public and political pressure on healthinsurers to lower their capital buffers in the Netherlands is high.	
3.1		
3.2		
3.3		
3.4.1		

	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
3.4.2		
3.4.3		
4.1		
4.2		
4.3		
4.4		
4.5.1		
4.5.2		
4.5.3		
5.1		
5.2		
5.3		
5.4.1		
5.4.2		
5.4.2.1		
5.4.2.2		
5.4.2.3		
5.5.1		
5.5.2.1		
5.5.2.2		
5.5.2.3		
5.6.1		
5.7.1		
5.7.2.1		
5.7.2.2		
5.7.2.3		

	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
6.1		
6.2		
6.3.1		
6.3.2		
6.3.3.1		
6.3.3.2		
6.3.3.3		
6.4.1		
6.4.2		
6.4.3.1		
6.4.3.2		
6.4.3.3		
6.5.1		
6.5.2		
6.5.3.1		
6.5.3.2		
6.5.3.3		
7.1		
7.2		
7.3		
7.4.1		
7.4.2		
7.4.3		
8.1		
8.2		
8.3		

	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
8.4.1		
8.4.2		
8.4.3		
9.1		
9.2		
9.3		
9.4.1		
9.4.2		
10.1		
10.2		
10.3		
10.4.1		
10.4.2.1		
10.4.2.2		
10.4.2.3		
10.4.2.4		
10.4.2.5		
10.4.3		
11.1		
11.2		
11.3		
11.4.1		
11.4.2		
11.4.3		
12.1		
12.2		

	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**
12.3		
12.3.1		
12.3.2		
12.3.3		
13.1		
13.2		
13.3		
13.4.1		
13.4.2		
13.4.3		
14.1		
14.2		
14.3		
14.4.1		
14.4.2		
14.4.3		
15.1		
15.2		
15.3		
15.4.1		
15.4.2		
15.4.3		
15.4.4		
16.1		
16.2		
16.3.1		

	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
16.3.2		
16.3.3		
17.1		
17.2		
17.3		
17.4.1		
17.4.2		
17.4.3		
18.1		
18.2		
18.3		
18.4.1		
18.4.2		
18.4.3		
19.1		
19.2		
19.2.1		
19.2.2		
19.2.3		
19.2.4		
19.2.5		
19.2.6		
19.3		
19.4.1		
19.4.2		
19.4.3		

	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
19.4.4		
19.5.1		
19.5.2		
19.5.3		
19.5.4		
19.6.1		
19.6.2		
19.6.3		
19.6.4		
19.7		
20.1		
20.2		
20.3		
20.4.1		
20.4.2		
20.4.3		
20.4.4		
21.1		
21.2		
21.3		
21.4		
21.5		
21.6		
21.7		
21.7.1		
21.7.2		

	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**
21.7.3		
21.8		
21.8.1		
21.8.2		
21.8.3		
21.9		
21.10		
21.11		
21.12		
21.13		
21.14		
21.15		
21.16		
21.17		
21.18		
21.19		
21.20		
21.21		
22		
23		
24		
25		
26		
27		
28		
29		

	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
30		
31		
32		
33		
34		
35		
36		