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9ης Μαΐου 2014

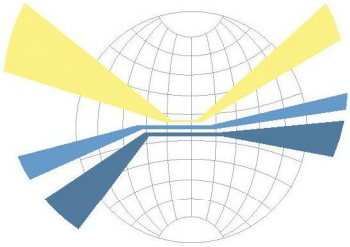
HILA-AIDA SUMMIT

ATHENS 2014

MAY 7-9, 2014

ATHENS, GREECE

Life, Health and Pension Insurance in the new Economic Environment



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Life, Health and Pension Insurance in the new Economic Environment

CONTENTS

Introduction

The present volume contains a collection of texts related to the presentations of the HILA-AIDA Summit Athens 2014, titled "Life, health and pension insurance in the new economic environment" that took place on May 9th. It is a compilation of expert opinions, commentaries and discussions on personal insurance, which is highly affected by the financial crisis of today. Our hope is that this volume will serve as brief overview and introduction to hot topics on life, health and pension insurance as well as an insight to the ideas and thoughts on both theoretical and practical market-related matters that have been identified throughout this challenging period by leading scholars and experts in the field.

The introductory presentation of the conference was delivered by the widely known for his contributions as Head of Insurance and Pensions at European Commission, Professor Karel Van Hulle, KU Leuven and Goethe University, who outlined the importance of creating efficiency and competition in the private pensions market, offering suggestions regarding the creation of pension programs freely movable across EU member state boarders. Mr. Michel Khalaf, President of MetLife Europe, Middle East, Africa, was next to address the audience and outlined the importance of customer centricity for the success of any insurance undertaking, while offering practical advice and related statistics.

Session one focused on long-term life insurance and safeguards for the insured, explaining the importance and functions of the private insurance guarantee funds, the auxiliary funds and in particular their relation to the local reality of the impaired economic performance, recognizing the overall positive role of EU related legislation, initiatives and supervision. Security funds for long term insurance were also discussed as they add value to consumers' trust; however, it was stressed that they must remain independent of the industry and function as a last resort mechanism. Solvency II is believed to serve as means to "easier" harmonization in the near future.

The second session focused on the dynamics between private and social insurance, examining whether private pension serves as a partial substitute or a supplement to social insurance. To that purpose, the role of EIOPA was explained along with the effect of policy choices on long term sustainability of life insurance and pensions always aiming to promote transparency, simplicity and fairness in the market for consumer financial products or services across the international market. The role of private insurance in the new economic context was discussed extensively by including data from EU member states. The consensus was that the Greek government cannot any longer maintain the burden of health care and that the answer to such problem includes supplementary/complementary private insurance, such as voluntary professional or regional mutual funds financed by contributions or contracting with public and private providers and forming networks of care. It was further suggested that in order to address the problems in the health care system faced by Greece it is necessary to commence a public-private partnership for health insurance as already applied in France.

The third and final session concentrated on premium pricing and transparency while examining several different country aspects and approaches. The examination of the German laws and regulations provided an insight on how the legislature aims to safeguard transparency; however it was concluded that transparency on premium pricing can only be assumed for experienced experts. Additionally, the Turkish model was also extensively analysed as regards the special rules for transparency in life assurance and pension contracts, outlining the time lapse before contracting and the continuing obligation to inform. Lastly, the importance of transparency and clarity were outlined, given that the lack thereof leads to higher costs, higher premiums and lack of standardization, and overall negatively affects customer confidence and market growth.

The conference was concluded by case studies on premium pricing and transparency that offered a closer look at the legal aspects and practical effects. Specifically, the case of a Greek insurance company was examined in relation to premium adjustments through the pre- and post-euro era. Such price adjustment resulted in costly and lengthy litigation, leading to the conclusion that the creation of a specific procedure capable of binding results for all parties without resorting to litigation is necessary. The Polish law and practice were visited next, presenting the issue of changing premium in life insurance contract versus protection against abusive clauses. In conclusion, the deciding factors in the adjustment process were explained, included but not limited to the evolution of the costs of hospitalization, indexation of compensations, as well as factors that are difficult to predict such as large increases in costs for the medical curing process and diagnosis due to evolution.

This volume is intended to address a broad audience, including academics, practitioners such as lawyers, insurance intermediaries, insurers, bank representatives, law students and all other parties interested in the insurance world. At the same time, it reflects the issues and expert opinions as well as suggestions for life, health and pension insurance in times of economic crisis.

I would like to take the opportunity to thank all the distinguished colleagues and honored guests who traveled great lengths to be present at the HILA-AIDA Summit and who shared our vision and were actively engaged in this work. Without such participation and fruitful exchange of knowledge, suggestions and ideas the conference would not have been so successful. In addition to the abovementioned distinguished speakers, I would also like to extend my gratitude to Dr. Herman Cousy, em. Professor, KU Leuven University, Belgium, Dr. Manfred Wandt, Professor, Goethe University, Frankfurt, Dr. Samim Ünan, em. Professor, Galatasaray University and Fmr Presiden, AIDA Turkish Chapter, Dr. Rafael Illescas Ortiz, Professor, Universidad Carlos III de Madrid, Mr. Michael Gill, attorney at law, President, AIDA World, Ms. Pamela Schuermans, Coordinator for Insurance and Occupational Pensions Policy Development (EIOPA), Mr. Minos Moissis, Fmr President, Hellenic Association of Insurance Companies, Mr. Evangelos Zerveas, attorney at law, President, Hellenic Consumers' Ombudsman, Dr. Milton Nektarios, Professor, University of Piraeus, Dr. Antonios Tsavdaridis, attorney at law, Lecturer, Democritus University of Thrace, Dr. Katarzyna Malinowska, Lecturer, Partner at BMSP Legal Advisors, Warsaw, Dr. Kyriaki Noussia, attorney at law, Dr. Christos Chrissanthis, Assistant Professor, University of Athens, Dr. Lykourgos Liaropoulos, em. Professor, University of Athens, Dr. Georgios Veliotes, General Manager Life & Health, Interamerican and Chairman, Insurance Europe General Health Committee, Dr. Ourania Chatzinikolaou Aggelidou, Professor, Aristotle University of Thessaloniki, Mr. Alexandros Sarrigeorgiou, President, Hellenic Association of Insurance Companies, Dr. Alexandros Kalantzis, attorney at law, Partner, V&P Law Firm and Mr. Marios Apergis, Director Life, Accident & Health, Carpenter Turner. Last but not least, warm thanks are ought to the publishers.

Prof. Dr. Ioannis Rokas
Attorney at law
- Chairman of HILA -
Member of PC AIDA World

HILA – AIDA SUMMIT

CONFERENCE

"LIFE, HEALTH AND PENSION INSURANCE IN THE NEW ECONOMIC ENVIRONMENT"

FRIDAY, MAY 9th, 2014

Michael Gill,
Attorney-at-Law, President, AIDA World

Ioannis Rokas,
President, AIDA Greek Chapter

Official opening
Karel Van Hulle,
Professor, UK Leuven and Goethe University, Frankfurt,
Fmr Head of Insurance and Pension, European Comminission

Michel Khalaf,
President, MetLife Europe, Middle East, Africa

Dr. I. ROKAS

(Professor, Athens University of Economics and Business and President, AIDA Greek Chapter (HILA))

It is a great pleasure for HILA, the Hellenic Insurance Law Association, Greek Chapter of AIDA, to welcome members of the international insurance community and Greek friends and colleagues as well, in Athens.

It is for the first time in the last decades that the Greek Chapter organises an international conference, in association with AIDA World. And I have to confess that we, at HILA, are all excited to have been given this opportunity.

We are grateful to our speakers and to the participants who have honoured us with their presence today and have made our conference as rich in content and turnout, as conferences hosted by large international organisations.

For our conference, we have selected to focus on personal insurance, a theme less usual for AIDA conferences, which is highly affected by the financial crisis of today. Our ambition is not for the present conference to contribute to the exit from the financial crisis, which has in some way, according to some politicians and officials, already been achieved. But we do hope it will serve as a means for greater collaboration and exchange of ideas between specialists in the field like yourselves and our honoured guests.

Now, on the pleasant occasion of having you as guests in Greece, we can consider our heritage of culture and science. When we look back to the ancient times, we see that our ancestors have considered most of the substantial issues affecting the organisation of the society. However, they did not reach as far as to deal with life insurance and its contemporary hot issues. And after all, hot issues is what we wish to touch upon throughout this conference, given also that some more of those have surfaced during the present Greek presidency of the European Union.

Mr. MICHAEL GILL

(President of AIDA World)

Mr. Michael Gill, in his capacity as the president of AIDA World, offered a very warm welcome to the constituents and, amongst others, noted:

"As I come to the end of my presidency, one of the things I am particularly proud of is that three of my Presidential Council meetings have been at the east end of the Mediterranean, in Tel Aviv and Jerusalem, in Istanbul in Turkey, where I spoke about a different form of relationship between Australia and Turkey but equally strong, and now of course in the great city of Athens.

It's wonderful to be here, to the Hellenic Insurance Law Association. Thank you so much for hosting us on this occasion. To the organisers, the people who have made this happen, I can tell you as somebody who has many years travelled the world attending conferences and seminars: I have experienced no better organisation, and I don't think I have ever experienced a better hotel. The staff here is absolutely fantastic. Every aspect of what they do is great, and I think the organisers have a lot to be very proud of.

Lastly, after Athens we focus on Rome at the end of September and October. Now, the Italian organising committee are doing a great job to provide for us a sensational programme in another great city of antiquity. That will bring up my four.

And I would encourage you all who have an interest not just in insurance law but in sharing your experience with your colleagues from all over the world, to come together in Rome in September. I personally think that the greatest thing about AIDA is the opportunity it affords for people of different

nation, language, culture, religion, legal tradition to come together under the auspices of something that binds them, something that is fundamentally important, not just to our industry and to our profession, but to the society at large.

We have a pivotal role to play within the rule of law and within access to justice. What we do is very, very significant work. And the extent to which it becomes better, because we do it together and we learn from each other, is, I think, what AIDA is all about."

Dr. K. VAN HULLE

(Professor, KU Leuven and Goethe University, Frankfurt, Fmr Head of Insurance and Pensions, European Commission)

«Should we continue to close our eyes to the true cost of pensions?»

"We live longer, but we do not know how long. Medical research will most likely make us live longer; however, we might well be the victim of some mental or other disease. We are dreaming of a nice and comfortable pension, but we have no idea how big or small our entitlement will be. We hope to retire at a reasonable age, but we have no idea when that will be. We have saved a lot of money for our old age but the money might be gone by the time we retire. Social security will "save" us all?

These messages that introduce the substance of my speech sound like bad news, but in fact, they are good news. We do live longer!

And as you may be aware, the basic message is that less and less people will have to support more and more people. And that, economically speaking, requires action. So, what are the options? When we discuss about demographics, things cannot change overnight. The situation may be different from country to country, but the situation in the EU does not particularly look very positive.

As for all countries in the world, in the area of pensions the two following messages are very important: adequacy and sustainability. The problem today is that we have a lot of promises, but these promises may not be adequate or sustainable and as a consequence people will live up to an old age without having the money to enjoy it. This is the reason why we need creative solutions:

The first pillar, the social security area: raise the retirement age.

The second pillar: enlist more people in pension funds.

The third pillar: stimulate private investment and insurance, life insurance.

The fourth pillar: promote home ownership.

And the fifth pillar: go back to where we were; the family circle as a solution.

These are five pillars, with linkages between them, which I have listed here. They are used by people in an effort to make things easy to understand and are, therefore, merely illustrative. But what is clear from this message here – five pillars – is that when we talk about pensions we must talk about options – as many options as possible – in order to deal with this difficult issue.

Looking at the replacement rate in a number of countries we see that some pillars are sticking out. Greece is one of them. How much do you get after retirement, based on state pension?

We also see that there are not that many countries that give you 60% replacement rates and things are looking worse and worse.

So let's examine what are the possible issues. If we look at the social security area, the first pillar, it's obvious that we can no longer rely on state pension as the only source of retirement income. In

certain countries we see that the pension income people will get from the first pillar is just above the level of subsistence; this is very low and we cannot continue to rely on that.

If you have a system of pay as you go it is unlikely that we will have adequate pensions, because of longevity. We live longer. Some people see that as a problem. I think it's great that we live longer. But still it's an issue.

During the same time that we have more people living longer, we have a decreasing birth rate. So we have less and less people that are going to pay in a pay-as-you-go system for the more and more people that are retiring. This is a particular issue to the baby boomers. What we are talking about, and I will point it out later, is that we are facing one of the potentially most difficult issues in society. It's an intergenerational problem. The people that are the baby boomers will come out of this rather well. You'll do well, but it's the next generation, your grand-children, and the question is how long will the young generation be prepared to fund the older generation? How long will they accept that they must pay but that there might no longer be money left for them?

Prioritisation is necessary in order to channel the funds to those people that really need the support, since some of us will be able to manage alternative sources of income. There will always be people in need, and for those people we need to really provide the necessary funding.

Postponement of retirement age will reduce the pressure on state budgets, but it meets resistance in the population. You will see that in many countries, when governments start pension reforms and they say we have to work longer, people demonstrate.

I found quite interesting the case of France. The French government was under pension reform and the students took to the streets to demonstrate against a reform, which was, in the end, in their interest. It is quite amazing how the communication is failing.

Increase in birth rates is recommendable of course. Smart forms of immigration are also going to be helpful. Having more people will provide some relief, but the issue is a major one.

The second pillar. One of the issues here is that not all employees are included in occupational pension arrangements. The UK example could be of interest, where a system of mandatory enrolment was introduced so as to include more people in an occupational pension arrangement.

One of the problems we have here is that occupational pension funds were often introduced to keep people working for the same company as long as possible, whilst what we see today is that people change jobs. The young generation will rarely start and finish a job in the same company. So what we need here is not only having more occupational pension fund enlistments, but also a system of portability where you can take your money with you when you travel to another country or another job.

Employers are closing defined benefit schemes, thereby pushing the risk back to private individuals. We see that in many countries where the employer promises guarantees and along the way it decides it is too costly and does not do this anymore. For people, this means they are now at risk.

Employees do not always have a choice in selecting their preferred investment strategy, or are badly informed about their final entitlement.

Two important issues: To what extent is the employer using my money in the right way so as to give me an optimal use and investment of my money? Ask people that are members of a pension fund: Do they know what their entitlement is going to be? You know that pension funds today will be very proudly publishing scores of how they were doing – we had a 10% return, and so on.

Who cares though? You want to know when you are going to be 75 and you retire how much you will get. You will not read that information today, not at least in many countries.

Occupational pension funds do not always have good governance arrangements, and the cost may be high. And once in a while we read in the press, that people running these pension funds collude with their business friends so as to channel the pension fund money to friendly companies, not necessarily in the best interest of the pension fund members. Sometimes, expensive asset

managers are hired to invest the money against very high commissions. Again, not necessarily in the interest of the people concerned.

We therefore need more transparency in this area. Regulation may be necessary to achieve this.

Another issue is the state itself. States have become more and more greedy. Just imagine for a moment you're the Finance Minister and you've got some budgetary problems. And you see these pension funds with billions of money. What are you saying? Oh, I like this. It happens in some countries: the finance minister says, "This is mine."

No, it's not their money. It's your money. But it is always a problem when much money is channelled in a fund. It makes Finance Ministers greedy. See what happened in Hungary. This is a disaster for the people, in terms of their funding.

Third pillar. The financial crisis brought us back to reality. There's nothing like a free lunch. Markets – we've seen that – they can go up; we love it. But they also can go down.

It is difficult for private individuals to decide which investment vehicle is likely to be profitable in the end. You go to your bank and you say, "I have some money. I want to invest it." the bank is saying, "Oh, I suggest you do this and that." Who are you to know that this is going to be the right investment?

Is the person behind the counter not looking at his commission more than at your interest in the investment? Many life insurance undertakings move away from long-term guarantee products. They are saying it is too costly and they blame Solvency II. They forget that Solvency II is not the cause, it is just the thermometer. Thanks to a risk based solvency regime, life insurers understand that when they make a promise, it costs if they really want to deliver what they promise. They must put a price to the guarantee that they offer.

And some companies are saying, "Oh, now that I know the cost, I'm stepping out. So I am going to put the risk back to the individuals. I am not going to offer guarantees anymore, but I will move to the direction of things like unit linked products."

What does that mean? It means basically that the person, the policy holder, bears the risk of the investment. Does he or she know that?

And, of course, states are not afraid to take their share of the profits. Watch these Finance Ministers. They will say, "Oh, people are building up these nice pension pots. Let them pay taxes on it now." And then people say, "Why should I have a pot when the Finance Minister will take it away from me?"

We do not want to know the truth. Very few countries in the world have a clear picture about the impact of the pension cost on the state budget.

Budgetary calculations are short-term. There is a tendency to overlook the long-term consequence. What is the long-term consequence in political words? It's something that goes beyond the next elections. But that's what we need. We need people who look at the long term.

Occupational pension funds and insurance undertakings rarely apply solvency rules that are reflecting the true cost of the pension liabilities. That has been a major issue in the finalisation of Solvency II.

I remember in the debates that even people in the insurance industry were saying, "We believe in risk management. That's the way to go." And when you ask them, did you calculate the cost of your liabilities when you are promising a 30-year fixed guarantee at 4.5% and you have a return on your investment of 1%? You don't need to be an actuary to know that this cannot last.

I have companies coming to me and saying, "Karel, do we need to be so serious about this? This is the long term. Can we just mix up a little bit the calculations so that it looks nicer?"

And the pension funds, they came to me and they said, "You are killing us. We have made such nice promises to our members, and you are telling us that we should tell them we don't have the money?" I said "yes, we need to tell people that you don't have the money". They did not like that and started their lobby exercise, as you have seen.

Some undertakings carry their pension liabilities in their balance sheet. These business enterprises bear the cost of their liabilities because they are their own insurers. Well, they tend to overestimate the return on investments and apply a favourable discount rate to reduce their liabilities. That's the beauty of accounting. We call that creative accounting.

It is complicated. I mingle a little bit with the discount rate and suddenly I'm very profitable. However, that is not the way to do it.

Transparency as a solution: Governments need to do their homework and confront the population with the real cost of state pensions in order to avoid, as I said, the intergenerational conflicts. This is something that is worrisome. Before I left my post at the European Commission, I remember that we were talking about this issue amongst colleagues with our Commissioner for the Internal Market, Michel Barnier. He was very worried about the potential of an intergenerational conflict. We were all worried about that. How long will it last? The day people will start to realise that there won't be any money left for them, they'll get angry and we'll get social conflicts.

Undertakings need to indicate clearly whether and to what extent there is a pension gap in the calculation of their pension liabilities and how they intend to deal with this.

Pension funds should more clearly indicate what the likely pension entitlement their members will receive is. There are some ideas that have been developed in this area. We call that a key investment document, a document which can be developed very simply and by which people are told what their choices are and how likely it is that they will get something when they retire.

Insurance undertakings and investment funds should communicate more clearly the investment choices and returns. It's widely known that when you have your money invested by so-called professionals they sometimes turn out to be not that professional and you only realise that when you see the return. Your money is gone and you wonder how does this happen. But they didn't tell you that they invested everything in the wrong currency or in the wrong equity or "bubbles".

Transparency requires discipline. The party that takes on the risk should be required to calculate the liability in a manner that reflects all the risks. That is very important, that's fair.

Occupational pension funds might consider using a holistic balance sheet as means to reduce the necessary capital buffer. This is a proposal that was made by EIOPA in its advice to the European Commission as a way to allow pension funds to better see what their true liability position will be.

The pension fund may be able to call on the sponsor (the employer), for instance in the UK, to contribute more, if things are not going well. Or the pension fund may be able to rely on a new agreement between the social partners to cut pension benefits, as is the case for instance in the Netherlands.

There is a possibility to show this potential increase in the funding or decrease in the liability in an accounting balance sheet, which is called the holistic balance sheet.

If you develop a solvency regime, you may also use some counter-cyclical solutions. Counter-cyclical solutions are used to take account for the fact that pension funding is a long-term issue. So if you have changes in the price of equities in the capital markets, they may be phased out. You can either apply a dampener exercise or you can extend the recovery period for the solvency capital, if you have a capital buffer, which should reflect the unexpected risks you may have. Well, if you go below the capital buffer because of market volatility, you may want to have a longer recovery period in order to recover your capital buffer. And long may be, in pension terms, very long; one could think of a recovery period that could last for 10, 15 or even more years. So it could be a long period. The advantage is the transparency and the discipline that follows from it.

Apply an appropriate discount rate for long-term guarantee products on the condition that there is a good matching of assets and liabilities. This is one of the solutions that were adopted during the last discussions on Omnibus II. Once a guarantee has been provided, it is very important both for insurers and pension funds to match assets and liabilities. Asset-liability management, in an insurance industry, is absolutely crucial. And if you do that well and you have a situation where the liability is illiquid, i.e. the undertaking or the fund knows exactly how much it has to pay because the policyholder or member cannot revoke the contract, it should be possible in the calculation of the

discount rate to take account of this particular situation. That is the reason why in the Omnibus II discussions, a matching adjustment was introduced for annuity business.

Truth and untruth in pension funds. The Commission's attempt to bring discipline into the way pension funds calculate their liabilities has been strongly criticised. I can assure you it wasn't always pleasant when I had to talk to the pension fund industry in Europe, because they all believed I was going to kill them with my bare hands. I was talking about their sustainability, and not about their short-term problems.

There is an unholy alliance between employers and trade unions and it is very interesting. Business Europe wrote to the European Commission and said, "We fundamentally oppose any reform in the area of pension funds. Stay out of our business." We had the trade unions sending the same letter to the Commission. Why could that be? Because, of course, the industry is saying, "If we are required to calculate the true cost of pensions, we can no longer tell our employees that we promise them a blue sky. Social unrest. And the employees are saying, "We don't care. It's not our responsibility. It's the employer that promised us the blue sky, so he's got to deliver." Unholy alliance. Both say, "Stay out. Don't tell us the truth. Let's keep sailing as if the sun will continue to shine."

After very difficult negotiations, the Commission introduced a proposal on the 27th of March 2014 for a revision of the Pension Fund Directive, aiming inter alia at improving the governance of pension funds. Everybody agrees today that it is not because pension funds are a creation of the social partners that the members of the Board of pension fund should not be professional. We need people who know what they are doing. The Commission's proposals introduces some specific rules in this area.

It also proposes to increase the transparency both to the members and beneficiaries. Yes, that's also a good idea.

But can you really have transparency to your members if you don't know how to calculate the liability? That's the problem.

Are we not creating now an unlevelled playing field between pension funds and the insurance industry? Because if I am an insurer and I have a strong solvency regime and delivering pension products, maybe I'll organise myself as a pension fund, not to be subject to these strong solvency rules. That's the way the market operates. We have learned that from the past.

This is the most terrible thing I remember from my career: A problem does not go away by ignoring it. I have tried it so often. It comes back, at night in your sleep. There it is. Have you got it resolved? No, get at it, tackle it, by the horns.

Even with long-term liabilities, there comes a time that payment is due. Aren't we all like that? It is very human to say, "I've got to pay in three months. Enjoy life." But the three months will be over, and I've got to pay. That's the problem.

The cost of managing pension schemes must also be clearly stated. It's true in all financial services areas. If you pay something to a service provider, you need to know what the cost is that he or she will charge you. Board members of pension funds must be fit and proper. We can't have a system where this is not considered to be as serious as in the case of a bank or an insurance undertaking.

What is also important is that people are more ready to accept bad news, if they have the feeling that something is being done about it. That's a positive message. Bad news can be good news, if you know that some people are going to take care of you.

Let us be honest about what we promise and what can really be expected as an outcome, whether we are in a defined benefit or in a defined contribution environment. The distinction between defined benefit and defined contribution becomes more and more difficult. If you ask the Dutch, do they have a collective defined benefit regime, or a collective defined contribution scheme, you have as many Dutch who say the first as who say the other. They don't know anymore.

To conclude, as I said from the beginning, adequacy is as much a necessity as sustainability. Don't promise things that you can't deliver, but keep in mind that when people grow old they will need money, and they will need money because they need care, long-term care. I have said that to the insurance industry many times. Why don't we have more long-term care products?

People are telling me life insurance is dead. I tell you it's alive and kicking, but it requires creativity, imagination, new products. That's what we need.

People should receive at an early stage an overview of the likely pension entitlement in each pillar. They have the right to have that. It can be easily organised.

Information about investment returns and pension entitlement should follow the KISS principle – don't we love that! – keep it simple and straightforward. A key investor document, a document that says, "You are at risk." That's where it starts. How can I diminish my risk? What are my alternatives?

Don't forget that the financial know-how of an average person is not higher than that of a seven year old boy. So we need to keep it simple; so that we can understand.

Pension capital should be portable. All these fights in Europe against portability should not continue. We should allow people to carry their money with them, so as to invest it in the most efficient manner. If longevity continues, we may want to change our life cycle.

Our pension system was designed by an old man with a moustache – you certainly know him – called Bismarck. In the time of Bismarck, it was almost unthinkable that anybody could live longer than 60 years. That's why the retirement age was fixed at 60. He could calculate very well. But why, if we now retire at 75, or soon 80 or 85, should we go to school until 23-24 and start working? Can we not just reorganise our lives – wouldn't that be great? At age 35 you go to Greece and the Greek islands, enjoy yourself, your kids, while an insurance company is paying your salary, for the five years of your break time? Let's be a little bit more creative in what we do.

So to conclude, there is still time. But it is time that we use the time.

Mr. M. KHALAF

President, MetLife Europe, Middle East, Africa

«Customer centricity: An enduring differentiator in changing markets»

We live at a time where we face many challenges, many external challenges such as the low interest rates, market volatility, some economic difficulties, and political instabilities in part of the world.

So I chose a subject that I think is a bit sunnier since we are in Greece after all. But a subject also, customer-centricity, that I think there are a lot of things we can do about, so a lot of the influence that we can exert, in terms of how much we can make it happen.

I will argue that, perhaps at a time where significant attention and resource in the insurance industry is going towards areas such as compliance and risk, and rightly so. Perhaps we should consider deploying equal resources in an area like customer-centricity, because it can truly create an enduring differentiator.

So let me start by sort of defining what is customer-centricity. Although I am sure that you have all read and seen articles about the subject, let me just give you our take on it. We believe that becoming customer-centric is to fundamentally change an insurance company's business model and culture, so it moves from one that is focused on selling to one that is focused on delighting customers.

This approach blends elements of marketing, including research, gaining deep insights from customers, changes to operations and processes, as well as using frontline staff to understand the issues that customers encounter every single day, often issues that are already built into our operating model.

Becoming customer-centric means making customers' everyday interactions easier, reducing frustration and fixing problems they are encountering. For this, customer-centric companies actively listen and engage with customers, to understand what is important to them, what is causing dissatisfaction, and then fixing those issues at the root cause.

And it's not just being reactive. Customer-centric businesses create clearly defined, deliberate and differentiated experiences, through all the channels that customers want to interact with or want to have access to. Customer-centricity is about standing in our customers' shoes, considering how an action would impact a customer, then creating a working environment of customer empathy, where we all know how customers feel and what they want from us.

Let's keep in mind that, especially in our industry, a customer may not be sure what a great insurance experience is, but they sure know what a bad one is. I will just share a couple of anecdotes that just may bring to life what customer-centricity is all about.

The first one is from this morning. I am the kind of person that needs to have a coffee when I wake up, to get going. Very difficult for me to get going without having a coffee as a first thing. So I woke up around 6am this morning at the hotel where I am staying, called room service. No answer. Contacted the reception; the guy at the reception told me, "Look, I'm sorry. Room service doesn't open till seven." I said, "OK, well, can I come down to the restaurant and have a coffee?" He said, "I'm very sorry but the restaurant doesn't open till seven. What were you interested in, sir?" I said, "I just wanted a coffee." He said, "You know, I'm very sorry. I promise you when the waiter comes, I'll have him bring you a coffee." I said, "OK, thank you very much," you know, expecting that I'll wait till seven, go down and have a coffee. Literally five minutes later, a knock on my door. The receptionist himself had brought me a coffee. Totally unexpected. My thoughts went from, what kind of hotel doesn't serve coffee until 7am, to thinking, well, I mean this is somebody doing something maybe beyond the call of duty to keep a customer happy.

Another story. This one is told by our head of customer-centricity worldwide for MetLife, and she tells it much better than I do but I'll give it a go. Also from the hotel industry, this one is about the Ritz Carlton. For hotels, delighting customers, ensuring that they extend their stay, that they recommend the hotel to others is extremely important, obviously. So this one is about a family that went to a Ritz-Carlton in California, a family of three with a five-year-old child. The child was very attached to a stuffed giraffe. The giraffe is called Joey. So wherever the kid goes, the giraffe is always with him, shows it to everyone, talks about it non-stop, etc. When the family left, as they were boarding their plane at the airport – they live on the East Coast – the mother realised that the giraffe was missing. So, panic. As soon as they arrived back in New York, she called the hotel and the hotel told her, "Look, we found Joey and Joey is on his way back to New York." Sure enough, 24 hours later Joey arrived and to the family's surprise, it wasn't just the stuffed giraffe in the courier envelope. It was also a photo album showing Joey lying by the pool relaxing, Joey at the spa table waiting to have a massage, Joey at the bar waiting for his drink. The message that came with Joey was, to the boy: "We hope you didn't worry too much, but Joey thoroughly enjoyed his extended stay with us."

So again, just an example of how you create an experience that is truly memorable and that truly differentiates your company, your offering, from anything else that's out there. I think the starting point for any initiative is that we have to take stock of where we are, first and foremost. And I'm afraid that research paints a pretty grim picture in terms of where we are as an industry.

Research says that only 11% of people have real interest in their life insurance provider. So, that says we are not engaging enough with customers, and if we are, we are not doing it effectively. And the perception out there is that insurance companies are not very approachable. So we have to ask: Do we really try to engage with customers after they have purchased from us? Do we really attempt to establish an ongoing relationship beyond that first initial purchase?

The second data point is that only 27% of customers are satisfied with the service they received from their life insurance provider. Twenty-seven per cent, and that's only satisfied, not very satisfied or delighted, so, clearly quite shocking numbers. And finally, only 23% would recommend their current insurance provider. And obviously in our business recommendation, referral, is very important to our business. And yet, again only 20% of customers would recommend their insurance company to friends or to family.

I think these figures tell us that we, as an industry, have a lot of work to do, to change those perceptions, to become more customer-centric. And probably the way we should look at it is that the good news is that there is a great opportunity for us here.

At MetLife, off the back of these initial findings we undertook further research to understand the specifics that were causing this general dissatisfaction. In order to really understand the drivers of this disappointing landscape, both for MetLife and for the insurance industry in general.

What we found out, what customers told us, was that insurance is difficult to appreciate and prioritise, until it is too late. We are not making people aware of the need for insurance and of the benefits that insurance offers. And if we do, we're not making it easy to do business with us.

When the customer does recognise that they have a need, when they are trying to make a decision about buying insurance, then we make that exercise a chore. There is a lack of information advising customers, especially younger ones, on what it is that they really need. So, you could get on the Internet to do some research and you'd find that one provider is telling you that the right amount of coverage is EUR200,000; another provider is telling you no, it's EUR500,000. So, this confusion often means that people don't take action at all.

Customers also told us that most of our communication consists of page after page of details, exclusions written in language that is alien to them and full of legalese. So, basically customers don't understand the documentation we supply them with, and as a result they don't understand their coverage.

We don't explain effectively what they are buying or have bought, and we don't follow up to reinforce, to make sure that they understand. So we take it for granted that once they have bought, then they do understand, and we do very little follow-up afterwards.

I think the worst and the most telling thing that we found from the research is that, even after taking all that into account – so: lack of understanding, awareness, peace of mind at the end of the day – customers were actually reluctant even to call and ask for the information – and remember, this is for the industry in general – because they thought that if they did call, then we were going to try to sell them more, up-sell, or to convince them to increase their coverage, rather than make a real effort to explain to them what it is that they bought, make sure that they are fully aware of their coverage.

So again, maybe a slightly grim picture, but there is good news here, and the good news is that customer expectations are so low that a better experience, even a subtly better experience, makes a huge difference to customers, providing differentiation and most importantly leads to a satisfied customer.

So how did we start to address this issue, and working on our customer-centricity agenda at MetLife? Well, we announced our corporate strategy in 2012, and I am not going to go through all the cornerstones, but I would focus on the bottom right one. This is the core of MetLife's strategy. We are saying that, for us, customer-centricity is a pillar of our strategy across all lines of business, across all of our 45 countries and markets. And we are saying that this is a journey that we are driving towards.

We made this public, so this is not just an internal piece of information; this is something that we have communicated to the outside world, to the outside community, including analysts and investors, because we view it as a firm commitment and one that we will continue to update those investors, that outside community, on the progress towards.

It's part of our strategy, but what does it mean for MetLife? And how will we achieve our goal of becoming more customer-centric?

Here you see the foundations that we are focusing on. And the starting point is always listening to customers and actually taking action with the insights that we gain from our interactions with them. As an organisation, this represents a huge opportunity, but it's also a challenge. It's a challenge because think of all the letters, emails, call centre calls, data, freeform website comments, social media information. You know, all of these things that we have access to, and then layer on top of it the data and information that we have gleaned from research.

Previously, we took this information, those comments, suggestions for improvement and complaints, and we resolved the issue for that single customer that raised the complaint or the issue. We are now focused on solving the root cause of the issue for all of our customers, so that this will make it easier for them in future interactions.

We are taking insights and learning from customers to develop a deep understanding of the issues our customers are facing in their everyday interactions with us as an organisation, and then globally, regionally and locally we are focused on efforts to fix those issues, fix the pain points at the root cause, so that the same issue does not keep occurring time and time again.

By better understanding customers, by listening to them and researching ideas with them, we can then not only deliver products that meet their needs, but we can also design the experience at every touch point that they have with us that will exceed their expectation at the key moments in their interactions with us.

Just to give you an example, we recently developed a new A&H product, which product targets children, specifically a product for children. And what we did is that we researched initial ideas. We thought we had some ideas in mind, but we researched those with target customers. And that really helped us refine the design of the product, the feedback that we received. We started at one point and we ended at a significantly different point, given all the feedback, all the information that we gathered. And then, based on that feedback and as part of the development cycle, we designed the exact experience we wanted customers to have with us. So, whether online, whether they are talking to an agent, whether they are being told about this product over the phone.

This is what we call an end-to-end journey. We term it shopping, buying, and using. A very deliberate design that we can measure and then we can track. And the sales results have been very good, but I think more important, from our standpoint, is that net promoter score results – and we use NPS or net promoter score as a measure of customer-centricity – those have been outstanding as well.

So, we merely took the trouble to listen to our customers, who told us about the product design and the service experience they want, and we acted by implementing it. And that's very simple, really. We created a specific experience that works and meets the needs of our customers.

It's also incredibly important to understand that this is a culture shift for the enterprise. And we can only achieve our customer-centricity objectives with our staff fully understanding what we are trying to do and fully on board.

So we undertook training of all of our associates, over 60,000 worldwide. We have active internal communication programmes. We added customer-centric objectives to our scorecards, and devised and implemented comprehensive empathy programmes, to ensure that our staff constantly stands in our customer's shoes. And this helps them in terms of how they undertake their roles.

This is at all levels of the organisation, starting with the executive group down to a new hire in an administrative capacity. So customer-centricity is embedded in the hearts and minds of all of our employees.

We think that this makes our environment a much more exciting one for employees to come and to work in. They feel that they are delighting customers, and they feel that they are enabled with the tools to do so effectively.

And of course customer-centricity has a significant financial impact on our business, be it from attracting new customers, to retaining existing ones longer, or to having existing ones buy more products from us.

Further programmes that aim at simplifying processes, to make the experience easier, and helping fix issues at the root cause, which prevents repeat issues from surfacing. All of these things have reduced expenses and generated savings that we capture and track across the enterprise.

This leads to some key findings from research undertaken by Harris Interactive in its 2011 Customer Experience Impact Report, which provides overwhelming confirmation for the business rationale of becoming more customer-centric. This research demonstrated that customer-centric companies – this is across all industries – who deliver a great customer experience outperformed a competitive set on all benchmarks – that's revenue, profits, cost of service and shareholder value. A very compelling reason indeed to focus on our customers.

Interestingly also, 86% of customers will pay more for a better experience. And very importantly, as you progress on your customer experience journey, more and more people within the organisation believe they have an impact on the customer experience. And this is across the whole organisation, so it's not just customer service. It's legal, compliance, operations, marketing and so on, all understanding the roles that they play in delighting our customers.

So what are some of key learnings that we have from this journey that we have embarked on? Well, one of the key takeaways is that we must start by listening to our customers. They want to be heard, and we have a tremendous amount of data of structured and unstructured feedback already that we can call upon to understand their needs, wants and expectations.

We should treat customer-centricity as a specific competence, a dedicated function that sets, supports and drives a customer-centric agenda. It doesn't have to be a large team – we started quite small – but a team that is dedicated to the customer-centricity strategy, sets the measures, develops the programmes and delivers in-country support.

We need to be clear that customer-centricity is a multi-year journey, and really you never reach a point where you say, well, I'm there, I'm done. This is an ongoing exercise and the commitment to it has to be relentless, has to be consistent.

And then, senior support is also extremely important. As I said earlier, for us at MetLife customer-centricity is a foundation of our corporate strategy. We have advised the market, our investors, and we openly talk about our progress on this journey.

Finally, we make our people, all of us, accountable for the delivery. Setting objectives and targets and rewarding success, exactly like we do with other financial measures that we run our business upon.

In these challenging environments, customers are constantly re-evaluating who they do business with. They demand products that meet their needs, backed by experiences that meet or even exceed their expectations. Becoming customer-centric ensures that we are the stand-out organisation for customers to do business with, and as an essential ingredient we believe in our quest to becoming a world-class organisation.

Customer-centricity: a simple yet effective differentiator.

SESSION I

LONG –TERM LIFE INSURANCE AND SAFEGUARDS FOR THE INSURED

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«The role of "Private Life Insurance Guarantee Fund" when an insurance undertaking becomes insolvent»

I. Introductory remarks

1. The problem

The basic characteristics of insurance are two twin concepts: expectation and hope for the future that every insurance offers to each member of the society of risks. These two concepts have a more profound meaning when long term life insurances of saving or investing character are involved, to which the consumers anticipate thanks to the credibility and solvency of the entities that offer them. Respectively, when an insurance undertaking becomes insolvent, it is an adverse situation that can shake down the institution of private insurance and create a systemic hazard if these consequences outspread in the financial system.

There is not an existing economy or society of risks that is faceless and with no legal obligations. All their operations originate from named entities and the community consists of certain groups of people. In this particular case, from one side there is the state with its supervisory role on insurance undertakings and the insurance entities themselves, which have to follow the rules of solvency that are enforced by the supervisory authority and from the other side there is the society of the insured persons, whose protection is covered by the state through Insurance Guarantee Schemes, which guarantee compensation for losses to the insured party when the insurance undertaking becomes insolvent.

2. EU status

Unlike the banking and investing sector, where there is community legislation, through which insurance deposit schemes and compensation of the investors have been established respectively, in the sector of private insurance there is no community obligation for the establishment of a harmonized regulation concerning the Insurance Guarantee Schemes in E.U. This situation can prevent the effective and equitable protection of the consumers in the Member States in E.U., since it can lead to the distortion of cross-border competition between insurance undertakings which operate in countries that do have such insurance mechanisms and insurance undertakings which are not covered by Insurance Guarantee Scheme.

After the financial crisis in 2008, the European Commission took more drastic measures to address insurance undertakings that have become insolvent and protect the rights of the insured persons, and issued in 2010 the White Paper which formulates fundamental principles that reflect the socio-economic policy of EU regarding the protection that must be offered by the Insurance Guarantee Schemes, as an ultimate protection of consumers when the insurance undertakings of all sectors become insolvent.

These initiatives by the Commission are promoted by EIOPA, the European Insurance and Occupational Pensions Authority, while Directive Solvency II (Recital 141. q.2) refers to harmonized and adequately funded insurance guarantee schemes. But in the EU, the situation for the final configuration of a harmonized insurance guarantee scheme has not taken a final form and each Member State differentiates according to their aspirations.

3. Funding

A serious issue for discussion among the Member States is funding an insurance guarantee scheme. Who bears or who should bear the cost of operation in a time of intense economic fluctuations? I would say in principle the state itself through the direct funding of the guarantee mechanism, if the problem is mainly due to the improper exercise of its supervisory duty on insurance undertaking. Subsequently the operation cost should burden the insurance undertaking itself, with the (usually) prior contributions and possibly additional ex-post funding, depending on the volume of

business and the balance of risks. The very participation of insurance undertaking in the financing of insurance guarantee mechanism is a positive sign because it constitutes a limiting factor in the issue of the so-called "moral hazard". The funding from insurance undertakings discourages them to take excessive risks, regardless of the adverse consequences. The limits on the amount of compensation to be paid to beneficiaries and supervisory authorities can limit the moral hazard.

In their effort to finance the guarantee systems, insurance undertakings usually pass on their costs to the society of insured members, through the payment of premiums. This is certainly contrary to the obligations of a welfare state, since the insured are the ones that are clearly not responsible for the insolvency of an insurance undertaking.

On the other hand, perhaps it is unrealistic in the current economic environment, to expect the state to fund one or more guarantee funds in the insurance industry. In any case, however, the inability of providing a state funding of an insurance guarantee scheme should be counterbalanced by the state with tighter controls on insurance undertakings in order to avoid creating adverse effects.

II. The Private Life Insurance Guarantee Fund

1. Purpose and institutional framework of operation

In Greece, the only insurance guarantee system that operates in the context of the 'EU commitments' is the Auxiliary Fund which operates in accordance with Law 489/1976 concerning compulsory liability insurance of motor vehicle accidents. This obligation of Greece derives from: a) the ratification of the European Convention of Strasbourg from Greece by Law 4147/1961 (art.9), which is an International Convention and b) Union law (art. 10 § 1), specifically the codified Insurance Directive No 2009/103/EC, obliging states to establish a Compensation Agency for victims of uninsured or unidentified vehicles.

In addition, the same recommendation regarding insurance undertakings is included in the preamble of the Directive Solvency II (Recital 76 of the Directive No 2009/138/EK), stating that they should participate in the funding of a Guarantee Fund which would operate in every state – member.

Such obligation imposed by EU law does not exist in Greece in any form of insurance, other than the Auxiliary Fund. Relatively recently pursuant to Law 3867/2010 the Greek legislature established the "Private Life Insurance Guarantee Fund" as an institution to provide last resort protection to holders of life insurance policies. This guarantee mechanism was established after the trouble caused to the sector of life insurance by the withdrawal of the authorization of "Aspis Pronoia". Although it has not been imposed by EU law, it follows the basic principles of the 2010 White Paper on Insurance Guarantee Schemes mentioned above.

The directive proposes that both the Auxiliary Fund and the Life Guarantee Fund have guarantee operation if the debtor liable insurance undertaking becomes insolvent. The liability of the Life Guaranty Fund is certainly not equivalent to the liability of the debtor insurance company, because there are ceilings to the amount of compensation.

The above mentioned "Life Guarantee Fund" established by Law 3867/2010 (art. 3-13 GG A128/3.8.2010) is a Private Legal Entity which is under the supervision of the Bank of Greece.

Its goal is to intervene after the withdrawal of the authorization of a life insurance undertaking which is during a winding – up procedure, in order to maintain and transfer this insurance undertaking to another contractor. If the search for a contractor and the transfer of the portfolio are unsuccessful then the Life Guarantee Fund initiates the process of compensation to policyholders and beneficiaries.

The role of Life Guarantee Fund is activated after the withdrawal of the authorization of insurance undertakings that have entered a winding – up procedure after the entry into force of Law 3867/2010 (3.8.2010). With regards to ongoing proceedings concerning insurance undertakings, whose authorization was withdrawn by the date of publication of this law, another process is applicable, which is defined by Article 2 of the same Act, which was recently modified to address problems of compensation of the beneficiaries of the insurance undertaking "Aspis Pronoia". In this

report we will not focus on this particular topic but on the operation of the guarantee fund as it stands today.

2. Operation of the "Life Guarantee Fund"

The establishment of a guarantee fund in the area of life insurance was necessary because, after the withdrawal of the authorization of an insurance undertaking, it is automatically terminated and enters a winding – up procedure. In addition, the insurance contract for damage of the insured persons is terminated within 30 days after the withdrawal of authorization. This setting does not apply to life insurance contracts where the insured event has not occurred yet. These contracts, due to their consuming characteristic as either saving or investment products, are not terminated if during the 30 day period of time another insurance undertaking takes the portfolio (art. 3 § 6.7-d.400/1970), and at the same time the rights and obligations of the insolvent company and continues the operation of these life insurances (art. 3 § 6-d.400/1970).

However, in an environment of economic recession it is difficult to transfer a portfolio, especially when the scope of the obligations of the insolvent insurance undertaking is very ample. In this case the Guarantee Fund decides on the fate of the insurance contracts and the settlement with persons entitled to compensation. In addition it is responsible for all the rights and obligations of the insolvent company, the insurance contracts are terminated and the pending trials are continued (Art. 5 § 3 N.3867/2010).

3. Provided coverage – territorial validity

The protection the Life Guarantee Fund offers involves insurance coverage regarding insurance compensations from life insurance policies issued by a Greek insurance undertaking in Greece or another state – member, as well as life insurance policies issued by European companies in our country with the exception of supplementary insurances for hospitalization (art. 5§3). Therefore, in terms of territorial validity, the institution of Life Guarantee Fund provides coverage based on the laws of the country of origin, which is compatible to the Supervising Authority of the country of origin whose supervisors are responsible for preventive supervision and solvency. According to the Greek legislator, the country of origin steps aside in favour of the host country, when the Community company operating in our country through a branch is not covered by an equivalent insurance guarantee mechanism in the country of origin.

Members of the Private Life Insurance Guarantee Fund (art. 6 N. 3867/2010) are, mandatorily and automatically, all the insurance companies which are headquartered in Greece and practice in the insurance market, according to art.13 § 2-d 400/1970, as well as branches of insurance companies from a third country operating in Greece. Also branches of insurance undertakings established in a Member State of the EU and EEC and European enterprises operating in Greece under the freedom to provide services as long as they are not covered by guarantee funds respectively in their country of origin. In this way it is combined the geographical area of the country of origin to the host country, ensuring equal protection for policyholders of Member States and providing harmonized coverage.

4. Administration of the Private Life Insurance Guarantee Fund

(Administrative Act of BoG 2629/4.10.2010)

The highest Administrative Body of the Private Life Insurance Guarantee Fund is the Assembly of members, which decides for every case with the absolute majority of its members, and its decisions are binding for members who disagree or that have not attended (art. 11), such as drawing up internal rules and reinsuring from the Private Life Insurance Guarantee Fund against the insolvency of its members to fulfill their obligations towards the Fund.

The Management Committee consists of five members, one of which is appointed by the Bank of Greece as the chairman and the other four members are elected by the Assembly. The Private Life

Insurance Guarantee Fund is represented judicially and extrajudicially by the Chairman of the Administrative Committee.

5. Funding of Private Life Insurance Guarantee Fund

The funding of the Private Life Insurance Guarantee Fund is based, according to the Greek legislator, on the system of the advanced funding of the insurance undertakings, as well as the insured individuals, as opposed to the ex post funding that is in force in other Member States of the E.U.

So, it was chosen so as the distribution of the annual contribution of the Private Life Insurance Guarantee Fund is half for the insurance companies and half for the members according to the weighting of risk management. The contribution was defined by the act of the D. of the BoG No. 2636/24.11.2010 and was scaled from 1.5% of total production of gross registered premiums for life insurance industry ranging in lower levels of 0.8% to 0.3 % in life-management of group pension funds, which completely lacks the assumption of risk.

The insurance companies attribute the contributions, which correspond to life insurance contracts concluded or renewed, to the Private Life Insurance Guarantee Fund at the end of two months. The Private Life Insurance Guarantee Fund has a right of action against members for collecting contributions and non – compliance of members to their obligations results in the withdrawal of the authorization for the life insurance industry.

The positive aspect in the advance funding is that it helps, as it has already been stated, in the minimization of the moral hazard, because insolvent companies have already contributed to the Private Life Insurance Guarantee Fund when their authorization is being withdrawn. At the same time it offers greater flexibility in contributions. A negative aspect is the shift of the cost of operation of the Private Life Insurance Guarantee Fund from insurance companies to policyholders and, in particular, the charge of the insured persons with an equal percentage of the premium for the payment of the levy, as if there are two parts with the same economic power.

In this way the Greek legislator gave precedence to the debt of social solidarity that according to art. 25 § 4 of the Constitution, the State is entitled to require from the citizens, putting aside its constitutional obligation according to art. 25 1 para. 1, to take positive measures to guarantee the rights of citizens.

6. The acting role of Private Life Insurance Guarantee Fund

Maintenance and transfer of life portfolio

A. The Private Life Insurance Guarantee Fund takes action in two cases. Its role is dual and is activated by the withdrawal of the authorization as a result of an offense against the Law.

The Bank of Greece gives to the liquidator of the insolvent insurance company all the data it has in its possession regarding the portfolio of life sector, meaning all life insurance policies of the insurance company. He is also at the disposal of the Life Insurance Guarantee Fund, which proceeds to the registration of the insured persons and the devaluation of the Life Portfolio.

In addition the Private Life Insurance Guarantee Fund starts the procedure of finding a contractor, examining the files of insurance companies that have expressed their interest regarding all or part of the portfolio, depending on the sectors and the type of coverage. The interested contractors, after having studied all the available information from the Private Life Insurance Guarantee Fund, submit their proposals within specific deadlines. The Private Life Insurance Guarantee Fund evaluates each offer according to the interest of the insured persons and submits its decision to the BoG. Within 10 days of the positive decision of the BoG, the liquidator and the contractor conclude a contract for the portfolio (art. 5 C. of BoG).

After the transfer of the life portfolio the contractor becomes involved in the rights and obligations of the life portfolio from the date of withdrawal of the authorization, subject to the reform of the benefits agreed (art. 6§2).

It must be emphasized that during the withdrawal of the authorization of the insurance undertaking and the transfer of the life portfolio and its receipt by the contractor, the collection of premiums, the payment of insurance and the right of redemption, existing and future, are suspended (art. 6§2).

After the transfer of the life portfolio, the contractor is the one that transacts the collection of premiums and the payment of insurance that come of the period of time between the withdrawal of authorization and the date of receipt of the life portfolio.

This solution is the most advantageous for the insured party, because it contributes to the continuation of long-term life insurance contracts in favour of the policyholders by ensuring the saving or investing nature of these eminently consuming contracts.

B. If the process of finding a contractor and transferring the life portfolio proves fruitless, all the life insurance policies are terminated automatically (art. 9§5 L. 3867/2010) and the Private Life Insurance Guarantee Fund is activated in its second role, meaning the compensation of the insured persons according to art. 7 L. 3867/2010.

Private Life Insurance Guarantee Fund activates the procedure for compensation of the insured persons, as soon as the liquidator hands the demand list from the life insurance policies (art. 3 D. of the BoG).

The amount of the claim from life insurance is calculated in accordance with statutory and contractual terms of any contract in force at the time of the withdrawal of authorization (art. 7 § 2 Law 3867/2010) and Private Life Insurance Guarantee Fund proceeds to the payment of cash benefits by setting a ceiling for each type of requirement.

So insurances for deaths or permanent total disability compensations shall be paid to a maximum amount of 60.000 €, other life insurances compensations shall be paid to a maximum of 30.000 € and benefits of value redemption, provided that the right has legally been exercised prior to the withdrawal of authorization, compensations shall be paid also to a maximum of 30,000 € (art. 4 d 1.2 D. BoG and 7 § 1 Law 3867/2010).

The above mentioned coverage of the Private Life Insurance Guarantee Fund is extended to all life insurance sectors e.g. life insurance and pensions, investment funds, other variables per insured person of insurance policy due to long-term commitments that these insurances had, except from claims arising from supplementary covers of hospital care.

Under the allocation mechanism of the operating costs of the Private Life Insurance Guarantee Fund and the balance of risks, the calculation of the contributions to the Guarantee Fund is matched to the maximum compensation to policyholders, in order to avoid moral hazard on the part of the insured persons from risky decisions and to achieve a balance between the guarantee of an equal minimum coverage and limits of liability.

Exceptions to the compensation are specified only for certain individuals that are closely related to the insurance undertaking, e.g. board members or stakeholders with shares above 5% (art. 8 L. 3867).

After verifying the claims, the Private Life Insurance Guarantee Fund makes the payments to the persons entitled, by crediting the bank account, following which the beneficiary has no claim against the Private Life Insurance Guarantee Fund. Compensation shall not be paid directly in full, but within 3 years in installments.

7. The “Private Life Insurance Guarantee Fund” model to other types of insurance?

Creating an insurance guarantee scheme as a mechanism of last resort can definitely strengthen credibility and public trust in the institution of private insurance and therefore it can prevent regulatory moral hazard. Its role is justified as an attempt to prevent the insolvency of insurance firms, and if this cannot be avoided, as a mechanism to cushion the adverse effects.

Theoretically, an insurance guarantee mechanism may cover life insurance policies and insurance losses. However on the basis of the average amount of losses sustained by holders of life insurance policies and losses when the insurance undertaking becomes insolvent, insured individuals with life insurance policies need greater protection through a support mechanism, due to the nature of long-term savings or investing programs, without of course ignoring the damage to the insured parties in the insurance for damage, i.e. financial risks.

Because of the cost involved in establishing a guarantee fund for all parties involved, it is more appropriate to limit the types of insurance that include greater risks, such as, besides life insurance and automobile liability insurance (Auxiliary Fund), professional indemnity insurance, e.g. medical liability.

For the establishment of a single mechanism insurance guarantee there should be a balance for all the interests involved, justice for all policyholders and effectiveness of all risk management bodies.

Only one situation should not be avoided, the insurance. According to Adam Smith, avoiding insurance is not a result of good calculation but recklessness and an arrogant contempt of the risk.

Mr. A. SARRIGEORGIOU

President, Hellenic Association of Insurance Companies

«Auxiliary funds as an underpinning of market credibility: "The Greek Case"»

AIDA is a respected international organisation, with important scientific work in the promotion and development of insurance and private insurance law, so it is with great pleasure that the Hellenic Association of Insurance Companies has put this conference under its auspices.

Many years ago, when I was starting my insurance career, an old wise man of the industry told me that *"insurance is a very strange business, because you sell a product and you find the cost of goods sold many years later"*, which doesn't sound very rational! So when you have a business like that, it means that you definitely have many important legal issues which arise and, therefore, you need organisations such as AIDA, and forums such as this conference, for the exchange of ideas and opinions on current developments.

I believe we are all keenly aware, internationally and certainly locally, of what has transpired over the past six years. We have had an economic crisis of unprecedented proportions, that definitely affected all industries but more importantly that has transformed the Greek economy and the way the average person in Greece thinks and feels about the future. And in the context of this, it has also transformed the Greek social state which, up to now, was providing pension coverage and health insurance in a way that was extremely generous and very inexpensive; numerous statistics can verify this. If, until now, we thought of the Greek state as an insurance company, at the end of the day, given the crisis, we unfortunately found out that this insurance company had neither proper reserves, nor enough capital.

So what happened? All these entitlements and all these very nice products for the average Greek citizen suddenly went away.

In a way, we had the Greek state crowding out private insurance – and here I think it should be noted that the Greek insurance penetration (gross written premium as percent of GDP) perennially has been at around 2-2.5% versus a European average of 7-8%. No wonder it wasn't growing. There was no need, in a way, if the state was giving away insurance "*for free*".

Today this has all changed and the state can no longer perform its role as the exclusive insurer of citizens. The Greek Insurance Industry went from EUR 5.5 billion gross written premium a couple of years ago, to EUR 4 billion last year. It is a very small industry, with many companies, about 35 insurance groups, that has performed extremely well its basic duty of compensating the policyholders, but at the same time did not have proper supervision for decades.

The insurance association is 107 years old. There are companies that have been in Greece for over 150 years. So we have a long history as an insurance industry.

At the same time the history of Greek insurance supervision is three years old. What this has caused is several spectacular failures, such as the one that was mentioned before, which have traumatised our credibility as an industry, and so this, together with the social state that I described before, has led to the underdevelopment of our industry.

But things, as I said, have changed. The average Greek citizen realises, starting with health and then pensions that they need to do something on their own, and do that despite the total absence of any tax incentive to buy insurance. We used to have some moderate tax incentives; we now have none, due to the crisis. We are hopeful that this will turn around again. We do hope that the state will see it that way as well.

So the average Greek individual now, despite the absence of tax incentives, during the economic crisis, has been buying health insurance. And we feel responsible and optimistic that in the next day of the Greek economy the private insurance industry will have a significant role to play in complementing the state in terms of coverages.

I am not going to go into well-known issues – the inverted demographic pyramid, all these things that are causing the system of entitlements to not be sustainable any longer. It is, in our day and age, becoming clear, fortunately, to the people out there, never mind audiences such as this, that the insurance product is not a luxury product, in that if, as Adam Smith I heard before said, the average person did not insure themselves essentially they are self-insuring.

And you are least able to self-insure if you are economically weak, both as a person, as a family, and certainly as a state. We have a situation here where we are in an earthquake zone, and yet any talk of mandatory cheap coverage for the entire population in terms of earthquake coverage is not met with let's say general acceptance. Any talk of private insurance in pensions, when pensions have collapsed, is again at the initial stage.

But again, as I said, things are changing and we are extremely optimistic that, given certain preconditions, to which I will refer in a second part, the Greek insurance industry is about to grow significantly.

What are these preconditions? One is a proper framework. Solvency II is that framework. It is theoretically the correct framework. It is a risk-based framework, so it makes theoretical sense. But let's not forget that Solvency II is the general guideline, which we are in the midst of a process of translating into national laws, interim measures, technical standards and a million other things.

And during this process we are all – the state, the supervisory authorities, the associations, the industry – responsible to have an effective translation into practice, a translation that will not create bureaucracy. Because that would be a disaster. Bureaucracy will be transferred to prices, prices will rise and the average Greek will remain uninsured, etc., etc. So the framework is the first item and as I said January 1st, 2016 it's going to be there.

The second item is proper supervision. Three years ago supervision of the Greek insurance industry was transferred to the central bank, along with many able employees that were coming from an authority that had another couple of years of life. And so we now have strict, proper supervision. The supervisors, the central bank, are responsible to make sure that, as Solvency II is implemented, they keep a level playing field. Otherwise there will be arbitrage and unfortunately there are some players that do not play a fair game, and this will create problems, problems for our industry, problems towards the end for our credibility, because the pillar for our growth and what we are missing and what we need to fix, is the issue of credibility. So Solvency II and the proper supervision are the two essential elements to improve our credibility.

And last but not least, the auxiliary funds. In Greece there are two auxiliary funds. There is a longstanding one, which is the one on motor. This is a fund that, despite significant and effective efforts from its current management, if it was a company it would be insolvent. It is several hundred millions 'in the red'. And this is, to put it technically, a "hot potato", because when you have a state in the fiscal condition this fund is, nobody wants to touch that. By the same token, this fund continues to perform, with difficulty.

The other fund is a new fund. It is the auxiliary fund for life. It is a fund that has a relatively low income from contributions from the companies, from the market. And provided there was no need to use it for the next few years, we would be OK. Unfortunately there are discussions using it to solve problems of the past, so there are some legal issues there, etc., etc. So even for that young fund … life is complicated.

So what is the Association's position on all this? Funds are extremely important. They are an underpinning of our industry; they are an underpinning of our credibility. But we must not forget that they are a last resort, a very, very last resort.

There is moral hazard, however. There is moral hazard because theoretically everybody should play a fair game, so that the fund is not used, so they are not asked to contribute. But you only need one or two not to play a fair game, and you create – you see what I am getting at.

The last point I want to make is sort of the back testing. The gaps, the deficits in the auxiliary fund for motor and any issues that might touch the auxiliary fund for life, are issues that are directly the effect of insufficient supervision by the state during decades in the past. Therefore it would be

absolutely unfair, and I think quite possibly illegal, for the state to ask the industry, and through the industry essentially to ask the new policyholders, the existing policyholders, to subsidise the deficits of the past. There are technical solutions, technical solutions in managing the funds and in financing the deficits, and even for Greece these days markets are very "hot" to manage the problem.

And I think that the solution is more in that direction, and definitely not in the direction of asking the industry to fix in one shot problems that arise from inadequate supervision in the past.

With this, I would like to close, just saying that we have turned a new page in the Greek insurance market. We have not seen the numbers yet. We are optimistic, but the optimism depends on us, as an industry, but also depends on the state; it depends on how Solvency II will be involved, will be implemented, and it depends on the supervisors.

I think the future is bright, but there is a lot of work that needs to be done.

Mr. M. MOISSIS

Fmr President, Hellenic Association of Insurance Companies

«Security Funds for Long Term Insurance. Do they have a role to play?»

The difference between a former president and a current president is that the current president is always bound by talking politically and being much more, I would say, kind and soft, whereas a former president is not bound by these limitations.

Let me start by something that is not in my presentation. In theory, everything is good and easy, but in practice things are much more difficult. I just want to share with you my experience when I was the president of the Association, almost five, four and a half years ago, when I had the bad luck to be the one who negotiated with the Ministry of Finance at that time, together with the Association of Insurance Companies, the formation and the law that was then being drafted on the life insurance auxiliary fund, which was set four years ago.

This is probably a good example of a law that says everything, but practically does not actually solve the problem. You don't have to be an actuary to understand that such a huge problem, which was created in the market by "Aspis Pronoia" and its subsidiary going bust a few years ago, could not be solved through a law that was aiming to solve it via the means of this auxiliary fund. That was impossible.

And people just did not want to hear at the Ministry, so they passed the law, and of course they passed the responsibility to the supervisor, the Bank of Greece, without the supervisor being able to actually, practically, do things that would solve the problem.

So five years ago we had a situation where still the insured people by this very company were not paid, are not yet paid. I am sure that there will be some procedure for them to get paid, there will be some kind of forward calculation, which I guess probably will be used as a guarantee for the fund to be financed by a vehicle of financing, for instance a bank loan or a bond or whatever, in order to have the money to pay the insured.

But I want to stress that theory says that these funds are set in order to protect the customer's confidence to the institution of life insurance.

So I am asking you: Let's assume that three years down the road from today everybody will be paid based on the rules of the fund with the limitations, etc. Will that have restored the confidence of the customers to the insurance, to the life insurance institution or the life insurance business, market? I think the answer is no.

It did not serve this purpose. And the issue is: These funds, do they serve a purpose? And I think that coming back to and connecting to what I have just said about the very case of the Greek situation and how it evolved, clear life insurance is by definition a long-term issue, a long-term business, and it's based on perception of trust. If there is no perceived trust and confidence on life insurance, in my view, there is no credible market out there.

Additionally, what makes things very difficult here is that this perceived confidence is of comparable, very long duration as well. So it's not enough to build on this credibility or to invest on this credibility, customers' credibility for a couple of years, five or ten years. You have to be there for the very long term. It has to be there for the very long term.

No long-term trust – does it mean no long-term business? I don't think the situation is as dramatic, but, certainly, the origination of long-term business, of the healthy long-term business, does relate to the long-term trust and confidence by the customers.

Life insurance is only attractive if people trust – that's a personal opinion – that companies will meet in full their commitments in the long term.

There is always the possibility of things going wrong. That's life. So task one is to minimise this possibility, and this is a joint responsibility of the market with some kind of self-discipline rules that

the markets have to adopt and of course supervision. And task two is applying the right treatment when things do not go right.

Life insurance guarantees, LIGs, are purposed to be the safety net tool to ensure that institutional credibility is not lost. That is a very important statement. They are there to ensure that credibility will not be lost. And of course they should operate as a last resort mechanism.

Now, some basic principles. Should LIGs be imposed across all companies, or should participation be at the companies' discretion? The answer is not that obvious. It could be either, in theory.

However, companies are all trustworthy at outset of an insurance contract. When you write an insurance contract, you make the assumption that the company, at that very moment, is trustworthy to write that business, otherwise they should not be allowed to write new business. So the issue is for the long term.

Can future long-term credibility – and I am urging the word 'credibility' – be the subject of competition between companies? My answer is no. The question of long-term credibility cannot be a subject of the healthy competition between companies.

So there is a clear advantage in my view of these schemes, the life insurance guaranteed schemes, being compulsory. However different solvency profiles of companies should result, in my view, to different levels of contributions.

They must be independent – that's very important – entities, not run by the industry. The industry should not run the guaranteed schemes. And corporate governance is very important, so BoD members should be appointed by state supervisor. And, of course, industry must participate, but they must not run the show.

Now, very important, when we are talking about the design of such funds and schemes – it's schemes better than funds, actually – are the criteria that one has in mind to meet.

Customer protection. We are talking about a mechanism that mitigates risk in the event of failure of an insurance company.

Market confidence and stability. We would all agree that increased confidence in this business promotes demand and enhances stability. But funding requirements may impact financial position of companies.

Levying on life insurance for such schemes, even if we are talking of a rate of 0.75% or 7.5%, or even 0.3% on long-term life insurance, makes the product less competitive. Let's not fool ourselves, even if contributions on the current life insurance fund in Greece are split between the companies and the customers, at the end of the day it's the customer that pays the whole bill.

Moral hazard is very important. In the way you design such a scheme, structure must minimise excessive risk taking behaviours or other distortions. There is always a question of what is being considered as a fair and proportional redistribution, because this is what these schemes are supposed to do. They are supposed to redistribute funds in favour of the clients of those companies that fail, while the cost is borne by the customers of the companies that continue to be there.

So this question of fair and proportional redistribution is very important. And there is always the question: Are these schemes supposed to just provide compensation, or should they first secure continuation of contracts? It is very good when continuation of contracts is being sought by these schemes, and direct payments should only happen when all other options have been exhausted.

Now, regulation is also very important. Failures have been rare. We don't have that many examples. I am talking on a European level. And of course when they have been there, they have not challenged the systemic stability.

Solvency II will certainly reduce the incidence of failures, going forward. However, there is not going to be a zero failure environment. LIGs should strictly be a mechanism triggered only when other protection mechanisms fail. That's a very important principle.

Costs to provide the guarantees is generally low, from the research I did, 0.1%, so this is one per mille of gross premiums, even in markets with relatively frequent failures. This is what the studies, the research is telling us. And expected rate of failure will become even smaller through Solvency II.

And let me also say that large failures, like the one we had here a few years ago, if dealt with through these schemes, will certainly result to increased funding requirements. In Greece it also resulted to the loss of the confidence of the customers.

So when one has to face big failures, they have to understand that other mechanisms should be there to provide these solutions, and not just the mechanism of last resort, which is these guaranteed schemes.

Limitations. There should be quite a few limitations. Now, one thing is for sure: that other financial services such as banks pave the way in what should be done also in insurance.

Redistribution of funds from solvent to insolvent players and between their customers respectively should limit moral hazard quite a lot. And that can be done when guarantees provided by these funds are not supposed to meet 100% of the claims, when there is an absolute maximum, or a low common threshold that everybody will receive, plus a percentage of the amount above that threshold.

So there should be methods, ways, to limit the guarantee provided by this fund, as that compares to the actual claim of the insured.

What does Solvency II do? Solvency II actually implements a risk-based approach, which reduces moral hazard, in the sense that it requires more capital for more risk. So if we just transfer this very principle to the guaranteed schemes, we should say, in my view, that levying weighted distributions to insurance companies, weighted to their risk profile and their solvency profile, is a fair principle. Not every company should pay the same amount of money as levy to the guaranteed scheme.

And not every customer of every company should pay the same amount of money, because companies that do treat better their solvency profile and their risk taking profile should be rewarded for that, and of course pass this reward on to their customers.

Funding, is very difficult. Too many parameters. Should that be a common rate or varying by product type? We are talking of a completely different situation when we are talking of an initial phase rather than a mature phase.

Will that be fully loaded on the premiums, or shared between the company and the customer?

Should that be flat across the players or risk weighted or weighted contributions? It depends on the extent of guarantee. Should that be pay-as-you-go? Because there are funds that provide pay-as-you-go, this kind of funds. For instance, there is one in the UK for a special part of the life insurance business. Or should they work based on reserves built over the years?

Funding rates must be affordable, so we need to have a funding rate which does not destroy the competitiveness of life insurance, which is usually a savings product, and of course adequate, because it has to build the money, if these funds are meant to instil market confidence.

The rule of thumb that I came up by a lot of research and all different schemes that I tried to understand what they do, is that 0.3% on premiums is considered adequate, making this double when funds are being at the very early stage, initial stage, that are being built. And certainly Solvency II will eventually decrease these rates.

Now, there is no harmonisation in the European Union. It was very difficult, based on a research report of Opsera a few years ago, to find two countries with similar systems. So no harmonisation there.

Again, other markets, like banking, are paving the way. However, in insurance it is much more difficult, because there is a lot of valuation in the product type. Deposits that are being guaranteed by common rules in the European Union by banks are deposits; I mean there is no valuation in the product of saving deposits or current deposits, generally deposits. Life insurance is not so easy. There

are so many variations between one country and another country. So it will be very difficult to harmonise 100%.

There is always the question, which has an impact on the moral hazard as well: Should LIGs be based on a host- or on a home-country basis? Those who say host-country basis, they are saying that this is being justified by the principle of level playing field in the same jurisdiction. Those who are pro-home basis say that rules for LIGs should follow rules for supervision. Supervision, as we all know, is based on a home-country basis, so the same should happen with rules for building up life insurance schemes.

And last takeaway: nice to have, certainly. This is supposed to be there in order to instil confidence. Similar schemes that exist in other markets that compete for the same share of wallets, especially when we are talking about long-term savings, etc., make these LIGs a must-have too, so this is something that we must have.

They should be independent, last-resort mechanisms. Design is very important. Confidence, stability of the market and reduction of moral hazard are keys to design such funds correctly.

And I guess that by 2020, with Solvency II well in place at that time, harmonisation across the European Union will be much easier than today. Today it is impossible to harmonise, yet some common rules should be there.

SESSION II

PRIVATE INSURANCE: A PARTIAL SUBSTITUTE OR A SUPPLEMENT TO SOCIAL INSURANCE?

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«Policy choices in ensuring long term sustainability of life insurance and pensions»

For those who are not fully aware of what EIOPA does, a very short overview. We are the European Authority for insurance and occupational pensions supervision, created three years ago in the wake of the financial crisis, when there was a need for restructuring the European financial supervisory system.

We are responsible for regulatory issues in pensions and insurance, as well as for monitoring financial stability; for customer protection and supervision in these areas. No direct supervision, but indeed oversight of the supervisory practices in Europe.

That is very broadly what we have to cover; so we may need the assistance of a few (Greek) gods to do that, but we take it with a lot of ambition and a lot of pleasure to try to advance the debate and also to provide solutions and options where there are critical areas in Europe.

And one of these critical areas indeed is the sustainability, or the adequacy, the availability maybe, of long-term options for the welfare of European citizens, be it through long term insurance products or pensions. And that sounds like a very ambitious, or a very large, area to work on, but if everybody contributes with certain solutions, I am sure we can move ahead.

And I think I will be repeating a few of the messages that were given before, but hopefully to add the European perspective to it, while also reflecting, on how it is relevant for your market, how it is relevant for individual Member States, because very often the first question is "why should Europe, and EIOPA in particular, be active in this area?"

Let's start with the challenges that Europe is facing in many different ways. The insurance industry is being called today to play an increasing role in financing growth, long term growth, to the extent it can cover deficiencies in social security or state funded pension systems. The identity crisis the insurance industry may be facing also affects citizens: the deficits of our governments in Europe, where public funding is not sufficient to continue ensuring the social welfare which the baby boomers may have known, also in combination with the challenges the markets are facing – looking for funding, being under competitive and regulatory pressure – ends up with imposing more responsibility on the citizens. Will pensioners have sufficient money to enjoy their life after retirement on a Greek island? Do citizens have sufficient health coverage to cover for their increasing life expectations and the disabilities that go with this kind of demographical evolution?

These are the challenges that we are facing, and for which we should, together, develop options.

It is very tempting to speak in Greece about pillars, be they Ionic pillars, Doric pillars or Corinthian pillars. The image of pillars applies thought in the general language to pensions and insurance. The three pillars in pensions: state-funded pensions, occupational pensions, private pensions.

In insurance we also have three pillars: quantitative measures, risk management and reporting and disclosure measures.

So with all these pillars we can build ourselves a very nice temple, where we shall put the goddess of wisdom in the middle, and think what the options could be among all these pillars.

To show the relevance of European action, we have seen that one cannot only rely on government initiative or continuous government funding for long term health or pension products. They are under huge pressure. At the same time, we cannot only rely on private market initiative, because everybody is facing the same challenges and competition issues.

Therefore, private responsibility for long term welfare is being increasingly called upon. And maybe a fourth pillar, a fifth pillar. Let's not forget about the different approaches you can follow. It does not only have to be in an institutional framework; it's a social issue we are dealing with here.

So a multi-pillar approach remains relevant. We are not going to focus only on private. We shall focus also on occupational, and governments shall continue playing their role.

A "cross-sector" approach is relevant. When we are speaking of private initiatives for retirement, there is always the social and the market, the solidarity and the market initiative. We cannot rely only on the solidarity. We also have to rely on market developments, the industry. It is about solutions moving between the pension industry, government-funded social solutions and the insurance market.

If we want the European internal market to remain a reality or even to become a better reality, labour mobility is one of the cornerstones. And we see in particular in times of crisis, in particular with younger generations who are used to study abroad, to live abroad, to speak different languages, labour mobility is a reality which should be built-upon for future solutions. Labour mobility can be used as an adjustment factor in macroeconomic situations, leading to economic depression. Future labour mobility should be supported by adequate financial and social security. It is a situation which many people are facing – shall I leave my country if I have no options for earning a living? How can I transport my pension? How am I covered with my health insurance?

And then of course we can speak about solvency requirements, about governance requirements, about all kinds of solutions or options that can be given to support the regulatory and supervisory framework. But in the end, it all comes down to ensuring that there is trust from the market in the products that are being offered, and also awareness. The citizen is being asked to take more initiative and to take more responsibility for its own long-term provision of welfare; this awareness may not exist yet.

Citizens are not "homini economici". We are not well aware of what the options are. We are not well aware of how to make decisions, and especially not if they are very long-term decisions.

Here European action is relevant, because the different pillars, the labour mobility, the awareness for long term saving are elements in common to citizens across Europe. This is not an issue of national sovereignty or national, let's say, monopoly.

So I have two areas in which options are being discussed in EIOPA today to deal with long term private insurance and pension solutions.

First of all, in pensions, we see that defined benefits are not so much *en vogue* anymore. And we see this because it requires a lot of solvency, a lot of funding for long term obligations and this is increasingly difficult in today's market.

This is leading defined contributions to being introduced more an more: rather than promising an output to the pensioner, you promise that they can contribute, and depending on what happens in the market, the outcome would be appropriate.

As EIOPA, we are not favouring one or the other system. Defined benefits, defined contributions: we are not focusing on one pillar or only one solution. But you will have to see that in a defined benefits scheme the option is to focus on the solvency of the provider, in other words the security of the guarantees. This leads EIOPA to working on defining a holistic balance sheet, which includes in a transparent manner any adjustment to the solvency, the role of sponsor support, which are other adjustments to the output that has been promised. Those are the options for defined benefit schemes.

In defined contributions, where you put more responsibility on the scheme member and beneficiaries, you will have different options, different approaches, focusing on information, disclosure, but also making sure that there are options for the pensioner to choose. How will my pension be paid out? Will it be a lump sum? Will it be an annuity? Why should I take an annuity? The benefits and the costs should be clearly shown for these options. More adequate information on costs and charges; as mentioned this morning, we pay in; we don't know what will come out. How often do we look at the pension statement, or is there a pension statement?

So, different options for different schemes. And as I said before, in an environment where there is less and less reliance on pay-as-you-go, due to the demographic changes, some options should still consider funded schemes as a solution.

As to occupational pensions you are aware that the IORP II proposal is a proposal which focuses mostly, at this stage, on the development of cross-border provision of occupational pensions (supporting labour mobility), and on the disclosure to the pensioners, through pension benefit statements, of what they know that can I expect upon retirement. IORP II also addresses the governance of the pension funds. And that is exactly where sometimes it goes wrong, where pension funds were facing some conflicts of interest, to put it mildly; in particular also the remuneration of their governing bodies.

EIOPA continues working on the holistic balance sheet. We have proposed it and we still think that this is the only way to make sure that solvency of pension funds is shown in a transparent and comparable manner.

Regarding personal pensions. What are the options there? Personal pensions have to be promoted, one cannot rely only on the first and the second pillar. So what are the first steps that EIOPA is taking here? The first step is a still quite theoretical debate: what kind of regulatory requirements could be needed or could be put in place to promote personal pensions? One is to promote in a general directive concerning the conditions for personal pensions. What should be the general defining criteria of personal pensions? This to fit in with the current approaches that national Member States have on personal pensions, while at the same time achieving a reliable common denominator.

The other option would be to focus on product regulation, on product governance. What about creating one simple private pension product - certified or not -, that can be offered by certain institutions who meet certain requirements, and everybody can buy it across Europe as a comparable, simple and efficient alternative product?

This is still theory, and it has to be seen whether either of these proposals, or both proposals, can be combined, and bring their efficiency gains as expected.

In insurance, high expectations are being posed on Solvency II. I am not going to present the A-Z of Solvency II, but I will just highlight two basic developments that have taken place. Basic, I mean really fundamental, and they happened at the near end of the project: long-term guarantees and long-term investments.

The question was how to ensure, in a risk-based framework which is underlying market consistent valuation and hence potentially volatile returns and pro-cyclical measures from undertakings and supervisors, that an insurer does not necessarily suffer from this short term volatility, where its obligations are due in a very long term?

One of the benefits of Solvency II is basically, one common risk-free rate across Europe: that is that there should be transparency and common valuation of the obligations – with the incentive to reassess unrealistic high rates of returns that are being promised in some countries, which cannot be delivered in the current market situations, as benefit.

This rate of return is, in the latest proposals, subject to amendments or adjustments where there are clear benefits to the risk management of the company, which should be able to carry on a long-term guarantee business in an adequate manner.

We heard it before: Insurance companies should increasingly play their role in supporting the long term growth of the internal market. A nice pot of money and resilience to the crisis (counter-cyclical business model) is taken as an argument. Increasingly, insurance companies are being incentivised to take over the funding role of banks, where banks do not deliver as much as they may have been in the past, the funding requirements which are necessary for a European prosperous market.

In Solvency II we have addressed this, with some relatively technical measures, to ensure that there is no punitive situation for insurers to keep or to start playing that role even more.

In a combination of supervision and regulation, the long-term low interest rates should be addressed. And that is where supervision plays a role in monitoring, identifying and taking action where the situation requires so.

And with this image in mind I would like to conclude: the journey we are embarking on may be a European Odyssey, where we may have to choose between Scylla and Charybdis. For this, what we can learn from Homer is that it takes courage, inventiveness, leadership and trust. Everything shall end well, so let's sail towards the blue sky, and act vigorously during the stormy weather ahead.

Dr. G. VELIOTES

General Manager Life & Health, Interamerican and Chairman, Insurance Europe General Health Committee

«The role of private insurance in the new economic context»

It is indeed a privilege and an honor for me to share with you some thoughts on how we see the macro environment at the social welfare level and how the driving forces behind them are impacting in the Greek context.

At the outset I want to stress that I believe there is no ideal health and pension system anywhere in Europe and that one cannot transplant one system from one country to another, without adapting to local conditions. Having said that, I think we can all learn from the mistakes and the success stories applicable in other countries.

Stepping back and looking at the fundamental architecture of the welfare system in Europe, there were broadly two models that were designed by two very prominent individuals historically, namely Otto von Bismarck from Germany and William Beveridge from the United Kingdom. The models they designed and developed had similar objectives and goals, which were to look after the needs of people for pension, for health, for disability and for loss of earnings.

The ways they are structured are somewhat different. Specifically in the Beveridge model, welfare is predominantly tax-funded; whereas in the Bismarck model, it is predominantly occupational contribution funded. What is common though to both of these models is that, when they were designed 50 - 100 years ago, the average life expectancy of people at that time was in the order of about 60 - 65 years. Therefore the underlying hypothesis and philosophy of both these systems is that the welfare system, will be funded till the age of 60 (when most people are economically active), and then for those that survive beyond that age this welfare system will look after their needs, particularly for pension and for health. Different countries, have adopted different versions of this model. However what has happened since these models were designed is that a few fundamental factors have changed.

The most important driver behind the changes in these systems is that people live longer. They no longer live till the age of 60 - 65. Today, with the advent of new medical technology people live closer to the age of 80. Their needs are quite different to what they were 50 - 100 years ago. This has a major impact on the sustainability of the model. And I would argue very strongly that maybe the Greek crisis is a case study of an example of the inherent design limitations of this model.

So, yes, Europe has gone through a difficult economic period. Hopefully we are on the road to recovery, but what we are seeing is that in some countries more than others the burden of the social welfare system is too great and some countries more and more are progressively retreating through structural reforms which include in some instances collaborations. However the void that is being left by the retreat of the social welfare system is increasingly being filled by the private initiative. In some countries, for instance in the Netherlands, if you look at the health sector, following a long period of debate, discussion and policy review, in 2006 there was a major healthcare reform where effectively the whole responsibility of the basic health package for the Dutch population shifted into a framework managed by the private sector, under very specific conditions.

Having said that, there are some countries that are further down the line and other countries that have made no progress in this respect. And we see this void being filled by complementary / supplementary private insurance. There is also a very big part, which is private out-of-pocket payment for many services, particularly in the private health sector. As people get older, the needs are not just medical or pension, but increasingly long-term care. This is becoming a reality and I think it is the biggest challenge if one takes a longer term perspective.

So, how does this impact on the insurance industry? The industry traditionally was driven by the need to cover the basic fears of early death, which to a large extent laid the foundations for the life sector, or the fear of loss of material goods, which laid the foundations for the P&C industry. As people get older though, it doesn't mean that those fears don't exist, but the priority of needs

change. As people get older physiologically, they also suffer more and more from chronic diseases. In most health systems around the world, 70% of total expenditure is for chronic disease. It is massive and it is a big challenge that we are facing. So we are seeing the pendulum swinging. It's not a rapid process; it's not an event. It is a journey that we have to go through and there is not one road that one can follow.

Turning to the Greek system, the Greek social welfare system to a large extent has components of both the Beveridge (predominantly), as well as the Bismarck system. In addition we have the public as well as the private sector. Specifically on the health side, we spend more or less about the same amount of money as the rest of Europe, although there have been some reductions due to the crisis in the last few years. Characteristically, the proportion of expenditure in the private health sector has been one of the largest in Europe, and the biggest part of this expenditure is out-of-pocket. Furthermore the penetration of private insurance has been relatively low compared to other developed markets, given the level of private expenditure.

In terms of supply and demand, there are several features of the Greek health system. One of the most striking features is that we have a huge oversupply of health professionals. We have the most doctors, the most dentists and the most pharmacists per capita in Europe. We also have very high prices -particularly- in the private hospital industry. At the root of this phenomenon are regulatory distortions, which create an imbalance in the supply and demand. Also, it is a predominantly specialists-driven model and a relatively underdeveloped primary care model with very few general practitioners. Characteristically the level of patient dissatisfaction from public health services is very high.

So, I think given the crisis (and everybody is familiar with the Greek crisis), there were accelerated drastic and urgent measures in the form of budget cuts. These budget cuts over a period of a few years have had a significant impact on the social welfare system and also on the private sector. In the last six years we have seen almost 25% of the GDP vanish, with a massive impact at all levels. But we are hopeful and we are encouraged by the signals of improvement and of development. We believe that the worst is over and that we are in a phase of recovery and all the indicators show some positive developments into the future.

Looking specifically at the social welfare system, there have been huge pension cuts. It appears that the basic pension in 2015 will be at the level of about 350 euros, which is extremely low.

In terms of the health sector, there have been some very large-scale healthcare reforms, pursuant to which essentially, in a very short period of time, a National Insurance Fund, (EOPYY consolidated fund) was introduced. The primary care services have been carved out into a structure called PEDY and there has been a significant and drastic cut in pharmaceutical expenditure.

While in general I believe that many of these reforms are in the right direction, I think the reality on the ground is that they have been implemented at such a rapid pace that the design and the implementation phases brought out a lot of difficulties and imperfections. These measures also provoked a lot of reactions from many stakeholders, in particular stakeholders with vested interests which are being challenged, in terms of maintaining the status quo. I think this is an important lesson. Such large-scale reform, whether it is in the pension or health sector, is a long process, it's not an overnight process and it needs very careful design, but more importantly it needs very good implementation capabilities. I think one of the problems in Greece is the intensity and the speed of these initiatives.

There is also another outcome of the crisis. In the past a lot of people used to go to the private sector for healthcare needs and pay out of pocket. With the crisis, the disposable income of individuals has diminished substantially. I mentioned earlier that private health costs are expensive, so people can no longer afford these services and we are seeing a shift back into the public system; into an already overburdened public system with lengthening queues and increased patient dissatisfaction. Therefore there is a growing need for people to move out of those queues back into the private sector, but they are looking for more affordable services. We believe that private insurance can serve as a gateway back into the private sector and we see that as a growth opportunity.

In closing, it's clear that the government cannot carry the burden. They would like to, but the reality is that demographic and economic realities show that it's not possible. There are major challenges ahead. Underlying this is the longevity factor and the continuous increase of costs in healthcare. We think that more and more the role of complementary / supplementary insurance will play an important factor in reducing the burden and sharing the burden between the public and the private sector, and in doing so, give people more access and a more balanced perspective.

There are different ways to collaborate between the public and private sector. There's no right solution, we have to find a local solution that works in the local context. There are many examples. In Australia or in France, Holland or Spain, there are several initiatives underway which combine the resources and make optimal use of existing resources. It's not an easy process. I would like to single out two critical success factors to make this work. The first one is that there needs to be trust and a common vision. The second thing, specifically for the health sector, is the need for a realistic basic package. Most healthcare reforms fall short when it comes down to defining the basic package. The easy way is for the politicians to pledge everything to everybody. The reality is that the limited resources do not allow for that. Somebody has to draw the line up to where the social welfare covers and from there, an appropriate framework should be established, for the private sector to fulfil the additional needs, through a complementary / supplementary basis.

In Greece, unfortunately, not much progress has been made in this respect and I think this is one of the urgent priorities that we need to address.

Dr. M. NEKTARIOS

Professor, University of Piraeus

«Public-private partnerships for health insurance»

The main issue of this presentation is a proposal for a public-private partnership in the health sector. The basic idea is to adopt the French paradigm in our explorations for a new partnership in the health sector in Greece. The country has a health sector which has a lot of spare capacity, due to an adequate number of hospitals which are adequately equipped with medical instruments and double the number of medical doctors and plenty of other facilities, and of course the main problem is the management of the public health sector, because of the serious involvement of the political personnel of the country. And this is a common theme almost everywhere, not only in this country, I have to admit.

The breakdown of the health expenditures is that more or less 60% is financed by the public budget and the rest 40% by out-of-pocket expenditures. The main idea therefore is to find a way to bring those people closer to the health insurance market, as the French have done. This 40% of the total expenditures financed by out-of-pocket resources of the citizens is something extreme all over the developed world. As a matter of fact, probably only the United States has a higher percentage, which is close to 54%, but the solution that they have adopted there is that some 37% is covered by private insurance and only 17% is burdening the budgets of the private households.

As opposed to the Greek situation, where only 6% of the out-of-pocked expenses is covered by private insurance and the rest is covered by the own resources of the people, and in my opinion this is the basic reason for the fact that during the last ten years, every year the Eurobarometer discovers that the Greek citizens are the least satisfied by the operation of the health system in the country. And we have to do that and my proposal is based on this fact.

Of course, there are some new developments that help in this direction. The first is that finally and eventually we have created a single health insurance fund, which absorbs everything in the public sector as far as health insurance is concerned. And as I said, we have a lot of spare capacity both in the public and the private sector. We have a very strong private sector here: relatively speaking, probably the strongest in Europe, and I am talking about profit seeking health sector. And of course we have a very strong public sector, with a lot of spare capacity, but not good management, and therefore this capacity cannot be made useful for the benefit of the people.

So, what's the basic idea here? The basic idea is to rebalance the whole system and find a new trade off between private and public health insurance, in order to facilitate on the one hand the public budget, which is strained by lack of resources to finance health from now on - and unfortunately this trend will be increasing in the future- and the second fact is that we should solve this problem with out-of-pocket payments that burden the average household.

And my proposal is a new public-private partnership for the coverage of the health needs of the population. We do not have time now to discuss this proposal in detail, but I will try to describe the operation of the French system in short, in order to derive some conclusions about what could be done for Greece.

In France, 92% of the population is covered by private insurance and mutual insurance companies, for all deductibles and coinsurances. And as you will see later on, it's a substantial amount of expenditure and of course the French system for those of us who know it very well is one of the best worldwide and especially in Europe. And there are certain deductibles for hospital services, for primary healthcare services, for pharmaceuticals, for medical equipment and dental services. Whereas the deductible is very low in hospital services, the deductibles are increasing very rapidly and are very high when you go to pharmaceuticals and medical equipment and the dental services. The important thing is that almost all people in the population are covered by this kind of partnership.

Another important characteristic of the French system is that the poor and the unemployed have their insurance premium paid by the state, and of course there are problems with aged people above

65, which are mainly covered by mutuals, and of course 7% of the population which are the worst cases with long-term illnesses and so forth are exempted from paying the premiums. This is the picture of the distribution of expenditure in France, that is 75% is covered by the public budget for health expenditures, private insurance covers 12% and 11% is the final burden of the private citizens. And you see the low percentages for secondary health and also for primary health and the very high burdens for pharmaceuticals, medical equipment and medical services.

Here is the situation for Greece. The 40% of total expenditure is distributed this way: 14% goes for financing hospital services, 34% for financing out of hospital health services, pharmaceuticals 17.5%, medical services and dental services 31%. What I am talking about is exactly that this package should be transformed to a private insurance product and that a new arrangement with the public sector on the logic of a new public-private partnership which would help people shift the family or household risk to the insurance companies should be made.

The average expected loss here for the average household is 10,000 euros annually and almost 40% of this represents the expected loss for out-of-pocket expenditures. A premium that would cover only the primary healthcare services from this package is around 200 euros. If we see the premium for primary healthcare services that the private insurance market currently requires, it is 55 euros, but here we have to admit that this premium does not include long-term illnesses and does not include aged people above 65. Therefore, if only 40% of the population compared to the 10% that we have now would adopt this new policy, in agreement and in cooperation of course with the State, it would have an additional premium of 2 billion euros per year.

I would like to say that this is a part of a general and broader study we undertook and completed actually at the University, where we identified five main sectors that could contribute in the next decade to the growth of the local insurance market and the health sector is one of these areas.

Of course, the next theme is the control of the quality of the public and private providers, the access of people to the providers, the control of induced demand by means of medical protocols, and I would like to conclude with some expected results.

The first result of the implementation of such a scheme would be to free the average Greek family from this huge burden of private health expenditures, which I repeat is the highest in all developed world. The second is that the Greek State will have means, a tool to shift health expenditures back and forth, whenever the public budget is not in a healthy situation to finance the expenditures in the future; the State will have, by means of such a structure, more freedom to manage the situation in the health sector.

The cooperation of the public health fund and private insurance companies will lead to the drastic improvement of health services to the population. And hopefully, this kind of cooperation will be able to wake up the public hospitals also and induce the government to improve the management of those hospitals and fortunately the country has a lot of competent people now, with good graduate studies in health management, who could be used to staff those positions. And it would be a first test for the increased role of the private insurance in the new situation that is going to develop in the country, that is if we pass this test as an insurance market, then we will be able to go back to the State and ask for some more public-private partnerships in other areas, like pensions, like catastrophe insurance, like agriculture insurance and all other areas that could contribute to the growth of the insurance business in the local market.

Dr. CH. CHRISSANTHIS

Assistant Professor, University of Athens

«Legal aspects of group policies and occupational pension schemes in view of the protection of the insured»

Social security systems have been the main means of health care and pension protection in the developed countries during the 20th century, as compared to private insurance. However, during the past decades social security systems show signs of decline and are progressively replaced by private and professional insurance. This is due to several economic, social, political and other factors; to indicate only some of them: sovereign States, having abandoned their sovereign privilege to determine the volume of money printed and monetary policy in general have placed themselves in a situation of scarcity of funds and are not any more able to guarantee the financial viability of social security systems; economic and demographic developments made financial viability of social security systems far more fragile; as a result, sovereign States seem to progressively favor the development of private insurance and professional insurance schemes as an additional and supplementary mechanism to social security, which will be deduced to the basics only.

In most countries social security has some type of constitutional foundation and is associated with basic constitutional and individual rights. In some countries the Constitution explicitly refers to social security, while in other countries were the constitution makes no such express reference, social security is considered to be associated with the very basic constitutional right of human dignity. As a result, it is generally accepted that even if sovereign States progressively retreat themselves from the provision of social security, such retreat cannot be utter and complete; States will always be responsible to provide some sort of basic social security. Moreover, it is a responsibility of the State to regulate and supervise private and professional insurance.

Greece, during 2005-2010 faced the situation of financial collapse of some professional insurance schemes, which were established in late '80 and early '90 through collective bargaining. Such schemes were funded partially by employers as well, mainly credit institutions, who had also guaranteed to cover any deficits. The deficits were so great that threatened to vanish any capital adequacy of the employers. In such a situation, the State intervened through legislation and absorbed the collapsed professional insurance schemes, effectively by incorporating them into its social security system. This intervention was legally challenged in court on several grounds, mainly because it was considered to violate the autonomy of professional insurance. Although legal literature provided ample support and argumentation towards this direction, Greek courts have reasoned that, so long as the State is responsible to protect social security according to its Constitution, it was also entitled to intervene to professional insurance in case of financial collapse, because professional insurance was supplementary to social security and served the same needs.

Moving to issues of private law:

An interesting issue is whether some of the provision of legislation on private life insurance should also apply, i.e. by way of analogy of law, to professional insurance schemes. This question can be raised in particular in connection to provision entitling the insured to redeem its life policy and collect any accumulated funds, or in connection to provisions regarding description of risk on the part of the insured, etc. Moreover, during the past decades courts have issued abundant judgments on disproportionate general terms in life insurance policies which violated consumer protection law; does this jurisprudence apply to professional insurance schemes and their internal organization charts allocating rights and liability among the participating members? I believe that the method to be followed to respond to this issue is to trace the very nature of professional insurance. Professional insurance is destined to be supplementary to social insurance; the main difference among social security and professional insurance is that in the later it is the sovereign State that bears the financial and investment risks of insurance, while in the later this risk is transferred to the insureds themselves. From this point of view, professional insurance is closer to social security than private insurance;

hence, any association or analogy among professional insurance and private insurance should be made with great caution.

Recently, private insurance practice in Greece is facing group health care policies where the insurer is entitled to recover any allowances made during each year, plus an administration fees. This is not true and genuine insurance, though, as the insurers bears no risk at all. The Regulator should have intervened, as such policies seem to represent a major violation of the existing insurance supervision and regulation. Insurance companies are obliged to be engaged in the field of risks coverage only and only exceptionally to handle investment policies on an administrative basis.

Group policies among insurers, employers and employees may also raise issues of labor law. Failure on the part of an employer to pay insurance premium or to meet other obligation under a group policy may qualify as a breach under an employment or a collective bargaining agreement as well. Greek courts have dealt with such situations by raising a distinction among cases where under the group policy (i.e. an investment – pension policy) the investment risk was born by the insurer and cases where the insurer was acting only as the administrator of funds. Usually, it is in the former case only that a breach of an employment or collective bargaining agreement will exist.

Finally, insurance policies, social security schemes and professional insurance schemes are arrangements destined to last for a very long period of time; hence, the need of adaptation to changing circumstances. All these types of policies will have to be renegotiated and amended until their maturity. It is of major importance that the legal system provide some mechanism of renegotiation and adaptation based on fairness and transparency. Private law seems unable to provide this mechanism, at least the basic principles of private law alone. Ideally, there should be a regulatory body that should intervene and approve any proposed amendment.

Dr. L. LIAROPOULOS

Professor, University of Athens

«Shift towards a viable health system in Greece: Tax-based National Health Insurance»

In the last decade, health costs all over the world, all over the OECD countries increased at a much higher pace than incomes in these countries. Then, with the crisis, what the governments chose to do was to allocate much more money to social services, social protection in general and health, as you can see here, relative to other priorities that the government may have. When the crisis happened, the financial crisis of 2007, which developed into an economic crisis, what most governments did was to reduce the dark blue lines, so the dark columns are the increase in health expenditures in the years of the recession and the blue bars are the times before.

Now, you see that Greece actually reduced the health expenditure and of course Greece is an outlier in this, and it reduced the expenditure by 11%. This raises the question of sustainability of health systems. Can we still hope to have the health systems that we grew up having? Can we give access to most or all citizens to services of added good quality? Can we distribute the burden in a way that is equitable and amenable with growth in the economy? Can we cover the cost in a way that will assure that we keep growing, as I said before? And should we start looking at health as both consumption and investment? Can we do that?

Now, Greece is in an unsustainable situation, where there are two pillars, two public pillars, tax-based and payroll taxes, private insurance at about 5% of the total expenditure and considerable state expenditure mainly for running the system.

Employment-based insurance has failed in Greece, and I think it will fail in every other country that uses this system, for the reasons I will just mention. In the best case, employment-based insurance hurts competitiveness; in Greece, employers have to put out 5.1% of the payroll tax on labour and employment contributions, and employees have to pay another 2.65% of their wages for health coverage. In the worst case, what this does is leaving many-many people completely, totally uncovered. In Greece we have a 26% unemployment rate. After two years, all these people lose their coverage, which means they are left with nothing. That's the employment payroll-based contributions.

In a snapshot, for the first time we have expenditure data according to the OECD system on health accounts, so we can actually construct this. You can see that out of a total of 20.2 billion in 2012, employees and employers paid 4.3 billion. This is the contribution of the social insurance funds. So, if we abolish this, as I propose, what we have to do is to find 4.3 billion in order to complete the void. And we have to do this, because, as I said before, that 4.3 billion constitutes what is the soft underbelly of our whole system. It hurts our economy because it reduces its competitiveness. It is extremely uncertain and difficult to collect, nobody wants to pay these contributions, and, anyway, it leaves many people open to catastrophic expenditures, should they have the bad luck of falling sick, especially seriously sick.

If such contributions are abolished, as per the study that I handed to the government and is under embargo, so I cannot give you details, the money, the 4.3 billion that would be lost, would be recovered to the tune of 30% in the very first year they would be abolished, through taxes that will come on increased take-home pay and company profits. If we apply the Blanchard multiplier, because this would increase the deficit, we hope to recover the rest in the next two years, because of the increase of GDP that will follow the increased competitiveness of the economy.

Now, my proposal for the health system is first tier, taxed financed public health insurance, as the one we have now for the farmers and the rest for the whole population, second tier, voluntary professional or regional mutual funds - Macedonia, Peloponnese, Athens, the Athens area, where separate entities may wish to provide health services to the population. The Alzira model in Spain is a very good example of that. And the third tier is private health insurance and, that's why I cannot

answer the question, complementary as you have it here, a partial substitute or a supplement to social insurance. I think it is both and actually I cannot really see the difference between a partial substitute and a supplement.

Let me give you the foundation of why I am proposing scratching the payroll-funded system. If you look at this, it shows three things. It shows that the major decisions the society must make are: how many people should be covered, with how many services and to what percent of the cost. So, these are major decisions that every society must make. Now, 150 years after Karl Marx and 30 million books sold in the United States alone, it says a very simple thing that we all knew, but we couldn't prove. It took 12 years, teams of people, and even the economists have to admit that he is right, but maybe his proposals are not good.

What it shows is that 10% of the people control 50% of the income. One percent of the people control 20% of the income. Question: Is the income that the 90% take home from their employment enough to finance the services they need when they get sick, when they get old? Obviously not; and there you have the reason for the recessions that you observe year after year and the recurrent recessions. And that 1% or 10% of the rich people do not consume. I mean, how much can they consume? What happens to that money? God knows what. Some of them want to go to space.

So, the share of capital, because of the globalization of the economies, is at an all-time high. The answer is to tax progressively their income, so what they cannot consume, the state can consume and provide the services that labour contributions cannot. The new axiom for the new era, healthcare is a fundamental human right; we have to admit that. Lack of income cannot hinder health security. There is a budget constraint that we must agree on, obviously, and fiscal policy should try to share the needs of people through progressive taxation on all sources of income, not just employment; rents, profits and capital gains as well.

Thank you.

SESSION III

PREMIUM PRICING AND TRANSPARENCY

Dr. Manfred Wandt,
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Dr. Samim Ünan,
em. Professor, Galatasaray University and Fmr President, AIDA Turkish Chapter

Marios Apergis,
Director Life, Accident & Health, Carpenter Turner

CASE STUDY ON PREMIUM PRICING AND TRANSPARENCY

Opening remarks by **Evangelos Zerveas,**
Attorney-at-Law, President, Hellenic Consumers' Ombudsman

Dr. Antonios Tsavdaridis,
Attorney-at-Law, Lecturer, Democritus University of Thrace

Dr. Katarzyna Malinowska,
Lecturer, Partner at BMSP Legal Advisors, Warsaw

Dr. Kyriaki Noussia,
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Dr. M. WANDT

Professor, Goethe University, Frankfurt

«Premium adjustment in health insurance under German insurance law»

When I first was informed about the topic of this session of today, my first reaction was, "Oh, quite a nice joke!". Premium pricing in health insurance and transparency; that doesn't fit together as we all know, at least from the viewpoint of an average consumer or an average policy holder. However, as we all know it's a very serious topic and we have to be serious with it, so let's start with an overview of the German health insurance system, because even if we focus on premium pricing in private health insurance, we have to see the whole picture, otherwise we'll get it wrong.

The German health insurance system is a mandatory system, so you have to be insured either by statutory health insurance (or public health insurance or social health insurance which are synonyms), and this goes for 90% of our population, or by private health insurance, which is the topic of our session today.

From a legal standpoint, it is interesting to know that until 1994 there were no legal provisions in the German Insurance Contract Act concerning health insurance, everything was covered by supervisory law. Not everything, because there were contracts, but we didn't have any provisions. This changed with the so-called EU Deregulation in 1994. The issue of premium pricing is embedded in the general question: What are the consumers' needs in private health insurance? Well, access to contract, providing coverage for cost for medical or medically required treatment. This interest of the consumer is matched in Germany by an obligation of the insurer to contract for the so called basic tariff. This basic tariff is regulated in coverage, analogous to the public health insurance system, no risks subtracted, no carve-outs.

Next interest would be coverage at affordable premiums. This interest is also covered by the basic tariff, because premium in this tariff may not exceed the average maximum contribution payable in the public health system. And at least there is an interest concerning lifelong coverage. This interest is covered by the provisions, according to which there is no ordinary termination by the insurer.

Outside the basic tariff it's almost the same, looking at the needs of the consumer. There is however no duty to contract for the insurer. But there are many mandatory provisions, especially concerning the calculation of the premium. And there is a strong, close interlink between supervisory law and contract law. Section 12 of our supervisory law, states that premium in health insurance shall be calculated in accordance with actuarial principles. There are a lot of other provisions of supplementary character. One of them is that premium for new businesses may not be lower than the premium for the insured at the same age for an existing portfolio. The aim is to avoid that the insurer attracts new customers with low premium and enhance the premium after the cut. So this is a very safeguard for the consumers. There is also a provision concerning equal treatment: all factors being equal, the same principles, actuarial principles must be used to calculate premiums and benefits.

Of course, there are more detailed provisions, because everything in private health insurance concerning premium is very strictly regulated in German law. It is worth to mention that there is a special regulation on actuarial methods. Calculation must be age-depended for each person, separate and sufficient for each tariff, separate for each class of tariffs, that means men, women, children, only risk adequate and so on and so on. One may ask what it means for transparency in premium pricing from the standpoint of the policy holder. Maybe there is an actuary among us who will say everything is clear, why do you ask? Look, everything is set and everything is covered. However be aware of any personal disclaimer.

But there is also good news concerning legal principles. There is one very important principle: remunerations must not increase because of increasing age. Therefore, the premium has to be calculated for lifelong duration of the contract. Until the age of 55 you pay more as premium to cover the risk, which is less, because you are young and healthy, and after the age of 55 you pay the same amount of premium concerning increasing risk of age. This is done by using the aging reserve to keep

premium constant. So this is good news: lifelong contract, constant premium. However we all know there are increasing premiums in health insurance and it is a real problem for every household.

The reason for this is that the level premium does not include increases of healthcare costs. Knowing that the insurer has no right to ordinary terminate the contract and is bound lifelong to the insured, the insurer has to react in some way and therefore there is a contractual right of the insurer to alter the premium during the contract. The insurer is entitled to recalculate the premium, except negligent miscalculation in the beginning of the contract or at a later stage. Whenever there is a miscalculation, he is not able to fill the gap of this miscalculation, but he is able to enhance the premium in order to go along with the increases of healthcare costs. Further requirements are as follows: There must be a not only temporary change of the basis of calculation meaning benefits and mortality rate. These are the only two bases which are of relevance in this context. There is a supplementary provision to this contractual provision in supervisory law, stating that the insurer has to compare the expected benefits with the required benefits annually, and if there is a deviation of more than 10% or of a lower percentage if it is agreed in the contract (trigger), he has to review the whole calculation of the premium and to re-determine it. The same is regulated for the comparison of mortality rate. If there is a deviation of 5%, the insurer has to review the whole process.

Third requirement is that an independent trustee has to be involved. He has to review everything which concerns the calculation of the premium, even to look whether there is a negligent miscalculation in advance. The independent trustee has to agree to the adjustment of the premium. By this the independent trustee acts like an outpost of the supervisory authority. However this doesn't hinder the consumer, the policy holder, to go to court. So if the consumer wants to have a judicial review, he may go to court. Of course it is very difficult for a court to review such an actuarial basis of premium adjustments. In order to avoid unfair proceedings, the German Federal Court has ruled that the insurer is restricted only to the documents he has given to the independent trustee. So he is not allowed to deliver further documents during the court proceedings. It's a very good instrument to assure that nothing is manipulated later on.

What does the whole picture mean for premium pricing and transparency? From a legal standpoint one can say there is transparency by mandatory provisions on the initial calculation, on actuarial bases, and on the requirement that premium may not increase due to increasing age. There is also transparency by mandatory provisions on the adjustment of the premium. Only if the named trigger is reached the insurer is allowed to start the review process. Thereby the insurer has to maintain the factors it chooses when starting the calculation. The insurer is not allowed to alter the factors. Finally the independent trustee has to be involved.

Even with these requirements, you can say it is difficult for the insured to go to court and it is difficult for the court to review the process of premium adjustment. It is important to add that there is a legitimate interest of the insurer for confidentiality, because it is business secrecy how to calculate its premium. Therefore there are some safeguards. Court proceedings may be on camera. The public may also be excluded from the pronouncement of the decisions and the court may obligate the persons present to observe secrecy in respect of what they heard in the proceedings.

Summing up, from the standpoint of an average consumer one can say there is no transparency, not at all, it's a black box. As an average consumer you don't know how the premium was calculated at the beginning of the contract and you don't know the bases and limits of the premium adjustment. As an average consumer you have to trust in the independent trustee. My conclusion: There is transparency concerning premium pricing, however this transparency is only for experienced experts.

Dr. S. ÜNAN

em. Professor, Galatasaray University and Fmr President, AIDA Turkish Chapter

«Special rules regarding the transparency in life assurance and pensions contracts in Turkish law»

I will briefly try to explain the situation in Turkey with regard to life and pensions contracts from the standpoint of the transparency issue.

We have transparency provisions in the law and we also have rules determined by the Turkish supervisory and regulatory authority. I will focus mainly on what the regulatory authority has done in Turkey, but first, here is a brief review of the legal provisions.

In our law on insurance contracts and in our law on pensions it is provided that all relevant information must be given to the prospective policy holder or to the contributor at the pre-contractual stage and even during the contract. So we have the pre-contractual information duty and post-contractual information duty in order to achieve the transparency. And in addition, we have regulatory rules.

Firstly, regarding life insurance, rules imposed by the supervisory and regulatory authority relate mainly to technical parameters, tariffs (when the word tariff is used it means the framework that the relevant insurance company establishes for each product and binds itself). There are rules about products, other than annuities and particular products where invested premiums are collected, and about annuities. For technical parameters we have special rules regarding technical interest, profit shares, general expenses, intermediary commissions and administrative expenses, and mortality and morbidity tables.

The tariffs must include premium for the risk and premium for savings, general expenses, intermediary commissions, surrender value, prepayments, technical parameters including formulations for calculating the mathematical reserves, and special conditions. So the insurance company will put all these in the life product tariffs and each tariff will have a separate scope and name. The scope of the coverage must be clearly defined. In case of scope change; whether the acceptance of the insurer is necessary or whether various alternatives and outsets are provided.

Also, for the surrender of the policy we have special rules. The insurer is able to make a reduction for early termination and this reduction will be based on the mathematical reserves. The prospect policy holder must be informed about this at the pre-contractual stage.

If the insurance money is determined by reference to a value or assets or index, the insurance company should also state whether the premium calculation will be made in the same way, be it indexed to a tariff or assets. The signs of variations or symbols that are used in the tariffs must be clearly explained. The tariffs will also contain the rate of the technical interest and mortality table used, the profit share distribution basis, assets' breakdown, in case of contract linked to a group of assets, whether the profit share distribution is depending on the type of the product and whether a tariff indexed to a foreign currency can be converted into a tariff indexed to Turkish currency, as well as whether the conversion is possible or not.

The expenses, fees to be paid by the policy holder or deduced at the end, must also be stated very clearly in the tariffs. The premium amount and the projection in respect to a mathematical reserve should also be included within the tariffs. The insured events must be very clearly defined and the policy holder must be informed thereof at the pre-contractual stage. If the contract is linked to investment instruments, detailed information on the instruments plus whether there will be a guaranteed profit equal to technical interest must also be stated in the tariffs.

The tariffs and also the profit shares must be conformed to generally accepted actuarial principles. The tariffs' and profit shares' technical parameters for products first launched must be submitted to the supervisory and regulatory authority, which may require changes if it deems necessary to intervene in order to protect the consumers and avoid later conflict.

When it comes to investment policies, meaning investment products where investment premium is collected, there must be a guaranteed benefit, except for products linked to an investment fund. In that case, profit share is mandatory for investment policies and the total sum of the contribution to expenses for each year must be stated on information documents and on the insurer's policy; and there is also a volume requirement. It must be at least 14 points.

If the contract is terminated before a surrender value is attracted, the insurer will be obliged to pay back all the investment premiums, plus the profit share, but there are some reductions to be made. The reductions must be made on a predetermined basis and, if there are taxes to be levied, the insurer will also take care of this. Otherwise it will be liable for that reserve to the tax authority.

For investment policies, at each anniversary of the insurance policy, a written statement must be sent to the concerned policy holder indicating the amount of the savings, the investment income, total amount of risk premium, if there is a risk premium linked to the product, and all the deductions.

We also have some specific rules for annuities. In respect of annuities, mortality tables can be revised to be brought in line with the actual mortality rate. The approval of the regulatory and supervisory authority is necessary for the tariffs concerning the annuities. The total sum of the contribution to expenses and fees must also be clearly stated. The insurer is under the duty to publicize on the website information about annuities, including calculation samples, and the insurer is required to use the forms sent by the regulatory and supervisory authority both at the pre-contractual stage and also on the policy. So the Turkish regulatory and supervisory authority tries to standardize the forms utilized in that area. And the insurer must have sufficient electronic infrastructure. Additionally, for individuals over 56 years of age only retirement products, products designed for retirement purposes, can be proposed.

Now, regarding the rules about pensions, in Turkey, private pensions are facultative; they are aimed at completing the state pension system. The clients are called contributors. The contributors are given the right to change the composition of the investment funds and, if they deem it necessary, they have also the option to change pension company; they may go from one to another pension company, under certain conditions.

The pension company must provide an informative entry form in order to inform the potential contributor or the sponsor, if there is a group contract, about how the pension funds system functions. The burden of proof that all information duties are complied with lies with the pension company. In distant contracts -this is an interesting rule existing in Turkey, maybe a little bit unusual- the contributors' confirmation that all necessary information is provided at the pre-contractual stage is a condition precedent for the validity of the contract. So, the prospective contributor must give the confirmation that he has received all the necessary information.

There is thereafter a proposal form. The pension company must inform the potential contributor on several points relevant to his decision to enter the pension system. The company must assist the potential contributor at the negotiation stage and at the drafting stage of the pension contract, especially on technical issues concerning the functioning of the system. Further, it provides information about respective rights and duties of the parties and it is also required to refrain from misleading the potential contributor.

Thereafter, the pension company will propose a contract, which is in line with the contributor's expectations. So, first, the pensions company must inquire about the needs and expectations of the client, his or her income or earning level and age. There is a cooling off period of 60 days. The pensions company must send the contract to the contributor within ten days of effectiveness, either by electronic means or on paper and, in that respect, the contributor will have a choice.

The pension company must send to the contributors' or the sponsors' email address or fax, or if there is no email address or fax, to the postal address, the statement of account, information on the transfer and the transfer request form, when it is a question of moving from one pension company to another. It must do this within five working days. The pension company is also under the duty to have all this information available on the internet in a manner that it can be downloaded easily.

The contributor, after receiving this information, applies to the new pension company with a statement of account and the new company will inform the contributor about the amounts that will be deducted for admission to the new company.

When the period provided for the contract is approaching the end, the pensions company will inform on options; retirement or the option to remain in the system. It will send a statement of the account and it will also provide projections on each option. There are fees that are levied; entry fee, management fee, fund fee and performance fee, but all those fees must be defined at the outset. And both the information form and the contract should mention the exact amounts of those fees and deductibles that will affect the contributor's situation.

There is also the requirement to inform the contributor during the contract; two years before the entitlement to retirement, the pension company shall warn the contributor to choose secure funds to reduce the risk, because it is approaching the end. This information will be given regardless whether the sponsor is still a sponsor or whether the sponsor is in default in paying sums to the pension company. The contributor must be also informed about this and changes in the parameters of the funds and legislation must also be given as information to the contributor. Lastly, the statement of account must be sent, as well as information and warnings about investment risks once in three months.

Mr. M. APERGIS

Director Life, Accident & Health, Carpenter Turner

«Premium pricing and transparency: The "key factors" for private health insurance»

The topic is the key factors that affect premium pricing and transparency for health insurance products. I would like to start with a definition of private health insurance products, which, for present purposes, will be those insurance products whose purpose is to cover medical costs of illness or accidents. It is necessary to make this distinction, simply because health insurers may include products such as critical illness, disability and long-term care in their health branch.

The pricing of private health insurance products is not substantially different to that of other insurance products, so one would expect that it would be at least as easy to demonstrate pricing transparency when it comes to pricing these products. However, a key differentiator with health insurance products has to do with the significance of the necessary loadings that need to be priced in for the expected future changes to medical costs and treatment frequencies. The claims payable are directly related to these; they are not fixed benefit amounts.

Only a month ago, and for the second time within the last three years, a number of private health insurance companies in Greece were fined by the General Secretariat for the consumer. The reason for the fines, according to the General Secretariat, was the use of abusive policy conditions to make arbitrary premium rate increases to health insurance products. The majority of these companies fined are subsidiaries of large European insurers in Greece and personally I am certain that these companies would do everything in their power so as not to be associated with such negative publicity. So why was it so difficult for them to demonstrate pricing transparency?

Regarding pricing of private health insurance products, in addition to frequency and cost of claims, there is a number of other key factors that greatly effect pricing. And it is these key factors that I will concentrate on.

The first key factor refers to the impact that the role of the state plays, together with clarity in the interaction between the state and the private health systems in the country. The second key factor refers to the impact that the continuous advancement of medical and related sciences have on the cost of future treatments. The third key factor refers to treatment choice options and who makes them, and the last, but not least, key factor refers to the role of the legal and regulatory framework.

I have to warn you, however, that these key factors cannot be accurately measured or priced, as their main impact is on the expected future cost of medical expenses. The result is that people outside the insurance health sector sometimes express concern for the lack of transparency, they demand and they challenge that insurers do not increase their premium rates and they are calling them to be more transparent both in the pricing and in the policy conditions that they use.

The duration of the health insurance policies is another important factor for aggravating these issues, and this is because the longer the term or life of the contract, the bigger the weight of the expected future costs of medical treatments that need to be taken into account and priced into the premiums.

One of the most, if not the most crucial key factor is the role that the state wishes to play in the provision of healthcare services in the country. It is this factor that also determines the role and room for development for private health insurance. Different countries in Europe have chosen very different roles for their private health insurance markets and this, together with the degree of effectiveness of their state healthcare systems, has resulted in the very different basic forms of private health insurance that we currently observe, with vastly different practices and insurance products.

It is also the state's responsibility to determine how the state and private healthcare systems will interact with each other. Clarity in the interaction between the private and the state healthcare

systems in the country is absolutely key for the best outcome. Whilst, the choices are political, they also need to be practical and effective, avoiding cost duplications wherever possible. It is clear, therefore, that the degree of effectiveness in the provision of public healthcare services, together with the state's political choices, are paramount to the creation of either a supportive or unfavourable market environment, in which private health insurance sector is called to grown.

As a result of political choices by different states, the private healthcare insurance market outcomes that we observe in Europe fall into four main categories: Substitutive, additional, duplicate or compulsory. Under the substitutive forms of private health insurance the state health system is totally replaced. We heard quite a lot about substitutive systems in the earlier presentations, so I will not give more information that you already heard. I will simply say two things. That it is important to remember that under a substitutive system, once somebody has opted out it is extremely difficult to rejoin the healthcare system, and the insurers that are taking on the insured have to provide all types of treatment and care to the insured, including those for long-term chronic conditions.

Additional forms of private health insurance are always voluntary and complete, rather than replacing the state health system. The best examples of these forms of private health insurance in Europe are to be seen in France, Belgium and Portugal.

We then have the duplicate forms of private health insurance. They are also voluntary and they are offering supplementary benefits on top of these offered under the state health system. These run in parallel to the state health system and they are offering private alternatives and the best example of this in Europe would be the UK. Spain, Greece and Turkey also have duplicate health insurance markets.

Finally, we have the compulsory forms of private health insurance that we observe in the Netherlands and Switzerland, with some public aspects and fully private complimentary covers.

By examining the differences amongst the various forms of private health insurance in Europe, one can reach the conclusion that it is the magnitude and the potential financial loss faced by the citizens that determines the potential for development and growth for private health insurance in that country.

The next key factor that I would like to examine is the impact continuous advancements in medical and related sciences have on future medical costs and frequency of treatments. We are all aware that medical science and new treatments are amongst the fastest growing sectors of our time, but so are the associated costs that need to be funded. Huge amount of capital is continuously invested in research and development, making it difficult to predict with certainty the future treatment landscape and its impact on associated costs. This is especially important for insurers that offer long-term renewal guarantees, as they need to ensure that they will be able to meet the increased future costs of claims. Furthermore, we have recently started to witness and to understand how medical science and treatments are increasingly influenced by the development of related sciences. The most recent related sciences expected to have a significant impact on medical science is big data and predictive analytics.

All these developments are resulting in an ever increasing pressure on healthcare budgets by the state and private health insurance premiums alike. The understanding of the mechanics that help ensure reasonable increases to future costs and, therefore, insurance premiums over time by all involved, be it regulators, insurers or consumer bodies, is of great importance.

A recent article that I read in the Financial Times provides a good insight of how big data and predictive analytics will possibly influence the landscape of treatments in the future.

These points bring us to the next key factor that I want to address; that of treatment options and who takes these decisions. Increasingly the health services consumed have become more preventative and elective as a result of proactive screenings and the new medical technologies that facilitate this. This will be even more so in the future, due to the development of predictive analytics and individualized treatments. In this new environment it is not clear in all countries how the provision of such health services that, strictly speaking, are not always maybe medically necessary at the time they are performed, are to be regulated going forward and funded.

When it comes to the provision of healthcare services through the social insurance system, it is clearly the State that decides which alternative treatments it chooses to provide and neither the patient nor the doctors can disagree with these choice decisions. However, when it comes to the provision of medical services through the funding of the private insurance contract, who is the appropriate actor to take the same decisions? In many countries, it is not clear as to who should take these treatment option decisions. Should it be the doctor who may have a conflict of interest, the insurer paying the cost of treatment, who also has a conflict of interest or the patient who doesn't always have the necessary knowledge to take the best decision, but may be greatly influenced by his doctor? The existence of medical protocols can help considerably, but these do not officially exist in a binding way in all countries. It is therefore of great importance for the actual medical costs incurred by insurers in the future how and by whom these decisions are to be taken.

And this brings us to the last key factor that I will be addressing in this presentation: The legal and regulatory framework within which all of the actors are operating, whether involved in the provision of healthcare services or in the private health insurance markets. An effective legal and regulatory framework is not only prerequisite for the existence of private health insurance; it is a major determinant of its size. Data shows that all countries with more regulated private health insurance markets have significantly larger size than markets that are loosely regulated. Examples of countries where both the insurance benefits provided and the pricing are defined by regulation are Germany, Netherlands and France.

Lack of clarity in the regulation will lead to reluctance of insurers to offer some covers, to higher costs and therefore premiums, to lack of standardization of benefits provided, negatively affecting consumer confidence and market growth.

Opening remarks by E. ZERVEAS

Attorney-at-Law, President, Hellenic Consumers' Ombudsman

Στην Ελλάδα, ένας στους δύο καταναλωτές έχει αντιμετωπίσει πρόβλημα που συνιστά καταναλωτική διαφορά με προμηθευτή. Πολύ λίγοι είναι, όμως, όσοι προέβησαν σε κάποιου είδους διαμαρτυρία ή καταγγελία και πραγματικά ελάχιστοι εκείνοι που κατέφυγαν στη χρονοβόρα και ακριβή δικαστική οδό προκειμένου να δικαιωθούν. Η σύσταση της Ανεξάρτητης Αρχής του Συνηγόρου του Καταναλωτή ήρθε να καλύψει αυτό ακριβώς το κενό, προσφέροντας στον πολίτη τη δυνατότητα της γρήγορης, αποτελεσματικής και χωρίς κόστος πρόσβασης σε μια διαδικασία εξωδικαστικής επίλυσης των διαφορών του με προμηθευτές με διαφάνεια και αμεροληψία.

Το όφελος από τη λειτουργία της Αρχής του Συνηγόρου του Καταναλωτή είναι μεγάλο και για τους προμηθευτές, καθώς η δυνατότητα της εξωδικαστικής παρέμβασης εγγυάται τη διαφύλαξη του κύρους τους από το δυσφημιστικό πλήγμα που μπορεί να τους επιφέρει ένα αδίκως, δια της δικαστικής οδού, εκφρασμένο παράπονο. Προσδοκία της Αρχής μας είναι να συμβάλει με τη λειτουργία της στη βελτίωση της επικοινωνίας ανάμεσα στους καταναλωτές και τους προμηθευτές μέσα σε πνεύμα αμοιβαίας καλής πίστης: Ο μεν καταναλωτής θα ξέρει ότι μπορεί να εμπιστεύεται τους θεσμούς που έχει τάξει η Πολιτεία για την προστασία του. Ο δε προμηθευτής θα είναι βέβαιος ότι θα αντιμετωπισθεί αμερόληπτα και με βάση τον νόμο.

Η ενημέρωση του πολίτη-καταναλωτή, ώστε να μπορεί να περιφρουρεί επαρκώς τα δικαιώματά του, καθώς επίσης η εμπέδωση καταναλωτικής συνείδησης και κουλτούρας, αποτελούν εξίσου κεντρικούς στόχους της λειτουργίας του Συνηγόρου του Καταναλωτή. Η συστηματική ενημέρωση των καταναλωτών αποτελεί ανάχωμα απέναντι σε φαινόμενα παραπλάνησης, αισχροκέρδειας και επιχειρηματικής ανεντιμότητας. Αυτόν τον συμβουλευτικό και υποστηρικτικό ρόλο διαδραματίζει καθημερινά η Αρχή μας, με τη σύνταξη ενημερωτικών φυλλαδίων, με δημόσιες παρεμβάσεις, αλλά και με τη δημοσιοποίηση των Συστάσεών της.

Δεν θα πρέπει να αγνοηθεί στο σημείο αυτό η δυνατότητα που εκ του ιδρυτικού του νόμου διαθέτει ο Συνήγορος του Καταναλωτή να παρεμβαίνει σε περιπτώσεις της αρμοδιότητάς του και αυτεπαγγέλτως, όπου και όταν κρίνει ότι μια επιχειρηματική πρακτική θίγει συστηματικά μεγάλο αριθμό καταναλωτών. Η συγκεκριμένη δυνατότητα έχει αξιοποιηθεί με επιτυχία κατά το παρελθόν και προσδίδει στον Συνήγορο του Καταναλωτή την ιδιότητα του ακέραιου εφαρμοστή της νομοθεσίας για την προστασία των καταναλωτών στη χώρα μας.

Επιπλέον, καλλιεργεί με έμπρακτο τρόπο το αίσθημα δικαίου και ασφάλειας ανάμεσα στους πολίτες, ενώ αποβαίνει προς όφελος και των σύννομα λειτουργούντων προμηθευτών, καθώς είναι σε θέση να εντοπίζει και να απομονώνει όσους με την επιχειρηματική συμπεριφορά τους δυσφημούν και υπονομεύουν τον κλάδο τους.

Τέλος, η διαδικασία της αυτεπάγγελτης παρέμβασης είναι χρήσιμη για την ίδια την Πολιτεία, διότι λαμβάνει γνώση προβληματικών τομέων της αγοράς, προκειμένου κατόπιν να αναλαμβάνει συγκεκριμένες πρωτοβουλίες για την άμεση και αποτελεσματική θεραπεία τους.

Παρ' ότι ο θεσμός του Συνηγόρου του Καταναλωτή είναι σχετικά νέος, έτυχε εξ αρχής θετικής ανταπόκρισης από τους καταναλωτές. Είναι χαρακτηριστικό ότι μέχρι σήμερα η Αρχή έχει δεχθεί περισσότερες από 27.000 αναφορές πολιτών, εμφανίζοντας πολύ υψηλά ποσοστά επίλυσης υπέρ καταναλωτή. Συγκεκριμένα, περισσότερες από 8 στις 10 υποθέσεις έχουν έκβαση θετική υπέρ του καταναλωτή και μόλις 1 στις 10 υποθέσεις δεν επιλύεται ύστερα από εξάντληση όλων των μέσων φιλικού διακανονισμού των οποίων κάνει χρήση η Αρχή.

Τα στοιχεία αυτά αποκαλύπτουν αφενός τη χρησιμότητα και την αποτελεσματικότητα της εξωδικαστικής παρέμβασης και, αφετέρου, τον υψηλό βαθμό αποδοχής που χαίρει ο θεσμός από την αγορά και την κοινωνία. Ομοίως υψηλή είναι η ανταποδοτικότητα του Συνηγόρου του Καταναλωτή προς το κοινωνικό σύνολο και την Πολιτεία, αν λάβουμε υπόψη τα χρηματικά ποσά που επιστρέφονται σε καταναλωτές ύστερα από ικανοποίηση των δίκαιων αιτημάτων τους.

Όλα τα παραπάνω έχουν αναδείξει τον Συνήγορο του Καταναλωτή ως εξειδικευμένο γνώστη και ως χρήσιμο κοινωνικό εταίρο του διαρκούς δημόσιου διαλόγου επί ζητημάτων της αρμοδιότητάς του. Τον έχουν καταστήσει, επίσης, πολύτιμο σύμβουλο στο πλευρό της Πολιτείας για τον σχεδιασμό σύγχρονων πολιτικών και νομοθετικών εργαλείων που απαντούν εύστοχα στη σύγχρονη απαίτηση για την αποτελεσματική προστασία των καταναλωτών.

Η αμφίδρομη σχέση του δραστήριου καταναλωτή και του υγιούς εμπορίου είναι όχημα για την οικονομική ανάπτυξη. Εκκινώντας από μια τέτοια παραδοχή, στόχος του Συνηγόρου του Καταναλωτή είναι να συμβάλλει με τις υπηρεσίες του στη διαρκή ανατροφοδότηση αυτής της σχέσης μέσα από την καλλιέργεια του αμοιβαίου σεβασμού και της συναλλακτικής εμπιστοσύνης. Σημαντική είναι η συνεισφορά του Συνηγόρου του Καταναλωτή και στον κλάδο της Ιδιωτικής Ασφάλισης με μεγάλο ποσοστό επιτυχούς επίλυσης καταναλωτικών διαφορών.

Ένα σημαντικό θέμα που απασχόλησε και εξακολουθεί να απασχολεί τον Συνήγορο του Καταναλωτή, καθώς λαμβάνει μεγάλο αριθμό αναφορών, είναι η μονομερής εκ μέρους των ασφαλιστικών εταιριών αναπροσαρμογή των ασφαλίστρων, που με τον τρόπο που πραγματοποιείται, αλλά και με τον τρόπο που προβλέπεται στα ασφαλιστήρια συμβόλαια, θέτει θέμα διαφάνειας και ελλιπούς ενημέρωσης προς τους ασφαλισμένους.

Σε συγκεκριμένη, μάλιστα περίπτωση, ο «Συνήγορος του Καταναλωτή» τοποθετήθηκε με σχετική έγγραφη σύστασή του. Οι ασφαλισμένοι κατήγγειλαν την ασφαλιστική τους εταιρία για καταχρηστική και αυθαίρετη μονομερή αύξηση των ασφαλίστρων κατά 14% σε βασική ασφάλιση ζωής, που είχαν συνάψει με Συμπληρωματική Κάλυψη Ατυχήματος και Ασθένειας.

Η εταιρία επικαλέστηκε όρο του συμβολαίου, δυνάμει του οποίου "(...)διατηρεί το δικαίωμα να αναπροσαρμόζει το ασφάλιστρο για κάποιες από τις παροχές, όταν μεταβάλλεται οποιοσδήποτε από τους παρακάτω παράγοντες, είτε μεμονωμένα είτε σε συνδυασμό με οποιονδήποτε από τους λοιπούς:

το κόστος των νοσηλίων, το οποίο καθορίζεται ενδεικτικά από τη χρέωση για κλίνη, τις τιμές των φαρμάκων και των υλικών που απαιτούνται για τη νοσηλεία, τις αμοιβές ιατρών, κ.λπ.

το κόστος των εφαρμοζομένων μεθόδων διάγνωσης και θεραπείας και της τεχνολογίας που χρησιμοποιείται από τα νοσοκομεία.

η σχέση μεταξύ αποζημιώσεων και ασφαλίστρων (δείκτης ζημίας)

η αναλογιστική τεχνική που εφαρμόζεται για την τιμολόγηση, καθώς επίσης και τα διαθέσιμα στατιστικά στοιχεία από την εμπειρία της εταιρίας και των ελληνικών και διεθνών οργανισμών (Εθνική Στατιστική Υπηρεσία, Παγκόσμιος Οργανισμός Υγείας, κ.λπ.). Κάθε αναπροσαρμογή γίνεται από την εταιρία κατά δίκαιη κρίση και μόνο σε οποιαδήποτε επέτειο από την ημερομηνία έναρξης της ισχύος του ασφαλιστηρίου".

Ο σχετικός όρος αναπροσαρμογής κρίθηκε καταχρηστικός, γιατί αφήνει χωρίς σπουδαίο λόγο τη μελλοντική αναπροσαρμογή του ασφαλίστρου στην απόλυτη μονομερή κρίση της ασφαλιστικής εταιρίας, καθώς η αύξηση των ασφαλίστρων εξαρτάται από «κριτήρια» γενικά και ασαφή, τα οποία δεν προσδιορίζονται κατά τρόπο αντικειμενικό, εύλογο και συγκεκριμένο, ούτε ποσοστό αύξησης αυτών, με συνέπεια το τίμημα στην ασφαλιστική σύμβαση να είναι αόριστο, χωρίς να υφίσταται προς τούτο σπουδαίος λόγος.

Ειδικότερα, σε ό,τι αφορά την επικαλούμενη αναπροσαρμογή λόγω αλλαγής τιμολογιακής κλάσης η εταιρία επικαλέστηκε στις απαντήσεις της ότι αυτή γίνεται σύμφωνα με τις κατηγορίες ηλικιών του τιμολογίου του νοσοκομειακού προγράμματος, ήτοι σύμφωνα με κείμενο εκτός του συμβολαίου, που δεν τέθηκε υπόψη του ασφαλισμένου κατά την υπογραφή της σύμβασης, με αποτέλεσμα να μην έχει λάβει γνώση αυτού και ως εκ τούτου να μην αποτελεί δεσμευτικό συμβατικό περιεχόμενο, αφού στα εν λόγω ασφαλιστήρια συμβόλαια δεν περιλαμβάνονται σχετικοί ηλικιακοί πίνακες. Εξάλλου, η αλλαγή στην ηλικία του ασφαλισμένου δεν μπορεί να δικαιολογήσει αοριστία στο ασφάλιστρο, καθώς, αφού κατά τον χρόνο ασφάλισης η εταιρία γνωρίζει την ηλικία του ασφαλισμένου, είναι σε θέση να εκτιμήσει την όποια μεταβολή επιφέρει στο ασφάλιστρο και κατ' επέκταση στην επίταση του ασφαλιστικού κινδύνου.

Ως προς τον πρώτο και δεύτερο παράγοντα αναπροσαρμογής, ήτοι του κόστους των νοσηλίων, των τιμών των φαρμάκων κ.λπ. και του κόστους των εφαρμοζομένων μεθόδων διάγνωσης και θεραπείας και της τεχνολογίας που χρησιμοποιείται από τα νοσοκομεία, για να είναι προσβάσιμοι και ελέγξιμοι από τους ασφαλισμένους, προτείναμε να γίνεται συσχέτιση με τον αντικειμενικό υποδείκτη Υγείας της Εθνικής Στατιστικής Υπηρεσίας.

Ως προς τον τρίτο παράγοντα της σχέσης μεταξύ αποζημιώσεων και ασφαλίστρων (δείκτης ζημίας), πρέπει να λεχθεί ότι η ίδια η φύση και ο χαρακτήρας της ιδιωτικής ασφάλισης στηρίζεται στην ανάληψη κινδύνου και στην καταβολή σχετικής αποζημίωσης, επομένως η τυχόν επικαλούμενη από την εταιρία ζημία, που απορρέει από τη σχέση αποζημιώσεων - ασφαλίστρων, δεν μπορεί να αποτελέσει κριτήριο και για το λόγο ότι βρίσκεται στο πεδίο ευθύνης της εταιρίας και ως εκ τούτου δεν αποτελεί αντικειμενικό μέγεθος, προσβάσιμο και ελέγξιμο από τους ασφαλισμένους.

Τέλος, και ο τέταρτος παράγοντας, που χρησιμοποιεί η εταιρία, της αναλογιστικής τεχνικής που εφαρμόζεται για την τιμολόγηση, καθώς επίσης και των διαθέσιμων στατιστικών στοιχείων από την εμπειρία της εταιρίας, δεν μπορεί να αποτελέσει κριτήριο αναπροσαρμογής των ασφαλίστρων, καθώς η αναλογιστική τεχνική αποτελεί μέθοδο και όχι κριτήριο, την οποία εφαρμόζουν οι ασφαλιστικές εταιρίες για την εκτίμηση του κινδύνου, που αναλαμβάνουν.

Επιπρόσθετα, τα εν λόγω «κριτήρια» δεν επιτρέπουν την πρόβλεψη του ανώτατου ποσοστού αύξησης του ασφαλίστρου. Η αιτία μάλιστα της αύξησης δεν είναι ευκρινής, καθώς άλλος παράγοντας δημιουργεί την εντύπωση ότι η αύξηση γίνεται για λόγους αποκατάστασης της ζημίας της εταιρίας (π.χ. δείκτης ζημίας) και άλλος ότι η αύξηση αφορά σε αντίτιμο για παροχή (αύξηση κόστους νοσηλίων κ.λπ.), με αποτέλεσμα να μην τηρείται η αρχή της διαφάνειας, ενώ κάποια από τα κριτήρια εξαρτώνται από εσωτερικές αποφάσεις της εταιρίας.

Τέλος και η διατύπωση στον εν λόγω όρο ότι «Κάθε αναπροσαρμογή γίνεται από την εταιρία κατά δίκαιη κρίση (…)», είναι αόριστη και δεν μπορεί να αποτελέσει μέτρο προσδιορισμού και υπολογισμού για τον καταναλωτή της αντιπαροχής που καλείται να καταβάλει, καθώς δεν μπορεί ο καταναλωτής να παραδίδεται στη μονομερή κρίση του προμηθευτή για την ορθότητα και αναγκαιότητα της αναπροσαρμογής, χωρίς να μπορεί να αντιληφθεί τις προϋποθέσεις, υπό τις οποίες θα υποστεί επιπλέον επιβάρυνση και σε ποια έκταση.

Επιπρόσθετα, διαπιστώσαμε ότι σε ορισμένες περιπτώσεις η ασφαλιστική εταιρία δεν είχε καν ενημερώσει εγγράφως τους ασφαλισμένους της νωρίτερα και έγκαιρα για την αύξηση των ασφαλίστρων, αλλά αντίθετα προέβη σε αποστολή προδιατυπωμένων σχετικών επιστολών, στις οποίες ανακοίνωνε την ήδη αποφασισθείσα από αυτήν αύξηση των ασφαλίστρων, το ποσοστό αυτής και τους σχετικούς λόγους ταυτόχρονα με την αποστολή της ειδοποίησης πληρωμής ασφαλίστρων, χωρίς να δίνεται η δυνατότητα στον ασφαλισμένο να λάβει γνώση της αναπροσαρμογής νωρίτερα, να τη σταθμίσει και να συζητήσει με την εταιρία οποιαδήποτε αντίρρησή του ή να τη διαπραγματευτεί, όταν πλέον οι ασφαλισμένοι θα πρέπει πιεζόμενοι από το ειδοποιητήριο πληρωμής ασφαλίστρων να καταβάλουν εμπρόθεσμα το αναγραφόμενο ασφάλιστρο.

Η αυθαίρετη αύξηση των ασφαλίστρων και η χρέωση του καταναλωτή με αυτά έχει σαν αποτέλεσμα τη διάψευση των τυπικών και δικαιολογημένων προσδοκιών του ως προς την εξέλιξη της συναλλακτικής του σχέσης και τη διασάλευση της δικαιολογημένα προσδοκώμενης ασφάλειας των συναλλαγών.

Ένα άλλο ζήτημα που ανέκυψε και σχετίζεται με το ως άνω θέμα της αναπροσαρμογής ασφαλίστρου, αλλά και γενικότερα με την τιμολόγηση του ασφαλίστρου είναι η εισαγωγή του Φ.Π.Α. στις υπηρεσίες υγείας τον Ιούλιο του 2010. Ασφαλισμένοι-καταναλωτές, που διατηρούσαν από πολλών ετών ασφαλιστήρια συμβόλαια ζωής με συμπληρωματική κάλυψη εξόδων νοσοκομειακής περίθαλψης, υπέβαλαν στον Συνήγορο του Καταναλωτή αναφορές σχετικά με άρνηση της ασφαλιστικής τους εταιρείας να τους καταβάλει το ποσόν που αντιστοιχούσε στον αναλογούντα επιβαλλόμενο φόρο προστιθέμενης αξίας σε αναγνωριζόμενες ως ασφαλιστικά καλυπτόμενες δαπάνες υπηρεσιών νοσοκομειακής περίθαλψης που παρασχέθηκαν από ιδιωτικές κλινικές.

Οι θέσεις της εταιρείας επί των εις βάρος της καταγγελλομένων συνοπτικά ήταν ότι:

Οι όροι των επίμαχων ασφαλιστηρίων συμβολαίων, στον βαθμό που προβλέπουν ότι όλες οι φορολογικές επιβαρύνσεις αφορούν τον αντισυμβαλλόμενο ή τον ασφαλισμένο, δικαιολογούν την εξαίρεση του αναλογούντος Φ.Π.Α. από την εκάστοτε καταβαλλόμενη ασφαλιστική αποζημίωση.

Συγκεκριμένη αναφορά σχετικά με το πού επιρρίπτεται ο Φ.Π.Α. δεν θα μπορούσε να υπάρχει εντός των επίμαχων ασφαλιστηρίων συμβολαίων, αφού κατά τον χρόνο σύναψής τους τέτοια επιβάρυνση δεν υπήρχε (ο Φ.Π.Α. επί της παροχής υπηρεσιών νοσοκομειακής και ιατρικής περίθαλψης από ιδιωτικά νοσηλευτήρια επιβλήθηκε για πρώτη φορά από την 1-7-2010 με συντελεστή 11% και ήδη από την 1-1-2011 με συντελεστή 13%) ούτε και μπορούσε να έχει προβλεφθεί, ώστε η τυχόν υποχρέωση ανάληψης του σχετικού οικονομικού βάρους να έχει ενσωματωθεί στο αναλογούν ασφάλιστρο και να αποτελεί μέρος του ασφαλιζόμενου κινδύνου.

Αντίθετη εκδοχή, σύμφωνα με την εταιρεία, θα δημιουργούσε κίνδυνο παραβίασης της αρχής και της εκ του νόμου υποχρέωσης τα ασφάλιστρα στις ασφαλίσεις ζωής να είναι επαρκή, βάσει λογικών αναλογιστικών υποθέσεων, ώστε η εκάστοτε ασφαλιστική επιχείρηση να είναι σε θέση να εκπληρώνει όλες τις υποχρεώσεις της.

Η ορθή, κατά την εκτίμηση της εταιρείας, ερμηνεία των επίμαχων συμβάσεων κατατείνει στην απαλλαγή από την υποχρέωση κάλυψης της απρόοπτης φορολογικής επιβάρυνσης, αφού εάν οι συντάκτες των συμβατικών όρων γνώριζαν ή ήταν σε θέση να προβλέψουν την επιβολή Φ.Π.Α. στις υπηρεσίες νοσοκομειακής περίθαλψης των ιδιωτικών κλινικών, είτε θα είχαν περιλάβει σχετική αναφορά στη σύμβαση είτε θα είχαν τιμολογήσει διαφορετικά το συγκεκριμένο ασφαλιστικό προϊόν.

Η Αρχή μας επιχείρησε τη συναινετική επίλυση των επίμαχων υποθέσεων με την πραγματοποίηση συνάντησης στα γραφεία της, η οποία απέβη άκαρπη. Είναι σκόπιμο εδώ να επισημανθεί ότι στην περίπτωση τεσσάρων άλλων υποθέσεων, με εμπλεκόμενη την ίδια εταιρεία και παρεμφερείς αιτιάσεις των καταναλωτών αναφορικά με το ίδιο ασφαλιστικό προϊόν, επιτεύχθηκε συμβιβαστική επίλυση των διαφορών, με αμοιβαία αποδεκτή τροποποίηση των συμβατικά συμφωνηθέντων. Κατόπιν τούτων, ο Συνήγορος του Καταναλωτή, λαμβάνοντας υπόψη τις διαφαινόμενες περιστάσεις και μέσα στο πλαίσιο των όρων των επίμαχων ασφαλιστικών συμβάσεων και του υφιστάμενου νομοθετικού πλαισίου, καθώς και της έως σήμερα διαμορφούμενης και γνωστής νομολογίας των Ελληνικών δικαστηρίων, προέβη στη διατύπωση έγγραφης Σύστασης, υποδεικνύοντας την κάλυψη του συνόλου των δαπανών νοσηλείας, συμπεριλαμβανομένου του εκάστοτε αναλογούντος Φ.Π.Α., από την αναφερόμενη και επισημαίνοντας, παράλληλα, ότι άρνησή της να εκπληρώσει σε όλη τους την έκταση τις συμβατικές της υποχρεώσεις δημιουργεί αβεβαιότητα ως προς την ασφάλεια των συναλλαγών, διασάλευση της εμπιστοσύνης και αιφνιδιαστικό κλονισμό των δικαιολογημένων από την ασφαλιστική σχέση προσδοκιών των ασφαλισμένων ως προς την έκταση της ασφαλιστικής τους κάλυψης, προκαλεί παράνομη και υπαίτια περιουσιακή ζημία στους ασφαλισμένους-καταναλωτές και παραβιάζει διατάξεις της κείμενης νομοθεσίας.

Εν κατακλείδι, η αναπροσαρμογή του ασφαλίστρου έχει στόχο να καλύψει τη μελλοντική μεταβολή του συνολικού κόστους των υπηρεσιών υγείας, που θα χρησιμοποιήσουν οι ασφαλισμένοι και για τις οποίες θα πρέπει να αποζημιωθούν από την ασφαλιστική εταιρία, ενώ πρέπει ταυτόχρονα η εταιρία να διατηρεί επαρκή κεφάλαια, για να εξασφαλίσει τη φερεγγυότητα της ίδιας, κατ' απαίτηση, μάλιστα, της Οδηγίας Φερεγγυότητα ΙΙ και την εντεύθεν βιωσιμότητα των ασφαλιστηρίων συμβολαίων της. Επιπρόσθετα, όπως συνέβη και με την επιβολή της έμμεσης φορολόγησης των υπηρεσιών υγείας, που αποτέλεσε ένα αιφνιδιαστικό και επαχθές για τις ασφαλιστικές εταιρίες μέτρο, αλλά και με την κατάργηση από τον Δεκέμβριο του 2012 του φύλου, ως παράγοντα που λαμβάνεται υπόψη για την τιμολόγηση των νέων ασφαλιστηρίων συμβολαίων, μπορεί, πράγματι, να υπάρξουν και παράμετροι, μη προβλέψιμες, που μπορεί να επηρεάσουν την τιμολόγηση του ασφαλίστρου, που δεν θα έχουν κοστολογηθεί από την ασφαλιστική εταιρία, αλλά, σε κάθε περίπτωση, πρέπει να προκρίνεται η ανάγκη προστασίας του καταναλωτή, ο οποίος πρέπει να είναι επαρκώς ενημερωμένος για τη δέσμευση που αναλαμβάνει, προκειμένου να μην είναι το τίμημα αόριστο, όταν αποβλέπει σε ένα ισόβιο πρόγραμμα ασφάλισης.

Τα τιθέμενα, επομένως, κριτήρια αναπροσαρμογής των ασφαλίστρων πρέπει να είναι αντικειμενικά και προβλέψιμα για τον καταναλωτή, για να μπορεί να ελέγξει το μέτρο της αύξησης και το σύμφωνο αυτής προς τη ρήτρα που προβλέπει την αύξηση, ενώ το μέτρο της αύξησης μπορεί

να συγκρατηθεί και με τη χρηστή εκ μέρους των εταιριών διαχείριση των κεφαλαίων τους, καθώς και με την σύναψη συμβάσεων με τα μεγαλύτερα ιδιωτικά νοσηλευτήρια, για τη συγκράτηση των τιμών, που ήδη επιχειρείται με επιτυχία από πολλές ασφαλιστικές εταιρίες και είναι προς τη σωστή κατεύθυνση. Ο Συνήγορος του Καταναλωτή, λοιπόν, στο πλαίσιο των αρμοδιοτήτων του, και εν αναμονή τυχόν νομοθετικών πρωτοβουλιών, που θα διευθετήσουν οριστικά το ζήτημα, επιχειρεί τη συμβιβαστική εξωδικαστική επίλυση των διαφορών, που τίθενται υπόψη του, προτρέποντας τα μέρη, ει δυνατόν, σε μία αμοιβαία αποδεκτή τροποποίηση των συμβατικά συμφωνηθέντων.

Dr. A. TSAVDARIDIS

Attorney-at-Law, Lecturer, Democritus University of Thrace

«Filling of supervenient gaps in premium adjustment clauses»

The topic of my presentation is related to a case study on the filling of supervening gaps in premium adjustment clauses, and of course it is obvious to all of you that when we refer to supervening gaps, we are not talking about gaps that were existing at the time the agreement was concluded and executed by the parties, but the gaps that appear at subsequent points in time.

Let's see a few things about the background of coverage in the contract and the premium adjustment clause that was contained in it. A Greek insurance company issued life policies back in the 1990s. These life policies contained an addendum additionally covering hospitalization costs. Now, one category of these policies, and in particular these addenda, provided for unlimited coverage, which compensates for all covered hospitalization costs, irrespective of their value during the period of the policy that lasted for life. The addendum contained a premium adjustment clause, which was linked with the fluctuation of the exchange rate between the Greek drachma and the European Currency Unit, as both of them were at the time.

What were the events that led to this supervening gap? As you all can imagine, both the Greek drachma and the European Currency Unit were abolished and replaced by Euro in 2002. As a result, the premium adjustment mechanism that was provided in the agreement was made redundant. At the same time, the cost of the insurers' consideration kept increasing as a result of the unlimited coverage and this of course went on, or was supposed to go on, for life. Let's see now, how the insurer acted. First things first, Greek law does not provide for a specific procedure in a case of supervening gap in premium adjustment clauses which would avoid litigation and be binding for the parties involved.

Therefore, we need to litigate, if we don't have an agreement. But the insurer proceeded to adjust the premium unilaterally, after informing the insured in 2005. So what did the insurer do? The insurer used as a legal basis, the method of supplementary interpretation of the contract, according to Articles 200 and 288 of the Greek Civil Code, which in effect always takes into consideration good faith and business ethics when interpreting a contract and when we are trying to see how the debtor is going to fulfil his obligations.

How consumers reacted? Well, surprise-surprise, in 2008 a consumers' association filed a class action against the insurer. The consumers' association requested the court first to declare illegal the premium adjustments already made by the insurer and second, to prohibit the insurer from making any other adjustment in the future, claiming that the premium became fixed for life – which would make it quite a lucrative contract for the insured.

Let's go now to the first instance and appellate judgments that followed. The judgment of the first instant court was issued in 2010. The court upheld the first request and declared illegal the premium adjustments already made by the insurer. Nevertheless, it dismissed the second request by holding that the unlimited coverage for life by its very nature cannot justify a fixed premium, which should be adjusted by agreement of the parties.

Well, both parties were not satisfied by the first instance judgment, and they appealed, but the court of appeal came in 2011 and upheld the first instance judgment.

What did the insurer do? Well, the insurer chose a twofold approach, a business approach on the one hand and a legal approach on the other. First of all, the insurer started negotiations with each insured individually since 2010. The insured totalled approximately 14,000, which made the task a little bit complicated, but nevertheless agreement was reached with 13,700 of them, which amounts for 98% of the total, which is quite a significant achievement. The rest 300 of them, which is 2% of the total, refused to accept any premium adjustment mechanism, claiming that the premium had to remain fixed for life.

Then came the legal approach, because the insurer had to deal with these 300 people. The insurer filed proceedings in 2011 against the 300 insured, refusing to agree to any premium adjustment mechanism. What did the insurer do? The insurer requested the first instance court (we are back to the first instance court, because this is a new litigation) to fill the gap by selecting one of the two alternative premium adjustment clauses that were proposed by the insurer, or alternatively devise a different one (the court indeed has the right to do so).

The case is still pending. The hearing has not taken place as of now and we expect that by 2020 we may have an irrevocable and un-appealable judgment.

Will, there are some lessons to learn.

First of all, litigation appears unavoidable under the Greek legal system in this kind of situations. The solution is costly, it is time consuming and the outcome is uncertain. All these together form what we could call an unsatisfactory solution to this problem. So what is needed? We need to create a specific procedure leading to binding results for all parties, without resorting to litigation. Maybe the creation of a committee that would hear complaints by either party, the insurer or the insured in respect of supervening gaps in premium adjustment clauses would be very welcome and its decisions should be binding to everybody, not only to the parties that have resorted to the commission, but to all other categories of insured or insurers dealing with the same issue.

Dr. K. MALINOWSKA

Lecturer, Partner at BMSP Legal Advisors, Warsaw

«Changing premium in life insurance contract versus protection against abusive clauses – Polish law and practice»

Thank you. Good afternoon, ladies and gentlemen. It's a great pleasure and honor to participate in this Conference and I would like to thank Professor Rokas for inviting me and giving me an opportunity to present to you the Polish perspective of the problems concerning life insurance. I realize that it may seem a bit exotic to present a Polish case, a case law at an international Conference taking place in Greece, but the fact is that Poland is a member of the European Union, we are quite a big country in the central Europe and on 1st of May we are celebrating the 10th anniversary of the EU accession, so we are here and the fact is also we have pretty much the same law, pretty much the same insurance contracts, and I think also that we have similar problems related to these contracts.

So, today, I will present to you only one case and before I do it, I would make a short introduction of how we implemented the law and what are the problems being the source of the court judgments, because there are in fact many disputes in Poland concerning life insurance, concerning insurance contracts, and many clauses are confirmed as being abusive by the Polish courts. The case I will present you is a good illustration of the insurance contract difficulties and how much the concept of the insurance nature is manipulated very often by Polish judges, in order to reach their goal, however justified it is.

And just very shortly, how we implemented the consumer law into the Polish system. It was done in 2000, so before the EU accession, mainly to the civil court. Most of the provisions of the Directive were implemented to the civil court and as before there was no coherent system of ideas. These provisions were implemented quite accurately, of course with some exceptions.

The second one is the insurance activity act, which regulates mainly the insurance activity as the title shows, but also there are some provisions on transparency included with the aim of protecting the policy holders. And finally, we have got also the act on protection of competition and consumers and an authority. The President of this authority is given a special power to control the standard terms, also the insurance terms, and this may be also an abstractive control, even if there is no complain of a policy holder, and the results of such controls are very often the suits filed to the court in order to get specific clauses confirmed as abusive by the court. And recently, such a control was also held with respect to the life insurance standard terms, it was in 2010, and there were many suits filed after that control, because the insurers refused to change the clauses challenged by the authority.

So, as you can see on the screen, I am just trying to skip some of the slides quicker, because I know we are quite short of time, so as you can see on the screen the definition of abusive clauses is very similar to what the Directive says and the effect of using the abusive clauses is the same also with what the Directive provides for, because it is non-binding upon the consumer. And we have a grey list, an indicative list of 22 abusive clauses in the civil court. A grey list means that they are not automatically non-binding, but must be acknowledged as such in given circumstances.

But now I will stop shortly and present to you what our transparency problems are in insurance, because this is the clue I think, even if the Polish judges don't understand it, I will show it to you in the court case. But the truth is that the insurance is one of the most famous examples of bad wording of the standard terms. That is why some time ago a special provision was introduced in the act on insurance activity, which says that ambiguous clauses shall be interpreted in favor of the insuring party.

Of course, we have such a provision also in civil court, but it concerns only consumers, but some time ago, the legislative Parliament came to the conclusion that it's not enough, because there were so many disputes between insurers and policy holders, where the insurers applied the negative interpretation of the clauses in life and other standard insurance terms. There were so many disputes

about it and the courts issued so many verdicts about it that finally the Parliament decided to introduce a special provision to the act on insurance activity, which makes it easier to take control measures by the insurers' supervisory authority and to put fines on insurers for introducing such ambiguous clauses into the standard terms.

What is the result of that? The clauses which are ambiguous are interpreted in the favor of the insuring party, whether it is a consumer or not, so it applies also to B2B contracts and it doesn't mean that there are no more disputes in this respect. Of course there are still disputes, but they are more and more positive to the insuring parties and the courts say and repeat that in case of any doubts of what is the meaning of the clause, the point of view of the party who is covered by the insurance is prevailing. So this is very important and this sentence is repeated very often in the Polish verdicts and the Polish judgments.

Poland also implemented the provisions of the Directive, saying that ambiguous clauses are subject to the control, even if they concern the main subject matter of the contract. I know that some of the European Union countries have not implemented this provision, but Poland did it. But that does not mean that there is no space for discussions; of course there is, because in result of paralleling with these provisions a discussion started of what is the main subject matter of the contract, of the insurance contract. And there are two concepts, as you can see on the screen.

The first one is the old one that it is a payment of the benefit by the insurer after the insured event occurred, against the payment of the premium by the policy holder. Or, the second option, that the main subject matter of insurance is covering the risk against the payment of the premium. And of course most of the doctrines support the second option and it could be only an academic discussion, but the result of choosing one of these options is what the scope of the control of the standard text is. And unfortunately, Polish judges are not consistent about it. They adopt such a view each time, which ensures better rights to the policy holder, which ensures better verdicts to the policy holder.

So, if for example we have a case about the scope of insurance, some restrictions of the insurer's liability, the courts say, "Well, we support the first option, so we can control the scope of liability of the insurers, because the main subject matter of insurance is payment of the benefit against payment of the premium." But if the case concerns insurance sum, as I will show in the end, the courts say, "Well, the insurance sum is not something about the main subject matter of the insurance, because it is about covering the risk and my verdict does not concern payment of benefits, but covering the risks, so still I can control this clause." So the law is quite precise; the application is not precise at all, because when we see the many verdicts, when we analyze many verdicts issued with respect to the insurance clauses, we may see that the courts have also one concept, but the concept is to give positive verdict to the policy holder and not keep in line with one theoretical concept of what the insurance nature is.

So, now the second part of the problem, because the transparency is one part of the Polish problems with life insurance and the second is changing standard contracts. First, I will give you just a few words of explanation about the general rules, because insurance contract is subject to general rules, though there are some modifications with which sometimes the main idea is lost. But I cannot explain to you the case, without giving just this short introduction on what conditions we can change the contracts in Poland.

This is the main point. There is a possibility of changing the standard contract unilaterally by the insurer or not. We have in Polish civil law only one provision and this is very ambiguous to us, it still does not get to the point, and there is also discussion what the possibilities are, what the conditions are, the prerequisites that change the contract. It says that standard terms issued during the term of the contract shall be binding upon the other party, in case it has not terminated the agreement in a due time. What does it say? What we know is from verdicts and from the opinions of the academics. So, first important thing is that in spite the clause of standard terms during issuing the contract, it is applicable both to introduce a whole set of new set of standard terms during the term of the contract, but also this rule is applicable to changes of particular clauses. So, you can try to change one clause based on this provision.

But what is discussed nowadays is whether this provision is exhaustive or maybe it introduces only the procedure of how the changes should be introduced to get binding force. So the prevailing

view is that this is kind of only a procedure, and in fact the basis of introducing the changes should be a modification clause which should be included in the contract, otherwise the changes could not be admissible. And this view is challenged sometimes, because no general rule of Polish civil law imposes an obligation to include the modification clause in the contract. This is a situation only in specific types of contracts, like in banking law or others, but there is no general rule. Also the provisions concerning the unfair clauses as here, also they do not give any tip whether the modification clause is necessary or not. This clause says only how the modification clause should not be written.

So, I will go back for a moment. So, what is necessary to change the standard contract during the term is that first the contract should be based upon standard terms. Then the contract should be continuous, which we understand as the time factor, the duration in time is important and also that the contract may be terminated via notice. This is also a condition that such a change is made by one of the parties. So, this is derived from the fact that we assume that if a party has the right to terminate the contract freely, it should be possible for him also to change the contract, because if the other party has a right to terminate it, it ensures somehow the contractual balance between the parties and the consumer rights are not abused and not endangered.

So, these are conditions to introduce unilaterally the changes to the standard terms. And if we see to the insurance contract, if we analyze the features of the insurance contract, we could say all these prerequisites, all these conditions are fulfilled. The insurance is a continuous contractual relationship when time factor really matters, then the insurance contract is based upon standard terms, but when we come to the third condition, terminating via notice, then there appear many restrictions and this is the main problem which we discuss now in Poland, whether the insurance contract can be terminated or not. And if there are problems with terminating the insurance contract, then also the restriction of changing in unilaterally by the insurer should be imposed. There are no rules which will answer very precisely this question and we have then only general legal provisions and from the other side we have a very strict approach of the consumer protection authorities, because all the powers have no respect to filing the suits in the court with respect to the abusive clauses, there is no insurer supervisory authority, but only the authority on consumer protection.

So they are not specializing, the insurers, but file so many suits that we are waiting for the verdicts a very long time and there is an overall impression that nobody understands what insurance really is filing by the persons filing these sues and judges considering those cases.

There is only one provision concerning life insurance contracts, which says about the termination and it is very clear that the insurer may terminate the life insurance contract only in the events provided by the law. And as I said before, the provisions concerning termination of the contract are applicable to the possibility of changing the contract during its term. So the conclusion is that the change of the life insurance is possible only in cases provided by the law and what the law says.

We have one very nice provision in the act on insurance activity, which says that the insurer may apply an adjustment of the insurance premium and/or other fees due from or to the policy holder, under the condition of including the methods and dates of applying the adjustment in the insurance contract. You can see that there is a kind of modification clause which is necessary, so the criteria of the change must be written in the insurance contract. But also, there are some further restrictions that this modification clause, even if it is placed properly in the insurance contract, does not exclude the possibility of applying the rules of abusive clauses and requires applying the procedure concerning the issuance of new or amending standard terms, which are presented before. I mean that there should be a possibility of rejecting the changes, but then we have a very big discussion about what the results are of the proposal of the insurer to change the particular clauses in the insurance contract. I mean mainly the adjustment of the premium, because we are talking now about this point. But by the way, this provision is the only one in the Polish law, allowing to some changes to the insurance contract during its term, but still it is subject to some dispute.

So, if the general law provisions say that the changes may be applied if the other party does not terminate the contract in a due time, what should we say if the insurer should not terminate the contract? What are the results of the proposal of such changes? There is a concept, which again is derived from some opinions and verdicts that in case the policy holder disagrees, the general rules

then do not apply, so the contract does not terminate, because otherwise it would be a splendid idea for the insurers that would like to get off risky life insurance contracts, when the risk increases.

So in case the policy holder disagrees, the contract remains unchanged. But that does not mean that we have no disputes about that point. Of course we have, and I presented just the recent case, the recent verdict, which was a result of the recent control of the life insurance standard terms and one year ago, the court stated that abusive is a clause saying that increase of the regular insurance premium does not entail the increase of the insurance sum, beginning from the anniversary of the policy after the policy holder reached the age of 60.

So, this is my last slide, so I will end in a minute. What the court said. The court said that in this particular case the prerequisites of the abusive clause saying that unilateral changes without reasons to the specific features of the service, these prerequisites of this abusive clause are fulfilled by this particular term. Also, the court said that this clause does not relate to the main subject matter of the insurance and this was the really surprising thing, because to most of us it does relate to the main subject matter. The insurer of course refused to change this provision and that's why the case was considered by the court. The insurer said that in the beginning of the life insurance contract the adjustment of the premium serves the purpose that the benefit remains economically at the same level, this is in spite of inflation results. But after the policy holder reached a certain age, the insurance premium must remain still at the economically same level, in order that the insurer is able to cover the risks still. But the court said that of course, changing and adjusting the premium is after all possible, but when it does not entail the increase of the insurance sum, it causes that there is an imbalance in the contractual relationship and that there is no consideration on the side of the insurer that the burden of such a change is imposed only on the policy holder and stated that such a clause is prohibited.

So, this is the end, thank you very much, I hope I have not abused your patience and maybe you have some comments on that under Greek or European law. Thank you.

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«Some conclusions from the existing Greek court-precedents on pricing and readjustment of premium»

It has been said that on the matter of pricing and readjustment of premium, different principles collide.

Indeed, on the one hand we have the legislation on the supervision of insurance undertakings, which provides that pricing of premium is free, according to the techno-economical requirements of each undertaking and that, in the context of life insurance, pricing must be sufficient, on the basis of reasonable actuarial assumptions, to enable insurance undertakings to meet all their commitments and in particular to establish adequate technical provisions.

On the other hand, in consumer contracts, we have the judicial control of the terms which determine the price. It must be made clear though that the judicial control does not refer to the pricing per se, but to the manner, according to which the relevant term on pricing has been formulated, so that we can specify the height of the price, what it consists of and how it has arisen.

Such control is made by the courts on the basis of the provisions of the law on consumer protection, which, as we know, introduces a fundamental principle, the principle of clarity or transparency.

There are several court precedents on the principle of transparency; however, in the context of pricing and readjustment of insurance premium under Greek law, probably the most important precedent is the decision of the Greek Supreme Court No. 1030 of 2001. The importance of that decision becomes even greater by the fact that, by virtue of a relevant authorization of Consumer Law, there was a Ministerial Decision issued in 2011, incorporating the rulings of the decision of the Supreme Court No. 1030 of 2001 and obliging all the insurance undertakings from now on to comply therewith under penalty of fines.

The Supreme Court issued the decision in question upon a dispute that had begun with a class action filed by a consumer's association in relation to a general term of a hospitalization health policy, coming as an addendum to a life insurance policy. The general term that was challenged provided that the insurer had the right to unilaterally proceed to readjustment of the premium at any renewal date of the policy.

The consumer's association requested the Court of First Instance to acknowledge the abusiveness and nullity of the above general term and to condemn the insurance undertaking that was using such term to pay monetary compensation for moral harm, as provided for by the law. The Court of First Instance and later the Appeal Court accepted the above class action and granted both the above requests.

The Supreme Court that looked into the matter following an application of cassation by the insurer upheld the rulings of the Appeal Court.

The Supreme Court ruled that the principle of transparency must govern the formulation of all the general terms of an insurance policy. In the case of a term allowing the insurer to unilaterally proceed to increase or readjust the premium during the term of the policy, the policyholder must be in a position to understand the extent of the premium increase and to appreciate whether such increase was made in accordance with the relevant term of the policy or not. For this reason, the Supreme Court goes on ruling, the presuppositions and the framework of the readjustment need to be specified in the policy as far as possible. Also, the policyholder must be able to have an adequate understanding of the financial burdens that he undertakes when he concludes the policy.

Any insurer who does not conform to these principles is acting in an abusive manner and violates the law on consumer protection.

According to the rulings of the Supreme Court, the policy term that allows the insurer to unilaterally change the amount of the premium at any renewal date is abusive and prohibited,

because the insured surrenders to the judgment of the insurer regarding the correctness and the necessity of the readjustment, without the insured being in a position to foresee the presuppositions and the extent of the additional burdens he undertakes.

The abusive nature and nullity of the above policy term is based on the general clause of the law on consumer protection, which prohibits the conclusion of general contract terms that have as their result the significant imbalance, between the rights and obligations of the parties to the contract, to the detriment of the consumer.

In addition, the above term of the policy (which allows the insurer to unilaterally proceed to readjustment/increase of the premium) falls into at least two categories of the list of the law on the per se abusive and void terms, specifically:

The terms that allow the supplier (in this case the insurer) the right to unilaterally amend the contract without a specific and important reason, which must be mentioned in the contract, and

The terms that leave the price vague and do not allow the specification of the price to be made with specific criteria, which must be mentioned in the policy and be reasonable for the insured.

According to the Supreme Court, the abusiveness of the above term cannot be removed by the right on the part of the insured to terminate the policy, because such right does not change the uncertainty of the future additional burdens of the insured.

The Supreme Court in its above decision has made it absolutely clear: readjustment of premium in life insurance-hospitalization policies not only must be made on the basis of fair and reasonable criteria, but also such criteria must be specifically and explicitly laid down in the policy.

The question is how far the above requirements for specificity and definiteness must go. Because a further question is whether in a life term policy we can find reliable, objective criteria for the readjustment of the premium that can be agreed by the parties at the conclusion of the policy, which are fair and reasonable on the one hand, and specific and definite on the other hand, allowing the consumer, throughout the term of the policy, to foresee and to understand the extent of the increase of the premium and to appreciate whether the increase was made in accordance with the relevant term of the policy or not, as the Supreme Court requires.

It is arguable whether the readjustment criteria that are currently in use by the insurance industry meet the standards of specificity and definiteness set by the above decision of the Supreme Court.

In April 2014, the General Secretariat for Consumer of the Ministry of Development and Competitiveness announced that once more it imposed big fines to five major insurance undertakings on the grounds that the criteria used for the readjustment of premium in hospitalization policies were vague and did not allow the consumer the possibility to check and verify the premium increases. As far as I know there is no court judgment in relation to these latest developments and the fines imposed.

There is a view in legal theory that in case of a long-term, usually a life-time, insurance policy, it is impossible to become entirely definite and specific, regarding the readjustment criteria of the premium and that the obvious limit of the principle of transparency is that it must not frustrate the right of the insurer to readjust the agreed premium.

Striking a balance between the above conflicting interests seems to be indeed a tough matter, which, I believe, is still open. The answer to this conflict has to be given in the framework of the principle of transparency. Assuming that fair and reasonable premium readjustment criteria are selected in the first place, one possible option could be that the insurer must then be required, on the basis of a relevant term of the policy, to provide to the insured a breakdown of the calculations and data, on the basis of which any readjustment of the premium was made. The provision by the insurer of the above calculations and data, however complex they might be, will enable the insured to do his checks and verifications, possibly with the assistance of an expert, and thus have the requirement of transparency satisfied.

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«Premium Pricing and Transparency: Deciding factors in the adjustment process»

This case study is about the deciding factors in the adjustment process. As introductory points, it should be noted that during the premium pricing process, as well as in subsequent adjustments, there are various factors which play a key role in the determination of the adjustments. Transparency and fairness are some of the key principles that should always be observed, as well as the general principles of law, always bearing in mind that the aim of the legislator and the aim of the industry as well should be to protect the consumer, that is the insured in this case.

Now, when we talk about the criteria for the adjustment of premium pricing in health insurance, the obvious question is which parameters should be taken into account when we enter this process. The insurance companies take into account the evolution of the average numerical figure of the cost of hospitalization; they take into account the indexation of compensations as per the cost of living indexes, and various statistical and actuarial data and parameters. And by that, I mean for example detailed matrixes with the annual change in price, according to the factor of the age, as one of the examples of statistical and actuarial data.

What practice has also shown is that insurance companies adjust the premium price at the annual contract renewal, as per the age of the insured, based on a percentage defined by those actuarial matrixes, but they also adjust automatically to the same percentage the benefits which are offered under the contract. And also, practice has shown that insurance contracts may also define a maximum gap of the percentage of the adjustment of the premium price.

Now, health insurance coverage is one of the many insurance products in the market. However, we could say here that it is only in health insurance coverage schemes where one notices that the premium adjustment clause during the annual renewal process leads to a quite augmented percentage of premium increase. This is not due to the fact that the premium adjustment clause is abstract. It is due to the fact that, the general and specific inflation figures apart, many factors are unable to be predicted and to intervene, such as for example the factor of the big increase in cost of the medical curing process and diagnosis. And I have to say that this increase in the cost is due to the evolution of medicine and to new and expensive ways of treatment.

Moreover, we don't have in Greece, according to what my research has revealed, reliable and large in extend medical services indexes. There are some figures and indexes, however, this is something very new and hence the results of such indexes have not yet been assimilated into the insurance practice in Greece. Hence, as stated above, in the case of Greece, no reliable and large in extend medical services indexes exist, on which one could base the premium adjustment process. This is mainly due to the fact that one cannot predict either the new medical technologies of the future or the implementation of the costs of these new technologies.

Moreover, whether the pricing and adjustment in certain types of insurance will be sufficient depends also on the characteristics of the buyer of the insurance product. More specifically, it is also dependent on the customer's history of losses and claims.

Now, health insurance forms also a special and eminent category and the premium is calculated and formed on the basis of the claims paid in the previous years. So any control regarding the configuration of non-reasonable premium pricing falls under the jurisdiction of the competition authority.

The premium pricing adjustment clause may contain general principles of underwriting. It may be based on factors which the insurer considers based on internationally recognized principles of the insurance and actuarial science, as well as on technical and market factors.

Other factors for the rise in the premium adjustment prices are the rise of the insurance premiums by foreign insurers due to the increase of the country risk or the tightening of the rules and the further increase of regulatory capital via the premium price adjustment.

Now, it has been argued that during the premium adjustment process, insurance companies effect unreasonable rises and, in this way, they bridge the transparency principle of the Consumer Law 2251/1994 in Greece. However, we should bear in mind that this law does not regulate the control of premium price adjustment and the rises that may occur, but it only regulates the way in which the premium price adjustments are affected and now how big these adjustments will be. Therefore, law 2251/1994 does not impose the determination of a satisfactory to the customer price. There is case law already, although the final judgment is pending, whereby an insurance premium rise was held illegally performed, the act of rising it, and by that -this is what I said before- the way of it having become very big was held illegal, but not the act of actually having the right to adjust the premium.

Now, what happens in practice is that we end up with long and costly litigation. For us, the lawyers, this is good; but for the insured person this is not good, because he would like to have a fair treatment and not to be dragged in long-term proceedings. And Germany has been far ahead in this respect, because they have solved the issue. So, in Germany the adjustment clause of course needs to be fair and transparent in the first place, however, if it is not or if it is challenged, the solution there is not to resort to litigation, but to have it reviewed by a three-membered party committee which readjusts it.

So, what can we say from all that? Where does that lead us and what can we conclude? I think it is not right to state and to determine the percentage of the adjustment that would make such an adjustment fair and reasonable, because if we do so we act in a way that we try to regulate pricing and this is against national and EU law on competition.

What we can only do is set the criteria that should be taken into consideration when adjusting the premium. A Supreme Court decision stated that perhaps a solution to that, a solution that would allow us to say that there are criteria which are fair and reasonable and just, would be to have those criteria specifically laid down in the policy. I am not so sure if this is a panacea and if this is a golden solution, however, because we cannot be exactly definite and there is no perfect adjustment method, I think this is somewhere in between and this is better than the situation that we have now.