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SUBJECT: Financing of the EPO Health Insurance

SUBMITTED BY: President of the European Patent Office

ADDRESSEES: Administrative Council (for information)

SUMMARY

The Office proposes fundamental changes to the financing of the EPO health insurance. The Central Staff Committee questions whether these changes can be justified by the data provided. The Staff Committee has further concerns about a number of strategic and legal aspects that seems to have been insufficiently considered.

In the light of the open issues the Staff Committee recommends postponing further changes in the EPO health insurance system until the agreed cost containment measures are introduced and have taken effect, the security and ownership of the proposed fund have been clarified and the necessary legal mechanisms implemented, and a full actuarial study has been performed. In the interest of social peace and the provision of a sound basis for the reform, a step-wise approach accompanied by a moratorium of three years is recommended.

This document is submitted by the staff representatives via the President of the European Patent Office, in accordance with Article 9 (2.2) (b) of the Administrative Council's rules of procedure (see CA/D 8/06).

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I. HISTORICAL BACKGROUND

The obligatory health insurance system of the EPO (most commonly referred as "Vanbreda") has essentially remained unchanged since the creation of the Office until recently (2009). Its legal basis is Art. 83 of the EPO Service Regulations. The Article foresees that one third of the required contribution, up to a ceiling of 2.4% of the basic salary, shall be charged to the employee. This ratio is in line with the practice in many international organisations. The remaining two-thirds of the contribution and the "staff" contribution exceeding the 2.4% ceiling are borne by the Office. This sum covers not only the employee but also non-working spouses and children.

The EPO health insurance system is a classical "pay as you go system" (PAYGO) with an inherent strong solidarity aspect, whereby staff with high income cover part of the costs of staff with a low income, singles pay part of the higher costs for staff with family, and active staff pay part of the higher costs for pensioners.

Already in 1995 the Office first feared that the costs of the health insurance would explode and a working group was created to find solutions. This group proposed 20 measures to lower costs and/or increase the contributions. At the time the financial situation of the system improved and none of these measures were then implemented. Some of the measures that were proposed (e.g. the measures relating to working spouses) at the time have recently been implemented. Some (like the creation of a fund) are now again on the table.

In 2003 the insurers agreed with the Office that profits in excess of 3.25% would be set aside in a virtual fund and used to offset premiums for the next plus one year.

In 2006 changes were introduced to the Dutch health care system, resulting in spouses being obliged to register with the Dutch health care insurance. This has resulted in annual savings of 1.5 million Euros, thanks to the use of primary insurance for a large group of insured persons in The Hague.

In 2008 the administration implemented several measures to reduce the costs of the health system for the Organisation[1]. These include an obligation for working spouses who are insured elsewhere to claim reimbursement from their primary insurer first. Also: for working spouses with an income above C1(3) who are not otherwise insured, the EPO employee is made to pay for the full (average) costs of the spouse, or the spouse is excluded. The Office thus does not contribute an

[1] CA/158/07 Rev. 2

additional two-thirds for these spouses, although the EPO health insurance is supposed to cover the employee and his or her family. Moreover, the sums thus collected remain with the Organisation. The result is indeed a reduction of the costs for the Organisation, *entirely* at the expense of staff.

In 2009, following the Office's submission of the documents CA/191/07 and CA/137/08, and the injection of 300 million Euros into the Reserve Fund for Pensions and Social Security (RFPSS) the Administrative Council decided (CA/D 14/09) to create a fund for the *Office's* liabilities for after-service healthcare insurance. The *Staff's* liabilities were already funded through the contributions to the pension reserve fund made by staff from their salaries. Accordingly, when pensions are paid, the staff contributions for healthcare are withheld.

With the creation of this fund for after-service healthcare insurance the Office now has a PAYGO system *assisted* by a reserve fund for the health care liabilities of the *Office*. This is similar to the United Nations proposal set out in document A/64/366: a PAYGO system assisted by a reserve fund for the health care liabilities of the *organisation*. On the other hand, the Staff Committee knows of no organisation with an actuarially funded health insurance scheme as set out in CA/66/10 Rev. 1.

While acknowledging the financial benefits of the above measures, the Staff Committee considers that for staff in place, introducing a contribution to be paid by working spouses would seem to violate its acquired rights. Furthermore, it considers the fund *as set up* under CA/D 14/09 to be illegal. Internal appeals have been filed.

II. THE OFFICE'S PROPOSAL

The proposal as set out in CA/66/10 Rev. 1 consists essentially of two parts:

(a) transition from a PAYGO system to an actuarially funded system, to be paid for partially by staff through

(b) removal of the 2.4% ceiling for the staff contribution whilst maintaining the one-third two-thirds split in the contributions.

The contributions required for the proposed funded system are presently estimated at around 9% of the net basic salary mass. Of this the staff would thus contribute around 3%. Much higher contributions are, however, not excluded. In that case the increase in Staff's contribution would be capped at 10% per year. This nevertheless allows for a doubling of the Staff contributions every 7-8 years.

III. POSITION OF THE STAFF COMMITTEE

The Staff Committee supports prudent handling of our health insurance, which it sees as a valuable common good.

A. COST CONTAINMENT

The Staff Committee has for years requested various cost containment measures to no avail. These have included:

- self-insurance, while maintaining Vanbreda as the administrator, thus eliminating the costs of the insurers,
- the creation of a “white list” of medical doctors and/or preferred providers in order to avoid the sometime excessive invoicing in particular in Munich,
- awareness raising and better information for staff concerning medical costs,
- better prevention within the Office in order to avoid RSI-like symptoms and work-related stress, both of which it considers to be major contributors to staff ill health, including invalidity.

These measures have been discussed but very little progress has been made thus far despite the installation of a dedicated Prince2 project.

Cost containment is most critical in Germany and Austria, where health costs are up to 3 times higher than in the Netherlands, partly due to strong cost containment elements already built in to the Dutch health care system. Staff in The Hague is thus currently subsidising staff at the other EPO sites.

Furthermore, unlike the EU, the EPO has no separate or additional insurance for accidents at work and/or occupational disease. In practice these costs are paid for by the health insurance, i.e. for roughly one-third by staff.

Finally, by creating reserves for the future while removing any limit on the contribution rate, the proposed system actually *reduces* the incentives for cost containment, which will result in further exacerbation of the current inequalities between sites in terms of cost of health care..

The Staff Committee considers it essential to *first* implement the cost containment measures outlined above *before* raising contribution rates in order to generate support for reform and maintain support for the principle of solidarity among staff at all sites.

B. NO ADAPTATION OF THE CEILING CURRENTLY NECESSARY

During the 30 years that the current ceiling has been in place it has become effective only from 2003 to 2009. Apparently the total amount in excess of the ceiling that has been taken over by the Office amounts to approx. 12 million Euros, i.e. significantly below 2 million Euro a year on average over the seven year period. Whereas this may not be pleasing to the administration, the sum is relatively modest. According to ILO-AT the mere desire to save money at the staff's expense is not by itself a valid reason for departing from an established standard of reference (ILO-AT 1682 point 6, ILO-AT 990 point 6).

It is noted that recently costs have again gone down, possibly as a consequence of the cost containment measures that have already been implemented. In 2008 the insurers exceeded the capped profit level of 3.25% by almost 5.5 million Euro[2]. A correct application of the method for calculating the contribution would thus have resulted in a staff contribution level of 2.2% for 2010. Nevertheless the staff contribution has been kept at 2.4%. The legality of the present contribution level is questioned[3] and internal appeals have been filed. Further cost containment measures requested by the Staff Committee are now planned (see section III. A).

Given that the current costs do not exceed the ceiling, the Staff Committee questions the need for action now.

C. HEALTH RESERVE FUND OR HEALTH FUND?

It is at present not clear whether the Office merely proposes the creation of a reserve fund for health care costs or a fully funded system. That the difference can remain unclear even if a formal distinction has been made is shown by the Office's pension reserve fund, renamed reserve fund for pensions and social securities (RFPSS), which strives for full coverage of the pension liabilities despite being called "reserve fund".

[2] See GAC/DOC 20/09, p.16

[3] The accumulation of Office/staff funds in the hands of a 3rd party (the insurers) also raises the question what would happen if the Office were to change service provider.

Staff health costs at present represent less than 60 million Euros a year. Of this about one-third is carried by staff. The remaining 40-odd million Euros represent 3.2% of the Office's approx. 1.2 billion Euro budget (Financial Statement 2008). Whereas this is a significant amount of money, even a doubling of staff health costs would hardly represent a serious threat to the Office's budget.

If the Organisation nevertheless wishes a health cost **reserve** fund to cover such a risk then the 300 million Euros now set aside for this purpose with the decision CA/D 14/09, i.e. the equivalent of about 5 years of total costs, or 7.5 years of the Office's costs, and about 175 (!) years of an average excess of the ceiling incurred between 2003 and 2009, would seem largely sufficient.

If, however, the Organisation would wish a transition to a **fully funded** system according to the rules of IFRS, the situation would be entirely different. In that case the totality of the future health care liabilities would need to be funded, even for the case the Office would cease to exist, while disregarding future contributions. First, it must be pointed out that this would be entirely uncharted territory: the Staff Committee is not aware of any health care system that has attempted to build up such a fund. It would also mean a very major change in the working conditions if staff were asked to build up the fund needed to cover their future costs, *while continuing to carry their current costs,* in particular when future contributions would need to be disregarded, as required by IFRS. It seems obvious that for fully funding the Office's health care liabilities according to IFRS, even without assuming an increase in the costs per individual, an increase of the total contributions merely from 7.2% to 9% would be insufficient.

The Staff Committee therefore notes that the proposal in CA/66/10 Rev. 1 does not differentiate between a fully funded system and a PAYGO system with a reserve fund, which we currently have.

The administration is respectfully requested to clarify its intentions in this respect before any decision be taken by the Council.

D. BASIS OF THE DECISION

CA/66/10 Rev. 1 estimates the yearly costs for a funded system at around 9%. This is a rough estimate that is not based on a full actuarial study.

The Staff Committee demands that no changes to the health insurance system be made before the need has been convincingly shown by a full actuarial study. Furthermore, prior clarification is requested with regard to

the actuarial assumptions in view of e.g. uncertainties in the development of medical inflation, overestimation of future costs due to lack of data on aged pensioners, changing demographics and nationality distributions, lack of clarity regarding contributions (Office and staff) from the newly introduced salary savings plans (SSPs), etc.

E. STRATEGIC ASPECTS

The actual cost of the EPO health insurance, and the contributions needed to finance it, depend on a multitude of factors. Obviously the health reforms currently being introduced in various European governments are likely to have an impact on health costs. Some of these cost factors are related to staff behaviour, e.g. to which country EPO pensioners will retire.

Other costs factors are related to political decisions e.g.:

- the hiring of more external and/or contract staff, or the outsourcing of activities currently performed by permanent EPO staff, resulting in fewer permanent staff contributing to the health care system,

- the hiring of fewer staff in The Hague, where health costs are low, while increasing recruitment in Munich, where health costs are much higher, with the result that currently over 30% of pensioners retire to Germany. The hiring of a broader range of nationalities, commensurate with the significant growth in the number of EPC Contracting States, would result in future pensioners retiring to a wider range of countries with significantly lower health costs.

- the hiring of older, more experienced staff, resulting in an overall increase in the average age of the EPO population (and an increase in the average number of dependents also covered by the EPO health insurance),

- the development of the salary and career system of the Office, where any cuts in salary and reduction of career possibilities would lead to a relative increase in staff contributions,

- the development of the EPO pension system.

The staff has no influence on the above political decisions although these all act to increase the level of staff contributions required to pay for health care in an actuarially funded scheme with no cap on staff contributions.

The Staff Committee demands that staff shall not be made to pay for political decisions which have a negative impact on the cost of health care.

F. SECURITY OF THE PROPOSED FUND

The legal construction of the health fund as proposed in CA/66/10 Rev. 1 as part of the RFPSS seems questionable. Within the RFPSS there is no ring-fencing of costs. It is unclear how the Organisation can guarantee that the 300 million Euros now presented as covering previous obligations ("alte Last") of the health insurance will only be used for that purpose and not be reassigned. This problem becomes more pressing once staff contributions are concerned. It is not clear what would happen with the health fund should the Organisation cease to exist in its present form, e.g. after being taken over by the EU. For EPO pensions a guarantee from the Member States exists. This is not, however, the case for the health insurance. However, it seems clear that Staff would share with the Office the risk that the health fund underperforms.

The Staff Committee demands that the legal situation of the health fund be clarified and its security be guaranteed before staff are asked to contribute to such a fund.

G. OWNERSHIP OF THE STAFF CONTRIBUTIONS TO THE FUND

If a staff member leaves the Office before retirement age the part of the pension contributions he/she paid towards his/her pension is paid out. At present nothing of this kind is foreseen for the health fund, i.e. it seems that the staff member will be disowned at leaving the Office. The legality of such a construction is questionable.

If a funded system is to be introduced, the Staff Committee demands that measures are taken to guarantee individual staff members the ownership of any sums paid in excess of what is necessary to cover the costs incurred.

H. THE COST OF OCCUPATIONAL DISEASE

As pointed out above, the EPO has no separate insurance for the costs of accidents at work and occupational disease. In practice these costs are paid by the health insurance, i.e. roughly one-third by staff. Providing a safe and healthy working environment falls under the duty of care of the employer. There are strong indications that the EPO is failing in this respect. A 2004 survey by external experts (TNO) found a prevalence of Upper Limb Disorders (RSI-type symptoms)

ranging from 36% to 43% in all major function groups except managers[4]. Invalidity cases from ULD/RSI are known. ULD/RSI is, however, a preventable occupational disease. TNO also found a high level of burn-out symptoms. Sociological studies and Staff Surveys performed at the EPO consistently confirm high levels of stress, low levels of trust, and a high level of dignity offences. Significantly, roughly 1/3rd of staff retires on invalidity[5] and 2/3rd of the invalidities have psychological causes. It is thus likely that a significant part of the relatively high sick leave rates seen in the EPO – and the ensuing medical costs – are occupational.

Staff should not be made to pay for the costs of accidents at work and of occupational disease.

The EPO has set up an Occupational Health department and introduced a Health Policy. This seems to be having a positive effect on the sickness statistics. It is, however, too early to draw any firm conclusions.

I. STAFF PERCEPTION

In recent years the administration has hastily abolished the partial tax compensation for staff recruited after 1 January 2009, introduced a new pension system and converted the invalidity pension into an invalidity allowance. The results of these decisions have been only short of catastrophic, and are perceived so by staff. The abolishment of the partial tax compensation has led to a massive increase of costs and liabilities for the Office. Moreover, in contrast to the previous situation it seems highly likely that at least the German government will tax the partial tax compensation for staff recruited before 1 January 2009, leading to a loss of income also for those staff. Likewise, the German Tax Authorities do not recognise the internal tax levied on the invalidity allowance and want to apply national taxation to said allowance[6]. The consequences of the introduction of the new pension system will only become clear in a decade, but uncertainty about its effects is already a cause of concern to new staff.

There are other recent decisions and/or developments that cause concern to staff:

- Office spending on “communication”, including external publicity such as the 1 million Euro “Inventor of the Year” event,

[4] See TNO report, *"Risk evaluation and the prevention of Upper Limb Disorders at the European Patent Office"*, 19 October 2004
[5] CA/20/2009, page 113.
[6] See Letter of the German Ministry of Finance to Mr. Alexander Holtz dated 18.03.2010

- an about 8 million Euro budget for external experts and consultants who are perceived as lacking independence (i.e. who seem to be used mainly to confirm previously established management positions),

- the explosion of the costs for renovating the Isar building from an originally estimated 35.5 million Euro to now 48.6 million[7] and very probably more, due to bad handling of the contractors,

- the tripling of the estimated costs of the introduction of the Single Patent Process from 80 million to currently 240 million, and the insistence of the Office on the project despite strong warning signals issued by external auditors (Berenschot) and internal audit (IA-103).

The overall impression of staff is one of a management trying to save relative small sums at the expense of staff whilst spending huge sums on other projects despite serious concerns of the oversight bodies (e.g. the Board of Auditors, the Administrative Council). Both threaten the survival of the Office in the long run.

IV. CONCLUSIONS AND RECOMMENDATIONS

The current proposal to reform the EPO health insurance is not justified by the facts and arguments presently on the table.

The cost containment measures as unanimously agreed by the joint Working Group in 2009 have not yet been put in place and have thus had no opportunity to impact on health costs. As well as lowering overall costs of healthcare, cost containment measures are essential to reduce the inequalities between The Hague and the other sites and to gain staff support for any health care reform.

The legal status of the proposed fund, and of the staff contributions paid into it, requires further clarification and elaboration.

For the above reasons, the current proposal does not have the support of staff or the Staff Committee.

The Staff Committee therefore recommends suspending the creation of an actuarially funded system until the end of 2013. In the intervening period the Staff Committee proposes:

- the implementation of a self-insurance scheme from 1 January 2011.

[7] CA/131/08; CA/155/09

- to set up a joint committee from 1 January 2011 responsible for the long-term management the healthcare insurance scheme.

- that the Office implements in 2010 all remaining cost containment measures proposed by the Working Group in 2009. The newly implemented joint committee shall assess the impact of these measures from 2011 to 2013.

- to perform a health risk analysis to identify the likely causes of staff ill health, including occupational disease, and to take appropriate measures to improve staff health. In the meantime the costs of accidents at work and occupational disease should be taken out of the common health insurance and be borne by the Office. Making the costs of occupational disease thus visible would enable the Office to see the “business case” for better staff health.

- a discussion with the Staff Committee to take place in 2013 on the basis of the findings of the joint committee, the impact of the cost containment measures, the outcome of the health risk analysis and the financial situation of the health care insurance scheme in order to determine whether:

  1. the reforms have achieved their goal and the PAYGO system can be maintained for a period to be determined based on the recommendations of the joint committee;

  2. within the framework of the PAYGO system, a raising of the 2.4% cap should be envisaged under conditions to be negotiated;

  3. a move to an actuarially funded system should be considered under conditions to be negotiated;

- to postpone proposals for further changes in the EPO health insurance system until the above measures have taken effect, and only after a full actuarial study has been performed.

- If the introduction of a separate health fund is then still deemed necessary, it is essential that the legal position of the fund, and the security and ownership of staff contributions paid into the fund be clarified beforehand.

The Staff Committee views the process outlined above as imperative if the staff is to be persuaded of the need for reform, and to ensure that said reform results in a fair, secure and legally sound healthcare insurance scheme for the future. Proceeding otherwise risks incurring further social unrest and expense.

Under the current conditions, and in the light of the concerns outlined in this document, any principle decision to introduce an actuarially funded healthcare scheme as set out in CA/66/10 Rev. 1, prior to addressing all financial and legal concerns, risks seriously damaging the credibility of the Office, the actuaries and the Administrative Council, in the eyes of the staff.