An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0456
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Premium rate increases Results of policy review/failure to notify of policy reviews
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a life assurance policy in **November 2001** through their financial advisor (the **Broker**). The policy was subject to a guarantee whereby the annual premium was fixed for 20 years without any change in the level of cover. However, the Complainants believe the Provider has unreasonably increased the premium required to maintain the level of cover under the policy.

The Complainants' Case

The Complainants' Broker explains that a Whole of Life policy was incepted with a financial services provider in **November 2001** to provide inheritance tax cover. The policy consists of a savings element and risk cost element. It was a term of this policy that premiums were fixed for the first 20 years are were subject to review thereafter. In **2015**, the Provider, against which this complaint is made, merged with the financial services provider that incepted the policy and took over the Complainants' policy.

In **2016**, the Provider wrote to the Complainants advising that a premium review was due and that the current premium was not sufficient to sustain the benefits under the policy. The First Complainant reminded the Provider that under the terms of their policy, the premium was to remain unaltered for 20 years. It is stated that the Provider subsequently apologised for its error.

In **September 2017**, the Complainants received, as normal, their benefits statement. Statements up to that point usually contained a statement to the effect that following a review of the premium payments and policy benefits, the current premium payments were sufficient to cover the cost of the benefits under the policy.

However, in the **2017** statement, there was a suggestion that in order to maintain their benefits until **2027**, the premium would need to increase from €13,546 per annum to €113,951 per annum: an increase of over €100,000 or 841%. The Complainants also noted the statement indicated the value of the savings element of the policy was minus €30,027, and this was the first time there had been a negative balance on the savings element.

The Complainants state that this was followed by a *protracted engagement* between the Broker and the Provider over a 12 month period. From the information obtained from the Provider during this period, the Broker was able to compile a table outlining the decreasing trend in the value of the savings element and the increasing trend in the cost element of the policy. This table is contained in the Complainants' submissions.

The Broker remarks that the **2018** figures show a fund value of minus €76,969 and a cost of life cover of €59,747. The Provider claims that the cost of providing the risk benefits has increased by 405% since **2010**.

Referring to the Provider's Final Response letter, the Broker states that the Provider sought to justify the increase in risk benefit cost based on mortality rates amongst those aged 80, in that Central Statistics Office (**CSO**) mortality rates for those aged 80 were over five times higher than those aged 65, being the age of the Complainants when they incepted the policy. In response, the Broker observed that the mortality rate increased thirteen fold between the ages of 73 and 85, and as such, the increases did not appear to bear any relation with the rise in mortality rates. In a further Final Response letter, the Provider refused to deal with this point, contending that the rates calculated by their actuarial department were commercially sensitive.

It is submitted the 841% increase suggested by the Provider is *non-sensical*. In the **2018** statement, the Provider indicated an increase of €135,330 was required to sustain the policy for another 9 years. However, to date, the Complainants have paid €231,504 towards the policy. If the Complainants follow the Provider's advice, they will have paid more than the insured benefit of €634,870 within three years of paying the revised amount.

It is further submitted that *"[t]here is something seriously flawed in this whole process."*, and the increase in the cost of cover is *unjustifiable*. The Broker explains the Complainants are not taking issue with the Provider's entitlement to review the costs associated with the policy, rather *"… it is the extent of these increases [that] is disputed."* It is stated that if this Office forms such a view then *"… at a minimum [the Provider] had a moral duty to inform customers adequately of the pending issues in a far more-timely manner."*

/Cont'd…

The Provider's Case

The Provider explains that when the Complainants applied for the policy in **2001**, they did so on the understanding that the life cover in place would be €634,869 (£500,000) and the level of payment would be fixed for the first 20 years.

When the *Twenty Year Guarantee Option* is chosen, the initial level of payment is set for the first 20 years of the policy and will not change during that period. While reviews may be carried out, no change to either life cover or the level of payment can be sought by the Provider. The first change likely to be applied to a policy will be after its twentieth anniversary.

The level of payment agreed with the Complainants was calculated assuming life cover of €634,869 over a term of 20 years and a future growth of 6% per annum. In addition, a loading applied to a male life which increased the yearly amount to €13,546.16. The Complainants opted to pay this on a yearly basis. Therefore, so long as the Complainants made their yearly payment, they would remain on the agreed cover.

The Provider states it was made clear to the Complainants that at the end of the 20 year guarantee period, their plan would be reviewed in order to determine the level of payment required to continue providing the same level of benefit going forward. At no stage were the Complainants led to believe their payment would be the same after the twentieth anniversary.

The Provider states that as the core issue raised by the Complainants is the extent of the future increases required to maintain the existing level of life cover, section 6 of the policy states:

> ***"6. Charges***
>
> ***A Benefits Charge***
>
> *The cost of providing all benefits, with the exception of Income Protection benefit, will be recovered monthly in advance by cancellation of Units from the Benefit Fund …*
>
> *The amount of the monthly charges recovered through the cancellation of units will be based on the amount of the benefits held at the start of the month multiplied by a factor determined by the Actuary.*
>
> *In determining the factor, the Actuary will refer to:*
>
> a) *the age, smoker status and sex of the Life Assured at the Policy Anniversary, which precedes or coincides with calculation date.*
> b) *such other factors relevant to the benefit in question as were agreed between the Life Assured and the Company at the Commencement Date or subsequently."* [Provider's emphasis]

/Cont'd…

The Provider submits that in determining the cost of providing the agreed life cover, the Provider's Actuary would base the cost of the life cover in place, amongst other factors, on the customer's age.

The Provider states the cost of any insurance policy is set by first determining the risk of a claim being made. It argues that this is not exclusive to the Provider and protection benefits but is the same across the insurance industry. It is submitted that the relevance of a customer's age in a life cover policy is that as a person gets others, the mortality rate associated with their age increases. The higher the mortality rate, the greater the risk of a claim being made and the higher the subsequent cost of cover.

On **14 August 2013**, the Provider received an email from the Broker seeking confirmation as to how long the existing level of payment, subsidised by the policy value, would maintain the current level of cover. Projections were sent to the Broker confirming that based on the value at the time of €59.555.73 at 11 years and 10 months, the current payment was expected to maintain the policy for 17 years and 2 months. When the Broker queried the continuation of cover and the guarantee period, it was confirmed that despite the fact the current payment would not be able to sustain the level of cover past **2018**, as the policy had a guaranteed term of 20 years, cover would continue regardless.

The Provider notes that it incorrectly reviewed the plan in **2016** and subsequently sent an Annual Benefit Statement confirming that the cost of the benefits the previous year was €42,446.31. This triggered several queries from the Broker in early **2017**, in which the Broker questioned the erosion of the Complainants' fund and the actual costs of the benefits at the time. The Provider submits that the Complainants and their Broker were aware of the rate at which the cost of their benefits were increasing each year.

The Provider refers to the Annual Benefit Statements issued between **2014** and **2019** which set out the yearly cost of the benefits for the previous 12 months. The Provider asserts that it is clear from reviewing these statements, that the Complainants were aware of the increasing cost of the benefits and the rate at which they were increasing.

The Provider points to the Annual Benefit Statements from **2012** onwards and states they showed the charges associated with the policy were higher than the payment being made. The Provider remarks that it has been confirmed that the Complainants fully understood the mechanics of an open ended Whole of Life policy, and as such, it is reasonable to assume they understood that excess costs were being met by encashing excess units from the fund value.

The Provider explains it is not possible to discuss commercially sensitive information used when reviewing policies or setting payments on new plans. However, having reviewed the figures previously provided to the Complainants, the Provider states that the figures used were correct and a true reflection of the increased risk borne by the Provider in providing life cover for over €600,000 at that time in their lives.

/Cont'd…

It is also stated by the Provider that it cannot comment on what financial advice the Complainants received in **2001** or what expectation was set with respect to the cost of their required level of life cover when their policy was due to be reviewed in **2021** at the age of 89.

The Complaints for Adjudication

The complaints are that the Provider:

1. Wrongfully and/or unreasonably increased the premium and/or *Benefits Charge* required to maintain the agreed level of life cover under the policy; and

2. Failed to inform the Complainants of these increases in a timely manner.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 20 November 2020, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

/Cont'd…

Evidence

On **14 August 2013**, the Complainants' Broker requested a detailed breakdown *"… as to how long the existing premium subsidised ultimately by the surrender value, will maintain cover."* A *Projection Statement* dated **20 August 2013** was provided in response to the Broker's query. At page 2 of this statement, the *Projected cost of protection benefits to date* was stated as €2,661.72 at year 12 of the policy, increasing to €145,645.17 at year 17 with a *project policy value* of €2,294.57.

The Provider performed a policy review during **2014** and wrote to the Complainants and the Broker in respect of this review on **21 October 2014**. This letter advised that the current premium together with any fund value was sufficient to maintain the chosen level of cover until the next review.

A review was carried out in error during **2016**. On foot of this review, the Provider wrote to the Complainants on **2 September 2016**, to advise that their payments towards the policy would not be sufficient to maintain their current level of cover from **19 November 2016**. The letter outlined three options for the Complainants.

The letter also explained that *"[a]s you get older the cost of providing these benefits increased. When the cost to maintain your benefits reaches a stage where it is greater than your regular payments, **this difference is made up from your plan fund.**"* [My emphasis].

The Complainants made a formal complaint to the Provider on **2 May 2018**. The Provider issued a Final Response letter dated **18 May 2018**, explaining that:

> *"…*
>
> *Each time we received a payment for [the Complainants], we purchased units in their chosen fund, [Fund]. We then surrendered sufficient units to cover the cost of their plan's life cover and plan fee each month. This process of unit deduction was set out in the plan's Terms and Conditions. I refer you to the following statements:*
>
> *[Section 6. Charges]*
>
> *As you will note, we explained that the cost of [the Complainants'] life cover each month depends on current mortality rates. Any remaining units, following the deduction of the cost of the life cover benefit and maintaining their plan, made up the value of the fund attached.*
>
> *As a person grows older, the cost of providing life cover increases as the age-related risk to be insured is greater. With any life assurance plan, the risk involved is the death of a customer, which is in turn, linked to the customer's age. Taking this into account, the cost of life cover gets more expensive as one gets older.*
> *It is important to note that the cost of life cover at any stage is linked primarily to the proportion of people expected to die at those ages – i.e. the mortality rate.*

/Cont'd…

This increases substantially at older ages, as the following typical mortality rates indicate:

[Table]

**Irish population mortality 2005-2007 (from ILT15 table as published by the Central Statistics Office).*

So for example, the number of deaths (mortality rate) amongst those aged 80 ([the Complainants'] approximate ages) is over five times of those aged 65 (their approximate ages when this plan started). The cost of cover reflects this and therefore the level of payment increases required in respect of maintaining cover into older age, can be extremely substantial.

When [the Complainants'] payment was no longer sufficient to cover the cost of maintaining their plan and life cover (due to the increasing cost of providing this cover), we then rely upon the value which has built-up in the fund attaching to their plan. Rather than increasing their payment, we try to keep it as it is for as long as possible by taking the cost of the life cover from the value of the fund each month. This process reduces the value of the fund, until there is no longer a value attached.

When we no longer have the value of the fund to rely upon, or when we see that the fund is being reduced, we must review the payment being made. When a plan is being reviewed, we look at the payment being made, the age of the customer and the current mortality rates. It is based on these factor that we work out the highest level of cover that can be obtained by continuing with the current payment, or what payment is required to maintain the present life cover. …"

In a further letter from the Provider dated **20 July 2018**, the Provider explained that its previous letter contained information on mortality rates obtained from the CSO. However, this was for *"… illustrative purposes only [and] [t]he rates used by [the Provider] are calculated by our Actuarial Team. The rates used by [the Provider] are commercially sensitive; we are not in a position to provide this information to you. …."*

In terms of the correspondence issued by the Provider in **September 2016**, the letter states:

"… An increase in payment would have been needed when we reviewed the plan in 2016. Because we were asked to maintain it as it was until the end of the original 20 year term in 2021 negative units are building in the background as the current payment is insufficient to cover the cost of the cover being provided by the plan.

It is because of these negative units that the 2017 Annual Benefit Statement estimated that an annual payment of €113,950.81 was needed to maintain until 2027. …"

/Cont'd…

Analysis

The policy terms and conditions were accepted by the Complainants when they incepted the policy. Further to this, the Complainants appear to have had the assistance of the Broker throughout the life of the policy.

It has also been stated in an email to the Provider dated **11 June 2018** that:

> *"The customers fully understand the mechanics of an open ended Whole of Life plan when compared to a term plan, so it is not disputed that 'the cost of life cover gets more expensive as one gets older'. Nor is it disputed that the policy conditions allow [the Provider] to review costs."*

It seems from the Broker's correspondence with the Provider in **2013**, that the Broker was aware the surrender value (in essence, the *savings element*) was subsidising the cover or benefits under the policy. This would also have been clear from the *Projection Statement* provided at that time also. This clearly showed substantial increases in the cost element of the policy into the future. Policy reviews were carried out in **2014** and **2016** in which certain important information regarding the policy was communicated to the Complainants and the Broker. The Complainants were also provided with Annual Benefit Statements, and while the earliest such statement submitted by the parties is from **2014**, these statements set out the opening value of the fund, payments made, the protection benefit charge, and also outline the change in fund value from the previous year.

The cover letters enclosing these statements also advised the Complainants to contact their financial advisor if they required assistance. These statements clearly show a year on year decrease in the number of fund units held by the Complainants and a decrease in the fund value. The statements also show a similar trend of increasing fund charges, i.e. the *benefits charge/the risk costs elements*. Therefore, taking the evidence into consideration, I accept that the Complainants were reasonably aware or ought to have been reasonably aware of the status and performance of the policy, in particular the cost required to maintain the level of agreed cover relative to their annual payment.

Section 6 of the terms and conditions deals with the *Benefits Charge*. This is the *risk costs element* of the policy and essentially represents the cost of providing the agreed level of life cover. This section states the costs of providing benefits under to policy will be met through the cancellation of existing units multiplied by a factor determined by the Provider's actuary. Amongst the *factors* which influence this are the age, smoker status and sex of the life or lives assured (section 6(a)), and such other factors as were agreed at the date of commencement or subsequently (section 6(b)).

The evidence is that the Complainants were approximately 65 years of age when they incepted the policy and approximately 80 years of age in **2016/2017**. The Provider submits that the cost of providing cover and the likelihood of a claim increase with a person's age due to the increase in mortality rate. In explaining this to the Complainants/the Broker, the Provider referred to CSO mortality rates to demonstrate how these rates increase as a person gets older.

/Cont'd…

These data show a substantial increase in mortality rates from the age of 65 to the age of 80. This would tend to support the increase in the *Benefits Charge* under the policy. However, the Provider subsequently informed the Complainants/the Broker that the CSO data provided was for illustrative purposes only, and the rates it uses are commercially sensitive. While the CSO data are useful for illustrative purposes, they are insufficient for the purpose of addressing the substance of this complaint.

As such, while I am satisfied that the Provider is likely to have relied on mortality rates as part of its *Benefits Charge* calculation (which is not unreasonable), the Provider has failed to demonstrate how it has calculated the *Benefits Charge* by reference to age.

Further to this, age is only one of the *factors* contained in section 6 and considered by the Provider when calculating the *Benefits Charge*. I do not consider addressing this aspect of section 6 in a vague and general manner constitutes a sufficient response to this complaint, and I believe the Provider should have given more detail or explanation in respect of this and the other elements considered as part of section 6(a) and 6(b), which appear to have been ignored. I am satisfied this could have been done by the Provider while at the same time protecting what it considers commercially sensitive information. Furthermore, although the Provider is entitled to seek to withhold such information on the grounds of commercial sensitivity, the information it submits must be sufficient to justify or explain the conduct complained of if it wishes to successfully respond to a complaint. I am not satisfied the Provider has done so in this instance.

Therefore, as the Provider has chosen not to provide any information or explanation as to how the Complainants' *Benefits Charge* was calculated outside of the general and illustrative reference to mortality rates, I partially uphold this complaint and direct the Provider to furnish this information to the Complainants.

Goodwill Gesture

The Provider notes that it did not have a copy of the **2013** Annual Benefit Statement which issued to the Complainants, and offered a goodwill gesture of €500.00 in respect of this failing. The Provider also advises that if the Complainants wish to accept this offer, they should notify the Provider and immediate payment can be arranged.

While not necessarily part of this complaint, the Provider's offer in respect of being unable to furnish a copy of **2013** Annual Benefit Statement is noted. I would consider this goodwill gesture and the terms on which it is offered to be a reasonable amount of compensation of any inconvenience caused to the Complainants in this regard.

For the reasons outlined in this Decision, I partially uphold this complaint and direct the Provider to furnish the Complainants with a more detailed explanation of how the benefit charge was calculated. The Provider may take into account the need to protect commercially sensitive information in doing so.

/Cont'd…

Conclusion

My Decision is that this complaint is partially upheld, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, on the grounds prescribed in ***Section 60(2) (f) and (g).***

I direct pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** that the Respondent Provider furnish the Complainants with a more detailed explanation of how the benefit charge was calculated. The Provider may take into account the need to protect commercially sensitive information in doing so.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

14 December 2020

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address, and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.