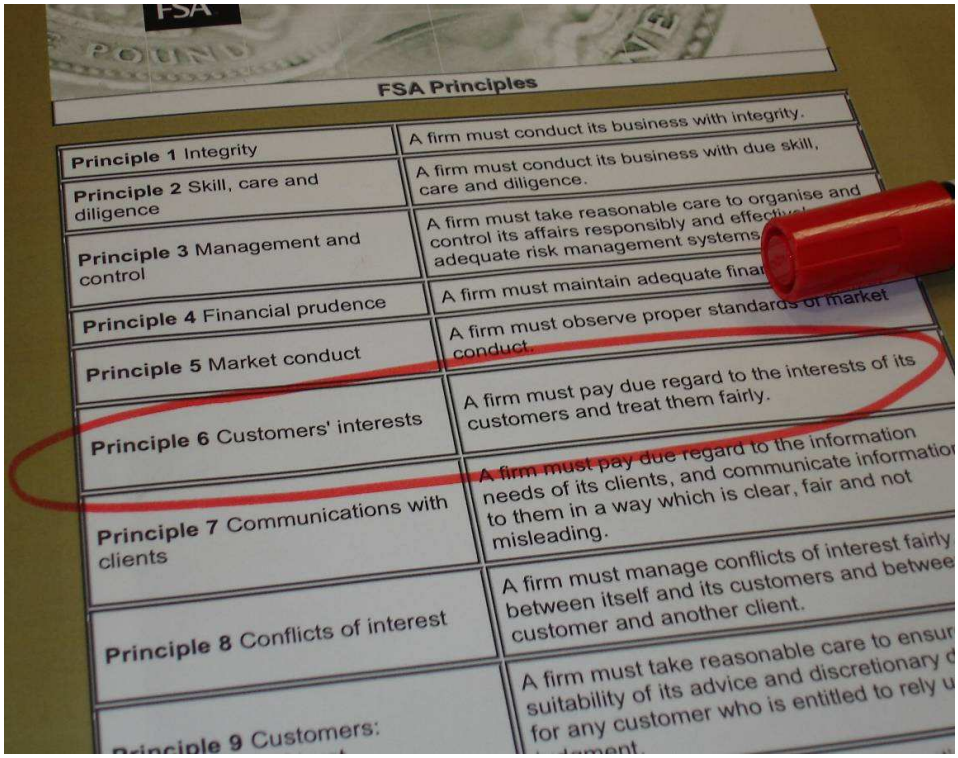

Life
Treating Customers Fairly

Report from the Life Treating Customers Fairly Working Party

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SIAS
Staple Inn Actuarial Society

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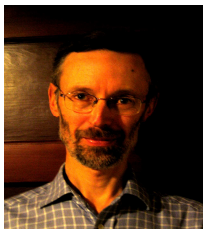

Alan Morris works for HBOS and has over 30 years' experience of the life industry. Within HBOS, he plays a central role for with-profits business, and chairs a Claims Committee for protection business. This has given him extensive contact with TCF issues across the business.

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CONTENTS

EXECUTIVE SUMMARY

The objective of the Life Treating Customers Fairly ("TCF") Working Party is to consider how life insurers can continue to improve how they treat customers fairly. We have not sought to duplicate the work of other industry bodies such as the FSA, but rather to build on the work already done, particularly from an actuarial perspective.

It is not our role to make firm recommendations but rather to raise awareness of the issues and to assist actuaries in their work in this area. The purpose of this paper is to set out certain conclusions and suggestions from our work but, more importantly, to stimulate discussion within the Profession. We would appreciate feedback either at the SIAS meeting or via e-mail to: tcf.workingparty@actuaries.org.uk

TCF covers most areas of the operations of any insurer and we could not conceivably aim to address all such areas. Indeed we made a conscious decision to focus our work on areas other than with-profits business and have focused on selected areas of non-profit business:

- Post-sale price-setting: unit pricing, surrender and alteration values, reviewable rates, discretionary charges (chapters 3 to 6);
- Product design: critical illness (chapter 7); and
- Customer communication: product disclosure (chapter 8).

We hope that each of these chapters can be read in isolation by actuaries with a particular interest in any of them and accordingly each contains an Executive Summary of the key points from that chapter.

Generic themes that we identified from the specific areas are considered in chapter 2 and so potentially this is the key chapter within the paper. These findings, from both the actuary's and firm's point of view, include:

- Customer knowledge and understanding;
- Documentation and communication;
- Impact on reserves and profitability; and
- Governance.

1 INTRODUCTION

1.1 BACKGROUND

The Life Treating Customers Fairly Working Party was set up by the Life Research Committee in 2005. The primary objective of our work was specified as "*to understand and promote the implications of the Treating Customers Fairly (TCF) initiative to actuaries working in financial institutions…*"

Our terms of reference went on to suggest that "*…the Profession can help define 'fairness' and the principles of 'fairness'…*" As a result we commenced by trying to define TCF for actuaries or otherwise addressing it as a generic issue, but found this unsuccessful, as we kept returning to what the principle of TCF might mean in different situations. In order to progress, we therefore adopted the approach of considering TCF issues in certain specific areas then seeking to identify common themes and high-level conclusions.

1.2 THE SCOPE OF THIS PAPER

We made a conscious decision to focus our work on areas other than with-profits business. This is because with-profits business has been the subject of considerable change in recent years:

- With-profits business is subject to detailed guidance by the FSA through the Conduct of Business regulations (COB 6.10 to 6.12), which considerably restricts the way in which discretion is exercised in the management of with-profits business. These rules also introduced the Principles and Practices of Financial Management ("PPFM") and the Customer Friendly PPFM ("CFPPFM") which must now be produced by firms with with-profits business;
- Addressing perceived conflicts of interest within the actuarial function by removing the role of the Appointed Actuary and introducing the roles of the Actuarial Function Holder ("AFH") and the With-Profits Actuary (as set out in SUP 4.3.16A). The With-Profits Actuary advises firms on the use of discretion in with-profits business and formally reports to both the Board and policyholders on his/her opinion on the firm's application of discretion each year; and
- The introduction of specific governance arrangements for with-profits business; these require an element of independent judgement, such as With-Profits Committees involving non-executives (COB 6.11.5).

In addition a predecessor working party had already explored many of these issues in the context of with-profits business[1]. Whilst there may still be areas of with-profits business where further discussion amongst actuaries would prove beneficial, in order to keep our task within reasonable proportions, we decided at an early stage to focus our attention on non-profit business, where we think TCF has had less formal discussion amongst actuaries.

We have also avoided the area of interface between life companies and distributors. In part this seems less actuarial than some of the areas that we have considered but we were also aware of ongoing work within the FSA and between the ABI and

[1] Report of the Customers' Interests Working Party, November 2002 available at: http://www.actuaries.org.uk/files/pdf/life_insurance/customerinterestsrep.pdf

AIFA that was likely to emerge (and indeed has emerged) before this paper would be completed.

As a result in chapters 3 to 8 of this paper, we consider the following specific areas:

- Unit pricing;
- Non-profit surrender, paid-up and alteration values;
- Reviewable rates;
- Unit-linked discretionary charges;
- Critical illness business, and
- Product disclosure.

We hope that each of these chapters can be read in isolation by actuaries with a particular interest in any of them. The common themes from the specific areas are considered in chapter 2.

1.3 AN OVERVIEW OF TCF

The TCF initiative has been very high-profile and we do not think that we need to include a detailed review of the FSA's stance within this paper. We therefore limit ourselves to a few comments in this opening chapter.

The FSA's Principles for Businesses came into effect with the adoption of the FSA Handbook and Principle 6 states that "*a firm must pay due regard to the interests of its customers and treat them fairly*". This is not the only principle that relates to how firms deal with customers, for example:

- Principle 7 – Communication with Customers – "*A firm must pay due regard to the information needs of its customers, and communicate information to them in a way which is clear, fair and not misleading*".
- Principle 8 – Conflicts of Interest – "*A firm must manage conflicts of interest fairly, both between itself and its customers and between one customer and another*".
- Principle 9 – Customers: Relationships of Trust – "*A firm must take reasonable care to ensure the suitability of its advice and discretionary decisions for any customer who is entitled to rely upon its judgement*".

However the current focus on TCF arises from initiatives undertaken by the FSA since 2004, for business other than with-profits, which appear to place TCF at the forefront of the move to principles-based regulation.

With the exception of with-profits business, TCF remains a high-level principle and has not been defined by the FSA – "*We conclude that 'fairness' is not a definitive concept. Instead it represents a series of values, which help us to decide how to behave and treat others*"[2].

In this regard, we did not think we could do more to define 'fairness' than to quote the non-exhaustive list of characteristics from the aforementioned paper by the Customers' Interests Working Party:

- Honesty, openness and transparency;
- Disclosure, on a continuing basis, of material information;
- Honouring representations, assurances and guarantees which create legitimate expectations;

[2] "Treating Customers Fairly after the Point of Sale" FSA (June 2001)

- Treating like situations alike and vice versa;
- Acting impartially and reasonably, having regard only to relevant issues;
- Acting with integrity and in good faith;
- Acting with reasonable competence and diligence;
- Refraining from exploiting customers or acting capriciously;
- Being reasonable about putting things right if there is a problem for which the firm is responsible; and
- Being accessible to customers.

As a result, the application of 'fairness' will vary in different circumstances, for example reflecting:

- Wording in individual product literature;
- Internal procedures within each firm; and
- The method of distribution.

It will also vary over time.

Whilst the FSA has produced a great deal of material, available from its website, it rarely addresses the more technical aspects of our business and still leaves a lot of space for actuaries and others in firms to debate the application and the appropriate courses of action. We hope that this paper is useful in helping life actuaries apply TCF within their work.

1.4 TCF & PRE

Whilst Principle 6 has only been applicable to regulated firms since 2001, there are many similarities with the earlier concept of Policyholders' Reasonable Expectations (PRE). These were also considered in the "Customers' Interests" paper referred to earlier.

The similarities between TCF and PRE include:

- Failure to meet PRE provided grounds for intervention by the regulator, as does the failure to treat customers fairly now;
- Expectations could be built up from many areas of interaction between a life company and its customers, that lie outside normal actuarial responsibilities;
- The Appointed Actuary had to take account of PRE, just as the Actuarial Function Holder does TCF;
- Much of the debate within the Profession on these topics has been on with-profits rather than non-profit business; and
- To our knowledge, PRE has never been precisely defined.

Clearly though, there are differences too – notably in the much wider scope of TCF, which applies to all FSA-regulated firms, not just life insurers, and its application within firms to a far wider range of decisions.

1.5 ACTUARIES & TCF

FSA has made it quite clear that it is the Board's responsibility to ensure that a firm treats its customers fairly. Many actuaries, therefore, may find themselves in a similar position to other employees of a firm (or to other Directors) in having to pay appropriate regard to TCF in performing their role.

Boards will, though, look to actuaries for detailed knowledge of the intricacies of pricing and product management and, in providing such advice, actuaries will need to formulate views on the impact of TCF. Where these are material to the advice, we suggest that the actuary involved should highlight their assumption and perhaps comment on alternative scenarios.

The Actuarial Function Holder, though, faces particular responsibilities; for example, the FSA Handbook Glossary defines *liability to a policyholder* to include "*…any liability or obligation arising …from the requirement to treat customers fairly under principle 6, including with regard to policyholders' reasonable expectations…*" This is considered further in section 2.7.

Similar considerations apply to Reporting Actuaries, Reviewing Actuaries and auditors in their respective roles in determining whether a firm has duly considered the impact of TCF in the calculation of its reserves, realistic balance sheets or embedded values. These specific responsibilities are not considered further in this paper.

1.6 LEGAL CONSIDERATIONS

Our focus has been on TCF, but in many areas this overlaps with legislative requirements arising, in particular, under the Unfair Terms in Consumer Contract Regulations. We have sought to offer our views on this in the context of Reviewable Rates in an appendix to that chapter.

However we would like to stress that this paper presents an actuarial perspective and has been written without the benefit of legal advice.

1.7 FUTURE WORK

TCF is far-reaching and evolving and hence any paper on this subject could not possibly cover all the areas impacted by TCF. In particular, this paper should not be regarded as providing a definitive view. This is perhaps not surprising given that TCF is so subjective.

Some of the topics that we have considered perhaps warrant a working party in their own right, whilst there are clearly other topics that we have not addressed.

We would welcome your thoughts on this paper and the future work that you think should be undertaken within the Actuarial Profession. Please send your comments to tcf.workingparty@actuaries.org.uk.

1.8 AND FINALLY…

As a Working Party we have held many stimulating discussions that have not always reached clear resolution. The views expressed in this paper are those of at least one of the authors, and usually of a majority, and should certainly not be regarded as the views of our employers!

In most of the chapters, we have tried to offer a "customer's perspective". This is an actuary's view of what a customer may think and has not been tested in practice and we recognise that we are not typical customers as far as life products are concerned! (In some chapters we have also included an "adviser's perspective" and similar caveats apply.)

We would .like to thank colleagues who commented on drafts of this paper, Audrey Cosens of the Actuarial Profession for her assistance throughout our work and Claire Hammond of Barnett Waddingham LLP for her help in the production of this paper. Any errors that remain are our own.

We hope that this paper will stimulate a lively discussion, both at Staple Inn and amongst life actuaries more generally.

2 GENERIC FINDINGS

2.1 INTRODUCTION

TCF is a broad area covering many aspects of the operations of UK financial services companies. In the chapters that follow, a number of specific TCF issues facing life insurers have been considered. Within this chapter we have drawn out the common themes and also used these examples to form more generic views on what constitutes TCF, how it can best be managed and the implications for actuaries.

2.2 CUSTOMER KNOWLEDGE AND UNDERSTANDING

The imbalance in knowledge

There is a significant imbalance in the knowledge of insurance products between firms and consumers and TCF imposes a requirement on firms not to make use of this additional knowledge to the detriment of customers. As a result TCF can appear to industry insiders to favour customers at the expense of firms.

This imbalance of knowledge raises the question as to how much discretion it is reasonable for firms to incorporate within their products and how product design might evolve in the future.

Using critical illness business as an example, there is clearly a risk that future experience will be worse than currently anticipated. Firms therefore apply reviewability clauses to their products because they are unwilling to take on the risks associated with worsening experience and/or because the costs of doing so lead to significantly higher premiums. However, this does not eliminate the risk; it merely passes it from the firm to the customer.

The knowledge gap can be addressed to some extent through the information provided to customers in product literature, particularly by clearly setting out the risks involved. However, it is often very difficult to express these risks in a way that really enables customers to understand the likelihood that certain events will occur and the resulting impact. On the face of it, the firm should be in a much better position to understand and manage the risk and should perhaps therefore aim to minimise the risks that are passed on to their customers.

Discretion in non-profit products

A significant feature of with-profits business is the level of discretion that firms apply in the management of that business. It is largely this feature of the business that has led FSA to introduce specific governance requirements, including the PPFM and With-Profits Committee. This paper highlights that many unit-linked and conventional non-profit products also have areas where significant discretion applies. These include unit pricing, discretionary charges, surrender values and reviewable premiums as described in subsequent chapters.

It is evident that TCF imposes greater requirements on firms than existed in the past to ensure that any discretion is applied fairly and in some cases will have removed the flexibility that previously existed to take certain actions. However, in our view

discretion is still sometimes incorporated in policy terms for firm-driven rather than customer-driven reasons.

Implications for product design

Firms must ensure that TCF is a key consideration when designing products. This ranges from keeping products simple, ensuring products are designed for customer needs, producing the right disclosure information and designing a robust process for reviews. Actuaries are likely to be involved in all these stages of the design process and, alongside his/her colleagues should have TCF in the front of his/her mind. As witnessed by the complexity of a large number of legacy products this has not always been the case in the past.

TCF will lead firms to reconsider the use of discretion and other practices in the design of new products. This might lead to changes, such as:

- More guaranteed rather than reviewable premium rates; or
- Unit-linked products where the charges are fixed, or linked to a published index such as RPI.

On the other hand, any reduction in discretion is likely to lead to increased capital requirements for firms. The ICA regime is placing greater emphasis on the identification and management of risks (and the resulting capital requirements) and capital is generally a scarce resource for firms. As a result, firms have generally been seeking to reduce the guarantees in their products.

It will be interesting to see whether new products over the next few years continue to incorporate the level of discretion that has existed in the past. In our view, there is still a valid role for discretionary terms but we would hope that firms consider the issues from the perspective of their customers as well as from their own viewpoint. It may well be that firms conclude that the best approach is to retain flexibility, but to set out much more clearly how and when that flexibility will be applied.

2.3 DOCUMENTATION AND COMMUNICATION

Internal Documentation

As noted earlier, discretion exists in many areas of the management of life business. Diverse practices also exist that may not be apparent to customers. These are considered in subsequent chapters.

It is essential that comprehensive documentation of how discretion is exercised and how practices are applied is available internally and maintained up-to-date. Firms should also have appropriate governance arrangements in place to approve material changes to such documentation.

Communication with customers

As insurance products are not tangible until a claim arises, customers must rely on verbal and written product disclosures to explain how their policies work including the policy features, costs, risks and potential benefits. Customers need to be provided with timely information that is concise, clear, consistent and relevant but complete and compliant with regulations.

Firms have had to document their principles and practices in managing with-profits business since May 2004. A customer-friendly version is also now issued at point of sale or with yearly statements (if there has been a material change since a previous version was issued). Policyholders must also be notified about changes to the Principles or Practices.

Although required by regulation, with-profits providers can now assess the advantages and disadvantages of this documentation and communication. We can see clear advantages from similar communications being introduced for non-profit business.

We are not suggesting that corresponding communications are imposed for non-profit business. Most customers are not particularly interested in financial products and the principles and detailed practices that firms follow. Mandated communications that do not add value for customers will bring additional expense that must ultimately be reflected in their premiums.

Customers can reasonably expect firms to have appropriate governance and documentation in place to ensure that they are treated fairly. They may also expect that information is available to them should they request it. Each firm should consider what information is made available to customers. It also needs to decide on the level of detail, for example a customer-friendly version or whether a complete specification is sufficiently clear and concise for a typical customer to understand. In addition firms will need to decide how best to make customers aware of this information and, in particular, whether to send some information automatically to customers at an appropriate stage of a product's lifecycle.

If firms do make more information available, they will also need to consider the process for notifying customers of any material changes.

By making this information publicly available, customers should have a greater confidence that they are being treated fairly. On the other hand, depending on the wording used, the fact that these documents are in the public domain could place unforeseen constraints on the future practices that a firm could adopt.

Constraints from past documentation and communication

Internal documentation and communications to customers considered suitable at the time it was produced may now be considered inadequate. These could place unexpected or undesirable constraints on how a firm manages its business. For example, a firm may have intended that premiums could only increase but because of inadequacies in previous communications they may now need to consider reducing premiums.

Firms should take steps to formalise their interpretation of previous wordings. It is likely that firms will need to seek legal advice to clarify any potential constraints, taking account of TCF and legislation, such as the Unfair Terms in Consumer Contracts Regulations 1999.

2.4 RETROSPECTION

Firms' practices change over time and so does the standard for treating customers fairly implied by those practices.

Where a customer started a contract some years ago, the practices at the time may differ from current standards, and the expectations given by the firm to the customer may also reflect the standards of the past. In any situation now where a firm has to decide what is fair practice for a contract started some time ago, it is forced to judge whether today's standards should apply or not. In some cases, there may be a difference of view between the firm and the customer: the customer may naturally expect today's standards, but as a result the firm may incur a cost that was not provided for when it sold the contract. In some cases, the firm may have no choice but to incur that cost.

Retrospection can even apply to past customers: in the context of unfair mortgage fees, FSA said "We would expect any lender that receives a complaint from a past customer to treat that customer in the same way they would treat a current customer in the same situation."

Separate from the discussion of what is fair in principle is the concern that firms may have that FSA and FOS will force firms to apply today's standards retrospectively. Both organisations vigorously deny that they do this. For instance, FOS says "we judge what did – or did not – happen against the law, rules, and codes and good practice that applied at the time." A particular example is mis-selling. Here too, FSA says firms are judged against the standards and rules of the time at which they give advice.

But judging what the standards and practices of the past may not be easy: records may be incomplete, and it is easy to forget differences in the social and economic climate between now and the past. FSA has at times surveyed past practices in order to gain a view, and more recently, AIFA and ABI have started a “stakes in the ground” exercise to document the current business environment and practices, as a record to be drawn upon in years to come.

Both the ABI and FSA publish documents that act as guides to good practice. The FSA look out for new areas in need of guidance, including subjects that feature in FOS complaints, and publish the results of "themed" reviews. Their approach now is 'principles-based' not rules-based, so any review considers how existing principles for businesses apply in that particular situation. This aims to give firms the predictability that they require, but requires firms to work out how to apply the principles themselves, instead of taking a compliance or legalistic approach.

The rules in force at the time are a key benchmark for TCF. There are three distinct periods:

- Before the modern regulatory regime came in with the Financial Services and Markets Act (FSMA) in 1988, there were no rules, so the benchmark is based on evidence of industry practice at the time. This applies to many mortgage endowment cases;
- 1988 till now, where there have been detailed rules, evolving over time; and
- From now on, where rules are principle-based.

As far as the law is concerned, there is a general presumption that it is not applied retrospectively, although there have been recent exceptions in the tax field. However, retrospective application can come in indirectly. For instance, if the unfair contract terms legislation affects the firm’s ability to change the annual management charge on a fund that started before 1 July 1995, a firm would have practical difficulties in differentiating between investors who entered before and

after that date, and indeed TCF considerations may mean they have to be treated identically.

2.5 MATERIALITY AND SMALL GROUPS OF CUSTOMERS

Sometimes an unfair practice can lead to a firm paying the customer an extra amount. Where the amount is small, the firm must judge when it is too small an amount to be worth paying, allowing for both the firm's administrative expenses, and what the customer will see as immaterial. One practice is to set a de-minimis limit, and then to pay to charity the sum of all smaller amounts that would otherwise have been paid.

Another instance where materiality is a consideration is in applying a practice to a small group of customers. TCF should apply to each and every customer, so the practice should not depend on the size of the group affected. But there are inevitably practical limits to how detailed a firm's approach can be, and the firm will look for an approach that is both fair and with proportionate cost to the firm. In this respect, we accept that TCF can be applied differently depending on the number of customers involved: it is hard to argue that complex processes or detailed documentation should be put in place especially for small groups of customers.

A possible solution is outsourcing or transfer of the business before it reaches an inefficient size. This is only a solution if the receiving firm is better able to balance the needs of cost and fair treatment, perhaps through consolidating the small block of business with a larger block.

A specific example is where a unit-linked fund declines in size, and here there is the solution of merging with another fund with a similar investment objective, and offering a charge-free switch into the continuing fund. This may change the nature of the investment that the customer purchased, so the customer must be given advance notice and may take the option to surrender.

2.6 IMPACT OF TCF ON RESERVES AND PROFITABILITY

TCF can have wide-ranging implications on life firms' reserving, capital calculations and assessments of future profitability, such as embedded value.

The impacts could include:

Reserving and capital requirements

- Surrender values are modelled within both the realistic and regulatory reserve calculations. TCF considerations may mean that the values that have been historically modelled are no longer appropriate and this could lead to increases in reserves.
- Within both the Pillar 1 regulatory reserve and Pillar 2 capital calculations, some firms allow for increases in reviewable charges and premiums that they consider consistent with the assumptions in the valuation scenario. The way in which charges and premiums have been historically described may restrict a firm's ability to implement these increases. These restrictions must be considered within the valuation. It is even possible that reviewable charges or premium rates may in effect become guaranteed.

- In assessing whether the firm has treated its customers fairly, there may be areas where a firm establishes compensation provisions to address past deficiencies.
- Both Pillar 1 solvency and Pillar 2 capital calculations may be dependent on the ability to change charge levels, particularly for unit-linked business. Firms may find that inappropriate wording of reviewability clauses may lead to an inability to actually change charge levels with a consequent impact on capital requirements.
- Operational risk components of a firm's Pillar 2 capital assessment should have regard to the potential impact of TCF and associated impacts in the form of compensation claims, reductions in future profits or additional cost implications.

Profitability

- As with reserving, profitability based on reviewable charges or premiums is dependent on the firm's ability to undertake reviews without any restrictions to comply with TCF.
- Where charges or premiums are reviewable, they are reviewable downwards as well as upwards unless very clearly described to customers to be reviewable upwards only, This may be an issue for life-only protection products due to improvements in mortality.
- Firms may find that TCF imposes restrictions on a firm's ability to apply cross-subsidies between differing groups of policyholders. These restrictions may result in a firm bearing costs that it would historically have recovered through the application of cross-subsidies.
- Compliance with TCF is likely to increase costs due to activities such as TCF reviews and additional communications to policyholders.

2.7 GOVERNANCE

Governance from the firm's perspective

Responsibility for TCF clearly rests with each firm's governing body, although certain relevant areas may be delegated to formal sub-committees or to actuaries, including the Actuarial Function Holder within the firm.

TCF is not an easily defined concept; it is quite likely that different firms, actuaries and consumers will have differing opinions as to what TCF means. It is therefore important that in their communications with policyholders firms should communicate in an unambiguous manner which makes it clear to the consumer how they will be treated and how the firm will apply any aspects of discretion within its control.

From an internal perspective, firms should formalise and document their own interpretation of TCF. As part of this process, wording of policy documentation and historic communications should be considered and in particular firms may wish to seek legal advice as to their legal position, where the wording may be interpreted as breaching the Unfair Terms in Consumer Contracts Regulations 1999.

On an ongoing basis, it is important that firms should put in place adequate internal documentation, processes and controls to demonstrate to their senior management, the FSA and other regulatory bodies that they are treating their customers fairly in all key operational aspects including:

- Policyholder disclosure and communications;
- Determination of claim values;
- Determination of charges, reviewable rates and unit prices; and
- The sales process including product suitability.

Finally, firms need to recognise that market practices and interpretations of fairness change over time and that historic practices may no longer be appropriate. It is important that the firm's processes and controls incorporate a regular reassessment framework in order to address possible changes.

Role of the Actuarial Function Holder (AFH)

The AFH is the actuary within the firm who is likely to have the most influence on day-to-day actuarial decisions which affect TCF, although the AFH will be dependent on other actuaries to perform much of the detailed work which support his/her recommendations. The AFH will often be required to provide advice and recommend actions to relevant committees or to the Board, who can be expected to place significant reliance on this advice.

In addition, though, the AFH carries additional responsibilities to consider TCF when discharging their duties. In particular, SUP 4.3.13R (1) - (5) describes the requirement of the AFH to:

- Advise the firm's management on the risks the firm runs in so far as they may have a material impact on the firm's ability to meet liabilities to policyholders;
- Monitor those risks and inform the firm's management if he has any material concerns; and
- Advise the firm's governing body on the methods and assumptions to be used for the investigations required for the calculation of reserves, to perform the calculations and to report on the results.

INSPRU 1.2 states that when setting mathematical reserves, the firm must take into account its regulatory duty to treat customers fairly – therefore, although the overall responsibility will lie with the Board, the AFH has a key role in advising the Board when setting the method and assumptions for calculating reserves on whether these are compliant with TCF.

Furthermore, SUP 4.3.15 goes on to state that:
"SUP 4.3.13 R is not intended to be exhaustive of the professional advice that a firm should take whether from an actuary appointed under this chapter or from any other actuary acting for the firm. Firms should consider what systems and controls are needed to ensure that they obtain appropriate professional advice on financial and risk analysis; for example:…..

(7) pricing of business, including unit pricing;
(8) variation of any charges for benefits or expenses;
(9) discretionary surrender charges..."

These are areas which are discussed in this paper, and it would seem impossible for an AFH to provide the appropriate advice to the Board in relation to these matters without raising TCF as a key consideration.

This aspect of the AFH role is further reinforced through actuarial guidance; GN40 states: *"The actuarial function holder must ensure that the firm's management are*

aware at all times of his or her interpretation of its policyholder's reasonable expectations and of any other obligations to treat its customers fairly which need to be taken into account..."

The AFH therefore carries a great deal of responsibility to consider TCF when discharging his/her duties. AFH's need to be comfortable that appropriate governance structures are in place to ensure TCF is considered appropriately when making actuarial decisions in order that the AFH can advise the Board appropriately.

References to "the Actuary" in policy conditions

A vast amount of legacy business does not clearly define the circumstances in which, or the criteria against which, an actuary would consider changes to a contract in light of conducting a review. For example, many contracts contain wording along the following lines "the level of charges will be reviewed at the discretion of the actuary" – arguably giving carte-blanche to the actuary.

In our view, absolute discretion cannot be justified in the TCF framework. and firms need to establish procedures for undertaking reviews fairly.

In addition, there is a clear difference here between the contract term (which refers to the actuary) and current governance provisions (which place such responsibilities on the Board, normally taking advice from the actuary). We would be interested to know how firms have resolved this issue in practice.

Actuarial Guidance

We have not sought to review existing actuarial guidance in the light of TCF, but in the course of writing the paper we encountered a few areas where existing guidance could be viewed as incomplete or having the wrong emphasis.

Many of the areas of detail considered in this paper may be seen as areas where additional guidance could be considered. However given that the FSA is advocating a principles-based regime, and seeking to remove detailed guidance where it can, it is interesting to consider whether actuarial guidance should be extended. Indeed in our view the biggest issues posed by TCF – issues such as product suitability – are those least amenable to detailed guidance.

Third Parties

Several of the chapters in this paper make reference to third parties – parties external to the firm that has to exercise TCF in its decisions. These third parties include external fund managers in the Unit Pricing chapter and reinsurers, in the chapters on Reviewable Rates, Discretionary Charges and Critical Illness, but there may be others too, such as outsourced administration providers.

It is quite clear that the involvement of a third party in no way lessens the responsibility of the firm to treat its customers fairly.

However we did debate – at some length – the requirement for FSA-regulated third parties to treat customers fairly. We concluded that:

- These firms are required to treat their customers fairly;
- There is however no imbalance of power in a business-to-business (B2B) relationship analogous to that in a business-to-consumer (B2C) relationship, so that the nature of "fairness" is very different; and
- These firms do not have any direct responsibility to treat customers of the firm – as opposed to the firm as a customer – fairly.

Where third parties do not recognise the firm's responsibility to treat its customers fairly, the value of the service they provide is greatly reduced. For example reinsuring critical illness business with a reinsurer that exercises a "tight" claims philosophy may make commercial sense, if their rates are sufficiently attractive, but the insurer must recognise the liability on its balance sheet to pay any claims that arise from TCF considerations where this reinsurer might not meet its "share" of the benefit.

3 UNIT PRICING

3.1 EXECUTIVE SUMMARY

- We recognise that there are a number of different practices in unit pricing which may be viewed as treating customers fairly provided adequate disclosure of current practice is available to policyholders.
- Therefore we believe that customers should have access to sufficient information (on request) to enable them to understand how the key elements of a firm's practice could affect the value of their investment.
- Certain practices may also give rise to the opportunity for firms to exercise some discretion (e.g. allowance for capital gains tax) and we believe that the principles of how discretion will be exercised should be clearly stated and supported by detailed documentation.
- We recognise that in recent years many firms have improved the management of their unit funds and that many of the issues discussed in this section will have already been addressed. However, there is still a significant amount of 'legacy' business which firms should also take into account when considering whether they are treating customers fairly.
- Firms should have robust documentation and processes in place to ensure that their approach to unit pricing treats customers fairly. Firms should consider whether their pricing methodology exposes policyholders to undue anti-selective behaviour and ensure that processes are in place to minimise the potential detrimental effect this behaviour can have on policyholders' investments.
- In case errors in unit pricing do occur, firms should clearly state how errors in unit prices will be dealt with, what limits on any compensation will be applied, and how quickly corrections will be made.

3.2 INTRODUCTION

The customer's perspective

From the perspective of the customer, the unit price is a key piece of information used to calculate the value of their benefits, providing a transparent way of monitoring the performance of their investment. The customer is unconcerned with the complexities that underlie the unit price calculation. What will concern them is that the price is correct and reflects the performance of the underlying assets over the investment period.

Most customers will not be aware that there are different approaches to unit pricing that firms can adopt which may impact on unit performance (such as rounding) and that within certain approaches the firm has discretion in how unit pricing calculations are performed (e.g. the allowance for capital gains tax).

If customers were aware of the potential different approaches then they would expect:

- That the overall approach to unit pricing is fair.
- That where discretion exists, it is applied in a manner which fairly balances the interests of different policyholders, and balances the interests of the firm and policyholders as a group.

- That information on a firm's approach to unit pricing would be available publicly (on request) so that an expert reading the information could see that the firm had established practices in place to ensure the fairness of its approach to unit pricing.

In contrast to with-profits investments, most customers will not be aware that conflicts of interest may arise, and will not seek to gain an advantage over the firm or other policyholders by exploiting the manner in which the fund is managed. However, where such conflicts do exist, a customer might expect that:

- The firm exercises discretion in running the fund in a manner which has a minimal effect on the performance of the fund;
- The firm would not take advantage of its position of controlling the management of the fund in order to systematically make profits (beyond 'normal' profits) at the expense of policyholders; and
- The firm would have adequate controls in place to prevent such conflicts giving rise to distortions in the fund's performance as far as is reasonably possible.

Customers would not expect the performance of their units in the fund to be affected by the deliberate actions of other policyholders investing in the same fund taking advantage of how that fund is run. They would expect the firm to have controls in place to prevent this from happening as far as is reasonably possible. However this may occur where, for example, retail and wholesale investors can invest in the same fund. The level of sophistication of wholesale investors may place the retail investors in a position where they are exposed to anti-selection by wholesale investors.

Where the customer has "lost out" due to errors in the pricing process then they should reasonably expect to be compensated for those errors. Similarly customers would not expect to bear the cost of correcting any errors. The appropriate action to undertake when an error is detected would be dependent on the circumstances which led to the error and the overall impact on value to the policyholder and the fund, although the procedures which a firm will follow should be well documented.

The firm's perspective

To customers and others, unit pricing may appear to be a fairly mechanical and well defined process within a life firm, but there are a significant number of areas where practice or terminology can differ between firms and where significant discretion may exist. These differences in practice may not be apparent to policyholders and therefore may create TCF issues.

The UK life insurance sector is not in isolation in dealing with the TCF issues described below and may look to other industries and/or countries to identify examples of good practice.

The fund management industry has also been grappling with certain issues on unit pricing[3], whilst an example overseas lies in where the Australian Prudential Regulation Authority and Australian Securities and Investments Commission recently produced a guide on unit pricing covering similar issues to those set out in

[3] Investment Management Association and Depositary and Trustee Association – "Pricing Guidance for Investment Funds: Fair Value Pricing" September 2004

this chapter[4]. And more recently, the ABI has published its 'Guide of Good Practice for Unit Linked Funds'[5] which reiterates many of the themes drawn out in this chapter.

To date, where unit pricing errors have come to light this has largely been due to the unit pricing methodology being inconsistent with the contract terms. Going forward, firms will need to consider more closely whether, even if the unit pricing follows the contract terms, the pricing methodology treats customers fairly.

3.3 SUMMARY OF AREAS WHERE TCF MAY BE AN ISSUE

This section describes some of the technical aspects of unit pricing and how these may be impacted by TCF. We believe that these issues warrant professional discussion to address the key concerns of the customer that the price is an accurate reflection of the performance of the underlying assets during the period of investment. Where recommendations have been made, then this is to be taken in the context of best practice. It may be that practical issues (such as very small fund sizes) mean that following best practice would place unreasonable costs on the fund which cannot be justified when considered against the additional benefit policyholders will receive. In these situations firms should consider how best to reflect the issues raised in this chapter in a cost effective manner.

We consider below various areas where differing practices exist in unit pricing and firms can exercise discretion:

- Pricing methodology:
  - Historic and forward pricing,
  - Pricing frequency,
  - Rounding.
- Allowance for investment costs and bid/offer margins:
  - Coverage (or not) of investment costs by annual management charge,
  - Single vs. dual pricing,
  - Investment costs of non-liquid assets (e.g. Property).
- Operation of discretion:
  - Allowance for deferred capital gains tax in calculation of unit prices.
  - Determination of market value of illiquid assets (both frequency and valuation approach),
  - Box management.

We have also considered some of the implications of firms examining more closely their unit pricing methodology:

- Treatment of unit pricing errors;
- Addressing time-delays in unit allocation;
- Dealing with anti-selection; and
- Relationship to unit trusts and OEICS.

[4]Australian Prudential Regulation Authority and Australian Securities and Investments Commission – "Unit Pricing - Guide to good practice" November 2005

[5] Association of British Insurers "A Guide of Good Practice for Unit Linked Funds" 1 June 2006

a. Pricing Methodology

Historic and Forward Pricing

There are two fundamentally different approaches to pricing the units when allocating units to or de-allocating units from the policyholder:

- Historic pricing – whereby the policyholder can trade with prior knowledge of the unit price; and
- Forward pricing – whereby the policyholder trades with no prior knowledge of the unit price.

Whilst one can argue that there is nothing fundamentally wrong with historic pricing, it does leave certain policyholders more exposed to anti-selection by other, more sophisticated policyholders than forward pricing. Firms operating a policy of historic pricing should ensure that adequate controls are in place to limit the scope for anti-selection with particular reference to the detrimental impact anti-selective behaviour may have on the unit price and hence other policyholders.

We would not recommend firms should necessarily move to a forward pricing basis, and for some funds this may prove prohibitively expensive, but note this was the recommendation put forward by Australian Prudential Regulation Authority and Australian Securities and Investments Commission.

Pricing frequency

In some respects, the decision on how frequently units are repriced is linked to the approach firms adopt vis-à-vis forward or historic pricing approach. We believe it is rare for firms operating a forward pricing policy to price anything less frequently than daily

Where prices are published less frequently than daily, then there may be points in time when market movements are not adequately reflected in the claims made by policyholders or the value of units secured by premiums and we believe that firms should communicate to policyholders the frequency of unit pricing and the potential risks that arise from infrequent repricing.

Where market movements mean that the current quoted unit price may not represent a sufficiently accurate value of the actual price of the underlying units, then we recommend that firms should consider performing an off-cycle unit valuation.

Rounding

Policy conditions generally leave rounding of unit pricing to the discretion of the firm (rounding may be up or down).

We believe that firms should use an unbiased rounding methodology and that where firms round in a manner which systematically benefits the firm then this would appear to be an unfair application of the contract rules, unless clearly identified within the policy terms and conditions as an additional charge on the policy (and the effects included in policy illustrations).

The impact of rounding should be allowed for whenever policy illustrations are provided to policyholders and the impact is material.

b. Allowance for investment costs and bid/offer margins

Coverage (or not) of Investment Costs by Annual Management Charges ('AMC')

Investment costs (by this we mean ongoing investment costs, such as legal fees, not the costs associated with creating or destroying units which should be reflected in the unit price) incurred by the fund can principally be dealt with in two ways:

- The first is to reduce the investment performance of the fund by the investment costs. In this instance the investment costs are directly reflected in the unit price. In this arrangement, the AMC is not required to meet investment costs (since these have been met by the policyholder).
- The alternative is to allow unit prices to develop gross of investment costs. The investment costs will then be met out of the AMC applied to the units.

The two arrangements mean that the purpose of the AMC can be very different. In the first, investment costs are being met by policyholders and the AMC might be regarded as "pure profit" for the shareholder or, as is more likely, would be used (at least partially) to meet other costs. In the latter example, investment costs are met by shareholders out of the AMC (for a mutual, this cost will fall onto with-profits policyholders or the estate). What is appropriate will depend on what has been communicated to policyholders in terms of what the charges on the funds are meant to cover. Therefore it is necessary to revert to policyholder literature, including disclosure projections and policy conditions, to ensure practice is as stated.

Where it is clear from literature that charges are not intended to cover investment costs then the former approach may be appropriate (and vice versa). The grey area is where the literature is unclear as to what the unit charges are supposed to cover. In this case, firms will need to consider what other statements may have been made which may infer whether the existing arrangement is fair.

New product literature should identify whether the investment costs are covered by the annual management charges and this should be reflected consistently within any disclosure projections.

One particular area requiring careful consideration is where unit funds are invested in internal or external unit trusts. In these situations the charging basis between the unit-linked fund and the unit trust, and the operation of any rebates, needs to be clearly documented and understood and appropriately described and communicated to policyholders.

We believe that details of what the AMC is intended to cover should be available to the policyholder. Any change in practice should also be available to the policyholder, and material changes in practice should be agreed by the Board.

Single pricing and dual pricing

When allowing for the allocation of dealing expenses across policyholders there are two pricing methodologies in common use: single and dual pricing. For collective investment schemes, this topic has recently been addressed by the FSA in a policy statement[6] which did not conclusively favour one approach over another.

Single pricing and dual pricing does not refer to the bid/offer spread that might commonly be charged as an initial charge. It refers to the setting of the unrounded unit price on which the published prices are based. The key difference is how the assets within the fund are valued. The appendix to this chapter sets out the principle difference between and single pricing and a dual pricing approach.

If there are a material number of transactions in a fund using single unit pricing then there is a risk that passive investors in the fund will effectively meet the dealing costs of the more active investors. We would expect that firms would wish to monitor this potential impact over time, and if necessary take action to protect the passive investors through the application of appropriate dilution levies – and the circumstances in which the levies are made should be clearly documented.

For dual priced funds a discontinuity in unit price occurs when the fund moves from an open to a closed basis. It is therefore important from a TCF perspective that the criteria for moving from one basis to another is clearly documented and communicated to policyholders and the processes adhered to.

Since both pricing methods may be legitimately used in unit pricing, but they have different impacts on equity it is important that actuaries should understand the impacts on equity and advise their boards accordingly. In particular when new funds are established actuaries should consider which pricing approach will be the most appropriate for the investor profile to which the fund will be marketed.

Investment costs of illiquid assets

Investment costs of illiquid assets (such as property) may be incurred in a non-uniform manner and may be substantial. The directors should consider the most appropriate manner to reflect the costs in the unit price (if indeed investment costs are reflected in the unit price).

In an expanding fund, then it seems that an approach which smoothes the cost over investment periods would be most appropriate. A one-off adjustment to the unit price would penalise leavers and benefit new entrants over the investment period. Where the fund is declining then the most appropriate approach would be one where the cost is accrued in a manner which avoids the costs being spread over a declining number of policyholders as the fund runs off.

[6] Financial Services Authority – PS06/09 "Single and dual pricing for authorised collective investment schemes - Feedback on CP06/7" October 2006

c. Operation of discretion

Capital gains tax

Allowance for capital gains tax in unit pricing should be made in a fair manner. The technicalities involved have been discussed within the Profession in the past[7]. When allowing for capital gains tax, firms should look for the pricing regime to:

- Be consistent with policyholder literature and marketing materials where this is fair;
- Minimise the potential transfer of value from policyholder to firm and vice versa;
- Maintain broad equity across generations; and
- Allow an equitable implementation of changes to tax rates and/or regimes.

The application of undiscounted tax charges on unrealised capital gains would not normally be considered appropriate. Firms should make appropriate allowance for the period between when unrealised gains are made and when they are realised in the application of tax charges.

The principles for dealing with capital gains tax liabilities should apply equally to funds where there have been taxable capital losses. In particular firms should consider whether the practice of calculating the tax liability of funds in isolation creates a 'windfall' tax profit to the firm if the value of tax losses in one unit fund offsets gains in another unit fund in the firms overall tax calculation. If such a 'windfall' exists, firms should consider whether it is treating customers fairly if a proportion of that benefit is not shared with policyholders.

Firms should document their approach and ensure adequate systems and controls are in place to monitor the practice.

Market value of illiquid assets

In order that the unit price the policyholder trades at is a fair reflection of the value of the underlying assets in the fund, the market valuation of assets which are not freely available should be carried out in a timely and transparent manner. In particular updating of prices should be considered when it is evident from market conditions/ circumstances that a significant change may have occurred to the value of the asset.

Whilst, by definition, it is not possible to determine with absolute certainty that the value placed on an illiquid asset is its market value, directors should be satisfied that a process is in place which can be demonstrated to be fair and unbiased in the valuation of illiquid assets. A description of this process should be available to policyholders.

Unit trusts and OEICs are already governed by rules setting out the principles for valuing all assets which deal with some of these issues.

[7] JIA 112 (1985) 117-161 "Unit Pricing and Provision for tax on capital gains in linked assurance business" – R.J. Laker, R.J. Squires

Box Management

The box should be used to enhance the efficiency of unit management, although historically management may have taken a position in the box to gain investment exposure.

There are potentially some undesirable features of box management which would be hard to justify as TCF:

- Undue extreme positions in the box versus the underlying assets; and
- Systematic use of the box for management to benefit from insider knowledge of fund performance.

We recommend that firms should document the principles and practices of box management and consider making these available to policyholders. Firms should ensure that adequate systems and controls are in place to verify that the box has been managed in line with those statements.

d. Pricing errors

There are a number of issues that should be considered where pricing errors occur:

- What is the de-minimis limit above which compensation should be paid?
- How quickly should compensation be paid?
- How should policyholders who have benefited from the error be treated?

As with other areas of TCF, firms should ensure their procedures for dealing with pricing errors address clearly the criteria they would apply to determine the appropriate actions if a pricing error occurred and this should be communicated to policyholders. The documentation and processes should address each of the areas above.

De-minimis limits

Upon investigation, some errors are likely to require no further action. Firms should establish the limits below which no further investigation as to the source of the error is required. Beyond certain limits, firms should consider an investigation and possibly compensation. At higher limits compensation would be arranged as a matter of course. Firms should look to set out the principles they would follow and the limits they would apply and make these publicly available (on request).

For wholesale policyholders, the arrangements for charging the costs of correcting and compensating errors may be set out in the policy terms with the firm. Clearly, and depending on the terms, the wholesale policyholders would not want to be liable for the costs of error correction if this is in excess of any compensation paid. Flexibility in the format of compensation could provide the opportunity to reduce the costs of error correction (e.g. adjusting the unit price may be cheaper than cash compensation).

Speed of response

If an error is detected then the firm must consider:

- How quickly unit prices should be changed to reflect the correct price – there seems little argument that it is appropriate that this should be done as soon as possible, with no "smoothing" of the correction over time.
- How quickly rectification should be applied where compensation cannot be made via changing the unit price – this will depend on the size of the error, and for how long it has been present. Once firms have established that an error requiring rectification has occurred and that this cannot be rectified via the unit pricing mechanism then firms should inform policyholders of the error and what steps are being taken to (calculate and) pay redress.

Policyholders who have benefited from the error

If certain policyholders have benefited from an error, then the starting position of the firm may be that this would need to be reclaimed through an adjustment to the number of units held. There may be other commercial issues which prevent the firm from taking such action, but it is important that the principles of reclamation are established alongside the principles of compensation.

Losses in respect of policyholders who have benefited from the error and have left the fund should not be reclaimed from other remaining policyholders (subject to the specific considerations of a mutual).

e. Addressing time delays in unit processing

Where time delays occur between the receipt of instructions from a policyholder either to make a claim or to secure additional units and the actual processing, then it is important for that policyholder, and existing policyholders within the fund that the units are created or destroyed at the appropriate price.

This can be achieved by recognising that the fund can be split into two balance sheets:

- Assets versus created units owned by the firm; and
- Created units versus units allocated to the policyholder.

The units held within the fund are finite at any point and known definitively by management as they have been created as a result of management actions.

The units allocated to or de-allocated from policies are not definitive as they are the result of a myriad of policyholder actions and may be subject to processing delays and retrospective corrections.

The unit price at which corrections or late processing of policyholder transactions should be carried out at becomes clearer when these two sides of the balance sheet are considered:

- Unit creations/destructions should always occur at the price from the (current) unit pricing event.
- Unit allocations/de-allocations should always occur at the price that they should have occurred at even if they are "found" some years after the event.

Following this process means that the firm, and not the policyholders, are exposed to the impact of delays in processing.

f Dealing with anti-selection

Where firms become aware of systematic anti-selection by a policyholder or policyholders against the fund to the detriment of other policyholders then action should be taken to make good any material loss suffered by other policyholders due to anti-selection.

Firms should document and maintain processes for dealing with anti-selection which may include the right to delay or suspend the trading rights of policyholders who seek to select against the fund.

Anti-selection may be prevalent where one policyholder has significantly greater market knowledge and investment sophistication than another. One particular area where this may be the case is where both retail and wholesale policyholders are invested in the same fund. In this situation, the wholesale investor may be at more of an advantage than the retail investor. Firms should consider whether it is appropriate to continue with such arrangements and what protections should be put in place to ensure all policyholders are treated fairly.

g Relationship to unit trusts and OEICS

Although unit trust and OEICs have different taxation bases to unit-linked contracts, from the customers perspective the contracts operate in a similar manner where the plan value is equal to the number of units held multiplied by the unit price. The principles which underlie the calculation of the unit price for unit-linked funds should be no different to the principles underlying the pricing of unit trusts and OEICS.

The Investment Managers Association has had best practice guidelines in place for the fair value pricing of investment funds since September 2004. Many of the themes in its best practice have been carried forward into the recommendations in this paper.

Some aspects contained in the guidelines have not been considered in this paper, particularly roles and responsibilities – identifying these clearly will obviously assist in putting in place appropriate governance procedures, although these form part of the wider governance issue which TCF raises with firms.

3.4 PUBLICLY AVAILABLE INFORMATION

One of the recommendations of this chapter is that firms should strongly consider making information publicly available describing their unit pricing methodology and firms need to consider what information should be contained in such a document, and what format the document should take.

a. Format of information

As previously stated, policyholders are unlikely to be interested in the detailed mechanics of the unit pricing process, and will be more concerned with the belief that they are being treated fairly and protected from any ‘underhand’

practices. Therefore we would not recommend producing information which is systematically sent to policyholders, but would rather favour a process whereby policyholders are made available of the presence of such information and that this can be obtained from the firm (at the appropriate level of detail) on request.

In addition, firms may want to consider publishing higher level summaries of their practices on their website.

b. What information should be included?

If a firm establishes that it does want to have information publicly available on its unit pricing methodology then it must answer the question what should be made available. It is likely that the description of the unit pricing methodology would form part of a larger document considering all the other aspects of the unit-linked contract.

We would recommend that firms should consider disclosing the following in relation to unit pricing:

- What is the overall pricing approach (e.g. forward vs. historic pricing, pricing frequency, how frequently illiquid assets are valued) and how will the firm deal with delayed transactions?
- Who pays for transaction costs within the fund and how is equity managed between policyholders?
- Who bears the ongoing investment costs of the fund?
- Is the fund open to retail investors only, wholesale investors only or a combination of both?
- What is the firms policy of correcting and rectifying errors?
- What protections are in place around the management of the box?

Appendix to chapter 3 – SUMMARY OF SINGLE PRICING AND DUAL PRICING

Single pricing sets the value of the assets within the fund for unit pricing purposes to be at the mid-market valuation at the relevant date. The unrounded price is then set at this level and the bid price (or single published price if no bid/offer spread applies) is then set to a rounded version of this unrounded price. The offer price is then set (if applicable) after allowing for the bid / offer charge.

Dual pricing sets the unrounded price by reference either to the costs of buying all of the assets in the fund or the value achieved by selling all of the assets within the fund. The basic valuation is normally stated as being on a "buying basis" or "selling basis" or sometimes, perhaps confusingly, "offer basis" and "bid basis". The unrounded price is then calculated and the published bid price (or just the price if no bid/offer spread is charged) is then set based on this unrounded price.

Firstly, let us consider the single pricing method. This avoids large movements in unit price that are unrelated to movements in the value of the underlying asset and appears fairer to the customer. It does, however, mean that all of the unit creations or destructions take place at a price set on mid market valuation. On a unit creation, if the fund manager was then to purchase assets, he would not have sufficient cash to buy proportionately the same assets. On a unit destruction, if the fund manager had to sell assets, he would need to sell proportionately more assets to realise the cash demands of the unit destruction. In effect, the buying or selling costs are spread over the units already within the fund and not leaving. There is a transfer of value from those already within the fund to those entering the fund on a unit creation and similarly from those staying in the fund to those leaving the fund on a unit destruction.

A simple example can show what happens in extreme cases. A fund invests in one asset (say a unit trust) with a 2.5% net difference in buying values and selling values. The fund manager is under strict instructions to always hold the asset. The underlying price of the asset stays at 101.25p and 98.75p for the whole of the example with a mid market valuation of 100p. Units in the unit fund start with a bid price and unrounded price of 50p and have no bid offer spread. Initially, there are 20,000 units in existence (assets of 10,000)

Time	**Start**	**One week on – unit creation**	**One week further on – unit destruction**
Assets in fund at beginning	£10,000	£10,000	£19,876.54
Unit movement		+20,000	-20,000
Cash value		+£10,000	-£9,938.27
Assets in fund at end	£10,000	£19,876.54 as buys 10,000/1.0125 of assets to get 9,876.54 assets	£9,812.47 as sells 9,938.27 / .9875 of assets requiring 10,064.07 assets
Units in fund	20,000	40,000	20,000
Unit price unrounded	50.000p	49.691p	49.062p

Therefore, the unit price has lost 0.9p (or 1.8%) from the two transactions. Note that, irrespective of the direction of the transaction, the loyal policyholders always lose. This may seem extreme.

Firms do recognise this effect and have instigated various approaches to mitigate the impact on passive policyholders by imposing dilution levies or dilution adjustments on

transactions. However the frequency by which these adjustments are applied and the magnitude of the adjustment varies greatly from firm to firm.

Dual pricing would have required new units to be created at an unrounded price of 50.625p and units to be destroyed at an unrounded price of 49.375p. If you follow both transactions through at those prices, you would arrive at still dual unrounded prices of 50.625p and 49.375p at the end of the transaction. The units entering the fund and leaving the fund have "paid" the costs of purchasing and selling assets.

Single pricing has distinct marketing advantages if the fund is large with a large amount of liquidity and the unit creations and destructions are very small. The fund performance is still diluted but by only small amounts. Existing policyholders are not accruing purchase costs or sales costs when there is no intention of purchasing or selling underlying assets. Eventually, new assets may need to be bought at which time all policyholders pay the cost;

Dual pricing has distinct advantages when the fund manager will buy or sell assets in line with the unit creation / destruction. This may be because the fund is small or maintains minimal liquidity.

Dual pricing normally tracks underlying asset values well over the long term but (because of movements in valuation basis) can throw up short term anomalies;

Single pricing works best if purchase costs / sale costs are small. Stamp duty is a major element of cost on an equity portfolio. Property portfolios have large spreads in valuation;

To address the potentially different investment habits of certain investors, a very large fund may have two sets of prices: one on single pricing basis may be used for retail investors who normally invest in monthly direct debits through their ISAs and disinvest at different times from each other; one on dual pricing for institutional investors who tend to actively move large amounts in or out of the fund.

4 SURRENDER, PAID-UP AND ALTERATION VALUES

4.1 EXECUTIVE SUMMARY

Many non-profit policies are surrendered or altered before the end of their term. Despite this, prospective and existing policyholders often do not have adequate information to help them understand the potential impact of surrendering or altering their policy or knowledge that they are being treated fairly. We would expect firms to take into account the following considerations in addressing these points:

Policyholder communication and literature

- Product disclosure[8] should describe how surrender and paid-up values are calculated in a way that is sufficient to enable a policyholder to understand the main factors that may impact the return on their policy. It is important that the presentation of this information is in a format that an ordinary policyholder is likely to both read and be able to understand.
- The methods and assumptions used to calculate these values should be consistent with the product disclosure.
- Where policy documentation is unclear on existing policies, firms should formalise their interpretation of current or intended principles and practices.
- In particular, firms should formalise their interpretation of wording which may be interpreted as breaching the Unfair Terms in Consumer Contracts Regulations 1999.

Principles underlying the setting of values

- Firms should consider whether the practices adopted in setting these values should be influenced by changes in market practices and interpretations of fairness since the contracts were originally issued.
- Surrender and alteration values should generally not be set so as to extract higher levels of profits than the firm would have obtained had the contract remained in force until maturity, but may reflect reasonable costs to the firm of effecting such a surrender or alteration.
- If approximate methods are used for practical reasons, firms should satisfy themselves that any approximations are not likely to significantly disadvantage individual policyholders. This is especially relevant to small blocks of business or where certain forms of alteration are rarely undertaken.

4.2 INTRODUCTION

The purpose of this chapter is to highlight the TCF issues arising from non-profit surrender, paid-up or other alteration values and to provide guidance on considerations actuaries should take into account in the determination and communication of these values.

It is worth first considering the customer's and the firm's perspective on what fair treatment is likely to entail.

[8] Product disclosure here includes the policy documentation, sales literature, illustrations and subsequent communications to policyholders regarding their policy.

The customer's perspective

Many policies are taken out with a long-term objective in mind and with no intention by the policyholder that they will surrender, make paid-up or alter their policy before its maturity. Therefore, policyholders often do not explicitly consider how their surrender, paid-up or alteration value will be determined until the point at which they request the surrender or alteration to take place. Although they may not have realised it at the time the policy was taken out, policyholders are likely to consider that they should have been provided with a minimum level of information to understand how these values may be determined and where relevant and significant, factors that may affect the value.

The policyholder is less concerned about the detailed mechanics of how the surrender or alteration value calculation will be performed, than in understanding what they will get back and that they have been treated fairly.

In considering what is 'fair', policyholders are likely to expect that the surrender or alteration value calculation will be consistent with what they have previously been told. Policyholders with savings policies may expect that the surrender value will be closely related to the amount of premiums they have paid at early durations and similar to the maturity value near the end of the policy term.

It is likely that policyholders would not expect to be sold policies where complex charging structures have been used with the sole intention of obscuring the level of charges.

In cases where a description indicates that the value will be determined by the Actuary or the firm, there is an implicit level of trust that the firm will apply any discretion in a manner that balances the interests of policyholders and the firm.

The firm's perspective

For unit-linked contracts and similar contracts with explicit charging structures, the determination of surrender values is usually well-defined, from a given unit value.

For conventional policies, policy wording has historically allowed the firm complete discretion (for both with-profits and non-profit policies). Most firms would strongly defend against any accusation that they used vague policy wording to allow them to extract additional sources of profits. Often, the rationale is to prevent the firm from needing to reserve for any potential onerous guarantees, to provide flexibility in determining surrender and alteration values to reflect emerging experience, new actuarial techniques and to allow cross-subsidies between policies, without being constrained to systematically follow a certain approach.

Another reason why policy wording has often been phrased in this manner is because the determination of surrender and alteration values on conventional business uses actuarial techniques which are not easily explainable to the lay person. The discretion given by the policy wording also has the practical benefit that the updating of these values can be carried out on relatively passive bases, as long as this is judged consistent with today's standards of fairness.

Firms may consider that historic alterations and payments made which were determined on the basis of techniques available and generally accepted practice at

the time, would not require to be re-evaluated in light of revised interpretations of fairness or newly developed technique.

4.3 SUMMARY OF AREAS WHERE TCF MAY BE AN ISSUE

The main areas where differing practices may exist that are considered in this chapter are:

- Policyholder communications and literature; and
- Principles underlying the setting of values.

The products within the scope of this chapter include non-profit and unit-linked policies taken out for both protection and savings purposes including policies that were originally with-profits but were subsequently converted to non-profit contracts. Where considerations differ between products, these have been addressed separately.

Given the relative infrequency of alterations (other than making a policy paid-up), the chapter focuses on surrender and paid-up values, though similar considerations are also likely to apply to other forms of policy alteration.

4.4 POLICYHOLDER COMMUNICATIONS

This section discusses areas actuaries should consider in relation to the timing of communications to policyholders and the information to be provided as part of these communications. The themes explored in this section apply to all types of policies, not just non-profit policies.

Timing of communications to policyholders

There are three natural trigger points at which information would be expected to be provided to policyholders; firstly as part of the sales process, secondly at the point at which a surrender, paid-up or alteration value is requested and finally when a claim is made. In addition to these three distinct trigger points, information describing the principles used to set surrender and paid-up values, together with illustrative examples for sample policies, should also be available on request.

Given the cost involved and relative policyholder apathy to reading policy communications, it is questionable whether policyholders would significantly benefit from annual statements or literature describing the methods used to calculate surrender or paid-up values. In addition, it may also distract from the key information shown in the statements. We therefore do not consider that this information should be required to be sent on a regular basis to policyholders, though the availability of this information, together with relevant contact details, should be highlighted within relevant policy communications.

Rather than documentation describing the mechanics in detail we consider that this documentation could take the form of a Principles and Practices of Financial Management (“PPFM”) for non-profit business much like the document that currently exists for with-profits business. A firm may prefer to produce a series of documents to cover this information as opposed to one document/PPFM. Either way, a firm would need to consider whether the document(s) are in a suitable format to send to customers on request or whether customer-friendly versions are more appropriate.

There is an argument that policyholders would benefit from communication of the amounts available on surrender at regular (e.g. annual) intervals, particularly for products where the value may fluctuate significantly from one year to the next. This would give policyholders more information on the policy options they have available to them and for investment policies how their policy has performed since the previous year. The ABI Review of Yearly Statements "Making information work for customers" (July 2006) provides support to this stance; the research indicated that existing customers want information such as the current and prospective value of their policies. A counter-argument may be that this is inappropriate as it may lead to higher levels of policies being surrendered or altered from their original contractual terms and may result in higher levels of expenses to the detriment of the firm and other policyholders.

Although firms may find that there are significant additional cost implications in providing this information to blocks of business which have historically not received statements or updates, we believe that firms should consider the extent to which this information would be beneficial to relevant policyholders (including whether failure to provide this information is consistent with the firm's duty to treat its customers fairly) and the frequency with which these options should be communicated.

The information on surrender and paid-up values that we consider should be provided to policyholders is considered in the sections below.

Descriptions of surrender value and paid-up methodology within policy documentation and sales literature

Historically, communication of how surrender and paid-up values were calculated, and what they might be, was limited, particularly for conventional non-profit policies. Although in recent years, disclosure illustrations have provided an indication of the payment a prospective policyholder may receive (the minimum information the firm is required to provide to private customers, is set out in COB 6.2 (Provision of key features or simplified prospectus)), there is normally no description of how these values are calculated, whether it is a 'fair' value or how the method used to determine the value might change in subsequent years.

Similarly, on an ongoing basis, policyholders may not be aware of what the surrender or paid-up value on a non-profit policy is or how this might change depending on their continuation of the policy.

Policyholders should be aware of how the benefits available from their policies, including paid-up and alteration values, are determined. The description in product disclosure (the policy documentation, sales literature, illustrations and subsequent communications to policyholders) should be sufficient so as to enable a policyholder to understand the main factors and how they would affect the level of surrender or paid-up value available. Given the potential complexities around the calculation of claim values, it is essential that where illustrations are provided, they are in a form such that a layperson can understand. It may also be appropriate for firms to carry out market research to assess how best to present this information to customers.

For conventional non-profit policies in particular, policyholder communications have often historically included statements which gave the firm powers to unilaterally vary the method and level of values paid or which did not specify any constraints on how the surrender values would be calculated. We do not consider

that wording indicating that "surrender/paid-up values will be set at the discretion of the actuary/firm" would constitute an adequate description of the method and where this is included in current policy literature we would expect the firm to document the approaches it takes to calculating these values and the supporting rationale. It may be appropriate to seek legal advice in such circumstances.

Surrender values

For newly-sold policies, illustrations are provided to prospective policyholders indicating potential values the policyholder may expect on surrender and the impact on their policy returns, often through disclosure of reductions in yield at different policy durations.

For existing policies we would expect that the current surrender value should be included with any yearly statements which are produced as part of business as usual. This is considered particularly important for policies which contain a significant savings element where the surrender value may change significantly from one year to the next.

We consider it fundamental that the information on yearly statements is provided in a transparent manner so that it is clear what the surrender value is, particularly in cases where this may differ from the unit account or face value of the contract.

For those products where no surrender value is provided, for example term assurance policies, it is already a requirement that this fact must feature prominently in the main policyholder literature rather than being confined to the terms and conditions. We consider this appropriate and that subsequent communication of surrender values for these products would not be required, but could be included if regular communications are being sent to policyholders

Paid-up values

It is of note that although surrender values are now usually disclosed for new business, the impact of making a policy 'paid-up' is not commonly shown, even for products where the occurrence of policies becoming paid-up is frequent. For example, for regular premium pensions policies it is far more common for policies to become paid-up than to transfer to other providers.

Few policyholders will take out a regular premium policy with the intention of making it paid-up; however, there is an argument to suggest that even if the policyholder has every intention to continue paying premiums until the maturity date, where experience suggests that this is unlikely, then the firm should provide some information at policy issuance with more detailed information and quotations at the point the request for the policy alteration is made. We consider that the level of disclosure provided at policy issuance should be proportional to the potential impact on policy returns from making the policy paid-up.

A potential impact of making a policy paid-up is that relative charge levels may become more significant. Where material, firms should consider an appropriate format in which to communicate this information to the policyholder.

In practice, paid-up values are normally only available on policies incorporating some form of savings element (rather than pure protection contracts); a significant proportion of the reduction in future benefits from making the policy paid-up is

therefore likely to result from the fact that no further premiums are to be paid rather than the impact of charges being more significant.

Disclosure and comparison of the projected reduction in yield (RIY) at maturity may be one way in which policyholders may be easily able to understand the impact of making the policy paid-up.

Where additional charges are levied, we consider it appropriate that the impact of these charges is disclosed to the policyholder in a transparent and understandable manner.

Another impact of making a policy paid-up is that the policy may no longer meet the objective for which the policyholder originally effected the policy. We consider it is therefore appropriate that the policyholder is made aware of the potential impact on the claim value or benefits provided from the policy once it is made paid-up. This could include a reprojection of the revised projected maturity value (for savings or pensions products) or estimates of when the unit fund will become exhausted for flexible unit-linked protection products.

When policies become non-profit through a policy alteration e.g. becoming paid-up, we consider it appropriate that policyholders are advised how subsequent surrender values will be determined where the approach changes materially on the alteration.

Other alteration values

Forms of alteration other than surrender or making a policy paid-up are far less frequent. Whilst, it is unlikely that a firm would wish to describe in detail the way in which other types of alteration values are calculated, it would be expected that firms should apply similar approaches and considerations to the setting of alteration values as for surrender and paid-up values.

4.5 CONSIDERATIONS IN THE SETTING OF SURRENDER AND ALTERATION VALUES

Unit-linked policies have tended to be relatively explicit on the charges that are applied on policy surrender. This section therefore focuses on surrender and alteration values on conventional non-profit policies, and in circumstances where the determination of these amounts has not been explicitly described for unit and index linked products.

Unlike with-profits policies, there is no accepted concept of what constitutes a 'fair' method in which to calculate non-profit surrender values for conventional non-profit policies. Historically, the calculation and underlying basis are at the discretion of the firm, with only 'indistinct' TCF considerations under COB 5.6 potentially being considered in the determination of minimum payouts.

COB 5.6 deals with "Excessive Charges" in connection with designated investment business. COB 5.6.3 indicates that "*a firm must ensure that its charges … are not excessive*". COB 5.6.4 expands on this stating that a firm should consider:
"*(1) the amount of its charges for the services or product in question compared with charges for similar services or products in the market;*

(2) the degree to which the charges are an abuse of the trust that the customer has placed in the firm; and

(3) the nature and extent of the disclosure of the charges to the private customer".

Although these points provide underlying principles, we consider that there are additional areas that actuaries need to consider, as discussed below.

Consistency with policy documentation and contract

A starting point in determining fair bases for calculating surrender and alteration values is that the methods and assumptions should be consistent with the contract (and the implied contract) with the policyholder. The implied contract includes any subsequent communications, whether written or verbal, made to policyholders and must be considered in the context of how these communications are likely to have been interpreted by a layperson.

Firms should establish adequate internal documentation, processes and controls to demonstrate that the methods and assumptions used in calculating surrender and paid-up values are consistent with the contract (and implied contract) with the policyholder and meet the firm's duty to treat its customers fairly.

A significant difficulty arises in respect of policies where the firm has not disclosed how values are calculated or where the description of the calculation of the value may appear unfair or significantly in favour of the firm (e.g. wording which describes that values are calculated at the discretion of the firm or Actuary). In these cases it might be considered that there is a risk that the firm does not comply with the Unfair Terms in Consumer Contracts Regulations 1999 (UTCCRs). Interpretation of these regulations in this context is outwith the scope of this chapter. In these circumstances firms should formalise their interpretation of current or intended principles and practices by ensuring that adequate internal documentation and review processes exist. In these circumstances firms may also wish to seek legal advice to confirm the appropriateness of these principles and practices.

In its role as a qualifying body, the FSA can challenge firms using terms which it views as unfair under the Unfair Terms in Consumer Contracts Regulations 1999. This has led to firms having to provide undertakings not to use terms which may be considered unfair or to clarify interpretation of existing terms, and these undertakings are published on the FSA website.

The undertakings issued include examples which have restricted firms' ability to unilaterally change the terms and conditions of its contracts and restrictions on the use of complete discretion by the firm to vary charges and premiums[9].

Although not in relation to life insurance product surrender values, it is of note that an undertaking has been provided by Blemain Finance Limited**,** in relation to the calculation of early redemption penalties it applies on its mortgages[10]:
"A term in Blemain's repayment mortgage contract said if a customer repaid their mortgage early, the firm would calculate the early repayment charge using a formula known as the 'Rule of 78'."

[9] http://www.fsa.gov.uk/pages/Doing/Regulated/consumer/relevant/index.shtml
[10]www.fsa.gov.uk/consumer/updates/updates/unfair_contracts/mn_unfair_mortgage_early_charges.html

The FSA considered this term was unfair (even though it was disclosed to mortgagees) because:
"it could result in the customer paying a charge much higher than would reasonably compensate the firm for charges lost through early repayment."

For affected mortgages, Blemain has updated their early repayment charges to use both the Rule of 78 and a different method to calculate the charge, with the customer paying the lower of the two.

Two particular points are worth noting from this example:

- Disclosure in policy documentation and communication of a term which is considered unfair may not be an acceptable demonstration that the firm has discharged its duty to treat its customers fairly.
- The FSA considered a surrender/early redemption charge which was much higher than would reasonably compensate the firm for charges lost through early repayment, to be unfair.

Whilst the undertaking provided was in relation to mortgages, the stance adopted can also be considered in the context of surrender values or penalties on other financial products including life insurance contracts. We consider that extension of this form of undertaking to insurance contract surrender and alteration values would have significant impacts on firms that apply penal surrender or alteration charges. In addition, we consider that actuaries should consider these points in determining charging structures for new products.

Interpretations of fairness and market practice may change over time. There may be circumstances where a condition or term that was considered fair at the time the contracts were originally issued are no longer appropriate. Application of methods and assumptions consistent with the original contract and policyholder communications may not be sufficient for the firm to demonstrate fairness. We consider that firms should consider these factors and on a regular basis reassess whether it continues to treat its customers fairly. For policies that have historically been altered and are still in-force, we consider that it would be unduly onerous for firms to have to retrospectively apply modern interpretations of TCF to alterations that have previously been made.

Throughout the remainder of this chapter, areas that should be considered from a TCF perspective when setting surrender and alteration values are described. In all cases, firms should consider the extent to which the approach is appropriate in light of the statements made to policyholders at the time the policy was purchased, in subsequent communications, and with due regard to current market practice.

Extent to which the expense, demographic and investment experience of the firm are allowed for in the setting of surrender and paid-up values

In the early years of a contract, there is a likelihood that the firm may have incurred high levels of expense in writing the business which it may not have fully recovered from premiums received or charges taken. Non-profit policies are generally written to generate profits for the firm or the with-profits fund and therefore we consider it is reasonable and expected that surrender and alteration values are set so as to recover the initial, maintenance and termination pricing expense loadings associated with the policy.

Firms often purchase and hold to maturity specific assets in order to back non-profit policies; for example, Guaranteed Equity Bonds are typically backed by structured products that match the benefits provided to the policyholder, or conventional non-profit policies may be matched with fixed interest securities to provide the guaranteed benefits at maturity. The return generated if these investments are required to be sold prior to maturity may differ significantly from the yields if held to maturity, due to factors such as changes in the yield curves, market volatilities or illiquidity premiums. In these circumstances we consider it appropriate that any negative or positive impact from changes to these factors is allowed for within the determination of the surrender value.

The firm will have assumed certain asset mixes, investment returns and bond default assumptions as part of its pricing of policies. We do not consider it appropriate for the firm to reflect adverse experience in factors such as default experience on bonds or where mis-matching of assets and liabilities by the firm has resulted in returns being less than expected, given that these losses would have been borne by the firm at maturity.

Actual demographic experience would generally not be expected to be reflected in the determination of surrender or paid-up values unless the relevant factors had been included within the terms that determine the return on the contract.

Prospective methods can be used in the determination of surrender values to the extent that they provide similar results to a retrospective method which allowed for the above factors.

Extent to which profits expected by the firm are allowed for in the setting of surrender values

Non-profit policies are generally written to generate profits for the firm or the with-profits fund. We therefore consider it is reasonable and expected that surrender values are set to extract certain levels of profits from the surrendering policy consistent with that assumed in the pricing so long as this does not allow for the recovery of margins that have been eroded as a result of actual experience being worse than expected, except in the circumstances described in the section above.

Ideally, the methods that firms apply in determining these values should be set to extract an increasing proportion of the profit that would have been generated had the policy remained premium paying for the full term. (In setting alteration values, firms should take account of future profits that will arise post-alteration). We do not consider it appropriate that the surrender or paid-up value should generate a higher level of profit for the firm than if the policy had been maintained until maturity.

Fairness to policyholders should be even-handed. Where the writing of non-profit business is being supported by with-profits policyholders, the firm must consider the impact on these with-profits policyholders if it pays enhanced surrender or paid-up values on non-profit business.

Smoothing of values and consistency of surrender values with maturity values

From a policyholder perspective it may appear unfair if there are significant discontinuities in the surrender or paid-up value available from year to year which arise other than from the receipt of premiums whilst the contract is premium paying. This may be unavoidable during the early years of the contract when for

example high levels of initial expenses are being recouped and surrender values may not be available or be very low.

We consider that in other periods of the contract lifetime, it is desirable for the methods applied in determining surrender and paid-up values, to be set so as to not cause marked discontinuities in these values and that these should flow into the ultimate maturity value. However, in certain circumstances, for example where 'in the money' maturity guarantees exist or where a discontinuity is used to remedy an unfairly low value, discontinuities may be appropriate.

Allowance for cross-subsidy between continuing and surrendering policies within product pricing

Firms may allow for cross subsidies between maturing and altered/surrendered policies within their product pricing. For newly issued with-profits policies, the payment of reduced values on surrendering policies in order to enhance maturity values is now generally not considered consistent with a firm's duty to treat its customers fairly. However, COB 6.12.5, which covers with-profits policies, indicates that this practice is not prevented if:

1. *"The firm has reasonably exercised its discretion to make those deductions;*
2. *Those deductions have been made in a clear, fair, lawful and consistent way over a period of time;*
3. *Those deductions have been made in accordance with a firm's previous statements to policyholders (if any); and*
4. *(as a result of (1) to (3)), the fact of those deductions and the firm's right to make them, now form part of the implied terms of the with-profits policies affected."*

We consider that applying similar considerations for non-profit policies would be logical and that the use of cross-subsidies appears appropriate as long as the application of these cross-subsidies is consistent with that assumed in the product pricing and the implications of surrendering or altering the policy have been clearly and adequately communicated to policyholders through for example, product disclosure of surrender or paid-up values.

Ex gratia payments

Issuers of some products, such as guaranteed equity bonds, sometimes indicate that surrender values are not available, even though in practice the firm may pay these values on an ex gratia basis. We consider that if the firm intends to offer ex gratia surrender values, then the same principles and considerations should be applied to the determination of these values as are applied to products which offer surrender values as part of their contractual terms.

With-profits policies that become paid-up and convert to non-profit status

The Treating With-Profits Policyholders Fairly requirements of COB 6.12.continue to apply to with-profits policies that become paid-up but remain with-profits. There is however, no guidance on the setting of paid-up values when with-profits policies become non-profit; relevant considerations for non-profit paid-up values on with-profits policies are therefore discussed below.

The conversion of a with-profits policy to non-profit can be considered analogous to the with-profits policy being surrendered and for a new non-profit policy being

taken out. The With-Profits Actuary should ensure that the methods applied treat these policyholders fairly in the determination of the surrender value and the 'price' at which the non-profit policy is being taken out. Considering each of these notional transactions separately:

Surrender of the with-profits policy – COB 6.12 includes guidance on the setting of surrender values for with-profits policies. This includes the requirement for values to be targeted within defined published ranges based around asset share. Appropriate allowance may be made for deductions as set out within COB 6.12.42 G, such as expenses associated with applying the alteration and for recovery of un-recovered expenses. We recognise that firms face significant practical difficulties in determining values for each cohort of paid-up policies consistent with the asset shares for these policies and that approximate methods may therefore be required. In these circumstances, we consider that it is still incumbent on the firm to be able to demonstrate that the claim values paid represent fair treatment for the relevant policyholders and that particular care should be taken in order that significant cross-subsidies do not arise within policies that have been grouped for the purposes of bonus setting.

Effecting the non-profit policy – in determining whether the price at which the non-profit policy has been effected, represents fair treatment, we consider that firms should test whether the return on the non-profit policy is likely to provide an appropriate return (adjusted where necessary for any additional protection elements provided) in comparison to other forms of investment available such as a bank savings account. In circumstances where the return is likely to be inferior, either in terms of level of return or flexibility, then we consider it appropriate that the policyholder is made aware of the implied return and also provided with an equivalent surrender value quotation.

Increments

A particular form of policy alteration which we believe requires special consideration is that of increments to existing policies. These may take the form of an increase to the sum assured for protection policies, increases to the premium for regular premium savings policies or additional payments for recurrent single premium contracts.

For many products, competition in the insurance market has resulted in reductions in premium or charge levels for new products compared to similar historic products, particularly in the term assurance and pre-retirement pensions market. It may be the case that a policyholder will find that it is more favourable to purchase a new policy with the same firm, rather than to alter their existing policy.

COB 5.6.4(1) (in relation to designated investment business) indicates that a firm should consider the charges *"for the services or product in question compared with charges for similar services or products in the market"*.

In the circumstances described above, we believe that the onus is on firms to consider the appropriateness of accepting alterations to existing, higher charging policies, rather than establishing a new policy based on more favourable terms for the policyholder.

Practical impacts

It is common practice for surrender and paid-up bases/scales to be changed infrequently; in some cases scales will still be based on that produced as part of the original pricing process.

In contrast to with-profits business, there are significant reasons why this might be reasonable for non-profit products, particularly where these bases are consistent with product disclosures made to policyholders at point of sale. However, firms should still consider the appropriateness of these bases in light of new interpretations of fairness and in particular UTCCRs and document the rationale underlying the decisions taken. The use of bases consistent with that applied in previous years or at the time the product was originally priced, is not necessarily sufficient for a firm to have discharged its regulatory duty to treat its customers fairly or to meet the requirements of UTCCRs.

The methods used to set surrender and paid-up values should be practical and not cause undue cost to the firm in applying them. In achieving this goal, it is likely that many firms apply surrender and paid-up scales that have been determined in an approximate manner. We consider that this can be an acceptable approach; however, we would expect that firms applying approximate methods should periodically perform calculations to demonstrate, that for the majority of their portfolio, these approximations do not result in surrender or paid-up values that are materially less than that which might be calculated paying consideration to the points raised in this chapter.

5 REVIEWABLE PREMIUMS

5.1 EXECUTIVE SUMMARY

- Currently the UK life industry offers customers a choice between buying long-term non-linked protection policies on reviewable, renewable or guaranteed rates.
- There are potential advantages to customers of reviewable rates, notably that they should, at least initially, be cheaper than a corresponding guaranteed rate policy or it may be the only structure available for new, innovative products.
- This inevitably means that the product may be regarded as higher-risk for the customer with the possibility of significant premium increases in the future.
- Guidance on reviewable rates has already been issued by both the FSA and the ABI. This is considered in the appendix to this chapter, together with consideration of Unfair Contract Terms legislation and the role of the Financial Ombudsman Service.
- Until recently, reviewable rates may have been viewed by some firms as a simple product design solution to uncertainty in future (claims) experience. We believe that this view is ill-founded and that considerable focus is required on reviewable rate business if it is to be managed effectively whilst also treating customers fairly.
- Whilst this chapter highlights many potential hazards, we believe that it is possible for firms to write business on reviewable rates but that they must recognise the risks inherent in this and price and set capital requirements accordingly. Actuaries – and lawyers! – have key roles to play in this area.
- Firms face greater challenges still in managing existing books of business fairly where documentation may be unclear and the range of actions constrained.

5.2 INTRODUCTION

This chapter considers reviewable premium rates on long-term protection contracts, by which we mean premium rates that can be altered by the firm for groups of policies, as distinct from reviewable charges within unit-linked policies, which are covered separately in chapter 6. In general, firms will seek to review rates if claims experience diverges from that assumed in pricing but they could reflect other divergences too.

The customer's perspective

Essentially there are two potential benefits to customers of purchasing a long-term insurance contract on reviewable rates rather than guaranteed rates:

- Cheaper cover (than guaranteed rates); and/or
- Availability of cover if firms are not prepared to write the cover on guaranteed rates.

Both of these are worth further consideration within the context of Treating Customers Fairly.

Reviewable rate cover should certainly be cheaper at outset than the equivalent cover on guaranteed rates so that, over the term of the policy, the policyholder may benefit from the cover being cheaper, at least initially. The differential between reviewable and guaranteed rates was often relatively low in the past but in the case of Critical Illness, this changed as concern over future medical advances meant that in 2002-3 guaranteed rates increased substantially whilst reviewable rates remained relatively stable.

There is though the danger that customers do not understand the risk that they are bearing by buying reviewable rate cover. The extent of this risk may be more transparent if identical cover is available on guaranteed rates, but even then would customers recognise the potential for (reviewable) premiums to increase to higher levels still? In many cases, substantial increases are likely to result in a significant proportion of policyholders lapsing their cover and perhaps being unable to afford replacement cover.

If there is a genuine chance of this materialising – and presumably there must be for the reviewable rate version to be attractive initially? – then it could be argued that the customer would have been better served by a renewable premium contract, either with guaranteed cover (i.e. Yearly Renewable Term) or without (i.e. general insurance).

The benefit for customers to be able to access a form of cover that firms are not prepared to write on guaranteed rates also raises the question of whether these policyholders genuinely understand the degree of risk they are exposed to. Again, other contract structures may be "fairer" to policyholders than long-term insurance on (potentially unstable) reviewable rates.

Customers will also find it difficult to compare the value provided by different reviewable premium products if they try to shop around, as they have no way of knowing what level of experience has been priced into the contract and at what level of deterioration the firm will increase rates.

When a review takes place, there is an obvious imbalance in information between the policyholder and the firm. The policyholder may face a considerable increase in premium for a policy that has yet to yield any tangible benefit, that they perhaps needed some persuasion to buy in the first place and that they had forgotten contained reviewable rates. If rates do indeed increase substantially, the policyholder may have little prior warning and have limited options, other than accepting the increase or lapsing valuable cover.

The firm's perspective

Unlike most other areas covered by this paper, where the implications of Treating Customers Fairly on non-profit business have generated little detailed guidance,

some of the issues surrounding reviewable rates have been addressed in documents from the FSA and the ABI. The latter originated from concerns expressed by the FOS in 2003 that reviewable rate policies might not comply with the Unfair Terms in Consumer Contracts Regulations 1999 (hereinafter abbreviated to "UTCCRs") and/or be fair and reasonable.

The appendix considers this guidance in the context of two questions – whether reviewable rates are legal and whether they are fair. We are unable to definitively answer these questions, but it appears to us that the legal requirements and the demands of Treating Customers Fairly have a very high degree of overlap and it makes little sense to consider either in isolation. If firms can truly treat reviewable rate policyholders fairly, then it is likely they are operating within the law, as we understand it, and the converse probably holds true also.

It is also clear that the position of the firm is strengthened by prominent positioning at point of sale of the message that premiums are reviewable, by clear explanation of how, when and why reviews will occur and by operating review clauses fairly and openly. The ABI guidance sets out practical examples of how this might be achieved, using example policy wordings, quotation and key features documents for a critical illness contract. Close adherence to the guidance will not eliminate the risk that review clauses could be struck out by the Courts or that the FOS may rule invalid the implementation of a particular review. However it should certainly help to reduce the risk of this if it is followed for new business.

Until recently, reviewable rates may have been viewed by firms as a simple product design solution to uncertainty in future experience. Passing this risk back to policyholders meant that capital requirements were reduced and firms perhaps did not need to invest as significantly in understanding and managing the risks inherent in the business. We do not see it as such a simple solution for reasons that are considered in the following section.

5.3 SUMMARY OF AREAS WHERE TCF MAY BE AN ISSUE

In this section we consider a number of areas that are worthy of comment and, we feel, further discussion amongst actuaries. Many of these issues are not solely the domain of actuaries, but as noted in Section 1.5 they will be considerations for the actuarial function holder in advising the Board on the adequacy of premium rates or the value of liabilities, taking account of the requirement to treat customers fairly.

We note in 10.2.3 of GN46 that "*Long-term adverse trends are particularly important where policy terms are guaranteed*." However GN46 does not refer to the impact of long-term adverse trends where rates are reviewable. We believe that such trends can have a greater – and a less predictable – impact if the ability to implement a review is in any doubt, which may be affected by many of the issues considered in this section.

a. Valid Reasons

The need to clearly specify valid reasons for reviews arises from the UTCCRs, as explained in the appendix. The ABI guidance sets out four principles that might help firms decide whether a particular reason specified in the contract is a valid reason: Control, Predictability, Impact, and Scope.

The ABI note that these principles should not be taken to be an exhaustive list of principles that might determine whether or not a reason is a valid reason, It is interesting to use this list to compare elements of the premium basis which firms might consider including as valid reasons to review rates:

	Claims Experience	**Lapses**
Control	Medical advances, such as new tools for diagnosis, are outside the control of the firm. Underwriting is in the firm's control, so poor underwriting cannot be used as a valid reason to increase premiums	The firm has some influence, but generally lapses can be considered outside its control
Predictability	The existing pricing basis should already reflect previous developments or events that affect the claims experience. Only new, unforeseen developments should be reflected at a review	Can be unpredictable, especially for a new product, or where it is affected by competitors' actions
Impact	Not all changes have a material impact though for most product designs, claims experience has more impact than other factors	Depending on the product design, lapses can have a substantial impact
Scope	Some medical developments could affect only a small subset of policies (e.g. older ages)	Changes in lapses are likely to have a material impact on the experience for all policies

The table above shows how, using the four ABI principles, lapses can appear to be as valid a reason for changing premiums as claims experience. But this might not be considered fair for a number of reasons including:

- Claims experience is likely to be viewed as central to the product, whereas lapses would not, so the customer will have difficulty understanding why lapses affect his/her premium;
- There is no visibility to lapses. In an ideal world the customer would be able to understand (approximately) the change in premium from publicly-quoted data sources (such as indices); and
- The customer might consider lapses to be within the control of the firm.

We therefore think firms need to give very careful consideration to what constitutes a "valid reason". It may no longer be sufficient to change a pricing assumption for the reason that "the claims experience was 10% worse than the expected experience". Rather, the past claims experience may only be relevant

to the extent that it helps guide the assumption of future experience. This point is considered further later in this chapter in 5.5b.

This is an area we feel warrants further discussion.

b. Recouping past losses?

We note a difference between the FSA Statement of Good Practice and the ABI guidance in this area, but as actuaries are unsure of the significance.

The FSA Statement says in 4.19 that "*However, a valid reason is, for example and in our view, unlikely to be one which, in a pure protection contract, allows the firm to recoup its investment losses on the contract incurred up to the date of the review or one which gives it the discretion to increase profitability margins beyond those assumed at the outset of the contract*." In particular we note the term "***investment losses***" in the context of pure protection business.

In contrast, in 4.5.1 the ABI guidance (mis)quotes the FSA Statement as referring to "recoups its losses" without the word "investment".

We would be very keen to hear of legal advice in this regard.

c. Robustness of pricing assumptions

One particular concern of the FOS was the possibility of firms deliberately setting a low price at the start with the intention of increasing the price at subsequent reviews. It is doubtful that customers could identify this practice unless it is clearly spelt out in the product literature, as was the practice with 'Low Start' policies, for example. Unless this is done, such practice is highly likely to be unfair to customers.

This implies that the profitability of the contract at outset must be recorded to avoid the possibility of inadvertently increasing profitability at a review. If the firm adjusted its initial premium rates to achieve target market positions, then the actual profitability will then vary between age/term/premium cells and the firm will need to record the actual profit accepted for individual cells.

Another potential complication arises in relation to expectations of future claims experience. Suppose the government announces a pilot project for screening of a particular form of cancer; as soon as the announcement is made, the true underlying expectation of future claims experience alters – even if the firm is not aware of the announcement or of its significance. It can then be argued that from that date forward the underlying profitability of the contract has altered, and the firm has no right at a future review to recoup the shortfall between the underlying profit and that assumed when the rates were set. The result is an implicit need to undertake regular reviews of pricing bases, and the implications on actual premium rates for new business and at reviews.

d. Describing premium reviews in policy literature

In order to minimise the risk that a review cannot be implemented, the firm must take great care to strive for clear communications to policyholders and comprehensive and clear internal documentation.

The timing and basis for reviews needs to be clearly set out in policy literature in "plain and intelligible" language. In many cases, the actuary will have a key role in developing and documenting a review philosophy that the firm will use at future reviews, but it may be left to others to simplify this in order to explain it to intermediaries and customers. In such circumstances, actuaries will want to assure themselves that the final description in policy conditions and other literature accurately reflects – and does not over-simplify – their intentions. However including more detail bears the risk of making it less, rather than more, intelligible to the average customer.

Valid reasons must be set out in a way that customers can understand. It is also necessary that policyholders understand the implications for them of these reasons, in terms of the possible effect on their premium. In this regard, it may be necessary to distinguish between the pricing assumptions and the valid reasons for them changing – an example being that the pricing basis includes an assumption on the number and timing of future critical illness claims, whilst a valid reason for changing this assumption might be unforeseen medical advances. This distinction is drawn in the specimen policy condition included in Appendix E of the ABI guidance.

There are clear dangers for the firm here – be too explicit about all the assumptions and all the valid reasons and you risk confusing the customer (and thereby losing on the "plain and intelligible language' argument). If, however, you keep this section too brief there is a risk that what you intended as a valid reason at outset cannot be taken into account at review.

It may also be appropriate to provide an indication of how revised premiums are calculated at a review in point-of-sale literature. The ABI guidance includes as an example:

> "*…the insurer will compare the value of each assumption applicable at the time of the review with those that were previously used and, by reference to that comparison, use a fair and reasonable method of calculating any change to the premium.*"

This example description of the method appears to be plain and intelligible, but only time will tell whether the Courts, the FSA and FOS consider that this provides sufficient information.

e. 1-way or 2-way?

In the past, we believe that many firms might have viewed premium reviews as an option that they could exercise, if required (and perhaps only in response to

more extreme variations). It is not immediately apparent that a 1-way option – whereby the firm can increase rates, but is under no obligation to reduce them – is not possible under legislation or would automatically be deemed unfair.

However, we think the firm will need to make clear to policyholders that it is a 1-way option, and this could necessitate using a term other than "reviewable", if most of the insurance market uses that term to describe products where reviews can move the premium either way.

Further complications may arise at the time of a review. For example, if rates are increased as a result of poor claims experience that is not then sustained, do rates remain at the higher level? If so, does this mean the firm should delay increases until such time as it can be sure that experience can be expected to remain at the higher level?

Such considerations may mean that in practical terms a 1-way option could not be managed in a way that is fair to policyholders.

f. Third Parties

Firms may wish to take into account changes in the terms of contracts with third parties at a review. However in doing so, they must still consider their legal and TCF obligations.

Reinsurers are of particular importance to many protection contracts and it can prove very difficult to get interests fully aligned on reviewable rates. Lack of alignment will mean that reinsurers may be able to increase rates for reasons or at times that the insurer cannot increase policyholder rates. The situation is complicated further where an insurer uses multiple reinsurers for the same original policy.

Where an insurer is unable to achieve full alignment, it will need to assess how much protection it gains via reinsurance. If the reinsurance merely acts to smooth experience between years, rather than transferring risk to the reinsurer, then the insurer may form the view that the reinsurance no longer fulfils its intended purpose.

Outsourced underwriting, administration and claims management services are other examples of third party arrangements that may need to be considered.

g. Responsibility for reviews

It seems clear that the FSA view is that the Board should take responsibility to treat customers fairly; however the actuary is likely to have a key role in advising the Board on premium reviews. We note that this is not explicitly required by SUP 4[11], which requires the actuary to raise concerns with the

[11] SUP 4.3.13R, available at http://fsahandbook.info/FSA/html/handbook/SUP/4

Board if the firm is "…*effecting* ***new*** *long-term insurance contracts on* [inappropriate] *terms*…" (our use of bold for emphasis). We believe most actuaries would expect to also do this when premiums are reviewed (and most Boards would expect actuaries to do so).

The Board should consider whether internal actuarial advice on a review is sufficient and it might consider seeking an independent actuarial opinion to verify that a premium review has been undertaken fairly. Whilst this may provide a valuable check, the responsibility for the fairness of the review remains with the Board itself. Whilst the use of an independent actuary for a particular review may be valuable, there seem to us to be a number of reasons why a firm would not commit to this in policy conditions:

- Use of an independent actuary might then be required even if there were no change proposed as a result of a review, which is likely to prove costly;
- The frequency with which reviews may need to be undertaken is unpredictable. Each policy may only require review at (say) 5-year intervals, but the need to review the basis will be much more frequent to ensure it is up-to-date for each policy as it reaches its review date; and
- In some circumstances, an actuary may not be the most appropriate person to advise the Board. For example, where the issue relates to the likelihood and impact of future medical advances, the Board may seek to ensure it has appropriate independent advice from medical experts, even though its own actuaries may then need to interpret this and calculate the implications. Legal advice will of course be imperative too for reviews.

h. Grouping at reviews

Typically at outset premiums for those in good health will vary by age, gender and smoking status. At a review, it would be normal to consider policies in similar groups and if a particular development only affects sub-groups of the insured population (e.g. a development in prostrate cancer might only impact on older males) then it would seem fair to adjust rates for that sub-group only.

But suppose it became apparent that those living in a particular location in the UK had been subjected to a particular risk (e.g. radiation). Would it then be fair to adjust the premiums only for that group based on postcode? Conversely, is it fair to those living elsewhere to spread the increase across all policyholders?

We do not think there is a clear answer to these questions – either approach could be deemed to be treating a group of policyholders unfairly. However we think such scenarios are highly likely to arise in practice and actuaries should therefore document their approach at outset.

i. Options at Review

The UTCCRs (and the FSA Statement) draw attention to the potential effect of customers not being able to withdraw from a contract on its fairness at the review point. Our reading of the legislation does not see the necessity for this,

but legal advice would be essential to confirm this. If it does apply then the interpretation of "free to dissolve" becomes important. In particular, the FSA states: "*In some cases the consumer may be technically free to dissolve but, in practice, may not be able to obtain alternative cover because of the need for fresh underwriting*."

This creates a clear difficulty for the firm as it may imply that they should offer a different option to policyholders in poor health, at the time of a review, as they will not be able to obtain alternative cover. The firm, though, will not know policyholders' health status at that time.

It may help the firm's case to offer alternatives to a premium increase – for example a reduced amount of cover or restrictions on the nature of the cover (e.g. to bring the definitions in a Critical Illness policy in line with those being used for new business). Offering such options may improve the position from a TCF and legal perspective, but also increases the scope for policyholders to make anti-selective choices though, especially where they have access to knowledge of their health that the firm does not.

5.4 NEW BUSINESS AND EXISTING BUSINESS

The issues considered in the previous section need to be considered carefully before the reviewability provisions are determined for a new portfolio of business. Actuaries are likely to be heavily involved, but legal advisors, compliance teams, administrators and reinsurers should all be involved in drawing up robust procedures and processes.

In doing so, it is very instructive to consider the lessons that may be learnt from existing policies, where the office has previously written business on reviewable rates, especially if it has already undertaken a review.

Many of the issues considered in the previous section can give added difficulty for existing business:

- Reviewability may not have been clearly explained at outset;
- Policy documents may not clearly state valid reasons;
- Reinsurance treaties may not be aligned, e.g. they may allow the reinsurer to increase rates when the insurer cannot;
- Policyholders' expectations may have been influenced by subsequent post-sale correspondence. This is especially so for business that has already passed a review date, as the processes and procedures at that review will have shaped policyholders' expectations, and in the extreme case reviews may not have taken place at all; and
- Prior documentation may be lacking.

Whilst firms can seek to follow best practice going forward, they clearly cannot go back and amend point of sale literature or subsequent correspondence on existing business. Particular issues may arise where corporate consolidation has occurred and less than complete records were obtained. This suggests that the ability to

review rates should perhaps be a consideration during due diligence, should the target firm have a significant volume of reviewable rate business.

5.5 PRICING AND RESERVING

a. Pricing at outset

In this section, we briefly consider the issues an actuary will consider when setting premium rates for new policies. We only consider those aspects which we expect to vary between a reviewable rate contract and a guaranteed rate one and we assume that the valid reasons for reviewing rates relate to claims experience, and not to other assumptions in the pricing basis.

The best estimate of current claims experience is unlikely to differ between reviewable rate policies and guaranteed ones, if all other aspects of product design are equal. One could argue that the cheaper, reviewable version might appeal to those with lower incomes and hence lower socioeconomic groups or conversely that reviewable rates should be recommended to those who can afford increases should they materialise. Without prior experience, we suspect that most actuaries would assume that the two groups of policyholders are identical, in terms of expected claims experience.

If claims experience is expected to deteriorate over the term of the policy, then we believe the actuary should take their best estimate of this into account in pricing at outset. Hence at a review the firm will only be considering unforeseen changes.

If, however, claims experience is expected to improve, then taking account of future improvements may create other difficulties – in particular the firm could find itself trying to increase premiums when experience has improved, because the improvements were lower than had been anticipated. We suspect customers would find this argument difficult to accept. However if future improvements are not taken into account, this may result in premiums that appear uncompetitive if compared with the corresponding guaranteed premium. In such a scenario the firm may choose not to issue contracts on reviewable rates.

As well as the expected cost of claims, other items where pricing might differ between guaranteed and reviewable rates are the cost of capital, expenses and persistency. The first of these will principally reflect differences in reserves – considered below – and statutory solvency margin.

Expenses are likely to be higher for reviewable rate policies than guaranteed, reflecting the cost of undertaking reviews and additional communications associated with this. These may prove particularly onerous for small blocks of business and firms should therefore assess at outset whether the costs of reviews are likely to outweigh the potential benefits, to determine whether it is viable to sell a reviewable rate policy.

Assumptions regarding persistency prior to the first review are likely to be similar to those for guaranteed rate policies, unless the actuary has prior experience to suggest otherwise. What is more challenging is the initial assumption regarding persistency at the review date, particularly if it necessary to increase premiums. We suggest that actuaries will want to model scenarios regarding premium increases and persistency, and indeed such considerations will be required for reserving too. It is however debatable whether initial premiums should be increased to allow for such scenarios, or whether the impact should come through – if necessary – at a review.

b. Pricing at Review

The starting point will be the calculation of the premium at outset (or at the last review). Ideally the firm will have both the pricing models and documentation of the basis, sufficient to allow it to recreate previous premiums. As noted in 5.3c, this may need to extend to profitability of individual cells, where profitability is not uniform across policies.

If the previous models and documentation are not available, premiums for model points should be calculated to a sufficient degree of accuracy that the actuary is confident that there are no material differences in assumptions or method. However the actuary will also need to assess individual policies, to ensure that their profitability did not diverge materially from the norm. We also note that the FSA Statement (paragraph 4.24) specifically mentions that it may be unfair for firms to alter premiums using a power that is only triggered when an assumption changes if their records do not indicate what the initial assumptions were.

The next stage is likely to be a comparison of actual experience against that assumed in the previous calculation. We again assume that claims experience is the only reason for varying rates in order to illustrate the issues involved at review. A comparison of actual claims experience against expected should be a straightforward exercise, but there are a number of areas where careful consideration is required:

- The period of the investigation. The period since the last review will be the natural choice provided this is long enough to generate sufficient claims to provide credible results. However if this period is too long it may bring unrepresentative historic experience into consideration.

- Lives v Amounts. The financial impact of claims experience is obviously best measured by amounts experience, but policy conditions may limit discretion if they refer to the "number (or frequency) of claims".

  If the firm does use amounts experience, then consideration should be given to capping large claims, since it may be considered unfair to increase rates where higher than expected claims experience arises from a few large claims. However the converse situation – where there have been no large claims – may be difficult to factor in.

- Firm v Industry. The firm will need to consider whether it uses only its own experience, or reflects industry experience, although again the policy literature may constrain the firm's actions on existing business. For smaller blocks of business, the firm may have little choice but to use industry experience, if policy conditions permit.

  It may find itself in a no-win situation – it might be considered unfair to profit from raising rates when its own experience does not justify an increase, but it could also be considered unfair to increase rates if poor experience is confined to that firm and general industry experience is in line with, or better than, expectations.

- IBNS claims. Where claims are subject to delays in settlement, an actuary would want to include Incurred But Not Settled (IBNS) claims to get a realistic picture of claims experience. However this is an area that can require considerable judgement – see for example CMI Working Paper 14[12]. The actuary may again find himself constrained by policy conditions on existing business.

- One-off events. We noted earlier that there is a lack of clarity over whether past losses can be recouped at a rate review. Consequently, it may be appropriate to identify losses that cannot realistically be expected to recur within the analysis and exclude them from the assumption of future experience. Again however the converse situation – allowing for one-off events that have not previously occurred – could prove more contentious.

As well as these issues in undertaking the experience analysis, other more fundamental issues may also arise:

- Of itself, a divergence between actual and expected claims does not constitute a valid reason for reviewing rates, and the firm will need to understand why the divergence arose. As noted earlier, whilst medical advances may constitute a valid reason if they result in increased claims, ineffective underwriting or a different socioeconomic profile may not.

- In addition to measuring past claims experience, an actuary will need to consider how future claims experience is expected to differ from current experience. The justification for reviewing rates when expectations change, if there is no divergence in claims experience to date, will need to be robust. Yet if changes are not applied, it could be argued that a subsequent review is invalid as these developments should have been identified at the previous review.

- As noted earlier, any upward review in rates may cause policyholders to question whether they wish to retain their cover. If lapses increase as a

[12] CMI Working Paper 14: Methodology underlying the 1999-2002 CMI Critical Illness experience investigation

result of a review, one would expect these to exhibit some degree of anti-selection, in that some policyholders in good health may be less likely to pay the increased premium. It is debatable the extent to which the deterioration in claims experience that arises from such selective lapsation should be reflected in the calculation of the reviewed premium. This selection by policyholders may be worse if they are offered multiple options, e.g. to reduce the benefit amount or to restrict the scope of the cover.

c. Reserving

Many of the considerations in setting reserves will be similar to those in pricing; in particular the Actuarial Function Holder will have to form a view on how reviewable rates really are in the light of the need to treat customers fairly.

Section 3 of GN44 sets out principles applicable to discretionary charges, namely that reserves must reflect contractual conditions and TCF, should allow for delays in implementing necessary reviews and should allow for the necessary expenses of the review. These appear to be equally valid for reviewable rates and we see no reason why this guidance does not extend to reviewable rate policies.

The passage of reserves over time is interesting:

- Initially it is likely that the statutory liability will be based on the best estimate claims cost, perhaps with a small margin for prudence, as the actuary will presumably assume that rates can be reviewed when required. The ICA assessment may consider scenarios where rates cannot be (fully) reviewed, offset by any margin for prudence in the statutory liabilities.

- If experience deteriorates (or becomes expected to do so), then the reserve will increase to take account of the increase in claims until the next review. The ICA is also likely to increase as the implications of the risk that the required review cannot be executed are greater. However if the actuary's view based on TCF considerations is that the firm will not be able to increase rates at the forthcoming review then we feel that this risk transfers from the ICA to the statutory liabilities.

We note that GN46 explicitly notes the issue of anti-selective lapsation in the event of an upward review. Whilst this relates to the ICA, we feel such considerations may be required in respect of statutory liabilities once the actuary recognises that an increase in rates is required.

The allowance for reinsurance must also be considered. GN44 recognises that "*…obligations to make payments to reinsurers which arise only after and to the extent of the receipt of a specific item of cash inflow … are properly valued together with that item of cash inflow*." Imperfect alignment of a reinsurance treaty may break the requirement set out in GN44 and necessitate that the actuary explicitly values potential reinsurance outgo.

Appendix to chapter 5 – LEGAL ASPECTS OF REVIEWABLE RATES

In 2003, the FOS expressed concerns over the legality of reviewable rate policies and whether they are fair and reasonable. This has contributed to the production of guidance in this field; hence in this appendix we try to consider whether Reviewable Rates are legal and whether they are fair against the background of two particular documents that have particular relevance to reviewable rates:

- The "Statement of Good Practice on variation clauses in consumer contracts"[13] published by the FSA in May 2005.
- An ABI publication[14] ("Advice on Practical Aspects of Unfair Contract Terms for Non-investment Protection Policies with Reviewable Premiums") specifically relating to Pure Protection business sold on reviewable rates, published in June 2006.

a. Are Reviewable Rates legal?

One of the key questions raised by FOS was whether reviewable rate contracts comply with the Unfair Terms in Consumer Contracts Regulations 1999[15] (hereinafter abbreviated to "UTCCRs"), so this seems to be a sensible starting point, especially as there appears to be little relevant case law. (The case that is sometimes cited is Director General of Fair Trading v First National Bank, but opinions differ on the relevance of this to reviewable premiums.)

The Unfair Terms in Consumer Contracts Regulations 1999

To our knowledge, the general topic of the UTCCRs has only once been previously discussed formally by the Profession, at a SIAS paper in December 1994[16].

What does appear to be clear is that the UTCCRs are difficult to interpret in the context of reviewable rates, not least because they encompass all consumer contracts (not just insurance policies). It therefore appears that the definitive position can only be decided by the Courts, if and when a case is brought before them (and given the roles of the FSA and the FOS, considered below, that might never happen). Even then, it will be determined on the basis of that particular case, and it could prove difficult to draw wider inference from this.

As noted above, we find the position of reviewable rate policies under the UTCCRs unclear and this uncertainty arises from difficulties in interpreting a number of provisions, some of which are considered below:

1. Under section 5(1), *"A contractual term which has not been individually negotiated shall be regarded as unfair if, contrary to the requirement of*

[13] See www.fsa.gov.uk/pubs/other/good_practice.pdf
[14] See www.abi.org.uk/BookShop/ResearchReports/Reviewability%20Advice%20-%20June%202006.pdf
[15] See www.opsi.gov.uk/si/si1999/19992083.htm
[16] "The actuary and the Unfair Contract Terms Directive" by Paul Kennedy, presented to the Staple Inn Actuarial Society in December 1994, see www.sias.org.uk/siaspapers/listofpapers/view_paper?id=unfair.pdf

good faith, it causes a significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer."

It appears clear that reviewability has the potential to create an imbalance because it is enacted by the firm and, if used to increase premiums, acts to the detriment of the policyholder. What is not clear, though, is whether this is "contrary to the requirement of good faith".

2. Under section 6(2) "*In so far as it is in plain intelligible language, the assessment of fairness of a term shall not relate–*
   (a) to the definition of the main subject matter of the contract, or
   (b) to the adequacy of the price or remuneration, as against the goods or services supplied in exchange."

   Put simply, a 'core term' does not need to be fair under the legislation! Given that the review clause determines the price (after a certain date) there is certainly a plausible argument that it is a core term, and the ABI document states that "*Our legal advice was that it would be possible to mount a case that premium reviewability is a 'core term' and therefore excluded from assessment against the provisions of fairness by virtue of Regulation 6(2).*" However, as the ABI also notes, the FSA take a different view in their Statement.

3. Schedule 2 (1) to the regulations contains an "*indicative and non-exhaustive list of terms which may be regarded as unfair*". These include:
   "(i)irrevocably binding the consumer to terms with which he had no real opportunity of becoming acquainted before the conclusion of the contract;
   (j)enabling the seller or supplier to alter the terms of the contract unilaterally without a valid reason which is specified in the contract; or

   The implications of these are considered further below.

There are other sections of the UTCCRs that need consideration, but we believe the 3 points above illustrate the potential for reviewability clauses to be deemed unfair terms. The implications of this are stated in Section 8:

"*(1) An unfair term in a contract concluded with a consumer by a seller or supplier shall not be binding on the consumer.*

(2) The contract shall continue to bind the parties if it is capable of continuing in existence without the unfair term."

In simple terms, it would therefore seem that if a review clause were deemed unfair by the Courts, then that clause would be struck out and the policy would be regarded as one with guaranteed rates, equal to the existing reviewable rates, with obvious implications for profitability and capital requirements.

However the firm could find itself in an even weaker position, if the effect is that the clause is struck out selectively or only if the firm seeks to use it to

increase rates. The firm would then be required to continue to undertake reviews and reduce rates for any groups of policies where it is appropriate, without being able to increase rates for other groups of policies. This will cause obvious difficulties for actuaries in reserving!

We also believe the 3 provisions considered illustrate some key points that need to be addressed in order that, if challenged, reviewability clauses would not be deemed unfair. The first is the fact that rates are reviewable must be prominent in policyholder communications – the ABI document drew a helpful comparison to a "variable rate mortgage" – and the concept ("principles and practices" perhaps?) of reviewability must be clearly explained when the policy is taken out. This is true if one seeks to argue that reviewability is a 'core term', but it would also seem to underpin the requirement of good faith in point 1 and (i) under 3. A second key point is that the policy must contain 'valid reasons' for rates to be reviewed. Both of these points are considered further in section 5.3.

If a firm follows these principles then it seems to us – as actuaries, not lawyers – that reviewable rates have a good chance of defending any challenge under the UTCCRs. Continuing to keep policyholders informed and exercising fairness at a review would also help to avoid such challenges arising, which is perhaps an even stronger position.

In conclusion, whilst the UTCCRs are difficult to interpret, it appears to us that the legal requirements of the UTCCRs and the demands of Treating Customers Fairly have a very high degree of overlap and it makes little sense to consider TCF and the legal position in isolation.

The FSA and the UTCCRs

The FSA is a Qualifying Body under the UTCCRs and it was in this role that it set out its views on fair variation clauses in its Statement of Good Practice noted earlier. In particular, this means the Statement does not form part of FSA rules under the Financial Services and Markets Act 2000.

The FSA had not previously issued guidance in this area. The Statement seeks to help firms avoid the risk that their contracts are deemed unfair, but makes clear that it is not adding to the requirements on firms. The Statement focuses on the UTCCRs and their interpretation of them, but does acknowledge that "*The interpretation of legislation is ultimately a matter for the Courts*", as we noted above.

The Statement has a wider brief than just insurance, relating too to variable interest rate deposit accounts, for example. Even in insurance, however, it has a wider brief than reviewable rate contracts that we are considering in this section of the paper. Its implications for other areas, such as discretionary charges on unit-linked protection and savings plans covered in chapter 6, also need to be considered.

Undertakings

As a qualifying body, the FSA can challenge firms using terms which it views as unfair under the UTCCRs if they are referred to the FSA by consumers, enforcement bodies or consumer organisations. This has led to firms having to provide undertakings not to use terms which may be considered unfair and these undertakings are published on the FSA website. The website names the firm and identifies the specific policy term and the part of the Regulations, which gave rise to the undertaking. It is therefore a useful indicator of the FSA's stance.

To date, we are not aware of any such undertakings that relate specifically to reviewable rate policies; however there are a number that raise points of interest. As an example, there is an undertaking published on 5 April 2006 in respect of Lifetime Care – Plans and Bonds issued by PPP lifetime care plc (now part of the AXA group)[17]. The policy conditions for these plans did not provide an exhaustive list of valid reasons, only the main factors which would be considered. Paragraph 1(j) of the UTCCRs, noted earlier, requires valid reasons to be specified in the contract. As a result, PPP agreed to treat the list of possible reasons for varying the premium that are set out in the contract as a complete list for the purpose of conducting premium reviews.

b. Are Reviewable Rates fair?

There appear to be two key parties with a statutory role in determining whether reviewable rates are fair (excluding interested parties such as consumers themselves and lobby groups such as Which?). The stance of the FSA and its Treating Customers Fairly initiative as part of a move to principles-based regulation is considered in chapter 1 so is not considered further here.

The other key party is the Financial Ombudsman Service (FOS) which is an independent public body, whose role "*…is to resolve individual disputes between consumers and financial services firms – fairly, reasonably, quickly and informally.*"[18]

When the FOS raised questions about reviewable rates, this was prompted by the trend for firms to sell reviewable rate critical illness policies in response to concerns over medical advances and the withdrawal of reinsurance capacity to support guaranteed rates. It was unusual for the FOS to publicly express such concerns, in so far as the FOS does not normally raise an issue unless they have received a relevant case to investigate. As far as reviewable rate policies were concerned, it appears that the FOS helpfully raised concerns with the industry at an earlier stage in the hope that by doing so, significant future problems might be avoided.

[17] See www.fsa.gov.uk/pubs/other/undertaking_ppp.pdf
[18] See http://www.financial-ombudsman.org.uk/about/aims.htm

When the FOS does receive a case, they judge it on the basis of whether the treatment of the consumer had been ‘fair and reasonable’ in all the circumstances of the case. Thus, regardless of the legal perspective, firms may not win cases related to review clauses that are submitted to the FOS.

However it again seems likely that – from the perspective of the FOS – the key issues are likely to be the clarity of explanations, and the understanding of the consumer. This applies to communications at the point of sale and the time of the review, but could be further strengthened by relevant intermediate communications too.

6 UNIT-LINKED DISCRETIONARY CHARGES

6.1 EXECUTIVE SUMMARY

- Many unit-linked charges are set at levels that are at the discretion of the Board of the firm The terms under which these charges can be varied are specified in policy conditions but customer expectations will also be based on sales literature, other communications to policyholders and past practices;
- Discretionary charges are useful to customers because the firm may be able to charge less than if the rates were guaranteed, as no risk margin is needed;
- The statutory restrictions that exist on exercising contract terms that can be considered unfair are a major restriction on the exercise of these options;
- TCF considerations need to be allowed for when firms exercise options on discretionary charges (or when they choose not to exercise those options);
- It may be that firms are unable to exercise options to increase charges and the policies are (in effect) contracts with guaranteed charges;
- Discretionary charges (within the original policy terms) can either be charges that can increase only (one way option) or are entirely flexible (two way options);
- Actuaries will need to give advice to the Board on the level of these charges;
- The advice should be structured into a proper review mechanism by the firm. This review should be formal, be documented and all decisions arising should be capable of audit.
- Charges should be reviewed to (at the most) maintain the original level of profitability foreseen by the Board. This may require recreating the original profitability study if that documentation does not exist, consistent with work that would have been carried out at the original launch date of the product;
- The actuary should be careful about the mortality experience and morbidity experience used in the review. This should reflect the experience of the firm adjusted for trends expected but should also consider removing the impact of any failings in underwriting that have occurred in the past. In reality, this may prove difficult and will require judgement;
- Restrictions on a firm's ability to vary discretionary charges will have an impact on the valuation reserves, embedded value and Individual Capital Assessments;
- Firms may wish to consider whether the lack of a proper review mechanism may remove their ability to claim that their expense charges are not fixed for solvency margin purposes.

The Unfair Terms in Consumer Contracts Regulations 1999 applies to unit-linked discretionary charges as it applies to reviewable premium rates (see the appendix to chapter 5).

6.2 INTRODUCTION

This chapter considers discretionary charges applying to unit-linked policies. These charges will include the annual management charge, variable policy fees and policy fee deductions from units, variable mortality and morbidity charges and any variation allowed in bid/offer spreads. The charges can be varied by the firm for groups of policies rather than individual policies. This is similar to the issues considered in chapter 5.

Unit pricing is covered separately in chapter 3, and not in this chapter. We also do not consider the firm's ability to review premiums (as a result of lower than expected fund performance or increased charges) other than to note than a firm's ability to increase its charges could be undermined if it then fond that TCF or legal considerations mean it is unable to increase premiums accordingly.

The customer's perspective

The customer has three major benefits from discretionary charges:

- The product is initially provided without large risk margins on the level of charges that apply. A unit-linked policy with guaranteed charges for expenses would necessarily charge more than a policy without the guarantee as allowances by the firm for the risks it is undertaking on the future level of expense inflation;
- The charge may be reduced in future as improvements in experience feed through; and
- The customer may be able to get cover where cover may not be available on guaranteed terms: such as critical illness and long term care.

Most collective investments do not have guarantees on the level of charges that can be made into the future. The fund manager (after undergoing some form of governance control) can increase the annual management charge that applies for all business in force as well as new business. Therefore, guaranteed charges could be considered to be an aberration from "wrapping" the collective investment in a life policy vehicle.

The disadvantage of discretionary charges is, of course, the power that the customer places in the hands of the firm to change some part of the contract terms. This is especially relevant if the customer feels "locked in" to a contract with little chance of being able to surrender the contract and take out a new contract with a competitor. There are, therefore, real issues of customer rights on protection contracts where the customer's health may decline causing them to become uninsurable. In contrast, there will always be plenty of providers of collective funds willing to take new savings from customers.

Also, the customer has no idea of the risk that they are exposed to. They do not know whether charges could double in the future, for example. However, they can

expect to be treated fairly and that any increases to charges are justified within TCF and are subject to appropriate controls.

The firm's perspective

The firm has a need to maintain flexible charges to make their product:

- currently competitive in the level of charges being deducted from policy values;
- able to avoid risks that would make the margins on the charges impossible to market; and
- able to write certain benefits that do not have well established experience.

The history of discretionary charges can be summarised as:

- The EU solvency margin regime generated a requirement for 1% of funds under management for unit-linked funds with guaranteed maxima on their expense charges and a nil requirement for unit-linked funds without a guaranteed maximum. Some firms decided to remove the clause in the contract stating that the annual management charge applied in unit pricing could never be more than x%. This was carried out without any large announcement and appeared to have been ignored by customers and by the distributors;
- Guaranteed maturity values on unit-linked policies were found to be expensive. The guarantee tended to bite on all policies simultaneously. Some offices had charged, say 2% of premiums, for this guarantee and found that clients would not pay this modest guarantee cost. Actuaries and marketing professionals in unit-linked firms came to the conclusion that clients would not pay market rates for guarantees. Removal of guarantees improved capital efficiency and led to no reduction in sales.
- There was a need to match margin cashflows to expense allowances and risk costs following the development of "flexible" unit-linked policies with varying benefit levels or menus of benefits being available within the one contract. In the 1980s, a large number of offices moved to charge mortality and policy fee deductions rather than apply annual management charges. This then avoided expensive sterling reserves and reduced capital requirements (again) used in the firm. It also enabled paid-up policies to pay the full cost of any risk benefits and their administration costs (frequently causing many policies to lapse without value after a certain time). The charges in this form had the added marketing advantage of being lower compared to the old annual management charge for the most valuable business to the distributor and the office;
- Guarantees on charges and on benefit levels were removed. There was no real backlash from customers. Charging structures became complex with some policies having annual management charges in the unit price (some returned to clients in "bonus units"), amounts not allocated to units, bid/offer spreads on unit prices, policy fee deductions and mortality deductions from units.

- Solvency 1 introduced a new solvency capital requirement for policies without guaranteed limits on charges of 25% of expenses incurred. This removed some of the solvency capital advantages of flexible charges.
- Stakeholder products entered the market. This brought a simplification in the charging structure back to just an annual management charge and reintroduced the guarantee. Charges could not rise above 1% or 1.5% of funds under management.

6.3 NEW BUSINESS AND PRODUCT DESIGN

We believe the key points for new product design with discretionary charges can be summarised as:

- Disclosure. Firms need to disclose the discretionary nature of the charge. Firms are already explaining the discretionary nature of the charges within their Key Features documents. However, we wonder whether there is sufficient clarity on the degree to which charges could be increased (or decreased) and what the intention is behind having discretionary charges;
- Governance. We believe that firms would gain real benefits from introducing firm and detailed layers of explicit governance around the discretionary charges;
- Explicit and open review mechanisms. We feel that transparent and explicit reviews of the general level of charges will not only make the process more robust but will also allow firms to protect themselves from complaints.

We discuss the review mechanism in section 6.5 below.

6.3.1 Disclosure

Policyholders could be felt to have a justified complaint if the discretionary nature of any charges appear to be hidden in small print or solely available in policy wordings rather than forming part of the marketing literature. We could understand complaints on the lines that "I did not realise that my annual management charge could double at the whim of the insurance firm" and all actuaries involved in the day to day management of life business could foresee the likely Ombudsman decision.

It is right for marketing literature to explain the discretionary nature of the fees and provide sign posts to get further information. We would suggest that firms may wish to provide on request full leaflets explaining their charges, how they are set and how they are reviewed for policyholders. Of course, most policyholders would only need to know that the level of charges are not guaranteed but having the documentation in place could help the firm defend any later complaint and would, certainly, be useful for the occasional interested policyholder and the intermediary. It would also act as a useful discipline for the firm in providing documentation around the process. This is one of the key advantages to firms of having PPFMs for with-profits business and we would suggest that this experience should be learned from.

Firms will need to consider areas where statements of the discretionary nature of charges are helpful to customers. We would suggest that marketing material may need statements especially if it focuses on the costs and benefits of the policy. It would be acceptable (in our view) for firms to include reasons for the lack of guarantee "We are keeping our current level of charges as low as possible but we cannot guarantee that they apply on your policy in the future but we will only increase them if we have a valid reason and we will inform you of any material changes." Fuller explanations could, obviously, be provided in the more detailed backing information.

6.3.2 Corporate Governance

The FSA's principle of Treating Customers Fairly is not only about taking actions that will treat customers fairly but also about being able to generate audit trails through corporate decisions that prove that Boards (and their actuaries) have taken into account TCF in decisions. Therefore, we believe it would be useful if a corporate governance structure was established to review any actuarial matters pertaining to customers' charges and benefits.

For with-profits offices, this could be the same body as the With-Profits Committee (or the with-profits individual for some offices) as long as the WPC can manage any conflict of interest between with-profits and non-profit or unit-linked policyholders. For firms without a WPC, the Board should consider whether it needs to establish a sub-committee or whether it wishes to consider all these matters itself. We would suggest that a senior actuary in the firm should either be on this committee or reporting to it.

6.4 EXISTING BUSINESS – MANAGING THE PAST

Policy documentation, sales literature and communications to policyholders.

The starting point for any review of discretionary charges must be to refer to the policy documentation, the sales literature and any subsequent communications made to policyholders; these items combine to form the contract (and the implied contract) between the firm and the policyholder. Training material for sales staff will also need to be considered as this would have affected the sales method and messages given to customers.

The actuary should examine this literature carefully (probably with legal advice) and see what the terms around the discretionary nature of the charges really are. This would normally be combined with an assessment on whether the terms will pass the test posed by the regulations on unfair contract terms. To be effective in a TCF environment, the literature must have been written in such a way that a layman could understand (in broad terms) the main factors affecting the decisions made and how these factors would impact the decisions made.

If the terms only allow for increases in charges in the future (example "the Board may in its absolute discretion increase these charges at any time in the future subject to…") and it is believed that this is still not unfair then the actuary need only consider the need to increase charges. If, however, the terms imply even-handedness (example "the Actuary will determine the charges to be made from time to time") then the actuary will need to consider whether charges need to be reduced. The firm should not consider only an upward increase in charges (a one way option) unless the literature made the policyholder extremely clear on this point. If the literature leaves any doubt or implies that charges could also be reduced (however vaguely), then the option should be considered a two way option which requires the firm to reduce charges if they are no longer appropriate. It should be remembered that sales literature has far more of an impact in determining the policyholder's views on the contract than the policy wording or detailed small print.

There may be specific mention in the literature of "the actuary". This was covered earlier in section 2.7.

6.5 PROCESS OF REVIEW

There should be a formalised structure to a review of rates:

6.5.1 Reporting changes to customers

If there is a material change in charges, then it would be good practice (in our view) to ensure customers are told of the change and the reason for it. It would also be good practice to make the aims of the review, the structure of the review and the methods of review available on request to customers in advance. If customers wish to know about the review, we would also suggest that the results are made available perhaps by publishing a short summary of the review including the results on the web site of the firm.

6.5.2 Dates of review

The dates of the review of discretionary charges are rarely specified in policy conditions. They should therefore be laid down in advance and approved by the Board. The reviews should be regular.

Reviews will, obviously, vary in frequency. Reviews should be frequent enough to ensure that the review mechanism is working and that charges reflect the current view of future experience. However for practical reasons, firms will not want to review charges too frequently. No change in charges should be carried out without a review.

The reviews will occur at set points of time and could, therefore, be shortly after the sale of a policy. The Board may wish to consider whether the results of the review should be immediately enacted; phased in on policy anniversaries after the review's results are known; or use some other

smoothing mechanism. There are arguments in favour of any of these treatments, but TCF considerations suggest that the choice should be clearly documented and followed consistently between upward and downward revisions, if applicable.

6.5.3 People who carry out the review

The body that makes the decision should also be formally decided prior to the review. It should be clear to all involved within the review (including to customers on request) who this body is. If there is more than one body involved in deciding discretionary charges, then a clear formal split by policy or by charge would be appropriate. We would suggest that the corporate governance body in 6.3.2 given oversight of TCF issues on discretionary charges will have to be involved in formally approving any review.

6.5.4 Criteria for the review and performance of the review

The key parameters which determine whether any discretionary charges should change should be disclosed to customers in an easily understandable form and made available on request. It is important that customers feel that the process is well established and capable of audit.

Again, the wording on the policy literature is key to deciding the criteria. The actuary should make sure that the criteria accords with a reasonable lay man's view of what the wording means, perhaps again with legal advice. The key points are:

- Whether increases only can occur or whether decreases are implied;
- The rounded nature of the charges: for example, an annual management charge of 0.75% pa may not need changing if the result of the review arrives at a required charge of 0.81% pa and this is within the disclosed rounding criteria, although TCF considerations imply this should then be applied consistently;
- The profit component expected in the charges: see section 6.5.8.

The firm should have documented detailed internal guidelines on how reviews are to be performed and charges adjusted as a result.

6.5.5 Data used

Comprehensive data should be used for the review. This data should be available (to a large extent) from the valuation process. The actuary should be able to use a mortality, morbidity and expense investigation using the most recent data that is practicable and should be able to update the results for the review.

Care has to be exercised in interpreting the office's own mortality and morbidity (or expenses). It is unlikely to be fair to use a review clause to

allow the office to generate margins to cover a major compliance failure (for example). However, the normal minimal number of complaints and minimal redress levels may be a normal cost of offering long term insurance under COB style regulation. Equally, poor unexpected mortality due to a systemic failure in underwriting or other controls should be left out. This may be difficult and will require comparison between the firm's own experience and industry experience adjusted for the marketing strategy of the firm. Planned heavier mortality due to a lighter underwriting regime for the groups of policies sold may mean higher charges are fair compared to competitors, but these should have been reflected in assumptions, and charges, at outset.

The actuary should also investigate trends in mortality, morbidity and expenses. This may involve industry data as well as data from the individual firm.

6.5.6 Documentation of the process

There should be a comprehensive and well laid out audit trail through the calculations used in the review. Actuaries should ensure that robust controls on systems and processes are in place.

The actuary should remember that the review could be challenged by the FSA at any time and should produce adequate documentation so that an independent third party with relevant expertise could see how the decision was reached.

6.5.7 Items to be reviewed

These should include all items not guaranteed by the policy literature and would normally include some or all of:

- The annual management charge applied in the unit price;
- The policy fee deducted from premiums or unit value if not specified;
- The mortality charge deducted from unit value;
- The morbidity charge deducted from unit value;
- Any other risk charges deducted from unit value;
- Any initial unit (capital unit) charges that are not guaranteed within the policy literature; and
- Exit charges from the policy.

Guaranteed charges do not need to be reviewed as these were part of the original contract terms. An interesting question arises on charges that have an implied guarantee (for example by the disclosure documentation not showing the ability to increase charges explicitly or by the regulations on unfair contracts). If these can be fully treated as guaranteed charges, they do not need to be reviewed. However, if the charges could be treated as

capped, it means that reviews need to be carried out to check whether charges should be reduced.

Any charges that are not considered reviewable should be taken as guaranteed charges for valuation and solvency purposes as well as in practice.

It may be useful for a full list of charges to be available for customers on request with a description as to whether the charge is guaranteed, can be increased only, can be reduced only or can be either increased or reduced.

6.5.8 TCF constraints on increases in charges for expenses

A firm's past history of reviewing charges for expenses may affect its ability to make increases now. For example, if expenses are charged for by policy fee deductions, then the customer may expect any increases to be gradual and to reflect inflation. If past increases have been missed, a large one-off increase will need careful justification from the firm. The firm needs to consider the scale of the increase and whether customers have been given reasonable expectations that increases will not occur or that an increase in any year will be for that year's inflation only.

Another implicit restriction might apply to the annual management charge. If the fund has become smaller – whether triggered by falls in fund values (for example, due to a stock market collapse) or outflows from the fund – the firm will get less income from the charges, and it may wish to increase the annual management percentage charge commensurately. If the firm has not given customers warning that fund contraction would trigger an increase in charge, and if it is did not reduce the charge when the fund was growing, it may be considered unfair to increase the charge in these circumstances.

Indeed, any increase in annual management charge may be difficult to justify purely on the basis of an expense investigation. It depends not only on what expectation the customer has been given, but also on whether an increase can be justified on the basis of a clear change in circumstances. It will be easier to demonstrate fairness if the change can be tied to some external event or benchmark.

6.5.9 Level of charges – costs and profit

The costs that can be reflected in the charges should be derived from relevant mortality, morbidity or expense experience for the block of business, with allowance (if appropriate) for industry trends. If one charge (say the amc) is used to cover a variety of costs, then a composite decision is needed.

It is fair to reflect the same level of profit within the charges as was originally foreseen in the original product pricing. If no documentation is available, then the actuary can back-test this item but needs to exercise caution. The method to be used will need to reflect the actuary's best endeavours to replicate the pricing basis that would have been selected at the launch of the product. The actuary can look to other pricing decisions made at the same time of the same nature (i.e. term assurance premium rate sets compared with unit-linked mortality charges for universal whole of life plans). The charges chosen must reflect the risks undertaken. Original reinsurance premium rate sets can often be useful indicators of loaded (for profit) risk premium rates.

We would suggest that it would not be considered appropriate for reviewability to be used to increase the profitability levels above that which were assumed in the initial pricing. Additionally, it would be difficult to use the reviewability of discretionary charges or rates to compensate for losses incurred on non-reviewable/non-discretionary aspects of the pricing basis unless this was clearly stated to policyholders in sales literature. We would also suggest that the review should only consider future charges and future profit levels.

A specific issue on unit-linked charges may be the minimum sum assureds that were originally given to the contract to ensure that they would be qualifying policies. This, effectively, restricts charges. Policies sold at the maximum sum assured may also restrict charges within the maximum sum assured review period.

6.6 EMBEDDED VALUES, LIABILITIES AND ICA'S

Reviewability of charges will have an impact on the embedded value and the valuation liability of the firm. The ICA may also be impacted.

Actuaries involved in these calculations should bear in mind the implications of TCF on the level of discretionary charges in the future. The actuary should approach these matters with the same care as they would when considering the impact of a PPFM for with-profits business.

Financial reporting will need to allow for the possible restrictions that might occur on charges due to TCF issues:

- Poor underwriting experience may result in losses to the firm even though the firm has the ability to increase charges;
- If no proper records exist of expected net profits at the policy type's outset, then the reviews are likely to be more restrictive on the firm's margins than otherwise; and
- Reductions in charges may occur reducing the net margins available to cover other cashflows.

7 CRITICAL ILLNESS BUSINESS

7.1 EXECUTIVE SUMMARY

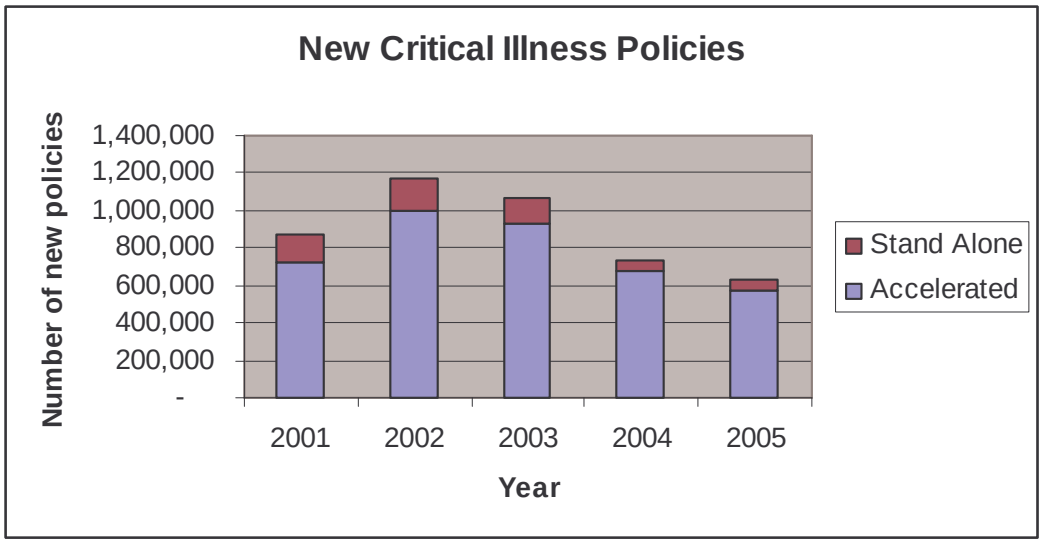
- Product design and product suitability are key areas where firms need to take TCF requirements into consideration.
- Many of the issues are not specifically actuarial but there are areas where we believe that actuaries could and should be contributing to the debate.
- There is a risk that critical illness policies may be sold where it is not the most suitable product available. However, a recent review carried out by the FSA suggests that this is not a widespread problem. We consider that income protection will sometimes match customer needs more closely.
- The impact of suffering some of the defined critical illness events will change over time, so it is not obviously suited to be treated as a long term product.
- The high level of declined critical illness claims suggests that there may be a lack of product understanding amongst customers. It also raises the concern that there may be general dissatisfaction with the product, or that this may develop over time.
- Firms need to investigate solutions to the problem that inadvertent non-disclosure of important medical information can make it difficult to treat customers fairly during any subsequent claim process.

7.2 INTRODUCTION

There are several life products currently sold in the UK where the design and sale of the product could lead to risks that customers are not treated fairly. Critical Illness ("CI") is a complex product which faces a number of challenges and we have therefore chosen to use this as an example to consider TCF in the areas of product suitability and product design.

Critical illness was considered to have been the success story of the UK life market in the 1990's when measured in terms of the volume and growth of new business. More recently, the product has faced a number of challenges and sales have fallen over the last few years, as shown in the graph on the following page. These challenges arise from inherent issues with the product and how it is sold in the UK and TCF considerations are pertinent to many of them.

We have considered a number of aspects of critical illness covering product design and sales and also aspects of the management of business post-sale. We have not considered issues related to reviewable premiums as these are not specific to CI and are considered separately in chapter 5.



Source: Swiss Re

The UK life industry is often accused of concentrating on selling products rather than meeting customers' needs. Critical illness has probably been an example of this in the past. However, the industry has paid out £1.7 billion in claims during 2000–2005 (source: ABI) that will clearly have provided valuable financial support to these customers.

The customer's perspective

The high volumes of sales during the 1990's demonstrated that CI products had considerable appeal to customers. This appears to be based on:

- CI usually offers a lump sum benefit, which customers find more attractive than an income benefit;
- It provides flexibility at the time of claim as to how the lump sum is used; and
- It is viewed as simple compared to some other products.

However, there are a number of features of the product which have contributed to it not always meeting the needs of customers as closely as anticipated.

The high level of claims that are declined, around 20% according to many statistics, suggests that customers may not fully understand CI products and the needs they are designed to meet. This reflects problems with the new business process and with customers' disclosure of information made at that stage. It may also reflect the lack of communication with customers post sale. These issues are explored further in the remainder of this chapter.

When purchasing a protection product, such as critical illness, customers are generally looking for "peace of mind" and the knowledge that they (and their dependants) will have some financial protection in times of need.

The firm's perspective

Firms have a valid objective to maximise profits from the sale of new products. They also need to protect those profits by avoiding anti-selection during the new business process and by ensuring that only genuine claims are paid.

But firms will also want to minimise the number of dissatisfied customers and we do not believe there is any intention to avoid paying genuine claims. Firms will wish to avoid the potential future costs and management effort associated with situations where customers feel they have not been treated fairly.

The FSA set out the findings of a review of the sales process surrounding critical illness business[19] in May 2006. The overall conclusion was that firms had been making good progress in a number of areas but that more should be done to ensure that customers are treated fairly. There was no suggestion of any widespread fundamental problems with the sales process. The areas identified where the FSA felt more could be done were:

- Making sure customers disclose relevant medical information;
- Explaining the CI product more clearly;
- Making policy documentation, such as key features, clearer; and
- Justifying individual CI sales and advice better.

The industry has worked hard to overcome recognised concerns, particularly with the ABI Statements of Best Practice[20] which aim to assist customers by helping them to understand and compare different policies. However, there is a limit to how much can be achieved through the standardisation of definitions and other measures put in place by the ABI, especially in the IFA market where firms face competitive pressures to differentiate their products.

The adviser's perspective

Many of the points made in this chapter relate to matching the CI product to customers' needs. The advice process and the role of advisers are therefore crucial to ensuring that customers are treated fairly.

The precise boundaries between the roles of provider and adviser have not always been clear and the FSA has sought to bring some clarity to this area through their discussion paper (DP06/04). This is particularly important for complex products such as critical illness, stressing for example the need for product providers to make suitable training available to advisers. But it also remains the case that the prime responsibility for ensuring that customers purchase the most appropriate product should rest with the adviser for an advised sale.

[19] The sale of critical illness cover: results of thematic work: FSA, May 2006
[20] Association of British Insurers – updated ABI Statement of Best Practice Critical Illness Cover, April 2006

7.3 DESIGNING PRODUCTS TO MEET CUSTOMER NEEDS

Critical illness is by nature a manufactured product covering a specified list of illnesses and events. These events have different levels of impact on peoples' financial circumstances with the result that critical illness benefits may fail to match customers' real needs, either in timing or amount.

The product is most often sold in conjunction with a mortgage, usually combined with term assurance cover. There is a clear need in most circumstances for a mortgage to be repaid on death and there will be advantages in being able to repay the mortgage following a critical illness:

- The illness may lead to a period out of work and a reduced income; and
- It can remove one financial concern during a time of naturally high stress.

The product provides flexibility and the policyholder can choose at the time of claim to use the lump sum to pay for adaptations required to their home, for specialist medical treatment or for a recuperative holiday. However, if the lump sum is used for these purposes, at least part of the payment will not then be available to repay the mortgage. Furthermore, the claim may not coincide with the inability to work and, if it precedes the real need, the policyholder may have used the benefit for an alternative purpose.

Critical illness is also bought for reasons other than to protect a mortgage. These will include:

- Protection for other loans;
- Protecting small businesses against the loss of key employees; and
- To provide individuals with a lump sum to help deal with the impact of a critical illness, without any link to a specific need.

For these purposes, the advantages of a critical illness policy can be seen although it is again not clear how closely the benefits will match the customer's needs in the event of a claim. It can be very difficult to assess the required level of cover as financial requirements will vary depending on the severity of any condition suffered. Similar considerations apply to those set out above in respect of critical illness taken out in conjunction with a mortgage.

There has been considerable debate over the need for fundamental changes in product design for both income protection and critical illness to ensure that they can better meet customers' needs. For CI, this might include tailoring benefits to more closely reflect customers' needs and the severity of their condition, although this potentially leads to additional complication. There has been at least one CI product introduced recently that aims to address these issues, but at the expense of additional complexity. Time will tell how successful this innovation is in terms of generating new business and in resolving the TCF issues associated with existing products.

7.3.1 Comparing Critical Illness with Income Protection

It is important for firms and advisers to consider whether CI provides a sufficiently close match to customers' needs. When sold in conjunction with a mortgage, the more obvious financial need is arguably to meet mortgage payments or other commitments during any period of reduced income resulting from illness or accident. This makes Income Protection ("IP") a more intuitive proposition.

Critical illness only pays out following one of the specified illnesses but these exclude some of the most common reasons for long term absence from work, such as musculoskeletal conditions and stress. In addition, the date a CI claim is paid may diverge markedly from when long-term absence from work starts, so that there is either a shortfall (if the CI pays out later) or the possibility that the funds will have been put to other means (if the CI pays out earlier).

Financial advisers should understand the key differences between IP and CI although they may underestimate the likelihood of long term disability resulting from an event not covered by critical illness. However, there remains a view that CI is sold in place of IP.

As far as we are aware, there are no artificial incentives (such as differing commission levels) encouraging distributors to favour CI against IP or other products. If they were to exist, then TCF implies that firms should consider the validity of such arrangements. There are several other possible explanations for the greater volumes of CI sales compared to IP:

- Advisers may find it easier to sell critical illness, perhaps because it provides a lump sum rather than an income and the cost appears lower to the customer;
- Similarly, IP may be considered to be a more complex sale because of the unusual features of the product (such as deferred periods, replacement ratios and the interaction with state benefits). This may be because advisers find it difficult to explain the intricacies of CI benefits;
- There may also be a perception that CI events are more common than IP, making a claim more likely, although this is inconsistent with the view that IP is more expensive. There is a perception that "everyone knows someone who has suffered from cancer or one of the other conditions covered by CI policies". However, in many cases this will be people who are above the ages covered by most critical illness policies; and
- CI may be popular partly because of fear of diseases like cancer, hence the early product name of 'dread disease'.

Some of these points tie in with the potential weaknesses in the sales process identified by the FSA. For example, much sales literature still refers to the need for income and suggests that CI can be a solution to reduced earnings.

7.3.2 Levels of Declined Claims

As noted earlier, one of the current problems with critical illness is the number of claims that are declined. These declinatures usually result from one of the following factors:

- Customers failing to disclose relevant medical information during the underwriting process. This may be deliberate but more often results from a lack of understanding of the product and documentation such as the application form and health questionnaire;
- Customers suffering from an illness that appears to be included in the list of those covered by the policy but where their circumstances do not meet the exact definition; and
- Customers assuming that any "serious" illness, for instance where they are unable to work for many months, would be covered by the policy, possibly through the Total and Permanent Disability benefit.

Published claims statistics suggest that approximately 10% of claims are declined due to non-disclosure and a further 10% because the CI definitions are not met.

The high level of declined claims is partly being addressed through work being undertaken by the ABI and through clearer policy documentation. Underwriting forms should also highlight the potential risks from non-disclosure.

Providers should be recording the reasons for declined claims and using this to improve future product design, and this should continue. A declined claim does not necessarily indicate that a customer is dissatisfied as they may accept the reasons for the decision. However, it is the large numbers of declined claims that indicate a potential weakness with product suitability or the sales process.

Actuaries will be aware of the potential impact on product profitability, reserving and capital requirements if a significant proportion of these declined claims had to be paid in future. This could happen, for example, if the ability to decline claims due to non-disclosure was restricted as a result of further customer pressure. The impact will be increased if firms are not supported by their reinsurers, whose contracts with firms are not subject to TCF.

7.3.3 Disclosure of Medical Information

The disclosure of medical information is a key part of the policy acceptance process for most life products, but an area that does not currently seem to be operating as effectively as possible for CI. Firms use medical history and current health status in order to offer competitive terms to healthy customers and this is a well-established practice for protection products.

It can be expensive and time-consuming to verify the information provided at point of sale with the result that firms often rely on the information disclosed by their customers. However, the current process of verifying the information at the time of claim contributes to the high level of declined claims. Whilst this is acceptable to

eliminate deliberate and fraudulent non-disclosure, it is questionable how fair it is where the non-disclosure has resulted from inadvertent misunderstanding.

Some people are beginning to question the extent to which it is reasonable to decline claims on the basis of non-disclosure. For example, the Law Commission and Scottish Law Commission issued a discussion paper[21] in September 2006 proposing changes to the law in this area.

By not checking out all of the information supplied by the customer at the point of sale, there is a risk that customers will have claims declined when firms check the information at the time of a claim. It is becoming less acceptable for firms to take this approach, implying that a fundamental change in approach to the underwriting process is required. Either, firms will ask fewer questions leading to an increase in premiums for healthy lives. Alternatively, they will get full medical records at the point of sale, which will create extra costs and make the process less efficient and longer for the customer. In either case, firms should be highlighting the risks of non-disclosure in application forms and at other stages of the new business process.

7.3.4 Future changes in the severity of Critical Illnesses

CI is sold as a long term product but is vulnerable to changes over time in the diagnosis and treatment of the events covered by products. It is likely that the current list of illnesses will not be considered the most serious illnesses in the future as some will become routinely treatable. There may also be "new" illnesses that are not currently covered, but that become increasingly significant.

Recent ABI work has sought to address this, although different approaches are used for different conditions. In some cases, the definition is based on current diagnostic techniques and in others it is based on the techniques available at the time of the claim.

These problems are a feature of the design of CI products which is based around definitions of illnesses rather than customer needs. There remains an inherent problem in designing a long-term product with cover based on definitions that may become out-of-date. As a result, the changing significance and impact of defined critical illnesses could further widen the gap between the conditions that lead to a claim being paid and those conditions where there is a real need for payment.

These considerations lead us to question whether it is appropriate for CI to be written as a long term product or rather as short term general insurance business, in which case the list of illnesses and their definitions could be reviewed annually.

[21] Insurance contract law – issues paper 1 – misrepresentation and non-disclosure: Law Commission and Scottish Law Commission, September 2006

7.3.5 Total Permanent Disability ("TPD")

TPD is added to the list of CI events in order to offset some of the problems associated with the limited list of conditions that are covered. It partially addresses some of the concerns set out elsewhere in this chapter and aims to fill the gap in terms of meeting customer needs.

However, from the customer's perspective, TPD adds to the expectation that benefits will be paid out when needed, for example if someone is sufficiently disabled not to be able to work. Unfortunately this is often not the case as the hurdle required to meet the "total" and "permanent" criteria is relatively high.

The inclusion of TPD adds to the importance of ensuring that product literature clearly sets out when claims are payable and the risks associated with not meeting the CI definitions.

7.3.6 Published Claim Acceptance Rates

There has been a trend in recent years for product providers to provide information on their claim payments and the proportion of claims that have been declined. This often includes information on the main reasons for declined claims, particularly those related to non-disclosure and the claim not meeting the CI definitions.

This provides valuable additional information enabling customers, and more often advisers, to understand the likelihood and causes of declined claims. It may also be used as a means of making comparisons between different firms. The published information is the source of some of the statistics quoted earlier in this chapter.

However, we are concerned that this information could be misleading as the approaches used to produce the statistics are unlikely to be consistent between firms. For example firms will have different approaches to classifying the notification of claims as potential claims. There would be value in an appropriate body setting out a standardised approach in this area.

7.3.7 Communication of Risks

This chapter sets out some of the features of CI business that need to be addressed to ensure that customers continue to be treated fairly. Some of the points can be addressed through changes in product design and in the processes operated by firms and advisers. More often, concerns should be addressed by ensuring that customers, and potential customers, understand the issues as clearly as possible.

For example, Key Features documents should make it clear that the policy will not pay out in the event of certain illnesses that could result in significant long term disability. One possibility would be for the risk factors to actually quantify the probability that the customer would be unable to work but not be able to claim on their CI policy. We realise there are practical difficulties, particularly as the probability will vary by sex, age and other rating factors, and therefore suggest this

be done in a standardised way across the industry.. The objective is to set out the risk factors in a way that will be more meaningful to customers and firms would need to test customers' understanding of any approach to be used.

Product providers should also consider addressing the following points, amongst others, within the risk factors in Key Features and in other product literature:

- The risks associated with failing to disclose relevant medical information;
- The potential for the outcome from defined events, and the impact they can have on a customer's lifestyle, to vary over the duration of a long term product.

8 PRODUCT DISCLOSURE

8.1 EXECUTIVE SUMMARY

- As insurance products are not tangible until a claim arises, customers must rely on verbal and written product disclosures to explain how their policies work including the policy features, costs, risks and potential benefits. Therefore TCF requires product disclosure to be effective throughout a policy's lifecycle.
- If regulators and firms produce effective written product disclosure, and if advisers explain the product with sufficient clarity, there should be no "nasty surprises" for customers over the lifetime of the contract. Effective product disclosure could therefore be key in helping to enhance confidence in the insurance industry, reducing complaints and improving persistency.
- However, customer research[22] has confirmed that current written product disclosure is failing to engage with customers and therefore manage their expectations.
- In particular, current regulations are forcing firms to produce lengthy and complex disclosure documents, which are overwhelming most customers.
- Firms could do more to ensure communications to customers are as concise as possible, clear, consistent, relevant and as appealing as possible for customers, whilst also complying with the necessary regulations. However, at the time of writing, many firms are reluctant to spend money on amending disclosure systems and documents until the outcome of the FSA disclosure review[23] is known. This is therefore hindering customers from receiving improved product disclosure.
- Robust customer research is essential to ensure that changes to disclosure regulations, which could involve significant implementation costs, will actually deliver effective product disclosure for customers.
- To help manage customer expectations after the point of sale, we suggest that firms should give serious consideration to issuing regular statements, even where not required by current regulations, for all life and savings products.
- We suggest that statements should include, from time to time, reminders of policy features such as policy options and guarantees and salient information about fund performance or where such information can be obtained. We also suggest that for investment contracts with a fixed term or with a targeted amount, statements include a reprojection even when not required by current regulations.
- Generally projections are governed by FSA rules, but those shown on annual statements for most pension policies are governed by pensions law, and by technical rules (TM1) prescribed by the actuarial profession. We recommend

[22] For example, FSA Consumer Research 55 "Investment disclosure research" (November 2006) & ABI Review of Yearly Statements "Making information work for customers" (July 2006)

[23] FSA Consultation Paper 170 "Informing consumers: product disclosure at the point of sale" (February 2003) etc.

that both these rule-sets are reviewed to make the disclosure consistent, simpler and more relevant to customers.

- Previous research[24] has shown that the way in which risks are presented to customers can strongly influence the financial decisions that they make. Hence, firms and advisers need to take care in in presenting risks to customers.
- We suggest that for investment products where charges are not level loaded, reduction in yield figures are shown for early durations on point of sale illustrations to illustrate the impact of higher charges on early surrender or transfer. However, we recommend that further research is undertaken to establish the best way of presenting this information to customers. For existing policies, we suggest that information about charges is made available on request.

8.2 INTRODUCTION

This chapter aims to cover product disclosure for both investment and protection insurance products as there are some overlapping considerations for disclosure for both types of product.

Unlike other forms of purchases by customers, insurance products are not tangible until a claim arises. Therefore, customers must rely on verbal and written product disclosures to explain how their policies work including the policy features, costs, risks and potential benefits. If product disclosures are inadequate then customer expectations will not be managed effectively. This is likely to lead to customer confusion and complaints. TCF requires advisers and firms to provide effective product disclosure throughout the life of each policy. However, the current complex regulations surrounding product disclosure and the concentration by firms on protecting themselves from the regulator and the Financial Ombudsman Service mean that the interests of the customer have not always been given enough prominence. If advisers, firms and regulators are to ensure that customers are treated fairly then changes are likely to be required to the current product disclosure regime. Until such changes take place, firms should ensure that product disclosures are as concise as possible, clear, consistent, relevant and as appealing as possible for customers, whilst also complying with the necessary regulations.

In producing effective product disclosure a balance needs to be struck between a customer's capacity for financial information and the information that needs to be presented for a customer to understand the product. In this regard, the simpler the product, the easier it will be for a customer to understand its features, and the easier it will be for a firm to produce concise information to explain the product.

The customer's perspective

Customers want and need disclosure from product providers and advisers to conform to the following:

- to be concise;
- to be written in plain language and set out clearly;

[24] "Consumer Understanding of Risk" – Alan Goodman (November 2004)

- to be timely, consistent and relevant;
- to contain key information only with the knowledge that further information can be obtained on request should they need this;
- to be balanced and not misleading; and
- for customers with investment products to have regular updates on the progress of their policy.

Above all, customers do not expect any "nasty surprises".

The reality is somewhat different. Currently, a customer will receive an array of product disclosure documents from point of sale through to the point at which a claim is made as shown below:

Point of sale: Sales promotional material, Initial Disclosure Document, Menu, Key Features document (or Key Facts for certain products), illustration, product brochure and suitability letter; and

Post-sale: Post-sale illustration, cancellation notice, policy document, Yearly/half-yearly statement, annual report, ad hoc in-force illustrations, ad hoc letters dealing with queries and complaints and claims letters and accompanying material.

Many of these documents can be lengthy, unclear, contain financial jargon and caveats and omit key information that customers want and need to manage their expectations. Most customers are overwhelmed by the amount of information received and are also unclear how the various documents interrelate and the purpose or relevance of each. Fortunately at point of sale this can be less of a problem as, for advised sales, the adviser should be able to explain the salient product features to the customer.

Furthermore, given the relatively low propensity for most customers to be interested in or understand financial information, the adviser plays a crucial role in explaining the product. Indeed some customers prefer to listen and rely on an adviser rather than reading the information themselves. This was confirmed in recent customer research[25] commissioned by the FSA:
"..the majority felt that the explanation given by the adviser was the most important factor for them in gaining a good understanding of the product. This was not to say that they felt the documentation was unclear or insufficient, rather than they preferred to listen to and rely upon the adviser. Furthermore, some respondents were put off by the amount of documentation and, for this group, the role of the adviser was felt to be crucial to their understanding of the documents. A number admitted that they would not have read the documents in the 'real situation' but would have relied wholly on the adviser."

The situation post-sale is very different. For many customers disclosures are received direct from firms without any adviser or other support leaving customers to their own devices to try to decipher the information. Any confusion and frustration may be compounded by customers seeking information and support

[25] FSA Consumer Research 55 "Investment disclosure research" (November 2006)

from family members or friends or via press articles, which may not always be accurate or balanced. In addition, adviser support for lower net worth customers may be very limited. This is largely due to the reluctance of some advisers to service such customers because of the time and costs involved for potentially little reward and the reluctance of providers to service customers who are "owned" by advisers. Without suitable support, customers may be confused by the product disclosures received, take potentially inappropriate actions such as surrendering their policy without proper consideration of the facts or may simply glance and file documents away where, in certain instances, a call to action may be required such as reviewing a pension plan or switching funds.

The adviser's perspective

Advisers' needs are similar to those of customers. In particular, advisers:

- Need good quality information in order to understand the products they are selling. Providers have a responsibility[26] to ensure that advisers receive clear product information, which points out both the benefits and risks in a balanced way, since this is information the advisers will rely on when advising customers;
- Have a responsibility to ensure that the customer has the information they need. If the adviser is not clear about the information supplied by the product provider (distributor) then they should question the provider to fully understand the product that they are selling;
- Want literature that is balanced and therefore which does not over-emphasise the negative aspects of the products that they are trying to sell; and
- May not want firms to contact customers direct with what they consider to be generic "advice", such as whether to transfer out of a fund, if they consider that they "own" the customer for the purpose of providing such "advice".

The firm's perspective

Firms will want to produce:

- Documentation that advisers and customers can understand. If such documentation is unclear then it is likely that the firm will have to deal with more queries and complaints;
- Disclosure that is cost effective. Developing and maintaining disclosure systems and documentation is a costly exercise and firms will be reluctant to spend money unless the benefits of doing so are clear;
- Documentation that includes necessary warnings and explanations. Firms will naturally be cautious in omitting policy exclusions, caveats and warnings from literature for fear of future complaints that such information was not provided to customers or not provided in the disputed documentation. They may also be reluctant to translate technical terms and conditions into plain language for fear of misinterpretation or placing unexpected constraints on future management actions;

[26] FSA Discussion Paper 06/4 "The responsibilities of providers and distributors for the fair treatment of customers" (September 2006)

- Documentation that may not include reminders of policy options and guarantees. Firms may benefit from customer inertia or ignorance such as not exercising valuable policy options or guarantees. They may therefore be reluctant to remind customers of such policy features. However, they must ensure that they comply with regulation and legislation and they would need to satisfy themselves that omitting such information is still in line with the principle of TCF;
- Products with extra features. Although firms may wish to sell simple products, they are likely to wish to add extra features to differentiate themselves from competitors – this complicates disclosure;
- Cost effective support to customers. Firms will naturally want paid advisers to focus on selling good quality new business as opposed to spending time servicing customers for very little perceived benefit to the firm. They may therefore want to service customers via less costly options such as call centres which rely on customers contacting them rather than proactively providing post-sale support; and
- Documentation that complies with all the relevant regulation and legislation. This can create a barrier to providing clear and concise product disclosure to customers.

8.3 DISCLOSURE THROUGHOUT A PRODUCT'S LIFECYCLE

Customer information needs vary depending on the stage of the product lifecycle, the nature of the product and whether they are receiving support from an adviser or direct from a firm. Without adviser support it is even more important that the information provided is concise, clear, relevant and as appealing as possible for the customer.

a) Point of sale disclosure

It is critical that at point of sale a customer understands what they are buying. In particular they need to understand:

- the benefits they might get back and any guaranteed minimum amounts;
- under what circumstances benefits will and won't be paid out;
- the "price" that they need to pay for the policy and whether or why it might change;
- the risks associated with the policy and the potential impact of those risks on the benefits to be provided or the price; and
- that their needs are being addressed by the policy.

If the point of sale disclosure fails to cover such key aspects effectively then it is likely that post sale the customer will be confused or disappointed by the sale leading to queries and possible complaints.

Unfortunately at point of sale, advisers have to issue several, usually lengthy, disclosure documents (such as Key Features) to customers to satisfy current regulations. The large volume of such documents can be criticised for being too lengthy for customers to make an informed decision about whether to

purchase a product. Such documents tend to overwhelm most customers and are likely to be simply filed or thrown away.

Given the complexity of current point of sale documents and the complexity of the products themselves, customers may prefer to rely on their adviser to explain the product to them verbally. Hence verbal product disclosures are crucial and if the adviser gets these wrong or misses some key information then future disclosures are unlikely to manage the customer's expectations leading to customer confusion or, at worse, a complaint. Even if the missing or correct information is in the Key Features document or terms and conditions, is it fair that customers should have to read through large volumes of product disclosure material to check on what a qualified adviser has said? Even if firms can successfully defend complaints based on such disclosures, this is hardly likely to improve customer confidence in the insurance industry. Firms should do more to make disclosure documents – in particular Key Features documents – more appealing and accessible to customers.

One way to make disclosures more effective is to use the "less is more" approach i.e. provide less, but more useful and relevant information to the customer. The FSA has explored this concept with its proposal[27] for a brief "Quick Guide" as a replacement for the Key Features document at the point of sale. The aim was to produce a shorter document, the Quick Guide, at point of sale with signposting to information in other documents. The FSA also proposed changes to the presentation of charges and projections. However, research[28] has shown that the costs to the industry of making significant changes to disclosure systems and documents to take account of these proposals could not be justified in terms of the additional benefits to customers. The FSA is therefore considering further ideas to address the issue.

A less costly alternative approach to the Quick Guide is for firms to provide clearer Key Features documents which customers can easily navigate to read about the key aspects of their product – the product features, the risks and the possible benefits. The ABI has recognised this need and developed some good practice suggestions for firms under its Customer Impact Scheme[29]. To reinforce this point, firms should ensure that training material and compliance guidelines for advisers are clear to ensure that advisers mention all the key aspects of a policy to customers at point of sale.

Of course, the simpler the product is in the first place the easier it will be to present the product features in a way which is understandable to customers. Firms should therefore assess whether their current products are overly complex and make refinements where possible to simplify product features.

[27] FSA Consultation Paper 05/12 "Investment product disclosure: proposals for a Quick Guide at the point of sale" (July 2005)
[28] FSA Feedback Statement 06/5 "Point of sale investment product disclosure: feedback on CP170 and CP05/12" (November 2006)
[29] ABI's Customer Impact Scheme and associated Customer Impact Guides – see www.customerimpact.org

Given the above issues with current point of sale disclosures, post sale disclosure – in particular the yearly statements – play a role crucial in managing customer expectations.

b) Post sale disclosure

Post sale a customer with an investment policy needs to be provided with a reasonable assessment of how their policy is performing and what they might get back in the future. For all policies a regular reminder of the product features that a customer's policy provides might be reasonably expected.

Yearly statements are not produced for all products. For example, there is no regulatory requirement for statements or any other form of regular post-sale communication to be produced for certain protection products such as term assurances. Given the general lack of interest and understanding of insurance products by customers, it is likely that many customers will have forgotten much about the product that they have purchased and at best may simply remember a handful of the product features. Where this can be a particular problem is for products with complex features such as critical illness (see also chapter 7). We therefore suggest that firms should give serious consideration to issuing, from time to time, reminders of the salient product features (with signposting to further information and support), even where this is not required by current regulations. This would enable customers to review their product in light of their current circumstances and take action if appropriate such as seeking advice to review their cover etc.

Although the issue of such statements/information would add costs to firms, it would provide a regular opportunity for firms to engage with their customers and better manage expectations. Keeping in touch with all customers on a regular basis is likely to lead to higher retention rates, more reviews of cover and benefits provided and hence higher top-up sales, less queries and complaints. Of course, providing customers with such regular information could also lead to more customers exercising valuable options and making valid claims. It could also lead to more customers surrendering their policies so care would be required to inform but not to alarm customers. If firms decide to issue statements where not required by regulations, they would need to consider the frequency for which such statements are issued. To assist with this decision, it would be sensible to seek customer feedback.

The statements need to be effective in managing customer expectations. Customers need key information to do this and don't wish to receive information that they regard as irrelevant and view with suspicion such as lengthy caveats.

Customers want the statements to be short with key information prominently displayed and with signposting to whether additional information can be found e.g. to a website or call centre.

Any further information is likely to overwhelm customers and distract from the key information that customers are interested in.

For example, recent customer and adviser research[30] conducted by the ABI has indicated that customers with investment products need and want the following key information:

- current plan value (allowing for all surrender charges and any Market Value Reduction);
- last year's equivalent value so customers can see how their plan is performing;
- a reprojection of what they might get back for products with a fixed term or with a targeted amount (see section below for more about projections);
- how much they have paid into their plan since the plan started and over the last 12 months; and
- how much they have taken out of their plan since the plan started and over the last 12 months.

If firms provided such information, the recent ABI research indicates that customer expectations are likely to be much better managed than the current situation and customers are more likely to use statements as a tool for taking action such as arranging to top-up their pension arrangement or to seek advice to review their plans.

Unfortunately the current complex regulations for yearly statements mean that firms are forced to produce longer and more detailed statements than most customers want or need. However, within these current constraints, firms could do more to make yearly statements more appealing for customers.

c) Claims stage

The acid test about whether a customer's expectations have been managed comes at the claims stage. If the benefit provided by the firm at this stage is in line with or exceeds the customer's expectation then it is unlikely that the customer will question or complain about the claim amount. For example, with critical illness policies, if written and verbal product disclosures have been effective to manage expectations then, in principle, a firm should experience lower rates of declined claims as customers would understand whether their 'claim' was valid. In practice the situation is complicated by issues such as the lack of interest and understanding by customers of policy details as well as issues such as customer non-disclosure.

Customers might expect firms to remind them of any options or guarantees that apply as the claim date approaches and at the claim date itself. In fact there are specific regulatory requirements that a firm must follow such as to publicise the existence of an open market option for pension contracts as the retirement date approaches. However, there are other options and guarantees that may not always be publicised such as guaranteed insurability options and Market Value Reduction (MVR) free dates. We recommend that firms should remind customers of such product features in advance of the relevant dates on which the options apply and what options are available to customers at such dates. Firms should also alert customers to the fact that certain guarantees (e.g.

[30] ABI Review of Yearly Statements "Making information work for customers" (July 2006)

guaranteed annuity rates, MVR free dates) may be lost in the event of the customer surrendering or transferring their policy.

In establishing the information needs of customers it is very easy to fall into the trap of deciding what customers should receive without undertaking appropriate customer research to establish if such information is actually useful. Firms should consider undertaking appropriate research to establish the information that customers need to manage their expectations and to assist with the presentation of such information such that customers will respond more appropriately to the information provided.

Where customers potentially need to take action this should be prominently drawn to their attention in good time and not buried in masses of caveats and lengthy documents. Expectations can be managed by regular reminders of product features and options available for customers.

The next sections consider some of the areas relevant for actuaries working in product disclosure and where actuarial input could be useful to ensure TCF.

8.4 PROJECTIONS

There has been much debate about whether projections for investment products are worthwhile given:

- The uncertainty of future investment returns;
- They may be wrongly used to compare future performance between different providers; and
- Many customers do not fully understand them.

However, projections tend to be one of the main disclosures that customers are interested in and focus on. Investment contracts are not tangible and so it's not surprising that customers want an indication of what they might get back in return for investing their money.

At point of sale, three projections are generally provided to customers purchasing an investment product. These projections are based on assumed future investment growth rates. The maximum growth rates for firms to use are prescribed by the FSA and are currently 4% p.a. (for the "lower" illustration), 6% p.a. (for the "middle" illustration) and 8% p.a. (for the "upper" illustration) for investments using net returns and 5% p.a., 7% p.a. and 9% p.a. respectively for projections using gross returns. The FSA rules[31] require firms to use lower growth rates where they believe that the prescribed rates overstate the investment growth potential for the product they are illustrating. For example, it would seem appropriate to use lower assumed growth rates, and possibly narrower ranges, for cash and fixed interest investments or for funds which have a significant holding in such investments.

The aim of showing three projections at point of sale is to illustrate to customers that future returns are unknown and what they might get back will depend on how their investments perform. However, whilst showing three illustrations provides a

[31] FSA COB 6.6.49R

spread of possible returns, customers will naturally focus on the "middle" projections believing it more likely to be the one that predicts what they might get back. FSA prescribed wording must accompany the projections to warn customers that the three projections are not minimum or maximum amounts and that they could get back more or less than the projections shown. However despite such warnings, customers may still believe that the projection shown using the lower growth rates is some form of minimum "guaranteed" amount that they might get back. Hence it is important that for advised sales, advisers explain the spread of possible returns to customers. If a negative return is possible then this possibility should be explained to a customer.

The Key Features illustration provides no indication of the chances of each of the returns being achieved. From a customer's perspective each of the three returns illustrated is equally likely although as mentioned above they are likely to focus on the middle projection as the most likely outcome. What is needed is an indication of the risk versus return for the customer. The absence of this analysis is a fundamental flaw in the current point of sale disclosure regime. Although, to address this issue, stochastic projections would seem an obvious starting place to consider, there are cost and practical barriers for some providers which mean that a simplified approach may be required. It may be that generic illustrations could be provided to highlight the risk versus return to customers and to illustrate the size of the funnel of doubt of future returns for different products and fund choices.

Actuaries are well placed to recommend a middle growth rate assumption to use and to advise on suitable spreads for the "lower" and "upper" projections. Currently the spread of returns is very similar for all products whereas in reality the spread is likely to be much wider for a more volatile investment such as an equity-based product or fund than for a safer form of investment such as cash.

It is essential that advisers can explain clearly the concept of risk versus return to customers using the Key Features illustration and other advice tools available. If this verbal or written disclosure fails to engage with customers then advisers and firms are likely to struggle to manage customer expectations from that point onwards. It's worth remembering that many customers with existing policies will have been sold policies based on marketing material with past performance figures and may never have been issued with either an illustration at point of sale or a reprojection post-sale. It is therefore not surprising that, following stock market falls or lower nominal returns than in the past, such customers are disappointed when they receive either a claim amount or ask for a reprojection.

Customers are interested in the performance of their policies and showing reprojections on statements provides a useful way of explaining to customers how their policies are performing and what they might get back. A particular example of this is the mandatory introduction of reprojections for mortgage endowment policies. This has naturally led to queries and complaints – partly owing to customers claiming they were unaware of the risk of a shortfall when they purchased the policy but also because firms may have failed to manage customer expectations since the point of sale. We therefore suggest that firms consider including reprojections on yearly statements for investment products with a fixed term or targeted amount where such information is not already required by current regulation or legislation. We recognise there would be costs to firms in providing

this information but we believe that the benefits to customers in terms of managing expectations, and to firms in terms of ultimately lower levels of queries and complaints, would outweigh such costs.

In providing reprojections, it is important to ensure consistency with previous projections issued such as those issued at point of sale. If this consistency is not achieved or the differences are not explained clearly to customers then this is likely to lead to customer confusion.

Statutory Money Purchase Illustrations (SMPIs)

SMPIs are a single illustration of what a customer might get back as a pension from their pension arrangement expressed in today's terms i.e. allowing for the impact of future inflation. They are usually issued with yearly pension statements.

SMPIs were developed by the Actuarial Profession on behalf of the Department of Work & Pensions (DWP) with the basis first published in Technical Memorandum 1 (TM1). They became mandatory from April 2003 for a wide range of money purchase pension arrangements such as personal and stakeholder pensions, additional voluntary contribution pensions and occupational money purchase pensions.

SMPIs were introduced following concern that people were not saving enough towards their pension. The DWP and the actuarial profession were keen to provide people with effective regular information about their future pension arrangements. The aim was to provide information which would act as a "wake-up call" to save more. The hope was that it would lead to people taking more interest in their pension arrangements and realising when they need individual advice.

Prior to the introduction of SMPIs, customers were rarely given pension projections expressed in today's terms. Instead the only projections they received tended to be at point of sale in Key Features illustrations where such illustrations were expressed in monetary rather than real (today's) terms. This meant that the true cost of a pension and how much customers needed to save to fund a decent level of retirement income wasn't clear. SMPIs provided a way for customers to see the impact inflation had on their pension arrangements. In theory this could be expected to lead to many customers realising that they needed to save more to fund a desired level of pension.

By requiring SMPIs to be issued each year, usually with annual statements, customers can now monitor more effectively how their pension arrangements are performing. In addition, because the SMPI basis is consistent across different pension arrangements and between pension providers, customers can simply add together all the SMPIs for each of their arrangements to establish their total pension provision.

Although the intentions were good there is no evidence to suggest that the introduction of SMPIs has, to date, resulted in the desired call to action by customers such as increasing their contributions to pension arrangements. Indeed

research[32] commissioned by the FSA and research[33] by the ABI has shown that SMPIs have not yet engaged with customers.

One reason why SMPIs may have failed to engage with customers is how the information is presented. TM1 requires various explanatory notes to be shown alongside SMPIs. Although TM1 makes it clear that such notes should be kept to a minimum, it mandates a list of statements that need to be included to explain the SMPI and suggests other statements that a firm may wish to include. Many firms make matters worse by including lengthy statements to cover these suggestions and as a defensive reaction to regulation, particularly the fear of a ruling by the Financial Ombudsman Service. Unfortunately firms feel they need to protect themselves, rather than meet the needs of the customer. For these reasons, SMPIs have, in themselves, added at least a further page to the length of statements. This makes them less likely to be read and acted upon, thereby defeating the very purpose for which they were introduced.

For pension policies, the introduction of SMPIs has meant that firms are issuing monetary illustrations at point of sale (as required by the FSA) and illustrations allowing for future inflation i.e. in today's money (real illustrations) post sale. This means that customers are not being provided with consistent projection disclosures, which is likely to confuse customers. The FSA is expected to be consulting in March 2007 on proposals for projections which are expected to include real illustrations at point of sale. Where real illustrations are currently shown, the pension format may differ from the SMPI basis e.g. a lump sum may be shown at point of sale and pensions illustrated are likely to be shown without RPI escalation. This inconsistency between pre and post sale illustrations is not helpful to customers and adds to the confusion. Therefore there needs to be a joined-up approach taken between the FSA, the DWP, and the Actuarial Profession to ensure that illustrations issued pre-sale, post-sale on request, and SMPIs are all produced on a consistent basis.

8.5 RISKS

Whilst the risks associated with taking out a policy are listed in Key Features documents at point of sale and should be drawn to the attention of customers by advisers, customers are unlikely to be given much information about the likelihood of each risk materialising and how this would impact on what they might get back. For example, a risk warning might say something along the lines of "There are no investment guarantees and you could get back less than you had invested." From a customer's perspective although this warns them that their capital is not secure, such a statement provides no indication of the likelihood of their capital being eroded.

Even where disclosures are clear, lack of customer understanding of financial products can leave some customers exposed to risks that they don't realise. This was confirmed in customer research[34] commissioned by the FSA:

[32] FSA Consumer Research 30 "Inflation and pension savings: Understanding the presentation of the Statutory Money Purchase Illustration (SMPI) in pension statements" (July 2004)
[33] ABI Review of Yearly Statements "Making information work for customers" (July 2006)
[34] FSA Consumer Research 33 "Consumer understanding of financial risk" (November 2004)

"...ISAs were perceived as being safe because they were provided by the government and few were aware of the distinction between cash and equity ISAs. Consequently, this confusion left some respondents unintentionally exposed to a level of risk they were not aware of."

....

"But when dug into in more detail, some misconceptions about risk were also evident; some respondents believed their products held little or no risk, when in reality they had equity-linked components, for example some respondents regarded personal pensions as a secure savings account."

Even when adviser support is available, customers are unlikely to be able to grasp the concept of risk without a clear explanation:
"Despite attempts by financial advisers to inform customers about risk, they admitted that many consumers did not fully understand the information and they were happy to pass responsibility to the adviser if trust had been established."

Following concerns that some customers were making poor financial decisions, even when they were assisted by financial advisers, the Actuarial Profession commissioned research[35] into consumer understanding of risk. In the press release which accompanied the findings of the research in November 2004, Alan Goodman commented:
"The main lesson of this important research is clear. It shows that insurance companies and financial advisers are able, fairly easily, to persuade people to adopt the investment strategy the provider or adviser believes will optimise their welfare. At one level there is nothing necessarily wrong with this. The potential dangers are obvious, however, unless we ensure that the same techniques are not used to maximise the financial well being of the provider or adviser, as opposed to that of the consumer."

This places responsibility on providers and advisers to ensure that risks are presented and explained to customers in a way that does not mislead them into making poor financial decisions.

Actuaries are well placed to provide assistance with the production of such communications to customers. However, whilst actuaries can provide valuable technical assistance, communications need to be written and presented in a way that customers will be able to understand and engage with – this may not play to every actuary's strengths!.

If the potential impact of risks cannot be explained to customers then it is questionable whether it is fair to sell such products to customers in the first place. For example, where a firm issues critical illness cover with reviewable premium rates (see chapter 5) then it is arguably reasonable for a customer to wish to know how much their premium could increase by in the future. However, it is not clear how such risks should be presented. For example, firms will be naturally reluctant to provide a range of possible outcomes for fear of these being viewed as some form of guarantee on the maximum premium that could be charged and hence having to set up reserves for such guarantees. Likewise for unit-linked products

[35] "Consumer Understanding of Risk" – Alan Goodman (November 2004)

with discretionary charges (see chapter 6), it is not clear how the risk of charges being increased should be presented.

A customer's attitude to risk can vary over time. For example, if they had an adventurous attitude to risk at point of sale in choosing the investment funds for their pension policy, this may change to a more conservative outlook as they approach retirement or during the term of the policy as their circumstances change. Unfortunately, customers are not always given the support they need in reviewing their fund choices and inertia can mean that customers will leave their fund choice unchanged. We recommend that firms and advisers do more to inform customers on an ongoing basis about the funds that they are invested in. In particular, firms should consider signposting fund information from statements where details about performance and risk ratings could be found. They could also consider prominently drawing to the attention of customers if a fund is no longer being offered to new customers, e.g. owing to poor performance, and reminding customers that they should review their fund choice from time to time.

8.6 CHARGES

Whilst it is clear how much customers will pay (or be charged) for pure protection products with guaranteed premium rates, for other contracts it may not be obvious to customers what the charges and charging structure are and what the impact will be on what they might get back. For pre-2001 new business, most firms provided little indication of the charges that might apply to a policy. In particular, although firms had to provide an illustration of what might be paid on maturity or on early surrender at certain durations and the reduced yield applying after charges, they did not explicitly set out the charges which applied. The ABI Raising Standards initiative which was introduced from 2001 required charges to be explicitly stated with Key Features illustrations and to be consolidated by charge carrier (e.g. fund, premium) to aid customer understanding. However, this scheme was voluntary and in any event the requirement to illustrate charges applied only to new business. Thus there are many in-force policies where customers will have little or no idea of what they are being charged.

For an investment product, we suggest that the reduction in yield (RIY) is an appropriate way of presenting the effect of all charges to a customer at the point of sale. For products which don't have level charges, we suggest that the RIY is shown at some early durations (e.g. after 3 and 5 years) as well as at the end of the projection term. This will therefore highlight the potentially higher charges that a customer would incur on early surrender. This was the approach suggested by the ABI's Raising Standards initiative. However, further research is required to establish the best way of presenting this information. For example, a graphical approach or pie chart with charges shown in monetary amounts may engage more with customers than the use of percentage figures which some customers may not understand.

For existing business, a firm should be prepared to make charge information available on request. Again the use of an RIY may be the best way of presenting this information but, as per point of sale charge disclosure, further research is needed to establish the best way of presenting charges to customers.