An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0104
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to provide product/service information Delayed or inadequate communication Fees & charges applied
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the alleged failure of the Provider to inform the Complainant that a group discount which he had enjoyed on his health insurance renewal premiums for a period of 5 years would no longer be applied.

The Complainant Case

The Complainant held a health insurance policy with the Provider.

The Complainant states that, when he first bought the policy, he was told that he did not need to take out a policy through his employer's group scheme, because a 10% discount would be applied to his premiums. He took this to mean that the cost was the same and opted not to join the group scheme (under which premiums are paid by way of deduction from salary).

The Complainant states that he received the 10% discount on his premiums for a period of 5 years but that the Provider then removed the discount without highlighting such removal or offering to switch him to the group scheme operated by his employer.

The Complainant seeks a refund amounting to the discounts he says he would have been entitled to if the 10% discount had been applied.

The Provider's Case

The Provider explains that the Complainant was, from 2007 to 2011, covered under a health plan that included a 10% discretionary discount. After that, the Provider states, the Complainant switched to different plan. That plan included, in 2011, the 10% discount.

However, the following year the discretionary discount no longer applied to that plan. The annual renewal invitation letters thereafter stated "0.00" under "Group Discount". The Provider therefore denies that it failed to highlight the removal of the discount.

The Provider further denies that it had a duty to offer to switch the Complainant to the group scheme operated by his employer. When he first took out a policy, he had opted not to join the group scheme and the Provider maintains that it is not reasonable to expect it to remind him of the option at every renewal. Rather, the Provider states, the onus was on the Complainant to tell it that he was an employee of the particular employer and that he wanted to be included in the group scheme. It would not assume that he was eligible to be included in the group scheme.

The Provider states that the Complainant's wife contacted it 1 year after the discount was dis-applied and it was confirmed to her that the policy was not, and never had been, on the group scheme. It had no further contact from the Complainant or his wife instructing it to transfer the policy to the group scheme until 2017, when he joined his employer's group scheme and changed to a different plan again (which did have a 10% discount).

Decision

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

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

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

A Preliminary Decision was issued to the parties 9 July 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that

/Cont'd…

period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

It is common case that the Complainant opted out of the group scheme when he first took out an insurance policy with the Provider in 2007. He did this on the basis that there would be no saving due to the 10% discount that applied to the policy he took out.

I note the renewal letter issued to the Complainant on 16 January 2010 applies a "*10% Discount*", it is not described as a "*Group Discount*".

The call recordings submitted by the Provider make clear that, in 2011, the Complainant's wife contacted the Provider at renewal time and went through a series of questions reviewing the family's health insurance needs. She asked if there would be any benefit to joining the group scheme, as against staying on the current plan.

She was told that there would be no further discount. After considering various cover options in considerable detail, she decided to switch plans. The 10% discount applied to the new plan also.

In 2012, the Complainant's wife again contacted the Provider at renewal time, and again spent a considerable amount of time considering alternative plans. The Provider did not mention the removal of the discount when the Complainant's wife telephoned. The Complainant's wife did not raise the possibility of switching to the group scheme.

While the table in the renewal letter of 24 January 2012 included a "*0.00*" in respect of Group Discount, I note the letter also states "*you may have noticed a change in your premium – this is as a direct result of an increase in the Government levy and rising medical inflation*".

The Provider in its response to this Office states "*this discount continued to be available on the Plan until 2012. At that point, the discretionary discount no longer applied to [Plan Name]*". Page I of the renewal invite displays a breakdown of his annual premium and €0.00 "Group Discount" is displayed.

The essence of this complaint is that the Complainant was not availing of the Group Discount from 2007 to 2012 because he was in receipt of the discretionary discount.

I believe there was a responsibility on the Provider, either in the correspondence issued or in the 'phone conversation to inform the Complainant (or his wife) that the discretionary discount had been withdrawn, particularly in circumstances where the Complainant had opted not to join the Group Scheme on the basis that he was in receipt of the discretionary discount.

/Cont'd…

I note the Provider's assertion that "*it is important to bear in mind however, that [the Complainant] was not entitled to enjoy the discount as it was not available on the Plan, and the subsequent Plans he chose*".

I believe this information should have been brought to the attention of the Complainant at the time he changed his policy so he could have opted to avail of the Group Discount at that stage.

The Provider in its response to this Office dated 20 February 2018, states "*When [the Complainant, his wife] did make contact with us at their renewal dates they did not tell us they wanted to be part of the [Employer] monthly salary deduction scheme and that it was imperative to them to be covered on a Plan that included a 10% discount*".

I do not find this statement to correctly reflect the interaction between the parties.

The fact is that in February 2011 when [the Complainant's wife] called to query the renewal of the policy, she informed the Provider that her husband worked for a business that had a Group Scheme and she queried if there were any benefits to setting up the policy as part of the Group Scheme.

The Provider informed her that there was no extra benefit to be gained as the Complainant was already benefitting from the 10% discretionary discount.

In 2013, when the Complainant's wife called at renewal time, she mistakenly thought that the family were on the group scheme. It was confirmed to her that they were not, and had never been, on the group scheme and she was told that they should go through the Complainant's employer if they wished to consider that. She did not do that, but instead went on to consider various different individual policies. She and her husband stayed on their plan, without a discount, and her son moved to a different plan which did have a 10% discount.

No changes were made in 2014, 2015 and 2016. In 2017, the Complainant's wife contacted the Provider at renewal time and again claimed that the policy was on the group scheme. It was confirmed to her again that this was not the case. Following this, the Complainant did switch to the group scheme.

It is clear that the Complainant's wife put a considerable amount of time and thought into her family's health insurance needs each year. However, in the years 2012 to 2016, she did not compare the policy with her husband's employer's group scheme. The Provider made it clear, whenever the group scheme was mentioned, that the policy was not, and never had been, on the group scheme. It suggested that they could explore that option through the employer.

The Provider spent considerable time with the Complainant's wife assessing the family's needs and objectives. I accept that, at the time, she was satisfied that she had chosen a product which met her needs and objectives. It is disappointing that neither in the correspondence issued nor in the telephone conversation relating to the renewal, that the

/Cont'd…

Complainant was not informed that the discretionary discount had been withdrawn and that the Complainant could consider a Group Discount in its place.

In 2013, she was reminded that the policy was not under the group scheme and invited to explore that, but chose not to. In the circumstances, I find that the Provider was not required to go any further on that occasion.

In the following years, no contact was made by the Complainant or his wife to explore changing policy. The Provider was not under an obligation to second guess their decision to continue with the same policy. It would not be reasonable to require the Provider to look behind the decision of the Complainant each year and inquire as to whether he is in a position to avail of a group scheme through his employer.

While I believe that better communication was required on the part of the Provider in bringing the attention of the Complainant to the fact that the discount was no longer available to him and that he may want to consider joining the Group Scheme if he wanted to continue to receive a 10% discount, I also believe the Complainant had some responsibility to query this matter further – especially in light of the inclusion on his renewal notice of €0.00 in the Group Discount column of the table in the renewal notice.

Therefore, given the shared responsibility of the parties in relation the matter, and in order to do justice between them, I partially uphold this complaint and direct that the Provider pay an amount of compensation in the sum of €750 to the Complainant.

/Cont'd…

Conclusion

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

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €750, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider.

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 July 2018

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

(a) ensures that—

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

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