An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0396
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to advise on key product/service features Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates to a private health insurance policy.

The Complainant's Case

The Complainant states that when she received the renewal documentation for her health insurance in **2017**, there were no obvious changes to her policy within the *"important information"* section of the covering letter. The Complainant states that she did note that the premium had increased from €721 to €834. The Complainant contends that given the increase in premiums '*it was not unreasonable to think that your cover at least was not reduced*'. The Complainant submits that because she was on an extended break she did not thoroughly review the renewal documentation on this occasion and added that it was *'late in the day'* before she decided to renew the policy.

The Complainant states that at the renewal stage in **2018**, she identified a reduction in cover and when she spoke to the Provider it stated that this reduction in cover was implemented in a previous renewal in **April 2017**. The Complainant submits that the Provider also stated that the information relating to this reduction in cover was included as part of the renewal pack issued at the time.

The Complainant states upon reviewing the **2017** renewal, '*I could see no attachments with covering email however* [The Provider] *advised one had to sign into "membership" and review'.* The Complainant states that upon entering the membership section she could not locate the information in relation to the reduction of cover, but whilst on the phone, the Provider advised her:

> '….*to go half way down right of page and click again and there was a renewal flyer which when I clicked on it opened with small print and 8 pages long.'*

The Complainant contends that any reduction of cover/changes to the policy at the time of renewal where not clearly highlighted and neither was it clear where these changes were located.

The Complainant submits that the '*whole process is not consumer friendly and is not transparent.'* The Complainant also states '*I am outraged at the manner that* [The Provider] *advised or more accurately did not transparently advise the amendments made to the policy.'* The Complainant contends that changes to a policy should be highlighted in the '*Important Information'* box within the renewal pack.

The Complainant also states that even in the event of logging into '*Membership area'* the reduction in cover is still not apparently clear and she contends that this should not be the case. The Complainant further contends that despite raising these issues relating to a lack of transparency in her complaint, this matter was not addressed in the Provider's Final Response Letter.

The Provider's Case

The Provider states that the disputed element of cover raised by the Complainant was removed for renewals starting from **1 April 2017**.

The Provider states that on the **20 October 2017** it advised the Complainant that her renewal pack was available in the Member Area and that "*This change was noted on the renewal flyer located in her renewal pack".*

The Provider also states that it sent the Complainant a text on **23 October 2017** as a reminder about her renewal and also it unsuccessfully attempted to call the Complainant in **November 2017**. The Provider states that it spoke to an authorised third party on behalf of the Complainant on **29 November 2017** and advised that the Complainant had until **14 December 2017** if she wished to make any changes or cancel this policy. The Provider states that it received a payment from the Complainant on the **5 January 2018**, '*without her making any contact with us'.*

The Provider states that it once again spoke to the authorised third party on the **25 October 2018** and submits:

> '*You were not happy with the way this change was communicated… so we offered to backdate her level of cover to **01/12/17** to include these hospitals and so avoid any upgrade rule as long as the difference in subscription was paid'.*

The Provider also states that it provided the Complainant with a number of policy options at that point. It states in conclusion that '*we did try on a number of occasions to speak to* [The Complainant] *about her renewal and we have offered a solution to her complaint'.*

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The Provider has made available a timeline of events that I have summarised as follows:

- **25 November 2015:** Complainant's Father sets up new policy for the Complainant. Renewal date is 1 December every year.

- **1 April 2017:** "[The Provider] *removed access to the* [Private Clinic] *and the* [Private Hospital] *on this plan starting with renewals on 1 April 2017. This was removed from the Complainant's policy from her renewal on 1 December 2017. The renewal pack advising the Complainant of this fact was issued on 23 October 2017".*

- **23 October 2017:** The Provider sent a reminder text to the Complainant.

- **10 November 2017:** The Provider called the Complainant but there was no answer.

- **29 November 2017:** *"a Customer Service Advisor (CSA) spoke twice to the Complainant's father but the documents hadn't been reviewed and the Complainant may be cancelling. Automatic renewal and the 14 day cooling off period was advised".*

- **5 January 2018:** The Complainant paid the Provider for her policy, without making contact with the Provider, so the policy automatically renewed on 1 December 2017.

- **18 October 2018:** The Provider issued next year's membership renewal pack to the Complainant.

- **25 October 2018:** Complainant's Father spoke to the Provider, who informed him that it had removed certain private hospitals the previous year. The Provider advised the Complainant's Father of a different plan to regain these private hospitals.

- **5 November 2018:** The Provider contacted the Complainant's Father but it was not a good time for the Complainant's Father to talk.

- **6 November 2018:** The Provider contacted the Complainant's Father and the Provider logged a complaint as the Complainant's Father was not happy.

- **6 November 2018:** The Provider telephoned the Complainant's Father and offered to backdate the policy to the previous year, so that the Complainant could avoid any waiting periods. The Provider also issued this offer by email to the Complainant.

- **15 November 2018:** The Provider telephoned the Complainant's Father but no change was made.

- **22 November 2018:** The Provider issued its Final Response Letter to the Complainant, including an offer to backdate the policy to avoid any waiting periods.

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- **28 November 2018:** The Complainant accepted "*the above offer…, the policy was backdated and the premium difference of €17.64 was paid".*

The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration, insofar as it:

1. Increased the cost of premiums at renewal whilst also withdrawing elements of cover;

2. Placed details of the withdrawal of certain elements of cover in an obscure place within the renewal pack and this misled the Complainant into thinking that no changes had occurred on her policy;

3. Did not address the lack of transparency in its Final Response Letter to the Complainant.

The Complainant wants the Provider to '*ensure that any changes to existing policies are highlighted to customers with full transparency'* following the outcome of this investigation.

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 on **31 August 2020**, 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 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.

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Following the consideration of additional submissions from the parties, and in particular a suggested error of fact, raised by the Provider, the final determination of this office is set out below. In reaching this decision I have had regard to the relevant terms and conditions of the agreement between the parties.

Policy Terms and Conditions

Page 16 of the Rules Booklet:

> ***"11. Changes to the agreement***
> *(a) We may change any of the terms of your membership of your schemes each year on your renewal date. These changes can include, for example, how much your subscription will be and how often you have to pay it. The changes can also include changes to benefits. We will not add any restrictions or exclusions to your cover that are personal and specific to you concerning medical conditions that started after you joined the scheme. Changes will only apply to you for the period following the renewal date when the change was made. The changes will not apply to the period before the renewal date.*
>
> *(b) We will write to tell you about any of these changes before the renewal date on which they are to take effect".*

Analysis

The Provider has stated in its submissions to this Office, that the Complainant received an email dated **20 October 2017** which stated:

> *"In an effort to maintain quality health insurance, we have carried out a full review of our schemes. As a result price and benefit changes may apply to your policy from your renewal, including the addition of our new health coach benefit exclusive to* [Provider] *members on all healthcare policies…….*
>
> ***IMPORTANT INFORMATION***
>
> - ***We have based your renewal on the scheme you currently hold.***
> - ***Please contact us if there has been any material changes in your circumstances or in your health insurance needs.***
> - ***Please contact us before your renewal date to discuss your health insurance needs as we may have a more suitable scheme for you.***
> - ***If you do not contact us prior to your renewal date your current scheme will be renewed for a further 1 year period.***
>
> *Your renewal premium is €8xx.xx, to make a secure payment or pay by instalments, log in to your Member Area at www.*[Provider]*/memberarea or call our team."*

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The Provider has stated that the Complainant was emailed her renewal pack six weeks in advance of her renewal date, in order to give her time to consider. In this regard I note that the Complainant received all the information well in advance and had time to consider the information made available. The Complainant has stated herself that it was '*late in the day*' before she decided to renew the policy. The Provider has stated:

> "*The renewal pack was emailed to the main member six weeks in advance of her renewal giving her ample time to renew same".*

Furthermore, the Provider made numerous attempts to contact the Complainant, prior to her renewal of the policy. On 20 October 2017, the Renewal Pack was sent, and I note that on 23 October 2017, the Provider sent the Complainant a reminder text. On 29 November 2017 the Provider spoke to an authorised third party, and advised that the Complainant had until the 14 December 2017 to change the policy.

I am conscious of the Provider's obligations in relation to *Provision 4.1* of the Code, which states:

> *"A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information."*

The Complainant has stated in her submissions that:

> "*I am outraged at the manner that* [the Provider] *advised or more accurately did not transparently advise the amendments made to the policy".*

The Provider has stated in its submissions that there is an option for the documentation to be posted to the Complainant, but the Complainant's chosen method of contact at the time was by email. The Provider submits that the method of contact is now changed on the policy since then, as the Complainant requested. Furthermore the Provider stated that the "*Renewal Flyer*" also advised the Complainant of the changes in benefits under the policy and since the preliminary Decision was issued in this matter, it has pointed to the specific terms published in the Renewal Flyer, entitled " "**Renewal Check -Up**" which specified on the cover page that

> ***"The following rule changes took place since you last received your rules booklet"***.

The Provider has pointed to the specific information made available at page 3 of the Renewal Flyer, which prior to listing 12 different Provider plans/levels of cover, advised:

> ***Benefit Changes***
> ***Cover for [Named Hospital] and [Named Clinic], except for specialist cardiac procedures and specified orthopaedic procedures, is no longer available on the following schemes:***

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I am satisfied that this renewal flyer made clear the changes which had been made, and specifically placed policyholders on notice that the purpose of the flyer was to draw attention to rule changes which had taken place since the policyholder had last received his/her rules booklet.

In reviewing the documentation available, I note that the Provider wrote to the Complainant's representative following his 'phone call, in order to address the complaint. This was submitted to the FSPO by the Complainant as the Final Response Letter, and although I am conscious that it is difficult to locate a date on this letter, nevertheless, I note that the Provider advised, amongst other things, as follows:-

> *"On 20 October 2017 we advised your daughter by email that her renewal pack was available on her Member Area. This change was noted on the renewal flyer located in her renewal pack, a copy of which I am including…."*

I have also considered the terms and conditions in the Policy Booklet, page 16 of which states that:

> "*We may change any of the terms of your membership of your schemes each year on your renewal date."*

I accept that the Provider was entitled to change or increase the premium calculated for the policy period, even if the elements of cover were varied and potentially reduced. Likewise, the Provider is also entitled to change the terms of the policy offered each year, upon the renewal date. In doing so, the Provider has an obligation to ensure that its policyholders are clearly notified of significant changes, such as the one which has been raised by the Complainant. In my opinion, the Provider met its obligation to make these policy variations clear, by specifying very precise information in the policy renewal document issued. I do not accept that the Provider placed this information in an obscure place, and I take the view that if the Complainant had read the renewal documentation, her attention would have been drawn to the changes in question, which the Provider had taken care to make clear in the information it issued to its policyholders.

In my opinion, the Provider, in addressing the complaint, acted very reasonably in offering to backdate the Complainant's renewal to the **1 December 2017**, when the Complainant was not happy with the way the changes had been communicated. I note that this solution was proposed, to allow the Complainant to avoid any upgrade rule on her policy, as long as the difference in subscription was paid. I also note that the Complainant, in my opinion prudently, accepted that offer and paid the premium differential in order to be covered by the hospitals in question, without having to serve any waiting periods.

Accordingly, I am satisfied that the provider has no case to answer to the Complainant and for the reasons outlined, this complaint is not upheld.

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Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

3 November 2020

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

(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.