An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0483
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to advise on key product/service features 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 Complainants' health insurance policy held with the Provider.

The Complainants' Case

The Complainants submit that the First Complainant held a health insurance policy with a third party financial service provider, and the renewal date of this policy was **1 January 2017**. The Complainants submit that this policy also covered their son.

The Complainants submit that they sought to consolidate their health cover, and took out an insurance policy on **1 March 2017**, covering themselves and their son, with the Respondent Provider, to which this complaint is being made. The Complainants submit that the First Complainant cancelled her policy with the third party financial service provider in **March 2017**, and was advised by that provider that the annual Government levy for her and her son had been paid by it. However, the Provider also charged the cost of the Government levy within its premium charged for the Complainants' policy.

The Complainants state that "*As [the First Complainant's] premia were deducted from salary, the pro rata amount of the Government Levy had to be repaid to [the third party financial service provider], €430.71. [The Provider has] also charged a Government levy in respect of [the First Complainant] and [the Complainants' son]".* The Complainants submit that the Revenue Commissioners guidelines advise that there is only one Government levy

per person per year payable, and that the third party financial service provider has already paid this levy for the First Complainant and their son for the same year. The Complainants state that "*We have to repay [the third party financial service provider]. The Government [has] the levy. We have paid it to [the third party financial service provider]. [The Provider has] also charged us for a Levy. Therefore the Government will have two [levies] in respect of [the First Complainant] and [the Complainants' son] and we will be out of pocket for €430.71*".

The Complainants state that they "*would like [the Provider] to deduct the amount of Government Levy already paid to the Government, [i.e.] €430.71 from premium payments in order that we are not paying the same levy twice*".

The Provider's Case

The Provider submits that the First Complainant, and the Complainants' son held a policy with a third party financial service provider, and the renewal date of this was **1 January 2017**. The Provider submits that the Complainants made a decision to consolidate the family's health cover and add the First Complainant and the Complainants' son to the Second Complainant's policy held with it. The Provider submits that the Second Complainant's renewal date with it was **1 March 2017**. The Provider submits that in order to avoid a lapse in cover, the First Complainant maintained cover with the third party financial service provider until **1 March 2017**, at which point she cancelled the policy. The Provider submits that the First Complainant's cancellation with the previous insurer resulted in a mid-term cancellation charge, which is standard across the industry where a contract is ended prematurely. The Provider states that "*This charge included the repayment of €430 in respect of the outstanding amount on the health insurance levy. Upon joining [the Provider] [the First Complainant] received a document outlining all charges related to the new policy. This breakdown included a Government Levy*".

The Provider states that it is not in a position to waive the Government levy on the Complainants' policy. The Provider states that "*This government levy and the mid-term cancellation charge are both noted in the terms and conditions of your policy, which are located in your membership handbook. As this is in the terms and conditions of your policy we will not be issuing a refund in this case*".

The Complaint for Adjudication

The complaint is that the Provider incorrectly and/or unreasonably charged the Complainants a Government levy on their policy, in circumstances where the levy had already been paid.

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Decision

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

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

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

A Preliminary Decision was issued to the parties on **15 October 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.

On **4 November 2020** a post Preliminary Decision submission was received from the Provider. This submission was exchanged with the Complainants who were afforded an opportunity to comment on the contents. No further submissions were received.

Following the consideration of the additional submission from the Provider dated **4 November 2020**, together with all of the submissions and evidence, my final determination is now set out below.

The issue to be determined is whether the Provider incorrectly and/or unreasonably charged the Complainants a Government levy on their policy, in circumstances where the levy had already been paid.

The Provider submits that the private health insurance system in Ireland is based on four core principles, all of which are necessary in order for the system to operate effectively. The Provider submits that the core principles are open enrolment, community rating, lifetime cover and minimum benefits, and are all set out within the Health Insurance Act 1994, as amended by the Health Insurance (Amendment) Act 2001.

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The Provider states as follows:

> "*Community rating means that with limited exceptions all persons who purchase the same health insurance plan do this at the same price regardless of age, sex or health status. As such no underwriting criteria are applied specifically targeted to any individual and no health data is collected when a person purchases health insurance as this is not necessary to establish price. Community rating in Ireland requires health insurance providers to offer health insurance policies at the same price to all persons without medical underwriting; it is the basis for premium calculation and prohibits insurers from varying rates based on health status or claims history*".

The Provider submits that Section 7 of the Health Insurance Act 1994, as amended, prohibits any variance in the premium charged by an Insurer in respect of the same contract for the same period.

The Provider submits that the Health Insurance Authority operates the collection of this fund, its transfer to the Risk Equalisation Fund and the distribution of credits. The Provider submits that in order for the scheme to be self-financing, the total contributions paid to the fund must equal the total contributions paid out by the fund. The Provider submits:

> "*To achieve this balance payments made out of the fund are ratioed up or down as appropriate to ensure they amount to the total payments made into the fund*".

The Provider further submits:

> "*Due to the operation of these formulae it is impossible to accurately calculate the pre-equalisation claims cost of a member at the beginning of a contract, at which point the levy is payable. As such the levy listed on renewal documentation is not the true cost of insuring that member under the risk equalisation scheme. Rather the cost listed is the claim cost the insurer would incur if that member has the average market risk profile for their age and gender and not their own personal risk profile. The actual cost of the levy to the business can only be calculated retrospectively at the end of the policy year and taking claim cost into consideration*".

The Provider submits that the community rated health insurance model is supported by a Risk Equalisation Scheme, which operates a process of levies and credits. The Provider submits that Section 125A of the Stamp Duties Consolidation Act 1999 (as amended) provides for a levy on health insurers in respect of health insurance contracts.

The Provider states:

> "*These levies are pooled in a risk equalisation fund which is managed by the Health Insurance Authority and used to issue credits back to the insurers in the market, proportionate to the number of high risk members they cover. A company with a worse than average risk profile (and therefore higher claims*

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costs) will be a net beneficiary from the scheme while a company with a greater proportion of younger and healthier members will be a net contributor to the scheme, but will benefit from having much lower claims costs".

On **4 November 2020**, the Provider wrote to this office and I note that it states, among other things, the following:

"*…As previously stated, the Risk Equalisation Scheme operated within the health insurance industry is funded by the imposition of a levy on the insurer which is collected by way of a stamp duty pursuant to Section 125A of the Stamp Duties Consolidation Act 1999. The legislation is clear in that the levy is not a liability of the member….*"

I accept that the Provider must operate in line with the core principles of the Health Insurance Act 1994, as amended by the Health Insurance (Amendment) Act 2001, including but not limited to open enrolment, community rating, lifetime cover and minimum benefits. However, I note that the Provider must also adhere to Revenue Guidelines in relation to the levy.

The Provider submits that Revenue Guidelines specify that only one levy is payable per year per person, to avoid the payment of duplicate levies, should a person move from one insurer to another within the same year, as the First Complainant and the Complainants' son did. The Provider submits that despite this, the guidelines do not allow for refunds to be issued where the levy has been paid by the first insurer.

The Provider states:

"*If the Revenue were to allow for such refunds this process would be in direct contravention of Section 7 of the Health Insurance Act 1994, as amended, which prohibits any member from paying a different price than another member for the same plan over the same period. The only exception to this is a maximum 10% group discount*".

Revenue Guidelines

The Provider has referred to Revenue Guidelines published online with guidance for health insurance providers in relation to the Government levy:

"Stamp Duties Consolidation Act 1999
(as amended by subsequent Acts up to and including the Finance (No. 2) Act 2013)

Notes for Guidance
…
Section 125A Levy on authorised insurers

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Summary

This section provides for the collection of a levy on health insurance companies based on the number of persons covered by policies underwritten by them.
…
(10) *Where a person during an accounting period switches from one authorised insurer to another and the first authorised insurer is required to include insured persons on that insurers' statement for that accounting period, the second authorised insurer may exclude those insured persons who are required to be included on the first insurer's statement from the statement required to be delivered by the second authorised insurer for the same accounting period. The Revenue Commissioners have issued guidelines to ensure that only one levy is paid in any 12-month period for each insured person regardless of the number of health insurance contracts that person has entered into in the 12-month period…*" [emphasis added].

I note from the guidelines, set out by the Revenue Commissioners as highlighted above, that in circumstances where a previous insurer has paid the levy during a 12 month period in respect to an insured person, the Provider, "*may exclude those insured persons who are required to be included on the first insurer's statement from the statement required to be delivered by the second authorised insurer [the Provider in this case] for the same accounting period"*. The Provider has noted within its correspondence to the Complainant dated **5 March 2018**, that it is aware of the Revenue Commissioners' guidelines, in this regard.

In my Preliminary Decision dated **15 October 2020**, I included direct quotes from the First Complainant's previous insurer, in respect of the levy. The previous insurer had informed the First Complainant within a letter dated **26 April 2017**, that it had paid the Government levy for that accounting period. The Provider noted in its letter to this office dated **4 November 2020** that following its review of the Preliminary Decision, it does "*not see the relevance of an alternative provider's wording within the context of this decision*" and that it "*would like to reiterate that this is a levy on the insurance company and not on the member, and we do not agree with the interpretation implied by this correspondence which did not come from [the Provider]*". Following the consideration of the Provider's position in that regard, I have removed the direct quotes from the previous insurer from the Legally Binding Decision.

However, it remains the case, and is not disputed by the Provider, that the previous insurer had already paid a levy to the Revenue Commissioners for the period **1 January 2017** to **31 December 2017.** In this regard, I note that the Complainants have submitted a copy of a letter from the previous health insurance company to the First Complainant, dated **26 April 2017**. I note that the previous insurer stated within this letter that the First Complainant's and the Complainants' son's previous policy had renewed on **1 January 2017** and that it would form a 12 month contract period. I also note that the previous insurer had informed the First Complainant within this letter that it paid a levy in respect of that insurance policy contract that was due to end on **31 December 2017**. Therefore, as the previous insurer had already paid a levy to the Revenue Commissioners for the period **1 January 2017** to **31**

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December 2017, it would appear from the Revenue Guidelines that the Revenue Commissioners would not be seeking this levy again, in respect of the Complainants, for the same period from the Provider.

During the investigation of the complaint, the Provider furnished this office with call recordings in relation to the subject matter of the complaint. I have considered the content of these calls.

I note that on a telephone call dated **1 February 2017**, the Second Complainant called the Provider to inform it that he wished to add his wife and son to the policy from **1 March 2017**. During the course of the telephone correspondence, the Second Complainant informed the Provider's representative that the First Complainant's insurance policy with the previous insurer was *"up at the end of December*". The Provider's representative asked him if she "*is still with [the previous insurer]?"* and the Second Complainant replied "*she is still with [the previous insurer] yeah*". The Provider's representative asked him "*Is your son with [the previous insurer] as well..?"* and the Second Complainant responded "*he is, yeah*". During this call the Provider's representative stated that the First Complainant and their son will "*be brought up on your policy on **1 March** OK*" and that "*They'll be active from **1 March 2017***". The Second Complainant informed the Provider's representative's that "*They'll remain with [the previous insurer] until then*".

I note that during a telephone call dated **7 March 2017**, the First Complainant informed the Provider's representative that "*[the Second Complainant] took out a policy there recently, the cover starts on the **first of March** for himself, myself and our son. Now myself and [the Complainants' son] had previously been covered with [a third party insurer] through my work scheme and so when I went to cancel it, the renewal date was the **first January**, when I went to cancel it they said I'd have to pay them €490, being the Government levy that they've already paid in respect of me and [their son] to the Government".*

On **14 March 2017,** the First Complainant telephoned the Provider again. During this call, the First Complainant advised the representative that she had called the Provider the previous week to discuss this matter and she stated that "*…I rang in last week and nobody got back to me and someone needs to get back to me before 12 o'clock today, our 14 day cooling off period expires today and I'm waiting a call-back from the specialist team… I need a call-back urgently, I'm waiting over a week for a call-back…*" During this call the First Complainant queried the levies on the policy premium and queried "*[does the Provider] just carry on and pay double levies all the time…?"* The Provider's representative responded by stating that "*no, no of course, it does come up quite a lot, em…there [are] a few queries on it, regarding that we'll say your old insurer would have paid the levy and now that we are paying it as well, but it's part of the premiums, they are all 12 month premiums that we quote people and they always have the Government levy applied to them, so we don't actually…<u>we wouldn't take into account the fact that the Government levy had been paid for a member with another insurer if they had moved over mid-term…</u> you know what I mean, it's just something that isn't in place at the moment for actually arranging something different, as an alternative…*"… "*It's not something that is looking to be changed right now…*" [emphasis added].

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I note that the '*Health Insurance Levy Section 125A of the Stamp Duties Consolidation Act 1999 (as amended by Finance Act 2013) Guidelines for Insurers in relation to particular situations'* states the following:

> *"The principle underpinning the guidelines is that one levy is paid in any 12-month period for each insured person regardless of the number of health insurance contracts that person has entered into in the 12-month period. Thus in making a levy return to the Collector General, insurers may exclude from that return any person for which a levy has already been paid in the 12-month period in question in respect of a contract that has commenced on or after 1 January 2013.*
>
> *A 12-month period is not necessarily a calendar year. A particular 12-month period commences when an insured person enters into or renews an insurance contract. So, for example, where a contract commences or is renewed on 1 January the 12-month period is the calendar year. However, where a contract commences or is renewed on (say) 1 July, the 12 month period is 1 July to the following 30 June."*

The Guidelines for Insurers further sets out the following example scenario:

Example Number	***Situation***	***Revenue Treatment***
…	*…*	*…*
2.	*Are there a maximum number of contracts a member can enter during a 12-month period for the levy? For example person joins the first insurer on 1 January 2013, leaves and joins a second insurer on 1 March 2013, leaves the second insurer and re-joins the first insurer on 30 March 2013 on a new policy? How many times is the levy payable?*	*One levy is paid per person in a 12-month period.* *It is up to any subsequent insurer to ensure that satisfactory evidence is obtained from the insured person to show that the levy was paid by the first insurer in respect of the 12-month period in question.*
…	*…*	*…*

I note from the Revenue Commissioner's guidelines, that it is up to the subsequent insurer, the Provider in this instance, to ensure that satisfactory evidence is obtained from the insured persons, which will show that the levy was paid by the first insurer in respect of the 12-month period in question, so that it is not required to pay the levy again in respect of the First Complainant's (and the Complainants' son's) policy. On **18 October 2019**, this Office sent an email correspondence to the Provider to query if it had made any attempt to exclude the First Complainant and the Complainants' son from the statement required to be delivered by it to the Revenue Commissioners for the same accounting period, and if not, why not. The Provider responded to this Office on **4 December 2019** stating that "*the*

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*First Complainant and their son were not excluded from the [Provider's] Levy return and a duplicate levy was paid by [the Provider] in **May 2017**. This will be rectified in **February 2020** in [the Provider's] next levy submission".* The Provider stated in its correspondence of the same date that the reason why the levy in respect of the contract for the First Complainant and her son was not excluded from its statement required to be delivered to the Revenue Commissioners was due its "*failure to capture the relevant details on [its] system*".

It is apparent from the above submissions that since **early March 2017**, the Provider was aware that the First Complainant's (and her son's) previous health insurer would most likely have paid the levy in respect of their health insurance contract for the accounting period commencing on **1 January 2017** and which was due to end on **31 December 2017**. Furthermore, it appears that, upon commencement of the policy on **1 March 2017,** the Provider had failed to take any action to obtain satisfactory evidence from the Complainants to show that the levy had been paid by the first insurer in respect of the First Complainant and their son for the accounting period in question and it appears that a duplicate levy was collected by the Provider.

It is clear that the Provider was aware of this matter since **2017**. Furthermore, according to the Provider's representative's comment noted above, this matter "*does come up quite a lot...there [are] a few queries on it*". I find it unreasonable that the Provider nevertheless failed to take any action to rectify the situation generally but most particularly in the context of this complaint in so far as it collected a second levy from the First Complainant and her son.

I also consider it unacceptable that the Provider only acknowledged this failure, when the question was put directly to it by this Office as part of the adjudication process in late **2019**.

I note that the Provider, when setting its premium price and allowing for risk equalisation, must act in accordance with the Consumer Protection Code 2012, the Health Insurance Acts, including in Section 7 of the Health Insurance Acts 1994-2016, and the Revenue Commissioners Guidelines as set out above.

The Complainants submit that "*the price of Health Insurance as specified under Section 7 of the Health Insurance Act is NETT of the levy*".

I note that the Health Insurance Authority website states the following:

> *"…*
> ***Community Rating:***
> *Section 7 of the Health Insurance Act 1994 (as implemented by Section 5 of the 2001 Act and Section 2 of the Health Insurance (Amendment Act 2014) prohibits non community rated health insurance contracts. This means that insurers must charge all consumers, with certain limited exceptions, the same net premium for a given level of cover regardless of age, sex and other risk factors*
> *…*

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Section 2(1) of the Health Insurance (Amendment) Act 2013 Act makes it clear that community rating applies to the gross premium less any risk equalisation credits and excludes any tax relief
…"

I note that Section 7 of the Health Insurance Act 1994 includes the following:

"7.—(1) (a) Subject to subsection (3), the premium payable under any health insurance contract effected by a particular registered undertaking shall be the same as that payable under every other such contract (after due allowance has been made in respect of the payment of any premium by instalments) that—
(i) is effected by that undertaking,
(ii) is in respect of the same period as that to which the first-mentioned contract relates,
(iii) relates to the same health services or ancillary health services as those to which the first-mentioned contract relates, and
(iv) provides for the same payments by the undertaking in respect of those services as those provided for by the first-mentioned contract.
(b) A registered undertaking shall not effect a health insurance contract that contravenes paragraph (a).
(c) A health insurance contract that complies with paragraph (a) shall be known as a community rated health insurance contract and "community rating" shall be construed accordingly.

(2) Without prejudice to the generality of subsection (1), premiums payable under health insurance contracts shall not be varied by reference to—
(a) the age, sex or sexual orientation or the suffering or prospective suffering of a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind,
(b) the frequency of the provision of health services or ancillary health services to a person, or
(c) the amounts of payments or the number of different payments to which a person becomes entitled under such a contract.
…"

I note that Section 17 of the Health Insurance Act 1994, which relates to the levy on registered undertakings states the following:

17.—(1) In this section "assessable amount", in relation to a quarter, means the gross amount received by a registered undertaking by way of premiums in that quarter in respect of health insurance business of the undertaking in the State on or after the establishment day but excluding any amount so received in the course or by way of reinsurance.

(2) A registered undertaking shall, within 30 days from the end of the quarter following the establishment day and within 30 days from the end of each quarter

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thereafter, deliver to the Authority a statement in writing showing the assessable amount for that undertaking in respect of that quarter.

(3) There shall be charged on every statement delivered in pursuance of subsection (2) a levy of an amount equal to such percentage of the assessable amount shown therein as may be prescribed having regard to the costs and expenses referred to in subsection (4).

(4) The levy charged under subsection (3) on a statement delivered in pursuance of subsection (2) shall be paid by the undertaking concerned to the Authority upon delivery of the statement and the amount so paid shall be used by the Authority to defray the costs and expenses (but not including payments referred to in section 12 (3) (b) incurred by it in the performance of its functions.

(5) There shall be furnished to the Authority by a registered undertaking such particulars as the Authority may deem necessary in relation to a statement under this section delivered by it to the Authority.
…"

I note that the health insurance renewal issued from the Provider to the Second Complainant dated **1 February 2017** included a breakdown of the full cost of the policy, which sets out the following:

Name	Premium €	Risk Equalisation Premium Credit 1 Less €	Levy 2 Plus €	Gross Premium Equals €	Group Discount 3 Less €	Loadings 4 Plus €	Net Premium Equals €	Your Tax Relief Less €	Amount You Pay Equals €
Total	2,305.89	0.00	940.00	3,245.89	324.60	0.00	2,921.29	468.61	2,452.70
[First Complainant]	1029.35	0.00	403.00	1432.35	143.24	0.00	1289.11	200.00	1089.10
[Complainants' Son]	247.19	0.00	134.00	381.19	38.12	0.00	343.07	68.61	274.50
[Second Complainant]	1029.35	0.00	403.00	1432.35	143.24	0.00	1289.11	200.00	1089.10
…									

1 Only applicable for members aged 65 years and over. These credits are funded by the risk equalisation fund which is shared among health insurers.

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2 An amount payable by [the Provider] to the shared risk equalisation fund for each person we insure. …

I note that the "*Premium Information*" attached to the Provider's letter dated **23 February 2017** to the Second Complainant, sets out the following:

	Premium	€5952.00
Less	Risk Equalisation Premium Credit	€0.00
plus	Government levy	€940.00
equals	Gross Premium	€6,892.00
Less	Gross Discount	€689.21
plus	Lifetime Community Rating Loadings	€0.00
equals	**Net Premium**	**€6,202.79**
Less	Your Tax Relief	€500.00
equals	Annual Amount You Pay	€5,702.90

The above premium information highlights that the Provider has included the Government levy within the net price of the Complainants' premium. The Provider submits that it is not in a position to waive the Government levy in question, on the Complainants' policy and it states that "*This government levy and the mid-term cancellation charge are both noted in the terms and conditions of your policy, which are located in your membership handbook. As this is in the terms and conditions of your policy we will not be issuing a refund in this case*".

I note that "*Government Levy*" is defined in the "*Definitions*" section of the Membership Handbook as follows:

> *"A stamp duty which health insurers must pay to the Revenue Commissioners on each health insurance **plan** sold. The **government levy** is paid into a central fund and is redistributed by the government to maintain a health insurance system where a person's age or health does not determine the level of premium they pay. The **government levy** is included in **your** premium for each of the **plans** listed in **your policy**. Where **your** premiums are being paid monthly, **we** disburse the cost of the **government levy** evenly across **your** payments. Details of the amount of the **government levy** are set out in **your** membership certificate."*

I note that Provision 4.1 of the Consumer Protection Code (CPC) 2012 provides that:

> *"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*

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*brought to the attention of the **consumer**. The method of presentation must not disguise, diminish or obscure important information."*

I note from the above extract from the policy booklet, that the Provider has stated within its definition of the Government levy that the Government levy is "*A stamp duty which health insurers must pay to the Revenue Commissioners on each health insurance plan sold*" as it is required to do under the Consumer Protection Code 2012.

Within my Preliminary Decision dated **15 October 2020** I indicated my disappointment that the Provider does not include in its definition of *"Government Levy"* within its policy document, that only one levy is to be paid to the Revenue Commissioners "*for each insured person, in any 12-month period, regardless of the number of health insurance contracts that person has incepted within that 12 month period.".*

In its **4 November 2020** submission the Provider states among other things the following:

"

…

While the premium breakdown in our materials does mention the levy, we do not feel this or any wording within our documentation would have created the impression that this levy was directly chargeable to the Complainant. The wording under this table also confirms that the levy is, 'An amount payable by [the Provider] to the shared risk equalisation fund for each person we insure.'… "

The Provider further noted within its submission dated **4 November 2020** that it does not see any benefit to its customer in noting *'that only one levy is payable to the Revenue Commissioner'* and it submits that this information *"would have no impact on those insured as this is a levy on the insurer, not the insured as referenced above".*

Nevertheless, notwithstanding the Provider's requirement to inform its customer on what the levy is and why is it being collected in respect of an insured member, I believe that the information set out in the Revenue Guidelines that only one levy is to be paid to the Revenue Commissioners "*for each insured person, in any 12-month period, regardless of the number of health insurance contracts that person has incepted within that 12 month period."* would afford further clarity to the Provider's customers. I remain of the view that this information would be beneficial as it would inform the Provider's customers of the circumstances in which it may exclude those insured persons from its statement to be delivered to the Revenue Commissioners.

The setting of premiums generally is a matter that falls within the commercial discretion of the Provider. I will not interfere with that discretion unless it is exercised in a manner that was contrary to law or is unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainants.

The Provider is required to set the premium in line with the relevant legislation, including the Health Insurance Act, Revenue Guidelines and the CPC 2012. I note that the previous

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insurer confirmed in it correspondence to the First Complainant dated **26 April 2017** that it had paid a government levy in respect of the insurance contract that was due to end on **31 December 2017**. Therefore, notwithstanding the Provider's requirement to charge all of its policyholders the same net premium price for the same health plan, I do not accept that it followed the guidelines set out by the Revenue Commissioners to ensure that only one levy is paid in any 12-month period for each insured person (the First Complainant and her son in this instance) regardless of the number of health insurance contracts that person (the First Complainant and her son) has entered into in the 12-month period.

I note the Provider's submission referenced above that the "*the mid-term cancellation charge"* is *"noted in the terms and conditions of your policy".* However, the Provider has stated in its response to the complaint, dated **5 March 2018**, that "*This policy is currently active*" therefore, I contend that this section of the policy is not relevant in this instance.

The Provider also submits that "*there is no mechanism to allow for a reduction or refund of this levy from the total premium payable. Any such refund or reduction would violate Section 7 of the Health Insurance Act 1994, as amended*" and "*If the Revenue were to allow for such refunds this process would be in direct contravention of Section 7 of the Health Insurance Act 1994, as amended, which prohibits any member from paying a different price than another member for the same plan over the same period*." The Provider submits that this is supported by an email which it received from a member of staff at the Health Insurance Authority which it submits emphasised that without strict adherence to Section 7 of the Health Insurance Act 1994, as amended, the community rating system would not be possible. I note that the email from the staff member of the Health Insurance Authority notes the following:

> *"The levy is paid by the insurer in respect of its number of insured lives. It is not a levy that is charged to insured persons or payable by insured persons or payable by the insurer on behalf of insured persons. The Revenue Guidelines specify that only one levy is payable per year. The Health insurance Authority has no role in the operation of this legislation.*
>
> *Section 7 of the Health Insurance Acts 1994-2016 specify that the same net premium is charged by an Insurer in respect of the same period for a particular contract except for discounts for children young adults and members of group schemes. This is known as community rating.*
> …
>
> *My understanding of the circumstances of the case as outlined in your email are as follows:*
> - *A woman (and her child) chose to take out a one year health insurance contract with [a different health insurance Provider]. [The third party provider] paid a levy to the Revenue Commissioners. The woman sought to cancel the one year contract during its term. [The third party provider] allowed the mid-term cancellation subject to a cancellation fee of €430. The woman accepted the offer and cancelled the contract.*

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- *The woman and her child were added to her husband's health insurance policy with [the Provider]. The premium rates charged complied with community rating rules and were the same as for other lives buying that product at that time. [The Provider] did not pay stamp duty in respect of the woman or her child as they availed of the Revenue Guidelines that only one levy was payable per year per customer*

...

An insurer has freedom in how it sets its prices and in particular how it allows for risk equalisation. However its actions must comply with the Health Insurance Acts and with Central Bank of Ireland Consumer Protection Code. It must in particular comply with the community rating rules as set out in Section 7 of the Health Insurance Acts 1994-2016"

I note from the Provider's submission above that the staff member of the Health Insurance Authority noted in its response, that the Provider *"did not pay stamp duty in respect of the woman or her child as they availed of the Revenue Guidelines that only one levy was payable per year per customer".* However, the Provider stated within its correspondence to this Office dated **4 December 2019**, that *"The First Complainant and their son were not excluded from the [Provider's] levy return and a duplicate levy was paid by [the Provider] in **May 2017**".* Therefore, it is evident that the Provider did not adhere to the Revenue Guidelines that only one levy was payable per year per insured person. Therefore, although the email correspondence above does set out the purpose of the levy and it provides an outline of Section 7 of the Health Insurance Acts 1994-2016, I note that the staff member of the Health Insurance Authority's understanding to the circumstances of the matter does not, in fact, reflect the reality of what occurred in this instance and the circumstances as outlined in the correspondence are not in accordance with what has been stated by the Provider in its response to this office dated **4 December 2019**. In any event, it is not entirely clear what information was furnished to the Authority in seeking this response.

The Provider states:

"It is understandable that the complainant believed a second levy was paid on her behalf given that €537 was shown on her documentation under "Government Levy". CPC requires that this be listed but as explained in the HIA's guide to risk equalisation the cost shown is illusory as it is not possible to calculate the net figure that will be paid for each contract until the end of the renewal year. The anticipated ratio of levies and credits is factored into the pricing of all policies at portfolio level and is not the case that [the Provider was] left with a net gain of €537 as a result of the levy having been already paid for this member. <u>In accordance with the Revenue guidelines levies are not paid in duplicate for members</u> and the risk equalisation mechanisms, as explained in the HIA's guide… ensure that insurers do not benefit financially when a levy has already been paid for a member. Rather the system aims to balance the levies paid and credits received among all insurers at the end of the year". [emphasis added]

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I note that the Provider had stated above that *"…In accordance with the Revenue guidelines levies are not paid in duplicate for members…"* I accept that the Provider is aware that the Revenue Guidelines specify that only one levy is payable per year, per insured person. However, I do not accept that it complied with the Revenue Guidelines in relation to this complaint, in so far as it appears that the Provider collected a duplicate levy for the same accounting period in respect of the First Complainant and her son.

The Provider states:

> "*Ultimately there are three key pieces of legislation underpinning this case, firstly the Revenue Guidelines stating that only one levy per person is payable, secondly, the Health Insurance Act which prohibits any variance in the price from one member to another and thirdly the CPC, which obliges each insurer to itemise all charges included in a premium. Unfortunately these regulations do not operate harmoniously together and impose conflicting responsibilities on health insurance undertakings*".

The Provider goes on to state the following:

> "*Given that the complainant held previous insurance cover the levy due for her was paid by this first insurer and [the Provider] was not liable to pay a second levy for this member. Despite this, there is no mechanism to allow for a reduction or refund of this levy from the total premium payable. Any such refund or reduction would violate Section 7 of the Health Insurance Act 1994, as amended*".

Within its submission dated **4 November 2020** the Provider stated, among other things, the following:

> *"…Aside from the requirements set out by Revenue, [the Provider is] also bound by Section 7 of the Health Insurance Acts which state that all persons must pay the same price for the same plan. We are not permitted to adjust premiums for any customer other than a limited discount of 10% in certain cases. The regulations make no allowance for a refund of premium where a Government Levy has already been paid by another insurer…"*

I do not agree with the Provider that these requirements do not operate harmoniously, at least as they apply to the conduct of the Provider in this complaint.

I am satisfied that the *"principle underpinning the guidelines… that one levy is paid in any 12-month period for each insured person regardless of the number of health insurance contracts that person has entered into in the 12-month period*" is very clear. The onus is on the Provider to ensure that it complies with each of these regulatory requirements, as they have been set out. It is a matter for the Provider to establish and manage its procedures for charging its premiums in a manner that accords with the regulatory requirements.

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The Provider has stated that as part of its review of the complaint, it noted shortfalls in its customer service in respect of the handling of the Complainants' complaint. This included that it supplied the First Complainant with inaccurate information regarding the Government levy during a telephone call on the **7 March 2017** *as "we told her that the levy was applied per policy as opposed to (correctly) per person".* The Provider also stated that when the First Complainant wasn't satisfied with the response that she received in relation to the levy charge to the policy, she requested a call-back from a supervisor, which did not occur. The Provider has acknowledged that there were lapses in its customer service in regards to the handling of the complaint, as the First Complainant had to contact it, to get the Final Response letter reissued to her home address. Though the complaint in question did not hinge on the Provider's failure to provide appropriate customer service, it has stated in its email correspondence to this office, dated **31 October 2019**, that the overall service which it provided to the Complainants did not meet the expected standards. As a result of these findings, the Provider offered the Complainants a customer service payment of €750 in an attempt to resolve the complaint and stated that "…*this payment would be in recognition of the service issues and would in no way be in respect of the non-payment of levy amounts to the [Complainants], which we believe was correct and in line with legal requirements*". The Complainants did not accept this goodwill payment as a full and final settlement of the complaint.

I welcome the Provider's acceptance of its failure to proffer an acceptable level of customer service as noted above and its *"goodwill*" offer in respect of that matter. I will therefore, not comment on the Provider's shortcomings in this regard. The key matter for me to determine relates to the Provider's conduct with regard to the Government levy in respect to the First Complainant and her son.

The Complainants as customers of the Provider have a right to expect that the Provider is correctly administering the levy to the Revenue Commissioners in respect of their contract with it. The Provider states that it is the insurer which pays the levy, which I accept and I also contend that the Revenue Commissioners guidelines set out that only one levy is paid in any 12-month period for each insured person regardless of the number of health insurance contracts that person has entered into in the 12-month period. However, notwithstanding that this is a levy on the Provider based on the number of persons covered by policies underwritten by it, it is clear from the evidence set out above that the ultimate source for the monetary amount of the levy in respect of the insurance contract in question, came from the Complainants, by way of inclusion in the premium charged.

It is apparent from the telephone conversation between the First Complainant and the Provider on **14 March 2017** that the Provider was aware of this matter during which time it stated that it*"…wouldn't take into account the fact that the Government levy had been paid for a member with another insurer if they had moved over mid-term…"* and that *"it's just something that isn't in place at the moment for actually arranging something different, as an alternative*…" and that "*It's not something that is looking to be changed right now…*". It is disappointing that the Provider did not take the necessary steps to ensure that the First Complainant and her son were not charged a duplicate levy in this instance.

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Notwithstanding the Provider's requirement to charge all of its policyholders the same premium price, I am satisfied that the conduct of the Provider in charging the Complainants the Government levy on their policy for the same accounting period in which the levy had already been paid, was unreasonable and wrong.

Given the potential impact of the Provider's conduct in circumstances where a consumer switches from a different insurer to the Provider during an accounting period, I propose to bring this matter to the attention of the Central Bank of Ireland for any action it deems necessary when I issue my Legally Binding Decision.

For the reasons outlined in this Decision, I partially uphold this complaint and direct the Provider to pay a sum of €2,750 (two thousand, seven hundred and fifty euro) to the Complainants. For the avoidance of doubt, this includes any offer made or already paid to the Complainants.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that that this complaint is partially upheld pursuant to ***Section 60(1) (b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, on the grounds prescribed in ***Section 60(2) (b) and (c) 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 Complainants in the sum of €2,750 (two thousand, seven hundred and fifty euro) to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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

22 December 2020

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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.**