An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0284
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Fees & charges applied
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a private health insurance policy.

The Complainant's Case

The Complainant says that the refund of premium paid to him by the Provider, arising from restrictions in access to private hospitals as a result of Covid-19, is not what was directed by the Minister for Health. The Complainant states that he received a refund of 21.37%. The Complainant submits:

> *"The Minister for Health has negotiated with the private health insurance providers to give customers 50%* [of] *their premiums back for the next three months".*

The complaint is that the Provider failed to issue the Complainant with a refund of 50% of his premium for 3 months. He says that this was "*as intended by the Minister of Health."*

The Complainant says that he pays the Provider more than €600 per month and in his calculation 3 months equals more than €1,800 which he expected to receive from the Provider. The refund of premium which he received however, was significantly less than the figure of €912, which he had calculated.

When making his complaint, he advised the Provider that it was:

> "*making a massive amount from the Government under very unpleasant conditions but you cannot resist trying to make more*!.
>
> *I note that* [different health insurance provider] *actually quote an average refund of 50%.*
>
> *… The hospitals and doctors are not busy as reported on most news broadcasts…* [the Provider] *had better improve the deal or I will go to the press and Simon Harris and tell how much you are really refunding members*!"

The Provider's Case

The Provider, in its letter dated **28 April 2020**, states that:

> *"The re-organisation of hospitals impacts all our members and as such, we made a decision that rather than link the benefit payment to premium, we will redirect claim cost savings in the form of a benefit payment to our almost 600,000 members."*

and:

> *"As well as the benefit payment, we are extending your essential healthcare benefits, giving you unrestricted access to healthcare from the safety of home and providing 1:1 video consultations with our GPs, Physios and Health & Wellbeing experts."*

The Provider says that the amount of money redistributed by the Provider was based on an estimate of claims costs that were saved during the period 30/03/20 to 30/06/20. No private claims were received during this period and it was this estimate, based on historical data, as well as intimate knowledge of the previous claims history of private hospitals, that was redistributed to its members.

The original objectives of the scheme were to give an immediate and speedy response to all of the Provider's customers. With that in mind, the Provider was the first insurer to deliver claims savings back to its members. This was done, as a benefit, rather than any other mechanism. The Provider paid out a set amount across the board. This made it clean cut and easy to communicate to its members and it also allowed the Provider to act, which at that time, it understood its customers needed, by way of a swift response from their insurer. The Provider says that it set a precedent for the industry. The Provider believes that if a comparison was made with all healthcare providers across the board, its benefit payment would come to a significant proportion of members' monthly premium.

The Provider makes clear that the benefit payment made to members was not a premium refund, nor was it required to be one. It points out that there was no regulation or requirement to issue a premium refund to members. Additionally, the Provider formally notified the Health Insurance Authority which was satisfied with the Provider's decision to redirect claims costs savings.

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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 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 **29 July 2021**, 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. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

In support of his complaint as made initially directly to the Provider, the Complainant quoted an article from an Irish daily newspaper published on **16 April 2020,** which printed the following:

> *Simon Harris has struck a cashback deal with health insurers.*
>
> *The Minister for Health has negotiated with the private health insurance providers to give customers 50% off their premiums back for the next three months.*
>
> *The massive consumer refunds deal comes after the Government's move to effectively take over the running of private hospitals during the coronavirus emergency.*
>
> *This means that the insurers who normally bankroll the private health sector in Ireland through payments to the private hospitals are now flush with funds.*
>
> *Mr Harris announced that he has secured 50% rebates for customers for the summer months because of this.*

The Provider states that it did not offer its customers 'refunds' (which it states it was *"not in a position to provide"*) but rather it provided each customer with a cash payment 'benefit'.

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In this regard, I note that the Provider asserts that *"there was no regulation or requirement to issue a premium refund to members*". Rather, it states that the benefit paid out to each customer was not linked to the precise premium paid by each customer but rather it was a set amount paid out in the exact same amount to each adult customer (and child customers received a smaller amount). The Provider maintains that this amount was calculated by reference to the savings achieved by the Provider in the relevant period, in circumstances where it was required to make no payments to private hospitals as no private claims were received during this period owing to the State's takeover of the private hospitals. The Provider submits as follows:

> *As access to private hospitals was effectively closed to all* [the Provider's] *members for three months, we considered it the fairest solution to compensate our members equally for this disruption to services.*

The Provider further states that the Health Insurance Authority "*fully supported each insurer putting different measures in place at their own discretion".*

I note that the Complainant seeks to rely on a suggested agreement reached between the Minister for Health and various insurers. The Provider submits that the quotation from the article accurately reproduced by the Complainant was however factually incorrect. In that context, the Provider has supplied a full copy of the press release from the Department of Health on 16 April 2020 which included the following details:-

> "*Minister for Health Simon Harris TD has today welcomed confirmation by health insurance companies to offer customers a rebate during the COVID-19 pandemic… following this engagement, private health insurers have been assessing how the pandemic will impact their claims costs and have been considering what financial supports can be put in place for their members in response to COVID-19. Three health insurers in Ireland have today (Thursday 16 April) announced a range of financial measures and supports being introduced to support their customers during the COVID-19 crisis."*

The Provider highlights that the part of the article, that directly quotes the Minister is in the following terms:-

> *"I welcome the measures announced by each of the insurers today, which are focused towards assisting health insurance customers impacted by the Covid-19 national response.*
>
> *The measures announced are being taken in recognition of the temporary changed landscape in which health insurers currently operate.*
>
> *I am pleased that insurers are exercising forbearance and providing appropriate assistance to their customers during this most challenging time."*

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The Provider disputes that it ever agreed or committed to giving *"customers 50% of their premiums back"* whether for the summer months or otherwise, as suggested in the article quoted by the Complainant. Rather, the Provider maintains that it retained a discretion as to how it would go about "*providing appropriate assistance"* which it is satisfied that it has made available to all its policyholders.

I am not satisfied on the evidence available that the Complainant has established that the Provider has breached any agreement or a regulatory obligation. Neither am I satisfied that the Provider has treated him unfairly or unjustly or unreasonably within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

On the contrary, I am satisfied that the Provider acted reasonably in the manner in which it issued payments to each of its customers. Whereas the Complainant may well consider that it would have been more equitable to link the payments to the amount of premium being paid by individual customers, I am satisfied that the Provider retained a discretion in terms of how it proposed to assist its customers. I don't accept that the manner in which the Provider opted to deal with the matter, was unreasonable, unfair or improper.

In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or conduct coming within the terms of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** that could ground a finding in favour of the Complainant, I do not consider it appropriate to uphold the complaint.

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

23 August 2021

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.

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