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Re: Thematic Review on Consumer Treatment when Purchasing or Renewing Health Insurance

Dear Head of Compliance,

The protection of consumers in a changing operating environment has been a key priority for the Central Bank of Ireland ('the Central Bank') for a number of years. We set out in our most recent[1] and in previous 'Regulatory and Supervisory Outlook Reports' firms' responsibility to navigate changes in a manner that places the best interests of consumers at the heart of their commercial decision-making. Recognising the impact of rising costs on consumers, including consumers of health insurance[2], the Central Bank previously issued a Dear CEO letter to set out our expectations for how all regulated firms should support consumers in the face of cost-of-living challenges. In addition, there remains a significant number of different plans available in the health insurance market, offering a wide range of benefits, making it difficult for consumers to compare the market.[3] All of this increases the likelihood that consumers will look to engage directly with their health insurance provider in order to obtain assistance and advice for a number of reasons, including:

- To ensure that they remain on the most suitable plan.
- To seek to reduce their level of premium.
- To ensure they are obtaining the maximum level of benefits for the premium being paid.

With the above in mind, the Central Bank has conducted a Thematic Review on 'Consumer Treatment when Purchasing or Renewing Health Insurance' ('the Review'). The main objective of the Review was to assess the approach taken by health insurance providers to encourage contact and to assist and advise consumers who do make contact to discuss their existing policy and/or the options available to them.

[1] https://www.centralbank.ie/publication/regulatory---supervisory-outlook-report
[2] As per the HIA's Market Report 2024, the average change in the price of individual plans was an increase of 12.2%.
[3] As per the HIA's Market Report 2024, at the end of 2024, there were 338 active inpatient plans.

Methodology

The Review was conducted as a desk based review, with a detailed information request seeking both qualitative and quantitative information issued to the in-scope firms. Additional meetings and system 'walk throughs' were also arranged, where considered necessary. The Review focused on six key areas, these were:

1) A review of calls between consumers and Customer Support Agents ('Agents') - The call listening exercise formed the main part of the Review. Its purpose was to assess and understand the level of assistance and advice provided to consumers who made contact with their health insurance provider. This entailed listening to a sample of 150 call recordings in total across the in-scope firms.

2) A review of renewal notice templates - This was an assessment of how consumers are engaged with through their renewal notices (i.e. the correspondence sent to them in advance of their renewal date), with the focus being whether consumers are being encouraged to make contact with their health insurance provider to discuss their plan prior to its renewal.

3) A review of health insurance provider websites - This was an assessment of the level of information and tools available to consumers, from a 'self-service' perspective, for those who may wish to conduct their own review of the options available to them instead of making direct contact with their health insurance provider, or in addition to making contact.

4) A review of processes, procedures and systems used (in particular, the comparison tools available to Agents) - This was an assessment of the approach that the in-scope firms have developed for how they engage with consumers who make contact to discuss their options. This included a review of the tools available for Agents to use during their conversations with consumers to identify other suitable plans for that consumer in real time.

5) A review of customer support functions from an operational perspective - This was a high-level assessment of the overall operation of each in-scope firm's customer support function.

6) An analysis of the book of business - This was an analysis of specific quantitative data gathered, to assess whether there are any trends that the Central Bank should to be aware of in its ongoing supervision of the in-scope firms and the health insurance sector as a whole.

Feedback to Industry

Over the course of the Review, the Central Bank identified a number of positive consumer-focused practices. However, there were also certain weaknesses and gaps identified. The Review highlights that health insurance providers need to take additional steps to ensure that consumers are provided with an appropriate level of assistance and advice, effective information and customer service that supports them throughout the customer journey. Details of the Central Bank's observations, expectations and required actions are set out at Appendix 1.

In all circumstances, we expect health insurance providers to be proactive in assessing the risks to consumers associated with their products and services, and in protecting their consumers' best interests by ensuring they are fully and effectively informed of their options, and of the supports available. As per the 'Guidance on Securing Customers' Interests'[4], we want health insurance providers to challenge themselves to ensure that they are not, consciously or unconsciously, taking advantage of consumers' inertia or any other habit or bias or taking advantage of any information asymmetry that may exist in the health insurance market. This is particularly important in the current economic environment where consumers continue to face cost-of-living challenges.

Follow-up Actions

All in-scope firms are required to complete a gap analysis, identifying any gaps and weaknesses that exist in comparison to the expectations, findings and positive/inadequate practices as set out in Appendix 1, and put a plan in place to address these gaps and weaknesses, where applicable. These plans must be presented to the Board for approval. Following approval from the Board, firms are required to submit these plans to the Central Bank and to implement the changes in line with the Board approved plan.

The Central Bank's expectations must also be considered in the context of any outsourcing arrangements that the firm has in place and should be shared with any other entity (including any other regulated entity) that distributes health insurance products exclusively on behalf of the firm. Please note that feedback provided in this letter and associated correspondence will be considered during future supervisory activities.

[4] The Central Bank's 'Guidance on Securing Customers' Interests' was published in March 2025. It sets out our expectations of firms in meeting their obligations under the Standards for Business to secure customers' interests.

Should you have any queries in relation to the contents of this letter, please contact the team at healthsupervisoryteam@centralbank.ie.

Yours sincerely

Mark Rowe
Head of the Domestic Non-Life and Health Function
Insurance Supervision

Appendix One

The expectations set out below are not an exhaustive list of issues, or risks, relating to how consumers are treated by their health insurance provider. However, these are the issues that we consider the highest priority of those identified during the Review. Health insurance providers should at all times be evaluating its own risks and deciding on how they are best managed or mitigated.

1. **The Central Bank expects that consumers will always be offered a full suitability assessment to identify the most suitable plan for them when they make contact to discuss their existing plan (including price) and/or the options available to them at renewal.**

Based on the call listening exercise, we identified that consumers were more likely to switch plans when a full suitability assessment (sometimes referred to during calls as a full review of cover) was undertaken. However, we found that health insurance providers did not always offer such an assessment in the first instance, if at all. We found some health insurance providers were less likely to offer a full suitability assessment than others, and we identified an inconsistent approach within health insurance providers where some consumers were offered a full suitability assessment early in a call, while others may not have been until later in a call, or not at all.

Where consumers were not offered a full suitability assessment at the early stages of a call, it tended to be offered only after the health insurance provider had talked through the benefits of the consumer's existing plan and/or recommended the next most similar plan (this was generally a plan with the same core in-patient benefits but with different additional features such as a higher excess, greater co-payments, or less day-to-day benefits).

In the context of consumers being offered a full suitability assessment and, more generally, on how consumers were engaged with during the calls we reviewed, the Central Bank identified a number of positive and inadequate practices, as set out below.

Positive practices:

- What we consider best practice, were the conversations where we observed consumers being offered a full suitability assessment early in a call. In these instances, we observed health insurance providers undertaking a sufficiently detailed fact find to gather appropriate information to ensure that they fully understood the consumer's current needs and

objectives with regards to health insurance, so that they could recommend what they identified as being the most suitable plan(s). The differences between consumers existing plan and the recommended plan(s) were then clearly explained to the consumer. In these situations, we observed that consumers were informed effectively and were more confident to switch plans during the call, whether it was to a plan that provided an adequate level of cover at a price they were more comfortable with, or to a more expensive plan where the consumer was satisfied that the additional benefits were worth the additional premium.

- During the full suitability assessment, the health insurance providers seek information from consumers in respect of their preferred levels of cover (e.g. preferred level of in-patient cover, preferred level of cardiac care, preferred level of day-to-day cover, level of excess etc.). In some instances, we observed consumers being given clear explanations in respect of how their stated preferences are likely to impact the premium of the recommended plan (i.e. differing levels of cover are likely to result in different levels of premium). When this was clearly explained to consumers, it allowed them to make a more informed decision in respect of their preferred levels of cover and the benefits that were of the most importance to them.
- Overall, health insurance providers were observed to provide clear explanations of the differences between a consumer's existing plans and the level of cover provided by any potential new plan e.g. the different benefits, the applicable excesses etc. In addition, the health insurance providers were also observed to be very clear in their explanation of the relevance and potential impact of waiting periods where a consumer is considering switching plans.

Inadequate practices:

- Where consumers gave a specific reason for making contact, the health insurance provider did not proactively broaden the scope of the call and did not offer a full review of cover. The two most common examples of this were when the consumer advised that they:
    - Wanted to know if there was a plan available with the same level of cover, but at a lower price. In this situation, the consumer was generally told that to reduce their premium they would need to switch plans and 'downgrade' their cover, with the benefits of their existing plan being highlighted at this point. Generally, there was no offer of a full suitability assessment.
    - Wanted to compare their existing plan with one or more specific 'self-identified' plan(s). In this situation, the health insurance provider generally only compared the consumer's existing plan to the 'self-identified' plan(s) and then advised on whether

this specific plan(s) was potentially suitable. Generally, there was no offer of a full suitability assessment.

- On a number of calls, consumers were asked to confirm that there has been no material changes since the last renewal. However, this approach is narrow in its focus and may only be relevant where the consumer actively engaged with the renewal process the previous year. If the consumer has not actively engaged at renewal for a number of years and had either allowed their policy to auto-renew, or just paid the premium in full, without considering the suitability of the plan that they are on, it may be the case that a material change occurred prior to the last renewal which may need to be considered during the current interaction.
- There was a sense that the role of the Agents who engage with consumers is seen as being a sales/retention role, as opposed to a service/assistance role. While we understand that health insurance providers will want to retain their existing consumers, our concern is that by not always offering a full suitability assessment at the outset of a call the opportunity to explore whether another more suitable plan may be available is not being utilised (whether suitability is on the basis of level of cover, affordability or both).

Expectation and Actions:

The Central Bank expects that consumers will always be offered a full suitability assessment, at the outset of a call/interaction, when they make contact to discuss their existing plan (including price) and/or the options available to them at renewal. This will ensure that consumers are fully informed of their options and the service available to them. The full suitability assessment should consider the full range of plans available from the health insurance provider, including all corporate plans, and ensure that the most suitable plan(s) is recommended.

Health insurance providers are to undertake a full review of their current approach and to update all relevant processes, procedures etc. to ensure that consumers are offered the option of a full suitability assessment, at the outset of a call/interaction, when they make contact to discuss their existing policy and/or the options available to them at renewal. This also includes, but is not limited to, updating all call scripts (where relevant) and providing appropriate training to any new and existing Agents to ensure that the above expectation is fully embedded. In addition, health insurance providers are expected to assess whether a full suitability assessment is being proactively offered to consumers when undertaking their own quality assurance monitoring of calls/interactions with consumers.

Health insurance providers should fully review and consider the appropriateness and the rationale for the data that it tracks internally and the MI that it reports (e.g. is there a defined business need for the tracking and reporting of 'downgrades/downtrades' and is this information being used accordingly?), as well as the messaging it coveys to its Agents during training and on a day-to-day basis (e.g. is there an over emphasis on sales/retention, with less focus on customer service/assistance?). Health insurance providers must ensure that they do not consciously, or unconsciously, create an environment/culture where assisting consumers to switch plans, where appropriate, is considered a negative outcome.

Health insurance providers must also ensure that all of the positive practices set out above are fully adopted. All of the inadequate practices should be stopped, or have appropriate controls put in place to ensure that any potential risk of consumer detriment is mitigated.

2. The Central Bank expects that health insurance providers will have appropriate systems and tools in place when engaging with consumers.

We observed that health insurance providers utilise a number of systems and tools when engaging with consumers. Of particular importance are the systems and tools used when recording the information gathered during the fact-find and how this information is used to recommend the most suitable plan(s) to consumers, especially when considering the large number of different health insurance plans available from the health insurance providers.[5]

In this regard, we were encouraged to see that most of the health insurance providers had developed systems and tools to be used by their Agents for recording the information gathered from consumers during the fact find and for automatically generating recommendations of the most suitable plan(s). Agents could then discuss the plan(s) with the consumer, explaining the various benefits and differences between the plans so that the consumer is in a position to make an informed decision. However, linking back to our previous expectation (above), these systems and tools were only used when the call progressed to a full suitability assessment. Where health insurance providers had not developed the systems and tools described above, there was a reliance on Agent knowledge of the full range of plans available.

[5] Under Provision 5.17 of the Code, regulated entities must offer either the most suitable product, or the most suitable selection of product options, to a consumer.

Expectation and Actions:

The Central Bank expects that health insurance providers will regularly review and assess the appropriateness of the systems and tools that they utilise when engaging with consumers, with upgrades and enhancements made, when needed. In particular, it is expected that health insurance providers will develop/maintain appropriate systems and tools for gathering information during the fact-find and for identifying the most suitable plan(s) to recommend to consumers.

In addition to the above, health insurance providers must ensure that the use of the relevant tools and systems are fully embedded and that, when undertaking a full suitability assessment, the appropriate systems and tools are used by Agents in all instances. This is something that should be monitored and assessed on an ongoing basis (e.g. when undertaking quality assurance monitoring of calls/interactions with consumers). This is of increased importance due to the large number of different health insurance plans available.

3. **The Central Bank expects that health insurance providers will utilise its communications with consumers to encourage them to make contact to discuss their existing policy and/or the options available to them at renewal.**

The review of the renewal notice templates did not raise any concerns in respect of compliance with the relevant legislative and regulatory requirements, namely:

- To include the specified 'important information' notice in a prominent place, encouraging consumers to make contact to discuss their plan, in particular where there has been a material change to their circumstances - as required by the Central Bank following the completion of the thematic review on the 'Renewal of Health Insurance Process' in 2016, with the wording of the 'important notice' updated in 2022. However, we did note that one health insurance provider continued to include the older version of the notice on some of its letter templates.
- To issue renewal notices at least 20 working days prior to the expiration of the current policy - as required under Regulation 5(1) of the Non-Life Insurance (Provision of Information) Regulations 2007.
- For renewal notices to include details of premiums paid by the consumer to the insurer in the preceding 5 years – as required under Section 12 of the Consumer Insurance Contracts Act 2019.

In addition, it was positive to observe, during the call listening exercise there were no instances identified of a consumer indicating that they had not received their renewal notice on time, or that their previous premium was not disclosed (a general observation was that consumers seemed to be aware of their premium for the previous year).

However, we were disappointed to find that one health insurance provider had stopped including its contact telephone number on its renewal notices. Having to search for the relevant contact number, effectively added an additional and unnecessary step for consumers who wanted to discuss their existing cover and the options available to them. In particular, this had the potential to have a greater negative affect and avoidable inconvenience for vulnerable consumers, for those who prefer to receive their correspondence by post, and for those who are not regular users of the internet. This matter was immediately raised with the relevant health insurance provider and has already been rectified.

Expectation and Actions:

The Central Bank expects that health insurance providers will utilise their communications with consumers to encourage them to make contact to discuss their existing policy and/or the options available to them at renewal. In this regard, health insurance providers are expected to:

- Ensure that they include the current and most recently agreed version of the 'important information' notice in all of their renewal notice templates.
- Ensure that all relevant contact details are included in a prominent place on their renewal notice templates, in particular the relevant contact phone number(s) that consumers may need to use.
- Ensure that, whenever renewal notice templates are being updated or reviewed, full consideration is given as to whether there are any additional meaningful prompts that can be included to encourage consumers to make contact to discuss their existing policy and/or the options available to them at renewal.

4. **The Central Bank expects that health insurance providers will have in place (and maintain/upgrade/enhance, as appropriate) websites that include fact-find and plan comparison tools, to allow consumers to undertake their own assessment of cover, should they wish to do so.**

The Review found that all-in scope firms have online fact-find and plan comparison tools to assist consumers in conducting their own assessment of cover. However, it is noted that there are differences in the functionality of the plan comparison tools available, with some plan comparison tools being more flexible than others. Listed below are the positive practices and approaches identified that we believe would be of benefit to consumers. We expect that all health insurance providers will seek to incorporate these into their plan comparison tools as part of future updates/upgrades, if they are not already doing so.

We consider it best practice where a consumer is:

- Able to complete an appropriately detailed fact-find online, which includes relevant questions to identify their health insurance needs, in order to be recommended the most suitable plan(s).
- Able, when utilising a fact-find tool, to adjust and amend their responses to questions asked in order to generate different results, without having to restart the fact-find process each time.
- Able to select to compare, with the aid of a comparison tool, their existing plan with any of the other plans offered by their current health insurance provider.
- Able to select to compare, with the aid of a comparison tool, any plan of their choosing from a health insurance provider with any of the other plans offered by same health insurance provider.
- Provided with clear and meaningful information on how to switch health insurance provider.

Another positive practice we identified was where one health insurance provider's comparison tool allowed consumers looking to switch provider, to compare their existing plan from other health insurance providers with any of the plans offered by the health insurance provider.

One weakness that we did identify was that there was no clear signposting for consumers to seek independent information on health insurance from bodies such as the Health Insurance Authority (HIA) and the Competition and Consumer Protection Commission (CCPC). The Central Bank would consider it best practice, and therefore expects health insurance providers, to include clear and meaningful information and signposting (via a link) to the HIA website and the health insurance section of the CCPC website.

In addition to all of the above, health insurance providers should also give full consideration to the recently published General Guidance on the Consumer Protection Code, in particular the section on digitalisation, which includes guidance on the structuring and layering of information, as well as the filtering of products on websites.

5. **The Central Bank expects that health insurance providers will have in place appropriate monitoring and oversight of the overall customer support function including the individual Agents.**

There were no adverse findings in this aspect of the Review, which was based on a high-level assessment of the overall operation of each in-scope firm's customer support function. Operational Risk and any issues arising will continue to be assessed on a regular basis as part of our ongoing supervision of health insurance providers. It was noted, as part of the Review, that the health insurance providers all have put structures in place to oversee their customer support function, as well as an approach to monitor the Agents within said function.

Expectation and Actions:

The Central Bank expects that health insurance providers will have in place appropriate monitoring and oversight of the overall customer support function and the individual Agents. In this regard, health insurance providers are expected to:

- Ensure that they identify and monitor KPI's that are relevant to their business, and that any issues identified are escalated and acted on, as appropriate.
- Ensure that appropriate and relevant MI is shared at the appropriate levels.
- Ensure that staffing levels are adequate to meet consumer demand in all roles and functions.
- Ensure that, when using variable remuneration, it is done so in accordance with the Central Bank's 'Guidelines on Variable Remuneration Arrangements for Sales Staff'.