Stamp Duties Consolidation Act 1999

Part 9: Section 125A - Levy on authorised insurers

This document should be read in conjunction with
sections 125A, 126B and 126C of the Stamp Duties Consolidation Act 1999.

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Table of Contents

1 Introduction 3
2 Terminology 3
3 Stamp duty levied on delivery of statement 5
3.1 Requirement to deliver statement to Revenue 5
3.2 Charge to stamp duty on delivery of statement 6
3.3 Payment of stamp duty on delivery of statement 6
3.4 Particulars in relation to statement 7
3.5 Relevant contract for period greater than 12 months 7
3.6 Delivery of statement by electronic means 7
3.7 Example 7
4 Requirement to deliver statement where business acquired 8
5 Exceptions from requirement to include insured person on statement 8
6 Compliance provisions 9
6.1 Interest, surcharge and penalties 9
6.2 Revenue assessment 10
7 Amending a statement 10

1 Introduction

Section 125A of the Stamp Duties Consolidation Act (SDCA) 1999 provides for stamp duty to be levied on certain health insurance contracts entered into between health insurers and their customers. The amount of stamp duty levied varies depending on the age of the persons insured under the health insurance contract and the level of cover provided, and is payable by the health insurer to Revenue.

In accordance with section 11D(4) of the Health Insurance Act (HIA) 1994[1], any stamp duty paid by virtue of section 125A is to be paid into the Risk Equalisation Fund. Health insurance legislation[2] makes provision for each insured individual, regardless of age, to pay the same net health insurance premium for the same product (this is referred to as community rating). Insurers receive risk equalisation credits for insuring members of less healthy groups from the Risk Equalisation Fund. The fund was established under section 11D(1) of the HIA 1994 and is operated and managed by the Health Insurance Authority. In practice, the stamp duty paid is transferred by Revenue into the Risk Equalisation Fund on a periodic basis.

Revenue's Large Corporates Division is responsible for administration and compliance in relation to this stamp duty levy.

The purpose of this document is to explain the operation of section 125A.

2 Terminology

Subsection (1) contains a number of definitions, which are key to the operation of the section. Many of these rely on definitions contained in the HIA 1994.

'accounting period' means a period of 3 consecutive months, beginning on 1 January, 1 April, 1 July or 1 October;

'advanced cover' and **'non-advanced cover'**, in relation to a **relevant contract**, have the same meanings as in section 6A of the HIA 1994;

'authorised insurer' means any undertaking (not being a **restricted membership undertaking**) entered in the Register of Health Benefits Undertakings which is lawfully carrying on health insurance in the State, and in particular cases, any undertaking (not being a **restricted membership undertaking**) authorised pursuant to the Third EU Directive on Non-Life Insurance where a policy of health insurance was taken out when the subscriber was not resident in the State but resident in another EU State;

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[1] An administrative consolidation of the HIA 1994 is available at https://revisedacts.lawreform.ie/eli/1994/act/16/revised/en/html#SEC6A.

[2] Health Insurance (Miscellaneous Provisions) Act 2009 and Health Insurance (Amendment Act) 2012.

'due date', in relation to an **accounting period**, means the 21st day of the second next month following the end of that accounting period;

'electronic means' has the same meaning as in section 917EA of the Taxes Consolidation Act (TCA) 1997. Guidance on section 917EA is contained in Revenue's Notes for Guidance on Part 38 TCA 1997[3];

'excluded contract of insurance' means:

- an insurance contract which falls under paragraph (d) of the definition of 'health insurance contract' in section 2(1) of the HIA 1994, or
- an insurance contract relating solely to charges for public hospital in-patient services made under the Health (In Patient Charges) Regulations 1987 (S.I. No. 116 of 1987).

'in-patient indemnity payment' and **'restricted membership undertaking'** take their meanings from section 2(1) of the HIA 1994;

'insured person', relation to a **relevant contract**, means:

- an individual,
- the spouse or civil partner of the individual,
- the children or other dependents of the individual, or
- the children or other dependents of the spouse or civil partner of the individual,

in respect of whom the **relevant contract** provides for the reimbursement or discharge, in whole or in part, of actual health expenses within the meaning of section 469 TCA 1997;

'relevant contract' means a contract of insurance (not being an **excluded contract of insurance**) which provides for the making of **in-patient indemnity payments** and for the reimbursement or discharge, in whole or in part, of actual health expenses within the meaning of section 469 TCA 1997;

Finally, the definition of **'specified rate'** sets out the amounts payable under section 125A SDCA 1999, which are provided for annually by amendment of the HIA 1994. These specified rates are set out in the table below:

[3] See https://www.revenue.ie/en/tax-professionals/documents/notes-for-guidance/tca/part38.pdf.

Period	Insured person < 18 years with non-advanced cover	Insured person < 18 years with advanced cover	Insured person ≥ 18 years with non-advanced cover	Insured person ≥ 18 years with advanced cover
On or after 1 April 2024	€35	€146	€109	€438
On or after 1 April 2023 to 31 March 2024	€36	€146	€109	€438
On or after 1 April 2022 to 31 March 2023	€41	€135	€122	€406
1 April 2020 to 31 March 2022	€52	€150	€157	€449
1 April 2018 to 31 March 2020	€59	€148	€177	€444

3 Stamp duty levied on delivery of statement

3.1 Requirement to deliver statement to Revenue

Subsection (2) provides that an **authorised insurer** is required, in respect of each **accounting period,** to deliver to Revenue a statement showing the number of **insured persons**:

- aged less than 18 years on the **first day of the accounting period** insured under a relevant contract which provides for **non-advanced cover**,
- aged less than 18 years on the **first day of the accounting period** insured under a relevant contract which provides for **advanced cover**,
- aged 18 years or over on the **first day of the accounting period** insured under a relevant contract which provides for **non-advanced cover**, and
- aged 18 years or over on the **first day of the accounting period** insured under a relevant contract which provides for **advanced cover**,

in respect of whom a **relevant contract** between the **authorised insurer** and the **insured person** is renewed, or entered into, during the accounting period concerned.

The statement must be delivered **on or before the due date** relating to the accounting period concerned.

3.2 Charge to stamp duty on delivery of statement

Subsection (3) provides for stamp duty to be levied on the statement delivered to Revenue by the **authorised insurer** in respect of each **accounting period**. The amount of stamp duty to be levied is calculated by reference to the number of insured persons in each category set out in the statement multiplied by the **specified rate** as defined in subsection (1) (see above).

In determining the category to which an **insured person** belongs, it is necessary to identify:

(a) the age of the insured person on the first day of the accounting period in which the relevant contract is renewed or entered into, and

(b) the level of cover the relevant contract provided for on the day it is renewed or entered into.

In relation to (b), where a relevant contract is renewed or entered into and the contract is subsequently amended to provide for a change in the level of cover provided, this will have no impact on the amount of stamp duty levied in relation to that contract.

3.3 Payment of stamp duty on delivery of statement

Subsection (4) provides that payment of the stamp duty is to be made to Revenue by the **authorised insurer** on delivery of the statement.

It is important to note that stamp duty will be payable regardless of the age of the insured person, whether or not the insured person is in full-time education and whether or not a premium is paid in relation to the insured person.

In addition, stamp duty will be payable in circumstances where the insured person allows his or her relevant contract to lapse after it has been entered into or renewed. The only exception to this is where a relevant contract is subsequently rendered void and no premium has been paid, no Tax Relief at Source has been claimed, no risk equalisation credit has been paid to the insurer from the Risk Equalisation Fund and no benefit has been received by the insured person under the relevant contract.

3.4 Particulars in relation to statement

Subsection (5) provides that Revenue may request particulars from an authorised insurer where deemed necessary, in relation to the statement.

3.5 Relevant contract for period greater than 12 months

Subsection (12) makes provision for the situation in which an **insured person** enters into a **relevant contract** for a period greater than 12 months. In such situations, the relevant contract will be deemed to be renewed on the 12-month anniversary of the date the relevant contract was taken out.

3.6 Delivery of statement by electronic means

Subsection (13) provides that any statement that is due to be delivered under subsection (2) is to be submitted by electronic means. Accordingly, statements are to be filed and stamp duty paid through the Revenue Online Service (ROS). This subsection was introduced by Finance Act 2022 and applies for the **accounting period** commencing on 1 January 2023 and each subsequent accounting period. Prior to this, statements were to be delivered to Revenue in writing.

3.7 Example

An example to illustrate the operation of the above provisions is set out below.

Example 1: Family of four takes out joint policy which provides for advanced cover

Tom, aged 54, takes out a family health insurance policy on 20 January 2024 for himself, his partner Sarah, aged 51, and their two children James aged 18 and Niamh, aged 16. James turned 18 on 19 January 2024, one day before the policy was taken out by Tom. The policy provides for advanced cover for each of the insured persons.

The authorised insurer will be required to include Tom and his family members on the statement to be delivered under subsection (2). Even though James was 18 when the relevant contract was taken out, the specified rate is the rate that matches the age James was on the first day of the accounting period, i.e. on 1 January 2024, which was 17 years old.

Therefore, the stamp duty that will be levied on the statement of the authorised insurer in relation to the health insurance contract Tom has taken out for his family will be as follows:

Tom = €438
Sarah = €438
James = €146
Niamh = €146

4 Requirement to deliver statement where business acquired

Subsection (7) provides for the situation in which an authorised insurer ceases to carry on a business under which it would be required to deliver a statement under **subsection (2)**, because another person (the **successor)** has acquired the whole, or substantially the whole, of the business. The legislation does not define what "substantially the whole" means, however, Revenue will accept that this refers to more than 50% of the business.

Where this occurs during an accounting period and the first authorised insurer was required but has not delivered a statement in relation to the insured persons, then the successor is required to include the relevant details on a statement and deliver it to Revenue instead.

There are two situations in which this may apply:

1. The successor is an authorised insurer and has an existing obligation to deliver a statement to Revenue under subsection (2).

2. The successor has become an authorised insurer for the first time following the acquisition of the business of the first-mentioned authorised insurer.

In the first situation above, the successor is required to include any details which the first-mentioned insurer would have included on the relevant statement, together with the details in relation to their own business (i.e. the details of the two businesses will be merged on the one statement).

In the second situation above, the successor will be required to deliver the statement as if it were the first-mentioned authorised insurer.

5 Exceptions from requirement to include insured person on statement

Subsection (10) provides for the situation in which an insured person renews or enters into a relevant contract with an authorised insurer and, in the **same accounting period,** changes insurer by entering into a new relevant contract with a second authorised insurer**.** The subsection provides that if the insured person can show to the satisfaction of the second authorised insurer that the first authorised insurer was (or is) required to include that person on the statement to be delivered to Revenue under subsection (2) in respect of the accounting period, then the second authorised insurer should exclude the insured person from the statement

that it is required to deliver to Revenue under subsection (2) in respect of the accounting period.

Similarly, **subsection (11)** provides for a situation in which an insured person is removed from one relevant contract because he or she enters into a relevant contract in his or her own right. The subsection provides that if the insured person can show to the satisfaction of the second authorised insurer that the first authorised insurer was (or is) required to include that person on the statement to be delivered to Revenue under subsection (2) in respect of the accounting period, then the second authorised insurer should exclude the insured person from the statement that it is obliged to deliver to Revenue under subsection (2) in respect of the accounting period. An example to illustrate the operation of this provision is set out below.

Example 2: James takes out a policy in his own name in the same accounting period

Following on from Example 1, James decides he does not want to be on the family policy and would like to take out a policy in his own name.

James enters into a relevant contract (policy of health insurance) in his own name on 20 March 2024. Under subsection (11), if James can show to the satisfaction of the second insurer that the first insurer was (or is) required to include him on the statement to be delivered to Revenue under subsection (2) in respect of the accounting period 1 January to 31 March 2024, then the second insurer should exclude James from the statement it must deliver to Revenue for that accounting period.

Where an authorised insurer excludes an insured person from a statement in accordance with either of these provisions, it should retain appropriate records in support of same. These records may be requested by Revenue in the event that a Revenue compliance intervention is commenced in relation to the statement concerned.

6 Compliance provisions

6.1 Interest, surcharge and penalties

Subsection (6) provides that where an authorised insurer, in respect of an **accounting period**, fails to:

- deliver the required statement by the due date, or
- pay the stamp duty chargeable on the statement upon delivery of that statement,

then **interest** shall be calculated in accordance with **section 159D SDCA 1999** from the due date of the statement until the date on which the stamp duty is paid.

Subsection (9) provides that any stamp duty and interest payable under section 125A will not be allowed as a deduction for the purposes of the computation of any tax or duty payable by the authorised insurer which is under the care and management of Revenue.

Section 126C SDCA 1999 provides for a surcharge to be applied for the late filing of a statement. Guidance on the application of section 126C is included in Stamp Duty Manual Part 9: Levies (page 8).

Section 134A SDCA 1999 provides for a **penalty** of €1,265, and a further tax-geared penalty, to be applied where a person acts deliberately or carelessly in relation to the filing of a stamp duty return, which includes a statement that is required to be delivered under section 125A. For further information on the application of section 134A, see Stamp Duty Manual Part 10: Enforcement.

6.2 Revenue assessment

Section 126B SDCA 1999 permits Revenue to make an assessment on a "relevant person", in this case an authorised insurer, where it appears to Revenue that the authorised insurer:

- has failed to deliver a statement under any provision of Part 9 SDCA 1999, or
- has not delivered a full and proper statement under any provision of Part 9.

The assessment will be of the amount which, to the best of Revenue's judgment, is the amount of stamp duty which would have been charged on the statement if it had been delivered and if it were full and proper.

An authorised insurer may appeal an assessment made under section 126B to the Tax Appeals Commission in accordance with section 949I TCA 1997, within the period of 30 days after the date of the notice of the assessment.

No appeal may be made against an assessment until the insurer has paid the stamp duty in conformity with the assessment (including any surcharge applicable in accordance with section 126C) and delivered the statement to Revenue as required under section 125A.

7 Amending a statement

In certain circumstances, an **authorised insurer** may need to amend the statement that has been delivered to Revenue under **subsection (2)** in relation to a particular **accounting period.**

For example, corrections for reinstated policies where the original stamp duty paid was refunded to the policy holder and where there is late notification of a policy holder's death.

Where a statement is amended, interest, a surcharge and penalties (see Compliance provisions above) may apply, as well as any additional stamp duty that is payable.

However, in accordance with *Revenue's Code of Practice for Compliance Interventions* (section 2.2)[4], a person may avail of self-correction without penalty provided that the following conditions are met:

1. The taxpayer notifies Revenue, within the applicable **12 months** from the due date of the statement (either in writing or through ROS) of the adjustments being made (Note: submitting an amended return on ROS does not constitute notification to Revenue – written notification is required).
2. The taxpayer provides a computation of the correct stamp duty and statutory interest payable.
3. Payment, in full, accompanies the submission.

It is important to note that interest and a surcharge will still be payable in these circumstances, where applicable**.** For further information regarding situations in which self-correction may be availed of, please refer to the *Code of Practice*.

Example 3: Backdated policy

A member joins their Employer's Group Scheme, but the Employer fails to notify the authorised insurer before the due date for that accounting period. Therefore, this member was not on the statement that was delivered to Revenue for the accounting period. The insurer facilitates backdating of the health insurance policy for that member.

For example, the member joined the employer on 1 January 2023, but the employer did not notify the insurer until 5 August 2023. The insurer agrees to backdate the member's policy to 1 January 2023.

In these circumstances, the **authorised insurer** will need to amend the statement it delivered in relation to the accounting period ending 31 March 2023, which was due to be delivered and paid to Revenue by 21 May 2023. Although this will result in the amended statement being delivered after the due date for the relevant **accounting period**, the authorised insurer may be able to self-correct without penalty, provided the conditions stipulated in the *Code of Practice* are met. However, interest and a surcharge may be payable.

[4] https://www.revenue.ie/en/tax-professionals/documents/code-of-practice-revenue-compliance-interventions.pdf