An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0044
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Rejection of claim - waiting periods apply
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant has held health insurance with the Company since **15 March 2012**. He upgraded his cover with the Company to Policy "X" on **1 January 2016**.

The Complainant's Case

The Complainant states that in October 2015 he had a routine blood test with his GP, the results of which showed a higher than normal PSA reading of 5.2. A second test on 7 January 2016 had a similar reading. The Complainant's GP advised at this time *"that this reading was not an indication/diagnosis of anything but as a precautionary follow up recommended I undergo an MRI and/or a Biopsy"*, both of which were carried out in March and April 2016. The Complainant was then advised by his Consultant on 15 April 2016 that he had early stage Prostate Cancer.

The Complainant states that *"based on my age profile, general health and prognosis regarding nerve retention* [his Consultant] *recommended a Robotic Assisted Laparoscopic Surgical Prostatectomy* [abroad] *by a leading Surgeon in this field"*. The Complainant notes that at that time the [Policy X] he held with the Company provided full cover for this procedure, with the *"the cost for Surgery* [abroad]*…€14,700"*. However, the Complainant was notified by the Company by way of correspondence dated 4 May 2016 that *"I was entitled to cover of only €6,441"*. The Complainant underwent this surgery on 24 May 2016.

The Complainant notes that has had continuous health insurance with the Company since March 2012. In February 2015, he upgraded his cover from Policy A, to Policy X. 4 months

later, in June 2015, following redundancy, he *"downgraded my policy to* [Policy A] *from July 2015 (whilst looking for new job)…By November 2015 I sought to upgrade my policy once again and was advised that the earliest I could do so was on the next renewal date, namely 1st January 2016"*. As a result, the Complainant upgraded his cover *"at the first available opportunity"* to the [Policy X] on 1 January 2016.

The Complainant states that his complaint is the *"interpretation of the Prostate Cancer Diagnosis date and consequently whether it is deemed a "New" or "Pre-existing" condition"*. In this regard, he submits, as follows:

> *"My GP…and my Urologist…insist I had Prostate Cancer on the date of diagnosis, namely 15th April 2016. Therefore my* [Policy X] *should apply whereby the full bill* [abroad] *of €14,700 is covered.*
>
> [The Company] *insist I had Prostate Cancer on date of the first high PSA reading, namely October 2015. Therefore, they insist* [Policy A] *should apply whereby only €6,441 is covered"*.

The Complainant submits that *"this is conjecture and I fail to see how such a critical assertion can be based upon this assumption"*. In addition, he states that *"this also has implications in the event that I need further treatment in relation to my Prostate Cancer.* [The Company's] *position is that I will only receive benefit of the lesser* [Policy A] *for a period of 2 Years (until October 2017) arising from any issues relating to my Prostate Cancer diagnosis, as they consider it a Pre-existing condition"*.

As a result, the Complainant seeks for the Company to recognise the date of his prostate cancer diagnosis as the date his Consultant first advised him of it, that is, 15 April 2016, and thus acknowledge that his diagnosis was not relating to a condition that pre-existed the upgrade of his cover on 1 January 2016. Following that, the Complainant then seeks for the Company to assess his claim for the surgery he had carried out on 24 May 2016, and any additional treatment that he may have had since or may require in respect of this diagnosis, under his [Policy X] which he upgraded to on 1 January 2016.

The complaint is that the Company wrongly assessed the Complainant's health insurance claim.

The Provider's Case

Company records indicate that the Complainant has held health insurance with the Company since 15 March 2012. He upgraded his cover with the Company from [Policy A] to [Policy X] on 1 January 2016.

On 18 April 2016, following a diagnosis of prostate cancer on 15 April 2016, the Complainant sought prior approval from the Company for benefit in respect of a laparoscopic prostatectomy that he was due to undergo abroad on 24 May 2016. As part of its assessment of this claim, the Company requested the medical records of the Complainant.

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Following its assessment of these medical records, the Company concluded that the Complainant's condition pre-existed his upgrade in cover on 1 January 2016. In this regard, the Company notes that the Complainant had a rising PSA documented in October 2015 and in January 2016 was referred to the National Rapid Access Prostate Clinic. As a result, the Company submits that *"It can be said with certainty that the diagnosis of prostate cancer made on 15th April 2016 pre-existed the upgrade in cover as* [the Complainant] *already had signs of this cancer back in October 2015 with a raised PSA"*.

The Company defines a pre-existing condition as *"an ailment, illness, or condition, where on the basis of the medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured on the contract"*.

The Company is satisfied that the Complainant's diagnosis was in relation to a pre-existing condition as he had signs, by way of a raised PSA, on 29 October 2015, prior to his upgrade in cover on 1 January 2016. As a result, the Company is satisfied that in accordance with his policy rules the Complainant's claim for the surgery he underwent on 24 May 2016 should be calculated under his previous level of cover, [Policy A] which he held at the time the raised PSA was first noticed on 29 October 2015. As [Policy A] does not provide cover for private hospitals, the average benefit was calculated on public hospital cover, which amounted to €6,641. In this regard, the Complainant had his radical prostatectomy treatment carried out abroad on 24 May 2016 and based on the receipts submitted, this treatment cost €10,892. The Company allowed the maximum benefit for this procedure under [Policy A] of €6,661.

The Company wrote to the Complainant on 4 May 2016 to advise, as follows:

> *"We refer to…your prosed treatment* [abroad]
> *Your case has been reviewed by our panel of medical advisors. We are pleased to confirm following this review that the costs for the proposed treatment, consistent with procedure code 709, will be eligible for inclusion in a claim subject to Rule 6 c (i) of your policy. We note that you were previously insured under* [Policy A] *and upgraded your level of cover* [Policy X] *on the 1st January 2016 with a two year waiting period for pre existing conditions. Therefore, as per rule 3 b) i), we are allowing the maximum benefit payable in respect of the proposed treatment of €6441 that is unless the actual charge is less, in which case the actual charge is the maximum benefit"*.

The Complainant telephoned the Company on 6 May 2016 to appeal this decision. Following a review of the file by its panel of medical advisors, the Company upheld its original decision and advised the Complainant and his Consultant of same by way of correspondence dated 17 May 2016, as follows:

> *"*[The Complainant] *attended for a routine check in October 2015. A PSA result at the time was elevated at 5.29. A repeat PSA was done in January 2016 which was 5.47. In the opinion of our medical advisors a raised PSA in a patient of this member's age is consistent with prostate cancer and would have necessitated the further PSA test*

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in January 2016. While we appreciate that [the Complainant] *did not have a diagnosis of prostate cancer on 1st January 2016 there was biochemical evidence of prostate cancer in the form of a raised PSA. In addition you had a histological diagnosis made on the 29th March which was less than 3 months after you upgraded your insurance cover. Therefore given the pathogenesis of prostate cancer and the raised PSA it is the opinion of our medical advisors that this condition pre-existed the upgrade in cover"*.

Following receipt of further correspondence from the Complainant's GP on 20 May 2016, the file was reviewed by the Company's medical advisors again and the original decision that the condition pre-existed the Complainant's upgrade in cover on 1 January 2016, remained.

Accordingly, the Company is satisfied that it has assessed the Complainant's claim in accordance with the terms and conditions of his policy and has paid the correct benefit due.

Decision

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

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

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

A Preliminary Decision was issued to the parties on 3 May 2018 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, the final determination of this office is set out below.

The Complainant has held health insurance with the Company since 15 March 2012. He upgraded his cover with the Company from [Policy A] to [Policy X] on 1 January 2016.

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In October 2015, the Complainant had a routine blood test with his GP, the results of which showed a higher than normal PSA reading of 5.2. A second test on 7 January 2016 had a similar reading. The Complainant's GP referred him for a MRI and biopsy, following which the Complainant was advised by his Consultant on 15 April 2016 that he had early stage Prostate Cancer. The Complainant underwent a laparoscopic prostatectomy abroad on 24 May 2016, which cost €10,892.

Following an assessment of his medical records, the Company concluded that the Complainant's diagnosis of prostate cancer made on 15 April 2016 was in relation to a condition that pre-existed his upgrade in cover on 1 January 2016 as he already had signs of this cancer in October 2015 when it was recorded that he a raised PSA. As a result, the Company assessed the Complainant's claim in respect of his surgery under the cover he held with the Company in October 2015, that is, [Policy A] and allowed the maximum benefit for the procedure in question, €6,661.

The Complainant's complaint is that as he was not diagnosed with prostate cancer until 15 April 2016, his claim in respect of the laparoscopic prostatectomy that he underwent abroad on 24 May 2016, and any future claims relating to this diagnosis, should be assessed under [Policy X] that he upgraded to on 1 January 2016.

I note from the documentation before me that in his correspondence to the Company dated 11 May 2016, the Complainant's GP states, as follows:

> *"I have been advised by* [the Complainant] *that* [the Company] *has declined to cover the full cost of his procedure* [abroad] *because of a dispute about the date of diagnosis of prostate cancer …*
>
> *Let me state categorically for the purposes of your decision-making that a single raised PSA blood test on a patient with no symptoms (as* [the Complainant] *had in October 2015) is not a diagnosis of anything, and certainly is not a diagnosis of prostate cancer. As general practitioners we are clearly instructed by the HSE and the National Cancer Control Programme* ***NOT*** *to refer anyone to the Rapid Access Prostate Clinic who is asymptomatic and has a single raised PSA test, without repeating the test at least 6 weeks later.*
>
> *Even a raised PSA test subsequently (as* [the Complainant] *had on 7th January 2016) is not a diagnosis of anything, because as your Medical Advisers will be able to tell you, the PSA test on its own is extremely unreliable.*
>
> [The Complainant]*'s prostate cancer was only diagnosed after he had had a biopsy of his prostate gland which revealed cancer cells. The exact date of this* [is 15 April 2016].
>
> *I can categorically state that on 1st January 2016 in my professional opinion,* [the Complainant] *did not at that time have a diagnosis of prostate cancer"*.

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I note that in its correspondence to the Complainant dated 17 May 2016, the Company states, as follows:

> *"Our panel of medical advisors have reviewed your case once again and our position remains as outlined in our letter dated 04th May 2016 …*
>
> *We refer to Rule 3(b)(i) of the* [Company] *Healthcare Rules – Terms and Conditions; "If you change your plan and you or any of the individuals included on the policy receive treatment during the applicable waiting period for a new condition or a medical condition which in the opinion of our Medical Director you already had on the renewal date on which you changed your plan and if the benefit payable for your claim is higher on your new plan, we will only pay the benefits which we would have paid if you had not changed your plan until the applicable waiting period has expired"*.
>
> *In addition "When determining whether a medical condition is pre-existing, it is important to note that what is considered is whether on the basis of medical advice signs or symptoms consistent with the definition of a pre-existing condition existed, rather than the date upon which the customer becomes aware of the condition or the condition is diagnosed.*
> *Whether a medical condition is a pre-existing condition will be determined by the opinion of our Medical Director"*
>
> *You applied to increase your level of cover from* [Policy A] *to* [Policy X] *at your renewal date, 1 January 2016 with a two year waiting period for pre-existing conditions. In the opinion of our medical advisors, the condition for which you were treated was present before you applied to increase your level of cover.*
>
> *Based on the medical information received we note you attended for a routine check-up in October 2015. A PSA result at the time was elevated at 5.29. A repeat PSA was done in January 2016 which was 5.47. In the opinion of our medical advisors a raised PSA in a patient of your age is consistent with prostate cancer and would have necessitated the further PSA test in January 2016. While we appreciate* [your GP]*'s statement that you did not have a diagnosis of prostate cancer on 01st January 2016 there was biochemical evidence of prostate cancer in the form of a raised PSA. In addition you had a histological diagnosis made on the 29th March which was less than 3 months after you upgraded your insurance cover. Therefore given the pathogenesis of prostate cancer and the raised PSA it is in the opinion of our medical advisors that this condition pre-existed the upgrade in cover.*
>
> *Therefore in line with Rule 3(b)(i) your claim will be eligible for benefit under your* [Policy A]*…the maximum benefit payable is €6441"*

Further correspondence from the Complainant's GP to the Company dated 20 May 2016 advises, as follows:

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"You have quoted to me [the Company]*'s pre-existing rule,* "*When determining whether a medical condition is pre-existing, it is important to note that what is considered is whether on the basis of medical advice* ***signs or symptoms consistent with the definition of a pre-existing condition existed****, rather than the date upon which the customer becomes aware of the condition or the condition is diagnosed…" (my emphasis).*

I can categorically state (again) that on 1st January 2016, [the Complainant] *did not have* ***any signs or symptoms of prostate cancer****. What he had was a one-off raised blood test, which is neither a sign nor a symptom), and which, as I have previously explained, is not diagnostic of anything, and certainly not in his age group. Therefore, this is not a pre-existing condition under the definition you have quoted"*.

I note that the Company then wrote to Complainant on 2 June 2016 advising, as follows:

"Our Medical Advisors have completed a review of your case in conjunction with [your GP]*'s letter however at the outset I must advise that we are unable to alter our original decision on this case…Based on the information we have received the onset of this condition would be prior to your upgrade in cover and therefore benefit would be payable in accordance with Rule 3(b)i), at the previous level of cover,* [Policy A] *up to a maximum of €6441.*

It remains the view of our Medical Advisors that while raised PSA may not be a clinical sign, it is a biochemical sig. A raised PSA can be caused by benign prostatic hyperplasia, infection, inflammation of the prostate and it can also be caused by prostate cancer.

A pre-existing condition is defined in our rules as: Pre-existing condition means an ailment, illness, or condition where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured on the contract.

For the purposes of defining a pre-existing condition, [the Company] *would consider abnormal radiology results or abnormal blood tests which are consistent with a medical condition to be a sign. Were this not to be the case, patients could have an abnormal blood test which is consistent and suggestive of a medical condition, join* [the Company] *and serve no pre-existing waiting period for an upgrade in cover. There are many conditions where routine blood tests detect abnormal blood parameters indicating conditions such as haemochromatosis, prostate cancer, anaemia, leukaemia, and renal failure amongst others.*

Many of these conditions will have no symptoms initially. The rule for pre-existing illnesses is essential in a community rated market where the cost of premiums for older people are subsidised by premiums paid by younger people. Obviously the ideal situation for the market is that all members be insured from birth however this is clearly not achievable and in the absence of the rule regarding pre-existing conditions people could adversely select against the community rating system and choose only

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to enrol when they are either already aware they have an illness or when the risks of developing an illness are greater i.e. later in life. The pre-existing rule applies equally to all members regardless of the medical condition including congenital conditions. Once the waiting period has lapsed however the benefit will be provided for the condition thereafter".

Health insurance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

In this regard, I note that the Company's 'Hospital Plans Rules – Terms and Conditions, applicable to new registrations or renewals on/or after 1st January 2016' booklet provides at pg. 3, as follows:

*"**Renewing the policy** …*

b) You can change your plan at your renewal date. If you upgrade your plan (i.e. subscribe for additional benefits), the payment of additional benefits will be subject to the following waiting periods:

[All Pre-existing conditions are listed as subject to a 2 year waiting period in the table]

… Please refer to definition of pre-existing illness in Section 12, Glossary.

When determining whether a medical condition is pre-existing, it is important to note that what is considered is whether on the basis of medical advice signs of symptoms consistent with the definition of a pre-existing conditions existed rather than the date upon which the customer becomes aware of the condition or the condition is diagnosed.

Whether a medical condition is a pre-existing condition will be determined by the opinion of our Medical Director.

i) If you change your plan and you or any of the individuals included on the policy receive treatment during the applicable waiting period for a new condition or a medical condition which in the opinion of our Medical Director you already had on the renewal date on which you changed your plan and if the benefit payable for your claim is higher on your new plan, we will only pay the benefits which we would have paid if you had not changed your plan until the applicable waiting period has expired".

In addition, Section 12, 'Glossary', of the Company's 'Hospital Plans Rules – Terms and Conditions, applicable to new registrations or renewals on/or after 1st January 2016' booklet provides at pg. 21, as follows:

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> *"**Waiting Periods***
> *The following definition apply to waiting periods: …*
>
> > ***Pre-existing Conditions***
> > *Pre-existing condition means an ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the contract"*.

As a result, I am satisfied that it was reasonable for the Company to conclude from the documentary evidence before it, that the Complainant's condition pre-existed the upgrade in his cover on 1 January 2016, given that the diagnosis made on 15 April 2016 was one arrived at as a result of investigations made pursuant to an elevated PSA reading on 29 October 2015. In this way, the diagnosis itself is an explanation for the elevated PSA reading first recorded on 29 October 2016. I am satisfied that the Company's Assistant Medical Officer Decision dated 7 September 2016 sets out this reasoning, as follows:

> *"If the final diagnosis in an individual with a raised PSA is prostatitis then the prostatitis is the underlying cause of the raised PSA. Similarly if the final diagnosis is cancer of the prostate in an individual with a raised PSA then the cancer is the underlying cause of the raised PSA. This requires a biopsy for definitive diagnosis. The situation is analogous to a patient having a breast lump on clinical examination. A breast lump can sometimes be a sign of breast cancer but there are also benign conditions that give rise to breast lumps. A biopsy is required to make a definitive diagnosis. If the biopsy is positive for cancer then the cancer is the underlying cause of the breast lump …*
>
> [The Complainant's] *raised PSA of October was a sign of a problem with the prostate. While we fully appreciate that there are many causes of a raised PSA…in this case the raised PSA led to a biopsy which confirmed the diagnosis of prostate cancer. Prostate cancer is one of the underlying causes of a raised PSA and as this was the final diagnosis in this case, the raised PSA was caused by the prostate cancer"*.

Accordingly, I am satisfied that the Company acted in accordance with the terms and conditions of the Complainant's policy when it assessed the Complainant's claim against the level of cover he held prior to the 1 January 2016, that is, under [Policy A].

Finally, I note that the Company acknowledges that it made an error in its correspondence to the Complainant dated 22 April 2016 when it stated *"We also note that you joined* [the Company] *on 1st February 2015"*. In fact, the Complainant has had continuous cover with the Company since 15 March 2012 but instead had amended his cover with the Company in February 2015. In noting this administrative error, I take the view that it did not adversely affect the Complainant or result in the Company wrongly assessing the Complainant's claim. Accordingly, for the reasons outlined above, I am satisfied that there is no reasonable basis upon which it would be appropriate to uphold this complaint.

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Conclusion

My Decision is that this complaint is rejected, pursuant to ***Section 60(1)*** 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

28 May 2018

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) in accordance with the Data Protection Acts 1988 and 2003.