An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0100
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant and her family had a health insurance policy with the provider, this policy was upgraded in September 2014. After this upgrade a two year waiting period applied for any ailment, illness or condition that existed prior to the upgrade in cover.

The Complainant's daughter underwent surgery in May 2015 in a hospital in Galway. The Complainant subsequently made a claim under the policy for the medical expenses incurred. The Provider refused the claim on the grounds that the medical condition pre-existed the upgrading of cover in September 2014 and the hospital concerned was not covered under the pre September 2014 policy because of the two year waiting period applied.

The Complainant's Case

The Complainant accepts that waiting periods must apply to pre-existing conditions however she states that the condition was not pre-existing in September 2014 and that it only became a relevant recurrent condition in December 2014/ January 2015.

The medical evidence on which the Complainant relies to show that the condition was not a pre-existing condition include the referral letter from Dr. M dated 3 April 2015 which states; "*Recurrent (condition) over the last 3 – 4 months*" and letter dated 11 April 2016 from Dr. M which states;

> *"She had previously suffered from occasional (condition) but in the preceding 6 months the frequency of her infections increased requiring referral for surgery. Most children and young adults will suffer from (condition), it was the increasing frequency of and severity of her infections that required specialist review and (surgery)"*

A further letter from Dr M dated 13 March 2017 states;

> *"in my opinion it was the fact that her episodes became recurrent between January and April 2015 that surgery was necessary, this could not have been predicted during insurance switch over in September 2014"*

By letter dated 12 April 2016 the Complainant states that; *"I made contact with both the consultant surgeon and the [Insurance Company] before undergoing any treatment and checked that all procedure codes were covered under our policy. Had I been made aware that the procedure would not be covered in the hospital in Galway then obviously we would have chosen to go elsewhere…"*

The Provider's Case

The Provider states that the Health Insurance Act 1994 allows for a two year upgrade waiting period when a customer upgrades their cover. It states that the Complainant upgraded on the 1 September 2014 when she moved from a plan that had no cover for the hospital when the procedure was carried out to full cover for a semi private room, subject to excess, in that hospital.

The Provider states that it will only apply an upgrade waiting period to claims made where the claim relates to an ailment, illness or condition that existed before upgrade in cover. The Provider states that its medical advisers will determine when an ailment, illness or condition commenced and their decision is final. The Provider states that the GP's medical records for the insured include an entry dated 9/5/2013 which confirm that the condition was present in 2013. The Providers case is that as the insured had the condition in 2013 the condition was a pre-existing condition and the waiting period applied.

The Provider states that the Complainant was advised, over the phone, that if the condition was a pre-existing condition there would be no cover in the hospital in Galway.

The medical evidence supporting the Provider's claim that this was a pre-existing condition are the GP's medical record dated 9/5/2013 referred to above and the memo from Dr [C], Medical Director, which states that;

> *"(surgery) is recommended for the treatment of (condition) especially when recurrent infections occur. By definition, a repeat infective episode is required for the application of this disease label but the course and timescale of the recurrent episodes must be determined from the first occurrence of the condition. In this case, it is clearly May 2013 and may have been earlier"*

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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 on 28 June 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.

I consider that the issue which has to be resolved in this instance is whether the condition was a pre-existing condition and whether the information given to the Complainant in advance of the procedure was correct or could have misled her in relation to how a pre-existing condition is assessed. The Complainant accepts that the waiting period applies for a pre-existing condition, the Complainant's complaint is that the condition only occurred after the upgrade in 2014 and therefore the waiting period does not apply.

I note that the membership handbook at page 22 states that;

> *"A pre-existing condition is determined from the date the condition commences rather than the date upon which the member becomes aware of the condition. A pre-existing condition may therefore be present before giving rise to any symptoms or being diagnosed by a doctor."*

The membership handbook does not state who decides if a condition is a pre-existing condition. However, I note that the Provider states in submissions to this Office dated 20

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October 2017 that; "*Our medical advisers will determine when an ailment, illness or condition commenced. Their decision is final*." This Complaint was declined because the Provider's medical advisors determined that the condition was not a pre-existing condition. This decision took place without sight of or request for the Consultant's report. This if fundamentally different from what the Complainant was told during a telephone calls with the Provider's agent. The Complainant was led to believe that the Consultant would have the final decision on whether it was a pre-existing condition.

Recordings of the telephone calls between the Provider's agent and the Complainant have been provided in evidence. I note that during the first call the Provider's agent advised the Complainant about the waiting period and that before her upgrade in 2014 she was not covered for the hospital in Galway. In relation to assessing whether or not the condition was a pre-existing condition the Provider's agent advised that if the condition was there prior to 1/9/14 she would not be covered in that hospital. The agent continued by saying that the Complainant "needs to be 100% sure with the consultant" was it a pre-existing condition as they go back and look at the symptoms and how long she has had the symptoms for and if they diagnose her as having the condition before 1/9/14 she would have no cover in hospital x for that condition. The agent reaffirmed that the Complainant needed to check with the consultant in relation to that.

What is clear from this conversation is that the Provider's agent advised the Complainant to check with her Consultant to see if the condition a pre-existing condition. It was reasonable for the Complainant to believe that the procedure would be covered if the Consultant deemed it was not a pre-existing condition.

In the second call the Provider's agent again advised the insured that she would not be covered in the hospital in Galway if it was a pre-existing condition before September 2014. The Provider's agent stated; "*we only go by the consultant's report anyway so if he is going to say that it is a new condition, it was something that only developed after 1st September 2014 you are fine and will be covered…. but if he says it was a condition prior to that you will not be covered in [that] hospital".* The Provider's agent advised the Complainant to speak to the consultant to confirm it was not a pre-existing condition as the Provider would go by what the consultant advised.

It is clear from the telephone conversations that the Complainant was advised to check with the Consultant whether the condition was a pre-existing condition and she was advised that the Provider would accept the Consultant's opinion on this issue. I note that the Complainant was not advised at any time, that the Provider's medical advisers would determine when the condition commenced. I consider that given the advice given to her over the phone by the Provider's agents, in particular the fact that she was repeatedly told to ask her Consultant was it a pre-existing condition, the Complainant was repeatedly wrongly advised by the Provider's agents who should have made it clearer how the claim would be assessed and informed her that it was the Provider's medical advisors and not her Consultant who would determine whether it was a pre-existing condition and that their decision was final, as far as the Provider was concerned.

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Having told the Complainant to ask her Consultant and informing her that the Provider would accept the Consultant's opinion it is unacceptable that the Provider did not seek the Consultant's report nor did they consider the Consultant's opinion, rather they sought GP records and used these as the basis of the decision.

I consider that the information given to the Complainant by the Provider's agent prior to the procedure was not correct and could have misled her and led her to believe that her Consultant would decide if the condition was a pre-existing condition; the Complainant was never advised that the Provider's medical advisers would determine when the condition commenced and that their decision is final.

For the reasons set out above, I uphold the complaint and direct the Provider to admit the Complainant's claim for assessment.

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Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld, on the grounds prescribed in ***Section 60(2) (b).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by admitting the Complainant's claim for assessment.

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

24 July 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) **ensures compliance with the Data Protection Regulation and the *Data Protection Act 2018.***