Decision Ref: 2019-0026

Sector: Insurance

Product / Service: Private Health Insurance

Conduct(s) complained of: Rejection of claim - pre-existing condition

Outcome: Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants, a husband and wife, incepted a health insurance policy with the Provider on **15 November 2015**.

The Complainants' Case

The First Complainant underwent a colonoscopy and a gastroscopy on **2 June 2017**.

The Provider declined the Complainants' ensuing claim on the basis that *"the condition that was treated during the admission was present before* [the First Complainant] *joined* [the Provider] *on the 15th of November 2015 and no benefit is payable for treatment of this condition until the expiry of the pre-existing waiting period on the 15th of March 2020"*.

The Complainants do not consider that the colonoscopy that the First Complainant underwent on 2 June 2017 was for reasons relating to any pre-existing conditions and in her email to this Office dated 3 July 2018, the Second Complainant submits, as follows:

> *"My husband was diagnosed with polyps 5 years ago (precancerous). The colonoscopy showed no polyps this time. If polyps were still there and had to be removed then yes I would agree to paying for the colonoscopy as this would be a pre existing condition …but it was not"*.

In addition, the Complainants do not consider that the gastroscopy that the First Complainant underwent on 2 June 2017 was for reasons relating to any pre-existing conditions but were instead carried out as a result of *"NEW symptoms"* which resulted in new diagnoses.

In this regard, the Second Complainant states, as follows:

> *"My husband was having complaints of nausea, decreased appetite, abdominal bloating and abdominal pain…My husband's doctor and I were concerned about these NEW symptoms and so an endoscopy was ordered…The outcome of the endoscopy was esophagitis gastritis with hiatus hernia. My conclusion is because my husband was on a PPI* [that is, proton-pump inhibitors] *as part of his daily meds (started 15 years previously) and the surgeon prescribed another stronger PPI, he was automatically indicated* [by the Provider] *to have a pre-existing condition! No consideration was given to* [the First Complainant]*'s symptoms"*.

In addition, the Second Complainant states in her email to this Office dated 3 July 2018, as follows:

> *"My husband…never had gastritis or oesophitis diagnosed before. My husband was diagnosed with hiatal hernia and gastric reflux (heartburn) and was on a lot of meds and [the] doctor wanted to protect the lining of his stomach. This is why he was on PPI"*.

Furthermore, the Second Complainant submits *"I also believe endoscopy and colonoscopy are diagnostic procedures and if deemed necessary they are used to diagnose more sinister diagnoses"*. In her email to this Office dated 3 July 2018, the Second Complainant further submits *"If diagnostic procedures are not covered by health insurances then no patient will go to look for assistance until after 5 years and this could prove deadly for people with early stage cancer"*.

The Complainants seek for the Provider to accept the Complainants' claim in respect of the procedures that the First Complainant underwent on 2 June 2017.

The Provider's Case

Provider records indicate that the Complainants, a husband and wife, incepted a health insurance policy with the Provider on 15 November 2015. The Complainants had been resident abroad prior to this and were new to private health insurance in Ireland. The Provider is satisfied that its Agent clearly and fully explained to the Second Complainant during the telephone call of 12 November 2015, the waiting periods and pre-existing conditions rules and the reasons for same, prior to the Complainants incepting their health insurance policy. In addition, the Provider issued the Complainants with the applicable

Health Insurance Rules – Terms and Conditions policy document on 13 November 2015, which also clearly and fully set out the waiting periods and pre-existing condition rules.

The First Complainant underwent a colonoscopy on 2 June 2017, some 19 months after incepting his health insurance cover with the Provider. The Provider notes that prior to the Complainants incepting their health insurance policy with the Provider, the First Complainant had a colonoscopy which diagnosed colonic polyps. It is standard procedure that when a patient has polyps they are removed or treated in some other way and that the patient requires follow-up with a repeat colonoscopy to ensure the polyps have been correctly treated and they have not become cancerous, or returned.

The frequency of follow-up depends on the number and size of the polyps initially diagnosed. For example, low risk polyps require follow-up five years later, intermediate risk polyps three years later and high risk polyps one year later. The Provider provides benefits for follow-up colonoscopies for patients with polyps on this basis.

However, in the First Complainant's case, the initial colonoscopy was performed and the diagnosis of polyps was made prior to him incepting his health insurance policy with the Provider. As a result, the First Complainant would have been aware of this diagnosis and the need for follow-up with a repeat colonoscopy prior to incepting his policy. In this regard, the particular colonoscopy performed on 2 June 2017 was the follow-up colonoscopy and consequently it is further investigation of the condition that was present and diagnosed prior to the First Complainant incepting his policy.

The Provider notes that the First Complainant's GP, Dr X. has confirmed that the reason the First Complainant was referred for colonoscopy was because of polyps. In her correspondence to the Provider dated 6 November 2017, Dr X. confirmed that the reason for the referral for the colonoscopy was *"*[the First Complainant] *told me he had a history of colonic polyps and this requires follow-up colonoscopy every 3 to 5 years"*. On 24 January 2018, the Provider wrote to the First Complainant's consultant, Mr T. who performed the colonoscopy, to see if there was any other reasons for performing it other than follow-up of the previously diagnosed polyps, as follows:

> *"Our Medical Advisors have carried out a review of this case and based on the information received to date it appears that this treatment relates to a pre-existing condition, pre-dating the patient joining* [the Provider] *on 15th November 2015. Therefore any treatment relating to a pre-existing condition would not be eligible for* [Provider] *benefit until after 5 years continuous membership.*
>
> *If you believe that this treatment was provided for a condition that did not pre-date the 15th November 2015 we would appreciate your comments, and we would be grateful if you could detail as to why you believe this is the case"*

As the Provider did not receive any response to this request for information or to the reminders that it sent on 5 March, 3 April and 20 April 2018, it concluded that the reason for performing the colonoscopy was, as advised by the GP who referred the First Complainant, to follow-up previously diagnosed polyps.

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The Complainant had a past history of polyps which were present prior to incepting his health insurance cover with the Provider. The reason for performing the colonoscopy on this occasion was surveillance of these polyps. The fact that no polyps were found does not alter the fact that the colonoscopy itself was performed because the First Complainant had a previous diagnosis of polyps predating the commencement of his cover and thus it is a pre-existing condition, subject to a waiting period of 5 years before benefit is available.

In addition, the First Complainant also underwent a gastroscopy on 2 June 2017. Based on the information received from his GP, Dr X., the First Complainant had a history of acid reflux and had been on treatment for this. Acid reflux is a condition where acid normally present in the stomach moves up into the oesophagus, which connects the mouth with the stomach, and can cause a burning feeling giving the typical heartburn feeling.
It can also cause irritation to the lining of the oesophagus, causing a condition called oesophagitis and can also be associated with symptoms of inflammation of the stomach, a condition called gastritis. Acid reflux is commonly associated with hiatus hernia.

In this case, the First Complainant attended his GP, Dr X. on 9 February 2017 and her Consultation Notes detail *"acid reflux – past history of same – has increased his romep to 20mg BD – refer scopes – last endoscopy 10 years ago"*.

The Provider notes that the initial referral from the GP to the treating hospital ticked *"reflux"* as the reason for referral for the gastroscopy. Despite his being on treatment with a proton pump inhibitor, the First Complainant's symptoms had increased and therefore his GP referred him for a gastroscopy. The Provider notes that this meets the medical necessity criteria for a gastroscopy and is in keeping with the indications for which the Provider provides benefit for a gastroscopy in accordance with its rules.

However, as the First Complainant had a history of acid reflux and was on treatment for this prior to incepting his health insurance policy with the Provider, the condition is a pre-existing condition and any treatment or investigation of this condition is therefore deemed the treatment or investigation of a pre-existing condition. The scope confirmed that the First Complainant had mild reflux and hiatus hernia. Whilst it has not been furnished with copies of his previous gastroscopy reports to confirm whether or not the First Complainant had oesophagitis and gastritis previously, the Provider notes that oesophagitis and gastritis arise from acid reflux and that the First Complainant had acid reflux for which he had been receiving treatment for a considerable period of time, prior to incepting his health insurance policy with the Provider.

In this regard, the Provider notes that the First Complainant's symptoms were present prior to his incepting his health insurance cover with the Provider and were treated. On this occasion, his symptoms had worsened and he required further investigation of his ongoing conditions. The scope was performed for further investigation of this condition and therefore related to the investigation of a pre-existing condition. Whilst the medical necessity to perform the investigation has been met, as it was to investigate a possible deterioration in the First Complainant's known pre-existing condition, nevertheless, because it relates to a pre-existing condition, benefit was not therefore payable until the end of a five year waiting period.

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The Second Complainant telephoned the Provider's Customer Care Centre on 22 May 2017 to advise that her husband, the First Complainant, was to undergo a colonoscopy and gastroscopy. The Agent informed the Second Complainant during this telephone call that all claims are assessed based on the medical information the Provider receives and she was specifically informed that if the proposed treatment arose from a condition that was present prior to the First Complainant incepting his health insurance policy with the Provider, that it would be considered a pre-existing condition. The Second Complainant then requested to speak with a nurse but the Agent correctly advised that a nurse employed with the Provider would not be in a position to determine whether a condition was pre-existing or not without the relevant medical information and that the First Complainant should discuss this with his GP and Consultant, who would have this information to hand. In this regard, the Provider, in the absence of the medical information relating to the claim, cannot guarantee that cover will be available or that a condition will not be deemed to pre-exist the policy inception for a relatively new customer.

The Provider provides benefit for all the procedures listed in the Schedule of Benefits which includes diagnostic procedures, however benefit is only payable in accordance with the policy terms and conditions. These policy terms and conditions specifically exclude benefit for treatment or investigation of pre-existing conditions until the end of a five year waiting period. Therefore it is not that the Provider will not cover diagnostic procedures, but simply in this instance that benefit is not payable for further treatment or investigation of a pre-existing condition. If the condition is not a pre-existing condition then benefit will be allowed for diagnostic and other procedures within the first five years, subject to satisfaction of general medical necessity rules and conditions pf payment/clinical indications, where applicable.

Accordingly, the Provider is satisfied that it declined the Complainants' claim in respect of the cost of the procedures that the First Complainant underwent on 2 June 2017, in accordance with the terms and conditions of the Complainants' health insurance policy.

The Complaint for Adjudication

The Complainants' complaint is that the Provider wrongly or unfairly declined the Complainants' health insurance claim.

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 Complainants were 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.

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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 January 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 complaint at hand is, in essence, that the Provider wrongly or unfairly declined the Complainants' health insurance claim in respect of the procedures that the First Complainant underwent on 2 June 2017. In this regard, I note that the Complainants, a husband and wife, incepted a health insurance policy with the Provider on 15 November 2015.

The First Complainant underwent a colonoscopy and a gastroscopy on 2 June 2017. The Provider declined the Complainants' ensuing claim on the basis that *"the condition that was treated during the admission was present before* [the First Complainant] *joined* [the Provider] *on the 15th of November 2015 and no benefit is payable for treatment of this condition until the expiry of the pre-existing waiting period on the 15th of March 2020* (I note that this date should in fact be 15 November 2020, that is, 5 years after the policy inception date)*"*.

The Complainants do not believe that the colonoscopy that the First Complainant underwent on 2 June 2017 was for reasons relating to any pre-existing condition, nor do they consider that the gastroscopy he underwent on the same day was for reasons relating to any pre-existing condition but instead they say that it was carried out as a result of *"NEW symptoms"* which resulted in new diagnoses.

The Complainants' health insurance policy, like all insurance policies, does 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, Section 2, 'Joining Us', of the applicable Health Insurance Rules – Terms and Conditions policy document that the Provider sent to the Complainants on 13 November 2015, provides*, inter alia*, at pg. 2:

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"c) ***If a customer has an accident after he/she is included, we will pay benefits for the treatment needed. However, for other treatment, we will pay benefits if it is carried out after the customer has been insured continuously for a minimum period of time, called a waiting period …***

Waiting periods and pre-existing conditions

Pre-existing conditions *… 5 years …*

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 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, as medical conditions may be present for some time before giving rise to signs or symptoms or being diagnosed.

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

Section 12 'Glossary', of this policy document provides, *inter alia*, at pg. 21, the following definitions:

*"**Waiting Periods***

The following definitions apply to waiting periods:

Waiting Period

A period during which we will not pay benefits for the customer until the customer has been insured continuously for a minimum period of time as set out in Section 2(c) …

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 the Complainants were new to private health insurance in Ireland when they incepted their health insurance policy with the Provider on 15 November 2015, I am satisfied that in accordance with the terms and conditions of their policy, a waiting period of 5 years applies before they can claim benefit in respect of any treatment relating to a "*pre-existing condition"* within the meaning of the policy.

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I note that a Provider Agent telephoned the Second Complainant after the Complainants had enquired online for a health insurance quote with the Provider. Having listened to a recording of this telephone call, I note that the following exchange took place:

Agent: *So, when you join health insurance there's a 5 year wait for pre-existing conditions, which hopefully you don't have, and there's a 6 month wait for new conditions, but from the start date of the policy if you had an accident or an emergency, the plan would cover you straight away.*

Second Complainant: *Ok, so if something happened to my husband where he had, em, an asthma attack, that's not covered there, you're saying?*

Agent: *If it's anything to do with a pre-existing condition, so, essentially, like I mean, when it comes to a pre-existing condition, or any claim for that matter, every claim is based on the medical information assessed at the time of the claim, so if it is a pre-existing condition it is going to be 5 years – now unfortunately that's not a rule, a* [Provider] *rule, It's an industry rule, its set down by the Health Insurance Authority of Ireland –*

Second Complainant: *Oh, but this doesn't make sense to me at all, em, because – so, if he had to go to the hospital because he had an asthma attack, he wouldn't be covered? That's what you're saying to me?*

Agent: *If he has asthma and he has an asthma attack, yes? No, the plan wouldn't cover him because it's a pre-existing condition …*

Second Complainant: *Are you sure about that now?*

Agent: *I'm certain. I'm certain. If you have a pre-existing condition it's not covered for 5 years. It's not a rule set down by* [the Provider]*, it's an industry rule set down by the Health Insurance Authority of Ireland. It's just that if that wasn't there, there wouldn't be an insurance company because people would then just take it out when they were sick, em, you know".*

In addition, I note that the Second Complainant, following this telephone call and having received a written quotation from the Provider for health insurance cover, telephoned the Provider to discuss the policy cover further. Having listened to a recording of this telephone call, I note the following exchange:

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Agent: *"Because, I suppose, you're new to health insurance there are certain waiting periods that you need to serve on joining, em, so those waiting periods, it takes 6 months for a new condition and 5 years for a pre-existing condition before you'd be covered -*

Second Complainant: *Wow*

Agent: *Yeah*

Second Complainant: *So what is a pre-existing condition then?*

Agent: *A pre-existing condition is something you have any signs or symptoms of an illness that's currently there at the moment before you take out the policy.*

Second Complainant: *Ok. Before I take out the policy?*

Agent: *Exactly, yeah.*

Second Complainant: *So, if I'm, I'm healthy now and my husband is healthy now, there's no pre-existing conditions?*

Agent: *Yeah…so basically we don't determine if its pre-existing, its your team of doctors and consultants that deem something pre-existing, so, we assess it most of the time if you make a claim on the policy, all of the information that's sent in from your medical team, that says something is pre-existing, they could say yes there is something there that you were unaware of and its just coming out now, it could be deemed pre-existing but it would depend, I suppose, on the information we receive at the time of the claim being submitted.*

Second Complainant: *So that could be anything?*

Agent: *It could be anything, yeah.*

The Second Complainant then stated that she wanted to proceed with the cover offered.

I am thus satisfied that the Provider clearly explained the waiting periods and pre-existing condition rules to the Second Complainant prior to the Complainants incepting health insurance cover with the Provider and that the Second Complainant indicated during both telephone calls that she understood these rules. In addition, I am further satisfied that these rules were clearly set out in the Health Insurance Rules – Terms and Conditions policy document that the Provider sent to the Complainants on 13 November 2015, as cited above. This document was then available to the Complainants if they wished to further familiarise themselves with the terms and conditions of their policy.

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Furthermore, I note that the Second Complainant telephoned the Provider on 22 May 2017 to query cover for the First Complainant for his impending colonoscopy and gastroscopy and she provided the Agent with the procedure codes for these. Having listened to a recording of this telephone call, I note the following exchange:

Agent: *All our claims are based on the medical information that we receive and the terms and conditions of your policy, ok? …*

Now he did take out the policy with us in 2015, ok? The 15th of the 11th. Now, he does have a five year wait if it's a pre-existing condition, so if the illness was there before he took out the policy unfortunately there is no cover".

The Second Complainant then asked to speak to a nurse in order to ascertain if benefit would be available for the First Complainant's impending colonoscopy and gastroscopy procedures, but the Agent referred the Second Complainant to the First Complainant's GP or Consultant as they would have the information to hand to determine whether the pending procedures were in relation to a pre-existing medical condition; the agent advised that such information would not be known to the Provider until it received the claim papers from the First Complainant's GP or Consultant.

In this regard, in her email to this Office dated 10 September 2018, the Second Complainant submits, as follows:

"During the telephone conversation with [the Agent] *of* [the Provider] *who states "I am not medically trained", I asked to speak to a nurse and was not given the opportunity. I was told by* [the Agent] *also that the only way I could find out if there was a pre-existing condition was after the procedure is completed which is too late. This information should be released to the patient before the procedures. Otherwise informed consent is not available to the patient".*

I am satisfied however that typically a health insurer will not be in a position to advise any policyholder in advance, whether treatment to be undergone is for a pre-existing condition. Such a decision can only be made by the insurer when it receives the claim papers and medical history from the policyholder's treating doctors. In this regard, I am satisfied that in this instance the Agent advised the Second Complainant to refer to the First Complainant's GP or Consultant to ascertain whether his impending procedures were in relation to a pre-existing medical condition, given that such information would not be known by the Provider at that time.

With regard to the colonoscopy that the First Complainant underwent on 2 June 2017, the Second Complainant states in her email to this Office dated 3 July 2018, as follows:

"My husband was diagnosed with polyps 5 years ago (precancerous). The colonoscopy showed no polyps this time. If polyps were still there and had to be

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removed then yes I would agree to paying for the colonoscopy as this would be a pre existing condition …but it was not".

I note from the documentary evidence before me that the Consultation Notes from the First Complainant's GP, Dr X. details, as follows:

"09/02/2017 … Past history colon polys"

In addition, I note that the First Complainant's GP, Dr X. advised in correspondence dated 6 November 2017, as follows:

"[The First Complainant] *registered with our practice in November 2015 …*

He attended myself on 9th February 2017.
I referred him for…colonoscopy as…

2. *He told me he had a past history of colon polyps – and this requires follow up colonoscopy every 3-5 years".*

Furthermore, Section 3, 'History of Illness – for completion by the Policy Holder/Member', of the Hospital Claim Form, provides:

"3.5 Has this patient had this or a similar illness before? Yes ☒No ☐

3.6 If Yes, please give date and details: Date: 02 06 13

Details: 4 years ago in America colonoscopy

I note that the First Complainant signed this Hospital Claim Form on 2 June 2017.

I am thus satisfied from the documentary evidence before me that the First Complainant had a past history of polyps prior to incepting his health insurance cover with the Provider and that the colonoscopy he underwent on 2 June 2017 was in relation to this pre-existing condition. As a result, I am also satisfied that in accordance with the terms and conditions of the Complainants' health insurance policy, a waiting period of 5 years from the date of the policy inception, applies before the First Complainant can claim benefit in respect of this pre-existing condition.

I note that in her email to this Office dated 10 September 2018, the Second Complainant submits, as follows:

"I would like to query why the director of claims would analyse that after a diagnostic procedure a clean bowel which has no polyps (thankfully) could possibly be classified as having a pre-existing condition. [The First Complainant's] *polyps were removed and, as proven by the colonoscopy he has no polyps".*

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In this regard, I accept the Provider's position that the First Complainant had a past history of polyps and that the reason for performing the colonoscopy on 2 June 2017 was surveillance and review. Although no polyps were found, this does not alter the fact that the colonoscopy itself was performed because the First Complainant had a previous diagnosis of polyps.

With regard to the gastroscopy that the First Complainant underwent on 2 June 2017, the Second Complainant states in her email to this Office dated 3 July 2018, as follows:

> *"My husband…never had gastritis or oesophitis diagnosed before. My husband was diagnosed with hiatal hernia and gastric reflux (heartburn) and was on a lot of meds and [the] doctor wanted to protect the lining of his stomach. This is why he was on PPI"*..

I note from the documentary evidence before me that the Consultation Notes from the First Complainant's GP, Dr X. detail, as follows:

> *"09/02/2017 acid reflux – past history of same – has increased his romep to 20 mgs bd – refer scopes – last endoscopy 10 years ago – advised stop ppi for 2 weeks before scope"*.

In addition, I note that the First Complainant's GP, Dr X. advises in correspondence dated 6 November 2017, as follows:

> "[The First Complainant] *registered with our practice in November 2015.*
> *He was already on omeprazole on joining us – and stated that he had a history of acid reflux.*
>
> *He attended myself on 9th February 2017.*
> *I referred him…for endoscopy…as*
> *1. He said that he had increased the dose of his omprezole and still had reflux"*.

I am satisfied therefore from the documentary evidence before me that the First Complainant had a past history of acid reflux prior to incepting his health insurance cover with the Provider. In addition, I consider it reasonable for the Provider to have concluded that this past history of acid reflux related directly to any new symptoms that the First Complainant was experiencing in 2017, and to the new diagnosis. Therefore, in my opinion, it was reasonable for the Provider to conclude that the gastroscopy the First Complainant underwent on 2 June 2017 was in relation to his pre-existing condition. As a result, I am satisfied that in accordance with the terms and conditions of the Complainants' health insurance policy, a waiting period of 5 years applies before the First Complainant can claim benefit in respect of this pre-existing condition.

In conclusion, I am satisfied that it was reasonable for the Company to conclude from the documentary evidence before it that both the colonoscopy and the gastroscopy that the First Complainant underwent on 2 June 2017 related to pre-existing conditions that predated the First Complainant incepting his health insurance cover with the Provider on 15

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November 2015. In addition, I am satisfied that the Complainants were provided with appropriate notice, both in writing and verbally, that any treatment relating to a pre-existing condition would not be eligible for benefit until after 5 years' continuous membership.

Accordingly, I do not consider it appropriate to uphold this 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
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

20 February 2019

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.**