Decision Ref:	2019-0228
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim – partial rejection
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the Provider's refusal to fully cover a claim made by the First Named Complainant on her health insurance policy in relation to surgery carried out on **23 September 2017**.

The Complainants' Case

The Complainants held a health insurance policy with the Provider since **1 February 2013**. The policy was part of a company group scheme entered into by the Second Named Complainant's employer. The health insurance policy for both of the Complainants were renewed annually since the date of inception.

In a letter of complaint dated **8 May 2018**, the First Named Complainant explains that on **23 September 2017** she underwent a procedure called a cross facial nerve graft. This surgery was undertaken in order to try and mitigate a serious brain tumour located in the First Named Complainant's cerebellum. The procedure took approximately 6 hours and was performed by two surgeons, two nurses and an anaesthetist in a hospital in Madrid, Spain.

Prior to the procedure occurring, a pre-approval request for treatment overseas was made to the Provider on **12 September 2017** and this was approved by the Provider by way of letter dated **21 September 2017**. In that letter, the Provider advised that cover for the procedure overseas had been authorised and details of the treatment and costs authorised

by the Provider were outlined in the letter. The letter advised of a maximum contribution of €2,229 for the procedure based on one night spent in the hospital (on the basis that the hospital was private). This figure of €2,229 comprised hospital fees of €1,155.54, consultant fees of €773.00, anaesthetist fees of €283.00 and pathology fees of €17.00.
The Complainants state that the actual cost of the surgery which was carried out in Madrid, Spain was €13,120 comprising hospital fees of €802.80, consultant fees of €9,000, anaesthetist fees of €900, operating theatre fees of €1,411 and fees for medicine of €1,007. The Second Named Complainant queried the authorised cost with the Provider immediately once the letter stating the maximum contribution approved was received on **21 September 2017**. The Second Named Complainant followed this up with a letter and an email dated **9 November 2017** again querying the cost approved for the surgery by the Provider. The Second Named Complainant particularly draws attention to the Provider's calculation of the hospital rates on the basis that the surgery would be carried out in a hospital in [First location in Ireland]. The Second Named Complainant has furnished documentation from the main consultant plastic surgeon in that hospital in [First location in Ireland] which states that she does not do a lot of the type of surgery the First Named Complainant underwent and the two surgeons in Ireland who carry out that surgery are based in two different hospitals in [Second location in Ireland]. The Complainants further assert that after discussion with the consultant plastic surgeon in one of the [Second location in Ireland] hospitals in relation to this surgery, he confirmed to the Complainants that the procedure undertaken by the First Named Complainant in Spain would cost over €10,000 if it was conducted in Ireland. Furthermore, the Complainants state that they have contacted the facial palsy organisation in the United Kingdom which has confirmed that the cost of the procedure in the United Kingdom would be between £4,000 and £11,000 depending on the condition of the patient.

On **21 December 2017**, the Provider's claims support team advised the Complainant that it would cover for one extra night's stay in the hospital in Spain. This would increase the total contribution by the Provider for the First Named Complainant's surgery to €3,459.00. The Provider also confirmed that after reviewing the costs provided regarding the procedure in Spain it was unable to make an additional contribution to those costs. The email specifically points to the costs of €2,418 for the operating theatre and medicines which the representative for the Provider states are costs included in the rates paid by the Provider to both public and private hospitals in Ireland and are costs which it is therefore not able to make any additional contribution towards the costs of the consultant and the anaesthetist, as it has an agreed rate with these individuals in Ireland.

On **8 March 2018**, the Provider reviewed the Complainants' file and confirmed that it was unable to alter its decision and its contribution for the First Named Complainant's procedure remained at €3,459.00.

On **2 April 2018**, the First Named Complainant wrote to the Provider again, asserting that the Provider had calculated the contribution based on the wrong numbers. Following this email and a subsequent review of the contribution amount, the Provider emailed the First Named Complainant on **12 April 2018** stating that it had agreed to increase the contribution amount to allow for 3 nights stay in hospital instead of 2 nights stay. The Provider further stated that it had based the contribution on the hospital costs of the hospital in the [First

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location in Ireland] as this is the highest rate it had available in all its hospital contracts. This resulted in the contribution from the Provider being increased to €4,689.62. This sum was transferred to the bank account of the Second Named Complainant by the Provider on **9 September 2018**.
The Complainants' policy was cancelled on **3 August 2018** by the Second Named Complainant's employer.

Ultimately, the Complainants want the full amount of the Spanish consultant fees (€9,000) to be covered by the Provider. The Complainants state that the €770 the Provider has covered for consultant fees is eleven times less than the actual cost in any other county and furthermore, it has placed a tremendous financial pressure on their family.

The Provider's Case

The Provider states that the wording of the policy and benefit is both clear and unambiguous. In particular, the Provider states that the elective overseas referrals section of the handbook clarifies:

- That the benefit covers some of the cost of having a procedure overseas;
- The requirement to seek pre-authorisation;
- That members will be liable for the difference between the amount charged overseas and the amount authorised by [the Provider]
- That members are required to pay the overseas hospital and claim back the pre-authorised reimbursement amount;
- That members must be referred for surgery abroad by a participating consultant in Ireland;
- How the pre-authorised amount is calculated;
- That pre-authorisation can take up to 15 working days;
- That the decision of the Provider's medical advisers is final.

The Provider states that the payment to the First Named Complainant was made in line with the terms & conditions of the policy, even though the First Named Complainant had not been referred by a participating consultant in Ireland and the pre-authorised amount was re-assessed on two separate occasions following the surgery.

The Provider points to the fact that it agreed to compensate the First Named Complainant for a stay of three nights at the hospital in Spain, despite the fact that she was only admitted for two nights.

The Provider confirms that its medical director made the decision on the re-imbursement amount using the agreed rates with Irish hospitals, consultants and anaesthetists, combined with the information that was provided and his own knowledge of the procedure undergone.

In relation to the consultant fees, the Provider confirms that a standard rate consultant would have received an amount of €773 from the Provider for the procedure undergone.

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The Provider explains that those who chose to register as standard rate consultants reserve the right to accept partial payment from the Provider and then to bill the patient directly for the balance of the professional fees incurred. The Provider further confirms that, despite the fact that the Spanish hospital saw fit to utilise two consultants for the surgery, the procedure undergone is not one for which the Schedule of Benefits in the Complainants' policy, allows payment of a second consultant.

In relation to the selection of the hospital in [First location in Ireland] for the hospital per-night rates, the Provider states that the per-night rates do not vary based on the type of treatment a member is receiving. The Provider clarifies that these rates are negotiated individually with each hospital and include the cost of the bed for the night, meals provided, any drugs administered, any disposables used during the surgery, the use of the surgical theatre and the cost of the nursing staff. The Provider confirms that the highest per-night agreed rate that the Provider had with any private hospital in Ireland at the time of the First Named Complainant's surgery was €1,155.54 per night and this is the amount that was allowed for the First Named Complainant's claim.

The Complaint for Adjudication

The complaint for adjudication in this instance is that the Provider incorrectly declined to cover the full cost of the surgical procedure undertaken by the First Named Complainant in Spain, in September 2017.

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.

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 10 June 2019, 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

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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, within the period permitted, the final determination of this office is set out below.

I have carefully considered the terms & conditions of the Complainants' policy that are applicable to the assessment and payment of the claim in question. In relation to elective overseas referrals, pg 18, clause 2.5 of the policy is clear that:

> *"Elective Overseas Referral benefits cover some of the cost of having a surgical procedure performed abroad…Please note that you will only be covered up to the amount pre-authorised by us. Your overseas medical facility and healthcare providers may charge more than this amount. If they do, you will be responsible for paying the balance."*

[My emphasis]

In relation to hospital costs, the policy confirms that:

> *"We will cover your hospital costs in a medical facility abroad up to the amount that would be covered under your Inpatient Benefits if you were to be admitted to a medical facility in Ireland to have the surgical procedure performed. Our medical advisors will base their assessment on the hospital costs that would be covered in the medical facility in Ireland, which, in their opinion, would have been most suitable for you."*

The policy also addresses overseas consultants' fees stating that: *"Consultants practising overseas are treated as standard rate consultants"* and page 9, clause 2.2 of the policy, clarifies that:

> *"standard rate consultant have not agreed to accept payment from us in full settlement of their fees. Only a small portion of the fees of standard rate consultants will be covered for performing the procedures and treatments in the Schedule of Benefits. Therefore, if your consultant is a standard rate consultant you will have to pay a large portion of their fees yourself. You will not be able to claim this back from us.*

Clause 2.5 of the policy also states that *"our medical advisers will decide hospital costs and the consultant's fees that would have been covered if you were admitted to a medical facility in Ireland to undergo the surgical procedure you wish to receive abroad."*

Taking all of the above into account, I am satisfied that the policy documentation alerted the Complainants to the fact that should the First Named Complainant elect to have surgery overseas, the First Named Complainant would only be covered in the amount pre-authorised by the Provider and that not all the costs of the overseas surgery may be covered. The pre-authorised amount was clearly communicated to the First Named Complainant in

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the letter sent by the Provider to the First Named Complainant on **21 September 2017**. Despite the fact that it was not obliged to do so, the Provider increased this pre-authorised amount, post the surgery, and as this was ultimately to the benefit of the Complainants, I can not find fault with the Provider for doing so.
I also note that the Provider was acting in the best interests of the Complainants by authorising the First Named Complainant for hospital costs at the level of the hospital in [First location in Ireland], despite the fact that the documentation provided by the Complainants establishes that in reality the procedure in question would not, in all likelihood, have been carried out there. I note that this enabled the Provider to grant authorisation for hospital costs at a higher level than it would otherwise have been able to grant.

With regard to the apparent disconnect between the consultant fees actually charged by the Spanish Hospital and the consultant fees authorised by the Provider, I accept that the Provider authorised the appropriate level of consultant fees. The procedure in question was not one which was recognised in Ireland as requiring two consultants, and the policy terms made it clear to the Complainants that overseas consultants would be treated as standard rate consultants for the purpose of covering fees. The policy also made it clear that this would result in a large portion of the overseas consultant fees, being a cost for the Complainants themselves to discharge.

In light of the above, I accept that the Provider was entitled to cover the claim only to the extent which it did. I further accept that the letter of **21 September 2017**, sent by the Provider to the First Named Complainant clearly set out the pre-authorised amount of cover for the procedure, which was carried out in Spain.

Accordingly, while I understand the loss and frustration the Complainants feel, I must accept that the Provider was entitled, under the terms and conditions of the Policy, to refuse to compensate the First Named Complainant for the full value of the Spanish consultants' fees and accordingly, on the basis of the contractual relationship which was in place as between the Complainants and the Provider, I do not believe that it would be 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

3 July 2019

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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.