An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0348
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues 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 is a child and her complaint is brought by her mother as her representative. The Complainant's representative contends that the Provider has acted wrongfully and/or unreasonably in refusing to admit a claim which she submitted to it, in respect of cardiac treatment which the Complainant underwent between 31 March and 06 April 2017. The Provider's position is that cover was declined on the basis that the Complainant's treatment was in respect of a previously existing condition, which was subject to a waiting period, not fully served.

The Complainant's Case

The Complainant's Representative incepted a policy of health insurance in respect of herself and the Complainant (plans -713 and -711 respectively) with the Provider on **18 August 2016**. She submits that when she took out these plans, she did so in good faith and that she answered all of the Provider's questions honestly. She submits that she fully disclosed all of her own pre-existing conditions and advised that at the time the Complainant was 3 years old, with no prior medical history.

The Complainant's Representative asserts that on **16 December 2016,** the Complainant was 3.5yrs of age and non-symptomatic when she brought her to the GP, because of a persistent cough, "*which to my horror resulted in open heart surgery".*

The Complainant's representative submits that the Complainant was seen by a specialist Cardiologist, on **22 December 2016** and he performed an echocardiogram which showed moderate right ventricular volume overload with dilated pulmonary arteries. This was diagnosed as being due to a sinus venosus atrial septal defect with partial anomalous pulmonary venous drainage.

On **31 January 2017** a transoesophageal echocardiogram was carried out on the Complainant, prior to her undergoing surgery on **31 March 2017**.

The Complainant's representative submitted a claim for the cost of the foregoing treatment, under her policy of insurance but the Provider informed her that the treatment she was claiming for was not eligible for benefits on the basis that the Complainant's illness was a pre-existing condition.

The Complainant's representative disagrees with the Provider's assessment of the situation and submits that she received supporting documentation from her GP and treating medical professionals which confirmed that the Complainant had never previously been diagnosed or treated for any medical conditions which were present prior to the inception of the policy with the Provider on **18 August 2016.**

The Complainant's representative submits that that she took out her daughter's policy with the Provider in good faith, and with "*100% honesty*". When entering into the policy she answered all questions truthfully and took out the policy in good faith, understanding that the Provider she had chosen would act accordingly should she require its assistance.

The Complainant's representative submits that she wishes the Provider to provide cover in respect of the Complainant's condition, as outlined in the table of benefits regarding cardiac care and for her claim to be approved. She states that she does not want the Complainant to have to wait for the 5 year waiting period to expire, in order to be eligible for cardiac care.

<u>The Provider's Case</u>

The Provider submits that the Complainant's sinus venosus atrial septal defect is a congenital defect and consequently, it has been present since her birth. It therefore pre-exists the Complainant's membership and was, accordingly, subject to the waiting period for pre-existing conditions.

The Provider submits that under the Policy terms and conditions, it is stated that:

> *'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*

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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.

Section 12 of its Terms and Conditions defines a Pre-existing condition as:

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'.

It submits that a "*sign*" of the Complainant's condition was present in the 6 months prior to the Complainant joining the Provider and that in accordance with rule 2c of the Terms and Conditions of Membership, any claims relating to this period are not eligible for benefit until the waiting period for pre-existing conditions expires on **18 August 2021**.

The Provider states that the waiting periods are set out in the terms and conditions governing the Complainant's policy. The waiting period for pre-existing conditions is 5 years.

The Provider contends that, *'[t]he pre-existing rule applies to all members regardless of the medical condition, including congenital conditions. In this regard, we do [not] believe that we are being unreasonable, unjust, oppressive or improperly discriminatory in our application to the complaint'.*

The Complaint for Adjudication

The Complainant's complaint is that the Provider has wrongfully and/or unreasonably declined the Complainant's claim under her policy of insurance.

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

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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 18 September 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 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.

The Complainant was diagnosed with a heart murmur by her GP on **16 December 2016**. On **22 December 2016** she was diagnosed with sinus venous atrial septal defect (ASD) following an Echocardiography. She was admitted to hospital from **31 March 2017** to **06 April 2017**, when she underwent surgery involving the closure of her atrial septal defect.

The Complainant's representative submitted a claim form to the Provider in respect of the cost of the Complainant's treatment, in **April 2017**.

By letter dated **22 May 2017** the Provider wrote to the Complainant's Representative, declining the Complainant's claim, as follows:

> *Thank you for the claim for the above patient's treatment at [Named] Hospital from 31 March 2017 to 06 April 2017.*
>
> *This claim has been assessed under the Rules – Terms and Conditions of the policy and unfortunately, this treatment is not eligible for benefit because:*
> - *Medical Conditions that were present before joining [the Provider] are not covered until a waiting period of 5 years has passed. For more details see Rule 2(c) in the Rules – Terms and Conditions of your policy.*
> - *The condition that was treated was present before the patient applied to join [the Provider] on 18 August 2016.*

The Complainant's representative disagrees with the Provider's assessment of the situation and has submitted, on that:

> *"I have been with the same GP practice for over 30 yrs. [the Complainant] had no evident symptoms relating to her illness, she presented to Dr. [Name redacted] with a persistent cough. [The Complainant's] diagnosis was never detected by any medical clinician from birth until seeing Dr. [Name redacted] on 16 December 2016, aged 3.5 yrs old."*

The Complainant's Representative points to a letter from the Complainant's Consultant Paediatric Cardiologist of **10 March 2017**, in which he states "*Although the defect is certainly congenital, it would not represent pre-existing condition as it was undetected prior to that. I*

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have come across this in situations before with insurers who try to deny coverage on the basis of a pre-existing condition. This clearly isn't correct".

The Complainant's representative has submitted a further letter from the treating Consultant, dated **13 July 2017**, in which he stated, "*As is common with atrial septal defect, signs and symptoms may not be noticed for many years and this would explain why [the named Complainant] has no signs or symptoms consistent with a sinus venosus atrial septal defect prior to joining [Redacted] on the 18 August 2016*".

In support of its determination that the Complainant's condition fell within the definition of a "pre-existing condition" the Provider has submitted the following notes of its Medical Officers. The first dated **16 February 2017**, states:

> *'…The diagnosis after examination was sinus venous atrial septal defect. This is a congenital condition and therefore being present from birth, would have been present at the time the member joined [the Provider] which was only 3 months prior to the actual date of investigation. I note the letter from the member's mother and the letter from the GP which states this was only diagnosed on 22/12/2016. However, in [the Provider] rules terms and conditions section 2 relating to joining us it is detailed in bold writing 'when determining when a 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 pre-existing condition existed rather that the date upon which the customer became 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 pre-existing will be determined by the opinion of our medical director'. Therefore this member would not have developed a murmur in the intervening period of time between August and December. While I accept this may not have been noticed until this time the murmur was present prior to August and therefore the condition pre-exists the membership of [the Provider]."*

A further note of one of the Provider's Assistant Medical Officer, dated **22 June 2017** states:

> *This member joined [the Provider] on 18/8/16 with a five year waiting period for pre-existing conditions. There is no 26 week waiting period. Subsequent to this the member was diagnosed with a sinus venous atrial septal defect on 22/12. This was following attendance with the GP on 16/12 when a murmur was noticed. We have a letter from [Cardiologist] which states "although the defect is certainly congenital it would not represent pre-existing condition as it was undetected prior to that". It should be clarified that in accordance with [the Provider's] rules terms and conditions Section 2 "when determining whether a medical condition is pre-existing it is important to note that what is considered 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." Therefore we should clearly clarify that it is not the date of diagnosis that is important but whether signs or symptoms consistent with a venous atrial septal defect were present (detected or not) at the time the member joined [the Provider]…"*

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The Medical Officer's Decision of **09 August 2017** stated as follows:

This member was born on 22/7/13 and joined [the Provider] on 18/8/16 with a five year waiting period for pre-existing conditions. She was diagnosed with atrial septal defect which is a congenital abnormality. While the diagnosis was only made following joining [the Provider] the condition being congenital pre-existed the membership and is not eligible for benefit in accordance with [the Provider's] rules.

In determining this complaint, it is necessary to have regard to the Policy terms and conditions governing the Complainant's policy.

Policy Terms and Conditions

I note that under the policy of insurance, which was taken out to provide cover to the Complainant, sets out certain waiting periods which apply.

Within the terms and conditions, Section c) Rule 2, "Joining Us", states:

> ***'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..'***

[original emphasis]

The waiting period for pre-existing conditions is set out as being 5 years.

The section further states that:

> ***'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.***
>
> *[original emphasis]*

Section 12 of the Provider's Terms and Conditions (Glossary) makes it clear that a Pre-existing condition is defined as:

> *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'.*

I accept that what is of relevance therefore in determining whether a condition is considered to be pre-existing under the policy of insurance, is whether *signs or symptoms* *existed* during the six month period prior to the inception of the policy.

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The Provider, upon being asked by this Office to clarify the basis for its position that there was a "sign" of Sinus Venous Atrial Septal defect present in the 6 months prior to joining, responded that:

> *"A sign of a medical condition is any objective evidence of disease (in this case the defect in the atrial wall is the objective evidence). It can be present but the patient may not be aware of it and can be objectively detected on clinical examination or by means of investigations such as radiology and pathology tests.*
> *The diagnosis of ASD is confirmed by echocardiography which shows the defect in the atrium (a sign of the condition) and also establishes that specific type of ASD, the size of the defect and detects other cardiac anomalies, if present.*
>
> *In this case the complainant had a persistent cough and was identified as having a murmur on clinical examination. Further investigation as required and an echocardiogram, the definitive diagnostic investigation, was performed as a result of which the defect was identified including the location of the defect and confirmed the diagnosis of a sinus venosus atrial septal defect. The defect being a sign of the condition, was present from birth and therefore present in the 6 months prior to joining [the Provider]. In addition, although undetected, it would have been detected had an echocardiogram been performed in the 6 months prior to joining.*
>
> *Therefore the sign of the condition (being the defect in the atrial wall) was present from birth, in the entire period prior to joining [the Provider] and after joining until the surgery that was performed to correct it."*

The Complainant's Representative responded to this by submitting as follows:

> *"the Complainant had zero signs/symptoms and she received zero clinical invention until the 16 December 2016. A sign is also a symptom, if she was non-symptomatic then what are the signs that [the Provider] are alluding to?... if my daughter was ill 6 months prior to joining [the Provider] she would have been reviewed by a clinical physician. An echocardiogram cannot be sought without a referral to a Consultant Cardiologist, self-diagnosis and preconceiving the future is not an option. Also, how can treatment prevail when there are no symptoms to present with or seek advice for?"*

Having considered the above submissions, I would note that the term "pre-existing" has a very specific meaning under the policy of insurance and does not depend on the date of awareness of the condition or the date upon which the condition is diagnosed. With regard to the Complainant's representative's submission that, "*if my daughter was ill 6 months prior to joining [the Provider] she would have been reviewed by a clinical physician*" – I accept that, insofar as the Complainant was suffering from a defect in her atrial septum, she was indeed ill, even though this was not known to her mother or to the medical professionals at the time. Although this was not detected until after she became a member with the Provider, her condition nonetheless falls within the definition of a pre-existing condition under the policy.

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Although the Complainant has submitted that a "*sign is also a symptom"*, the Policy wording refers to *"signs or symptoms".* I am satisfied that the use of the word "*or*" in the definition indicates a linking of alternatives rather than "*sign*" and "*symptom*", being synonymous or interchangeable terms. I accept that in the Complainant's situation, the hole which was present in her atrial wall since her birth comprised a sign of a condition, but which remained undetected until December 2016. However, in circumstances where the sign was present in the 6 months prior to her joining the Provider, this nonetheless fulfils the definition of a pre-existing condition.

I accept that the Complainant's representative acted in good faith and with complete honesty at all times. It is not the case that she failed to disclose any information of which she was aware, to the Provider at the time that the Policy was incepted. However, the decision of the Provider to decline cover in respect the Complainant's treatment does not arise because of any such failure to disclose but, rather, it is based on the definition of a pre-existing condition, within the policy terms and conditions, and the fact that pre-existing conditions are subject to a 5 year waiting period. In this instance, the Complainant did not hold medical cover under the policy for a period of 5 years, before she required treatment for the condition.

I appreciate that it will be disappointing to the Complainant's representative, however, having had regard to all of the evidence made available to me, I am satisfied that the Provider did not act wrongfully or unreasonably in determining that the Complainant's condition was pre-existing in the context of the policy cover and that it was entitled to decline the Complainant's claim, in the circumstances. Accordingly, I do not find that there are any grounds upon which it would be appropriate to uphold the Complainant's complaint.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint 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

10 October 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.