An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0387
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues Complaint handling (Consumer Protection Code)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the Complainant's health insurance policy with the Provider.

The Complainant's Case

The Complainant submitted a claim to the Provider for his hospital treatment between the dates **19 December 2016** to **21 December 2016**. The Complainant asserts that he was not advised of any difficulty regarding his claim until **26 July 2017** when he was informed that the claim was declined. Specifically, the Complainant contends that he was not advised of any difficulties in securing supporting information and documentation from his treating doctor. The claim was eventually accepted and paid in **February 2018**.

Prior to the acceptance of the claim, the Complainant states that he was receiving notification of an overdue account from the hospital in respect of the unpaid hospital bill, including a final notice dated **20 September 2017**. The Complainant submits that this caused him embarrassment and distress not least because his neighbour became aware of the issue.

The Complainant asserts that he was not advised by the Provider as to any failure on the part of his doctor to provide necessary information and documentation, and that he only became aware of an issue with his claim on 26 July 2017. The Complainant submits that the Provider has no regard for its "*obligations for fairness, openness, honesty and transparency*

in its dealing with" him. The Complainant also asserts that the Provider failed to provide him with a satisfactory level of customer service when he contacted it regarding his claim and subsequent complaint. In this regard, the Complainant identifies, in particular, phone calls of **3** and **14 August 2017**.

In his complaint form, the Complainant seeks a full investigation and that the Provider "*fully account for the incompetence, stress and disruption*" caused. The Complainant also sought compensation to be determined by this office.

In subsequent correspondence to this office of 12 September 2018, the Complainant identified the figure of €10,000 as being "*warranted as an objective measure of the loss suffered*". The figure was stated to represent fair compensation for "*stress, medical expense, and the unbearable disruption*" caused as well as providing "*restitution for the incompetence and failure to deal with our claim in an open, honest and professional way*". Reference is also made to part-indemnification for the "*public humiliation, reputational damage and potential loss of trust in the good name of our family caused by the* [Provider's] *ineptitude, recklessness and poor management decisions*"

The Provider's Case

The Provider maintains that it issued correspondence to the Complainant and to his doctor on **25 January 2017** to advise that additional material was required from the doctor. The Provider also contends that it sent a reminder letters to both the Complainant and his doctor on **24 February 2017** and that it sent a letter to the Complainant on **28 March 2017** indicating that it was closing its file due to the failure to provide the necessary information.

On **2 February 2018**, the Provider subsequently reassessed and paid the Complainant's claim in full, upon finally receiving the further information which it had requested from the hospital consultant.

With regard to the phone call of 3 August 2017, the Provider disputes the Complainant's account and maintains that the individual "*made every effort to offer assistance*". With regard to the phone call of 14 August 2017, the Provider accepts that it should have addressed the concerns of the Complainant without unnecessary delay and should have offered clear and concise information to resolve the claims issue.

The Provider has also referred to the quality of some of its communications which it believes did not meet its usual high standards, and has therefore offered the Complainant a customer service payment, referred to below.

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The Complaints for Adjudication

The first complaint is that the Provider dealt with the Complainant's claim in an unacceptable manner. The Complainant says in that regard that the Provider was reckless and negligent.

The second complaint is that the Provider dealt with the Complainant's complaint in an unacceptable manner.

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 10 July 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below. In that respect, the Complainant made an initial submission on 31 July 2019 and followed this with a comprehensive submission on 7 October 2019 (with a corrected copy on 16 October 2019, to amend some small typographical errors) which the Provider responded to with a limited submission on 17 October 2019. There have been additional communications from both parties, with this Office since that time, but these are not referable to the merits of the complaint, and rather concern a data breach by the Provider, which is a matter for the Data Protection Commission, rather than for this office.

Prior to addressing the substance of the complaints, I consider it useful to set out a chronology of certain matters quoting certain relevant correspondence.

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Chronology of Events

December 2016	Complainant's hospital admission.
25 January 2017	Letter from Provider to Complainant notifying him that it had written to the consultant requesting further information and indicating that "*on receipt of*" same, the Provider "*will be in a position to proceed with the assessment of the claim*". The Complainant appears to accept that he received this letter. A letter was sent to the Complainant's Consultant on the same day.
24 February 2017	Letter from Provider to Complainant noting that it had "*not received a reply*" to its original letter "*requesting the necessary information to support*" the claim. The letter went on to state that "*until we receive this information we are unable to proceed with the assessment*" of the claim. The Complainant disputes receiving this letter, though I note that it bears the same postal address as the letter of 25 January 2017. A letter was sent to the Complainant's Consultant on the same day asking again for the relevant information.
28 March 2017	Letter from Provider to Complainant noting that as the Provider: "*had not received a response to our letter of 24 February 2017, we have no alternative but to close this file. However, if we receive the information initially requested, we will re-open the file and proceed with the assessment of your claim*." The Complainant disputes receiving this letter which again contains the same postal details as the letters of 25 January 2017 (which was received) and 24 February 2017 (which the Complainant says he did not receive).
26 June 2017	Letter from Complainant's Consultant providing some details but not all of the information and documentation originally sought in January 2017.
26 July 2017	Letter from Provider to Complainant noting that it had recently received correspondence from the Consultant and stating that "*the information has been reviewed and the claim is not eligible for benefit as the medical necessity for the admission has not been established*". The Complainant contends this was the "*first indication*" to him that there was

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	any issue with his claim (because of his non-receipt of the Provider's letters in February and March 2017).
3 August 2017	Phone call between the Complainant and a representative of the Provider (commented on in detail below).
14 August 2017	Phone call between the Complainant and the supervisor of the individual who spoke with the Complainant on 3 August 2017 (commented on in detail below).
18 August 2017	The Complainant's letter of complaint to the Provider regarding the phone calls and its suggested failure to advise him prior to 26 July 2017, of any issue with his claim.
26 September 2017	Provider's letter to the Complainant noting that it had written to the Consultant seeking information
5 October 2017	Provider's letter to the Complainant noting that the Provider had contacted the hospital's account department which "*will not send any further letters*". This letter also notes that no response had yet been received from the Consultant.
6 November 2017	Provider's letter to the Complainant noting that no response received from the Consultant and noting that a reminder had issued to the Consultant that day.
5 December 2017	Provider's letter to the Complainant confirming that a response had been received from the Consultant and indicating that the claim was under review.
15 December 2017	The Complainant's Consultant provides balance of material required to substantiate the claim.
08 January 2018	Provider's letter to the Complainant confirming that a response had been received from Consultant and further confirming that additional medical notes had been received and indicating that the claim was under review.
29 January 2018	Complainant's letter of complaint to Provider regarding the fact that he had received a further demand for payment from the hospital despite being assured, in the letter from the Provider of 5 October 2017, that this would not happen.
2 February 2018	Claim accepted and paid out in full to the hospital.
9 April 2018	Provider's Final Response Letter.

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Analysis

This complaint can be addressed in two parts. In the first instance, the Complainant complains about the way in which his claim was managed. Secondly, the Complainant takes issue with the manner in which he was dealt with in the course of complaining about the first issue.

First Complaint

The Complainant's first complaint *apropos* his insurance claim stems from his contention that he was not, prior to his receipt of the letter of 26 July 2017, informed that there was any difficulty regarding the processing of his claim. In the course of the phone call of 3 August 2017, the Complainant articulated his grievance in the following terms:

> "*What you've just told me, which your correspondence has never told me, is that you failed to receive correspondence from the consultant, thus, to process the claim. You haven't told me that. Sorry, you have never me told me that. You've told me that now. Excuse me your correspondence did not tell me that.*"

The Complainant denies having received both letters of 24 February 2017 and 28 March 2017 (which, as noted above, were correctly addressed). This explains how it arose that he was unaware over that period that the information necessary to support the claim had not been received. He was therefore surprised in July 2017, when the Provider wrote to advise that the claim was declined, and very annoyed that this was the first he was hearing of any problem with the claim.

Both the February and the March letters expressly noted that the claim could not be processed until the medical information was received, and the March letter noted that, as no such medical information had been provided, the file was being closed. I take the view in those circumstances that the Provider sought to communicate with the Complainant at regular intervals to ensure that he was kept updated. For reasons unknown, however, the Complainant did not receive the Provider's two letters sent to him in February and March 2017 respectively.

The claim was never formally declined, prior to 26 July 2017 however this occurred only on foot of the belated provision, in June 2017, of insufficient information by the Consultant. The failure to provide information prior to that point had quite reasonably given rise to the file being deferred and then closed, albeit subject to re-opening upon the provision of the requested material. The declinature of the claim was eventually revisited once adequate supporting documentation was finally fully provided in December 2017.

The parties' relationship is governed by the provisions of the "***Rules – Terms and Conditions***" which explain the limits of the contractual obligations in place. In particular, under the heading "***Exclusions***" I note the following:-

> *"In addition to cover limitations mentioned elsewhere, we will not pay benefits for any of the following:*

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a) Treatment which is not medically necessary treatment."

In addition, under the heading "***Claims***" the Provider makes it clear that:-

> *"h) In order to establish the eligibility and appropriateness of any claim, we may request access to and/or copies of your medical records including medical referral letters…"*

In those circumstances, having received the Complainant's claim, the Provider was entitled to assess the claim for benefits in order to confirm that the claim was payable. It is indeed clear that the Complainant understood this, and I note that he advised, during his first 'phone call with the provider on 3 August 2017, that he had an expectation that his claim would be paid "*subject to the terms and conditions of the policy*".

On the basis of the evidence before me, I can find no fault with the Provider in respect of the manner in which it dealt with the claim. The Provider sought to keep the Complainant updated with sufficient information to keep him informed about the status of his claim. In my opinion, the timeline on the part of his Consultant in providing *any* information, and subsequently in providing sufficient information to the Provider (which was eventually fully provided in December 2017) cannot be blamed on the Provider, which I note reviewed the claim promptly, once the full medical information was made available, giving rise to the admission and payment of the claim in February 2018. Indeed, I note that the Provider confirmed to the Complainant in its letter of 2 February 2018, that it had also contacted the hospital accounts department to advise that the claim had been paid. At that point, the Provider also confirmed that it would review the Complainant's comments regarding "*the handling of this claim and indeed the two phonecalls*".

As the full medical details which the Provider had sought did not become available from the Complainant's Consultant until December 2017, in those circumstances, I take the view that there is no reasonable basis, upon which it would appropriate to uphold the Complainant's first complaint.

<u>Second Complaint</u>

The Complainant's second complaint relates to the manner in which his complaint was dealt with, and centres largely on two phone calls which are referred to in his letter of 18 August 2017 to the Provider. The Complainant says that, in the course of a phone call of 3 August 2017, the Provider's staff member (identified by name) was

> "*rude, inexcusably combative and deliberative* [sic] *obtuse*".

In respect of a later phone conversation of 14 August 2017, the Complainant claims that a different staff member (again identified by name)

> "*seemed content to re-interrogate me and effectively defend the inexcusable behaviour of her colleague*".

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The Provider has furnished recordings of these calls as part of the evidence made available. With regard to the phone call of 3 August 2017, I note that for the first 6 -7 minutes, the discussion between the parties was quite cordial. Having listened to the audio evidence however, I disagree entirely with the Complainant's characterisation of the nature of this call. On the basis of the recording available, the Provider's staff member was neither rude nor combative, nor indeed was she in any way obtuse. In fact, in my opinion, this staff member was notably professional, and she was very helpful and informative.
She clearly indicated the nature of the supportive evidence, which would be required to support the claim, explaining that the tests undergone would normally be done on an out-patient basis, and she explained the rationale for the need for the evidence from the consultant, as it was he who had kept the Complainant in hospital for the 3 day period. In my opinion, it was the Complainant who then became 'combative' and indeed it was he who was rude (in describing this staff member as being "*awkward*" and of "*making things up*" as she went along and in stating that she had "*an ability to twist and weave and wangle*").

One can appreciate that the notification of the declinature of the claim in July 2017, was stressful for the Complainant, particularly as it seems that this came as shock to him, because he had not received the two earlier letters from the Provider. Nevertheless, it is clear from the audio evidence that this staff member was seeking to help him to understand what evidence he would need to secure, if available, in order to have the claim admitted for payment. The Complainant however continually interrupted her. The Complainant also, having firstly checked that the call was being recorded (at circa 13 minutes into the call) accused this staff member of being "*deliberately obtuse, awkward and unhelpful*" and then clarified immediately afterwards, that he is somebody who is "*precise with language*".

I believe that this description of the staff member by the Complainant, was not only inaccurate, but it was also gratuitously rude. Customers of the Provider are entitled to be dealt with in a courteous manner, but likewise staff members of the Provider are no less entitled to a fundamental level of courtesy from the Provider's customers. The words "*deliberately obtuse*" were repeated on multiple occasions by the Complainant both in this call, in the later call and in correspondence. This statement was entirely unwarranted and inaccurate, in circumstances where the Provider's staff member was simply trying to draw the Complainant's attention to the precise content of the correspondence, which had previously been issued to him (which it seems he did not receive).

In correspondence to this office of 14 February 2019, the Complainant states that he is "*truly aghast to assert that I believe the recordings have been edited and manipulated*". The Complainant contends that certain aspects of the original recording of 3 August 2017 were "*'cut' and re-recorded*" and he highlighted, in particular, what he described as certain acoustic "*anomalies*" at "*precisely 6 minutes and 15 seconds into the recording*". The Complainant requested that a forensic expert examine the recordings to confirm his suspicions.

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Since the Preliminary Decision issued to the parties, the Complainant has advised that his

> *"submission identified a telephone conversation of 3 August 2017 as having been edited "such that the voice extract from the Customer Care Representative's discourse on [the Provider]'s fiduciary responsibilities, referred to as "scripted gibberish" by me in subsequent correspondence, has been completely "edited out". I identified the locus of the "cut" to be precisely 6 minutes and 15 seconds into the recording and I asked that a forensic expert be appointed to verify my claim and I offered to contribute to the cost involved".*

Although I had already considered the audio evidence in detail, I have, since receiving the Complainant's more recent submissions, listened again intently to this same recording of the particular telephone call on 3 August 2017. A playback of this recording does not, in my opinion, give rise to any reasonable apprehension of tampering. Certainly, the disc is inclined to skip during the entirety of the recording, which gives rise to some phrases being repeated here and there, throughout. The content of the call at 6 minutes and 15 seconds in, involves discussions as to the medical information which might be available from the Complainant's doctor to support his claim for 3 days as an in-patient, even though the tests he underwent would normally be dealt with as an outpatient, and that content causes me no concerns about the authenticity of the audio evidence which has been quoted from, in this decision.

I have therefore not considered it necessary in those circumstances to involve a forensic expert to assess the recordings. I am also conscious that the Provider clarified on 1 March 2019 that "*an internal message at the start of the call was removed which lasted 2 seconds and was not relevant to the complaint at hand*". The FSPO did not consider it necessary to call upon the Provider to furnish the calls again, in a version including the first 2 seconds. The FSPO must consider the essence of the Complainant's grievance, taking account of his overall conversations with the two representatives. Having considered the evidence available, I am satisfied that the Complainant has not substantiated in any way, his suggestion that the Provider's representative dealt with him in an inappropriate manner, in the course of this telephone call.

I have also listened to a recording of the phone call of 14 August 2017 and again I entirely disagree with the Complainant's characterisation of this call. The Provider's representative expressed her apologies on multiple occasions for the manner in which the telephone call on 3 August, had developed (although I am of the firm opinion that these apologies were entirely unnecessary). Notwithstanding those apologies, the Complainant told her that she was "*putting [him] through the ringer again*" and he adopted a confrontational and condescending approach, based largely on his perception as to the nature of the earlier call which, in my view, was unwarranted and incorrect. He referred to the previous representative of the Provider as "*outrageously obtuse*" and then indicated that he was seeking a "*business like approach*" from the Provider.

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Whereas this staff member of the Provider could have been more specific when speaking with the Complainant, I do not accept that she engaged in any 're-interrogation' or that she sought to defend the indefensible. Indeed, in a later phone call, the Complainant comments in respect of this staff member (whom he states "*clearly wasn't terribly bright*") that

> "*that lady was perfectly fine apart from the fact that she didn't obviously understand what the meaning of 'obtuse' was, that surprised me*" … "*her performance wasn't great, but she was a very pleasant girl, far more pleasant and far more sincere than the other, than the first girl* [whose] *conduct was quite really gruff and rough and completely obtuse and difficult in her dealing with me*".

I do not accept this however and I am satisfied that both representatives of the Provider dealt with the Complainant in a most professional manner in the face of his continual discourtesy.

Since the Preliminary Decision issued regarding this element of the complaint, the Complainant has sought to rely upon the details of Chapter 10 of the Consumer Protection Code 2012, suggesting that the Provider has failed to comply with its obligations as imposed by its Regulator, although this was not the original focus of his complaint. I note in that respect that the letter of 25 August 2017 from the Provider acknowledging the Complainant's written complaint on 18 August 2015, does not also make reference to his verbal complaint in the course of the telephone call of 14 August 2017. The letter in question however clearly identifies the issues raised by the Complainant regarding the handling of his claim and also his experience with its Customer Services Agents on the two calls that he had identified.

I also note that the Provider's letter of 25 August 2017 identified the author by name, with a direct dial telephone number confirmed. In addition every letter sent to the Complainant thereafter in September, November and December 2017 and in January, and February, 2018, addressing both the claim assessment and the Complainant's separate complaint arising therefrom, also had a named individual as the author of the letter and a direct dial telephone number to make contact. The Complainant has referred to the Provider's regulatory obligation to provide a Complainant with the name of one or more individuals appointed to be the point of contact. I am conscious in this regard that all of those letters met this requirement and indeed, the Complainant had the same point of contact from September 2017 onwards.

I am nevertheless conscious that the Complainant is correct that the Provider should have acknowledged his verbal complaint within 5 working days. The Provider's letter of 25 August 2017 did not specifically reference the complainant's verbal complaint, 4 days before he wrote his letter of complaint, and that verbal complaint was not acknowledged in writing by 21 August 2017. Consequently, whilst the Provider largely adhered to its regulatory obligations, in dealing with the Complainant's complaint, it is clear that there were technical breaches of Chapter 10 of the CPC. I do not consider that such breaches in themselves constituted any significant shortfall in the level of service provided to the Complainant in the course of the processing or the examination of his complaint as he had outlined it, but they were breaches of the CPC nevertheless.

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The Complainant has indicated his belief that the adjudication of this complaint has been biased and indeed that it has sought to rely on "*inferences drawn on the facts, and or an incorrect understanding as to the existence of certain facts, which no reasonable decision maker could have drawn*". This is disappointing. The FSPO must assess the merits of every individual complaint, having regard to the parties' respective submissions and the evidence available, and come to an independent and impartial opinion, based on such evidence. This is what I have sought to do in considering the Complainant's complaints against the Provider, regarding the way in which the Provider dealt with his claim for benefit under the policy, and also the way in which it subsequently dealt with his complaint. It is also disappointing to note the Complainant's suggestion that the investigation of this complaint was "*gamed*" in such a way as to undermine and negate the purpose of this office.

Insofar as the Complainant complains about the system operated by hospitals with regard to the signing of forms on the point of admission, and the "*abuse of this system by hospitals*", this is not a matter which falls for consideration in the context of a complaint against the Provider. The Financial Services and Pensions Ombudsman has no jurisdiction over the actions or conduct of individual hospitals, as a hospital is not a regulated financial service provider.

Equally, insofar as the Complainant complains about the fact that he received a further bill from the hospital, after the Provider had assured him that none such would issue, I am not of the view that the Provider can be held responsible for this, in circumstances where it had made the appropriate request to the hospital, but the hospital had (for reasons unknown) failed to comply with that request.

Finally, I note that in its letter dated 17 January 2019 the Provider indicated that it regretted that the Complainant felt aggrieved in any way by its handling of his case. In particular it took the view that the letters issued by the Provider during the claim adjudication process could have been more customer focused in providing advice to the Complainant in relation to the details it required from his Consultant and as to its rationale for declining benefit. It also noted that its letter of 26 July 2017, omitted to include details of its internal appeals procedure.

In those circumstances, it indicated its intention to conduct a review of its letters, with a view to improving its customers' experience of its service. In recognition of these issues the Provider also advised that it wished to put on record an offer of *"€2,000 customer service award*" which it took the view was fair and reasonable in the circumstances. Assuming that this very generous customer service award remains open to the Complainant for acceptance, it will be a matter for him to liaise directly with the Provider, if he wishes to accept that gesture on the Provider's part.

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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 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

4 November 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.